

**Written Statement of**

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**Before the  
House Committee on Energy and Commerce  
Subcommittee on Health**

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Chairmen Waxman and Pallone, (Chairman Emeritus Dingell), Ranking Members Barton and Deal, and Members of the Subcommittee, thank you for the opportunity to appear before the subcommittee today. I am Dr. Janet Wright, ACC's Senior Vice President for Science and Quality. I am a board-certified cardiologist having trained in San Francisco and practiced for 25 years in northern California.

On behalf of the 37,000 members of the American College of Cardiology (ACC), I commend you for setting out the many positive reforms in the recently released Tri-Committee health reform discussion draft. ACC believes comprehensive reform of our current health care delivery system is essential and we stand ready to assist in this important effort.

Health Care Transparency Commission Act of 2009

Ranking Member Barton invited me to speak today about his draft proposal, the "Health Care Transparency Commission Act of 2009," and I'm delighted to offer these written comments.

The ACC values performance measurement, analysis, and improvement and demonstrates this commitment by its 25 year history of clinical guideline development; its generation of appropriate use criteria for guidance in the optimal use of technology, procedures, and treatment; its implementation science efforts such as D2B: The Alliance for Quality and H2H: Hospital to Home, Excellence in Transitions; and finally by the development and maintenance of hospital and ambulatory registries/quality improvement programs, now present in over 2300 hospitals and 600 practices around the country.

These data are the foundation of performance and quality improvement (QI) and serve to stimulate innovation, healthy competition, and rapid and continuous learning among providers. As the science of performance measurement improves and the skill of communicating statistics to laypersons is honed, consumers will likewise find great value in quality information. **The College strongly supports the public's right to valid, actionable, current data to inform and enhance decision-making.** We have

committed to preparing our multiple registries for transparency and find Mr. Barton's proposal to be a laudable one and, should Congress proceed in this direction, we recommend consideration of the following principles:

**1. The driving force behind physician performance measurement and public reporting systems should be to promote quality improvement.** Ideally, any assessment program should promote improvement in the quality and outcomes of care and have limited unintended consequences. A well-designed public reporting program should, therefore, be aimed at raising the performance of all providers and thereby increase access to high-quality care for everyone.

**2. Public reporting programs should be based on performance measures with scientific validity.** The evidence supporting the clinical processes that are the focus of the measures being used should be explicitly stated, transparent with respect to data sources, the validation of the data collection, and the statistical and reporting methodologies used including the limitations of those methodologies. Physicians, through their specialty societies, are well-qualified to understand the clinically relevant issues facing the field as well as how these can be translated into credible performance measures.

**3. Public reporting programs should be developed in partnership with physicians.** Clinicians are responsible for the burden of data collection and should be ultimately the drivers of provider quality improvement. Therefore, physicians should participate in testing the measurement system prior to any public reporting and should be offered feedback in a manner that would help inform and stimulate practice change.

**4. Every effort should be made to use standardized data elements to assess and report performance and to make the submission process uniform across all public reporting programs.** A universal reporting format will lower the administrative burden of data entry; facilitate comparative analyses; maximize provider participation; and, therefore, create the most meaningful platform for performance assessment and improvement.

**5. Performance reporting should occur at the appropriate level of accountability.** The modern practice of cardiovascular medicine is accomplished by teams of providers that include nurses, nurse practitioners, physician assistants, primary care physicians, and physicians in the various subspecialties of cardiology. While individual provider data have value to the team in its effort to improve quality, these data are unlikely to be useful to payers and consumers. Attributing an outcome or measure to a single physician oversimplifies performance measurement at best. At its worst, such an approach undermines the preferred model of team-based care and the ideal collaborative design necessary to deliver patient-centered, effective, and safe health care.

**6. All public reporting programs should include a formal process for evaluating the impact of the program on the quality and cost of health care including an assessment of unintended consequences.** Physician performance measurement,

particularly in the ambulatory setting, is still in its early stage and there is limited experience with public reporting of these measures. The potential impact of unintended consequences on the quality and cost of care is great, especially with respect to patient access to care and physicians' practice patterns. Those who choose to publicly report data should be accountable for analyzing their program's consequences—both good and bad; reporting the results of those analyses to all of the involved constituencies; and modifying the program in order to achieve maximum benefit for patients. These rigorous analyses will not only serve to make reporting programs more effective but should also provide a stimulus for focused health-services research and offer the potential for providing an invaluable laboratory for quality improvement.

### Conclusion

At its best, public reporting is intended to stimulate focused efforts to eliminate the gaps in care that jeopardize the health of patients and contribute to excessive expenditures. Poorly designed programs risk misleading patients about the quality of their care, damaging the therapeutic relationships with their providers, and creating greater disparities in care delivery.

In closing, let me again congratulate the Committee for its discussion draft to reform America's health care system. The College appreciates how the draft seeks to reform the Medicare physician payment system ("the SGR"). We have some additional ideas on how we can improve cardiovascular care in such a way that will greatly improve quality, produce better patient outcomes, and reduce cost. We have significant concern, however, in the discussion draft's arbitrary adjustment to the utilization rate of imaging equipment from 50 percent to 75 percent and what impact that will have on patient access to imaging services.

I would be happy to address these or any other issues or assist your work in any way.