**Statement of Testimony of David G. Schulke**

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Good afternoon. My name is David Schulke, and I serve as the Executive Vice President of the American Health Quality Association (AHQA), the national association representing Quality Improvement Organizations (QIOs) and professionals working to improve the quality of health care in communities across America. It is my pleasure to provide testimony today about health information technology (HIT) and a new initiative providing hands-on help to physicians in every state and territory in the United States.

As many as 98,000 Americans die each year from medical errors while receiving hospital care, with another 90,000 serious or fatal preventable adverse drug events occurring in the community dwelling elderly annually. That revelation in a landmark 1999 Institute of Medicine report alerted the nation to a significant challenge and spurred hundreds of initiatives at the local and national levels to reduce medical errors and improve health care quality. Medicare and the national network of QIOs have been at the forefront of these efforts.

At the core of QIO quality improvement work is the identification of safer and more effective care processes, and the promotion of these clinical practices to improve patient safety and reduce medical errors. Under a performance-based three year contract with Medicare, QIOs work with thousands of hospitals, doctors, nursing homes, home health agencies and health plans across the country to help prevent disease, promote patient safety, and improve the delivery of high quality, evidence-based care. QIOs are now promoting HIT in hospitals, physician office practices, and

home health agencies, based on growing evidence that effective use of HIT can improve both quality and efficiency in health care.

**Helping Physicians Adopt Health Information Technology**

The QIOs' experience with helping physicians adopt HIT began two years ago in a four state pilot project known as the Doctor's Office Quality – Information Technology project, or DOQ-IT. The aim of this project was simple -- to achieve better quality outcomes for patients and improve efficiency for physicians by helping them adopt Electronic Health Records (EHRs).

Under the DOQ-IT project, QIOs in California, Utah, Arkansas and Massachusetts collectively helped nearly 1,000 practices adopt HIT. The QIOs provided assistance throughout each phase of HIT adoption, from assessment and planning to selection, implementation, evaluation and improvement. These QIOs helped practices to:

1. Assess their readiness for HIT,
2. Develop a project plan and timeline that takes readiness gaps into account,
3. Understand potential return on investment (ROI),
4. Identify the range of functionalities needed in an EHR,
5. Evaluate different products in a crowded market,
6. Select a product that meets their needs,
7. Know what to expect in contracting,
8. Redesign workflow and care processes, and
9. Use of all of the capabilities of the installed HIT system to improve care and efficiency.

What we learned from the pilot project is that providers and practitioners need help. While financial help is of paramount importance, and I know that the Chairwoman's legislation begins to provide some assistance in this area by addressing some anti-kickback provisions of law, the truth is

that even free equipment would not be well utilized without substantial changes to clinical operations. Physicians need help from independent organizations that can be there for them throughout the process of adoption, implementation and effective use of HIT. They need support from systems change experts who can help ensure that care processes are redesigned to reflect best practices . Providers also need support to ensure that they are utilizing their HIT system to its fullest capacity. As Members of the Subcommittee well know, the promise of HIT lies not in simply automating current practices, but in transforming them. If the result of our policies is merely to persuade providers to buy expensive EHR systems to automate practices that are inefficient and produce poor quality, all we will have accomplished is the proliferation expensive, inefficient and poor quality systems.

This hands-on support is needed because literature and experience tell us that as many as half of all EHR implementations fail for one reason or another, often because practices did not go through the rigorous preparation and development necessary for success.

The four QIOs in the DOQ-IT pilot spent considerable time trying to understand causes of failure and address them in their process change models. From the pilot, we know that some things are critical to success, for example, having a physician champion to lead the project and holding regular staff meetings. The QIOs created "readiness assessments" to gauge where the practice is with respect to critical success factors. When these factors were weak or missing, the QIOs helped build them into the practice's project plan and timeline. By increasing awareness and use of these best practices, QIOs contributed to physician success.

But what about the ten to fifteen percent of ambulatory practices already using EHRs? Why did so many of these doctors come to the QIOs asking for help?

The reason is that these practices know that their systems are capable of much more than simply serving as an electronic record of their care. In Utah, for example, one clinic had been using

their EHR system for seven years, but had never turned on the clinical decision support or disease management functions because using those functions on a regular basis simply did not fit into their daily workflow. The clinic asked their QIO, HealthInsight, for help. HealthInsight showed the clinic how to evaluate their existing workflow and redesign their care processes so that the practice could utilize these high-level functions of their IT equipment – functions which are so central to improving quality.

This illustrates why it is critical for QIOs to help physicians both with and without existing HIT systems -- helping one and not the other leaves a large gap by failing to address both effective adoption and effective use of HIT.

**HIT Assistance Now Available Nationally**

Right now, QIOs across the country are doing just that, based on the work of the pilot state QIOs, HealthInsight, Lumetra (the California QIO), the Arkansas Foundation for Medical Care, and MassPRO (the Massachusetts QIO). All QIOs have been trained on the models they used and the lessons they learned. In August of last year, QIOs nationally received funding from Medicare to support over 4,000 primary care practices across the country during the next two years, and 3,000 practices have already signed up for assistance from their local QIO in just the past eight months. This is despite the fact that QIOs don't give physicians any money to help them purchase or implement these systems.

This assistance is already proving to be highly valued by physicians in the field. As a California family physician told us, he is glad he worked with his QIO, Lumetra, on EHR adoption. Without their expert help, he says, "I would probably have gotten so fed up that I would have missed out on what is going to be a literal transformation in the way that I practice medicine."

Of the total number of practices QIOs will work with, at least 80% are the kind of practices that most need help – small and medium sized practices with no HIT systems to begin with. And these practices aren't just in suburban areas – they are urban, and they are rural. In addition, to reduce health care disparities, QIOs have made a particular effort to reach out to practices treating underserved patients. To date, nearly 700 of the 3,000 practices currently working with their local QIO treat a significant number of underserved patients.

QIOs begin by examining the practice's readiness, which includes reviewing and developing the practice's culture and leadership, financial planning, systems hardware and infrastructure needs, functionality requirements, workflow issues, and more. QIOs then offer assistance throughout the adoption continuum in areas including:

⇒ Developing a project plan and timeline
⇒ Hardware and infrastructure needs
⇒ Resources for system comparisons and selection, including site visits and access to EHR selector tools
⇒ Functionality requirements and preferences
⇒ Contracting principles and guidelines
⇒ Workflow mapping
⇒ Change management and preparation
⇒ Strategies for handling existing data
⇒ Planning for appropriate staff training
⇒ Guidelines for system maintenance and availability
⇒ Go-live planning
⇒ Optimal use of the software
⇒ Reporting quality data
⇒ Quality improvement processes and tools

QIO assistance does not supplant vendor assistance -- QIOs do not provide technical support for installation, programming, interface development, application training or troubleshooting software and hardware glitches. QIOs remain vendor neutral, although they do inform practices about vendors that either currently have or are planning to have the ability to extract a specific quality performance measure set from the EHR.

The performance measures that comprise this measure set are those that have the greatest impact on the Medicare beneficiary population, including heart disease, diabetes, hypertension, heart failure and preventive measures. These measures – known as the Doctor's Office Quality (DOQ) measures – were developed in concert with the American Medical Association, the National Quality Forum and others.

Practices that report the DOQ measures will be able to receive from their QIO customized reports on the quality of their patient care. QIOs can then work collaboratively with the practice to identify and implement strategies for making any necessary changes to workflow or care processes to improve on the performance measures.

Using HIT beyond patient care to report data, measure quality, and undertake improvement will give participating physicians a major leg up on what is likely to be the future of health care reimbursement – pay-for-performance.

**Pay-For-Performance**

A recent report from the Institute of Medicine noted, "…it is clear that a large need exists to help providers improve their quality of care and that the QIOs can help meet this need." The report goes on to recommend that "The QIO program must become an integral part of strategies for future performance measurement and improvement in the health care system."

Experience in community-based quality improvement shows that it is not enough to simply measure quality, or to publicly report quality data. It is unlikely even payment incentives will be sufficient to produce the results Congress and the public are demanding. A 2004 *Health Affairs* study by Rosenthal et al reviewed current incentive programs, concluding that "aligning providers' financial incentives with quality goals may be a necessary precursor to improvement, but it is probably not sufficient. Rather, quality programs should be viewed as part of a broader strategy of

promoting health care quality through measuring and reporting performance, providing technical assistance and evidence-based guidelines, and, increasingly, giving consumers incentives to select higher quality providers and proactively manage their own health."

Quality does not improve on its own – it takes hard work. Physicians, nurses, pharmacists and others benefit from help identifying the cause of quality gaps and then learning how to implement proven techniques to close those gaps. QIOs offer the only nationwide field force of experts dedicated to understanding the latest methodologies in quality improvement and working with doctors and other professionals at the local level to use those techniques effectively. Their hands-on local assistance will be key to helping physicians succeed under future pay-for-performance or value-based purchasing programs.

There is evidence that working with health care professionals accelerates the rate of improvement. The 2005 AHRQ National Healthcare Quality Report shows that health care providers working with their local QIO improved at a faster pace than those who did not. In two areas of care, heart attack and pneumonia, the improvement rate was four times the rate of all other measures nationally. Improving the quality of heart attack and pneumonia care saves both lives and money.

The primary role for QIOs in pay-for-performance is to support providers through technical assistance and the provision of evidence-based guidelines. We agree with the IOM's finding that QIO assistance must be a central part of future performance improvement initiatives because it reflects our experience that success in quality improvement happens faster when doctors work in partnership with experts who understand cutting-edge improvement techniques.

Our work with physicians to adopt and use HIT effectively also provides three key lessons that are relevant to the pay-for-performance dialogue: First, successful adoption and effective use

of HIT improves the quality of care and therefore better positions health care providers for financial success under pay-for-performance.

Second, EHR vendors tell us that it is easier for them to work with a physician who has also worked with the QIO because the practice is better prepared and thus more likely to succeed. Increasing the number of physicians who successfully and efficiently adopt EHRs can help motivate change in others and accelerate the pace of EHR adoption nationally.

Third, successful EHR adoption helps build the electronic infrastructure for data collection. This infrastructure is key to successful incentives programs because claims data alone –which largely reflect processes of care and not outcomes of care– do not provide a full picture of patient self-management or care quality overall. Data collection from EHRs is potentially more accurate and provides a better picture of the true quality of care.

**Interconnected Health Care:**

The most complete picture of patient care will not come from EHRs alone, but from an interconnected health care system where authorized providers have access to secure, accurate and comprehensive patient information at the point of care, in real time. I know that the Chairwoman has been a long-time champion of efforts to mobilize data across institutions in the health care system, and we support your efforts to move this promising field forward.

Quality measurement and reporting, combined with improvement assistance, are well known strategies for improving care. Yet the ability of providers to perform at the highest levels of excellence often depends on clinical data that are stored in disparate organizations across the health care system. Health Information Exchange (HIE) can help accelerate efforts to improve quality, safety and efficiency by delivering more comprehensive information about the patient at the point of care. Availability of this critical information is an important tool to help us address medical errors,

such as the dispensing of contraindicated prescriptions by two separate physicians treating the same patient.

I am pleased to share with you today findings from a recent report from the American Health Quality Foundation and the eHealth Initiative which finds that QIOs in 41 states and the Virgin Islands are currently supporting local, regional, and statewide initiatives to develop health information exchange networks, many in leadership roles.

QIOs are convening stakeholders and helping communities reach consensus on the goals, operations and functions of HIE initiatives. This is an especially valuable role for QIOs because of their experience and relationships in all settings of care. For example, to date, nursing homes and home health agencies often have not had a meaningful role in many local HIE initiatives, and yet these entities would benefit significantly from both HIT adoption assistance and community-based HIE. QIOs are leading the way in bringing diverse stakeholders together across communities so that all health care interests are engaged in a common agenda.

Many QIOs are participating in governance of these emerging HIE entities, and several are also helping their communities develop policies for information sharing, sustainable business plans and technical infrastructure. The report finds that, because of their structure, function, history and expertise, QIOs are helping accelerate the formation of these HIE networks.

**Future QIO Assistance**

As I've outlined today, the field force provided by QIOs offers health care providers in every state free and needed assistance for improving quality. From supporting and accelerating physician adoption of EHRs to working with nursing homes, hospitals, home health agencies and others, QIOs are helping health professionals utilize the latest techniques in quality improvement to

eliminate medical errors, reduce suffering and improve the quality of life for patients across the country.

Recent studies from RAND and others tell us that Americans get only about half of the recommended care for their medical conditions. As HIT, pay-for-performance and health information exchange increasingly become vital tools for transforming quality, all providers will need performance improvement assistance from quality experts like QIOs.

The QIO program represents the largest coordinated federal investment in improving health care quality – right now, that investment accounts for less than one tenth of one percent of overall Medicare spending. As Congress considers legislative action to realign incentives through pay-for-performance in support of health care quality and accountability, we hope you will encourage the expansion of this invaluable program to become a central fixture in our collective drive to provide the right care to every patient, every time.