COMMENTS BY CAROMONT HEALTH, INC AND GASTON MEMORIAL HOSPITAL, INC. ON THE PETITION FOR CHANGE IN POLICY AC-3 SUBMITTED BY THE ACADEMIC MEDICAL CENTERS

CaroMont Health, Inc. ("CaroMont") is the parent corporation of Gaston Memorial Hospital, Inc. located in Gastonia, North Carolina. Founded in 1946, the hospital began as a 70-bed facility, and has grown to be licensed for 435 beds (372 acute care beds). While CaroMont's flagship facility, Gaston Memorial Hospital, is located in Gaston County, CaroMont has facilities in surrounding counties as well, including Cleveland, Lincoln, and Mecklenburg Counties in North Carolina, and York County in South Carolina. CaroMont's services include a Community Hospital, Comprehensive Cancer Center, a Women's Center, a Neonatal Intensive Care Unit, an Open Heart Program, Cardiac Catheterization and Psychiatric Services, and a comprehensive array of diagnostic and therapeutic outpatient services.

As a large, independent health care system in North Carolina, CaroMont is attuned to the trends in health care and the intense competition for limited health care resources. CaroMont recognizes the importance of the health planning process, and the critical role of the Certificate of Need ("CON") process in limiting the proliferation of unnecessary health services. Because CaroMont believes that Policy AC-3 in the State Medical Facilities Plan ("SFMP") is fundamentally at odds with the purpose and the language of the CON Law, it submits these comments on the Petition filed by the state's four academic medical centers ("AMCs"): Duke University Health System, Inc. d/b/a Duke University Hospital ("Duke"), North Carolina Baptist Hospital ("Baptist"), Pitt County Memorial Hospital ("Pitt"), and UNC Hospitals at Chapel Hill ("UNC").

CaroMont, as a non-AMC, is bound by the need determinations in the SMFP. *See* N.C. Gen. Stat. § 131E-183(a)(1), which states that the need determinations in the SMFP

constitute a determinative limitation. Unless there is a need determination in the SMFP for a regulated health care asset, CaroMont cannot develop the asset. CaroMont understands the purpose behind the restrictive limitation of the need determinations in the SMFP, and it submits to the State health planning process and the authority of the CON Section to regulate providers in North Carolina with respect to the CON Law.

Policy AC-3, however, poses significant problems for the State's health planning process to which CaroMont is subject. These problems are the same as those set forth in Novant Health, Inc.'s ("Novant") Petition on Policy AC-3, submitted to the SHCC on March 2, 2011.[1] While CaroMont supports the Petition filed by Novant, these comments will focus on the reasons why CaroMont opposes the Petition filed by the AMCs.

A. The SHCC Should Not Adopt the Revisions to Policy AC-3 Proposed by the AMCs.

The AMCs' Petition addresses four basic concepts, as follows: expand the definition of an AMC eligible to use Policy AC-3; expand the 20 Mile Rule; exclude Policy AC-3 assets and corresponding services from the state inventory; and require minimal data reporting regarding AMCs' Policy AC-3 assets. CaroMont addresses each these proposals in turn below, and urges the SHCC to reject the AMCs' proposed changes to Policy AC-3.

1. Definition of an AMC.

According to the AMCs' Petition, they do not want the SHCC to retain the portion of the current policy that reads: "Exemption from the provisions of need determinations of the North Carolina State Medical Facilities Plan shall be granted to projects submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990 . . . ." The

[1] CaroMont is also submitting comments in support of Novant's March 2, 2011 Petition to the SHCC, requesting repeal of or revision to Policy AC-3.

AMCs suggest that the definition of an Academic Medical Center Teaching Hospital should be "refined" to make Policy AC-3 "available to separate campuses that may be approved for existing medical schools, as well as to new medical schools." In essence, they seek to expand the reach of Policy AC-3.

The problem with Policy AC-3, as the Petition submitted by Novant correctly points out, is that it is already too broad and allows four institutions to play by different rules than every other provider in the State of North Carolina. It allows those facilities, and only those four facilities, to develop services or facilities regardless of whether the state planning process has indicated that there is a need or not. If the AMCs' proposal is adopted, Policy AC-3 would be able to cast an even wider net, because more facilities (either a new medical school or new satellite campuses for existing schools) would be exempt from the need determinations in the SMFP.

As a practical matter, the AMCs' proposal is unnecessary. As a policy matter, it is unsound. The process of getting a new medical school chartered is a multi-year journey; there is certainly no reason to amend Policy AC-3 now, when there is no new medical school being planned anywhere in North Carolina for the foreseeable future. In the event a new medical school is chartered in North Carolina, the new provider (or all AMCs) could petition the SHCC to change the definition of Policy AC-3 at that time to include the new medical school. At that time, the SHCC would be able to assess the new medical school, evaluate any necessary accreditation-related issues, and determine whether the new medical school should qualify for an exemption from the need determinations in the SMFP pursuant to Policy AC-3. Without a new medical school on the horizon, the AMCs' proposed change is premature and unnecessary.

The AMCs' proposal to extend Policy AC-3 to satellite campuses of existing medical schools is also extremely problematic. The AMCs claim that the state needs to be prepared to train more physicians to address a foreseeable physician shortage nationwide. Apparently, in response to this need, the AMCs foresee additional "satellite" campuses for the existing four medical schools in the state. However, despite their premonition that there is a need for more medical students and more schools or facilities in the state to train them, the AMCs provide no data or support for their assertion. They cite to a statement by the president of the American Medical Association, Cecil B. Wilson, who apparently determined that there would be a shortage of 125,000 physicians by 2025. They provide no information or support to show what portion, if any, of this alleged shortage will be in the State of North Carolina, or how the alleged shortage will impact medical schools in North Carolina. They also provide no data or supporting information to explain how Dr. Wilson arrived at his estimate for the alleged physician deficiency. It should be noted that every other state that has a health planning process and a medical school will face the same challenges Dr. Wilson describes, yet North Carolina is the only state that treats AMCs differently for health planning purposes.

An implicit result of the AMCs suggestion to expand Policy AC-3 is that Carolinas Medical Center ("CMC") in Charlotte will achieve status as an AMC that can take advantage of Policy AC-3. In their Petition, the AMCs also cite that UNC has received approval to develop campuses in Asheville and Charlotte. Presumably, those campuses would be closely tied with an existing hospital in the area; in Charlotte, one can presume that CMC will form ties with UNC; in Asheville, Mission Health System ("Mission") will likely partner with UNC.

Of particular concern for CaroMont is the extension of Policy AC-3 to CMC and Mission, which would then allow them to apply for additional new institutional health services

regardless of whether there is a need for them in the SMFP. An expansion of the definition of AMC to include these satellite campuses would, in effect, extend the exemption of Policy AC-3 to even more hospitals in the State, perpetuating the problems of Policy AC-3 even more egregiously. There is no telling at what point the reach of Policy AC-3 would end; if the four AMCs each develop multiple satellite campuses, more facilities become exempt from the health planning process as they fall under the ever-expanding umbrella of Policy AC-3, then the existing providers who do not have ties to an AMC will be at an unmistakable and unavoidable disadvantage. The health planning process in North Carolina becomes meaningless. The exemption will have swallowed the rule.

The AMCs also ignore the reality that other facilities, besides the four AMCs who filed the Petition, currently train medical students. CMC serves as a training site for medical students and touts on its website that it is an academic medical center teaching hospital. However, it has managed to train medical students successfully without the benefit of Policy AC-3. Likewise, many other community hospitals enter residency training agreements with AMCs, which allow the community hospitals to serve as a training site for a particular specialty. Despite serving as a training site, these community hospitals are also not permitted to use Policy AC-3. Simply put, the training of medical students can and does take place without using Policy AC-3.

The AMCs, while claiming that additional medical schools and satellite campuses should qualify for Policy AC-3, give absolutely no reason why such an extension of the policy would be necessary or desirable. Apart from the AMCs' bald assertions that additional medical school campuses are needed, and that these campuses need to be able to use Policy AC-3, there is no data, analysis, or explanation why additional medical school campuses will

need to be exempt from the need determinations in the SMFP. The SMFP involves a careful inventory of the existing health service facilities and capabilities in the state, and a reasoned determination, through health planning methodologies, of what additional services or facilities are needed to meet the health care needs of the people of North Carolina.

Broadening or expanding the definition of an AMC will allow more providers to use the blank check of Policy AC-3, ignoring the need determinations in the SMFP. CaroMont is opposed to such an expansion of the policy, and urges the SHCC to reject the AMCs' proposal to expand the definition of an AMC. If Policy AC-3 is retained in any form, the definition of an AMC that can utilize that policy should not change.

The AMCs also do not explain why the normal petitioning process cannot be used to meet whatever needs they have. Pitt and Duke have both successfully used the normal petitioning process, and there is no reason why they and their AMC colleagues cannot do so again in the future.

2. The 20 Mile Rule.

The AMCs also propose that the language of Policy AC-3 be changed, so that instead of being required to show that a project "cannot be achieved effectively" at a non-AMC within 20 miles of the AMC (the "20 Mile Rule"), the AMC be required to demonstrate that it "cannot be met in a cost effective and clinically efficient manner." While this change on its face is not problematic, it ignores the fundamental problems and abuse of the 20 Mile Rule in the past. A change in the form of the 20 Mile Rule is irrelevant if there is not a change in the substance required in response to the 20 Mile Rule. If a non-AMC simply parrots the standard of the 20 Mile Rule, and states in its CON application that the proposed project cannot be met in a cost effective and clinically efficient manner, this change has no impact at all. As the

recent decision on the Baptist Policy AC-3 application for an outpatient surgery center shows, adding language to the rule does not solve the fundamental problem of ignoring the requirements of the rule.

The AMCs argue that their proposed two prong approach would allow "consideration of both the operational issues of pursuing the project" as well as "cost/revenue issues." While CaroMont does not object to consideration of both of these aspects, an AMC must give an explanation, with analysis and support, to demonstrate why the project cannot be done at a non-AMC.

In order to qualify for Policy AC-3, it is mandatory that the AMC seeking the exemption truly demonstrate with evidence that its proposal is absolutely necessary, and that the need for the project cannot be met at a non-AMC within 20 miles. The applicant must explain, with quantitative or qualitative support, why the project cannot be done at any such non-AMC. For example, Gaston Memorial Hospital is almost exactly 20 miles from CMC. Presbyterian Hospital is less than two miles from CMC. If CMC became a satellite medical school for UNC, CMC would need to demonstrate specifically why these two facilities, among others within the 20 mile radius, could not meet the purported teaching and research need. This would also include discussion of why CMC's own facilities in the 20 mile radius, such as CMC-Mercy and CMC-Pineville, could not meet the need. A simple statement that the AMC does not believe its proposal can be achieved effectively elsewhere is not sufficient to meet the 20 Mile Rule, under either the existing or proposed definition. Likewise, the expression of a preference by the AMC, stating that it would prefer to develop its proposed project instead of seeking to meet a need through non-AMCs within 20 miles when that is possible, is completely deficient as a response to the 20 Mile Rule.

The wording of the 20 Mile Rule, as it exists now is not problematic. The problem has been enforcement of the rule. The language change proposed by the AMCs is not necessary to solve any health planning issue. What is necessary is scrutiny of the Policy AC-3 applications to ensure the rule is satisfied.

3. Reporting Policy AC-3 Assets in the Inventory.

The AMCs correctly point out that the current system of how Policy AC-3 assets and services are included in the state inventory results in distortion about the utilization of assets. Under the current system, the beds or facilities developed pursuant to Policy AC-3 are excluded from the inventory, but services provided in those facilities are included in the inventory. For example, if an operating room is acquired pursuant to Policy AC-3, that room will not be included in the inventory of operating rooms, but all procedures performed in that operating room will be included. This results in the illusion that the rooms in the inventory are much more highly utilized than they actually are. Including the service, while excluding the facility, distorts reality and misguides the health planning process. However, the AMCs' proposed solution to engage in willful blindness and exclude both the service and the facility is equally distorted.

Instead, both Policy AC-3 facilities and services should be included. The reality is that these facilities exist, and they should not be ignored when the State takes inventory of what facilities are in the State. If they are ignored, the State's inventory is not correct and does not accurately reflect the facilities in the State capable of treating patients. In turn, the State planning methodologies, which rely on the inventory in order to make projections of need for the future, will not function as intended. Including both Policy AC-3 services and facilities in

the inventory is the only way to have an accurate picture of the existing health care resources in the state. Thus, the AMCs' proposal should not be adopted.

4. Data Reporting by AMCs.

In the AMCs' Petition, they agree to report in an addendum to the Hospital License Renewal Application, "the utilization of the facility, service, beds, operating rooms, and equipment acquired pursuant to the award of the certificate of need." They assert that this reporting would allow careful tracking of Policy AC-3 projects.

While the AMCs' willingness to report data is a good starting point, their proposal would not necessarily allow for careful tracking of how Policy AC-3 projects are being used for an essential academic purpose, such as teaching or research. A report of the utilization of those assets acquired pursuant to Policy AC-3 would only reflect the numbers showing those assets are being utilized – it would not indicate how they are being utilized for education of medical students or residents or for research. For example, how is the Policy AC-3 asset being used to enhance the quality of the education provided to the medical students and residents who are training at the AMC? How many medical students and residents used the asset? How did the asset help their medical education? How did the asset assist with research? Was the asset also used for non-academic purposes? This is the type of data reporting that would be truly useful.

CaroMont agrees that data reporting for AMCs' assets acquired pursuant to Policy AC-3 is essential, but the AMCs' proposal to simply report utilization, without any information about the academic function the Policy AC-3 asset served, is inadequate. The data reporting requirements should be extended to require the AMC to explain the educational, training, and research uses of those assets.

B. Changes in the Health Care Environment Do Not Support the AMCs' Proposed Changes to Policy AC-3.

The AMCs argue that changes in the health care environment will make Policy AC-3 even more critical. The AMCs are seeking security in Policy AC-3, because they know that they can apply for any health care asset they want, if it is for a purported research or teaching need, without going through the process that non-AMCs are forced to follow. However, they have cited no reason why they should be any more immune from any impending changes than any other provider. As all providers face the "unknown" of health care reform, the future development of accountable care organizations ("ACOs"), and rising levels of indigent care every year, no provider deserves preferential treatment in the health planning process so that it can "beat" its competitors. Indeed, expanding Policy AC-3 in the way that the AMCs suggest could defeat some of the central goals of health care reform and ACOs – providers working collaboratively, and in the best interests of patients, to improve quality and reduce cost, rather than building and expanding and unnecessarily duplicating services in order to gain a competitive advantage.

The contradiction between Policy AC-3 and the goals of health care reform are evident by the National Strategy for Quality Improvement in Health Care ("National Strategy"), released to Congress on March 21, 2011 by the Department of Health and Human Services. *See* Exhibit A. The National Strategy recognizes that improving health care starts on the local level, and depends on the communication and coordination of care among the providers in a community. Every provider in a community plays an essential role in the provision of quality care, and the national goals do not support or encourage special treatment for particular providers, such as Policy AC-3 provides for the AMCs. The National Strategy seeks to avoid

unnecessary duplication in care, avoid unnecessary costs and wasted resources, and avoid barriers to accessible quality health care. These goals are consistent with North Carolina's CON Law.

Contrary to these national and state health care objectives, Policy AC-3 allows the AMCs to disregard the need determinations in the health planning process, allowing for unnecessary duplication and wasted resources. The competing objectives between health care reform and Policy AC-3 further indicate that Policy AC-3 has outlived its useful life, and the AMCs' request for its retention and expansion must be rejected.

C. Piecemeal Litigation is Insufficient to Address the Problems Policy AC-3 Poses.

The AMCs also argue that litigation over a particular application provides a sufficient forum for challenging an application's conformance with Policy AC-3. While litigation is appropriate on a case-by-case basis, it is the policy itself that is a problem, and it is not efficient or cost-effective for CaroMont to be forced to challenge Policy AC-3 applications in litigation. Instead, CaroMont is commenting on the petitions submitted to the SHCC by Novant and the AMCs, which is the appropriate forum to address a fundamental issue of health planning that is of universal concern. CaroMont urges the SHCC to reject the AMCs' proposed changes, and to either repeal Policy AC-3 or adopt the changes to the policy outlined in Novant's March 2, 2011 petition.

CONCLUSION

CaroMont understands that the AMCs are unique institutions, because they have a teaching and research mission. However, they should not be given a free pass from the State's carefully constructed and stringently regulated health planning process. If Policy AC-3 is

repealed, CaroMont firmly believes that the State health planning process and the CON process in place can still accommodate their teaching needs. In the alternative, if the SHCC determines that it is necessary to retain Policy AC-3 in some form, the proposed changes to Policy AC-3 in Novant's Petition to the SHCC are sufficient to address the AMCs' special needs without unfairly disadvantaging other providers.

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This the 23rd day of March, 2011.

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Implementation Center

Report to Congress:

National Strategy for Quality Improvement in Health Care

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EXHIBIT A

Executive Summary

The Affordable Care Act seeks to increase access to high-quality, affordable health care for all Americans. To that end, the law requires the Secretary of the Department of Health and Human Services (HHS) to establish a National Strategy for Quality Improvement in Health Care (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it. This report describes the initial Strategy and plan for implementation.

The National Quality Strategy will promote quality health care in which the needs of patients, families, and communities guide the actions of all those who deliver and pay for care. It will incorporate the evidence-based results of the latest research and scientific advances in clinical medicine, public health, and health care delivery. It will foster a delivery system that works better for clinicians and provider organizations—reducing their administrative burdens and helping them collaborate to improve care. It is guided by principles (available at www.ahrq.gov/workingforquality) that were developed with input by stakeholders across the health care system, including Federal and State agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers. Most importantly, the implementation of this Strategy will lead to a measurable improvement in outcomes of care, and in the overall health of the American people.

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National Aims

The National Quality Strategy will pursue three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve the quality of health care.

- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

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Setting Priorities

To advance these aims, we plan to initially focus on six priorities. These priorities are based on the latest research, input from a broad range of stakeholders, and examples from around the country. These priorities have great potential for rapidly improving health outcomes and increasing the effectiveness of care for all populations. As the National Quality Strategy is implemented in 2011 and beyond, we will work with stakeholders to create specific quantitative goals and measures for each of these priorities. They are:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These priorities can only be achieved with the active engagement of clinicians, patients, provider organizations, and many others in local communities across the country, something the National Quality Strategy supports. Since different communities have different assets and needs, they will likely take different paths to achieving the six priorities. This Strategy will help to assure that these local efforts remain consistent with shared national aims and priorities.

Over time, our goal is to ensure that all patients receive the right care, at the right time, in the right setting, every time. The United States leads the world in discovering new approaches to prevent, diagnose, manage, and cure illness. Our institutions educate and train exceptional doctors, nurses, and other health care professionals. Yet Americans don't consistently receive a high level of care. Achieving optimal results every time requires an unyielding focus on eliminating patient harms from health care, reducing waste, and applying creativity and innovation to how care is delivered. That's what the National Quality Strategy will provide.

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Supporting Action to Address Priorities

The National Quality Strategy articulates broad aims and priorities that have been informed by extensive consultation with stakeholders across the country. At the same time, it explicitly recognizes that in the end, all health care is local.

Many stakeholders have important roles in promoting high quality care. It starts with clinicians and health professionals, but employers, government, advocates, and many others also have an interest in improving the quality of care. Employers and other private purchasers, for example, have been leaders in demanding better quality by pushing provider organizations to achieve new levels of excellence.

Until now, few of these efforts have been coordinated or aligned. The National Strategy will change that, outlining a common path forward that makes high quality, affordable care more available to

patients everywhere.

The Strategy will be updated annually and will provide an ongoing opportunity to identify and learn from those providers and communities that are ahead of the curve in delivering high quality, affordable care. It is our hope that this national strategy creates a new level of cooperation among all the stakeholders seeking to improve health and health care for all Americans.

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The Path Forward

The Affordable Care Act calls on the National Quality Strategy to include HHS agency-specific plans, goals, benchmarks, and standardized quality metrics where available. By design, this first-year Strategy does not include these elements, in order to allow them to be developed with additional collaboration and engagement of the participating agencies along with private sector consultation. We believe nation-wide support and subsequent impact is optimized when those needed to implement strategic plans participate fully in their development. We have begun implementation planning across HHS and have established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The Agency for Healthcare Research and Quality is tasked with supporting and coordinating the implementation planning and further development and updating of the Strategy.

The National Quality Strategy is designed to be an evolving guide for the Nation as we continue to move forward with efforts to measure and improve health and health care quality. As implementation proceeds, we will monitor our progress in achieving the Strategy's three aims along with other short- and long-term goals, and will refine the Strategy accordingly. We will provide updates annually to Congress and to the public.

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Section I. Introduction

The Affordable Care Act is improving the quality, affordability, and access to health care for all Americans. The law provides new protections for consumers in the private health insurance market, creates new coverage options for individuals and small business owners, and extends premium tax credits to moderate- and low-income Americans to make health care more affordable.

In addition, the Affordable Care Act has an array of provisions designed to enhance coordination, innovation, efficiency, and the quality of health care. These reforms build on progress that was already being made as a result of existing legislation such as the Children's Health Insurance Program Reauthorization Act of 2009 and the American Recovery and Reinvestment Act of 2009. Further, these provisions complement a wide range of State and local activities that also seek to make care more affordable, improve the quality of care, and promote better health.

To help guide and coordinate these public and private sector activities, the Affordable Care Act calls on the HHS Secretary to establish a National Strategy for Quality Improvement in Health Care (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it.

This report outlines the initial National Quality Strategy and plan. It identifies broad aims and priorities

for achieving better health and health care and describes examples of HHS initiatives that address the priorities. The Affordable Care Act also calls on the Secretary to establish a National Prevention and Health Promotion Strategy. The National Prevention and Health Promotion Strategy will align with the National Quality Strategy and will provide a more specific plan for improving population health.

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The Need for Improvement

The need to improve the quality and affordability of health care in the United States has been documented repeatedly. For example:

- In its groundbreaking 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine's Committee on Quality of Health Care wrote:

The performance of the health care system varies considerably. It may be exemplary, but often is not, and millions of Americans fail to receive effective care...The health care system as currently structured does not, as a whole, make the best use of its resources. There is little doubt that the aging population and increased patient demand for new services, technologies, and drugs are contributing to the steady increase in health care expenditures, but so, too, is waste. Many types of medical errors result in the subsequent need for additional health care services to treat patients who have been harmed. A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweigh the potential benefits. What is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes.

- Researchers at the RAND Corporation have found that nearly half of all adult patients fail to receive recommended care.
- Since 2003, the Agency for Healthcare Research and Quality (AHRQ), together with its partners in HHS, has published annual National Healthcare Quality and Disparities Reports. (Available at http://www.ahrq.gov/qual/measurix.htm#quality). Overall, these reports find that while health care quality is improving, the pace of that improvement is slow.
- The Business Roundtable, in its *2010 Health System Value Comparability Study*, compared the United States with its five largest trading partners on both quality and cost of care. While noting potential for improvement on many fronts, it also noted that costs are far higher in the United States than in any other country. The report found that for every dollar spent on health care in the United States, other major competitors spent just 47 cents. Despite this increased spending, evidence suggests United States health care quality is no better, or in some cases worse, than other countries.

When looking at how our health care system works, these results are not surprising. The United States leads the world in developing new approaches to prevent, diagnose, manage, and cure illness, thereby improving health. Our academic institutions educate and train exceptional physicians, nurses, and other health care professionals. But while these advances have dramatically improved care for millions of people, they do not consistently reach all who would benefit.

That's because health care in the United States is often fragmented and disorganized. Patients,

caregivers, and families are forced to retell their stories to each new medical professional they encounter. Tests are duplicated because medical records are lost or unavailable. Doctors, nurses, and other health care professionals spend hours on paperwork. This fragmentation leaves both patients and clinicians dissatisfied, and adds significantly to the cost of care—and it's reinforced by payment systems that reward piecemeal care instead of care delivered in a seamless, coordinated manner.

The National Quality Strategy aims to change that by focusing on eliminating patient harms, reducing waste, and applying innovation in how care is delivered with the goal of ensuring that each patient receives the right care, at the right time, in the right setting, every time.

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Developing the National Quality Strategy

The Secretary developed this initial National Quality Strategy and plan through a participatory, transparent, and collaborative process that reached out to a range of stakeholders for comment. More than 300 groups, organizations, and individuals provided comments, representing all sectors of the health care industry and the general public. In addition, the Strategy incorporates input gathered at national meetings and from the National Priorities Partnership, a coalition of some 50 organizations committed to revamping the health care system. (See www.nationalprioritiespartnership.org.) These public comments led to revisions and enhancements to the Strategy and gathered support for the principles, aims, and priorities that form the foundation of this report. A full summary of the public comments made in the development of the National Quality Strategy is available at www.ahrq.gov/workingforquality. This dialogue will continue in 2011 and beyond, as the National Quality Strategy evolves and develops a sharper focus on specific goals, measures, and additional actions to be taken by the government and private sector partners.

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An Initial Outline of the Plan

The National Quality Strategy will focus national, State, and local efforts to improve health care quality on common aims, priorities and goals.

It will promote health and health care centered on the needs of patients, families, and communities. It will incorporate the evidence-based results of research and scientific advances in clinical medicine, public health, and health care delivery. It will foster a delivery system that works better for clinicians and provider organizations—reducing their administrative burdens and helping them collaborate to improve care. It will be guided by a set of core aims and priorities that reflect shared values and best practices. Most importantly, the implementation of this Strategy will have a measurable impact on the experience and outcomes of care, and on the health of the American people.

The National Quality Strategy will pursue three broad aims that will be used to guide and assess local, State, and national efforts to improve health and the health care delivery system.

- **Better Care:** Improve the overall quality, by making health care more patient-centered, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in

addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

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Setting Priorities

To advance these aims, we plan to initially focus on six priorities. These priorities are based on research, input from a broad range of stakeholders, and examples from around the country, which suggest that we have great potential for rapidly improving health outcomes and increasing the value and effectiveness of care for all populations. As the National Quality Strategy is implemented in 2011 and beyond, we will work with stakeholders to create specific quantitative goals and measures for each of these priorities. They are:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These priorities can only be achieved with the active engagement of clinicians, patients, provider organizations, and many others in local communities across the country, something the National Quality Strategy supports. Since different communities across the Nation have different assets and needs, they will likely take different paths to achieving the six priorities. This Strategy will help assure that these local efforts are consistent with shared national aims and priorities.

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Building on Work in Progress

The National Quality Strategy builds on the work, achievements, and recommendations of millions of concerned and committed clinicians and other stakeholders. Over the past two decades, these stakeholders have devoted enormous energy and enthusiasm to defining, measuring, and improving quality. Many of these efforts have occurred through partnerships between government, private organizations, and consumers. And while some of these have been nationwide efforts, many have been deeply rooted in local communities.

Communities and States have often served as laboratories for expanding health coverage, improving quality, and controlling costs. That will be even truer in the years to come as States take the lead in implementing key parts of the Affordable Care Act, such as new State-based Health Insurance Exchanges. State Exchanges will improve health care quality by providing transparent information for consumers and by creating quality standards for health plans. And as we move forward, State leadership will be crucial to ensuring that the National Quality Strategy continues to reflect local needs.

Notably, these State and local efforts to improve quality have often occurred in spite of payment systems

and incentives that do not reward value or improve quality. In addition, for many clinicians and provider organizations, these efforts have been undertaken in the midst of competing incentives, regulations, and administrative complexity that foster confusion and create barriers to improvement. The National Quality Strategy will help change this.

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The Path Forward

The National Quality Strategy is designed to be an adaptable and evolving guide for the Nation. It is a broad roadmap that will require the ongoing development of specific goals, measures, benchmarks, and initiatives, through a continued transparent collaborative process with all stakeholders. It will continue to draw from pockets of excellence from which others can learn and which could eventually be brought to scale. At the Federal level, the National Quality Strategy will guide the development of HHS programs, regulations, and strategic plans for new initiatives, in addition to serving as a critical tool for evaluating the full range of Federal health care efforts.

The Affordable Care Act calls on the National Quality Strategy to include HHS agency-specific plans, goals, benchmarks, and standardized quality metrics where available. By design, this first-year Strategy does not include these elements, in order to allow them to be developed with additional collaboration and engagement of the participating agencies along with private sector consultation. We believe nation-wide support and subsequent impact is optimized when those needed to implement strategic plans participate fully in their development. We have begun implementation planning across HHS and have established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The Agency for Healthcare Research and Quality is tasked with supporting and coordinating the implementation planning and further development and updating of the Strategy.

As implementation of the National Quality Strategy proceeds, it will be periodically refined, based on lessons learned in the public and private sectors, emerging best practices, new research findings, and the changing needs of the Nation. Updates on the Strategy and the Nation's progress in meeting the three aims of better care, improved health, and making quality care more affordable will be delivered annually to Congress and the American people.

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Section II. Aims, Priorities, and Goals for Improving Quality

As noted earlier, the National Quality Strategy is guided by three broad aims: better care, healthier people and communities, and affordable quality care for all. These aims are not separate, but are interrelated and mutually reinforcing. For example, by reducing gaps in patient support that raise the risk of avoidable complications or readmissions, better care coordination leads to better patient outcomes. In addition, care coordination can also make care more affordable by reducing duplication and preventing costly hospital admissions or readmissions and avoidable emergency department visits. Because of these connections, national priorities should contribute to the achievement of all three aims.

As the National Quality Strategy is implemented in 2011, the priorities and initiatives listed in this report will be refined, additional goals will be identified, and quality metrics and benchmarks will be

applied to ensure accountability for performance. (The Appendix to this report lists examples of measures that may be useful for monitoring the Nation's progress in achieving the Strategy's priorities. Actual targets and measures will be identified later in 2011. And the first update on the National Quality Strategy provided to Congress and the Nation in 2012 will include additional detail on how Federal agencies are addressing the priorities and goals in agency-specific strategic plans.)

In this first report to Congress and the Nation, we describe initiatives that are currently underway within HHS for each priority area. The initiatives described are not intended to be an exhaustive catalogue, but rather a sample of initiatives that are already addressing the priorities identified in this plan.

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1. Making Care Safer

Health care-related errors harm millions of American patients each year and needlessly add billions of dollars to health care costs. The Centers for Disease Control and Prevention (CDC) estimate that at least 1.7 million healthcare-associated infections occur each year and lead to 99,000 deaths. Adverse medication events cause more than 770,000 injuries and deaths each year—and the cost of treating patients who are harmed by these events is estimated to be as high as $5 billion annually.

Health care providers should be relentless in their efforts to reduce the risk for injury from care, aiming for zero harm whenever possible and striving to create a system that reliably provides high-quality health care for everyone. This isn't easy. Such a system requires, for example, the design of standard operating procedures, a workforce with diverse yet complementary skills, workloads that allow enough time for errors to be corrected or mitigated and leadership that promotes continuous improvement. But this kind of system can also make a big difference in improving care, whether it's by preventing serious medication events or eliminating healthcare associated infections and other preventable conditions.

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Examples of Federal Initiatives Making Care Safer

1. **Michigan Keystone Intensive Care Unit Project:** Nearly one in every 20 hospitalized patients in the United States each year acquires a healthcare-associated infection while receiving medical care. Central intravenous line associated blood-stream infections are one of the most deadly types, with a mortality rate of 12 to 25 percent. In this AHRQ-funded project, a research team at Johns Hopkins University partnered with the Michigan Health and Hospital Association to implement CDC recommendations to reduce central line blood stream infections in 100 intensive care units throughout the State. The initiative, known as the "Keystone Project," reduced the rate of these central line bloodstream infections by two-thirds within 3 months. Over 18 months, the program saved more than 1,500 lives and nearly $200 million. These dramatic improvements have been sustained for 5 years and the approach used is now being spread to all 50 States and the District of Columbia. For more information, go to www.ahrq.gov/about/annualmtg07/0928slides/goeschel/Goeschel.ppt.
2. **Safe Use Initiative:** Today, tens of millions of people in the United States depend on prescription and over-the-counter medications to sustain their health—with as many as 3 billion prescriptions written annually. Too many people, however, suffer unnecessary injuries, and even death, as a result of preventable medication errors. The U.S. Food and Drug Administration (FDA) has launched the Safe Use Initiative to create and facilitate public and private collaborations within the health care community with the goal of reducing this preventable harm. The Safe Use

Initiative will identify specific, preventable medication risks and then develop, implement, and evaluate cross-sector interventions to reduce these risks.For more information, go to http://www.fda.gov/Drugs/DrugSafety/ucm187806.htm.

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2. Ensuring Person- and Family-Centered Care

Health care delivery in the United States is often not designed around meeting the needs of the patient. Instead, clinical services are often organized around specific clinical conditions and designed with little input or direction from the patient. We need to change that.

Health care should give each individual patient and family an active role in their care. Care should adapt readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds.

This kind of person-centered care, which sees a person as a multifaceted individual rather than the carrier of a particular symptom or illness, requires a partnership between the provider and the patient with shared power and responsibility in decision making and care management. It also requires giving the patient access to understandable information and decision support tools that help patients manage their health and navigate the health care delivery system. Person-centered care means defining success not just by the resolution of clinical syndromes but also by whether patients achieve their desired outcomes.

Some examples of person-centered care could be assuring that patients' feedback on their preferences, desired outcomes, and experiences of care is integrated into care delivery, integrating patient-generated data in electronic health records, and finding additional ways to involve patients and families in managing their care effectively.

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Examples of Federal Initiatives Fostering Person- and Family-Centered Care

1. **Building Patients' Perspectives Into All Performance Assessments:** The Federal government has taken the lead in assuring that the patient's perspective of care is a core measure of performance for providers and health plans. Starting with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare has used its purchasing power to get virtually all hospitals to publicly report standardized information on the perspective of all patients (including Medicare beneficiaries, Medicaid beneficiaries, and those with private insurance). This was the first large-scale initiative to include patient experience as a factor in quality reporting. In addition, the Affordable Care Act uses HCAHPS as one of the measures to calculate value-based incentive payments to hospitals beginning in 2012, and also calls on CMS to expand the use of patient experience information to assess physicians and other facilities, including nursing homes. For more information, go to https://www.cms.gov/HospitalQualityInits/30_HospitalHCAHPS.asp.
2. **Establishing the Patient-Centered Outcomes Research Institute:** Established as an independent, nonprofit organization under the Affordable Care Act, the Patient-Centered Outcomes Research Institute (PCORI) will build on the current work of AHRQ and NIH to assist patients, clinicians, and policymakers in making informed health decisions. To do this, PCORI will identify research projects that provide quality, relevant evidence on how diseases and health conditions can be effectively diagnosed, prevented, treated, and managed. The Act requires that

initial priorities for PCORI be informed by the National Quality Strategy, and that consumer input influence all phases of sponsored research, starting with developing the questions researchers will try to answer. The 21 members of the PCORI Board of Governors are made up of 19 members appointed by the Comptroller General and the Directors of AHRQ and NIH. For more information, go to http://pcori.org/.

3. **AHRQ's Patient-Centered Care Improvement Guide:** AHRQ has developed a guide to help hospitals become more patient-centered. It outlines best practices and addresses common barriers to implementing patient-centered care. For more information, go to http://www.innovations.ahrq.gov/content.aspx?id=2383.

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3. Promoting Effective Communication and Coordination of Care

When all of a patient's health care providers coordinate their efforts, it helps ensure that the patient gets the care and support he needs and wants, when and how he needs and wants it. Effective care coordination models have begun to show that they can deliver better quality and lower costs in settings that range from small physician practices to large hospital centers.

Health care systems need to encourage coordination and help providers care for patients with chronic diseases so they get the kind of seamless care that is most effective. Gaps and duplication in patient care delivery can be reduced or eliminated through proven technologies such as electronic health records, e-prescribing, and telemedicine. Hospitals and long-term care and rehabilitation facilities, along with physicians, nurses, and other clinicians working together, are helping recently discharged patients avoid unnecessary rehospitalization. All too often, however, the way health care is paid for does not foster coordination but instead pays more to providers for doing more instead of working together. Policies advanced by the National Quality Strategy will help change that.

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Examples of Federal Initiatives Promoting More Effective Care Coordination

1. **Advancing Primary Care Services and Medical Homes:** The Federal government is promoting better care coordination through multiple programs. In November 2010, CMS announced: (1) the participation of eight States in the Multi-Payer Advanced Primary Care Practice Demonstration to evaluate the effectiveness of health professionals across care systems working in a more integrated fashion and receiving more coordinated payment from Medicare, Medicaid, and private health plans. Ultimately this will provide advanced practice primary care for up to 1 million Medicare beneficiaries; (2) support to help States establish "health homes" to provide care to Medicaid beneficiaries with at least two chronic conditions; (3) the participation of up to 500 Federally Qualified Health Centers to test the effectiveness of health professionals working in teams to treat low-income patients at community health centers; and (4) the opportunity for States to apply for contracts to support development of new integrated care models aimed at improving care quality, care coordination, cost-effectiveness, and overall experiences of beneficiaries who are eligible for both Medicare and Medicaid, also known as "dual eligibles." For more information, go to http://innovations.cms.gov/news/pressreleases/pr110910.shtml.
2. **Developing Accountable Care Organizations:** As part of the Affordable Care Act, Congress directed CMS to establish a "shared savings program" to bring together groups of providers and

suppliers to deliver better quality and more cost-effective care for Medicare beneficiaries. CMS is currently engaging with physicians, hospitals, employers, and consumer groups to help plan this program, which the statute requires be established no later than January 2012. For more information, go to https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf.

3. **Improving Care Coordination Through Health Information Technology:** The Health Information Technology for Economic and Clinical Health (HITECH) Act allows HHS to establish programs to improve health care quality, safety, and efficiency through the adoption of health information technology, including electronic health records (EHRs) and private and secure electronic health information exchange. Eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives for improving care. Altogether, more than $27 billion in incentive payments is available to eligible providers and hospitals that meet these "meaningful use" objectives. A Federal regulation defining the first stage of meaningful use objectives was released in 2010. For more information, go to https://www.cms.gov/ehrincentiveprograms/. Meaningful use of health information technology improves quality by making needed clinical information accessible to all appropriate providers and in a more complete and timely fashion than paper records.

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4. Promoting the Most Effective Prevention and Treatment of the Leading Causes of Mortality, Starting With Cardiovascular Disease

More than 133 million Americans have at least one chronic illness, and many have several. As individuals and health systems feel the strain of this growing trend, we need to do a better job preventing and treating a number of leading causes of mortality and illness in adults and children including cardiovascular disease, cancer, diabetes, HIV/AIDS, premature births, and behavioral health conditions.

Among these, cardiovascular disease is the most deadly, accounting for one of every three deaths in the United States. Over $503 billion is spent annually on cardiovascular disease. And approximately 75 million Americans have high blood pressure, 18 million have a history of heart attack or angina, 6 million have a history of heart failure, and 6 million have a history of stroke. While mortality from cardiovascular disease has declined dramatically over the past forty years, current quality initiatives can help us do even better. For example, health plans with the best performance in managing cardiac risk factors (90th percentile) still only report effective care for 71 percent of patients.

Decades of research and practice have demonstrated that public health and clinical strategies can greatly reduce the risk of cardiovascular disease. The key interventions are referred to as the "ABCS": aspirin, blood pressure control, cholesterol reduction, and smoking cessation. Under this umbrella, activities that can improve heart health include reducing uncontrolled blood pressure and cholesterol, decreasing sodium and trans-fat intake, eliminating smoking and exposure to secondhand smoke, increasing aspirin use to prevent and reduce the severity of heart attacks and strokes, and lifestyle interventions to modify risk factors such as obesity.

By focusing on cardiovascular disease, we'll provide a model for how the Nation can make a dramatic and immediate impact on the health and health care of millions of Americans. And the lessons from this effort will inform complementary efforts addressing other conditions, including HIV/AIDS and other

chronic illnesses. Future initiatives will address a broad range of diseases and age ranges.

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Examples of Federal Initiatives Addressing the Leading Causes of Mortality

1. **CDC Community Transformation and Self Management Grants:** In 2011, the Affordable Care Act provides $750 million in prevention and public health funding to support a variety of activities to promote healthy living These grants represent a major commitment to promoting health in local communities, including reducing heart disease. Funding from CDC will support programs that reduce risk factors for chronic illnesses and discourage behaviors that increase risk.
2. **Focusing on Priority Conditions:** The National Quality Strategy highlights cardiovascular disease as a place to start, partially out of recognition of other important efforts already under way. For example:

- **The National HIV/AIDS Strategy:** On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the Nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015. In December 2010, HHS and five other lead agencies submitted NHAS operational plans to the White House, which were made public in February 2011. HHS is committed to NHAS priorities of preventing HIV infections, making more people aware of their HIV status, and giving people greater access to HIV care and treatment, using innovative, culturally appropriate means. For more information, go to http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/.
- **The Strategic Framework on Multiple Chronic Conditions:** In December 2010, HHS issued its new Strategic Framework on Multiple Chronic Conditions—an innovative, private-public sector collaboration. The new strategic framework will improve the overall health of individuals with multiple chronic conditions and reduce their risk of complications by providing more information and better tools to help health professionals—as well as patients—learn how to better coordinate and manage care and by facilitating research to improve care. For more information, go to http://www.hhs.gov/ash/initiatives/mcc/.

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5. Working With Communities to Promote Wide Use of Best Practices to Enable Healthy Living

Health is a state of physical, mental and social well-being and not merely the absence of disease or infirmity. Our health is affected by a range of factors such as individual behavior, access to health services, and the environment in which we live, in addition to biology and genetics.

The broad goal of promoting better health is one that is shared across the country, whether it's promoting healthy behaviors such as not using tobacco or fostering healthy environments that make it easier to exercise and get access to healthy foods. For that reason, successful efforts to improve these health factors rely on deploying evidence-based interventions through strong partnerships between local health care providers, public health professionals, and individuals.

One specific opportunity to improve health is by increasing the adoption of clinical preventive services for children and adults. When used correctly, these services can prevent illnesses and also identify them

at an earlier and more treatable stage. Clinical preventive services include such things as tobacco cessation services, screening for hypertension, high cholesterol, and depression and screening and counseling for risky alcohol behavior and other drug use. Another specific opportunity is to increase the adoption of evidence-based interventions to improve population health, such as those recommended by the CDC's Task Force on Community Preventive Services. The forthcoming National Prevention and Health Promotion Strategy will also align with the National Quality Strategy and will provide a more specific plan for improving population health.

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Examples of Federal Initiatives Supporting Better Health in Communities

1. **Putting Prevention to Work in Communities:** The American Recovery and Reinvestment Act of 2009 provided $650 million to carry out evidence-based clinical and community-based programs to prevent or delay chronic diseases and promote wellness in children and adults. Some of those funds went to "Communities Putting Prevention to Work," a program which supports policy and environmental changes at the local and State level that aim to increase levels of physical activity; improve nutrition; decrease obesity rates; and decrease smoking prevalence, teen smoking, and exposure to second-hand smoke. For more information, go to http://www.cdc.gov/CommunitiesPuttingPreventiontoWork/about/index.htm.
2. **First Lady's Let's Move! Campaign:** The Let's Move! campaign, started by First Lady Michelle Obama, has an ambitious national goal of addressing the challenge of childhood obesity within a generation so that children born today will reach adulthood at a healthy weight. Let's Move! is combating the epidemic of childhood obesity through a comprehensive approach that is engaging all the parties that affect the health of children, and providing schools, families, and communities with simple tools to help kids be more active, eat better, and get healthy. At the launch of the campaign, President Barack Obama signed a Presidential Memorandum creating the first-ever Task Force on Childhood Obesity to conduct a review of every single program and policy relating to child nutrition and physical activity, develop a national action plan to make the most of Federal resources, and set concrete benchmarks toward the First Lady's national goal. For more information, go to http://www.letsmove.gov/.
3. **Preventing Substance Abuse and Mental Illness in Tribal Communities:** Helping communities promote emotional health and reduce the likelihood of mental illness, substance abuse, and suicide is the goal of the Substance Abuse and Mental Health Services Administration's "Circles of Care" initiative. This initiative focuses on providing grants to Tribal communities to develop models of care, create new partnerships, and help community members to obtain comprehensive behavioral health services. Circles of Care currently support eight tribes and urban Indian organizations across the country. For more information, go to http://www.samhsa.gov/samhsaNewsletter/Volume_18_Number_6/CirclesOfCare.aspx.

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6. Making Quality Care More Affordable

For the past 30 years, health care spending has risen at a faster rate than the economy nearly every year. These rising costs have put a burden on America's families as patients, taxpayers, business owners, and employees who have seen a growing share of their paychecks go to pay for health care.

Yet there is good evidence that health care costs can be reduced while quality is improved. Making sure the right care is delivered to the right person at the right time every time can also make care more

affordable. The National Quality Strategy recognizes that while this will be a challenge, the goal of reducing costs is important to all because of the impact of increasing costs on families, employers, and State and Federal governments. Reducing costs must be considered hand-in-hand with the aims of expanding access, providing better care, and promoting population health.

For that reason, the National Quality Strategy will foster care strategies that reduce redundant and harmful care, for example, by reducing health care-acquired conditions; establish common measures that will help assess the cost impact of new programs and payment systems on families, employers, and the public sector, along with how well these programs support innovation and effective care; build measurement of cost and resource use—along with patient experience and outcomes—into the full range of public and private sector efforts to reform payment; reduce waste from undue administrative burdens; and make health care costs and quality more transparent to consumers and providers, so they can make better choices and decisions.

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Initiatives Making Care More Affordable

1. **Establishing Health Insurance Exchanges:** Today, individuals and small businesses looking to buy health insurance are often on their own, forced to choose between several undesirable options. Starting in 2014, State-based health insurance exchanges will lower costs and improve health care quality for individuals and small business owners by creating a more transparent and competitive marketplace. Exchanges will offer information on price and quality, so that insurers will compete on offering the best providers and services for the most affordable premium. By pooling people together, exchanges will also give individuals and small business owners purchasing power similar to that of large businesses. For more information, go to http://www.hhs.gov/news/press/2011pres/01/20110120b.html
2. **Fostering Innovations to Promote Quality and Reduce Cost:** The Affordable Care Act established a new Center for Medicare and Medicaid Innovation in CMS, charged with testing innovative payment and service delivery models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) that improve care and save money. In 2011, the Innovation Center will begin testing additional models and engage clinicians, consumers, employers, and other stakeholders around the common pursuit of creating a health care system that delivers high-quality care while keeping costs down for Medicare, Medicaid, and CHIP beneficiaries. For more information, go to http://innovations.cms.gov/.
3. **Administrative Simplification:** The Affordable Care Act includes provisions to foster "administrative simplification." Under those provisions, new tools will be adopted to help doctors and other providers focus on patients instead of paperwork, such as a standard unique identifier for health plans, a new standard for electronic funds transfer, and operating rules that provide more specificity to existing transaction standards. These provisions are expected to generate significant savings. As electronic transactions become easier, more providers will use them in place of costly paper or telephone communication. As a result, providers and plans will save from reduced phone calls, reduced postage and check printing costs, fewer rejected transactions, and more automated processes.

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Section III. Policies and Infrastructure Needed to Support Priorities

The National Quality Strategy sets forth broad aims, initial priorities and goals, and maps out early initiatives. Reaching these goals will be the product of the actions of many individuals and groups across the Nation. At the forefront, are the millions of committed clinicians and health professionals seeking to partner with their patients in providing the best possible care. States, licensing organizations, health care professional specialty organizations, accrediting organizations, consumer advocates, and private sector purchasers will also contribute. A national strategy must build on and support these efforts and create a common path forward that results in high quality, affordable care everywhere.

To achieve its objective of improving health and health care for all Americans, the National Quality Strategy promotes collaboration among stakeholders in the Nation's health system around several initiatives, including the Healthcare Associated Infection Prevention Initiative, Accountable Care Organizations, and Communities Putting Prevention to Work. The strategy counts on the actions taken by doctors, nurses and other clinicians; better informed choices made by patients and family members; and systems of care put in place by health care providers and institutions to ensure high quality and reliable care.

The Federal government plays a vital role in supporting the delivery of safe, high quality care, including paying for care, monitoring quality, addressing disparities, providing technical assistance, supporting research, and directly providing care to veterans, members of the military, Native Americans, and others. Similarly, State, local, and tribal governments can support better care delivery in their communities.

At the same time the strategy provides an ongoing opportunity to identify and learn from those providers and communities that are ahead of the quality care curve. It is our hope that this National Quality Strategy launches a new level of cooperation that reflects the Nation's highest aspirations for health and health care for all Americans. With the appropriate modifications and enhancements, the current "building blocks" of the U.S. health care system can become a foundation for a system that provides better care, a healthier population, and lower health costs

This National Quality Strategy—and all efforts to improve health and health care delivery—must be guided by a core set of principles. We identify 10 principles (available at www.ahrq.gov/workingforquality) that can be used when designing specific initiatives to achieve the National Quality Strategy's three aims.

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1. Payment

Payment arrangements should offer incentives that foster better health; promote quality improvement and greater value while creating an environment that fosters innovation. Health care systems should be rewarded for working collaboratively to improve efficiency and adopt evidence-based practices across the spectrum of inpatient and outpatient services. Medicare, State Medicaid programs, and many private sector health plans and purchasers are moving rapidly to change payment systems to reward coordination and better outcomes. New payment incentives and delivery models that will be launched under the auspices of the Medicare, Medicaid, and private sector partnerships will provide the opportunity to evaluate and bring successful models to scale.

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2. Public Reporting

Public reporting initiatives offer consumers and payers vehicles to compare costs, review treatment outcomes, assess patient satisfaction, and hold providers accountable. This is done while ensuring the protection of personal health information and adjusting for factors beyond providers' control. Reporting also provides important resources and motivation for clinicians and other providers to improve performance. You can see examples of these initiatives—sponsored by health plans, States, nonprofit groups and community consortiums, employer coalitions, and individual firms—on a variety of scales. Many provide information that can help guide patients' decisions about their health care providers. This reporting should be further refined and expanded with broader use of commonly endorsed measures of performance. The new consumer focused web site, healthcare.gov will also improve transparency. The site allows all consumers to view the insurance plans in their area, compare them by price and benefits and pick the one that is best for them and their families. There will also be hospital pricing information, in addition to performance data, available online to help inform consumer decisions about where to obtain care.

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3. Quality Improvement/Technical Assistance

Public and private efforts to support providers' desire to deliver higher quality care are critically important. These include programs sponsored by provider organizations and clinical specialty groups and quality improvement organizations (QIOs) that work cooperatively with physicians, hospitals, nursing homes, home health agencies, and others to disseminate research evidence to the point of care, share best practices and technical assistance. HHS is contracting with QIOs to drive quality improvement through collaboratives at the State level. Collaborative efforts at the local level are also a vital resource for measuring, monitoring, and improving quality of care.

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4. Certification, Accreditation, and Regulation

State and Federal regulations create public standards for safe, reliable care. Certification by State, Federal, or federally-approved accrediting organizations lets public and private payers, consumers, and other stakeholders know that a clinician or organization meets certain quality standards for health services. Standards applied by accrediting entities should continue to draw on the expertise of provider organizations, clinicians, purchasers, health plans, consumers, and measurement experts and be mindful of the burden placed on providers. Through their regulatory authority, State and Federal agencies overseeing provider organizations and facilities should continue to monitor providers, ensure feedback and accountability, and strengthen patient safety and quality improvement. For example, provider participation in public programs will be conditioned on more rigorous screening to ensure providers meet appropriate standards.

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5. Consumer Incentives and Benefit Designs

Consumer incentives, such as financial assistance for tobacco cessation programs, can help turn good

intentions into action. Some employers and private health plans already use the evidence-based programs to promote better health. Similar approaches can improve adherence to recommended medications, which many Americans fail to take, often due to cost. At the Federal level, HHS is promoting value-based insurance models. Value-based insurance provides incentives for consumers to choose high quality, efficient providers. In addition, clinicians and patients need information on the evidence supporting the care they give and receive.

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6. Measurement of Care Processes and Outcomes

Public and private stakeholders have worked hard to create accurate measurements for health care services quality. However, those efforts have relied largely on incomplete data generated from claims or patients' charts after an encounter with the health care system. Valid, reliable measures are the cornerstone of monitoring quality improvement efforts. In order to achieve the quality improvements envisioned by the National Quality Strategy, data on care delivery and outcomes should be measured using consistent, nationally-endorsed measures in order to provide information that is timely, actionable, and meaningful to both providers and patients. Across the country, there are efforts based in States and regional collaboratives that are at the cutting edge of measuring performance.

At the national level, HHS continues to help coordinate quality measurement efforts that address the National Quality Strategy's six priorities. The department will also develop national consensus on specific measures, data sources, and data collection procedures. Efforts will focus on aligning measurement efforts within value-based purchasing programs and will move toward measuring outcomes and patient experience. HHS will promote effective measurement while minimizing the burden of data collection by aligning measures across its programs, coordinating measurement with the private sector and developing a plan to integrate reporting on quality measures with the reporting requirements for meaningful use of electronic health records.

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7. Health Information Technology

Increased adoption of EHRs has the power to cut health care costs, reduce paperwork, improve outcomes, and give patients more control over their health care, while maintaining full protections on the privacy of individual health information. To promote adoption and improve the performance of the health care system, the HITECH Act was signed into law in 2009. The Act addresses obstacles to the adoption of EHRs and provides substantial financial incentives for the adoption and meaningful use of certified EHR technology. Meaningful use criteria include quality measurements that will be built on over the next several years. The goal is to build a system that supports clinical practice, research, public health, and the health of individual patients. The Office of the National Coordinator for Health Information Technology is focusing its efforts on engaging the private sector, including vendors, service companies, and insurers, to make health information exchange a reality. It is also working with health care providers through Beacon Community Programs, State Health Information Exchange Programs, and Regional Extension Centers to help expand the use of EHRs. At the same time, it builds on State and local efforts to promote better use of health information technology by engaging clinicians, employers, consumers, and others.

An increasing number of case studies demonstrate that health information technology improves quality.

A recent review published by AHRQ contained numerous examples of how health information technology can, for example, increase the likelihood that patients received life-saving treatment, or lower the frequency of a common type of hospital-acquired infection. (See *Using Health IT: Eight Quality Improvement Stories*, available at http://healthit.ahrq.gov/SuccessStoriesTHQIT.)

In one case, 15 nursing homes implemented an electronic documentation and clinical decision support system and subsequently observed a 34 percent decrease in high-risk pressure ulcers. In another case, a clinical decision support for emergency medical responders resulted in lower time-to-treatment for patients experiencing heart attacks. This increased the likelihood that patients received timely life-saving treatment. In a third example, use of clinical decision support through an EHR system in rural Iowa helped to reduce the rate of urinary tract infections after surgery. Using health information technology can also lead to improved efficiencies in health care delivery. One example from the AHRQ report is a continuity of care record that helped decrease the number of emergency room visits made by children who had experienced barriers to care. Another involved using formulary decision support to identify prescription drug savings for insurers and patients.

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8. Evaluation and Feedback

Clinicians and other providers need timely and actionable feedback in order to improve. Similarly, new innovations in delivery and payment need robust and rapid evaluation to support potential widespread implementation. One example of this can be found in patient safety organizations (PSOs). PSOs were created to provide feedback to health care organizations, on a voluntary basis, to improve patient safety and quality of care. These private organizations have expertise in identifying and analyzing confidential data reported to them by hospitals and physicians. They then provide feedback on ways to reduce or eliminate risks. Another example of useful feedback is the information provided to clinicians as part of their professional certification. Health plans also provide feedback to their contracted providers to identify gaps in care.

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9. Training, Professional Certification, and Workforce and Capacity Development

To achieve the aims and goals of the National Quality Strategy, health care professionals should be encouraged to maximize their training and skills through life-long learning that includes the application of quality improvement principles and patient safety systems concepts such as teamwork. At the same time, there is a need for a new generation of health care professionals. The Affordable Care Act provides $1.5 billion over 5 years to expand the National Health Service Corps (NHSC). This follows a $300 million investment that the American Recovery and Reinvestment Act of 2009 made in the program. As of September 30, 2010, the NHSC is a network of 7,500 primary health care professionals and 10,000 sites in underserved communities across the country providing valuable services to persons who would otherwise lack access to primary care. To support their service, the NHSC provides physicians, nurse practitioners, physician assistants, and other health professionals with financial support in the form of loan repayment and scholarships. The Health Resources and Services Administration's National Center for Health Workforce Analysis is working to identify workforce shortages and advise where resources might be best placed. At the same time, boards of medicine, nursing, and other providers enhance the quality of care that patients receive by requiring that practitioners continually demonstrate skills and

knowledge critical to their field. Promisingly, board policies are increasingly promoting a lifelong commitment to learning and the adoption of new evidence-based practices. Certification programs can also serve as a valuable tool for consumers to use as they choose a health care provider.

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10. Promoting Innovation and Rapid-Cycle Learning

Thanks to innovations in care, collaboration, and communication our health care system has made major strides in the detection and treatment of diseases and care delivery. But too often, these improved models are not known outside of the organization that created them. The Center for Medicare and Medicaid Innovation is part of a broad array of public and private sector efforts seeking to fix that problem. The Innovation Center is supporting new models of care and innovative practices for Medicare, Medicaid, and CHIP beneficiaries, with the goal, for example, of improving transitions from various health settings within a patient's community.

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Section IV. Next Steps

The National Quality Strategy is designed to adapt with the evolving health needs of the Nation. It is a broad roadmap that will require the ongoing development of specific goals and agreed-upon metrics. It will depend on initiatives launched through a public and private sector collaboration that builds on the successes already under way and respects the needs and priorities of local communities. This approach reflects the direction and support provided to the Secretary by the Affordable Care Act.

The National Quality Strategy will be shaped by recommendations and feedback from the private sector and with State engagement. Consumers, hospitals, clinicians, insurers, businesses, drug and device manufacturers, representatives of the health information technology industry, and other key stakeholders will be engaged to participate in improvement initiatives, identify the practical impact of public and private sector policies to improve quality, and guide public and private sector policymakers to expand or modify those policies as needed.

From the perspective of the Federal government, the National Quality Strategy will serve as a guide for HHS agencies as they develop programs, regulations, and new initiatives, as well as a vital tool in evaluating the full range of Federal health care efforts.

The Affordable Care Act calls on the National Quality Strategy to include HHS agency-specific plans, goals, benchmarks, and standardized quality metrics where available. By design, this first-year Strategy does not include these elements, in order to allow them to be developed with additional collaboration and engagement of the participating agencies along with private sector consultation. We believe nation-wide support and subsequent impact is optimized when those needed to implement strategic plans participate fully in their development. We have begun implementation planning across HHS and have established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The Agency for Healthcare Research and Quality is tasked with supporting and coordinating the implementation planning and further development and updating of the Strategy.

In addition, a Federal Interagency Working Group on Health Care Quality will begin working in 2011. It will be composed of senior-level members of Federal departments and agencies with jurisdiction over

health care quality and quality improvement. Their mission will be to collaborate, cooperate, and consult with departments and agencies that develop and disseminate the strategies, goals, models, and timetables that will advance the national priorities outlined in the National Quality Strategy. The main goals of this effort are to avoid duplication of efforts, assure accountability, and, where possible, develop a streamlined approach for quality reporting.

The National Quality Strategy will continue to be refined based on public and private sector experiences, best practices, research findings, and emerging health needs. Updates on the Strategy and the nation's progress in meeting the three aims of better care, improved health, and making care more affordable for all Americans will be reported annually to Congress and the public.

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APPENDIX: National Quality Strategy Priorities and Goals, With Illustrative Measures

The goals and illustrative measures described here are designed to begin a dialogue that will continue throughout 2011. The next version of the National Quality Strategy will reflect specific measures and include short-term and long-term goals. HHS will promote effective measurement while minimizing the burden of data collection by aligning measures across its programs, coordinating measurement with the private sector and developing a plan to integrate reporting on quality measures with the reporting requirements for meaningful use of electronic health records. All measures will be specifically assessed with the goal of making sure they can be included in electronic collection systems.

Appendix Table: National Quality Strategy Priorities and Goals, With Illustrative Measures

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
#1 Safer Care	**Goal:** Eliminate preventable health care-acquired conditions **Opportunities for success:** • Eliminate hospital-acquired infections • Reduce the number of serious adverse medication events **Illustrative measures:** • Standardized infection ratio for central line-associated blood stream infection as reported by CDC's National Healthcare Safety Network • Incidence of serious adverse medication events
#2 Effective Care Coordination	**Goal:** Create a delivery system that is less fragmented and more coordinated, where handoffs are clear, and patients and clinicians have the information they need to optimize the patient-clinician partnership **Opportunities for success:** • Reduce preventable hospital admissions and readmissions

	• Prevent and manage chronic illness and disability • Ensure secure information exchange to facilitate efficient care delivery **Illustrative measures:** • All-cause readmissions within 30 days of discharge • Percentage of providers who provide a summary record of care for transitions and referrals
#3 Person- and Family-Centered Care	**Goal:** Build a system that has the capacity to capture and act on patient-reported information, including preferences, desired outcomes, and experiences with health care **Opportunities for success:** • Integrate patient feedback on preferences, functional outcomes, and experiences of care into all care settings and care delivery • Increase use of EHRs that capture the voice of the patient by integrating patient-generated data in EHRs • Routinely measure patient engagement and self-management, shared decision-making, and patient-reported outcomes **Illustrative measures:** • Percentage of patients asked for feedback
#4 Prevention and Treatment of Leading Causes of Mortality	**Goal:** Prevent and reduce the harm caused by cardiovascular disease **Opportunities for success:** • Increase blood pressure control in adults • Reduce high cholesterol levels in adults • Increase the use of aspirin to prevent cardiovascular disease • Decrease smoking among adults and adolescents **Illustrative measures:** • Percentage of patients ages 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg • Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is <100 • Percentage of patients with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period • Percentage of patients who received evidence-based smoking cessation services (e.g., medications)
#5 Supporting Better Health in	**Goal:** Support every U.S. community as it pursues its local health priorities

Communities	**Opportunities for success:** • Increase the provision of clinical preventive services for children and adults • Increase the adoption of evidence-based interventions to improve health **Illustrative measures:** • Percentage of children and adults screened for depression and receiving a documented follow-up plan • Percentage of adults screened for risky alcohol use and if positive, received brief counseling • Percentage of children and adults who use the oral health care system each year • Proportion of U.S. population served by community water systems with optimally fluoridated water
#6 **Making Care More Affordable**	**Goal:** Identify and apply measures that can serve as effective indicators of progress in reducing costs **Opportunities for success:** • Build cost and resource use measurement into payment reforms • Establish common measures to assess the cost impacts of new programs and payment systems • Reduce amount of health care spending that goes to administrative burden • Make costs and quality more transparent to consumers **Illustrative measures:** • To be developed

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