The Honorable Max Baucus Chairman Senate Finance Committee United States Senate 219 Dirksen Senate Office Building Washington, DC 20510

#### Dear Mr. Chairman:

In an effort to improve the quality and efficiency of health care delivery in the U.S., those who pay for health care--from private insurance companies to the Centers for Medicare & Medicaid Services--are seeking to financially reward providers for delivering care that meets certain standards. While we agree with the laudable goal of rewarding excellence through these "value-based purchasing (VBP)" programs, we believe there are a number of important issues that will need to be taken into consideration in your ongoing discussions in the Senate Finance Committee about the relationship between VBP and the care provided to minority populations.

Most quality improvement efforts standardize the care delivery process so that quality improvements can be measured. However, because some minority populations have different cultural, linguistic and physiological needs, any effort to adopt VBP on a nationwide basis should proceed slowly and cautiously so that we can be sure that those needs are taken into account. Otherwise, such standardization could have a negative impact on the ability of some minority patients to get the care they need. This can happen in several ways:

- Current development of measures ignores the impact on racial or ethnic groups. In developing measures to be used for public reporting or pay for performance, researchers are not asked to assess the measures' impact on patients of various racial or ethnic backgrounds.
- Measures may not adequately recognize cultural differences.

  Existing quality measures, for example, assume that differences in hospitals' mortality rates are always tied to differences in the patients' conditions or in the care they received. However, personal and cultural traditions often determine whether a patient will want to be hospitalized at the end of life, or receive extraordinary means to sustain life. This can skew a hospital's mortality rates and may result in a hospital being rewarded for providing care against a patient's stated wishes.
- Survey tools may not be translated into relevant languages.

  The HCAHPS survey, for example, which measures patients' satisfaction with the care they received and their overall hospital experience, is administered only in

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English and Spanish. This omits large portions of many hospitals' patient populations.

## • Measures may not address complications.

Minority populations make up the bulk of patients who do not receive adequate primary care, and that lack of primary care may translate into complications when a patient comes in for a specific health issue. Standardizing care to make it more likely that a patient would receive the regularly recommended medication or treatment might actually put these patients at risk of receiving the wrong treatment.

Additionally, we believe the Committee must take sufficient care in developing VBP programs to take into account the additional challenges that may face safety net hospitals that serve large numbers of patients who do not have adequate health insurance. Many of the low-income patients of safety net hospitals, including many minority patients, have special needs. Hospitals serving disproportionate numbers of such patients may be at a disadvantage when it comes to achieving levels of performance or improvement that compare to other hospitals if those needs are not adequately taken into account.

The unique circumstances faced by both public and private safety net providers include:

# • They have fewer resources.

Electronic health records, sophisticated diagnostic equipment and other high-tech tools can help hospitals put the right information at the fingertips of doctors, which can ensure that they order the medications and treatments that meet VBP standards. But these technologies are expensive, and safety net hospitals that run on the narrowest of margins often cannot afford them.

## • Follow-up on patients is more challenging.

Some measures, such as unexpected readmission to the hospital and mortality within 30 days of admission, track patient progress after leaving the hospital. These measurements can skew the results for hospitals that serve large numbers of patients who can't afford medications after they have been discharged, or who have inadequate access to primary care physicians or others who can meet their care needs.

#### National measures may divert resources from local needs.

Hospitals that serve ethnically and culturally diverse patients may find that national improvement measures, which are based on average hospital populations, do not take into account specific diseases and disorders most commonly found in their patients. This puts these hospitals in the untenable position of diverting resources from quality efforts that address their particular patients' most critical needs.

## • Diversity affects communication.

There is a great deal of attention being paid to improving communication when patients transition from, for example, the hospital to their home. Scoring well on measures of patient understanding of discharge instructions is more difficult for The Honorable Max Baucus June 25, 2008 Page 3

hospitals with a diverse population than those with a more homogenous population, due to different languages and reading capabilities.

Data are critical elements of any quality improvement initiative, but no data exist to address the concerns we have outlined here. The American Hospital Association and its affiliate, the Health Research and Educational Trust (HRET), however, have developed the HRET Disparities Toolkit to provide hospitals and health systems with the very information and resources needed to systematically collect race, ethnicity, and primary language data from patients. The National Quality Forum is considering naming this toolkit as the standard for collecting racial and ethnic data, and a decision is expected soon. The toolkit will greatly enhance hospitals' ability to understand their diverse patient populations and look for differences in care outcomes. Coupling this toolkit with other quality measurement activities can help hospitals better meet the unique health care needs of their diverse patients. As Congress continues its deliberations, we would urge caution as VBP initiatives are designed so that these concerns can be addressed.

We hope that, as you consider legislation to implement VBP programs, you will keep in mind these concerns. People who are part of a minority population often have unique and vastly different cultural and health needs. Standardizing the delivery of care in order to measure and reward improvement is, again, a laudable goal and one with which we certainly agree. But we must also ensure that in the process, members of minority populations do not slip through the safety net.

We look forward to working with you to ensure that all who need care get the care they need.

Sincerely,

American Hospital Association
National Association of Public Hospitals
National Medical Association
National Minority Quality Forum
National Rural Health Association
National Urban League