



Statement from the Alliance of Specialty Medicine in reaction to HHS Report on National Strategy for Quality Improvement in Health Care

On March 21, 2011, the Department of Health and Human Services released a report to Congress detailing the National Strategy for Quality Improvement in Health Care, as required by section 3011 of the “Patient Protection and Affordable Care Act” (PPACA). Under section 3011, this annual report to Congress includes agency-specific plans, goals, benchmarks, and standardized quality metrics. This first report outlines the initial strategy for quality improvement and plan for implementation. In reaction to this report, The Alliance of Specialty Medicine released the following statement:

The Alliance of Specialty Medicine supports the federal government’s effort to develop a transparent, coordinated, and actionable national quality strategy, and thanks HHS for collaborating with physicians, patient, and other important stakeholders to develop a National Strategy for Quality Improvement in Healthcare. Each of the Alliance’s specialty association members is committed to providing the highest quality patient care and has been actively engaged in efforts to improve quality in a manner that is feasible, based on the best available clinical evidence, and most appropriate for the individual patient.

We are very pleased to see that the U.S. Department of Health and Human Services placed a significant emphasis on reducing cardiovascular disease, a chronic illness that accounts for one of every three deaths in the United States. Cardiovascular Medical Societies welcome new direction on health care delivery and shares in the National Quality Strategy commitment in promoting effective prevention and treatment practices, as well as accreditation guidance for providers, to enhance quality cardiovascular patient care.

The foundational goal of any national quality strategy should be education and reliable information rather than enforcement. We hope HHS will keep this goal in mind while implementing its national strategy and encourage the development of clinically meaningful educational tools and programs that promote continuous learning and improvements in care.

We applaud HHS’s effort to encourage consistency and alignment among public and private quality improvement efforts. The current quality enterprise is ambitious, but often fragmented and poorly coordinated, which results in inconsistent goals and unnecessary duplication of effort. Requiring physicians to devote more time to paperwork than to patient care will result in dissatisfied patients and physician, reduced patient access to care, and increased costs—all of which will undermine the intended goals of quality improvement in health care.

The Alliance also supports HHS’s goal to reduce redundant and harmful care. However, it is critical that efforts to rein in health care spending are not simply about cutting costs. Public and private

payers must distinguish between appropriate, necessary, and evidence-based care and arbitrary cost-cutting mechanisms that could hamper patient access to such care. Similarly, strategies must be developed to differentiate between unwarranted variation and warranted variation in care.

Patients need objective, transparent, reliable and understandable information on which to base their health care decisions. The Alliance cautions HHS that public reporting should only take place when an evidence base exists to ensure information is accurate, meaningful, and well constructed. Physicians, patients and even payers must clearly understand health care data in a way that allows for both actionable quality improvement and useful decision-making.

Finally, we continue to caution that quality goals be set at an attainable level and take into account whether the infrastructure needed to achieve those goals has been developed, is well-tested and is functional. Federal incentives programs aimed at stimulating the adoption of health information technology, for example, still do not reflect differences in “meaningful use” across different specialties. There are also still gaps in the availability of federally certified systems that support information exchange. As a result, these programs continue to represent a substantial burden for most specialists, who are already facing substantial cuts in Medicare reimbursement, new requirements for ICD-10 coding, new privacy and security rules, and multiple other current quality reporting requirements. Furthermore, commonly adopted measures of both quality and cost have not yet been carefully tested, do not yet incorporate fair risk-adjustment mechanisms and have not yet been shown to result in improved patient outcomes. While the need to improve the quality of health care is urgent, artificial timelines that do not account for clinical readiness could hamper the achievement of that goal.

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