American Board of Internal Medicine

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Hearing on "Crossing the Quality Chasm in Health Care Reform;" January 29, 2009

Chairman Kennedy, Senator Enzi and members of the Health, Education, Labor and Pensions Committee, thank you for the invitation to testify about improving health care quality. My name is Christine Cassel, and I am a board certified internist and geriatrician, and the President/CEO of the American Board of Internal Medicine (ABIM).

ABIM is an independent, non-profit organization that is "of the profession but for the public." We assure via board certification that physicians who practice internal medicine and 17 different subspecialties have the knowledge, skills and attitudes to practice within their specialty. ABIM certifies about a third of the nation's practicing physicians and is the largest of the 24 boards that constitute the American Board of Medical Specialties (ABMS). The standards that we set shape both medical residency training programs and physician practices of all sizes in many varied settings.

Since the publication of the Institute of Medicine (IOM) *Quality Chasm* report in 2001, many strides have been made to improve the quality of care, with the development and reporting of performance measures as a particularly visible accomplishment. Having had the privilege of serving on the Committee that produced the IOM report, I derive satisfaction from those gains while acknowledging that we have a long way to go. Specific, select accomplishments over the last eight years include:

- The healthcare community, under the auspices of the National Quality Forum's (NQF) National Priorities Partners, has set national priorities for improvement — including patient and family engagement, reducing overuse of inappropriate services, and enhancing end of life and palliative care, which are key areas to focus on from my vantage point;
- The medical community is developing and implementing a broader array of evidence based clinical guidelines, which translate research into practice recommendations, and they are beginning to enhance them with the integration of appropriateness criteria. These guidelines are then translated into performance measures;
- There is growing agreement about using standardized performance measures – focused on both clinical conditions and on patient experience – and the role that the NQF plays in facilitating consensus in this arena;
- There is some evidence that reporting of performance measures is driving improvement at hospitals and health plans, although that is less clear at the individual clinician level. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) data, used at the health plan level, has shown improvements across multiple dimensions over the nine years that the National Committee for Quality Assurance (NCQA) has been publicly reporting results.

As we build a more scientifically robust performance measurement and reporting system with appropriate, valid measures linked to payment, we must simultaneously focus on assessing and enhancing the skills and competencies that clinicians need to practice in an increasingly complex 21st century healthcare system.

My training in geriatric medicine emphasized a set of competencies that are necessary for the provision of high quality care. These competencies focused on the importance of making the right diagnosis (particularly with patients that have multiple, complex problems), working in clinical teams, care coordination, integration with other specialists, management of multiple chronic conditions and linking community and clinical services. But these skills are not utilized by many clinicians for a number of reasons: our training and education systems do not adequately focus on such competencies; such knowledge and skills are not supported by the systems in which clinicians work; and perhaps because these more complex areas do not easily lend themselves to performance measurement.

A case in point are the policy discussions about the patient-centered medical home, which are largely focused on practice infrastructure and related payment models that can facilitate integrated and coordinated care, but fail to emphasize the competencies that physicians and other clinicians need to effectively meet the promise of the medical home concept. These competencies must be a part of primary care residencies and physicians in practice need support to work effectively in teams and engage patients in managing their chronic conditions, among other skills that the vision of the patient-centered medical home model requires.

At ABIM, we provide internet-based tools that are available to close to 200,000 physicians that can help them to assess their practice strengths and weaknesses and offer links that guide them towards improvement. By tapping into most physicians' intrinsic motivation to do well by their patients, the certifying boards have demonstrated that with trusted and actionable data, physicians engage in improving the quality of care. These very same data can then be used – if the physician so chooses – for reporting to health plans, NCQA, hospitals and to the Centers for Medicare & Medicaid Services. This alignment reduces redundant data collection, lessening the administrative burden on physicians (particularly in smaller practices), and can help in accelerating improvement.

ABIM's tools assess physician's performance in practice – using standardized NQF clinical measures, Consumer Assessment of Health Providers and Systems (CAHPS) patient experience surveys and a condensed version of NCQA's Physician Practice Connections (PPC) – as well as his or her knowledge base, diagnostic ability and medical judgment in a given medical specialty.

In a survey of over 5,000 physicians who have used ABIM's performance assessment tools, 70 percent of respondents reported that they found these tools valuable in identifying strengths and weaknesses in the care they provide. More importantly, 73 percent of respondents changed their practice as a result of completing one of ABIM's performance assessment modules.

Yet, there are aspects of practice that do not easily lend themselves to being assessed via performance measures. Therefore, other types of assessment tools are needed. Key examples include:

- Our current performance measurement system assumes that a correct diagnosis has been made and may even result in performance payments that stem from faulty diagnoses. This is not an outlier problem. The literature suggests that diagnostic errors account for 5-15% percent of medical errors, depending upon the specialty, and they are not declining over time. Certifying board examinations include clinical scenarios that test diagnostic acumen.
- Further, making the correct diagnosis and recommending an appropriate treatment plan requires up-to-date knowledge of new therapies, an ever-evolving understanding of the strengths and weaknesses of existing therapies and, often, the skill to know how to manage and integrate multiple therapies. Certifying board examinations test medical knowledge and provide scenarios to assess clinical judgment and management.
- Finally, it is less likely that performance measurement bundles will be developed for less common illnesses, such as thyroid disease, viral meningitis or rheumatoid arthritis. Yet patients will, and should, expect that physicians can diagnose and treat such conditions. Instead,

clinical scenarios involving rare conditions lend themselves to board examinations and online point of care tools.

As members of the HELP Committee contemplate shaping a reformed health care system, you have already taken important steps in the stimulus bill by articulating the importance of both health information technology (HIT) and comparative effectiveness research. These investments can help deliver to physicians and other clinicians important data and information that they need to understand "how they are doing" to help in facilitating care coordination and integration; aid in reducing wasteful, redundant testing; and provide a resource that objectively compares treatment options. But these important investments in a 21st century healthcare system will not reach their full potential unless physicians and other clinicians actually use the information they provide to inform their treatment decisions or to change their practice patterns. ABIM – and very likely other certifying boards – would be happy to work with the HELP Committee to facilitate physician engagement related to both HIT and comparative effectiveness.

Going forward, the HELP Committee might also want to consider how community health centers (CHCs) define their services, making sure that the definition allows for the effective delivery of and payment for comprehensive care to patients with complex and multiple conditions – the kind of care that geriatricians are trained to provide and that many patients beyond the elderly need. CHCs will also serve as patient-centered medical home sites, and will be most effective if the definition of provided services is expansive and staff is supported in learning new competencies to effectively practice in a redesigned model.

Finally, there are two other important, and related, areas of intersection: revitalizing primary care and providing better care for underserved populations. In both arenas, ABIM Board-level committees have been working to define, implement, test and evaluate new tools to assess related competencies. We would welcome the opportunity to share our learnings with you and others as you consider how to advance primary care and to

close disparities gaps as part of a reformed healthcare system. For example, in the underserved area physicians using our tools in large and small practices will eventually be able to compare the quality of care they deliver across various sub-populations.

Thank you for the opportunity to reflect on what the quality community has and has not yet accomplished over the eight years since the *Quality Chasm* report was published. We would welcome the chance to partner with you as you consider how to shape the reforms that lie ahead. In the process, we ask that you consider the skills and competencies of the nation's clinicians as essential to achieving the vision of a dramatically reformed system as laid out in that landmark report.