



**Statement of Robert A. Greene, MD
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Before the Quality Measures and Clinical Quality Workgroups
May 19, 2011

Introduction

Chairs Lansky, Walker, and Kmetik, and Members of the Work Groups, thank you for the opportunity to testify today about electronically reported meaningful use quality measures that are both useful and meaningful.

I am Dr. Robert A. Greene, National Vice President for Clinical Analytics at UnitedHealthcare. UnitedHealthcare (UHC) is the insurance benefits business of UnitedHealth Group. UnitedHealthcare serves 37 million members in employer and individual insurance, managed Medicare, managed Medicaid, and military benefit plans. UnitedHealth Group (UHG) serves the health care needs of more than 75 million individuals, develops and advances new health technologies and enhances financial and operational connectivity across the health care system. Our role as a national leader in both private and public health benefits programs and services enables us to continuously foster innovative health solutions aimed at creating a modern health care system that is more accessible, affordable and higher quality for all Americans. Through our relationship with more than 5,200 hospitals and 650,000 physicians and other health professionals, including 65,000 pharmacies in all 50 states, we have a very detailed picture of the health care delivery system.

I appreciate the opportunity to talk with you today about the need for solid quality measures to drive better health system performance based on outcomes, quality, and cost. After reviewing the MU Stage 1 measures, and Stage 2 and 3 frameworks, we conclude that while these are necessary and laudable efforts, **they suffer from a conspicuous, consistent, and striking omission: they are insufficient in that they do not provide high-value measures that address the urgent need to evaluate the efficient use of healthcare assets in addition to evaluating the quality of care delivery.** At this moment in our nation's history, both of these concerns are essential, and the proposed measure sets and framework are inadequate to meet this critical task. We suggest the Work Groups refine the measure sets and framework to add high value measures that will assist in improving care while lowering costs. There also needs to be a fundamental coordination of effort across programs to ensure proper performance measurement.

Background

Any discussion of the future and desirable direction of clinical quality measures should start with the general issues and limitations of current standards. Addressing the Work Group's questions in this context is important to highlight the gaps in measures, and the need to move aggressively to better standards based on a hierarchy of preferred outcomes, namely, decreased defects in care, improved patient safety, improved care and lower health costs. I believe the Committee should take immediate and specific short-term actions to improve the proposed quality measures sets, and will suggest a longer term strategy for future measure development.

Classifications of quality measures

Quality measurement in medicine has been described by two dominant models. Dr. Avedis Donabedian proposed a descriptive taxonomy: structure, process, or outcome measures¹. Many add “intermediate outcomes” for example laboratory tests such as hemoglobin A1c (HbA1c) levels, where good results are strongly associated with preferred long term disease outcomes.

Examples from meaningful use Stage 1 include maintaining active problem, medication, and allergy lists (structure measures) and perform medication reconciliation (a process measure). There are virtually no pure outcome measures. NQF 0018, Controlling High Blood Pressure, and NQF 0575 Diabetes: HbA1c Control (< 8%) are intermediate outcome measures.

Underuse

A second important dimension is a functional taxonomy proposed by Dr. Mark Chassin, now of the Joint Commission.² In this schema, measures address underuse, misuse, and overuse of interventions. Underuse measures encompasses the interventions of which more are desirable, and include well know measures related to breast and cervical cancer screening, yearly tests for diabetes control, and appropriate use of inhaled medications for asthma. These are well represented in the meaningful use measures.

Overuse

Overuse represents the opposite situation: interventions where there is evidence against use, and where fewer are desirable. The appropriate use of magnetic resonance imaging (MRI), in low back pain is a classic example of an overuse measure. Addressing overuse and related clinically inappropriate care would increase quality while decreasing costs.

Misuse

Misuse was originally intended to describe the occurrence of preventable complications despite otherwise appropriate services, such as a patient receiving penicillin appropriately for strep throat, but developing a rash from a known medical allergy. The term is most commonly used in its usually English language connotation, however, to describe situations such as the use of antibiotics for viral upper respiratory infections, and in that way tend to blur into the definition of overuse.

Utilizing these schemas to analyze quality measures

¹ Donabedian A. 1988. The quality of care. How can it be assessed? *JAMA*. 1988;260:1743-1748.

² Chassin MR, Galvin RW. The Urgent Need to Improve Health Care Quality. *JAMA*. 1998;280:1000-1005.

A number of important measures do not neatly fall into these categories. While care coordination is important, it seems somewhat contrived to call it an underuse measure of communications process. Nonetheless we find these dimensions useful because they enable identification of significant areas where progress remains to be made. Among several commonly used measurement sets (NCQA HEDIS, NQF Endorsed Measures, the proposed ACO measures, and the AMA PCPI measures) fewer than 10% of measures address overuse or appropriate use.

National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS): The 2011 edition³ contains 40 effectiveness of care measures. **Three** (7.5%) of the 40 address overuse: imaging in low back pain, use of antibiotics in adults with bronchitis, and use of antibiotics in children with upper respiratory infections. The remainder are underuse process measures related to chronic disease and preventive care. A separate section contains 6 measures of relative resource use. (NCQA also measures several other characteristics of health plans such as access to care.)

NQF Endorsed ® Measures: The current list⁴ contains 730 measures. Approximately 40 (6%) are overuse or appropriate use measures. There are about 100 measures of poor outcomes, readmissions, or mortality, with a number of overlaps.

Proposed ACO Measures: The notice of proposed rulemaking contains 65 measures, including 5 structure measures, 34 process measures, 9 intermediate outcome measures, 9 outcome measures (readmissions, hospital acquired conditions, and 7 AHRQ PQI measures), and 8 patient experience of care measures. All 34 process measures are underuse measures.

AMA Physician Consortium for Performance Improvement (PCPI) Measures: Out of more than 260 individual measures,⁵ only 14 address overuse or appropriate use (about 5%).

MU stage 2 eMeasures: Of the 113 proposed measures, fewer than 10 (<9%) address overuse or appropriate use.

Using the Donabedian and Chassin dimensions, it can be seen that the majority of the measures are structure and process measures, and that they are very heavily weighted to underuse measures and not overuse or appropriate use measures.

UnitedHealthcare is committed to filling gaps in underuse of key medical interventions, and has implemented several large scale programs to help physicians to do so. Underuse

³ NCQA Measure Summary Table, accessed May 9, 2011, at <http://www.ncqa.org/Portals/0/HEDISQM/HEDIS%202011/HEDIS%202011%20Measures.pdf>

⁴ National Quality Forum, accessed May 9, 2011, at http://www.qualityforum.org/Measures_List.aspx

⁵ AMA PCPI Measures, accessed May 10, 2011, at <http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.page?>

quality measures are well represented in the UnitedHealth Premium ® physician designation program, which includes an extensive quality reporting system. We have developed, and will deploy later this year, an online HEDIS gap portal, to be updated monthly, so that any physician seeing a UHC patient can assess needed interventions at the point of. We support traditional medical quality measures including patient safety measures, underuse of cancer screening, and measures of chronic disease care. However, such measures are not sufficient to address the crisis of rising health care costs.

Underuse Measures Are Important but Do Not Address Key Problems

Many additional measurement sets could be analyzed, and few if any are significantly different from the examples cited above. Despite the urgent need improve affordability, current measure sets and short term plans for performance measurement in health care are plagued by:

- **Important Gaps:** There is a conspicuous lack of outcome, appropriateness (in the sense of proper indication), utilization, and overuse measures at every level, especially for specialty and surgical care, outpatient diagnostic and therapeutic procedures and new biological agents
- **Lost opportunities:** Use of measures with limited scope, and lack of use of important NQF endorsed measures.
- **Low Value Measures:** Continued use of measure representing minimal standard of care, such as optic nerve evaluation for primary open angle glaucoma.

The meaningful use measures, and especially the 113 proposed NQF eMeasures, reflect these problems. The overwhelming majority of current quality measures are weak structure and process measures that only indirectly address costs.

We note furthermore that the NQS strategy includes affordability (Slide 5 of the April 12 presentation) but only as two general priority areas: Providing effective communications and coordination of care, and working with communities to promote wide use of best practices to enable healthy living.

We repeat: although all these efforts are praiseworthy, they are insufficient in that they do not provide high-value measures that address the urgent need to evaluate the efficient use of healthcare assets in addition to evaluating the quality of care delivery. .

The bottom line: we must go beyond structure and process underuse measures to measures that solidly address clinical appropriateness and overuse. In this area we as a profession, and the program standards for Meaningful Use specifically, are significantly lacking. This paucity of appropriate use and cost-efficiency measures in HEDIS, NQF, PCPI, meaningful use, and other programs translates into worse care and higher costs for all.

Suggested Short-Term Improvements

Certain measures can be added to the meaningful measure set immediately to improve quality and costs:

- **Address lost opportunities:** Meaningful use should include an all-condition all-cause readmission measure such as NQF #0329, maintained by UnitedHealth Group. We do not recommend the three CMS disease specific all-cause readmission measures because they leave 85-90% of readmissions on the table.
- **Use additional NQF Endorsed measures:**
 - Couple NQF #0328, adjusted inpatient average length of stay, to the all condition all cause readmission measure. NQF #0328 is also maintained by UnitedHealth Group. Unnecessary hospital days increase patients' exposure to hospital acquired conditions and infections. In addition, intentionally coupling average lengths of stay with readmissions is an effective counter-balance, since readmissions could conceivably be reduced by simply keeping patients in the hospital unnecessarily longer during the index admission.
 - Use the two antibiotic overuse measures
 - NQF #0058, Inappropriate antibiotic treatment for adults with acute bronchitis
 - NQF #0069, Appropriate treatment for children with upper respiratory infection (URI)
 - Use of AHRQ Patient Safety Indicators (PSIs) in eMeasures
- **Focus effort:** Spend less time and effort on measures of low impact such as NQF #0086, Primary Open Angle Glaucoma: Optic Nerve Evaluation: Percentage of patients who have an optic nerve head evaluation during one or more office visits within 12 months (represents a minimal standard of care). Additional low impact measures are listed in the attached comments on MU eMeasures

A Path to Future Measure Development

We believe that the current approach to quality of care measurement should be reframed. While our existing quality measures are consistent with the well understood responsibilities of physicians and health professionals to continuously improve the quality of care, we are still falling short on the related responsibility to address affordable access to healthcare for our nation's citizens and patients. The widespread adoption of the charter on professionalism provides eloquent support for this dual accountability.

As such, it is well past time for healthcare to learn from other industries by addressing defects in the processes required to deliver a service. Our existing quality measures do not correlate well with costs, while in other industries increasing quality means decreasing defects in production, with resultant decrease in costs. This suggests the need to develop and utilize measures that reflect true care quality deficits.

Measure development always begins with assessing and prioritizing according to the basics such as:

- High volume
- High cost
- High degrees of variation
- High opportunity for improvement
- Existence (and incorporation or development) of an evidence base
- Areas that are actionable
- Feasible sources of data

We believe that the next step in measure development should be prioritization by the severity and type of the quality defect. We suggest the hierarchy below. We have begun to use this hierarchy to develop additional measures, guided by data on the size and severity of these defects. We give examples of areas we believe are especially important to address.

- Defects in outcomes of medical care
 - Readmissions, coupled with adjusted inpatient average length of stay per admission
 - Hospital acquired conditions/infections (HAC/HAI), using broader definitions than CMS
 - Outpatient facility acquired complications and infections
 - Patient Safety Outcomes such as AHRQ PSI
- Inappropriate diagnostic or therapeutic interventions where each instance directly exposes patients to harm
 - Inappropriate CT scans: Unnecessary radiation
 - Inappropriate spinal fusions: Unnecessary surgery
- Overuse issues, understood as inappropriate interventions with potential to cause harm
 - Antibiotic overuse (potential adverse effects and antibiotic resistance)
 - Inappropriate MRI or CT scans
 - Dye exposure
 - False positive results generating anxiety and additional procedures
 - Inappropriate site of service such as ER escalation to inpatient admission, which exposes patient potentially to HAC
- Selected underuse measures
 - Underuse of prophylactic migraine medication
 - Medication use linked to outcomes such as blood pressure control
- Selected structural measures
 - Lack of an advance directive could lead to inappropriate interventions

I have attached our additional specific recommendations to my testimony regarding defects in the process and specific clinical quality measures the Committees should adopt in order to move patient safety, care quality, outcomes and cost improvement forward.

For any given measure, analogous versions are needed across multiple levels of care, such as physician groups, patient centered medical homes, and accountable care organizations, corresponding to payment reform needs. Therefore a critical piece to this puzzle is alignment across programs and standards developers to ensure we are moving towards a common goal of uniform assessment. For example, the three standards in MU will not prepare health professionals to become an Accountable Care Organization as part of the Shared Savings program. The 65 clinical quality measures in the ACO NPRM will enhance care coordination across providers, but in spite of, not because of, MU. We need to do a better job of alignment and coordination. I was glad to see the Work Group discussed these issues on May 5, and we have provided our thoughts to the ONC in our comments on the Five Year Strategic Plan that was recently released.

Conclusion

We cannot get where ONC, HHS and many in this room want to go in cost and quality improvement without the right tools. We are not on track through the MU process to achieve the goals of a high value health system. With costs escalating unsustainably, and patient safety threatened on a daily basis, not acting simply is not an option. We must address quality defects and costs ASAP.

The problems we have are largely understood: we leave good measures unused, and known gaps unfilled. UnitedHealthcare is committed to applying and developing additional quality, overuse, and appropriateness measures. We are committed to leadership where we can influence the outcomes. But we need the ONC, and your Work Groups, to step up, take charge, and demand the measurement tools necessary to transform health care services into better, more efficient outcomes for patients. The question I have for you is, will we continue down an incremental path to a few more measures, or will your Work Groups lead?

I appreciate the opportunity to testify today and welcome any questions you might have.