FAIRVIEW

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Before the United States Senate Committee on Finance

"Improving Health Care Quality: An Integral Step Toward Health Reform"

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Chairman Baucus, Ranking Member Grassley and members of the committee, my name is Greg Schoen, M.D., regional medical director at Fairview Northland Medical Center in Princeton, Minnesota. On the behalf of Fairview Northland and the 2,000 not-for-profit hospitals in the Premier healthcare alliance, I am pleased to have the opportunity to testify before you today.

Fairview Northland Medical Center is a rural 54-bed regional hospital and clinic, located approximately 50 miles north of the Twin Cities. In addition to services in Princeton, area residents can access primary care at three additional clinics in surrounding communities. We are part of Fairview Health Services, an integrated, not-for-profit healthcare network serving Minneapolis-St. Paul and communities throughout greater Minnesota and the upper Midwest. Fairview Northland Medical Center is a member of the Premier healthcare alliance, a hospital quality and cost improvement alliance which operates one of the nation's most comprehensive repositories of hospital clinical and financial information.

Considering that our focus is on improving the health of the communities we serve, I appreciate the opportunity to speak today about Fairview Northland's quality improvement journey. My testimony will describe how our participation in the Centers for Medicare & Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration (HQID) project was and is a catalyst for quality improvement at our facility and how we overcame challenges we face as a small, rural hospital to achieve status as a top performer in the project. I will also present some key issues for the committee to consider as it moves forward with its quality agenda in the context of healthcare reform.

Fairview Northland's journey to becoming a top-performing organization started in 2003 when Premier announced a new three-year demonstration project with CMS to encourage improvements to hospital quality. The CMS/Premier HQID project, which has since been extended for an additional three years through 2009, is the first-ever national test of performance-based incentives across a broad array of acute care conditions in Medicare patients. The project includes more than 250 hospitals with participants located in 35 states and provides incentives to hospitals that successfully use evidence-based, widely accepted clinical treatments and measures to care for patients with these conditions: heart attack, heart failure, coronary artery bypass graft (CABG), pneumonia and hip/knee replacement. Rewards come in the form of public recognition and annual quality incentive payments

from CMS to top performers. Those hospitals that perform in the top 10 percent of a clinical area—heart bypass, for instance—receive an incentive payment equivalent to 2 percent of their applicable Medicare base rates; those in the top 20 percent receive a 1 percent payment. In the third year only, those hospitals that were low performers based on year 1 baseline results were financially penalized.

The quality of care provided by HQID participating hospitals has significantly improved across all five clinical focus areas from the inception of the program in October 2003 through September 2007, the timeframe for which the most current data is available. Notably, the range of variance among HQID participating hospitals is closing, as those hospitals in the lower deciles continue to improve their quality scores and close the gap between themselves and the demonstration's top performers. *In addition to the rising thresholds, the data shows a compression of the ranges, or a reduction in variation, across project participants. All hospitals, even the low performers, are making strides in quality improvement.*

- In AMI (heart attack) the variance between the highest and lowest score was 40.68 percent in year 1 and has declined to 18.38 percent in year 4.
- In heart failure the variance between the highest and lowest score was 70.97 percent in year 1 and has declined to 41.24 percent in year 4.
- In pneumonia the variance between the highest and lowest score was 37.64 percent in year 1 and has declined to 24.85 percent in year 4.
- In heart bypass the variance between the highest and lowest score was 31.60 percent in year 1 and has declined to 19.39 percent in year 4.
- In hip and knee replacement the variance between the highest and lowest score was 27.97 percent in year 1 and has declined to 23.89 percent in year 4.

Among the 252 participating hospitals in the third year, 112 hospitals earned an incentive payment. In contrast, there were 1,028 potential areas where participants could receive a negative payment adjustment by falling below the payment adjustment threshold, the ninth decile threshold set in the first year. Only 11 total penalties occurred across nine total providers.

The HQID project has shown that pay-for-performance is a powerful stimulus that can be used to accelerate performance. Participating hospitals have shown performance gains that have outpaced those of hospitals involved in other national performance initiatives. In fact, analyses by Premier using the Hospital Compare dataset showed that participants scored on average 6.7 percent higher than non-participants when looking at a composite of 19 measures shared in common between HQID and Hospital Compare.

The HQID project was extended for an additional three years to test new ways to measure quality, as well as new incentive models. We would like to take this opportunity to thank Chairman Baucus for his support of continuing the project beyond the initial three years. The extension will continue to track hospital performance in the five clinical areas, with flexibility to add quality measures and clinical conditions in the extension's second and third years. During the first three years of the project, only top performers were eligible for incentive payments. In the extension bonuses have been expanded to provide incentives for hospitals that achieve the highest quality improvement, those that attain a defined level of quality, along with those that are in the top 20 percent of quality in each condition. In addition, the extension will allow for penalties for low performers on an annual basis.

As a hospital system, Fairview Health Services decided to participate in the HQID for a variety of reasons. In addition to a long-standing commitment to high-quality care, we believed the HQID

measures would eventually become a CMS requirement. Wanting to be “ahead of the curve,” Fairview called on each hospital in our seven-hospital system to participate.

As the medical director for Fairview Northland, I was charged with leading our local effort. When the first set of quality measures was reported, we were surprised by our poor performance. We were in the bottom 10 percent of participating hospitals.

The scores served as a wake-up call that we had work to do. The quest to improve quality started with a straightforward approach to physicians and staff: we can, and will, do better. Our employees — particularly physicians — responded positively to the fact that our hard work would not only improve patient care, but it would also be rewarded with incentive pay from the demonstration project.

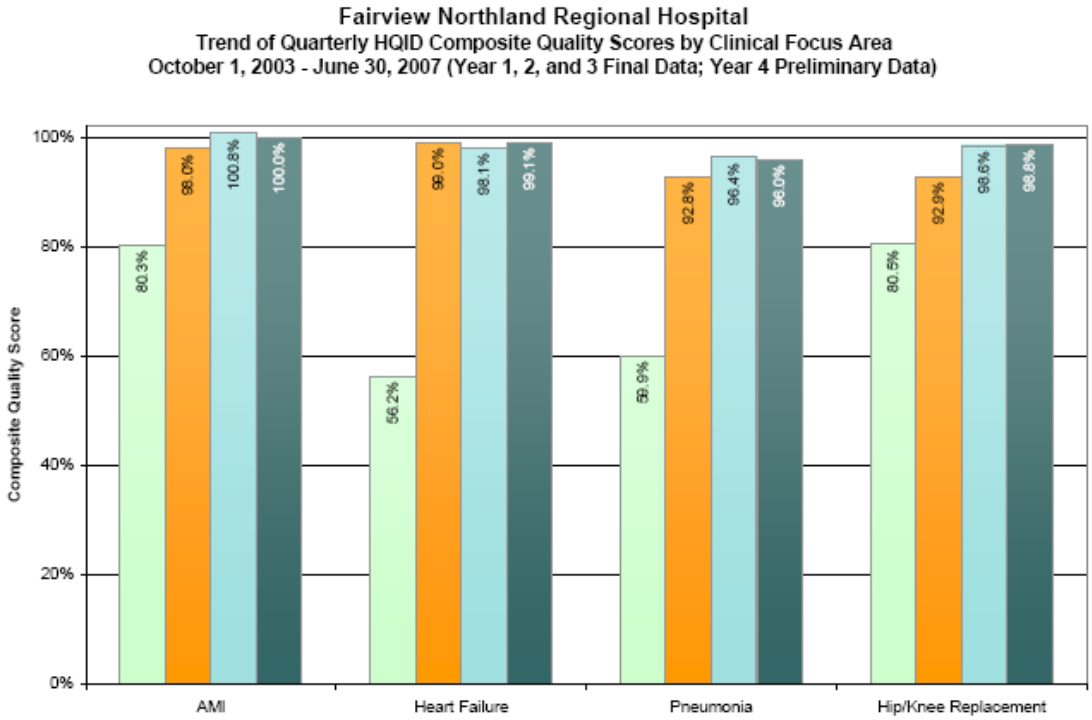
Some of the changes we issued were easier to achieve than others. A common reaction to our low scores was to blame them on documentation errors, meaning the critical care steps were being performed, just not recorded through charting or billing. This proved to be true for several processes. For example, prior to our participation, physicians were conducting oxygenation assessment on patients with pneumonia, but there was no line-item billing code to reflect this work. Based on the way data is collected for this project, it looked like our compliance with this clinical step was 0 percent. A new billing code fixed that problem. This kind of “low-hanging fruit” was a relatively painless adjustment.

The harder work came when we realized we had good people using bad processes. And those bad processes needed to be fundamentally changed. That work was assigned to existing interdisciplinary care teams in the appropriate clinical settings. The teams—comprised of physicians, nurses, X-ray and lab technicians, support staff and administration—had to build new processes to achieve better results. These were the best people to create new processes, since they would have to use them everyday. They created new and better ways to provide care and then hardwired these processes into place. For example, we developed protocols for nurses to initiate care to patients with chest pain systems, such as performing EKGs, administrating aspirin prior to physician notification, and standardizing order sets for care of AMI, heart failure and pneumonia.

We’ve also incorporated numerous monitoring mechanisms to be sure we stay on track, such as adding prompts in paper documents and order sets for physicians, and hiring staff to audit and monitor compliance. Through focused efforts, we moved from the bottom to near the top of the pack in one year. Since then, we’ve sustained our efforts and success.

In the first year we participated in the project, we performed in the bottom 10 percent of all project participants in four clinical areas. By the end of year 2, we were among the top 20 percent of project participants in the heart attack, heart failure, and pneumonia clinical areas, and by the end of year 3, we were also in the top 30 percent of participants in the hip and knee replacement clinical area. Our Composite Quality Score, an aggregate of all quality measures (both process and outcome) within each clinical area, improved by an average 29.24 percent over the project’s first four years:

- From 80.3 percent to 100 percent for patients with acute myocardial infarction (heart attack);
- From 56.2 percent to 99.1 percent for patients with heart failure;
- From 59.9 percent to 96 percent for patients with pneumonia; and
- From 80.5 percent to 98.8 percent for patients with hip and knee replacement.



Our success is based on a number of factors. First, our hospital administrator supported the work. When the decision to strive for the highest quality possible is supported from the top, it is far more likely that staff and physicians will work together to improve processes and achieve results.

Secondly, our hospital physicians and staff "owned" the process redesign work and therefore were invested in the project. The involvement of those who are responsible for implementing the processes is an integral part of quality improvement efforts. Because we are a small hospital, which presents its own unique challenges, we also had an advantage in that a smaller medical staff and employee population means you can make change faster. Also, the measures were strongly supported by research showing that these were appropriate clinical treatments for the four conditions, so the physicians did not question the validity of the measures themselves.

While we are part of a larger, integrated system, staff at Fairview Northland accomplished the bulk of the work. For us, healthy competition among hospitals within our system spurred us to move quickly and make improvements.

In implementing these processes, we have certainly faced challenges. Any time you change a process, you have to change human behavior, and that takes time. While I have cited a relatively small nursing and medical staff as an advantage to making improvements more quickly, there is a downside to being small. Because our inpatient volumes are small in these condition subsets, a single patient who is not provided all correct clinical measures could affect our scores, enough to drop us out of the top decile and lose reimbursement. However, in the HQID project overall, small hospitals have proven that they can provide excellent care. Thirty-one hospitals with fewer than 100 beds and 12 hospitals with fewer than 50 beds received bonus payments during the first three years.

Our small size also means we have limited resources. We incurred start-up cost and made the commitment to add some staff time to appropriately monitor our efforts. This investment is necessary to maintain results. It is important to note that the project was launched prior to the implementation of the Medicare quality public reporting program which covers all Medicare inpatient prospective payment hospitals. Going forward our biggest concern is the number of

organizations that are requesting or requiring hospitals to report conflicting quality measures. Separate pay-for-performance initiatives in the private-payer market while well-intentioned, add considerable costs for hospitals. Fairview believes in "call for standardizing" measures so that CMS and other payors have the same ones; thus, additional resources do not have to be applied at "no value added."

During the first three years of the project, we received bonus payments totaling $40,445 for our quality achievement. While we are improving quality to provide the very best outcomes for patients and not for the money, having an incentive as a reward in the HQID project for achieving outstanding results is a welcome component. This is especially true for a small hospital with limited resources.

Over the long term, however, standardizing hospital processes brings about efficiencies in the delivery system. In fact, in an analysis released this year, Premier found that as hospital quality continues to improve, hospital costs are declining among participants in the HQID project. According to the analysis of 1.1 million patient records, if all hospitals nationally were to achieve the three-year mortality improvements found among the project participants for pneumonia, heart bypass, heart failure, heart attack (acute myocardial infarction), and hip and knee replacement patient populations, they could reduce hospital costs by more than $4.5 billion annually. The 1.1 million patient records represented in this analysis encompass 8.5 percent of all patients nationally within the five noted clinical areas over the three-year timeline of this analysis.

The same Premier analysis also showed that, if all hospitals nationally were to achieve the HQID three-year mortality improvements across the project's five clinical areas, an estimated 70,000 lives per year could be saved.

A separate study[1] published in Health Affairs last year about hospital performance and evidence-based quality measures and mortality rates found that hospitals in the top quartile of quality performance, compared with hospitals in the bottom quartile on quality performance, had 11 percent lower mortality for acute myocardial infarction, 7 percent lower mortality for congestive heart failure, and 15 percent lower mortality for patients with pneumonia.

There has been concern by some that providing incentives based on a subset of the many aspects of patient care will cause hospitals to "teach to the test" or perform well on the processes that are measured while giving cursory attention to other aspects of care. A recent analysis[2] that evaluated the effectiveness of the HQID project by comparing performance to a group of hospitals involved in another program devoted to heart attack quality improvement revealed that HQID hospitals performed noticeably better on the non-HQID measures (13.6 percent compared to 8.1 percent improvement in the composite score) and also achieved greater levels of improvement on all the HQID measures than the control group hospitals. This would indicate that pay-for-performance hospitals appear to adopt a more serious and comprehensive approach to performance improvement that extends beyond the areas measured in the project to overall patient care.

In conclusion, we believe that aligning financial incentives is the right approach to pushing quality to a higher level. By creating a positive incentive to improve quality, pay for performance is an engine for improvement and can be a framework for fundamental transformation. In addition to aligning

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[1] A. K. Jha, J. Orav, Z. H. Li, A. M. Epstein, The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures, *Health Affairs* July/August 2007 26(4):1104–10

[2] Glickman SW, Ou FS, DeLong ER et al. Pay for performance, quality of care, and outcomes in acute myocardial infarction. *JAMA* 2007 June 6;297(21):2373-80.

incentives, we recommend that measure development organizations assure alignment between physician and hospital measures, and that all new measures be tested and publicly reported before being used in a pay-for-performance program.

We also support the government directing attention and resources to lower performing hospitals. As I mentioned earlier in my comments, we achieved 90 percent of the improvement without assistance from any source outside of our 54-bed hospital.

Lastly, when our state quality improvement organization (QIO) came to visit our facility, we were already well on our way to achieving our quality improvement goals, and the QIO staff made comments about how they can learn from us.

Collaboration and the sharing of ways to implement best medical practices is the key to quality success. We support both public and private organizations that conduct such work and encourage Congress to look to them for insights into improving quality of patient care.