# FTC/DOJ Hearings on Health Care and Competition Law and Policy

# Statement of the Federation of American Hospitals

# May 29, 2003

**Presented by:**

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**Hospitals: Quality and Consumer Information**
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On behalf of the Federation of American Hospitals (FAH), I am pleased to offer our views on the quality of hospital services and consumer information to improve consumer understanding of hospital care. FAH is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America. Our members believe in market-oriented health care, and believe that competition plays a valuable role in the provision of quality health care.

Our goal, over the course of these hearings, has been to assist the Federal Trade Commission (FTC) and the Antitrust Division of the Department of Justice (DOJ) to better understand how health markets work, as you consider the direction of future enforcement of antitrust laws to improve the health care marketplace. The Federation presented its views at two prior FTC/DOJ hearings on February 27 and April 10, 2003, and we appreciate the opportunity to do so today on this important topic.

At the outset, it is important to point out that the mission of FAH member companies is to provide high quality care to the patients we serve. We believe that it is the responsibility of hospitals to provide high quality care and safe environments, and that better-informed consumers will make better personal health care choices. So, we believe the hearing today provides a good opportunity for us to describe what hospitals are doing to enhance the quality of health care and the health care choices of the American consumer.

Background

FAH has taken an active role in advancing policy initiatives to improve the safety and quality of hospital care in this country, and to promote patient education regarding care. Our Board of Directors has adopted policy statements regarding principles for patient safety reporting systems; methods for reducing medication errors; requirements for creating effective quality measures; and most recently, the reporting of such measures.

Today's FTC hearing on quality and consumer information is timely. We are entering an important period in the evolution of the measurement and improvement of hospital quality as well as the potential for disseminating those measurements to third party payers and consumers. The growing energy and momentum surrounding health care consumerism has been fueled by the capacity of the Internet, making it possible to disseminate information about health care services and health broadly for the first time.

By all accounts, the American public wants more information about health care services. A public opinion survey conducted for FAH last fall found significant support for a website that evaluates hospitals about the treatment of certain diseases and new procedures. Almost half of survey respondents – 45 percent – said that this information either could be the most significant factor, or an important factor, in helping them decide which hospital to choose for care.

Current Quality Information is Fragmented and Confusing

From our point of view there are two primary objectives for the collection of information on hospital quality measures. First, and foremost, such information can serve as a critical tool for clinicians and hospitals to learn about their relative performance so that improvements in care can be made. And, second such information can enable consumers to make better health care decisions.

Unfortunately, despite the best of intentions, many of the varied hospital quality reporting efforts in place today are working at cross-purposes regarding these two objectives. These reporting efforts are creating expensive, burdensome and unpredictable requirements on hospitals. At the same time, the current mix of quality reporting approaches has produced incomplete, poorly analyzed, conflicting and even misleading information for clinicians, hospitals and consumers alike.

A growing number of states have or are considering hospital quality reporting programs. These include programs in New York, Pennsylvania and California regarding performance about coronary artery bypass graft (CABG) surgery mortality rates. Maryland and Texas have implemented state-wide hospital quality reporting programs that measure performance on a number of medical conditions.

In addition to the states, the private sector has launched several hospital quality and safety reporting initiatives. For the last two years, The Leapfrog Group, representing

several of the nation's largest employers, has advocated that employees consider hospital performance by using three safety indicators before selecting their choice for care.

This spring, PacifiCare, a managed care plan, announced the availability of public reports about individual hospital performance, across 56 quality measures, for 200 California hospitals. Also this spring, J.D. Power and Associates and Health Grades, Inc. joined forces to develop a tool to measure, and publicly recognize, superior quality hospitals based on service and clinical excellence.

All of these efforts are attempting to empower consumers with information to make them better decision makers about their care. However, they raise many questions regarding whether or how this consumerism model will actually work in health care.

As a first step, providers must have valid and standardized information on their quality performance to allow them to measure improvement and compare their improvement to other hospitals. Currently, there is no standardized information collected across all hospitals.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Quality Forum (NQF), the states, insurers and other payers, the business community, consumer organizations and commercial enterprises all are advocating reporting initiatives. However, many of these parties are proceeding on separate tracks. Clearly, we need a more rational and coordinated approach.

A second issue is understanding whether and how consumers will use information about hospital quality since patients generally do not choose their hospitals. Patients generally go to hospitals based on where their physicians have admitting privileges and where the hospital is located. None of the current hospital reporting programs has addressed whether, or how, information about hospital quality is used within the physician-patient relationship.

To begin to come to grips with these concerns, hospitals and regulators have developed "The Quality Initiative—A Public Resource on Hospital Performance." To meet the goal of creating a rational framework for providing evidence-based quality information for the purpose of improving hospital quality and informing consumers, hospitals, led by the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges, have initiated an effort to address our nation's currently fragmented and disjointed data collection and quality reporting efforts.

Working in conjunction with several public and private sector organizations, our purpose is to forge a shared national strategy for hospital quality measurement and public accountability. Together, we want to build a national uniform framework, available to all payers and the public that provides valid and useful quality data, improves hospital care, and provides the public with meaningful information.

The organizations began their collaborative work in mid-2002 with strong support from HHS Secretary Tommy Thompson and CMS Administrator Tom Scully.

In addition to the hospital groups, the initial partners in the collaborative effort included the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), JCAHO, and NQF. We announced the Quality Initiative in December 2002, and were joined by two consumer organizations, the AFL-CIO and AARP. Since then, a number of other organizations have joined the Quality Initiative.

Earlier this month, we sent to every hospital in the country a pledge package encouraging them to participate in the Quality Initiative. We asked hospitals to submit to CMS their performance with ten measures related to their treatment of cardiac illness and pneumonia. These ten measures were selected because they are supported by evidence showing their effectiveness, because frequently, hospitals already collect these data, and because these measures were agreed upon universally by quality experts, including the National Quality Forum.

These ten measures are just the first step in building a national, standardized hospital quality measures database. Over time, the plan is to add meaningful and evidence-based measures that cover high priority national medical conditions.

I am pleased to report that the majority of FAH members plan to participate in the Quality Initiative. Our largest members expect to have 100 percent of their hospitals participating in the program.

Beginning this summer, the CMS website (www.cms.hhs.gov) will post the first round of data submitted by hospitals. The website, targeted to clinicians, will be updated quarterly. During 2003, a three-state pilot program (in Arizona, Maryland and New York) will test ways to maximize the usefulness of the quality data to consumers. Based on the pilot test results, the information will be displayed on the HHS website – *www.Medicare.gov* – a site aimed at the public at large—in 2004.

Today, our energies are focused on three goals: encouraging hospitals to participate in the Quality Initiative; ensuring that the first round of implementation goes smoothly; and beginning the consensus process for determining which set of quality measures should be added next. Selecting the next set of measures will be based on national priority conditions identified earlier this year by the Institute of Medicine.

The Quality Initiative has huge significance within the context of today's FTC/DOJ hearing. We can begin to answer several questions, which have, until now, been academic. These questions include:

1. Will hospitals act on their reported results and implement changes to improve their quality performance? We certainly believe they will, otherwise, we would not have helped initiate this effort.

2. What will we learn about the role of physicians as the critical link between patients and hospitals? How does consumerism work in a system where physicians largely direct decisions for consumers?

3. Is the quality information that is meaningful to clinicians also meaningful to consumers? What information *is* useful to consumers?

4. Can a national infrastructure be created and maintained that identifies valid, evidence-based and standardized measures applicable to all hospitals?

Systems Issues

In addition to these "big picture" questions, there are a number of systems and political issues that need to be resolved if the Quality Initiative is to become a permanent and widespread program.

- Information Technology

Improvements in information technology are essential for hospitals to report data about a growing number of medical conditions.

Bar-coding medications – as proposed by the Food and Drug Administration – will go a long way toward reducing medication errors, especially if unit dose packages are included.

Computerized physician order entry (CPOE) holds great promise in reducing medication errors and improving patient care – especially when integrated with other clinical data bases. However, a range of issues prevent CPOE's broader implementation at this time. Widespread off-the-shelf software for CPOE is just beginning to be developed, and there are significant cost and training requirements. The key to successful CPOE implementation is ultimately physician compliance.

Finally, for hospitals to implement widespread quality reporting, it will become essential to be able to extract data from electronic medical records, rather than from paper. The increasing burden on clinical staff time to collect and report data will not be sustainable otherwise.

- Definition of a "Good" Quality Measure

Another challenge to building a national framework is defining what constitutes a "good" quality measure.

We believe that a "good" measure must be based on widely accepted evidence that the practice improves quality, that it is feasible to collect while still allowing hospitals to fulfill their primary mission of providing patient care, and that it is meaningful to users—

both clinicians and consumers. Finally, a "good" measure must be one that all hospitals can implement so that it can be adopted universally.

When evaluated against these criteria, many worthy ideas are just that—they do not rise to the level of becoming a standard for all hospitals. Examples of such efforts include the use of hospital intensivists, and nurse staffing ratios. Neither is based on adequate evidence, nor can they be implemented by all hospitals.

- Measuring Hospital Quality versus Patient Satisfaction or Experience

Although not a measure of the quality of clinical care, patient satisfaction or experience while hospitalized is believed by many to be related to hospital quality, and therefore should be included in any public reporting on hospital performance.

AHRQ and CMS have developed a draft survey instrument designed to measure a patient's perspective of his/her care that will be tested during 2003 in three states. CMS indicates that it will require all hospitals to conduct such surveys once the survey instrument is finalized. CMS also will ask hospitals to publicly disclose their results on the previously mentioned government web sites.

FAH supports the concept of measuring patient satisfaction with their hospital stay. In fact, FAH members routinely conduct such surveys. However, several issues need to be

resolved before FAH can support this proposal. The survey tool must be designed to provide consumers useful information that has a demonstrated link to quality. Also, this survey should not repeat or duplicate current hospital survey efforts. Given all of the competing demands for hospital quality information, hospitals simply can not afford to take on the additional cost of a redundant survey that does not lead to quality improvement in a hospital.

- Political Issues

As I indicated earlier, many different types of organizations, both public and private, have begun hospital quality reporting initiatives. We strongly believe that these fragmented and disjointed efforts must be united under a common and standardized infrastructure so consumers can have access to common information that applies to all hospitals.

Achieving this level of cooperation across so many players will not be easy. However, we believe that the greater good warrants that leaders of all stakeholder organizations support a single common approach. The three hospital associations, AHA, FAH and AAMC – along with CMS, AHRQ, JCAHO, and NQF – have worked together to begin this process. FAH seeks to continue this collective effort, and we encourage others to join and strengthen our initiative, rather than begin or continue their own.

Conclusions

- Quality Initiative Will Provide Answers

The hospital Quality Initiative will give policy makers the opportunity to observe and evaluate a number of important questions, including whether such information will result in improved quality care in hospitals, and whether information about quality truly is used by consumers. FAH supports this initiative and is working hard to make it successful.

- Build a Common National Framework

However, to achieve widespread hospital participation, there must be a coordinated and unified approach at the national level. All stakeholder organizations must support the use of the same measures or there will be mass confusion by the public, and an unreasonable burden placed on hospitals.

- Linking Quality to Payment is Premature

It is premature to conclude that payment can be linked appropriately to hospital quality performance. The first step is to determine if we are measuring quality correctly. After that, testing and demonstrations, such as the recently announced CMS demonstration project with Premier hospitals, are important and necessary second steps.

I hope our comments have been useful to your deliberations today. Thank you for the opportunity to share our views. I am happy to answer any questions that you might have.