



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

June 23, 2011

Robert Saunders, Ph.D.
Program Officer
Institute of Medicine
500 5th Street NW
Washington, DC 20001

Dear Dr. Saunders:

The American Academy of Family Physicians (AAFP) appreciates the opportunity to comment on the Institute of Medicine's (IOM) proposed study to transform the nation's healthcare delivery system into one of continuous assessment and improvement. The AAFP, representing over 100,000 family physicians, family medicine residents and medical students interested in family medicine, has shown a long term and deep commitment to improving the care provided by family physicians and working to assist members and their practice staff to transition to a culture of quality measurement and improvement.

The proposal paper from the IOM Consensus Committee represents a truly noble cause to address the quality of healthcare in the United States and the results could be very valuable. In order for significant movement to occur though, a momentous change in the culture and norms of accountability will be necessary. The AAFP has reviewed the study plan and has offered the following comments and suggestions:

Measurement: Clinical performance measurement has to be viewed by clinicians as a path to a better place rather than just a draconian tool for payment and judgment. The greatest hurdle we face is the lack of performance measurement in the everyday conduct of medical care. Currently, performance measurement is viewed by many clinicians as burdensome and judgmental. There is a burgeoning number of measures that apply to primary care with only a few truly focused on patient oriented outcomes of care. Measurement systems should be evaluated on their ability to leverage change and improvement. A positive attitude that embraces feedback on performance as the key to improvement and the catalyst for positive change will contribute to a greater impact on improving healthcare. We should study the places where performance measurement and feedback of performance results are woven into everyday work.

Training: Wide-spread training in the science of improvement should be specifically targeted at medical students, residents and practicing physicians until it becomes "the way we do our work". The perception of quality in our current culture is far too dependent on the knowledge base and in keeping that knowledge base up to date. Although it is important, knowledge about what to do is not enough to qualify for a learning organization. In addition to an up-to-date knowledge base, high performance requires a systematic approach to care. Training in process mapping, systems analysis and performance measurement will be critical to success.

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Policy: Individual clinicians should be recognized, rated and rewarded on “knowledge, skills, attitudes and participation in quality improvement work”. The AAFP is one of the founding organizations of the AQA (previously known as the Ambulatory Quality Alliance), helping to shape guidelines for the selection, implementation and reporting of performance measures. We believe that public reporting of a few measures, as a sole strategy, is insufficient to promote the desired culture change or to move medicine toward the concept of a learning organization. Payment reform that places significant value on improvement work, clinical performance and results for patients will be a vital tool to stimulate the needed changes in culture. It will be necessary for policy makers to understand the critical importance of primary care as the foundation of a redesigned health system. Comprehensive and capable primary care will provide better access for patients and lower overall costs for the health care system.¹

Public Perspective: What is not specifically stated, although may be inherent in the workgroup’s thinking, is that a Learning Healthcare System will require not just substantive transformation in the delivery of healthcare but also a transformation in the way that Americans interact and use healthcare services. Public health messaging and social marketing will be needed to reshape the current public expectation that more is better. It is very interesting that much of the current development of performance measures revolves around specific provider types. We could change the conversation in a positive way by thinking about measures as a way to get the best outcomes for patients. In other words, measures should be about patient outcomes and not about who provides the care. Outcome measures also need to be ones that matter to the public and not only what the provider values.

Information Systems: The medical enterprise in this country has been slow to adopt information technology that supports clinical work. Computerized support systems must be integrated into the clinical workflow to improve reliability, service and efficiency. It is unrealistic to think that we will reach the desired levels of efficiency and effectiveness without fully integrated and semantically interoperable health information technology. We actually have the technology needed to do the job but vendors have been slow to incorporate things like registries, integrated email with patients and patient portals because their customers (physicians) have not demanded these important components. Even with the financial incentives and threatened penalties of meaningful use, there remains a significant misalignment between the HIT needs of physicians in a Learning Healthcare System and the current business models, products, and development strategies of existing HIT vendors. The pattern of extended development cycles and increasing regulatory requirements within the industry further delays the market availability and affordability of products with the necessary feature sets for several years.

Potential Barriers: The primary barrier to creating a Learning Healthcare System is that most people do not know the implications of that terminology. If the meaning is to create and promote learning organizations as described in “The Fifth Discipline: The Art & Practice of The Learning Organization” by Peter M. Senge (Mar 21, 2006), there will need to be a tremendous effort to educate health care leaders in these ideas. The majority of small to medium sized practices in the US lack the organizational maturity to actively manage their finances, their personnel and their clinical quality. Moving to the level of a learning organization for most of them would be a tremendous leap. We should search out examples of positive variance, practices where quality measures are used routinely to inform improvement efforts. Direct and timely feedback to clinicians on the outcome of their work is critical to success.

Other Concerns: The current debate about accountable care organizations has made it very clear that efficiency and effectiveness must be characteristics of individual components as well as the integrated enterprise. Payment reform that fosters a shared responsibility for both cost and quality will be necessary to stimulate the required level of financial, clinical and IT integration. Care management and care coordination must be centered in a comprehensive and capable primary care setting for maximum efficiency and effectiveness.

Timeline: The need for a catalyst to move our health care system toward a learning organization is urgent. Although the date for completion is the summer of 2012, every effort to complete this work as soon as possible should be considered.

We will see increased learning in provider organizations when the culture of healthcare systems shifts to a continuous improvement environment. Discovering more about the barriers and best practices to implement such

a task will be an important step in order to move in this direction. The AAFP looks forward to the findings, conclusions and recommendations of the committee. For further information or to discuss any of these ideas in more detail, please contact Bruce Bagley, M.D., Medical Director for Quality Improvement at 913-906-6000 ext. 4120 or by email bbagley@aafp.org

Respectfully submitted,

A handwritten signature in cursive script that reads "Lori Heim".

Lori Heim, M.D.
Board Chair

LH/jl

¹ **The Political Economy Of U.S. Primary Care** -- Sandy LG, Bodenheimer T, Pawlson LG, Starfield B. Health Aff (Millwood). 2009 Jul-Aug;28(4):1136-45.