

Giving Patients the Right Care At the Right Time

SUMMARY

Consumers Union's goal for health reform is a sustainable system that contributes to a healthy American population. Achieving that goal involves more than just ensuring that all Americans have access to health care insurance. It also means improving the way health care is delivered and used in our nation.

Today, there is a substantial gap that exists between what we know works and what is provided in the U.S. health care system. Far too many patients do not receive recommended levels of care. An unacceptable portion of the care we receive is unsafe and even harmful. Furthermore, too often doctors and consumers lack basic information about which, among alternate treatments, are the most clinically effective.

While we don't have all the answers, there is some consensus on the types of changes that can improve our nation's health care delivery system. In general, these approaches change the incentives facing patients, doctors and hospitals to encourage more engaged patients, increase the focus on prevention and promote greater more coordination of care.

New legislation or regulations, by themselves, can't deliver better patient care. However, Consumers Union supports reforms can remove barriers and provide incentives to providers and health plans to adopt new practice methods. These reforms include aligning financial incentives with the provision of patient-centered care; developing common standards so it is less risky to invest in the needed technological infrastructure; requiring greater transparency of health care prices, quality, safety, treatment effectiveness, and business practices; and, most importantly, funding and evaluating "pilots" that improve our understanding of the deliver system changes that our country needs.

Improving Health Care Delivery

Consumers Union’s goal for health reform is a sustainable system that contributes to a healthy American population. Achieving that goal involves more than just ensuring that all Americans have access to health care insurance.¹ It also means improving the way health care is delivered and used in this nation.

Today, an unacceptable portion of the care we receive is actually harmful.

Today, doctors and consumers lack basic information about which, among alternate treatments, are the most clinically effective. Less than half of the medical care provided in the United States that is based on, or supported by, adequate evidence, according the Institute of Medicine.²

Today, even when effective medical practices are understood, this is often not the care provided. On average, American adults received just 55% of recommended care.³ The uninsured and underinsured often receive too little care. In contrast, many insured patients receive too much care. Doctors and hospitals are paid for every service performed, which encourages over treatment. Furthermore, some providers face “conflicts of interest,” where they have ownership in a lab, imaging or surgery facility. Such conflicts can lead to more referrals for services than are medically indicated. Receiving too much care is not only costly, but it can actually harm patients.⁴

While we don’t have all the answers, there is some consensus on the types of changes that can improve our nation’s health care delivery system. In general, these approaches try to change the incentives facing patients, doctors and hospitals to encourage more engaged patients, focus on prevention and promote greater coordination of care. It also puts the underlying “tools” in place such as electronic medical records and better information on the clinical effectiveness of alternative treatments.

New legislation or regulations, by themselves, can’t deliver better patient care. However, Consumers Union supports reforms that remove barriers and provide incentives to adopt new practice methods. Thus, Consumers Union recommends specific federal reforms to:

- Improve patient safety by reducing all types of preventable medical harm
- Make sure patients get the right care and the best possible outcome, by identifying and promoting clinically effective care
- Improve patient experience by paying for high-quality, safe, patient-centered medical care
- Ensure an adequate supply of doctors, nurses and other health care practitioners practicing where they are needed

Let's change the incentives facing patients, doctors, and hospitals to encourage more engaged patients, focus on prevention and promote greater coordination of care.

- Let transparency—in prices, quality, outcomes and business practices—drive change

Reduce Preventable Medical Harm

An unacceptable portion of medical care is actually harmful to patients.

An unacceptable portion of medical care is actually harmful to patients. More than 2 million American hospital patients experience preventable medical harm in a given year and about 100,000 of them die every year from preventable medical harm.⁵ Deaths linked to preventable medical errors in hospitals alone exceed deaths from motor-vehicle accidents, breast cancer, and AIDS.⁶

Preventable medical harm is an overarching term that includes specific types of adverse medical events:

- Health care-acquired infections - an infection that was contracted in the hospital or other health care setting during the course of receiving treatment for other conditions.
- Medication errors - giving or prescribing the wrong drug, giving patients the wrong dose or giving the drug in the wrong way.
- Surgical errors - surgical injuries, leaving objects in the body and wrong-site surgery
- Other errors- for example, restraint-related injuries or death, falls, burns, serious bed sores, and mistaken patient identities.

Not all adverse medical events are preventable but studies indicate that a majority (54% - 70%, depending on the type of harm) can be prevented.⁷

Preventable medical harm has a steep personal and financial toll. Patients who contract health care-acquired infections caused by MRSA, a common antibiotic resistant infection, spend nearly four times as long in the hospital as patients who do not get these infections.⁸ Their hospital stays cost six times more. Estimates of these hospital costs for society as a whole are as high as \$45 billion every year.⁹

In its 1999 groundbreaking report, *To Err Is Human*, the Institute of Medicine (IOM) emphasized that the key to reducing medical errors is to focus on improving the *systems* of delivering care. Adopting checklists (as is already done by airline pilots) is an example of a system improvement that can make health care safer.¹⁰ The World Health Organization says that if surgical teams adopt three lists to be reviewed before anesthesia, before the incision is made, and before the patient leaves the operating room, they will decrease risks for the

GLOSSARY OF DELIVERY SYSTEM REFORM TERMS

Accountable Care Organizations (ACOs): An ACO includes three components: primary care physicians, specialists, and at least one hospital. These three groups would share responsibility for the quality of care and the cost of care received by the ACO's patients. In creating an entity with overall responsibility for the patient's outcome, it becomes possible to reward successful outcomes. In other words, if the ACO achieves both quality and cost targets, it could receive a bonus; if it fails, it could face lower payments. Note that an ACO could be set up in different ways. They could be based around an integrated delivery system (like an HMO), a physician-hospital association, or an academic medical center.

Comparative Effectiveness: Comparing two or more approaches for treating a given condition. Studies may compare similar treatments, such as two drugs, or it may analyze very different approaches, such as surgery and drug therapy, or surgery versus no surgery. Comparative effectiveness evaluations may focus only on the relative medical benefits and risks of each option, or they may also weigh both the costs and the benefits of those options.

Electronic Medical Records (EMR): Comprehensive, computerized versions of the paper medical records most doctors now use. Electronic medical records record all of the patient's medical information—including test results, diagnoses, medications, drug allergies, and family history in one place. Because they are electronic, it is easier for authorized providers (like doctors, nurses and pharmacists) to access their patient's records. Patient privacy must be strictly protected.

Health Care–Acquired Infections (HAI): Infections that patients acquire during the course of receiving treatment for other conditions in a health care setting (like a hospital or surgical center). Sometimes referred to as Hospital Acquired Infections.

Patient–Centered Care: Patient-centered care keeps the focus on the needs and values of the patient. It is characterized by engaged patients and family caregivers, shared decision-making between doctors and the patient, and a team approach to comprehensive primary care.

Payment Bundling: A provider payment structure in which health care providers are paid for "episodes of care" rather than individual medical procedures. For example, a single, global payment for a coronary artery bypass graft, instead of separate payments for each doctor, lab test, imaging work, and hospital services. The goal is to improve outcomes and reduce costs by providing doctors and hospitals with an incentive to reduce complications and unnecessary procedures.

Preventable Medical Harm: Medical mistakes that result in harm, such as death, disability, or prolonged treatment. This catchall category includes (but is not limited to) health care-acquired infections, medication errors, surgical errors and serious bed sores. Sometimes called preventable medical errors, although this term doesn't always include health care acquired infections.

Primary Care Practitioners: These are the doctors, nurse practitioners and physician assistants who provide primary medical care like routine physicals, vaccinations, and treatments for everyday illnesses like colds, flu and injuries. They often focus more on chronic care and preventive care than other physicians.

Pay–For–Performance: A program in which healthcare providers—clinicians, hospitals, and other facilities—are rewarded (paid) for the quality of the services they provide for their patients or receive a lower payment if the quality is low. For example, a small bonus for ensuring that every heart attack victim receives aspirin within two hours of hospital admission, beta-blockers at discharge and smoking-cessation counseling, or a cut in payment if a hospital is in the worst 25 percent of hospitals in terms of their rate of avoidable infections.

three biggest causes of death in surgery – infections, excessive blood loss and anesthesia complications – by as much as 50 percent.¹¹ Other potential system improvements include:

- Use of information technology, such as hand-held bedside computers, to eliminate reliance on handwriting for ordering medications and other treatment needs.
- Avoidance of similar-sounding and look-alike names and packages of medication.
- Standardization of treatment policies and protocols to avoid confusion and reliance on memory, which is known to be fallible and responsible for many errors.

Unfortunately, in the 10 years since the IOM's report, there is no evidence of overall improvement in patient safety.¹² A study by Consumers Union finds there is little systematic measurement of preventable medical harm, and few evaluations of programs that attempt to change hospital and physician culture to make care safer. Consumers remain in the dark about the safety, quality and real cost of the hospitals, physicians, and services that they turn to each day.

RECOMMENDATIONS:

- Public and private insurers should not pay for care that is needed due to preventable medical harm, including preventable hospital-acquired infections.¹³
- Likewise, patients should not be forced to pay for care that is needed due to preventable medical harm, including preventable hospital-acquired infections. Hospitals, surgical centers and doctors should provide for an expedited complaint process in cases of extra billing to ensure patients' costs will be covered following these harmful events.
- Publicly report, and widely disseminate, provider-specific information on health care-acquired infection rates and "serious reportable events" (as defined by the National Quality Forum).¹⁴

Less the half of medical care in the United States is based on, or supported by, adequate evidence.

Promote Clinically Effective Care

According the Institute of Medicine, less than half of the medical care provided in the United States that is based on, or supported by, adequate evidence.¹⁵ That means many patients are getting too little care, too much care, or simply the wrong care.¹⁶ One factor contributing to inappropriate care is the absence of a rigorous and well funded agenda for "comparative effectiveness" research.

Comparative effectiveness quite simply means comparing two or more approaches for treating a given condition. Studies may compare similar treatments, such as two drugs, or it may analyze very different approaches, such

as surgery versus drug therapy, or surgery versus no surgery. As such, comparative effectiveness research (CER) has the potential to promote safer, more effective care.

Surprisingly, many medical innovations come to market without an understanding of how effective they are compared to existing treatments. For example, when most drugs are approved by the FDA, they are compared with placebos – they just have to work better than nothing to be sold. Meanwhile, drug and device companies spend billions each year marketing their products to doctors and consumers – with the singular goal of maximizing sales, not making sure people get the most appropriate care.

Failing to integrate research and dissemination goals could derail efforts to translate research into meaningful action.

Currently, there is no independent entity in the U.S. whose sole mission is to compare the benefits and risks of alternative treatment approaches and make this information publicly available.¹⁷ Consequently, there is no overarching public agenda allocating comparative effectiveness funding so it addresses our most pressing health care conundrums. For example, most CER today is around a few conditions (primarily mental health disorders and cardiovascular disease).¹⁸ In addition, innovation in diagnostics, therapeutics and devices currently receive the bulk of funding.¹⁹

Comparative effectiveness research can be costly to do well and private research sponsors have difficulty recouping these costs. It therefore requires an independent, credible, and stable source of oversight and funding. Hence, there is a central role for the federal government in funding this type of research.²⁰

In addition to establishing a research agenda and providing funding, the federal government must learn to effectively disseminate the findings from the comparative effectiveness research to various audiences, in culturally appropriate and consumer-friendly ways.²¹ Today, these findings are not consolidated in a central archive nor are the findings in a format that is easy for health care decision makers to use. Surrounded by thousands of new articles every year, it is difficult for doctors to know what information needs to be incorporated into their medical practice. One study found that it takes about 17 years on average for a new therapy to enter into mainstream practice.²²

Failing to integrate research and dissemination goals could derail efforts to translate research into meaningful action. For example, research indicates expensive and risky surgery to open up blocked heart arteries rarely yields better medical outcomes than safer and much less expensive treatment with medications, yet the more invasive approach is widely practiced.

RECOMMENDATIONS:

- A comprehensive, federally-directed comparative effectiveness research program that operates with full transparency, scientific integrity and public input should be created and funded over a long time frame. The program

would fund research that compares the effectiveness of drugs, devices, medical procedures, surgical procedures and delivery systems.

- Ensure that comparative effectiveness research accounts for differences in racial, ethnic, geographic, and co-morbidity patient populations. Specifically, the secretary of HHS must develop a feasible standard that researchers can demonstrate that their clinical trial(s) included racial, ethnic, geographic, and co-morbid patient populations.
- Adopt a federal translation and dissemination strategy that puts comparative effectiveness findings into the hands of consumers and practitioners.
- Create an all-payer research claims database (similar to the Medicare claims data available now but adding privately insured patients) so that independent researchers can identify effective treatments and providers. Patient identities would be excluded from the database.

Patient-centered care isn't a single, rigid method of delivering health care but an adaptive, flexible system that accommodates a wide variety of patient preferences, needs and values.

Improve Patient Experience

There are many aspects to a patient's experience, including whether the patient received *appropriate* care in a timely manner, ease of communication with medical personnel, customer service, helpfulness of office staff and access to information that supports decision making. When a patient is highly satisfied with all these aspects of their care, then their care is said to be "patient-centered." While there is no single definition of patient-centered care, it is characterized by engaged patients and family caregivers, shared decision-making, and a team approach to comprehensive primary care.

Patient-centered care isn't a single, rigid method of delivering health care but an adaptive, flexible system that accommodates a wide variety of patient preferences, needs, and values. For example, some patients want to be very active participants in their care.²³ But others don't feel they have the expertise, interest or energy to play this role. What they want is to be able to trust that their caregivers have the knowledge, experience and incentives to make the best decisions about their health, according to the patient's personal values.

New legislation or regulations, by themselves, can't deliver patient-centered care. However, policy can help—by implementing the technological infrastructure that makes it easier to coordinate care; ensuring that financial incentives are aligned with patient-centered care; and funding pilot programs that test new methods of improving patient care.

One approach being pursued encourages the formation of integrated "systems of care." Sometimes called Accountable Care Organizations (ACO), these entities consist of primary care providers, specialists, and at least one hospital. Together these three groups share responsibility for the quality and cost of the care received by the ACO's patients.

An ACO seeks to emulate the successful outcomes realized by well known systems like Geisinger Health Plan or the Mayo Health Clinic. However, integrated systems of care like these represent only about 15% of the total delivery of health care.²⁴ Outside these settings, primary care doctors, specialists and hospital are each responsible for a *component* of your health care but no one entity has overarching responsibility.

Federal payment policies (in the Medicare program, for example) can encourage the formation of these ACOs and evaluate their performance. Well advertised successes will likely be emulated by private payers.

Another strategy is to focus on measurement and payment strategies that reward good patient outcomes. For the most part, our health care system pays providers for the number of treatments and procedures they do, and pays more for using expensive technology or surgical interventions. It is not designed to reward better quality care or prevention. If, instead, doctors, hospitals, and labs earn a combined flat fee for managing an episode of illness, it provides an incentive to get you back to health.

Federal policies can also help ease the cost burden of Health Information Technology (HIT) and ensure that one, uniform standard is used. For example, electronic medical records are comprehensive, computerized versions of the paper medical records most doctors now use. Ideally, they consolidate in one place all the care received by the patient: all tests, lab results, medication history, diagnoses and treatment recommendations. These electronic records allow patient information to flow seamlessly from one *authorized* provider to the next. To realize the promise of electronic medical records, a common standard must be used and strict patient privacy protections must be developed and enforced.

Another HIT example is electronic prescribing, or "e-prescribing." E-prescribing replaces the need for handwritten, printed or faxed prescriptions and is seen as a more accurate and efficient means of prescribing medications. E-prescribing could greatly reduce medication errors because it eliminates problems with handwriting legibility and, when combined with decision-support tools, automatically alerts doctors and pharmacists to potentially harmful drug interactions, allergies, and other potential problems.²⁵ However, it is estimated that only 7 percent of eligible prescriptions currently use e-prescribing.²⁶

Moving towards patient-centered care will require multiple approaches and pilots to assess which works best for both patients and practitioners. The preferences and needs of patients and practitioners will vary from one community to the next. The federal government can play a vital role by funding, measuring and evaluating these pilots.

Our nation's supply of practitioners must be sufficient to meet the new demand.

RECOMMENDATIONS:

- Test and evaluate new payment methods that encourage coordinated, patient-centered care. Payment reforms would reward team delivery of care, prevention, and reimburse for the tasks associated with coordinating care.
- Fast track the completion of interoperability standards and privacy protections for electronic medical records.²⁷ Consumer protections must protect patients from *any use* of electronic health information that allows health insurers, employers or other entities to discriminate against them on the basis of health status, either for the purpose of obtaining health insurance, gaining employment, housing, or credit.
- Strengthen the inducements for doctors to adopt electronic medical records.

Ensure An Adequate Supply Of Providers

To go beyond access to health *coverage* and ensure access to health *care*, our nation's supply of practitioners (nurses, nurse practitioners, physician assistants, pharmacists, chiropractors, physical therapists and doctors) must be sufficient to meet the new demand.

Until greater experience is gained with a reformed health care system, we can't say exactly what mix of providers will be best for providing the high quality care that patients deserve.

In the near term, however, providing earlier care to the uninsured and increased care coordination for all will likely increase our nation's need for primary care practitioners. Some studies suggest that the supply of primary care practitioners –particularly those serving adults–may be insufficient to meet this demand, with rural areas facing the worst shortages.²⁸ Likewise, predicted increases in the number of people with chronic illnesses may lead to shortages of certain types of specialists.

America needs a central federal agency responsible for medical workforce planning. Developing and implementing a medical workforce strategy will require inter-agency cooperation as responsibility for medical education loan repayment, provider reimbursement methods and direct payments to teaching institutions spans several agencies today. The overarching goal should be a coordinated strategy that produces highly trained health care practitioners, in the needed specialties (including primary care), where and when they are needed.

RECOMMENDATIONS:

- Develop an integrated, comprehensive national health workforce policy. This policy should incorporate a broad concept of primary care that includes all

types of primary care practitioners and encourages those trained in the new, team based approach to care delivery.

- Expand current federal programs, such as the National Health Services Corps, as needed to increase the supply of practitioners, either primary care or specialists as needed, and ensure that these practitioners are located where they are needed.
- Structure compensation systems to reward team delivery of care, effective primary care and decrease the payment disparities between primary care and specialty care.

Let Transparency Drive Change

Without access to comparative data on outcomes, price, safety and quality, consumers cannot play their role as informed purchasers of health care.

A transparent health care system is defined as one in which patients and health care providers have ready access to information that supports the full range of their health care decision making. For the patient, such information includes provider-specific outcomes and performance measures, patient satisfaction measures, and information on charges and costs.

Without access to comparative data on the outcomes, price, safety and quality of all options, consumers cannot play their role as informed purchasers of health care. Providing better information in ways that consumers are likely to use it is fair and may help to bring about better, safer care that costs less. In several experiments by Dartmouth researchers and others, when patients are fully informed of their treatment options, the majority of the time they choose fewer interventions, more conservative and usually less expensive care.²⁹

Likewise, if doctors and hospitals don't know how their performance compares to their peers, it becomes more difficult to drive quality improvements and stimulate competition based on quality. Just the act of measuring and reporting price, safety or quality data can compel improvement in the way care is delivered. According to one analysis of Medicare Part D data, better data on competitors drug prices drove many drug plans to lower their prices.³⁰ This improvement was driven not by changes in consumer purchasing but by the availability of information on how their prices compared to that of their competitors.

We need public access to meaningful information about treatments, providers and health plans. The data on safety and quality must be methodologically rigorous and validated for accuracy. If the measures being reported are limited, they can provide an incomplete picture of care or lead to "gaming" of the system. (Gaming is when the institution makes changes to improve the indicator, which falsely appears to indicate an overall improvement in quality.)

Transparency should also include detailed information on the business practices that determine consumers' charges. For example, a recent investigation of United

Health found that their system for determining “usual and customary” charges cheated consumers and doctors out of tens of millions of dollars a year in out-of-network insurance payments.³¹ Similarly, pharmacy benefit managers have long been criticized for not disclosing the discounts they receive from drug manufacturers.

Finally and of great importance, transparency should include full public disclosure of conflicts of interest. Several reviews have shown that financial relationships among manufacturers, clinicians, scientific investigators, and academic institutions are widespread.³² If we require public reporting of all drug and device company payments and gifts to providers, many of those payments will wither away under the “sunshine” of full disclosure.

RECOMMENDATIONS:

- Implement a system for collection of and public access to useable, consumer-friendly quality, safety and cost information on treatments, physicians, hospitals and health plans. Data on clinical effectiveness should be included for treatments. Data for drug and health plans should include information on business practices. Make sure the measurements are accurate and meaningful to consumers.
- Enact strong Conflict of Interest rules for all providers requiring disclosure of the receipt of anything of value (gifts, travel, etc.) from drug, device, and other suppliers. Encourage steps prohibiting financial relationships between practitioners and industry. No patient should have to compete with shareholders for a doctor’s fiduciary loyalty.

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Consumers Union has a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a non-profit, non-partisan organization with an overarching mission to test, inform and protect.

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ENDNOTES

- ¹ See CU's policy brief *Health Care – A Prescription for Change* (September 2009) for a discussion of policies that provide better access to health insurance coverage.
- ² The Institute of Medicine. *Learning What Works Best: The Nation's Need for Evidence on Comparative Effectiveness in Health Care*, September 2007.
- ³ Elizabeth McGlynn. *The Case for Keeping Quality on the Health Reform Agenda*, Testimony presented before the Senate Committee on Finance on June 3, 2008.
- ⁴ Maggie Mahar. "The *State of the Nation's Health*," *Dartmouth Medicine*, 5/1/2007. See also "Too Much Treatment," *Consumer Reports*, July 2008.
- ⁵ Preventable medical harm includes preventable health care-acquired infections and other types of medical errors. Health care-acquired infections are estimated to affect 1.7 million people per year (Klevens R.M., and others, "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002," *Public Health Reports*, March-April 2007; Vol. 122). Other types of preventable medical errors are estimated to number more than 700,000 per year (Zahn C, and Miller MR, "Excess length of stay, charges and mortality attributable to medical injuries during hospitalization," *JAMA*, 2003;290:1917–19). The U.S. Centers for Disease Control and Prevention estimate that health care-associated infections in hospitals (just one type of medical harm) kill 99,000 Americans a year (Klevens, op cit.).
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- ⁸ Pennsylvania Health care Cost Containment Council. Research Brief - MRSA in Pennsylvania Hospitals, 2004.
- ⁹ R. Douglas Scott. *The Direct Medical Costs Of Health care-Associated Infections In U.S. Hospitals And The Benefits Of Prevention*, Centers for Disease Control and Prevention, March 2009.
- ¹⁰ Atul Gawande. "The Checklist. If something so simple can transform intensive care, what else can it do?," *The New Yorker*, December 10, 2007 .
- ¹¹ Alex B. Haynes, M.D., M.P.H and others. "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population," *the New England Journal of Medicine*, January 29, 2009.
- ¹² Peter J. Pronovost, MD, PhD; Elizabeth Colantuoni, PhD. "Measuring Preventable Harm Helping Science Keep Pace With Policy ," *JAMA*, 2009;301(12):1273-1275.
- ¹³ Since October 2008, the Centers for Medicare and Medicaid Services (CMS) halted hospital payments for care due to harm the hospital caused, including certain hospital-acquired infections. It also prohibits the hospital from billing patients for this care. Infections on the list include catheter-associated urinary tract infections, vascular catheter associated infections, and mediastinitis, a type of infection from bypass surgery. See http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp for list.
- ¹⁴ Twenty-six states have laws requiring hospital-specific public reporting of health care-acquired infection rates. Pennsylvania, an early leader in infection-rate reporting, showed an 8 percent reduction in infection rates statewide from 2006 to 2007. Pennsylvania Health Care Cost Containment Council, *Hospital-Acquired Infection Rate Drops 8%*, January 22, 2009 News Release. "Serious Reportable Events" are defined in: *Serious Reportable Events in Healthcare – 2006 Update*, National Quality Forum, 2007.
- ¹⁵ The Institute of Medicine. *Learning What Works Best: The Nation's Need for Evidence on Comparative Effectiveness in Health Care*, September 2007.
- ¹⁶ Studies show that about 30 percent of the health care we consume is of no benefit to patients. Elliott Fisher, "More Care Is Not Better Care," *Expert Voices*, Issue 7 (National Institute for Health Care Management, January 2005).
- ¹⁷ The Institute of Medicine (IOM) been temporarily been charged with coordinating research as part of the 2009 stimulus package, but no central entity regularly reviews and establishes research priorities. In its temporary role, the IOM will make recommendations about what to study and coordinate research between three federal agencies: the Agency for Healthcare Research and Quality, the National Institutes of Health and the Department of Health and Human Services (HHS).

- ¹⁸ Congressional Research Service. *Comparative Clinical Effectiveness and Cost-Effectiveness Research: Background, History, and Overview*, October 15, 2007.
- ¹⁹ Federal Coordinating Council for Comparative Effectiveness Research. *Report to the President and the Congress*, June 30, 2009.
- ²⁰ The 2009 economic stimulus package included \$1.1 billion in federal funding for comparative effectiveness research to be spent over a three year period but a more permanent commitment is needed.
- ²¹ Americans identify a personal physician as the most trusted source when consider potential risks and benefits of using a new technology. This means that effective dissemination of CER to physicians remains at the center of comprehensive CER strategy. Claudia L. Schur and Marc L. Berk. "Views On Health Care Technology: Americans Consider The Risks And Sources Of Information," *Health Affairs*, 27, no. 6 (2008): 1654-1664.
- ²² Elizabeth McGlynn. *The Case for Keeping Quality on the Health Reform Agenda*, Testimony presented before the Senate Committee on Finance on June 3, 2008.
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- ³⁰ A CU requested memo from DestinationRx, entitled "Relying On Premiums Alone to Compare Plans Results in Higher Costs to Consumers," September 18, 2009. Available, by request, from Consumers Union.
- ³¹ State of NY, Office of the Attorney General. *Health Care Report: The Consumer Reimbursement System is Code Blue*, January 13, 2009.
- ³² Justin E Bekelman, Yan Li, MPhil; Cary P. Gross. Scope and Impact of Financial Conflicts of Interest in Biomedical Research: A Systematic Review, *JAMA* 2003;289:454-465.