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HEALTHCARE REFORM ROUNDTABLE (PART 2)

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

EXAMINING HEALTH CARE

JUNE 12, 2009

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C O N T E N T S

STATEMENTS

FRIDAY, JUNE 12, 2009

ADDITIONAL MATERIAL

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HEALTHCARE REFORM ROUNDTABLE (PART 2)

FRIDAY, JUNE 12, 2009

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:17 a.m. in Room 216, Hart Senate Office Building, Hon. Christopher Dodd presiding.

Present: Senators Dodd, Mikulski, Brown, and Reed.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The committee will come to order, and my apologies to our witnesses and colleagues in the audience.

As some of the staff and members know, I am the father of two very young children, a 4-year-old and a 7-year-old, and my 7-year-old had a moving-on ceremony this morning from first grade to second grade. So I apologize that it went a little longer than I anticipated. I apologize for holding you and my colleagues up and the staff, as well.

I thank all of you for being here this morning, and let me also express the apologies of my colleagues. We had the last vote yesterday afternoon around 3 o'clock and as happens toward the end of the week, you can't anticipate these things, many members headed back to their respective States.

Senator Enzi particularly was going to be here earlier this morning and we would have started the hearing earlier but for this—my daughter's matriculation and so he had to go back to Wyoming a little earlier. So, I apologize on his behalf, as well, and he'll probably submit some questions for all of you and would ask you to respond to those. We will include every statement of yours in the record and any supporting materials you think would be helpful for us as we begin consideration of this most important of issues.

Let me introduce our witnesses. I made an opening statement yesterday about the importance of the issue and I know all of you, as all of us do, agree with the magnitude of the problem and the determination to try and get something done here to move us off the status quo which is unacceptable, I think, to most, if not all.

Our witnesses today include Dr. Gary Raskob, and if I mispronounce names, I apologize. Is that the correct pronunciation?

Mr. RASKOB. Perfect, Senator.

Senator DODD. Thank you very much. The doctor is the Dean of the Oklahoma College of Public Health where his research in the

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prevention of blood clots has the potential to save 15,000 lives a year in our country.

Dr. Jeffrey Levi, is that correct?

Mr. LEVI. Yes, it is.

Senator DODD. Dr. Levi is the Executive Director of the Trust for America's Health, where he leads the organization's evaluation of and the advocacy for public health preparedness of the United States.

Dr. Fay Raines is a mental health nurse, thank you for being here, and is the President of the American Colleges of Nursing and the Dean of the College of Nursing at the University of Alabama in Huntsville.

Dr. Wayne Jonas is the President and CEO of the Samuel—he's not here—in Alexandria, VA. He was previously the Director for the Office of Alternative Medicine at the NIH.

Dr. Delos Cosgrove is the President and CEO of the Cleveland Clinic where he leads the $4.6 billion healthcare system comprised of 4 clinics, 9 community hospitals and 14 family health and ambulatory surgery centers.

Dr. John Rother is the Director of the Legislation and Public Policy for the American Association of Retired Persons, considered an authority on the healthcare and long-term care.

Last, Dr. Judith Palfrey is the President-elect of the American Academy of Pediatrics, researches the development of innovative systems of care, including medical homes for children with special healthcare needs, and we are honored to have all of you with us here today.

Is Dr. Jonas going to be joining us, do we know?

Senator MIKULSKI. Yes. He's right here.

Senator DODD. Oh, I am sorry.

Senator MIKULSKI. Dr. Jonas, hello.

Senator DODD. He's in conversation. Hello, Doctor.

Senator MIKULSKI. We will have that conversation later.

Senator DODD. Yes. Doctor, thank you.

Senator MIKULSKI. I asked him to talk to my staff this morning.

Senator DODD. Oh, good.

Senator MIKULSKI. I didn't mean this minute.

Senator DODD. No. Well, Doctor, thank you for joining us, as well.

Hi. Good morning, Barbara. Nice to see you.

Senator MIKULSKI. Good morning.

Senator DODD. Nice to see you. Dr. Raskob, we will begin with you.

Barbara, do you have any opening comments you want to make?

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Well, first of all, good morning to everybody. We are just glad to see you and we look forward to this conversation.

I also want to acknowledge we are a few minutes late getting started because our good colleague went to his daughter's preschool graduation. That was your mental health benefit?

Senator DODD. Yes, it is.

Senator MIKULSKI. It was effective- and evidence-based which is a good thing, and we apologize and we are ready to roll.

Senator DODD. The pediatrician here.

Doctor, we will go ahead and we will begin with you.

STATEMENT OF GARY RASKOB, Ph.D., DEAN, OKLAHOMA COLLEGE OF PUBLIC HEALTH

Mr. RASKOB. Thank you, Mr. Chairman.

I want to begin by thanking you and your colleagues for the opportunity to comment on the health reform options being considered by the committee.

I am here today representing the 41 accredited schools of public health in the United States that have missions in education, research and public health service.

In the time available, I will focus my remarks on the importance of building health reform on a foundation of prevention and public health, and the culture of the healthcare system in the United States needs to be transformed from one that emphasizes treatment, often late in the natural history of disease, to a different paradigm, a culture of wellness.

Public health sections of the current bill contain several provisions for improving the health of the American people. I will highlight four overarching elements that will be key to creating a culture of wellness.

First, the bill underscores the importance of the full spectrum of prevention, from community-based primary prevention to clinical preventive services. Because the rising prevalence of chronic diseases requiring treatment accounts for the majority of the growth in healthcare spending—efforts to prevent disease through primary prevention, what we do before an individual engages a healthcare provider, are critical to controlling costs.

Second, the bill recognizes the importance of the community, the school and the workplace as locations for implementing prevention and wellness efforts. We applaud the provisions to provide technical assistance to businesses, to establish employer-based wellness programs, and ASPH supports providing tax incentives to encourage employers to adopt workplace wellness and prevention programs that are evidence-based and yield a two to threefold return on investment.

Third, the bill recognizes the need for sustained and expanded public health research, especially in the areas of prevention and public health systems, including comparative effectiveness research. Particular attention should be given to developing and translating evidence to reduce childhood obesity, smoking, and responding quickly and effectively to emerging health threats.

Comparative effectiveness research should include research on a wide range of policies and interventions that affect health, including nonclinical programs, organizational and systems characteristics and policies and regulations.

Fourth, the bill identifies the critical importance of a strong workforce. We emphasize that these efforts should address the broad public health workforce needs. The current public health workforce is significantly undersized, given its responsibilities which include ensuring safe food, clean water, an immunized popu-

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lation, and protecting the public from emerging threats, such as the H1N1 influenza virus.

ASPH estimates that by 2020, the Nation will need an additional 250,000 public health workers, and we believe that the provision of scholarships, fellowships and loan repayment tied to a service obligation is an important strategy to achieve this goal.

Thank you again for this opportunity. I look forward to taking your questions and I will apologize in advance that I will have to leave at 11:30 but I apologize for that.

Thank you very much.

[The prepared statement of Dr. Raskob follows:]

STATEMENT OF GARY RASKOB, PH.D., ON BEHALF OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH (ASPH)

POLICY BRIEF—CREATING A CULTURE OF WELLNESS: BUILDING HEALTH CARE REFORM ON PREVENTION AND PUBLIC HEALTH

EXECUTIVE SUMMARY

Policies and programs that emphasize both community-based prevention and clinical preventive services as part of primary care should be the foundation of health care reform, in the view of the Association of Schools of Public Health (ASPH).

A consensus is emerging in the Obama administration and the U.S. Congress that significant reforms are necessary to provide affordable, high-quality health care to all Americans, and ASPH has called for legislation that will achieve health insurance coverage for all Americans, both children and adults, within 2 years. As efforts advance to meet those goals, the culture of the health care system needs to be transformed from one that emphasizes treatment to one that builds on public health and prevention. Targeting behavioral patterns and social and environmental circumstances in the home, the workplace, and the community, and promoting the systematic adoption of prudent clinical prevention practices, offer tremendous opportunities to reduce premature death, disability, and disease.

ASPH recommends seven key strategies to accomplish the transformation of the U.S. health care system:

KEY STRATEGIES FOR ACTION

The ASPH blueprint for creating a culture of wellness is based on the following recommendations:

1. Emphasize leadership and articulate a vision for prevention. Use of the "bully pulpit" to articulate a vision for a prevention-oriented health care system may do more to speed the transition than any other single measure. President Obama, the Department of Health and Human Services (HHS) Secretary, the U.S. Surgeon General, and other HHS leadership should use their voices and influence to clearly state that prevention is the core value of health care reform.

2. Increase the Federal cigarette excise tax to prevent smoking-related morbidity and mortality, spending much of the resulting revenue on prevention-focused activities. ASPH recommends an additional Federal cigarette tax of $1/pack, which would bring the total tax to $2.01. This tax increase would drive down the rate of smoking, especially among youth, while generating approximately $13.6 billion a year in new revenues, after factoring in declines in smoking associated with the higher costs of cigarettes. (The proposed tax is in addition to the $0.62 increase that went into effect March 31, 2009 and is expected to generate $7 billion annually, which has been allocated to the State Children's Health Insurance Program [SCHIP]). Revenues from a further $1 tax increase should support a Public Health Trust, to be used for tobacco cessation and prevention, public health research, and other public health programs. The tax revenues should also provide relief to the States and fund a range of other public initiatives.

3. Implement evidence-based measures to fight the obesity epidemic. The worsening epidemic of obesity in America, which now rivals that of tobacco in its overall impact on health, accounted for more than 25 percent of the growth in the Nation's health care costs between 1987 and 2001. ASPH endorses a wide array of obesity prevention measures that would improve surveillance, support nutrition programs, promote physical activity, provide guidance on advertising and marketing to children, and significantly expand funding for obesity prevention research. A govern-

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mentwide, HHS-led task force on obesity should be established to define and coordinate all Federal actions and establish nutrition standards for food and beverages sold in schools. In addition, ASPH believes that an excise tax on sugar-sweetened beverages warrants consideration.

4. Rebuild the public health workforce. Addressing the public health workforce crisis requires short-term and long-term initiatives designed to:

- Increase Federal funding to support students pursuing graduate degrees, expand practice opportunities, and promote a more diverse workforce. Expand capacity at Schools of Public Health to educate more graduate students, more public health professionals, and more workers in health care and other intersecting fields, to increase research training, and to develop competencies and curricula in emerging areas.
- Introduce public health into the curriculum at all levels, from primary school through undergraduate education.
- Establish a U.S. Global Health Service to coordinate U.S. efforts to build a workforce prepared to meet international needs.
- Institutionalize a process for enumerating the public health workforce to assess current capacity and future needs.

5. Build and utilize information technology architecture to measure clinical prevention services and health outcomes uniformly. The fragmented U.S. health care system is in urgent need of world-class data management systems to measure performance, improve decisionmaking, enhance accountability, and provide surveillance data for longitudinal analysis and research. Developing a culture of wellness depends in part on the availability of uniform assessments of health outcomes and system performance and surveillance.

6. Empower employers to promote wellness strategies that can be integrated with primary care. Employers can have a strong influence on the demand for more prevention-oriented health insurance and health care delivery services. ASPH also calls for a National Workplace Prevention Program, defined by the CDC and approved by the HHS Secretary and the Surgeon General, which would provide tax credits to all public and private U.S. employers that meet program requirements.

7. Empower communities to put prevention and public health programs at the forefront of primary care. Public health and primary care are both practiced at the community level, creating opportunities to integrate them in ways that would change the culture of local health systems and emphasize prevention as a core competency. Long-term investments, especially in underserved communities, are needed to train workers, including primary care providers and community health workers; expand facilities to house prevention programs; and develop information systems and governance oversight that link public health and prevention with primary care, resulting in more efficient and more cost-effective integrated models.

About ASPH: The recommendations in this paper reflect the consensus of the Association of Schools of Public Health (*www.asph.org*), which represents the 40 Council on Education for Public Health (CEPH) accredited schools of public health in North America. A critical national resource, the Nation's Schools of Public Health educate the next generation of public health leaders; conduct cutting-edge research; and translate knowledge into public health policy and practice. They currently enroll 22,000 students, produce more than 7,300 graduates a year, and employ 9,600 faculty.

ASPH is committed to collaborating with the public health practice community, governmental agencies, academic medicine, non-profit organizations, and business groups. This policy paper is part of a series exploring the Nation's public health priorities.

OVERVIEW: AN URGENT NEED

High spending, low health status in the United States. At $2 trillion in 2005, health care spending in the United States far surpasses that of all other countries (on a GDP per capita basis). The Nation also remains the global leader in biomedical research and tracks health care indicators with exceptional rigor. Nonetheless, it ranks low in many measures of health status.

- The U.S. ranked 25th in infant mortality; 22d in maternal mortality; 23d in life expectancy for women; and 22d in life expectancy for men, among the 30 developed nations within the Organization for Economic Cooperation and Development.

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• Among all 192 nations for which 2004 data was available, the United States ranked 46th in life expectancy and 42d in infant mortality (Schroeder, 2007).

Public health should be at the center of efforts to meet the Nation's health challenges. Premature death is most heavily influenced by human behavior (which accounts for 40 percent of the risk), as evidenced by the fact that the vast majority of deaths in the United States are associated with obesity and inactivity (365 deaths/100,000) and smoking (435 deaths/100,000) (Schroeder, 2007). Genetics is also an important risk factor (30 percent), as is the social and working environment (20 percent), whereas health care itself is relatively less important, with only a 10 percent influence on premature death.

It is no surprise, then, that four of the six "serious and complex challenges" to health identified in a recent Institute of Medicine (IOM) report deal with prevention and public health (IOM, 2009).

According to the IOM:

• The U.S. model of health care delivery does not ensure the efficient and effective prevention and management of chronic diseases, nor does it consistently apply principles of evidence-based medicine.

• The possibility of global pandemics, emerging infections, and bioterrorism threatens to harm many Americans and to strain limited resources further.

• The public health infrastructure is weak and, in many locales, hard-pressed to meet current demands, much less those of the future.

• The United States trails many other countries in achieving desired health outcomes and longevity, despite the world's highest level of per capita health care spending.

Prevention is a cost-effective way to reduce morbidity and mortality. The value of public health measures in saving lives and reducing chronic disease and disability has been well-documented. Reductions in traffic fatalities as a result of the widespread use of seat belts, and better health outcomes from the improved control of workplace environmental exposures, are just two examples. We also know that if a basic package of cost-effective prevention measures were practiced by the entire population—including daily aspirin use, smoking cessation, influenza vaccine, and screening for colorectal cancer and problem drinking—more than 100,000 lives per year could be saved (Maciosek, et al., 2006).

Investing in prevention is cost-effective, as the following evidence demonstrates:

• The Urban Institute estimates that a $10-per-person investment in prevention in the United States would generate a return of $16.543 billion in 5 years and $18.451 billion over 10 years. These calculations were derived from evidence-based studies on lack of physical activity, poor nutrition, and tobacco use (Trust for America's Health, 2008).

• The cost-effectiveness of preventive clinical services for working-age adults has been well established, using quality-adjusted, life-year metrics and based on U.S. Preventive Services Task Force recommendations (AHRQ, 2005; Maciosek, et al., 2006).

• The Congressional Budget Office concluded that potential savings from health behavior and health promotion activities were only "modest" (CBO, 2008). However, that was based largely on assessing clinical preventive services, including expensive tertiary prevention, rather than on just cost-effective primary and secondary prevention. Also, the CBO did not consider the gains in health and productivity that accrue from employment-based wellness programs.

• IBM reports significantly improved employee health metrics and a $1 billion in savings since the inception of its comprehensive and fully integrated program for its employees and their families in 2001. Free preventive services, first-dollar coverage for primary care, worker safety programs, and incentives for healthy behaviors have helped reduce employee health care costs to single digits (compared to 12–15 percent for other companies) and created a more health-literate workforce (Sepulveda, 2008).

The United States has made only a limited commitment to prevention and public health systems. At present, the United States invests less than 2 percent of each heath care dollar on prevention while spending 75 percent of that dollar on treating chronic diseases, many of which are preventable. Those figures are even higher for the major Federal health insurance programs; 83 percent of every Medicaid dollar and 96 percent of every Medicare dollar is spent on treating chronic diseases.

As the health care reform debate gets underway, this formula must change. ASPH has called for legislation that will achieve health insurance coverage for all Americans, both children and adults, within 2 years. Prevention and public health strategies should be the foundation of a newly designed system.

A PREVENTION-FOCUSED FRAMEWORK FOR HEALTH CARE REFORM

ASPH recommends that a prevention-focused framework for health care reform be built around the following priority areas:

1. Ensuring every American an opportunity for a healthy life through two interrelated commitments:
   - Providing access to affordable, quality health care.
   - Eliminating health disparities linked to race, ethnicity, socioeconomics, and other factors.
2. Strengthening the public health infrastructure, with special attention to integrating health care delivery and public health, and to workforce development.
3. Increasing investment in efforts to prevent disease, injury, and disability.
4. Increasing investment in public health research, including prevention, public health systems, and population health.
5. Strengthening American leadership and investment in global health.

The remainder of this paper offers a blueprint for building that framework.

STRATEGIC APPROACHES FOR A PREVENTION AND PUBLIC HEALTH EMPHASIS

ASPH has identified the following strategies for putting prevention and public health at the core of the health care system, and building a culture of wellness:

1. Emphasize leadership and articulate a vision for prevention.—Use of the "bully pulpit" to articulate a vision for a prevention-oriented health care system may do more to speed the transition than any other single measure. President Obama, the HHS Secretary, the Surgeon General, and other HHS leadership should use their voices and influence to clearly state that prevention is the core value of health care reform.

Corporate America has learned that wellness programs do not succeed unless they are championed by the CEO and other top managers (IOM, 2005). The Federal Government should recognize this as well. Long before health care reform legislation is passed, heads of the key HHS agencies, and other Federal agencies with health-related missions, should emphasize their commitment to prevention, and prioritize the implementation of administrative directives to advance that goal.

The many HHS agencies with roles to play include the Agency for Healthcare Research and Quality (AHRQ), the Center for Medicaid and Medicare Services (CMS), Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Other Federal agencies with health-related activities in their missions should also emphasize the importance of prevention, including the Department of Defense, the Department of Homeland Security, the Environmental Protection Agency, and the Veterans Administration (VA).

ASPH endorses IOM recommendations for using the authority of HHS to advance public health and prevention. Five IOM recommendations highlight opportunities for HHS to take a leadership role (IOM, 2009):

- To meet 21st-century challenges to America's health, the Secretary of HHS should clearly articulate and actively promote a vision for the Nation's health, ensure that HHS's mission supports that vision, and establish a small number of measurable goals focused on critical challenges.
- The Secretary should align and focus HHS on performance and encourage creative use of scientifically based approaches to meet new and enduring challenges.
- The Secretary should accelerate the establishment of a collaborative, robust system for evaluating the health care system that would incorporate existing HHS and external research, stimulate new studies as needed, synthesize findings, and provide actionable feedback for policymakers, purchasers, payers, providers, health care professionals, and the public.
- The Secretary should place a high priority on developing a strategy and tools for workforce improvement (1) in HHS, (2) in the public health and health care professions nationwide, and (3) in the biosciences.
- A new compact between Congress and the department is essential as HHS works toward achieving its vision for a healthy nation, departmental mission, and key health goals. Under this compact, the Secretary would provide regular, rigorous reports about departmental activities to Congress and the Nation, and assume greater accountability for improving performance and obtaining results. In return, Congress should allow HHS greater flexibility in its internal operations and decisionmaking.

ASPH favors expanding the role of the Surgeon General. The IOM has called for a more "prominent and powerful role" for the Surgeon General (IOM, 2009). ASPH endorses the recommendation that this individual be "a strong advocate for the health of the American people and work actively to educate Americans on important health issues."

The Surgeon General should issue an annual *Report to the Nation* that reviews the progress being made on disease and injury prevention. As a vehicle to educate all Americans and provide accountability, the report should include:

- Population-based survey assessments, at the national, State, and health plan levels, of health determinants, behaviors, and the Organization for Economic Cooperation and Development health indicators.
- Prevention report cards for all insured individuals issued by publicly funded health plans and based on federally approved and mandated clinical prevention measures. The goal is to drive the technology to develop new forms of patient prevention education and accountability by the private sector (Stagmo, et al., 2004; AHRQ, 2005; Campbell, et al., 2006).
- National and State-based assessments of employer participation in workplace prevention programs, based on documenting the tax credits provided for health promotion and health protection programs.
- Accreditation of all State and local health departments by a National Board of Public Health, State public health boards, and public health professional organizations, based on metrics developed by the CDC and approved by the Secretary of HHS.
- Other health behavior and health outcome national data authorized by the Secretary of HHS.

2. Increase the Federal cigarette excise tax to reduce smoking-related morbidity and mortality, spending much of the resulting revenue on prevention-focused activities.—ASPH recommends increasing the Federal cigarette tax by $1/pack, bringing the total to $2.01/pack. This increase would generate an annual revenue stream of $13.6 billion. (This is in addition to expected revenues of approximately $7 billion/year from the $0.62 tax increase that went into effect March 31, 2009. Those revenues have been allocated to the State Children's Health Insurance Program [SCHIP]).

Of all tobacco control measures, price increases are widely regarded as the most effective, reducing smoking significantly and quickly. Research suggests that a new tax increase of $1/pack will reduce smoking among adults by 6.25 percent, and lead 1.4 million adults to stop smoking altogether. That ultimately translates into approximately 700,000 fewer smoking-associated deaths. The results will be even more dramatic among young smokers, who are two or three times more responsive to cigarette price increases than adults.

The new taxes would be in line with the 12 States, plus the District of Columbia, that have taxes of $2 or more, and closer to those in many other developed nations. In Europe, some national cigarette taxes exceed $7/pack.

New revenue for public health, State relief, and other public purposes. The $13.6 billion/year in new revenues generated by an additional $1/pack increase could be used for the following purposes:

- A Public Health Trust to promote public health. Use of those resources should include substantial new funding for:
  - A media-based antismoking campaign targeted at youth and high-risk adults.
  - Smoking cessation services, including quit lines and nicotine replacement programs at the Federal and State levels.
  - A media-based campaign to educate the public about what public health is, and what it accomplishes. The goal would be to promote behaviors that enhance health and reduce health care expenditures, and ultimately to broaden interest in public health in order to increase demand for funding.
  - Public health research in population health, primary prevention, and community-based and public health systems, among other areas.
  - Other essential public health purposes, including improving access to quality health care; eliminating health disparities; strengthening the public health infrastructure by integrating prevention and primary care and developing the public health workforce; investing in disease and injury prevention and health literacy; and strengthening American leadership in global public health.
- Compensation to the States for declines in their own excise tax revenues as cigarette sales decrease (leading to an anticipated loss of approximately $1.17 billion), and for the loss of Master Settlement Agreement revenues. Providing those funds to the States should encourage them to support a Federal tobacco tax increase.
- A broad range of other public purposes, which could include additional public health projects, educational support, deficit reduction, and more.

3. Implement evidence-based measures to fight the obesity epidemic.—The epidemic of obesity in America now rivals that of tobacco in its overall impact on health. The health consequences of tobacco are contracting with tobacco control efforts while the much more recent epidemic of obesity continues to expand, with worsening health outcomes and higher health care costs predicted.

• The prevalence of obesity among adults, among preschool children ages 2–5, and among adolescents ages 12–19 has doubled since 1970, while tripling among children ages 6–11 (CDC, 2009). Over 9 million U.S. children are now estimated to be obese.

• Obesity is a well-recognized risk factor for diabetes, heart disease, hypertension, stroke, certain cancers, and a host of other adverse health outcomes among adults. Children are more likely to have diabetes, hypertension, and dyslipidemia, which presage heart disease. Obesity among young people also has a significant impact on emotional health, with a link to low self-esteem, depression, discrimination, and social marginalization (IOM, 2005).

• Obesity accounted for more than 25 percent of the growth in the Nation's health care costs between 1987 and 2001, with estimates of the epidemic's cost ranging from $98–$129 billion (2004 dollars) (IOM, 2005; Thorpe, et al.).

• Lost productivity from obesity-related morbidity and mortality was estimated to be $47.5 billion nationally in 1995.

ASPH endorses recommendations made by the IOM (2005) to prevent childhood obesity and supports the following prevention initiatives:

• Establish a governmentwide, HHS-led task force on obesity to define and coordinate all Federal actions and establish nutrition standards for food and beverages sold in schools.

• Develop CDC-funded state-based nutrition programs designed to provide grant opportunities and technical assistance to local communities.

• Cover the costs of nutrition counseling and require body mass index (BMI) to be measured as a vital sign among all publically insured patients.

• Support nutrition counseling and physical activity as a component of CDC- and HRSA-funded community health programs, especially for high-risk individuals and vulnerable populations.

• Develop and evaluate guidelines for advertising and marketing to children and youth through an IOM study and a national conference.

• Significantly expand funding for prevention intervention research, experimental behavioral research, social marketing research, and community-based research.

• Expand and standardize surveillance and evaluation of dietary patterns, obesity-related health outcomes, and related costs through new information systems and the monitoring of electronic medical records.

• Develop Federal grants, and grants to States and local communities, to fund and evaluate changes in the built environment that would promote physical activity, especially in underserved communities.

In addition, ASPH believes that an excise tax on sugar-sweetened beverages warrants consideration. Consumption of soft drinks and many other beverages sweetened with sugar, high-fructose corn syrup, or similar products has increased significantly over the past three decades (Popkin and Nielsen, 2003), and now contributes about one-third of the added sugar in the American diet (Guthrie and Morton, 2000). There is clear evidence from both observational and experimental studies that increased consumption of sugar-sweetened beverages leads to weight gain (CDC, 2006).

Several States already levy soft drink taxes, often earmarking the revenues to subsidize health promotion programs and health science schools. The Congressional Budget Office has proposed a Federal excise tax of 3 cents per 12 ounces of "sugar-sweetened" beverages as one option (Option 106) to help fund health care reform, and estimates that it would generate an estimated $24 billion in revenues from 2009–2014, and an estimated $50 billion from 2009–2018 (CBO, 2008).

The goal of an excise tax on sugar-sweetened beverages would be to drive down portion size and overall consumption, and to generate revenues that support a wide array of obesity prevention programs and offset obesity-related Federal health insurance costs. Further study is necessary to determine how best to realize these benefits.

4. Rebuild the public health workforce.—The Nation is facing a public health workforce crisis, with particularly critical shortages forecast for public health physicians, public health nurses, epidemiologists, health care educators, and administrators. Drawing on an array of data generated by the Association of State and Territorial Health Officials, the National Center for Health Workforce Information and Analysis, and other sources, ASPH observes that:

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- The public health workforce is diminishing over time even as the U.S. population increases. In 2000, the total workforce was 448,000, or 50,000 fewer workers than in 1980.
- More than 100,000 public health workers in government—approximately one-quarter of the current workforce—will be eligible to retire by 2012.
- By 2020, the Nation will need more than 250,000 more public health workers than are available today.

Short-term and long-term workforce strategies. To meet the urgent need for a significantly expanded public health workforce, traditional models of training will have to be re-thought, and a combination of short-term and long-term initiatives will need to be implemented. ASPH endorses and extends a set of recommendations made by the Institute of Medicine (2002) to advance these goals and offers additional strategies:

- Increase Federal funding to support public health professional education by:
  - Providing financial support to graduate students pursuing public health degrees through loan repayment and forgiveness programs, training and service obligation grants, and fellowships.
  - Strengthening "real-world" experiences for public health students by expanding both the number and the type of organizations that serve as sites for practice rotations.
  - Promoting a more diverse public health workforce by using financial incentives to attract underrepresented populations to public health, supporting students engaged with reducing racial and ethnic health disparities, and developing special training opportunities targeted at minorities.
- Build capacity in Schools of Public Health, enabling them to:
  - Enroll and train more degree-seeking graduate students.
  - Develop competencies and curriculum in emerging areas of public health practice.
  - Increase public health research training in population health, primary prevention, and community-based and public health systems. Particular emphasis should be placed on transdisciplinary research programs at the AHRQ, CDC and the NIH, which fund most research training at Schools of Public Health.
  - Expand joint degrees and other opportunities for cross-disciplinary training (combining public health graduate training with training in medicine, nursing, pharmaceutical science, veterinary medicine, dentistry, law, business, health and public administration, public policy, social work, and the behavioral sciences, among other professions).
  - Expand undergraduate public health training.
  - Promote training through short courses, certificate programs, distance learning, and other opportunities for lifelong learning. Targeted programs are needed to meet the needs of credentialed public health professionals, undertrained and non-credentialed public health workers, and other workers engaged in public health activities.
- Provide grants to State health departments to promote training. Grants can be used to encourage States to support worker training through MPH programs and public health certificates, and to promote credentialing.
- Ensure that all primary, secondary, and post-secondary schools offer curricula to ensure a basic understanding of public health and the importance of prevention in health care.
- Establish a U.S. Global Health Service to coordinate U.S. efforts to build a workforce prepared to meet international needs.
- Institutionalize a process for periodic enumeration of the public health workforce, under the guidance of the Surgeon General or Federal agency, to assess current capacity and evaluate future needs.

5. Build and utilize information technology architecture to measure clinical prevention services and health outcomes uniformly.—The fragmented U.S. health care system is in urgent need of world-class data management systems to measure performance, improve decisionmaking, enhance accountability, and provide surveillance data for longitudinal analyses and research. Developing a culture of wellness depends in part on the availability of uniform assessments of health outcomes and system performance.

The information technology to provide and evaluate clinical preventive health services is already available. Many leading U.S. corporations have long used some form of scorecards to manage their health care programs (IOM, 2002). For instance, the National Business Group on Health developed Employer Measures of Produc-

tivity, Absence, and Quality (EMPAQ), which provides the methodology and a set of standard metrics for employers to measure program outcomes, participate in benchmarking, evaluate vendor performance, and identify best practices (National Business Group on Health). EMPAQ offers a common lexicon and platform for uniform content and rigorous accountability. At the patient level, "smart phones" are now available with an array of prevention programs and chronic disease management tools that can be linked to a personal electronic medical record. Systematic, national-level evaluation of individual prevention report cards, designed to provide feedback to patients and involve them in achieving prevention and treatment goals, is just beginning (Stagmo et al., 2004).

Tracking and reporting on prevention should occur at many levels.—ASPH recommends the following strategies as part of developing a nationwide data management system for measuring preventive health care and outcomes:

- HHS should develop a uniform prevention report card utility so that all health care plans can provide a limited dataset using a common lexicon and platform. Standard measures of clinical preventive health care, such as those defined by the U.S. Clinical Preventive Services Task Force, are evidence-based, reimbursed by most health plans, and responsive to IOM recommendations (2009). Moreover, these measures are already included in the electronic scorecards used by many businesses and insurers, and are being evaluated nationally in Sweden. If mandated for use in publicly financed health plans, they could drive the development of Smartphone-based prevention and chronic disease management technology (Stagmo, et al., 2004).
- Prevention report cards developed by the CDC and approved by the HHS Secretary and the Surgeon General, should be required of all health plans, regardless of payer, to assure uniform measurement and provide accountability and prospective surveillance. Scorecards to document health plan compliance with clinical prevention measures are well developed and available online (AHRQ, 2005; Campbell, et al., 2006).
- Many other entities should implement, track, and report their compliance with clinical prevention measures, including:
  - State health departments, in conjunction with public and private insurers. States should have the option of including other clinical prevention measures, beyond a Federal minimum, as their own health care policies dictate.
  - Federal health care programs, including the Veterans Administration and Federally Qualified Health Centers (FQHCs), which include community health centers, school-based clinics, and rural and migrant health clinics. Special attention should be paid to implementing and evaluating prevention measures for vulnerable rural and urban subpopulations.
  - Employers providing health insurance to their workers should integrate clinical prevention measure reporting as a part of a fully integrated employee health program.
  - Hospitals and other medical providers, in line with a trend among accrediting organizations, should adopt clinical prevention measures as quality performance indicators.
- All parties should advance transparency and accountability by sharing their clinical prevention measures with the populations they serve, via Web sites and annual prevention and health care quality reports.
- Initiatives to help individuals and families become more health literate and to understand evidence-based health care are essential to promote participation in clinical prevention programs. While full reimbursement for all approved prevention services is essential, high rates of participation will not occur without transparent information systems, education across the lifespan, and continuous documentation and feedback on the benefits of prevention.

6. Empower employers to promote wellness strategies that can be integrated with primary care.—Employers are a largely untapped resource for transforming the Nation's health care culture into one that emphasizes prevention. ASPH believes American employers can have a strong influence on demand for more prevention-oriented health insurance and health care delivery services.

With appropriate incentives, employers can also be galvanized to develop employment-based prevention programs. To date, most fully integrated employee wellness programs are found among larger corporations (Linnan, et al., 2008; Lind, 2008). Less than 5 percent of employers with 50–99 employees and 24 percent of employers with more than 750 employees offer "comprehensive" workplace health promotion programs (Linnan, et al., 2008).

Yet a benchmarking study found that achieving "best practice" levels of performance in health and productivity management helped companies annually save as much as $2,562 per employee, reflecting savings distributed among group health

costs, turnover, absenteeism, and disability and workers' compensation programs (Goetzel, et al., 2001). In general, investing in workplace wellness programs yields a two- to three-fold return, with savings divided equally between health care and productivity (Thygeson, et al., 2009).

Defining a healthy workforce. The Institute of Medicine (2005) has documented the fundamental linkage between healthy employees and productive employees, describing a healthy workforce as follows:

- "Healthy—demonstrating optimal health status as defined by positive health behaviors, minimal modifiable risk factors, and minimal illness, disease, and injuries.
- "Productive—functioning to produce the maximum contribution to achievement of personal goals and the organizational mission.
- "Ready—possessing an ability to respond to changing demands given the increasing pace and unpredictable nature of work.
- "Resilient—adjusting to setbacks, increased demands, or unusual challenges by bouncing back to optimal well-being and performance without incurring severe functional decrement."

Guidelines for workplace wellness programs. Recent efforts to identify the essential elements of employer-based wellness programs and promote their use include:

- IOM recommendations for an employee health program, based on a model it designed for NASA, integrate the following elements: health advocate; health plan design; disease and case management; fitness; absence management; primary care (medical home); wellness programs; health risk assessment; health portal; occupational and environmental health; and behavioral health (IOM 2005).
- The CDC's National Institute for Occupational Safety and Health (NIOSH) has implemented the WorkLife Initiative, an intramural and extramural program designed to raise awareness and provide evidence-based data about employment-based prevention programs, and disseminate the results of research, outreach, and related information (*http://www.cdc.gov/niosh/worklife/*). NIOSH has also disseminated guidelines describing the Essential Elements of Effective Work site Programs (*http://www.cdc.gov.niosh/worklife/essentials.html*).
- Proposed Federal legislation would use tax incentives to encourage employers to adopt workplace wellness programs through tax incentives. Under the legislation—Incentives for a Healthy Workforce, a component of the Healthy Lifestyles and Prevention (HeLP) America Act—programs would be certified by the HHS Secretary, in conjunction with the CDC Director, if they:
  - Are consistent with evidence-based research and best practices.
  - Include multiple, evidence-based strategies, such as those outlined in the CDC's Guide to Community Preventive Services (CDC, 2009) and the AHRQ's Guide to Clinical Preventive Services (AHRQ, 2005; Campbell, et al., 2006).
  - Include strategies that focus on employee populations with a disproportionate burden of health problems.
  - Include worksite policies related to occupational safety and health exposures, tobacco use, availability of nutritious food, strategies to minimize stress and promote positive mental health, design of the "built environment," and promotion of physical activity before, during, and after work.

A two-tier tax credit program would give companies up to $200 per employee for the first 200 employees, and $100 per employee thereafter for developing certified workplace wellness programs (paying up to 50 percent of program cost).

Implementing a National Workplace Prevention Program. ASPH endorses the intent of the healthy workplace provisions of the HeLP America Act, which provide an excellent template for prevention programs. More concretely, ASPH makes the following recommendations:

- Implement a National Workplace Prevention Program, including an aggressive awareness campaign, an information clearinghouse, and benchmarks for all public and private U.S. employers. The program would be developed by the CDC and approved by the Secretary of HHS and the Surgeon General.
- Provide a four-tier schedule of tax credits for workplace wellness programs, based on the number of employees. Credits should not exceed 50 percent of the program cost for employers with fewer than 25 employees, falling to no more than 10 percent of program costs for the largest employers (over 1,000 employees). Requiring electronic reporting of tax credits by the Secretary of the Treasury would provide the accountability and surveillance data essential for implementation.
- Require all participants to meet basic program requirements as defined by the CDC, including smoke-free workplace policies.

• Authorize and fund a significant expansion of the CDC/NIOSH WorkLife Initiative, which is designed to promote evidence-based research and provide technical and policy assistance at the State and national level. This expanded initiative should include a targeted investigator-initiated grant program, a national network of WorkLife Centers of Excellence, and a robust demonstration research grant program to engage employers, unions, worker associations, insurers, wellness and informatics vendors, and universities.

• Authorize and fund a CDC/NIOSH state-level, employment-based health promotion and protection program.

• Authorize and fund a CDC/NIOSH program for public and private entities to develop, implement, and evaluate health communication and health literacy products designed for employers, unions, insurers, and other vendors, and targeted at employees and their families.

• Authorize and fund the development of a CDC/NIOSH Web site to serve as a national and global clearinghouse for all elements of this national employee wellness program, including all applications and all outcome data.

7. Empower communities to put prevention and public health programs at the forefront of primary care.—Public health and primary care are both practiced at the community level, creating opportunities to change the culture of local health systems to emphasize prevention as a core competency. Significant gaps currently exist because many community prevention services are not reimbursed as a part of primary care or adequately funded by local health departments, and are typically siloed organizationally, and by funding sources.

Expanding community-based preventive services and attracting essential personnel to underserved rural and urban communities is as essential to eliminating health disparities as an element of universal insurance coverage. Residents in these communities typically have the highest rates of poverty, the most limited primary care and prevention services, the lowest rates of insurance coverage, and the poorest health outcomes. Long-term investments are especially necessary to provide adequate prevention and public health training to local primary care providers and community health workers, to expand facilities to house prevention programs, and to develop information and administration systems that link and evaluate public health programs with primary care and make the entire community health system more efficient and cost-effective.

A new form of Federal support for prevention and public health programs at the local level should be used to supplement the core program of uniformly inadequate funding of local health departments and to assure that Federally Qualified Health Centers, rural clinics, free medical clinics and local primary care providers are integrated and utilize prevention in primary care. This new Federal program should share a common public-private governance board with the local public health department, hospital, and other local health programs to assure integration, efficiency, and accountability.

To meet the prevention and public health needs of communities throughout America, especially those that are underserved, ASPH recommends action to:

• Develop and fund a national network of Community Health Education and Resource Centers (CHERs), a new entity modeled on Federally Qualified Health Centers, to integrate and coordinate community-based prevention services, including core health education, mental health counseling, and outreach services. CHERs could be integrated with existing FQHCs, and with local hospitals, public health departments, primary care providers, and other community health programs through a common public-private governing board. The Health Resources and Services Administration should provide adequate funding to finance new facilities and provide core funding for CHER staff and programs, which could also be supported financially by the hospital community-benefit programs and other charitable contributions. A CHER could be located at and led by any community-based health entity and would serve as a platform from which to advocate for additional support for community-based prevention programs.

• Authorize and fund a nationwide grant program to allow FQHCs, local health departments, and publicly owned hospitals to develop and fund innovative CHER models; to organize public-private governance boards that include all community health stakeholders; to administer and evaluate CHERs; and to ensure they are integrated with other community prevention and primary health care programs.

• Authorize and fund new state-based community preventive health intervention grants, based on U.S. Community Preventive Services Task Force recommendations, to ensure State investment and engagement with Federal community preventive health programs.

• Authorize and fund community prevention training grants for community health practitioners and educators, mental health nurses and counselors, and dental

primary care providers. Funding should include support for an expanded clinical practice authority for dental hygienists to train to become advanced dental hygiene practitioners.

• Authorize and fund a CDC-based program of community health research demonstration grants. These should take advantage of current CDC state-based and university-based grant and center programs, including national networks of Injury Prevention Research Centers, Prevention Research Centers and Agricultural Health and Safety Centers, which contain many of the required research elements for developing, implementing, and evaluating community-based demonstration grants.

• Authorize and fund the development of a web-based national clearinghouse to promote the development of community-based prevention programs. The clearinghouse should also provide organizational information and track research outcomes.

Authorize and fund Native American nations to assure that they receive the same benefits as other underserved communities through targeted Native American CHERs, community health demonstration grants, prevention and public health training programs, and a culturally appropriate community health clearinghouse for all community-based prevention and primary care programs.

CONCLUSION

As health reform policies are debated, ASPH again emphasizes the importance of putting prevention and public health at the forefront of the debate. Even this cost-effective approach, however, will be expensive. Significant revenues, as well as important health benefits, would be generated by the $1/pack tobacco tax ASPH recommends. Policymakers may also want to consider two other taxes—on sugar-sweetened beverages or other high-sugar foods, and on alcohol. ASPH is currently reviewing the scientific evidence for these taxes, which offer a possible opportunity to generate revenues while taking action with positive health consequences.

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Senator DODD. Thank you.

Dr. Levi, thank you for joining us.

STATEMENT OF JEFFREY LEVI, Ph.D., EXECUTIVE DIRECTOR, TRUST FOR AMERICA'S HEALTH

Mr. LEVI. Thank you, Mr. Chairman. Thank you, Senator Mikulski.

I want to begin by thanking you and your colleagues for assuring that public health and prevention are a central part of this year's health reform effort.

The public health title of this bill helps to ensure that reform efforts address the health of the American people, not just financing sick care.

In the short time that I have, I want to emphasize the importance of key portions of the public health title. The Right Choices Program provides crucial assurance of access to proven clinical preventive services for the uninsured. We are pleased that the coverage section mandates no co-payments for evidence-based preventive services endorsed by independent authorities.

Just as importantly, the public health title places emphasis on prevention that takes place outside the doctor's office, those initiatives that help to make healthy choices the easy choices by promoting lifestyle and environmental changes that remove barriers to healthy living.

Ultimately, engaging in preventive behaviors is the personal responsibility of all Americans, but we cannot expect them to exercise that personal responsibility unless we make the communities in which they live ones that promote this wellness approach. That is why the community transformation grants and prevention education campaigns are so important.

All the prevention programs in this title will be of diminished value without a concerted coordinated effort to implement effective programs. Thus, the mandate for a national prevention and health promotion strategy is an essential component to assure that the American people—to assure the American people that all parts of the Federal Government are working on shared goals in targeting the conditions most important to the public's health.

And finally and perhaps most important of all, we are strongly supportive of the Prevention and Public Health Investment Fund. Public health programs have not achieved their potential primarily because public health has been chronically under-funded.

The Investment Fund would assure reliable funding for prevention that will make Americans healthier as they become part of a reformed healthcare system. The $10 billion level will assure that a good mix of clinical and community prevention services will be available.

Thank you again, Mr. Chairman, for your leadership and for this opportunity to express our strong support for the public health provisions of this historic legislation.

[The prepared statement of Mr. Levi follows:]

PREPARED STATEMENT OF JEFFREY LEVI, PH.D.

Thank you, Mr. Chairman for the opportunity to testify. My name is Jeff Levi, and I am the Executive Director of Trust for America's Health (TFAH), a nonpartisan, nonprofit organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. I want to begin by thanking you and your colleagues for assuring that public health and prevention are a central part of this year's health reform effort. The public health title of this bill helps to ensure that reform efforts address the health of the American people, not just financing sick care. I want to emphasize the importance of key portions of the public health title:

• The Right Choices program provides crucial assurance of access to proven clinical preventive services for the uninsured. We are pleased that the coverage section mandates no copayments for evidence-based preventive services endorsed by independent authorities.

• Just as importantly, the public health title places emphasis on prevention that takes place *outside* the doctor's office—those initiatives that help to make healthy choices the easy choices, by promoting lifestyle and environmental changes that remove barriers to healthy living. Ultimately, engaging in preventive behaviors is the personal responsibility of all Americans. We cannot expect them to exercise that personal responsibility unless we make the communities in which they live ones that promote this wellness approach. That is why the community transformation grants and prevention education campaigns are so important.

• It is critical to note that we know this approach to prevention can and does work—and often can save us money. Trust for America's Health worked with the New York Academy of Medicine, Prevention Institute, and the Urban Institute to see if there were indeed evidence-based approaches to community prevention that could both prevent chronic diseases—the biggest cost drivers in our health care system today—and potentially save money. We found that for an investment of $10 per year per person in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use the country could save more than $16 billion annually within 5 years. This is a return of $5.60 for every $1 spent.

• We also found that the evidence base needs building in other areas of prevention. That is why we are pleased that this title provides the authority and resources to assess the data currently available on clinical and community preventive services and authorizes the Centers for Disease Control and Prevention to conduct more extensive public health services and systems research—to be sure that we are successfully and cost effectively translating prevention science into good practice.

• All the evidence in the world, however, is not of value without a concerted, coordinated effort to implement effective programs. Thus, the mandate for a National Prevention and Health Promotion Strategy is an essential component to assure the American people that all parts of the Federal Government are actively engaged in targeting the conditions most important to the public's health and that government agencies are accountable for achieving measurable health outcomes with the resources taxpayers provide for public health.

• And finally, and perhaps most important of all, we are strongly supportive of the Prevention and Public Health Investment Fund. Public health programs have not achieved their potential primarily because public health has been so chronically underfunded. This has occurred at a time when States and localities have been making major cutbacks due to the recession. The Investment Fund would assure reliable funding for prevention efforts that will make Americans healthier as they become part of a reformed health care system. The $10 billion level goes a long way toward closing the funding gap and will assure that a good mix of clinical and community preventive services will be available.

Thank you again, Mr. Chairman, for your leadership and for this opportunity to express our support for the public health provisions of this historic legislation.

Senator DODD. Well, thank you very much, Doctor, and we will have some good questions for you, as well, in a few minutes.

Dr. Raines, thank you again for being with us.

STATEMENT OF C. FAY RAINES, Ph.D., RN, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING, AND DEAN, COLLEGE OF NURSING, UNIVERSITY OF ALABAMA, HUNTSVILLE, AL

Ms. RAINES. Thank you, Senator Dodd.

I am Fay Raines, President of the American Association of Colleges of Nursing, which represents baccalaureate and graduate programs in nursing across the country, and I am the Dean of the College of Nursing at the University of Alabama in Huntsville.

It is my great honor to testify before you today, and first, I would like to commend all members of the HELP Committee and their staff for drafting this legislation which promises to re-invigorate our country's healthcare system.

I am pleased to offer AACN's insights, especially as it relates to the workforce, which are further developed in our written statements. I hope that these insights and suggestions will provide some assistance as you continue working through this challenging, difficult but hopefully very rewarding process for the citizens of the country.

AACN commends the Senate HELP Committee's work to reauthorize Title VII and VIII of the Public Health Service Act. These programs are vitally important to the efforts of nurses and other health professionals to address the workforce needs of the future.

A major hindrance in increasing the number of practicing nurses is the nursing faculty shortage. While AACN strongly supports the effective strategies in this bill to address that shortage, we also highly recommend that the 10 percent cap on doctoral nursing programs, a no-cost measure, be removed from the Advanced Education Nursing Grants Program. Failing to remove this cap may significantly limit the number of advanced practice registered nurses as well as doctorally prepared nurses who can serve as faculty in the very near future.

AACN also recommends that the Capitation Grants Program outlined in the Nurse Education, Expansion and Development Act of 2009, which was introduced by Senator Durbin, be included in this bill. Capitation Grant Programs have had historical success and will address the most pressing needs of our nursing schools, including infrastructure and clinical training.

At my own school, for example, we turn away between 1 and 200 qualified applicants each year due to lack of resources and this is typical of many schools across the country at a time of a very serious nursing shortage.

Capitation Grant Programs will enable schools to expand capacity and produce more nurses to meet the critical workforce needs for health promotion and other programs cited in this legislation.

AACN is very pleased that the committee thought broadly about healthcare providers while drafting this legislation. The term "provider" and "practitioner" show a commitment to a new model where quality care is delivered by a team rather than any one provider and we encourage the consistent use of that terminology throughout the bill.

AACN and numerous other nursing organizations commend the use of community-based multidisciplinary teams to support primary care through the medical home model. However, we are con-

cerned that the current language under section 212 suggests that advanced practice registered nurses cannot lead a medical home and the purpose of the medical home speaks directly to the skills and education that advance practice registered nurses receive and we encourage the committee to look at that part of the legislation again.

Finally, we would like to suggest that, as an adjunct to the Senate HELP Committee's important work regarding expanding nursing education, parallel work be done with the Senate Finance Committee to expand clinical education for advance practice registered nurses through a modification of Medicare funding for nursing, to include funding for training APRNs.

It is clear that this committee recognizes the fundamental need for accessible quality care and understands the contributions nurses will make in ensuring the implementation of the provisions of this bill.

Thank you for your leadership and for the opportunity to testify and offer our comments on this momentous legislation.

[The prepared statement of Ms. Raines follows:]

PREPARED STATEMENT OF C. FAY RAINES, PH.D., RN, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING AND DEAN, COLLEGE OF NURSING, UNIVERSITY OF ALABAMA IN HUNTSVILLE, ON BEHALF OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING (AACN)

Good afternoon distinguished committee members. I am Dr. Fay Raines, President of the American Association of Colleges of Nursing and Dean of the College of Nursing at the University of Alabama in Huntsville. The American Association of Colleges of Nursing (AACN) is the national voice of baccalaureate and graduate nursing education, representing over 640 schools of nursing that educate approximately 270,000 students and employ over 13,000 faculty members. Together, these institutions produce about half of our Nation's Registered Nurses (RNs) and all of the nurse faculty and researchers. It is my great honor to testify before you today on the *Affordable Health Choices Act of 2009*. First, let me commend and congratulate Chairman Kennedy, Senator Enzi, Members of the Health, Education, Labor, and Pensions (HELP) Committee, and their staff for drafting this legislation, which promises to re-invigorate our country's healthcare system. I am pleased to offer AACN's insights on this comprehensive legislation.

TITLE IV—HEALTH CARE WORKFORCE; SUBTITLE D—ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING; SECTION 438, ADVANCED EDUCATION NURSING GRANTS

AACN commends the Senate HELP Committee's work to reauthorize Titles VII and VIII of the Public Health Service Act (PHSA). These programs are vitally important to the efforts of nurses and other health professionals to address future workforce needs. As the committee is well aware, our Nation's 11-year nursing shortage persists, and more positions continue to open for RNs across the country. The U.S. Bureau of Labor Statistics (BLS) recently reported that the healthcare sector of the economy is continuing to grow, despite significant job losses in nearly all other major industries. Hospitals, long-term care facilities, and other ambulatory care settings added 23,500 new jobs in May 2009, a month when 345,000 jobs were eliminated across the country. As the largest segment of the healthcare workforce, RNs likely will be recruited to fill many of these new positions. Moreover, according to the latest BLS projections, more than 1 million new and replacement nurses will be needed by 2016.

The nursing workforce is not growing at a pace that will adequately meet long-term needs, including the demand for primary care, which is often provided by Advanced Practice Registered Nurses (APRNs). This challenge is further compounded by the number of nurses who will retire or leave the profession in the near future, ultimately reducing the nursing workforce. The supply of nurses nationwide is stressed due to an ongoing shortage of nurse faculty. The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet the demand. According to AACN, 49,948 qualified applicants were turned

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away from baccalaureate and graduate nursing programs in 2008 primarily due to a lack of qualified faculty. Of those applicants, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach.

AACN commends the committee's efforts to include effective strategies in the *Affordable Health Choices Act of 2009* to address the nursing faculty shortage. Yet, we are concerned that one measure, which has no associated costs, was not included in the text of the bill.

• Therefore, we strongly suggest that the 10 percent cap imposed on traineeships awarded to doctoral students under the Advanced Education Nursing Grant program be lifted by striking section 296j(f)(2) of the current title VIII authority.[1]

Failing to remove this cap may significantly limit the number of APRNs, as well as doctorally prepared nurses who can serve as faculty in the very near future. The need for nurses with doctoral degrees is growing at an exceedingly high rate. By 2015, nursing education is moving toward preparing all new APRNs and other nursing specialists in Doctor of Nursing Practice (DNP) programs. According to AACN, between 2007 and 2008, the number of new DNP programs and enrollments more than doubled. Additionally, graduations from these programs in that time span nearly tripled. Neglecting to remove this cap will cause significant strain on the educational pipeline of future APRNs and other nursing specialists.

Furthermore, this cap inhibits the expansion of the doctorally prepared nurse faculty population. The need for nurse educators is acute as schools reported last year that more than 50 percent of the faculty vacancies required a doctoral degree. Unfortunately, schools are not preparing enough doctorally prepared nurses. According to AACN's 2008–2009 report, enrollment in research-focused doctoral nursing programs were up by only 0.1 percent or 3 students from the 2007–2008 academic year. With increased access to these trainee-ship funds by removing the 10 percent cap mentioned above, more doctoral nursing students can be supported. This critical edit will directly impact the supply of nurse faculty and primary care providers.

TITLE IV—HEALTHCARE WORKFORCE; SUBTITLE D—ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING

As evidenced by the rapid growth in nursing school enrollments, nationwide attention to the nursing shortage has sparked the interest of thousands of men and women across the country. However, nursing schools are struggling to overcome a variety of barriers beyond the faculty shortage that preclude them from further expanding student capacity and increasing the pipeline of registered nurses. Thousands of potential nursing students are being denied the opportunity to pursue a nursing education despite the high demand for RNs.

Each year, schools of nursing turn away tens of thousands of students due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Although, schools pointed to faculty shortages as a major reason for not accepting all qualified applicants into nursing programs, many schools of nursing are literally crumbling since congressional funding for infrastructure ceased in the mid-1970s.

Compared to other academic disciplines, the cost of nursing education is relatively high, like medicine, which further increases the financial burden on nursing schools. Schools require specialized laboratory equipment, computer software, and simulated hospital units to prepare students to provide lifesaving nursing services in a complex healthcare system. Moreover, nursing education is also faculty-intensive with a high ratio of faculty to students, on average 1:10, as mandated by state-registered nurse practice acts.

From 1971 to 1978, Congress provided Capitation Grants (formula grants based on the number of students enrolled) to schools of nursing in support of nursing education. These grants have had a stabilizing effect on past nursing shortages by addressing the financial obstacles of nursing programs. Notably the Nurse Training Act of 1971 (P.L. 92–158) and the Nurse Training Act of 1975 (P.L. 94–63) facili-

[1] On behalf of the American Association of Colleges of Nursing (AACN), we would like to amend our written and oral testimony provided on June 12, 2009. In the testimony we addressed that the 10 percent cap awarded to doctoral students under the Advanced Education Nursing Grant program be lifted by striking section 296j(f)(2) of the current Title VIII authority of the Public Health Service Act. The *Affordable Health Choices Act of 2009*, does indicate the removal of this provision. This was an oversight and unintentional error by AACN and we would like to correct our comments to reflect the legislation does include the removal of this cap. It was not our intent to mislead the Senate Health, Education, Labor, and Pensions Committee. (See Letter dated June 19, 2009 in Additional Material).

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tated increased enrollments in schools of nursing and helped resolved nursing workforce shortages.

The March 2002 Health Resources and Services Administration *Tenth Report to Congress on Health Personnel in the United State*s recommended Capitation Grants funding as a strategy to expand the nursing workforce pipeline.

• **Therefore, AACN respectfully requests that the Capitation Grants program outlined in the *Nurse Education, Expansion, and Development Act of 2009*, (S. 497), which was introduced by Senator Richard Durbin (D-IL), be included in this section of the bill.**

Just as in the past, today's schools of nursing need additional resources, particularly nurse faculty, to educate the next generation of nurses. Capitation Grants would complement and expand the existing authorities under Title VIII of the PHSA by providing nursing schools with the opportunity to improve the structural and programmatic conditions that inhibit student capacity growth. For these reasons, Capitation Grants would provide a flexible funding stream to meet the fiscal barriers faced by schools of nursing.

TITLE IV—HEALTH CARE WORKFORCE; SUBTITLE D—ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING; SECTION 432, TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS

Section 432, Training Opportunities for Direct Care Workers creates "Primary Care Training and Enhancement" on page 493. While this program includes physicians and physician assistants, AACN is concerned that this program does not include APRNs such as Nurse Practitioners (NPs).

There are over 125,000 NPs practicing in the United States today. Of those NPs, 66 percent serve in at least one primary care setting. Therefore, approximately 82,500 NPs are practicing in primary care. According to the American Academy of Nurse Practitioners (AANP),

• 39 percent of NPs hold hospital privileges; 13 percent have long-term care privileges.

• 96.5 percent of NPs prescribe medications and write an average of 19 prescriptions/day.

• NPs write over 513 million prescriptions annually.

• 62 percent of NPs see three to four patients per hour; 12 percent see over five patients per hour.

• Malpractice rates remain low; only 1.4 percent have been named as primary defendant in a malpractice case.

Nurse Practitioners are widely used as primary care providers, with outcomes equivalent to their physician and physician assistant colleagues.

• **AACN recommends that the "Primary Care Training and Enhancement" program, under section 432 of this bill be expanded to include APRNs such as Nurse Practitioners.**

TITLE IV—HEALTHCARE WORKFORCE; SUBTITLE B—INNOVATIONS IN THE HEALTH CARE WORKFORCE; SECTION 411, NATIONAL HEALTH CARE WORKFORCE COMMISSION

AACN supports the development of a National Health Care Workforce Commission. Quality data on the national healthcare workforce is critical to ensure that care is comprehensive and coordinated and all providers are used to their full scope of practice. This can only occur with the collaboration from all healthcare providers in the planning and development of national standards for data collection and analysis.

• AACN recommends that the membership of this commission has an equal representation among health professionals.

TITLE II—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE; SUBTITLE B—HEALTH CARE QUALITY IMPROVEMENTS; SECTION 212 GRANTS TO ESTABLISH COMMUNITY HEALTH TEAMS TO SUPPORT THE MEDICAL HOME MODEL

AACN and numerous nursing organizations commend the use of "community-based multidisciplinary teams" to support primary care through the Medical Home Model. For the reason cited earlier, AACN firmly believes that APRNs should be clearly identified as primary care providers and authorized to lead Medical Homes. However, we are concerned that the current language under section 212 suggests that APRNs could not lead a Medical Home.

• **AACN strongly suggests using the language defining Medical Homes from the Schwartz-Cantwell bill, *Preserving Patient Access to Primary Care Act of 2009* (S. 1174, H.R. 2350).**

The purpose of the Medical Home speaks directly to the skills and education APRNs receive.

TITLE IV—HEALTH CARE WORKFORCE; SUBTITLE D—ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING; SECTION 455, PRIMARY CARE EXTENSION PROGRAM

AACN and members of the Nursing Community are pleased to see the inclusion of the Institute of Medicine's definition of primary care and commend the committee for the emphasis the legislation places on delivering primary care and preventive services under a reformed healthcare system. However, we feel that the definition of primary care providers, as noted on page 573 of the legislation, could be unintentionally limiting as it describes the clinician as providing preventative and health promotion services for " . . . men, women, and children of all ages. . ." This suggests that a single primary care provider must offer care to all three populations and would indicate that certified nurse-midwives, pediatric nurse practitioners, pediatricians, and other specialists would not be viewed as a primary care provider since they serve a subset of the population.

• **If this is not the intent of this language, we suggest its removal or clarification. A viable option would be to incorporate the definition of primary care providers from the Schwartz-Cantwell bill, *Preserving Patient Access to Primary Care Act of 2009*, with the inclusion of certified nurse-midwives.**

OVERALL COMMENTS

Nurses and Quality Measures

Nurses are a central element in healthcare quality and safety. It is clear that the committee recognizes the fundamental need for accessible quality care and understands the connection nurses will make in ensuring the provision of the bill are implemented. The *Affordable Health Choices Act of 2009* details new and expansive quality programs in titles II (Improving the Quality and Efficiency of Health Care) and III (Improving the Health of the American People). These programs will expand the role of and need for nurses as they will be critical to collecting and implementing established quality indicators. Therefore, AACN is appreciative that Section 442 (Authorization of Appropriations for Parts B through D of title VIII) of the bill seeks to increase funding for the title VIII programs to ensure that more nurses are educated to address the need for emerging nursing positions.

The Future Healthcare Team

AACN is pleased to see that the committee thought broadly about healthcare providers when drafting this legislation. Use of the terms "provider" and "practitioner" demonstrates a commitment to a new model where quality care is delivered by a team rather than any one provider. We encourage consistent terminology, where applicable, throughout the legislation.

Clinical Education for APRNs

We would like to suggest that as an adjunct to the important work the Senate HELP Committee is doing regarding expanding nursing education, parallel efforts be undertaken with the Senate Finance Committee to expand clinical education for APRNs. AACN suggest a modification of the Medicare funding for nursing to include funds for training APRNs. In hospitals, the vast majority of care is provided by nurses, yet nurses receive little Federal funding for clinical training. Unlike the Graduate Medical Education program that has been the primary vehicle for physician training in hospitals over the last 40 years, nursing education programs have not had the support or the funding to sufficiently provide nurses with the training needed for the complex healthcare environment. Because of the critical role nurses play in quality care and patient safety, nursing clinical education should be viewed with the same importance as medicine when reshaping healthcare and move toward systemwide reform.

CONCLUSION

The *Affordable Health Choices Act of 2009* offers numerous programs that would augment the nursing workforce for the benefit of American patients. For example Section 412, State Health Care Workforce Development Grants; Section 428, Nurse-managed Health Clinics; Section 429, Elimination of Cap on Commissioned Corp; Section 430, Establishing a Ready Reserve Corps all have the potential to improve

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the health professions workforce and directly impact the quality of patient care. AACN would like to reiterate our appreciation to the Senate HELP Committee for the significant efforts to draft such a comprehensive piece of legislation. AACN looks forward to working further with the committee to address the concerns raised above during the legislative process. Thank you for the opportunity to testify and offer our comments on this momentous piece of legislation.

Senator DODD. Well, thank you, Dr. Raines, very, very much.

Dr. Jonas, welcome.

STATEMENT OF WAYNE B. JONAS, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, SAMUELI INSTITUTE

Dr. JONAS. Thank you very much. Thank you, Senator Dodd, Senator Mikulski, Senator Brown, members of the committee, for the opportunity to testify again on the importance of health promotion, prevention and integrative practices in healthcare transformation.

I want to congratulate you on a bill that has opened the dialogue beyond the treatment and funding of our current sick care system of which we have a major one and the importance of developing a 21st Century prevention and wellness system with equal power and equal stature.

I think the bill opens up opportunities for this and my testimony will focus on specific areas that can enhance that practice.

I run the Samueli Institute. It is a nonprofit research organization, one of the few that has a track record in research on integrative medicine, healing relationships, optimal healing environments, and military medicine in which we do a considerable amount.

Let me say that it is axiomatic, self-evident in my opinion, that the goal of healthcare reform should be health. We should be producing health. The most powerful way to do that is to tap into the inherent healing capacities of the individual and the community through the systematic application of behavioral and lifestyle change areas and integrative practices that we know contribute to 70 percent of the chronic diseases that we suffer from.

To achieve this goal, to create a 21st Century health system that is as powerful as our medical healthcare system, could transform and create health and flourishing Nation.

On the Affordable Healthcare Choices Act that is currently before the committee, there are several provisions that I think, if emphasized, would create such a wellness system. The most important of these, in my opinion, is the National Prevention and Health Promotion and Public Health Council, the S302, in your language.

What this does is it examines policies that cross multiple agencies, not just the health delivery system, and looks at those that enhance the production of health. The council can move the Nation and the culture and, most importantly, the healthcare industry toward prevention and wellness.

There are other key provisions also that could support this, if they were done in a coordinated fashion. The Public Health and Prevention Investment Fund, by linking the use of this fund to the policies of the council, would give it some true powers, some true teeth in these areas.

The clinical community preventive services that have already been mentioned provide delivery mechanisms for sustained individual and community behavioral change. These, however, need to

be combined with others that are mentioned in this bill, such as the community health teams, the community transformation grants, the employer-based wellness programs, and the education and outreach campaign.

Let me point out, however, that the educational and outreach campaign has to go beyond information, as it is currently described in the bill. It has to include actual training and skills, values and attitudes that promote health and wellness, and it has to link up with what I call the healthcare home, so that there are teams of qualified practitioners of all disciplines, not simply the medical side.

Finally, the healthcare workforce section should include provisions to develop wellness professionals who are as fully trained and supported as we currently have medical professionals. Leaders in wellness would encompass nurses, would encompass primary care and integrative practitioners and there would be standards for wellness behavior and skills that can be further disseminated through other aspects of the act, such as the Primary Care Extension Program, the National Health Service Corps, and the Youth Public Health Program.

Things like that, however, need to produce youth with leadership skills that can deliver wellness and prevention activities. They need to be able to model this so the experience in those areas is key to that.

If the above provisions were coordinated and implemented, a wellness initiative for the Nation could ensue and launch to produce a true goal of health reform which is health from womb to tomb.

I appreciate the opportunity to appear before the committee and look forward to any questions.

[The prepared statement of Dr. Jonas follows:]

PREPARED STATEMENT OF WAYNE B. JONAS, M.D., PRESIDENT AND CEO, THE SAMUELI INSTITUTE

Thank you, Senators Kennedy and Enzi, and members of the committee for the invitation to testify about the central role of prevention, health promotion and integrative health care practices to address many of the ills of today's health care delivery system. First, let me congratulate you on your leadership in producing a bill and offering legislative options that go beyond the issues of medical care coverage and payment, and open an opportunity to deliver the central factors that we know can produce health and wellness, and enhance productivity and healing.

The Samueli Institute, a 501(c)(3) non-profit scientific research organization, investigates healing processes and their application in promoting health and wellness, preventing illness and treating disease—one of the few organizations in the Nation with a track record in complementary and integrative health care, healing relationships and military medical research.

It is axiomatic that the goal of health care reform should result in—health. To achieve this goal, our culture should be empowered to create a wellness system that is as powerful as our disease treatment system is today. We cannot expect to improve the health of our citizens through more or better access to the current broken system, or by simple payment or insurance reforms of that system. **We need a new vision and approach to creating health. We need a Wellness Initiative for the Nation (WIN).** In previous testimony before this committee, I presented an overview of WIN, see (*http://www.samueliinstitute.org/news/news-home/WIN-Home.html*).

The Affordable Health Choices Act currently before the committee has several provisions that can help create a 21st Century Wellness System. **The most important of these is The National Prevention, Health Promotion and Public Health Council [S. 302]!** By examining policies across the multiple agencies that

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either enhance or interfere with health production, the Council can move the national culture and health care industry toward prevention and wellness. Other key provisions for creating a wellness culture and system include:

1. *Prevention and Public Health Investment Fund.* By linking the use of this Fund to the policies developed by the Council, it would have true power to create a wellness system;

2. *Clinical and Community Preventive Services.* Delivery mechanisms for sustained individual and community behavioral change would be created if the provisions of this section were combined with the Community Health Teams, Community Transformation Grants, Employer-based Wellness Programs, and the Education and Outreach Campaign. The educational system must go beyond information, however, to include actual training in the skills, values and attitudes that promote health and wellness; and

3. *The Health Care Workforce* section should include provisions to develop Wellness Professionals who are as fully trained and supported as medical professionals. Leaders in wellness would encompass nurses, and primary care and integrative practitioners. Wellness behavior and skills can further be disseminated through the Primary Care Extension Program, a National Health Service Corps, and the Youth Public Health Program—provided the latter produced youth with leadership skills needed to deliver wellness and prevention.

Senator DODD. That's very, very good, Doctor. We thank you.

Dr. Cosgrove.

By the way, I should let Senator Brown introduce you, I guess. Cleveland Clinic gets talked about a lot. Back at the White House the other day, the President was bragging on the Cleveland Clinic and your Senator brags about you all the time.

STATEMENT OF SENATOR BROWN

Senator BROWN. Thank you. I would like to take a moment. Thank you, Mr. Chairman.

Dr. Cosgrove, welcome to the committee. It was good to see you yesterday here, too, sitting through a long day, as we have all done in the last few days and few weeks on this, and Dr. Cosgrove is the CEO of the Cleveland Clinic and as Chairman Dodd said, we were at the White House last week and the President was talking about institutions that provide extraordinarily high-quality care and find a way to do it less expensively than most around the country and cited a very small number of places and the Cleveland Clinic was one of them.

I was there this week visiting with again Dr. Cosgrove and much of his management team and the kinds of things that he will talk about, I am sure, so I will not say much, but in terms of what they're doing with IT, what they're doing with prevention, what they're doing with wellness, it was exceptional.

We look forward to hearing that and welcome back and good to see you.

Thank you.

Senator DODD. Good to have you with us.

STATEMENT OF DELOS M. COSGROVE, M.D., CEO, CLEVELAND CLINIC

Dr. COSGROVE. Thank you very much, Senator Dodd, Senator Mikulski.

Senator Brown, you've been a great friend of the Cleveland Clinic and an advocate for better healthcare and we very much appreciate that.

I appreciate the opportunity to tell you a little bit about the uniqueness of the Cleveland Clinic which is and has made it possible for us to achieve access, quality and affordability for our patients.

We are major proponents of preventive and wellness care. However, we think that in order to achieve what we have, we also have to look after the sickness and it has to be done in a significantly different model.

The organization had its beginnings in World War I when four doctors came together from different disciplines in France and worked as a unit. They came back and started the Cleveland Clinic at that time and the obsession with quality has driven this organization to grow where it is now 2,000 physicians and scientists and a 120 specialties, 40,000 employees, and we see 3.3 million outpatient visits and 120,000 hospitalizations annually.

The major portion of the success of the organization is its model which is an integrated model. The hospitals, the physicians, the clinics, the medical school, the research institutes are all one part, a part of one organization which are physician-led.

The second portion of this is the group practice. The physicians at the Cleveland Clinic are all salaried. We all have 1-year contracts. There's no tenure. Each year we have an annual professional review which ensures quality and salaries are adjusted on the basis of the quality of the physician's performance.

We have recently changed our organization to go from a physician-centered organization where the physicians were in Departments of Surgery and Departments of Medicine to an institute model which is patient-centered. Essentially, a Neurologic Institute will have neurosurgeons, neurologists and psychiatrists all in the common location with common leadership, and this begins to change the focus of the physicians' work.

We have also had an obsession with quality. We have been measuring quality and publishing our outcomes. Every institute publishes on an annual basis the outcomes, not just the procedural outcomes but the actual clinical outcomes on an annual basis and makes it public. The transparency is vitally important because it begins to translate the moving of competition in medicine from one around reputation and cost to one around quality.

The thing that holds our entire organization together is our healthcare IT. We have electronic medical records that goes from our facility in Las Vegas to Abu Dhabi, from Canada to Florida, and all of our facilities are connected electronically. This drives additional quality and allows us to measure the outcomes of our activities.

I appreciate the opportunity to begin to share our experience with you and I look forward to answering your questions.

[The prepared statement of Dr. Cosgrove follows:]

PREPARED STATEMENT OF DELOS M. COSGROVE, M.D., CEO

Cleveland Clinic is a unique medical enterprise whose organization and practices parallel key goals of the "Affordable Health Care Choices Act." Cleveland Clinic's integrated structure enables it to control costs, measure and improve quality, and provide access to high-quality healthcare services across a broad regional system.

Cleveland Clinic was founded in 1921 by four physicians who had served in World War One and hoped to replicate the organizational efficiency of military medicine.

They established Cleveland Clinic as a not-for-profit group practice with a mission of patient care, research and education. Today, it is one of the largest and busiest medical centers in the world, with the highest CMS case-mix index in America.

Cleveland Clinic Health System includes a main tertiary care campus, 8 community hospitals and 16 suburban family health and ambulatory surgery centers. With 40,000 employees, it is the second largest employer in Ohio, and is responsible for an estimated $9 billion of economic activity every year.

Cleveland Clinic employs 1,800 physicians and scientists in 120 medical specialties and sub-specialties. The organizational model is designed to optimize quality and efficiency. The system's physicians, employees, hospitals, clinics, medical school, and research initiatives are all part of one organization which is physician-led. There is no tenure, and all employees have 1 year contracts. Physicians are evaluated annually and salaries adjusted according to performance. All receive a salary with no bonuses or other financial incentives. Physicians get no financial benefit from ordering unnecessary tests or expensive devices. The hospital and physicians share a financial interest in controlling costs.

Cleveland Clinic is organized into patient-centered Institutes based around diseases or organ systems (Heart & Vascular Institute, Neurological Institute, etc.). Each Institute combines medical and surgical services at the same location under the same leadership to provide multi-disciplinary care and improve quality and experience.

Each Institute measures quality according to sentinel metrics. Institutes publish annual outcomes booklets showing volumes, results, innovations, publications and other information relevant to patients and referring physicians. This promotes competition on quality rather than cost or reputation.

A pioneer in the development of health information technology (HIT), Cleveland Clinic integrates at all facilities with an extensive electronic medical records system. This system includes participating community physicians and patients who are able to access test results and portions of their medical records at home via the internet.

We support the goals of this committee and believe the integrated delivery system described above is best designed to carry out the mandates of reform across the multiple settings through which care is delivered.

Mr. Chairman, I am very grateful for this opportunity to appear before the committee to discuss the important topic of healthcare reform.

I am especially pleased that Senator Sherrod Brown of Ohio is a member of this committee. Senator Brown is knowledgeable about the Cleveland Clinic and visited us earlier this week to discuss healthcare reform. We were thrilled last week when President Barack Obama cited Cleveland Clinic as a medical center that is able to provide quality care at a lower cost.

I know the committee has introduced the "Affordable Health Care Choices Act." I commend the speed and urgency you bring to the legislative process. Hopefully, I can add to your body of knowledge by telling you something about Cleveland Clinic's model of healthcare delivery.

Cleveland Clinic was conceived in the battlefields of World War One. It was founded by four Cleveland doctors who had served in the medical corps. They were impressed by the model of care delivery which brought multiple specialists together to work as a unit. When they returned home, they planned a new kind of medical center, where specialists would collaborate selflessly for the good of the patient. Cleveland Clinic opened its doors in 1921.

The mission of Cleveland Clinic is, in the words of its founders, "Better care of the sick, investigation into their problems, and the further education of those who serve them."

In addition to our clinical practice, we operate a vibrant research institute and a large graduate medical education program with 1,100 residents and fellows. We also operate a medical school focused on training physician researchers. That school graduated its first class of MDs this year.

Our research program and medical education programs are fully integrated with our clinical services. We believe that research and education carried out in the clinical setting add to the depth and quality of patient care. It promotes innovation and helps us expedite the movement of new treatments and technology quickly to the bedside.

Most Cleveland Clinic patients come from Ohio and the surrounding regions. Additionally, they come to us from all 50 States of the United States, as well as from more than 80 foreign countries. In 2008 alone, we had 3.3 million patient visits.

Cleveland Clinic is proud of its military legacy. The founders of Cleveland Clinic explicitly modeled their institution on the Army field hospitals of the First World

War. Twenty-five years later, in the Second World War, Cleveland Clinic's Naval Reserve Unit established one of the first mobile hospitals in the South Pacific. In 1968, I had the personal honor of leading the casualty staging flight unit in Danang, Vietnam. Today, Cleveland Clinic proudly collaborates with our armed forces in programs to help wounded warriors and returning veterans.

Cleveland Clinic is co-leader of the new Armed Forces Institute of Regenerative Medicine (AFIRM). This multi-specialty consortium is dedicated to finding new technologies to assist in the recovery of wounded service members. Cleveland Clinic and U.S. Army Reserve have joined in a unique program to recruit and train soldiers who are interested in securing a position in the growing field of healthcare while they continue to serve our country. Under the program, Cleveland Clinic guarantees a job interview for all qualified participating soldiers no later than 30 days after completing military occupational specialty training. In addition, Cleveland Clinic will give priority placement consideration to qualified Army Reserve soldiers. Recently, we have begun collaborative activities with the Military Health System.

Cleveland Clinic is the world's second-largest group practice. We employ 1,800 physicians and scientists in 120 medical specialties and sub-specialties. The delivery of quality healthcare is the preoccupation of our entire organization. We believe that doctors are the principal drivers of quality care. To join our staff, physicians need to meet rigorous standards. There is no tenure. Every physician has a 1-year contract. All physicians are paid a salary. There are no bonuses or other financial incentives. Salaries and contract-renewal are based upon the results of a comprehensive annual performance review. Our physicians compete only against themselves, and work together to assure that every patient gets a correct diagnosis and the most effective treatment.

The Cleveland Clinic group practice model has benefits that parallel the cost-lowering goals of the "Affordable Health Care Choices Act." All of the elements of the system, including the hospitals, clinics, medical school, research institute, and physicians are part of one organization which is physician-led. The group practice model allows us to control costs by controlling utilization, and measuring quality and safety. It does this by aligning the financial interests of the hospital and the physician who practices there. It allows the rational deployment of hospital resources for the benefit of the patient. Since physician and hospital are on the same financial page, there is no incentive for our doctors to order expensive devices, or unnecessary tests or procedures. All parts of Cleveland Clinic are completely integrated and share billing, finance, purchasing, legal and all other support and medical services. Since we are all part of the same organization, we work together to control and rationalize purchasing, expenses and the use of resources. Because we all share the same goals, we are able to standardize recordkeeping, establish benchmarks, and control quality.

We believe that value in medicine is defined by measurement of quality and outcomes. We believe that to improve value we need to measure costs against quality in terms of results. Further, we believe that results should be published and made widely available. Patients benefit when providers compete on the basis of results. Providers need to supply patients with data to help them make informed decisions.

Cleveland Clinic has a long history of measuring and publishing results in cardiac surgery. In 2004, we began measuring outcomes in every medical specialty. This meant finding the metrics for specialties that had never measured themselves. Each specialty is now responsible for finding metrics, setting benchmarks for improvement, and moving the metrics toward greater quality. Measurement provides insight, but to be most effective it must be coupled with transparency.

Cleveland Clinic is the first major medical center to publish annual outcomes and volume information for its medical specialties. Last year, we published 16 outcomes booklets. Each outcomes booklet includes comprehensive data on procedures, volumes, mortality, complications and innovations. We publish these guides consistent with our belief that transparency is an essential part of quality.

Each specialty continually refines their benchmarking and includes more sophisticated data every year. This is information that can be used by referring physicians or patients to choose a doctor or hospital for specific procedures and specialties. They promote competition based on quality, not cost or reputation.

In keeping with a policy of transparency, Cleveland Clinic became the first major medical center to publish the industry relationships of all of its physicians in our online staff directory, including the names of company collaborators, royalties, and fiduciary position and consulting relationships of more than $5,000 a year.

Finally, we have approved a new Open Medical Record Access Policy. This policy gives patients (or their designated emergency contact, next-of-kin, or holder of power-of-attorney) the option of reviewing their medical record in this hospital.

As a not-for-profit, Cleveland Clinic has no owners or stockholders. Income above expenses is used to support research, to supplement graduate medical education costs, and to provide a community benefit. In 2007, our most recent year of compilation, we delivered more than $420 million of community benefit. Our community benefit includes charity care ($123.4 million in 2007), Ohio's largest Medicaid practice, neighborhood wellness and preventive care programs, support for minority health programs, extensive support for local schools, and the provision of necessary but unprofitable services.

Cleveland Clinic began as a single building at a single site. Over the years we have grown considerably. In the late 1990s, we merged with eight community hospitals to form a comprehensive regional health system. In addition, we have established 16 suburban family health and ambulatory service centers to serve. Altogether, we are the largest health system in northeast Ohio.

Our main campus includes 50 buildings on 166 acres in a Cleveland inner-city neighborhood. (We are proud to collaborate with neighborhood organizations to provide jobs, improve housing, and bring new businesses and employers to the area.)

With 40,000 employees, we are the largest employer in northeast Ohio, the second largest employer in the State, and the largest employer in the history of Cleveland.

Cleveland Clinic is one of the largest and busiest medical centers in the United States. We saw 3.3 million patient visits in 2008, and performed almost 73,000 surgical cases. Our patients are severely ill. We have the highest CMS case-mix index in the country.

Cleveland Clinic's effort to enhance care resulted in a massive reorganization beginning in 2007. We have abandoned the traditional physician-based silos of surgery and medicine. We have replaced them with 18 patient-centered institutes.

Institutes are patient-oriented units based around organ systems or disease. All the disciplines relating to the system or diseases are co-located in the institute and share a common leadership. The result is a movement from a physician-centered organization to one which is organized around patients' needs.

Our Heart & Vascular Institute, for instance, includes the departments of Cardiovascular Medicine, Thoracic and Cardiovascular Surgery, and Vascular Surgery. Our Neurological Institute combines the departments of Neurology, Neurosurgery, and Psychiatry & Psychology.

Institutes erase the barriers between disciplines and promote "flow" among services. Patients can stay in one location for all their care, including consults, tests and images. Diagnostic and therapeutic decisions become more authentically multidisciplinary. Duplication of services is reduced, innovation is fostered, and education broadened.

The history of Cleveland Clinic from 1921 to today is the story of intensifying focus on patient needs, expansion of our regional system, and greater integration of services across the continuum of care. These trends are being enabled today by our pioneering use of health information technology (HIT).

As a leader in the innovative use of HIT for the effective delivery of healthcare, we applaud this committee's support for investment in the widespread adoption and implementation of interoperable HIT services nationwide.

A national HIT system needs to be carefully planned. We believe that to maximize the value of a national HIT investment, it should be coupled to an integrated group practice healthcare delivery system. Such a system would include hospitals, physicians, sub-acute facilities and home healthcare professionals. They would share a common commitment to the delivery of coordinated care of the highest possible quality, supported by a secure and integrated information infrastructure. This infrastructure would bring the right information to the right person at the right time, whenever and wherever it is needed.

Looking forward, we see movement away from reliance on the brick-and-mortar hospital, and the growth of virtual systems of integrated, coordinated services, shared information and standardized quality on a broad geographic grid.

The need to move information across our system has its physical counterpart in our need to move patients from one location to another within our broadly dispersed service areas. It is not possible for all physicians to be all things to all patients. Concentration of patients in centers of excellence will drive quality. As a tertiary care center, Cleveland Clinic transports critically ill patients to our main campus on a daily basis. Many of these patients need immediate care from trained intensivists. We have established a comprehensive international air and ground fleet to make this possible. Our fleet includes fixed-wing aircraft, helicopters, and ambulances. Each aircraft and ambulance is a mobile ICU. Each can carry a Cleveland Clinic physician directly to a patient anywhere on earth to begin care according to Cleveland Clinic protocols.

Respect for your time and attention limit the examples I could relate to illustrate the many correspondences between our organization and practices at Cleveland Clinic, and the goals of this committee and the spirit of the "Affordable Health Care Choices Act."

We believe in the Cleveland Clinic model of medicine. Cleveland Clinic delivers high-quality care at a low cost to a large volume of patients with a high case complexity. We believe that this model of medicine can lower costs, improve quality, enhance value, improve access, and assure that every patient gets world-class care.

I would like to compliment the committee on its comprehensive legislation to reform our healthcare system. You have recognized several critical issues and are confronting difficult decisions that must be made. Healthcare coverage for all and stemming the rising cost of healthcare in this country are essential elements of healthcare reform. By challenging the health care industry and employers to provide citizens with the necessary information and services to lead healthier lives, you are enabling Americans to take responsibility for their health and building the foundation of a healthcare system that will meet the demands of the future and in which we can be proud.

In order for this or any healthcare legislation to succeed, the American people must feel that it addresses their needs. It is too much to ask that reform be perfect from the beginning. It will, I believe, meet their expectations if they can look forward to having access to a system that provides quality, affordable healthcare for all in which coordinated patient care is the central concern. I believe that individuals are ready, with the proper amount of education, to assume the responsibility for their healthy well-being. We, as providers, must be structured so that those expectations will not be dashed. I believe that an integrated delivery system which I have described is best designed to carry out the mandates of reform across the multiple settings through which care is delivered.

Mr. Chairman and members of the committee, thank you for the opportunity to participate in this historic hearing.

Senator DODD. I apologize, Doctor. We will have a lot of questions for you, I can tell you that.

Dr. COSGROVE. I am ready.

Senator DODD. Yes. Mr. Rother, how are you?

STATEMENT OF JOHN ROTHER, AARP EXECUTIVE VICE PRESIDENT, POLICY AND STRATEGY

Mr. ROTHER. Good morning, Mr. Chairman. Thank you for your leadership on this. Senator Mikulski, Senator Brown, Senator Bingaman, AARP is very privileged to be here today.

We have many, many priorities with healthcare reform. Today, I am going to try to address four. The main one is affordability.

AARP's membership includes about 20 million who are over 65 and another 20 million who are between the ages of 50 and 65. We have broad interests on both sides of the age 65 divide. Among the population 50 to 64, we estimate at least 7 million are uninsured today and those are the people who have a usually high need for healthcare services.

To make healthcare affordable, we need fair rating rules for insurance premiums. We need an adequate benefit standard. We need Medicaid expansion combined with sliding scale subsidies that help those with low- and moderate-incomes.

We believe that no American should in the end pay more than 10 percent of their annual income for healthcare, including both premiums and out-of-pocket costs.

Now today, we are nowhere near that. In the individual market today, a 60-year-old couple making $44,000 faces an average premium cost of $9,210 which is equal to 21 percent of their income and that average policy has a deductible of $2,700. This is not affordable insurance by anyone's definition and age rating is a big part of the problem, as is a poorly-regulated insurance market.

Of course, those with pre-existing conditions often cannot purchase at any cost. We support the important insurance reforms in the committee's bill that would amend these practices and we especially support limiting premium variation bans by no greater than 2:1 based on age. This is critical to keeping insurance affordable and keeping the costs of subsidies down to the taxpayer.

Now measures to promote quality are also an important part of getting better value for our health dollar, and we are pleased with the committee's attention to creating a very strong quality infrastructure.

One other aspect of affordability is the cost of prescription drugs. We urge the committee to promote greater competition in that very expensive class of drugs, biologics, and we think we need to authorize follow-on biologics that would greatly benefit consumers.

A recent FTC report has confirmed that creating follow-on biologics would actually promote competition and would not harm the industry's ability to innovate.

In order to save consumers and taxpayers significant costs, we also urge the committee to keep the exclusion period for such drugs to a relatively short period, perhaps as short as 5 years.

Now, we also believe that savings from pharmaceuticals should be re-invested in part in improving the Medicare Prescription Drug Benefit by narrowing the infamous donut hole. There's no issue more unpopular today among the Medicare population than the requirement that they pay full price for medications for part of the year and as a result many do not take their prescriptions as ordered and they put their health at risk as well as their finances at risk.

A second priority for AARP, I'll mention more briefly, is to change the delivery system to better serve those with chronic conditions. Those with chronic conditions make up about 75 percent of all Medicare spending today, yet the delivery system is still based largely on acute care models.

We support a new transition benefit in Medicare to help people leaving the hospital. It will save money by reducing hospital re-admissions and we certainly support the patient-centered medical home to better coordinate care. We applaud the inclusion of shared decisionmaking in the committee's bill.

Let me just mention briefly also the issue of long-term care. We applaud very much the committee's inclusion of the Class Act in the legislative package. That's designed not to increase the deficit and it would make a huge difference if we could move long-term care away from a welfare system based on Medicaid to one that is more consistent with American values of self-reliance.

And finally, I just want to mention we applaud the workforce provisions in the bill. We have to prepare now for greater workforce needs, particularly in primary care and nursing, and this is extremely important.

Thank you very much. We look forward to working with you.

[The prepared statement of Mr. Rother follows:]

PREPARED STATEMENT OF JOHN ROTHER

Chairman Kennedy, Ranking Member Enzi, distinguished committee members, thank you for inviting AARP to this timely discussion on health care reform options. I am John Rother, executive vice president and director of policy and strategy for

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AARP. AARP appreciates your leadership and the opportunity to participate in this roundtable.

Today, I am proud to represent nearly 40 million members of AARP—half of whom are over age 65 and therefore participate in the Medicare program, and half who are under age 65. As many as 7 million of all persons age 50–64 are uninsured today, both age groups face serious problems in access to appropriate care, even if they are insured. I am happy to be here today to discuss some of the options you are considering to address these problems.

INSURANCE MARKET REFORMS

There are few issues of greater concern to AARP's membership than improving health insurance markets across the United States to assure that all Americans have available to them affordable high quality coverage choices. Many older Americans, especially those age 50–64 who are not yet eligible for Medicare or those with pre-existing chronic conditions, often cannot secure health coverage at any price. Industry data show that insurers reject between 17 percent and 28 percent of applicants aged 50–64.[1] Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay premiums that are three times higher and have total out-of-pocket spending that is over twice that of those with employer coverage.[2] The AARP Public Policy Institute estimates that 13 percent or 7.1 million adults aged 50–64 were uninsured in 2007—1.9 million more than in 2000—and this figure is growing rapidly in our current difficult economy.[3]

AARP believes that the best way to make coverage affordable for everyone is by:

- Guaranteeing that all individuals and groups wishing to purchase or renew coverage can do so regardless of age or pre-existing conditions;
- Prohibiting insurers from charging higher premiums because of age, health status or claims experience;
- Providing a choice of qualified plans through a "Gateway" or Exchange with subsidies based on income and the actual premiums each age group faces in the market so coverage is affordable for everyone;
- Addressing costs systemwide through prevention and wellness, care coordination, fighting fraud, waste, and abuse, and revising incentives to reward quality rather than quantity of care; and
- Ensuring that any cost-sharing obligations do not create barriers to needed care.

We are pleased that many of these issues have been addressed in the committee's proposed legislation released this week.

Connector/Gateway: The intent of the Gateways is to facilitate the purchase of coverage and products at an affordable price by qualified individuals and employer groups. AARP embraces the establishment of an Affordable Health Benefit Gateway in each State. As described, the Gateway construct would provide balance and flexibility—clear Federal guidelines and standards to assure quality coverage while maintaining the traditional State role in the oversight of insurance.

Planning grants would be provided to States to create State or regional Gateways. Further encouragement for the State to proactively launch or participate in a Gateway lies in the stipulation that residents of the State would not be eligible for premium credits or an expanded Medicaid match until they adopted specified standards. If a State takes no action, the Federal Government would step in and operate that State's program. Gateways would become financially self-sustaining through a surcharge on participating health plans. As envisioned, consumers would be able to purchase insurance either inside or outside of the Gateway and private or public entities would offer navigation assistance to help individuals and employers obtain affordable coverage. Quality standards for health plans offering essential health care benefits through the Gateway would be specified.

Policymakers have learned much by observing and studying the laboratory of Massachusetts and its successful health coverage experiment. Over the years, other States have adopted alternative health reform models. We are pleased that the committee bill treats Puerto Rico and the other territories equally with the States with respect to the programs in its jurisdiction. We commend the committee, especially the leadership of Senators Kennedy and Dodd, for recognizing that quality, afford-

[1] HIP, "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

[2] AARP Public Policy Institute, "Health Care Reform: What's at Stake for 50- to 64-Year-Olds," March 2009.

[3] Ibid.

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able coverage should be available to all Americans wherever they reside. It is important to make certain that the insurance market rules are the same inside and outside of the Gateway.

In short, the proposal appears to embrace a reasonable and practical balance between Federal policy direction and the reality of diverse insurance markets and State regulatory capabilities across the United States.

Underwriting and Age Rating: In general, AARP supports community rating, where insurers do not charge higher rates or deny coverage based on age or preexisting conditions. If age rating is not seriously constrained within national health reform, insurers will likely charge higher rates to older people to substitute for rating based on medical condition.

If any age differential is allowed, AARP believes it should be narrow— no greater than 2 to 1, as in the committee's proposed legislation. Individuals living in States where no or narrow age rating is allowed today should not be disadvantaged as a result of national health reform. We strongly commend the committee's leadership in striving to limit age rating bands to a ratio of 2 to 1. We believe it is essential that health care reform result in providing affordable coverage to those who have the most difficulty obtaining it in today's market and that is particularly true for older adults.

We have serious concerns about the adverse impact on AARP members of alternative proposals that allow insurers to charge older Americans up to five times or more premium rates. We question why age rating, especially as high as 5 to 1, is necessary when virtually all health reform proposals under consideration include risk adjustment to compensate for higher costs of enrollees who are sicker or older. Independent actuaries confirm that appropriate risk adjustment should mitigate the need for age rating.

Experience in Massachusetts indicates that without strict age rating limits and adequate subsidies, coverage would still be unaffordable for millions of older Americans. Although Massachusetts capped rate variation for factors including age at 2 to 1, affordability remains a significant issue for some AARP members. Even at a 2 to 1 age rating, the lowest priced "bronze" benefit package costs 60-year-olds between $420 and $575 per month. If the rate band were set at 5 to 1, the "bronze" package would cost $1,050 to $1,335 per month, or up to $16,020 a year—over half the median annual income of $30,000 for uninsured Americans aged 50–64 today[4] AARP's concern about age rating and subsidies only increases as we consider most other States where rates of the uninsured are higher and family income levels are much lower than in Massachusetts.

Age is a poor proxy for income; older uninsured Americans do not have substantially higher incomes than younger uninsured individuals, whose median income is $28,461, only slightly lower than uninsured 50–64 year olds.[5] Continuing to allow health care coverage to remain unaffordable to those who need it most is a serious societal problem. Uninsured adults in their late 50s and early 60s experience worse health outcomes and use more services when they enter the Medicare program, and in the years before Medicare their uncompensated health care costs will continue to be shifted to those who have insurance.

Hardship exemptions are not an answer, and are cold comfort for those who cannot afford coverage due to high premiums and are in an age bracket where high quality coverage is essential for maintaining health and avoiding preventable conditions that will only increase expenditures once these individuals become eligible for Medicare.

Subsidies: Shared responsibility is an important attribute of the proposed legislation. As the legislation proposes an individual requirement for obtaining health insurance and an employer requirement for providing health insurance, assuring affordability of plan premiums is *essential* if AARP is to support this legislation. Adequate subsidies for low- and moderate-income individuals must be guaranteed. Subsidies must be adequate, available, secure and administratively feasible, and take into account any higher cost related to any level of age rating that is allowed.

For those who are low-income, expansion of Medicaid eligibility across the United States is an efficient and effective way to assure quality coverage and access to care. AARP believes that offering Medicaid as a wrap around benefit or offering subsidies and/or tax credits to help low-income individuals purchase private coverage could mean that the most vulnerable Americans will not benefit from health reform; such a design will lead to unnecessary expenditures as the construct is administratively unfeasible.

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[4] AARP Public Policy Institute analysis of U.S. Census March 2008 Current Population Survey.

[5] Ibid.

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Subsidies should be set on a sliding scale so individuals and families pay no more than a certain percentage of income on premiums as well as other out-of-pocket health care costs. Thus, subsidy calculations should include both family income and actual premium costs that may vary by region or age. AARP asserts that no one should spend more than 10 percent of their income for health care, including premiums and all other out-of-pocket costs. Those with more limited incomes should pay even less, with exemptions from cost sharing for the poorest for whom any cost sharing can create insurmountable barriers to care. In addition, in order for subsidies to remain affordable and sustainable over time, we must also enact measures to manage skyrocketing costs.

Premium credits and subsidies should be generous enough to effectively help those with modest incomes comply with their new responsibility—to secure qualifying coverage. Premium credits and subsidies should be provided on a sliding scale; the scale should reach high enough that vulnerable families and older adults will be able to afford both their premiums and health costs. Otherwise, Americans will continue to face the prospect of being uninsured or underinsured and will be forced to seek an exemption from their shared responsibility. Further clarification is needed on how the subsidy would work.

Benefit Packages: We strongly support requiring insurers to cover a broad range of essential benefits, as suggested in draft legislation on this committee's Web site. Preventive services—including services necessary to manage chronic conditions that otherwise result in serious, expensive complications—should be provided with no or minimal cost sharing. We are pleased that the committee is considering including provisions to provide incentives for providers to encourage care coordination, disease management and similar efforts to improve quality of care and help reduce spending for avoidable and costly institutional admissions, preventable complications, and errors for people with multiple chronic conditions.

Individual and Employer Responsibility: The HELP proposal would require individuals to have health coverage that meets minimum standards and to report such coverage annually. Employers who do not provide qualifying coverage will be required to contribute to the cost of their coverage for their employees, including those who access forms of public coverage.

Requiring everyone to participate is necessary because it greatly reduces insurers' interest in underwriting based on age or health status and because it ensures that healthier individuals are included in the risk pool. However, AARP can support these requirements only with the assurance of adequate subsides. We cannot support mandated coverage that people or businesses cannot afford—subsidies must be adequate, available, secure and administratively feasible. In order to ensure that subsidies remain affordable and sustainable, we must also enact measures to manage skyrocketing costs while improving quality.

COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

AARP appreciates Chairman Kennedy's leadership and commitment to including long-term services and supports in comprehensive health care reform legislation. AARP strongly agrees that long-term services and supports must be included in any health reform package. People with disabilities and older adults need better options to help keep them independent and functioning at their highest level. Our members want to live in their homes and remain independent in their communities as long as possible. That is why expanding access to home and community-based services is one of AARP's key health care reform priorities.

Our current welfare-based Medicaid policies vary tremendously from State to State, include an institutional bias, and only assist people after they have exhausted their assets. Medicaid provides critical services for millions of people and must be improved, such as by expanding access to Medicaid home- and community-based services. At the same time, individuals also need more choices to help them pay for the services they need to live independently. Home and community-based services are also often more cost-effective than institutional care, and an aim of health care reform is to assure affordable insurance coverage for everyone.

The HELP Committee's bill includes a modified version of the Community Living Assistance Services and Supports Act (CLASS Act, S. 697/H.R. 1721), which would create a voluntary public insurance program that individuals could purchase and if they become eligible, receive a cash benefit to pay for the long-term services and supports they need to remain independent. The CLASS Act provisions would offer a generally broad-based opportunity for individuals to receive a minimum level of coverage for long-term care services and supports without having to deplete their assets or be denied coverage due to a pre-existing condition. These are important features, as is the cash benefit that would give enrollees choice and control over the

services and supports they need. We applaud Senator Kennedy's efforts in taking this positive step toward providing important insurance protection for individuals long-term care services and supports. We also appreciate that the program is designed to be budget-neutral. We look forward to working with Senator Kennedy, Senator Enzi, Senator Harkin and other leaders on the committee who are committed to finding solutions that meet the needs of families and their caregivers.

The committee's narrative also notes that it is considering the Long-Term Care and Retirement Security Act that would provide tax incentives for the purchase of private long-term care insurance and address private long-term care insurance consumer protections. AARP believes a sustainable financing system for long-term care services and supports will require a combination of sustainable public and private resources. Tax incentives for private long-term care insurance may lower the cost of this insurance for some individuals and encourage them to purchase it, but these incentives would not benefit individuals who cannot afford such insurance or cannot qualify for it due to pre-existing conditions. Updating and strengthening consumer protections for private long-term care insurance is critical. If a CLASS Act approach is enacted, individuals could choose to purchase private long-term care insurance coverage to supplement their CLASS Act benefit and could be helped by the consumer protections and tax incentives.

We also note that this legislation includes a family caregiver tax credit to help family caregivers who are providing assistance to their loved ones. AARP strongly supports efforts to support family caregivers. In 2007, about 34 million family caregivers provided care at any given point in time, and about 52 million provided care at some time during the year. The estimated economic value of their unpaid contributions was approximately $375 billion in 2007, up from an estimated $350 billion in 2006.[6]

CREATING A PATHWAY FOR SAFE AND AFFORDABLE GENERIC BIOLOGIC DRUGS

Spending on biologic drugs is growing nearly twice as quickly as spending on traditionally developed "small molecule" drugs. Overall biologic drug sales reached $75 billion in 2007,*[7] and it is estimated that spending on biologics will continue to increase substantially through 2012.[8]

Biologics treat serious diseases such as cancer, multiple sclerosis, and rheumatoid arthritis but often cost 10, 15, or even 20 times more than most non-biologic drugs. Users of these often life-saving medications are typically forced to pay exorbitant amounts to treat their conditions.

AARP agrees with the report released just yesterday by the Federal Trade Commission (FTC) that lacks of competition in the biotech market has resulted in higher costs and less innovation. Another major contributor to the increase in spending on biologics is the lack of a statutory pathway at the Food and Drug Administration to approve generic, or bio-equivalent, biologic drugs.

AARP has endorsed the "Promoting Innovation and Access to Life-Saving Medicine Act (S. 726/H.R. 1427)," which would create such a pathway as well as a process for timely patent dispute resolution and we applaud Senators Brown, Collins, Schumer, and Vitter for their leadership in sponsoring this critical legislation.

While we continue to have concerns—also echoed in the FTC report about the 12-year exclusivity period included in the Senate HELP Committee compromise, we believe that the underlying legislation that includes Chairman Kennedy's amended language to close the so-called "ever-greening" loophole is a constructive and important contribution that merits inclusion in this package. We, therefore, believe it should be included in the committee health reform mark. Conversely, if the ever-greening provision is not addressed, we believe that this legislation would represent an empty promise in that it would set up an environment in which biotech companies could make modest changes to the underlying product and get continual 12-year cycles of effective monopoly protection.

We appreciate the continued leadership of committee members Senators Kennedy, Brown, Hatch, Enzi, and Bingaman on this issue. We look forward to working with them on the promise that on this—the 25th Anniversary of the Hatch-Waxman law—we provide a workable pathway for generic options in order to provide more choice in a marketplace that works to the advantage of consumers.

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[6] AARP Public Policy Institute, Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update. Insight on Issues 13, November 2008.

* IMS Health, "IMS Health Reports Global Biotech Sales Grew 12.5 Percent in 2007, Exceeding $75 Billion," Press Release June 17, 2008.

[7] A IMS Health, "IMS Health Reports Global Biotech Sales Grew 12.5 Percent in 2007, Exceeding $75 Billion," June 17, 2008.

[8] Express Scripts, "2007 Drug Trend Report," April 2008.

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Lowering the costs of biologic drugs also presents an opportunity to begin to close the coverage gap—or doughnut hole—in the Medicare Part D benefit. This is an issue of great concern to AARP members. About one in four Part D enrollees, not enrolled in low-income subsidies, who filled one or more prescriptions in 2007 fell into the doughnut hole in 2007, according to a Kaiser Family Foundation report. On average, patients' out-of-pocket drug spending doubles when they reach the doughnut hole. A pathway to generic biologics can help more people avoid the coverage gap, as well as provide savings to begin to close the doughnut hole.

HEALTH QUALITY AND DELIVERY SYSTEM REFORM

Care for people with chronic conditions makes up three quarters of total health spending, yet many experts agree that much of the health care system is not well organized to meet the needs of people with chronic conditions. Clinicians tend to focus on the particular problem that a patient presents at each visit. Delivering good care for people with chronic diseases calls for proactive steps by both individuals and providers to care for chronic care between visits. For patients, this could include adhering to advice on exercise and diet, taking medications as prescribed, and monitoring signs and symptoms. For providers, this includes monitoring care over time and settings and having good systems and communication—among providers and with patients and caregivers—that allows tracking and patient-centered care.

Barriers to improvements in care for people with chronic disease include the fragmentation of care delivery, poor transitions between and among settings, and misaligned payment incentives that fail to recognize the value of better integration of services. Poor information systems make these problems worse because providers find tracking patients over time and across settings difficult. Adherence to medications is a key component of effective chronic care management, and patient's failure (or inability) to take prescribed medicines is another major barrier to improvement.

Addressing these barriers requires a multi-pronged strategy that relies on better knowledge, tools, and incentives. For each of these strategies, our recommendations are aimed at providers, family caregivers, and patients—who can play a critical role in managing their own care. Key recommendations for improving coordination of care for people with chronic disease include:

- More testing of care delivery models (for example, medical homes and accountable care organizations) to find out what works.
- Rapid adoption of those models that work. Models that provide care during transitions between hospitals and other settings have proven to improve care, reduce re-hospitalizations, and show a positive return on their cost, and should be adopted.
- Incorporating best practices into clinical preparation and training for providers.
- Engaging patients with chronic conditions who are able to participate in their care, providing them with tools to empower their conditions.
- Supporting and engaging family caregivers.
- Encouraging wise use of pharmaceuticals, including making medication more affordable.
- Improving coordination of care through adoption of health information technology and improving incentives through changes in payment policy.
- Ensuring an adequate workforce, including making the most of the workforce we have.

AARP commends the committee for recognizing the necessity of improving quality and efficiency in health care, focusing on outcomes of care, and addressing the challenge of quality improvement by integrating quality improvement and patient safety training into the clinical training of health professionals. Quality and safety problems in the United States pervade our health care system. We are gratified to see the growing determination of all sectors to attain greater value from the health system so that organizations deliver high quality, efficient, safe care and engaged patients make informed health decisions that reflect their values and preferences. We are convinced that better quality will lead to a more affordable, sustainable system. To accomplish this, we need better information to support clinical and patient decisions, enabled by the appropriate use of health information technology; and aligned incentives (for providers and patients) to encourage coordinated, patient-centered care that ensures patients the care they need when they need it.

Quality Improvements Infrastructure: AARP is pleased that the committee proposes to support the development of an infrastructure to sustain quality improvements throughout the system by directing the Secretary of DHHS to first identify national priorities for improvement and then to pursue the realization of these priorities through performance measurement and public reporting. AARP already par-

ticipates in multi-stakeholder activities through consensus organizations (such as the National Quality Forum and the National Priorities Partners) in pursuit of quality improvement, and we agree that the Secretary should help bolster these nascent, but increasingly important, collaborative initiatives through a variety of consultative opportunities identified in the draft legislation. The capacity to evaluate performance throughout the health care system is integral to several features of a reformed health care system, such as improvement in the delivery of chronic care, reduction in disparities among racial and ethnic minorities, and aligning payment with desired outcomes.

It will be important to ensure that priorities are harmonized and made consistent to achieve maximum benefit from resources devoted to quality improvement activities. We note that the draft legislation would require the Secretary to receive recommendations on priorities for performance improvement from a qualified consensus-based entity (section 204(d)(1)) while section 399LL (b)(4) identifies 9 specific areas that the Comptroller General would be required to evaluate. Although we believe the identified areas are worthy, there may be some inconsistency in requiring input from the consensus body on the one hand and establishing specific priorities on the other. Similarly, section 213 that provides grants to implement medication management services in the treatment of chronic disease would allow the Secretary to fund (via grants or contracts) the development of performance measures to assess the use and effectiveness of medication management services. Here again, although we think medication management programs offered by pharmacists have merit to promote safety and encourage greater patient adherence, measures to evaluate performance in this area should be consistent with the requirements applicable to all performance measures specified in section 204 (i.e., that they be evidence-based, consistent with national goals and priorities, and endorsed by a national consensus body.)

We are very pleased to see the committee's implicit recognition of the fact that performance measurement in support of quality improvement and decision support should be considered a public good. AARP agrees that providing the Federal resources to support measure development, research, dissemination of information on best practices, and the provision of technical assistance is necessary.

Medical Homes and Community Health Teams: We have been a strong supporter of the concept of a patient-centered medical home as a promising approach to promote primary care and encourage not only care coordination throughout the care continuum but patient self-efficacy as well. The committee's idea of establishing "community health teams" to support the medical home model takes in to account the reality that most Americans receive their care from small clinical practices. Therefore, the infrastructure support that is proposed in the draft legislation could help small practices become medical homes that can live up to the promise of the concept. However, we urge that the definition of medical home be expanded to include non-physician clinicians, such as advance practice nurses.

Emergency Care Response and Research: Section 1204 proposes competitive grants for regionalized systems for emergency care response and Section 498D provides support for emergency medicine research. Subsection (d)2(vi) requires applicants for such grants to address pediatric concerns related to the integration, planning, preparedness, and coordination of emergency medical services for infants, children, and adolescents; and section 498D(b) provides for pediatric emergency medical research. We urge the committee to also require that prospective grantees be required to address a similar list for geriatric patients and for the Secretary to conduct research applicable to a geriatric population as well. There is an increasing trend in emergency departments (ED) for visits from older patients: visit rates over the past 11 years have seen substantial increases among patients age 50 and older. In addition, patients over the age of 75 are more likely to arrive at the ER via emergency medical transport (49 percent) than all other patients (4.2 percent) Finally, older adults are especially vulnerable during disasters and face special risks due to the fact that they are more likely to have chronic illnesses, functional limitations, as well as greater sensory, physical, and cognitive disabilities than younger persons.

Reducing and Reporting Hospital Re-admissions: Almost one fifth of Medicare patients discharged from a hospital were re-admitted within 30 days; these readmissions cost Medicare $17.4 billion in 2004. These hospital stays, many of which are preventable, pose a major concern—from both a quality and financial perspective—and must be addressed. AARP concurs with the committee that information about rates of re-admission should be reported to hospitals so that they have the opportunity to act on the information and take steps to eliminate preventable readmissions. We also believe this information should be reported to the public so that patients and clinicians can factor it into their choice of hospitals and also to stimulate improvement (because we know that publishing performance information gets

the attention of the provider community and encourages them to pay attention to the data.)

Transitions from hospital to home can be complicated and risky, especially for individuals with multiple chronic illnesses. Patients frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. In cases where multiple providers are involved, patients often get conflicting instructions from different providers.

A study published in April 2009 in the *New England Journal of Medicine* found that almost one third of Medicare beneficiaries studied who were discharged from a hospital were re-hospitalized within 90 days. Additionally, one-half of the individuals re-hospitalized had not visited a physician since their discharge, indicating a lack of follow-up care.

AARP has endorsed The Medicare Transitional Care Act (H.R. 2773) which would directly address continuity of care problems by increasing support to patients as they move from the hospital to their new care setting and ensuring that appropriate follow-up care is provided during this vulnerable period. The benefit would be phased-in, initially targeting the most at-risk individuals by providing evidence-based transitional care services tailored to their specific needs. We hope to have a Senate companion bill soon and we urge the committee to include this transitional benefit in any final health care reform legislation.

Programs to Facilitate Shared Decisionmaking: The Institute of Medicine identified "patient-centeredness" as one of six attributes of high quality care. In addition, based on its understanding that engaged, activated patients are likely to have better health outcomes, the National Priorities Partners, a broadly representative group of 28 organizations with an interest in improving health care, identified patient and family engagement as one of six national priorities and goals. From a patient's perspective, the concepts of patient-centered care and patient engagement cannot be fully realized unless patients (or their designated family caregivers) are able to participate as full partners in their health care. This means they must have access to and are able to use information that is relevant, meaningful, applicable, and reliable. Therefore, AARP commends the committee for recognizing the role evidence-based shared decisionmaking tools can play in improving care, and we support opportunities to expand the availability and implementation of such aids that meet specified criteria and that are suitable across the age span, including vulnerable populations and children. Since use of shared decisionmaking tools is a relatively new idea for patients and providers, the idea of establishing resource centers to provide technical assistance to providers to develop and disseminate best practices could accelerate adoption of these tools.

Increasing the Supply of the Health Care Workforce: We applaud the committee's leadership in addressing the needs of the health care workforce, including their education and training. Health care services should be provided by a well-trained, fairly compensated workforce who put their patients' needs above all else and who carry out their responsibilities under rules that permit clinicians to maximize the full scope of their training. The Nation must have an adequate workforce trained and prepared to take on the needs of an aging population.

AARP supports your proposal for a health workforce commission, which would develop recommendations for workforce needs in the future. Nurses, in particular, are in short supply. Nursing workforce development is appropriately included in the HELP bill. However, we are concerned that the bill does not go far enough in increasing nursing workforce capacity. Because there is no dedicated stream of funding for this purpose, we may be left with an inadequate supply of highly skilled nurses to meet the health care needs of an aging population in the 21st century. We do support provisions to authorize funding for training of primary care "extension" workers, which is inclusive of nursing. AARP also appreciates the committee's authorization of funding for the development of additional nurse-managed clinics. If we truly are going to reform our delivery system, so that it is person-centered and team-based, we must re-orient and re-train our Nation's health care workforce.

We are pleased that provisions from the AARP-endorsed Retooling the Health Care Workforce for an Aging America Act (S. 245/H.R. 468) are included in the HELP Committee's bill. These provisions would help ensure that more individuals are trained in long-term care, chronic care management, and geriatrics and that direct care workers have new training opportunities. In addition, the provisions include voluntary training opportunities for family caregivers.

CONCLUSION

Thank you again for the opportunity to be with you today. AARP believes our health care system costs too much, wastes too much, makes too many mistakes, and

gives back too little value for our money. That is why AARP, on behalf of our 40 million members, believes Congress must pass health care reform that controls costs, improves quality, and provides all Americans with affordable, quality health care choices. We look forward to working with you to enact health care reform this year.

Senator DODD. Thank you very much, Mr. Rother. We appreciate it very much.

Dr. Palfrey, we are delighted to have you with us. Speak right into these microphones.

STATEMENT OF JUDITH PALFREY, M.D., FAAP, PRESIDENT-ELECT, AMERICAN ACADEMY OF PEDIATRICS

Dr. PALFREY. Senator Dodd and members of the committee, on behalf of the American Academy of Pediatrics, thank you so much for what you have done this year already for the benefit of children through the CHIP authorization, the passage of Medicaid funding under ARA, and now by highlighting children's needs in your bill.

As a Nation, we have come far but we are still not at the finish line. With close to 9 million children still uninsured, an infant mortality rate worst than 23 other nations, and intolerable racial disparities in healthcare, we cannot be proud yet.

We must provide insurance coverage to all our children in this country and that coverage should mean access to the right benefits in the medical home with appropriate payment.

The focus on children is the foundation of a health system that works. In this economic environment, we are all looking for cost containment. There's no better way than to invest early in a healthy citizenry.

We commend the committee's recognition that all HRSA-funded preventive guidelines, a/k/a Bright Futures, receive first dollar coverage in the new gateway plans. The benefit of Bright Futures is that it begins family-centered life-long health promotion activities that emphasize healthy nutrition, exercise, oral health, positive mental health, injury prevention, healthy sexual development, violence prevention, the avoidance of tobacco, drugs and alcohol.

All of these sow the seeds for healthy lifestyles. Doing the right thing for children will prevent the adult consequences, the serious adult consequences of obesity, cardiac disease, mental illness and even Alzheimer's.

The HELP Committee focus on those left out is also critical. Many of those are our children with special healthcare needs. Their needs are not covered in the traditional healthcare insurance. The medical home with inclusion of care coordination provides access to full benefits for most of these vulnerable children.

It is also critical that the notion of pre-existing condition not be a barrier to the health for young children whose illnesses begin early in life and continue throughout their lives.

We very much appreciate the HELP Committee's recognition of the need to strengthen our workforce delivering pediatric primary care and, importantly, pediatric subspecialty and surgical subspecialty care.

Finally, sometimes we as child advocates find it hard to understand why children's needs are such an afterthought and why because children are little policymakers and insurers think that it should take less effort and resources to provide them healthcare.

How else could it be that there continue to be recommendations that Medicaid payments for healthcare for children are considered adequate at 70 to 80 percent of Medicare rates?

There's good evidence that appropriate payment of providers results in children having better access to comprehensive health services in a medical home. As the health reform process evolves, thank you so much for your recognition of the priority of the needs of children.

We look forward to discussing their coverage, their benefits and access, and I am happy to answer questions.

[The prepared statement of Dr. Palfrey follows:]

PREPARED STATEMENT OF JUDITH PALFREY, M.D., FAAP

Good morning. My name is Judith Palfrey, M.D., FAAP, and I am proud to be the president-elect of the American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Pediatricians believe that the life success of every child should be our highest national priority.

I appreciate this opportunity to testify today before the Committee on Health, Education, Labor, and Pensions on health reform. I am a general pediatrician and child advocate. With my colleagues, I have developed medical home approaches that address health inequities and provided guidance for practices and school systems on the comprehensive care for children with special health care needs. I have advocated for S–CHIP and CHIP, improved school health services and payment to pediatricians for developmental screening and coordination of care.

On behalf of the American Academy of Pediatrics, I want to thank you for what you have already done so much this year to benefit children, through CHIP reauthorization, passage of Medicaid funding in ARRA, and now by highlighting their needs in your bill. As a nation, we have gone far, but we are still not at the finish line. With close to 9 million children still uninsured, an infant mortality rate worse than 23 other nations, and intolerable racial disparities in health care, we cannot be proud.

To hold our heads up high, we must provide insurance coverage to all children in this country. That coverage should mean access to the right benefits in a medical home with payment rates that allow real access to services in public and private programs. I am here to urge you to keep children's health needs prominent as the health reform process plays out. I urge you to do this not just for the children, but because a focus on children is the foundation of a health system that works. In this economic environment, we are all looking for cost containment. There is no better way to do that than to invest early in a healthy citizenry.

We commend the committee's recognition that all HRSA-funded preventive guidelines (also known as "Bright Futures") receive first dollar coverage in new *Gateway* plans. The benefit of Bright Futures is that it begins family-centered life-long health promotion activities that emphasize healthy nutrition, exercise, positive mental health, injury prevention, healthy sexual development, violence prevention, and the avoidance of tobacco, drugs, and alcohol. All of these sow the seeds for healthy adult life styles. These preventive services will have enormous benefits not only for children while they are young, but doing the right thing for children will help prevent the adult consequences of obesity, mental illness and developmental dysfunction. Bright Futures focuses on parental responsibility for their children's health and places the appropriate emphasis on families and provides the tools they need to help their children.

The HELP Committee's focus on "those left out" is critical. Within this group are many families of children with special health care needs, who face extraordinary burdens because many of the services their children need are not covered through traditional health care insurance. The medical home with its inclusion of care coordination addresses these concerns and can provide access to full benefits for these most vulnerable children. It is also critical that the notion of "pre-existing condition" not be a barrier to health care for young people whose illnesses begin early in life.

We appreciate the HELP Committee's recognition of the need to strengthen the work force delivering pediatric primary care, and perhaps as importantly, pediatric subspecialty and surgical specialty care. Once diagnosed with a serious health problem by a primary care pediatrician, families can find it very difficult to access the

services of a subspecialist or pediatric surgical specialist and so we appreciate the committee's recognition of the unique needs of children in this area.

Finally, some times we, as child advocates, find it hard to understand why children's needs are such an afterthought and why because children are little, policymakers and insurers think that it should take less effort and resources to provide them health care. How else could it be, that there continue to be recommendations that Medicaid payments for health care for children be considered adequate at 80 percent of Medicare rates? Are providers who care for children second-class health professionals? There is good evidence that appropriate payment of providers will result in children having better access to comprehensive health services in a medical home.

We are hopeful that as the health reform process evolves, you continue to prioritize coverage, benefits and access to medical homes through appropriate payment rates for child health services. Health insurance for children is a smart investment that President Obama prioritized in his campaign. We hope to see all children benefit as a result of your important work.

Thank you again for the opportunity to testify. I look forward to your questions.

Senator DODD. Well, thank you, Doctor, very, very much, and I often say this. I've chaired or been the ranking member over the years of the Subcommittee on Children and Families, and the American Academy of Pediatrics has been my best ally, whether it was the Family and Medical Leave Act——

Dr. PALFREY. Exactly.

Senator DODD [continuing]. Legislation on premature births, infant screening, better pharmaceuticals for children. All of these issues, you and your colleagues have been great, great advocates, going back to Dr. Koop, C. Everett Koop, the Surgeon General, who was a great advocate of Family and Medical Leave. In fact, I am not sure I could have passed the bill without him. I thank you for all your work.

I am reminded by staff, as well, each of you have caused me to think of this again, we'd like as a committee for you to submit, by the way, any ideas on this legislation. The staff are taking notes of what you're saying, but we want you to go beyond your statements now. Some of you have specifically looked at sections of the bill and made some recommendations.

It would be very, very helpful for us in the coming days—and fairly quickly, if you would, so we are sort of moving on this. Any specific ideas you have, either by omission or moderation or change would be very, very welcomed by the committee, and we thank you for that.

We have been joined by Senator Jack Reed, by the way, of Rhode Island. I thank you, Jack, for joining us this morning.

Let me begin, Dr. Raskob. I have a lot of questions for all of you, but let me begin with you.

I understand that Oklahoma City has done a great deal in the area of improving the health of its citizens. I wonder if you could tell me what you think of our Prevention Investment Fund. We are putting in some $10 billion, that is the number at least we have crafted at this point. There's obviously costs in all of this and the President has said we are all determined to try and make this deficit-

neutral over 10 years which is going to be a challenge obviously with all the things you need to do in order to bring costs down, to bend that curve that we are all hearing about in the right direction.

Some investments will be needed obviously if you're going to bend that curve in the right direction, but in the area that many of you have been talking about this morning and which all of us, I think, embrace, it is one of the few areas where there's little or no dissent and that is in the prevention, quality, and workforce areas.

There's some discussion obviously, but there's no real debate on the fundamentals of whether or not we ought to do a better job in those areas and how we can achieve it, but I was looking at just this smoking issue.

Yesterday, it was quite a day. It may have been lost in a lot of other news going around, but for the first time it looks like we are going to finally give the Food and Drug Administration the ability to regulate tobacco products. It is incredible to me that it has taken 50 years since the Surgeon General made this a priority. I am looking at all your heads nodding here. Talk about prevention with 400,000 deaths a year and 4,000 children starting to smoke every day and no ability—we regulate mascara and pet food but I couldn't regulate tobacco products. That's a hard one to sell to the American public. That's changing now as a result of the vote yesterday.

This whole idea, I was looking at the costs of smoking and I thought the number was like $90 million. Someone doubled the number, and said it is more like $180 billion a year if you take healthcare costs, lost wages and the like.

When we start talking about $10 billion as a Prevention Trust Fund and considering the number of problems out there that could help produce wellness, reduce illness, and produce health as a result of those efforts, what do you think about that, Doctor?

Mr. RASKOB. Well, thank you. We would strongly support an investment in prevention, clearly. I mean, we unequivocally and strongly support that. The amount of $10 billion in the context of the numbers you mentioned and then if you take it in the context of total spending on healthcare or just on what the Federal Government spends of a little over $800 billion clearly isn't high.

Where the money comes from is for Congress to decide. If you think we can't afford it or if anyone thinks we can't afford it, I would say we can't afford not to do it because it is clear from the economic studies that what's driving the growth in healthcare spending is the increasing prevalence of chronic diseases in the population that require treatments. We're doing a wonderful job of finding new drugs and new technologies. We have an increasing number of sick people in the population who need those things and it costs money. The solution is not more drugs, more technology but less disease in the population. Until we make an investment to break that vicious circle of increasing chronic disease in the population, we are not going to be able to delay and interrupt the rising costs.

So, an investment in prevention is absolutely critical. The amount of $10 billion by any means can't be considered excessive, I don't think, and so we strongly support investment in prevention.

Senator DODD. Do any of you on the panel disagree with that at all, this idea of having this as an appropriation.

Does anyone think that is a mistake or if it is a mistake, I presume what you may say is it is too little? Is that your general view if I am looking—I see heads nodding for the record anyway. It is probably too little in the context of what we are talking about.

Dr. Cosgrove, again, we are so impressed with what you do at the Cleveland Clinic.

Dr. COSGROVE. Thank you.

Senator DODD. We hear about it all the time. Senator Mikulski, I can hear both of you mumbling to each other as you were testifying.

How do you keep physicians that you hire on a 1-year contract where their evaluations are based on—is it outcome or performance in terms of the evaluations, no tenure? How do you get people to even want to come when you consider other places will offer you multi-year contracts, I presume, and tenure and all sorts of protections? How does the Cleveland Clinic compete with other institutions that will offer a lot more, I presume, financially and a lot more security financially than what you offer? Why is it that works for you?

Dr. COSGROVE. That's an excellent question and one which we have addressed.

We try to set our salaries according to the scale of academic medical centers across the country, so we are competitive in that aspect, but as far as maintaining them, it is the working conditions. We try to provide physicians the opportunity to do physician work and support them across the way with all the necessary support that they need.

For example, I've never sent a bill. The institution looks after that. I don't have to worry about hiring secretaries or nurses or equipment, et cetera, as I practice. So you're allowed to do what we are trained to do, the practice of medicine, not be business people.

I've gone to the dark side now and tried to begin to do the business aspect of that, but for 33 years I had the luxury of being a doctor and not worrying about the business aspects.

The conditions under which physicians can practice are superb.

Senator DODD. Yes. Did you happen to read *The New Yorker* article by Dr. Gawande?

Dr. COSGROVE. I did.

Senator DODD. Have any of you read that article in *The New Yorker*? It looks like all of you have.

I was taken aback by it. What do you think of that article, the conclusions of it? Do you agree with his conclusions about why these cost disparities exist?

Dr. COSGROVE. Yes.

Senator DODD. Something like Hildalgo County?

Dr. COSGROVE. Yes, I do, and just parenthetically, I might say that I think the reason that we have been able to have high quality and low cost is because we are an integrated system and because there's no financial incentives for us to do an additional procedure or order additional tests, that we all get paid the same amount whether we do that or not.

We are very proud of the fact that we have removed the financial incentive from the decisionmaking around medicine and I think

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that that is part of the reason that we have very low cost, as demonstrated by the Weinberg-Dartmouth report.

Senator DODD. Yes. Experts at Dartmouth and elsewhere have said that nearly one-third of annual health care spending is on treatments and procedures with no proven benefits. Do you agree with that?

Dr. COSGROVE. Yes, I think I wouldn't put a number on it because I haven't studied it enough personally to do that, but I agree that there is a great deal of that that is done. When you remove the financial incentives, it begins to change that.

Senator DODD. And last, then I'll turn to my colleagues, Dr. Palfrey. The work on children is something that a lot of us, all of us, care about up here, and Bob Casey of Pennsylvania, who is also very interested in this subject matter, has raised some very good questions in yesterday's panel, as well.

I wonder if you might just comment. One of the things we are looking at are these—as we talk about insurance products sold in our gateway or exchanges, whether or not they will include minimum standards. I appreciate particularly your point that children are not just small versions of adults. We have proven that with the better pharmaceuticals for children, looking at medical device issues, as well, and the importance of accommodating the needs of children, particularly in the wellness and prevention area.

I wonder if you might comment on that.

Dr. PALFREY. Absolutely. Thank you very much for the question.

Because we believe there are specific benefits that children need and we'd love to see a pediatric component to the benefits. Children are different. They have developmental needs. If you think about a 2-year-old or a 2-week-old or your 7-year-old, those youngsters are different from our 17-year-old and there are specific benefits that we need for these children.

Now, it is a little ironic that our Medicaid Program has EPSDT which is a full benefit program and yet our private payers don't always give all of these benefits.

The flip side of that irony is Medicaid doesn't pay for the benefits. What happens is that the practitioners who are seeing Medicaid patients try to do the best they can but can't afford to do it, whereas those getting the private insurance don't have to do the benefits and get paid at a 120 percent of Medicare.

We would like to see that evened out and we would like to see a specific pediatric benefit.

We also are very interested in seeing maternity benefits because our young women, our young girls then become young mothers and we know prevention starts at the moment that that baby is even thought of being conceived because it is important that they need to be wanted and then from then on.

We would like to see specific pediatric benefits and specific maternity benefits.

Senator DODD. I totally endorse your maternal benefits. In fact, a study I was looking at was developing some correlation between premature births and obesity.

Dr. PALFREY. Absolutely.

Senator DODD. I don't think there's any argument that obesity is not one of the causes of four chronic illnesses we are grappling

with and if there is a connection between that, then what better case could you make? There are other cases to make, but certainly that one, I think, makes the point.

Senator Mikulski.

Senator MIKULSKI. Good morning, everybody. First of all, I just want to thank you all for being here, and I also want to thank you for what you do every day. Each and every one of you every day in your own way makes a considerable difference.

I'd like to invite you to not only in your participation today—but this is going to be quite a process and what's going to happen is that after we move out our bill and Finance moves out their bill, there's going to be a bill and then all this, and we are going to be doing things late at night and when we do things late at night, it is not that we want to pull fast ones. We could make mistakes in which the unintended consequences to public policy and therefore to patients could be significant.

We invite both you and your organizations and so on to really stand sentry as we go through this and give us ongoing feedback that this is, oh, you've talked to us and it is done. There's a lot to be done before it is done. So that is one thing.

The second thing I just also wanted to talk about is our good colleague Senator Harkin very much wanted to be here because of this emphasis on prevention. He's in Geneva, Switzerland, this morning giving a talk on child labor where he's been one of our leading advocates. He wanted me to say good morning and let's all stick together.

Senator Harkin and I were each given a working group, Tom on prevention, me on quality, and we worked together because they were both intertwined and each one should leverage the other. We want to thank you for your testimony on behalf of Senator Harkin and his able staff is here to give feedback. I just wanted to set that stage.

I want to focus on just two questions in my area of quality. One is on comparative effectiveness in which we had a robust discussion last night, and then the other one, the concept of medical home.

On the issue of comparative effectiveness, we had a substantial discussion about, first, should we have it, second, are you going to do cookbook medicine, stifle innovation, and tie it to the payment system, and third, the confusion between comparative effectiveness and best practices.

Let me say for this record, as I said last night in our discussion, we in comparative effectiveness or health outcomes are building on the stimulus language in which there is no mandate for either clinical practice or payment. It will be simply news but not simply news that you can use.

Having said that, I would like first to turn to Dr. Raskob who talked about this and then any who would like to comment on, No. 1, do you view comparative—having health outcomes research and the expansion of what was done in the stimulus package, a crucial point to quality or are there too many fears around it to pick this as a fight?

Dr. Raskob.

Mr. RASKOB. Thank you. To give a direct and brief answer, comparative effectiveness research is critical to quality. If we don't re-

search and compare options for how patients are taken care of or for how other interventions occur, how can we possibly make decisions about what is better quality? That's the first point.

The second, I would just reiterate that our view is that comparative effectiveness research should be broader than simply researching drugs and procedures but should include policies and interventions that affect health, non clinical programs, behavioral interventions, organizational systems characteristics, and even the impact of regulations.

Comparative effectiveness research should be broad. It should engage everything we know from science about other study designs than just the randomized clinical trial that works well for drugs and medical procedures, and it should include also efforts to synthesize the existing evidence in ways that can be digested by practitioners and incorporated into useful elements of translation.

Senator MIKULSKI. It goes beyond simply identifying the best practices that had been identified by the appropriate academies, the Academy of Pediatrics, the Academy of Cardiology, Family Physicians, is that right?

Mr. RASKOB. Yes, and I would say that we have been doing comparative effectiveness research in the United States for a long time under different names. To get a drug approved at the FDA, we have to do a comparative clinical trial.

Senator MIKULSKI. But it has been wimpy.

Mr. RASKOB. So—yes.

Senator MIKULSKI. The efficacy of drugs and procedures is important but the FDA has been primarily focused on the safety and efficacy's part of it, but that part has been secondary.

Mr. RASKOB. I agree with you. My only point was that there shouldn't be a fear of this research because we have been doing it and we need to broaden it and to make it——

Senator MIKULSKI. Did anybody else want to comment on comparative effectiveness?

Dr. Palfrey.

Dr. PALFREY. I just want to indicate that doing comparative effectiveness correctly is going to be a very expensive procedure and while we are doing it and we should be looking for outcomes, we must not throw out the best practices that we now have and we must not hold up the care that is being provided currently to wait for the results of comparative effectiveness studies.

Senator MIKULSKI. Well, and we wouldn't because it is not tied to a payment system. In other words, the way we envision it and the way I envision it as the author of this part of the bill is essentially, I'll use the term "consumer report," but it is news you can use, if you want to.

Dr. PALFREY. Right.

Senator MIKULSKI [continuing]. Whether it is to administer a major institution or what you would do in your individual practice.

John.

Mr. ROTHER. Yes, Senator Mikulski. AARP very strongly supports comparative effectiveness, but I think really in the longer run, it has got to be thought of in the context of a learning healthcare system.

Information fed back to providers and to patients about the effectiveness of various treatments, and there will be variation in the population. Some people will respond differently. It is not going to be a cookbook. It is not going to be just a separate study published in a journal 3 years later. It has to be built in to the ongoing delivery of healthcare.

Senator MIKULSKI. Would you really look at what we said and how you would really either further amplify or further target?

Dr. Cosgrove, did you want to comment on that?

Dr. COSGROVE. Yes, Senator. I think this is a very important topic, and I would reaffirm that it has been going on now for a long period of time in medicine and these comparisons do regularly happen.

I think the most important thing that you said is it is not going to be tagged to payment and the reason for that is it can be a major impediment to our innovation. For example, it takes 10 years now to get a heart valve approved. I think if someone knew that they were then going to have another long period that they would—it would stifle innovation and that is a major—our devices and our pharmaceuticals are a major export from the United States as well as a major industry.

I don't think you want to tag it to, in any way, payment.

Senator MIKULSKI. Right. So you and Dr. Palfrey would be very clear that tying to payment, one, would, first of all, deal with the physician's concern. Are we going to mandate medicine, which I don't believe Congress or any arm of it should, or any part of our government, but, second, it also deals with this issue around innovation, which, when you talk to the guy or to the people in the U.K. who've done this, that was one of the other major arguments against it, innovation.

Dr. COSGROVE. That's been a big problem.

Senator MIKULSKI. Either in practice or tools of practice or whatever. OK.

Did Dr. Jonas and Dr. Levi want to comment? Then, I'll stop and I'll come back and if I may, Mr. Chairman, and do my medical home.

Dr. JONAS. Yes. I just want to say I think information is not enough. If all it is about is getting more information, then a crucial step of how do you deliver it is going to be key. It has to be attached to appropriateness and the processes for delivery and care.

I'll give you one example I know quite well from integrative medicine. Ten years ago, the NIH did a consensus conference on acupuncture and said the evidence is currently well established for nausea, postoperative nausea and acute pain that acupuncture works.

I daresay that very few of the clinics that we have surveyed actually use it. So it is effective. It is not used. Why? Doesn't get into the delivery system.

There's now good comparative effectiveness research on chronic pain done in Europe, done in this country, done in England, showing that acupuncture works for chronic pain, back pain, headache, osteoarthritis almost twice as well as our current best guideline-based therapy and yet there's no incentives for moving it in and

there are other delivery obstacles. Training, for example, of individuals.

I think the information needs to be tagged to the delivery issue and how do you actually get it into practice.

Senator MIKULSKI. But how do you do that without a mandate? So if you could ponder that.

Before I move to Dr. Levi, if I could just say, Dr. Jonas says he was from Samueli Institute which you should know is, No. 1; he was a Walter Reed doc. He headed up the NIH Office on Complementary Medicine and now is one of our lead advisors in integrative medicine and how we could best achieve it.

Dr. Levi, did you want to comment?

Mr. LEVI. Just very briefly. I want to underscore what Dr. Raskob said about the breadth, the scope of what we talk about when we are thinking about comparative effectiveness research, that it should not just be about medicines and devices and in fact, if we—a lot of the comparative effectiveness research already being done often compares nonclinical interventions with clinical interventions and sometimes those nonclinical interventions are more effective.

The second point I would make is what you, Senator Mikulski, referred to as—you talked about looking at health outcomes and when the FDA approves a drug, it looks to see whether it is safe and effective. It isn't necessarily comparing or looking at the long-term outcomes and, you know, one of the things we strongly supported in the Recovery Act was that prevention programs be tied to health outcomes and I think it is also time to be looking at our clinical interventions and really providing clinicians and consumers with the information they need, to know what it means over the long-term in terms of health outcomes, because the published data, the data around clinical interventions that reaches FDA approval does not necessarily provide us that answer.

Senator MIKULSKI. OK. I know my time's up.

Senator DODD. No. Very, very good. Very, very helpful, too, by the way.

Senator MIKULSKI. OK. If I could, Mr. Chairman, I'd like to, when everyone's concluded, come back.

Senator DODD. Absolutely, absolutely.

Senator Brown.

Senator MIKULSKI. Thank you very much. That was a very helpful discussion.

Senator DODD. Very helpful.

Senator MIKULSKI. It kind of followed on to what we talked about last night and drew the distinction between best practices which the academies often identify in a much broader scope.

Senator BROWN. Thank you, Mr. Chairman. Senator Mikulski, your comments and questions and answers you elicited were particularly helpful.

As Chairman Dodd commended *The New Yorker* article, there was a—I commend to my colleagues the *Time Magazine* article that was, I guess, this week. "This Doctor Does Not Want to See You," and it mentions—actually features—a Lifestyle 180 Program of the clinic and Dr. Royce, who's head of the Wellness Institute or part

of the clinic, and the work he's doing on everything from nutrition to smoking and other issues.

In fact, something pretty remarkable and I don't think the clinic tries to take full credit for this, but they are certainly a major part of it. Since the clinic began, its anti-smoking efforts in this 180 Program, this Lifestyle 180 Program, that the smoking rates in Cuyahoga County, the county for which Cleveland's the county seat, it is a county of a million and a half people, smoking rates have gone from 21 percent to 18 percent, some of the lowest rates in the State.

That leads me to a question for Dr. Cosgrove about wellness and prevention.

Senator Whitehouse, a colleague in my class, came here in 2007, sits on this committee, has mentioned repeatedly that those who pay for the wellness programs and the prevention efforts often and perhaps usually don't get the payoff for it. The employers that pay or the public—the health entities, the public entities, whatever, that expend money for prevention and wellness often don't get significant benefit for it, which just sort of begs the issue of how do places like Safeway—Safeway has found a way with a very comprehensive program, as Dr. Palfrey knows, to keep their healthcare premiums almost constant over the last 5, 6, 7 years, while everyone else has gone up industry-wide or country-wide, we have gone up some 35–38 percent during that time.

Dr. Cosgrove, if you would sort of talk about how—and I understand your rates, your healthcare premiums are going to be pretty flat this year for 2010.

How do you do that? How do you bring in—a couple of questions about it. What's your story about how the clinic does the program in wellness and prevention and what's your recommendation for this legislation, for other large employers to mimic it and replicate it?

Dr. COSGROVE. Well, as you know, Senator, the 40 percent of the premature deaths in the United States are due to behavior and three things: smoking, obesity, and lack of exercise, and so we began to approach those systematically, starting with smoking, and eventually took a program where we began, I think, eliminating smoking on our campus, then we moved to supporting the legislation in the State of Ohio to prevent smoking in public places.

Then we offered smoking cessation to all of the inhabitants of Cuyahoga County, including patches, and to all of our employees, as well, and then ultimately we stopped hiring smokers.

We thought that this was an important step because it began to signal what a healthcare organization should do. In other words, we should walk the talk and we did that.

The second thing that we did was, we began to look at food in our organization. We took trans fats out of all of the food that we served to patients and employees. We began to take things like French fries out of our cafeterias. We baked them, Senator.

Senator MIKULSKI. No. I know. It is that you just say hello to a different thing. I know. We are for it. We are for you.

Dr. COSGROVE. We also began to have portions labeled with the amount of calories that there were on them in our cafeteria and, finally, we began to look at the problem of lack of exercise and we

gave all of our employees opportunities to go to Curves or Weight Watchers. We had a walking program. We had access to our gymnasiums and work-out areas for our entire organization.

So far in the first 6 months of this program, we have lost 76,000 pounds as an organization and we know that for every pound that you're overweight it is essentially $50 in healthcare costs per annum. We have already paid in 6 months for the cost of all of our activities.

Senator BROWN. Why are other employers—understanding your business is healthcare and your business has also become health prevention, but putting aside that you're the Cleveland Clinic instead of company X manufacturer, whatever.

Why are so few companies doing what you're doing? If you can show—yesterday, the CEO of Safeway had some stunning statistics, as Chris heard, and it was just—the number of doctors visits per year for someone obese is, I believe, 10 times the number of someone that is—some ratio. I am not sure of that number. That was my recollection of it. I believe it was 10.

Why are more companies not doing that? How do we incent them to do that when perhaps they shouldn't need incentives when you're talking about $50 per pound?

Dr. COSGROVE. Well, I think the incentives are generally not well known. Let me give you just a couple statistics about smoking.

It costs essentially $3,500 a year or more in healthcare costs for a smoker than a nonsmoker. Smokers take an average of 2 weeks smoking break a year. That's 2 weeks of lost productivity while smokers are on smoking breaks, and when those statistics begin to become known and available, I think people will begin to address that.

One of the impediments has been the concern about pushback from unions and from the employees. I personally got a great deal of pushback from my HR group about not hiring smokers and so I think that there is a concern that this is going to limit the number of people who want to work for your organization.

We monitored this very closely. Interestingly, the biggest percentage of smokers in the hospital are respiratory therapists. We did not have a decrease in the number of nurses or respiratory therapists applying for our facility when we made this move.

I think once you go public about it and once you take these steps and everybody's quite afraid of them, I think you can begin to deal with it.

Senator BROWN. Sure. Dr. Levi.

Mr. LEVI. Senator, if I can add a different, slightly different perspective and put some larger numbers on this. The first is Trust for America's Health is a small employer and we would love to be able to model some of the things that Cleveland Clinic has done and we tried to walk the talk.

We promote these kinds of workplace innovations. It is very, very, very hard for a small employer to patch together these kinds of wellness benefits because unless you have a certain scale, it can't be done.

I'd also like to mention just the potential impact and I think you mentioned earlier that sometimes the people who are paying for these prevention interventions aren't necessarily seeing the return

on that investment and we very much depend on the public sector to do a lot of this work.

We worked with the Urban Institute to develop a model to look at what would the savings be to the healthcare system if we had a comprehensive program of community-based interventions, so changing the environment, similar to what Cleveland Clinic did but did it in the community, that focused on smoking cessation, nutrition and physical activity, and if we spent only $10 per person and only had a 5 percent impact on these conditions, we could save within 5 years a net savings of $16 billion and that is a return of $5.60 per dollar invested.

The proportion of the investment, these tend to be done with public dollars and that is why we think the community transformation grants are so important because that is what these would be built to do, but the savings accrue mostly to the private sector, to the private insurers and to those individuals paying out-of-pocket.

Of that $16 billion savings, there would also be a $5.2 billion savings to the Medicare Program. Just within the Medicare savings the government would see its return on investment. If you think about this $10 billion Investment Fund, you'll see that money come back just in savings in the public sector.

Senator BROWN. Thank you. The problem we have, we have this arcane scoring system in this Congress where we don't—in some sense, as we pay for healthcare reform, we don't get the score, we don't get the credit, if you will, when we do prevention healthcare and that is our problem, but that is an impediment to us that we have to work through.

A real quick question for Dr. Palfrey. I chaired for Senator Kennedy and the Health Committee, a couple of months ago, a hearing regarding access to primary and specialty care.

Dr. Marcia Wallerson, a pediatrician from Alabama.

Dr. PALFREY. Yes.

Senator BROWN [continuing]. Spoke about the nearest pediatric specialist was 90 miles from her practice. She's in a small town, I believe, of 9,000, if I remember right.

Dr. PALFREY. Right. That's right.

Senator BROWN. Senator Dodd and Senator Casey, whom Chris mentioned earlier, introduced legislation this week, the Pediatric Workforce Investment Act, to create a loan repayment program for licensed physicians who decide to go into a pediatric subspecialty which should help deal with this problem.

Just for a moment talk about the shortages in the pediatric workforce and what you think we should do about it.

Dr. PALFREY. Well, first of all, thank you very much for taking this on and thank Senator Kennedy, who we all miss today.

We have several problems here. One is getting people into medicine at all because of the heavy loans that the medical students have to pay, a $140,000 loans, which are being very, very much a barrier.

The second thing is that we do have many subspecialists but they tend to aggregate near the university centers, the academic medical centers, for a whole variety of reasons. So that we do need incentives for our subspecialists to move to the more rural and

some of the deep urban areas and it may be that we need to have programs of incentivizing those areas or more clever ways of integrating them with something like Cleveland Clinic where they're part of it and can be participating in research and that kind of thing.

It is an absolute question for some of the subspecialties. In other words, there are absolutely not enough. It is a relative question for most of the subspecialties. It is a distribution issue, but we very much appreciate your looking into this. It is a terrible problem for many of our practitioners not being able to get the subspecialty care.

If I could just have one follow-on to that? In terms of the primary care, because our primary care physicians are working on a clock that says see a patient every 10–15 minutes, et cetera, et cetera, a lot of our primary care physicians will opt to send a patient to a subspecialist for a fairly minor problem because they just don't have time—that 10 or 20 minutes more, to delve into it themselves.

When the patient ends up at the subspecialist, they are required in a sense to do all those extra tests because, after all, you sent the patient to me to check out the constipation or to check out the heart murmur. Having a little bit more leeway in our primary care offices to do the right kind of work-ups and diagnostics and only send the very difficult patients to our subspecialists would be another way of easing this burden.

I think the general public wants us to do the right things in our offices but the incentives are aligned on this throughput of see patients, see patients, see patients, and it just doesn't work.

Senator BROWN. Very good point, and I'd like to ask one more question.

Senator DODD. By the way, that is one of those examples of sending us soon those provisions. That would be where are the restrictions in current law so we can begin to look at it.

Senator BROWN. Obviously it is two things that come about from that. One is saving money for everybody and, second obviously is the subspecialty shortage. It would obviously make it less acute.

Mr. Rother, you mentioned the biologics, the follow-on biologics, some legislation that I've introduced with a handful of others, including Senator Bingaman on this committee.

I share your concerns that costs of biologics are an extraordinary issue, sometimes $100,000 a year or sometimes upwards of that.

The market exclusivity, there's a debate on the length of that. Our legislation is 5 years. It is bipartisan in the Senate. It is bipartisan in the House, Congressman Waxman, Congressman Diehl and others.

Talk, if you would, about why this timeframe is necessary, 5 years rather than 12 years. We know it will save a lot of money for the payer, for the government, for others, too, other payers, but we want to make sure that, as you suggest, from the study, the FTC report, that this actually is good for competition and good for innovation.

Would you share your thoughts with us about that?

Mr. ROTHER. Well, thank you, Senator Brown, for your leadership in this area, and I noted that the committee's draft had just a placeholder for biosimilars.

I think any policy has to balance the incentives for innovation that you want to preserve with savings to consumers and taxpayers and I think the FTC report is a good guide to that. It is a very thorough study of the industry, that basically concluded that the industry does very well at getting a return on their investments in just a few years, and that a fairly short exclusionary period could actually be consistent with maintaining that innovation and yield very substantial savings to individual consumers but also to taxpayers as these drugs are part of the costs of the healthcare system.

It is a balance and I certainly would favor limiting the exclusion period to as short as we can to keep innovation but to achieve——

Senator BROWN. Should it be any different from Hatch-Waxman which has pretty inarguably worked pretty well over the years?

Mr. ROTHER. Hatch-Waxman has worked well and, as you know, generics now are the majority of the market for prescription drugs. It is a very vital way to save money again.

I think this is a different market. I think there are different considerations of biologics and so I would go back to the FTC report.

Senator BROWN. OK.

Mr. ROTHER. I think when you're talking about a small molecule of drugs, it is a different balance, different equation.

Senator BROWN. OK. Thank you. Thank you, Mr. Chairman.

Ms. RAINES. Senator Brown.

Senator DODD. I am sorry. I want to get you. I want to get one question, Dr. Levi. I know you've got to leave very shortly and I just wanted to raise another question with you.

Can you describe the community transformation concept in a bit more detail and then how would these grants differ from the current CDC programs and are there examples?

Senator MIKULSKI. Community transformation grants?

Senator DODD. Yes, yes. How would they differ from the CDC and are there examples of other publicly or privately financed programs that have taken a similar approach that we are not aware of?

Mr. RASKOB. I am sorry. I've not had time to really vet that in detail yet. With our association, I sort of can't speak to that in detail this morning, but we'd certainly be willing to follow up with your office and others with the thoughts on that.

Senator DODD. Do you have a question for Dr. Levi before he runs?

Senator MIKULSKI. No. Dr. Raskob, no. I think he did a good job and I have no questions for him, because mine will go to the medical home which goes to Jonas, Raines, Dr. Palfrey, and so on.

Senator DODD. Why don't we get to Dr. Raines because this is——

Senator MIKULSKI. She was going to finish up on medical homes.

Senator DODD. Yes. I'll give you a chance to respond to this last point that has been raised, but also obviously we are going to hopefully expand the universe here not only among the uninsured obviously accessing the system already but obviously in very different circumstances.

Those who have coverage today but have high deductibles or are reluctant to exercise their rights under the law—so there's going to

be an expansion obviously of our fellow citizens who are going to access the system, even with all the prevention and the like. We hope that works, but we have this problem with providers and I've been given the statistics, I think you and I have talked about this at some point, the average age of a teaching nurse professor is 62, I think is what I've been told, and the average age of a nurse is 55.

Ms. RAINES. Right.

Senator DODD. We have heard a lot of conversation, I want to expand this question not only to you but to others, and obviously Senator Murray's done a lot of work on the workforce issues. We have all provided input to this.

In fact, I think Senator Mikulski pointed out we all have had so much input, it began to be a laundry list of ideas, but I think——

Senator MIKULSKI. Workforce issues were getting longer in our pages than the bill itself.

Senator DODD. The bill itself. Obviously what we are missing in a lot of this is how do you do this, what we'd like to see, but how do you get there?

My question is, tell me how to get there.

Ms. RAINES. You're right. It is a very complicated problem with many facets.

I would like to tie into that with Dr. Palfrey's comments earlier relating to the need for primary care providers and some of the specialties because the nursing workforce also can feed into that issue in terms of primary care in some of the rural areas and in some of the subspecialties. Nurse practitioners are particularly effective at that type of care.

The issues of the workforce and particularly the nursing workforce is really a multifaceted problem. One is sufficient numbers of nurses in the pipeline to meet the projected need, as you said, because the demand is exploding very rapidly over the next several years.

The other, and that is related to numbers of people coming in, the increasing demand and the aging of the workforce. The average age of staff nurses in this country now is 55 and so many of those nurses will be reaching retirement age very shortly.

At the same time, we have a fairly critical shortage of nurse faculty who are available to teach the new nurses, and the average age of nursing faculty in the country now is in the early 60s. Many of those will also be retiring.

It is something that has to be faced, both from getting the students, new students, new nurses into the pipeline but also preparing people who can teach them when they're there.

I think that one of the points that AACN is particularly supportive of is looking at the training grants for advanced nursing education and removing a cap that is in there that indicates that only 10 percent of the current funds allocated for advanced nursing training can be used in doctoral programs and our recommendation is that that cap be removed because those are the funds that could then be used to prepare additional faculty.

I think other programs that bring more nurses in to the workforce in terms of student support, loan repayment plans are critical.

I think that this, as other issues related to the workforce—while my focus is particularly nursing, I think we have to look across disciplines because I think the time of us being able to look at a single discipline solving all of the healthcare problems are gone.

AACN looks forward to working with you as we look for solutions.

Senator DODD. Dr. Cosgrove, others want to comment on this? How do we get there? What's your ideas on how we do that?

Dr. COSGROVE. As far as the nursing shortages and personnel——

Senator DODD. Primary care physicians, a range. I think we all can almost ask the question ourselves. We are all asking the question. We all know where we want to be, but we have yet—we have heard about obviously assistance on student loans and allocating doctors to certain areas where they're underserved right now in return for forgiveness on loans. There's a lot of ideas around there and I presume many of them are very good ideas.

I just wonder if there are any ones out there that you're looking at or we ought to be looking at that would expand this opportunity.

Dr. COSGROVE. Yes. I think you have to look at both ends of the spectrum. Let's take the specialists end of the spectrum to start with. You can't expect all hospitals to be all things to all people.

Senator MIKULSKI. All the time.

Dr. COSGROVE. Yes. You're going to have to have areas of specialty where you move patients to those facilities and that should be increasingly done.

It does two things. First of all, it increases the efficiency and, second, it improves the quality. It is called the practice of medicine and the more you practice that, the more patients you see with that, the better you get at it.

On the other end of the spectrum, we are going to have to begin to have additional groups of people come in to provide care. It is no longer reasonable to expect a nurse to be the only one that can take a blood pressure or record a temperature. We have to bring technicians in.

The example of that is superbly done by the U.S. military. I ran a 100-bed hospital in Vietnam with two doctors, 11 nurses, and untold number of corps people who treated people superbly.

We have to develop additional groups of technicians to come into the healthcare arena to remove the technical tasks that people are charged with, particularly nurses.

Senator DODD. Yes. I was——

Senator MIKULSKI. Dr. Palfrey.

Dr. PALFREY. I just wanted to approach this from——

Senator DODD. In the pediatric area, our problem is not enough primary care physicians. Like in the specialty area, it is the reverse of almost everything else.

Dr. PALFREY. Right. Exactly. I am actually really addressing this from the pediatric point of view from our adolescent population.

One of the things we see with our adolescents, particularly among diverse populations and so forth, is a sense of no hope, no future, no jobs. I think addressing preparation for health careers might be beyond this committee's purview to do that, but really thinking about our new populations who are here in this country

and working and really thinking about healthcare preparation as things that young people can do. Get a 17–18-year-old who can now work as this corps person, et cetera, et cetera, give them a sense of a future and jobs and so forth and really looking at it as a double whammy. Even for our PCAs, for people to help with the people with disabilities, make those attractive, give the high schools ways to do this and get a more diverse population into our health systems who speak the variety of languages that we have now in our communities, et cetera.

That's a kind of double whammy way to give people a sense of hope and maybe not be in gangs, not to be on drugs, et cetera, et cetera. I know it is not in this committee but at least to get——

Senator MIKULSKI. But it is in this committee.

Senator DODD. It is. That's what——

Senator MIKULSKI. Well, if I could just jump in here and, first of all, I think right now it is how are we going to do the health bill. It isn't within the purview of this committee and only in the purview of this committee to meet workforce needs.

What we have here through the Murray framework that we have all collaborated on is essentially to take what we have and how we can amplify it or strengthen it as we go through this passage.

I believe, however, we need, and Senator Murray has a commission identifying where the demographic challenges are, but I think we need the kind of fresh approach that was at the beginning of the 20th Century when we looked at a total revision of it.

I come, as you know, from Baltimore in which a woman by the name of Mary Garrett radically transformed medical education because she held the purse strings to Johns Hopkins. Johns Hopkins got the money but it only got halfway done. They had to go to Mary Garrett, heir to a railroad fortune, and she said three things.

No. 1. You have to admit women. It took them 3 years to agree to do that. No. 2. It has to be a graduate program. No. 3. It has to really have a sound admissions requirement for students.

Dr. PALFREY. Quality.

Senator MIKULSKI. We need to focus on academic curriculum. Now where we are, though, is we began to look at new ways. Do you only begin medical school after you've graduated from college? Do you begin earlier on with nursing?

As much as I really support the doctoral program efforts, is that really practical to really think about how many doctorates we are going to produce in nursing as compared to achieving quality, making sure everyone's properly credentialed and so on?

I think that is something, though, that has to come in the works. I think we have to really take a look at not only what we have but where we need to go with our new demography, Dr. Palfrey, what you said, and our new challenges, recognizing that many people don't come into these fields after they're already adults.

Dr. Cosgrove, that medical corpsman coming back from Iraq or Afghanistan who says, wow, I never thought I could do this kind of stuff and I love doing it, but I am now 27 years old, where do I go and what do I do and, by the way, I've only finished high school and everybody says uh-huh, and so new thinking, new approaches without sacrificing quality or appropriate credentialing.

Senator DODD. You wanted to comment on that, Dr. Cosgrove?

Dr. COSGROVE. Yes. We have done this on two levels. We have done it, first of all, with high school students. We bring in 140 or 180 high school students each summer and pay them and put on a program for them to encourage them to come into healthcare.

The second thing was we have worked out an arrangement with the military so that people can come back from Iran—from Iraq and Afghanistan and come——

Senator MIKULSKI. We don't want them to go to Iran.

Dr. COSGROVE. No. I am sorry. I mis-spoke.

Senator MIKULSKI. I am teasing.

Dr. COSGROVE. And come—that is right.

Senator MIKULSKI. Something happened overnight.

Senator DODD. We don't have jurisdiction over that.

Dr. COSGROVE. Apologies.

Senator MIKULSKI. But they come back.

Dr. COSGROVE. Yes, so they can come back and work for us, and in fact we established our Cardiac Surgical Program totally on the basis of Vietnam veterans who'd been corpsmen and we have employed some 80 of them in the Cardiac Surgical Program.

Senator DODD. Are you getting any follow-on with these high school students, these 180 you're bringing in?

Dr. COSGROVE. Well, we have seen them, a very high percentage of them go on to 4-year colleges and we have not yet seen them go into—the rationale for this was that I had a high school student who graduated—who came and worked in my laboratory. He graduated valedictorian, then went to Senator Brown's alma mater where he was also valedictorian, then to Johns Hopkins. He came back to the Cleveland Clinic and is now one of our star cardiac surgeons where he could have gone any place and it was on the basis of the fact that he had worked for us in the past.

Senator MIKULSKI. Dr. Raines.

Senator DODD. Dr. Jonas, you wanted to comment on this, too.

Dr. JONAS. I just wanted to say that sometimes we forget the fact that incentives are not always about money, that healing professions, there are still many, many people who come into the healing professions because they want to be healers. They want to work in an environment where they can serve in these areas.

I think if we were able to create an environment in which we are healing and wellness were a focus and was an environment to do—you'd see droves of people coming into those areas.

I'll give you one example. We worked with a hospital up in New Jersey that was having a major problem with nurse turnover. They could not get nurses. Twenty-five percent-plus turnover per year, huge expense. They brought in a training program that empowered the nurses to be a core part of the person-centered care team and leaders in that, where they were providing care, healthcare coordination delivery in those areas, not just filling out the paperwork aspect.

Within 2 years, they dropped from 25 percent turnover to 4-percent turnover and had a line out the door trying to get into that program. People wanted to do that and that can be done if we created the environment in those areas.

Senator DODD. That's great.

Senator MIKULSKI. Dr. Raines.

Senator DODD. Yes, Dr. Raines.

Ms. RAINES. Thank you. Thank you, Dr. Mikulski, for what you've done to champion nursing education over the years.

Senator MIKULSKI. I only have an honorary doctorate, so.

Ms. RAINES. I agree with you that we need to continue to look at innovations and how we educate not only nursing students but students across the health professions.

In nursing, though, we have a little bit of a different issue than some of the others in that we have students standing at the door. We turned away, last year, a total of about 50,000 qualified nursing student applicants from our baccalaureate programs across the country because of lack of capacity in our schools of nursing and that lack of capacity is primarily faculty which I've mentioned, infrastructure, physical facilities, and clinical training sites.

Senator MIKULSKI. You mean classrooms and labs?

Ms. RAINES. If we could expand the capacity of our schools of nursing, it would be a major step in increasing the nursing workforce.

Senator DODD. Dr. Levi.

Mr. LEVI. Just one comment. It is also the public health workforce that is facing tremendous shortages. The provisions that are in this bill, I think, are excellent in moving things forward, everything from loan repayment programs to also youth initiatives that will encourage high school kids to become interested.

Dr. Raskob, I hope, would agree that as important as master's training is and graduate training is in public health, there are other ways of doing public health. I teach in the School of Public Health at George Washington University. Public health nurses are a critical part of the public health response.

We need to be thinking also, as we reform and re-engineer the healthcare system, about the different roles public health will be playing and the different skills that will be necessary and so we need to be retraining people. We need to be encouraging kids starting in high school to be interested in this field and finding alternative pathways, in addition to master's training, to provide this workforce.

Senator DODD. Yes.

Senator BROWN. Let me comment on something. We have talked about nurses. We have talked about pediatric specialists. We have talked about a large swath of the workforce.

There's a program, and my colleagues have heard this before, so I apologize, but there's a program in Mansfield, OH, where I grew up, where they had particularly high low-birth weight baby rates in two zip codes. One was predominantly Appalachian white, one was predominantly African-American, something like four times the national average low-birth weight baby rates, and over—they brought in what are called community health workers.

It is a new designation in Ohio. Other States have it in different iterations, been around maybe 6 or 7 years, and they're high school graduates with about 3- to 6-month training beyond that. Some got their GEDs and they took young women from these neighborhoods and they dramatically cut the low-birth weight baby rate.

These young women—because they lived in the neighborhood—would be able to find women when they were pregnant, in the early

stages of their pregnancy. They got them nutrition counseling. They brought them in to OB–GYNs for visits.

I mean, the beauty of it and the success of it was terrific. The tragedy of it in some sense is this healthcare system isn't really quite equipped, No. 1, to train enough of them but, No. 2, to pay them. These women, these young women are paid $11–$12 an hour. The OB–GYN is paid under Medicaid, but the workers that are doing this aren't and we are working with the Finance Committee. We are also working with Senator Murray on beginning to sort of recognize and train more workers like this.

We need to be conscious as we practice high-tech medicine especially of what we can do with these young women and similar to Dr. Cosgrove's comments about these high school students, I met with several of these young women and I said to them, you know, you've already saved lives. You've already made lives better and you can bet that some of those young women who had very little opportunity in their lives and were in dead-end jobs at McDonald's and other places before this, some of them were going to become nurses, some of them were going to become doctors if we do this right and empower these young low-income women coming from homes where there wasn't much opportunity for them to move ahead with education.

If we really do this right and find a way to focus on and empower those women of that age in the kind of health outcomes that will mean it will save us in so many ways.

Mr. LEVI. To come back to Senator Dodd's question about the community transformation grants, I mean that could be a part of what community transformation grants are about, creating within a community a core of people who are going to start changing the norms and educating people, and that is really what we need to be doing, not just with low-birth weight babies but about all of these chronic disease issues that have the behavioral base.

Senator MIKULSKI. I'd like to jump in. I have to leave at 12, and I'd like to ask, as really engaging as this conversation is, about community health teams.

In terms of the community health teams, I mean, community-based multidisplinary teams, excuse me. I was a little distracted. The medical home idea, I really am going to invite those at this table and others who've participated in the roundtable to look at this and scrub it.

My idea that came through extensive hearings that we had on integrative health and others and, Dr. Jonas, you were really an active participant, was this, that building on the Baucus paper and Medicare, the idea of a medical home.

The first discussion we had is what is a medical home and I looked at the CMS definition. Oh, my God. It was just so laborious, tedious, and technical. Who would want to live in that home? OK.

I went to the definition provided by the Academy of Family Physicians and I did it for two reasons. I felt it was comprehensive and, second, when people would say to me where did you get that, I would say that I turned to those who actually have been the primary orientation.

I'd like you to look at that and give us feedback. Am I right on the right track? The whole idea of a medical home was to leave

flexibility that it would not be oriented only to a primary care physician but also to that who would be appropriate.

For example, a child would have as his or her medical home a pediatrician. There might be those with MS that their medical home was going to be with their immunologist which is the person that you're going to be most likely to turn to and most likely to confide in and most likely to need for your ongoing care. We didn't want to lock it in to a narrow definition of primary care docs.

The second thing was that knowing that, the management of chronic illness, which is three-quarters, as you said, John, of our funding, required behavioral change for either teaching self-care initiatives around diet and exercise to whatever.

That's where we went to the access to community health teams. We don't have the power of the payment system in this committee. We established grants to States to set up these community health teams. I am a little ambivalent about that because I am not sure it will be fair—it could be uneven, et cetera.

And, third, my other flashing light was that sometimes a physician—we want the physician to be a guide but not a narrow gatekeeper, so that if you wanted to go to a licensed provider in order to be able to seek other help, for example chronic back pain, if you really wanted to go use acupuncture and you had a doctor who was hostile to it, you still would be able to have access to it.

My question to you, and I think you can give me answers today, fine, and if you can't, I really need the written testimony as we move through the legislation, No. 1, am I on the right track for my definition of a medical home because my colleagues are counting, quite frankly, on me to do this right as is America.

And No. 2, the access to community health teams that get people what they need, knowing that it isn't all about medicine—not everything is medicalized.

Dr. Jonas, do you want to kick off that, and then throw it open?

Dr. JONAS. Thank you, Senator. I think that this is a very important concept.

We, so much in this country, tend to get attracted to and invest in and value high-tech and yet at the same time we don't really appreciate, we under-appreciate the power of the high tough and the processes of care in these areas.

Dr. Mary Jo Crissler, a nurse who runs the Institute for Health and Healing at the University of Minnesota, has taken the medical home concept and broadened it exactly to what you're talking about in terms of team care. She calls it the healthcare home, in which a leader in the area of person-centered care could be a licensed and should be a licensed practitioner that then could look at what's needed to properly care for the complex, often multifactorial components that are needed for individuals with chronic illness from their mind, body, and spirit.

I think a concept that looks at that team care is important. It leads to efficiencies. It requires efficiencies, similar to what Dr. Cosgrove talked about, where everyone has an important role.

Senator MIKULSKI. Do you like the definition I've got in here now?

Dr. JONAS. I like the definition from the American Academy of Family Physicians which has been adopted by the American Academy of Pediatrics, OB–GYN, and Internal Medicine.

I think there are some modifications to it that need to broaden the definition beyond simply making the physician the healthcare leader to other health care leaders, especially if we want to put prevention and health promotion, as we have talked about in this panel, in the lead because those practitioners or those specialties then need to do that.

Senator MIKULSKI. Dr. Raines.

Ms. RAINES. I would certainly agree with Dr. Jonas' comment. I think that it is an important concept and one that can be terribly useful in terms of revising our healthcare system, but I would encourage broadening the definition a bit to look at——

Senator MIKULSKI. Well, I need specific language where we broaden it but we don't set ourselves up for a lot of pushback arguments and even ridicule because I've had to go through a lot to get to this.

Dr. Palfrey.

Dr. PALFREY. The medical home actually was born in the American Academy of Pediatrics in the 1960s and we are very proud of the medical home concept.

The idea of it is that we have continuous care 24/7. It is comprehensive. It includes primary care, subspecialty care, access to hospitals, and that the primary care physician or the medical home physician takes full responsibility for what happens from diagnosis through treatment through care and accepts the malpractice or whatever happens as a result of that.

The medical home should also be family-centered and community-based and so it is the best care that you can possibly get. It can be provided absolutely by a subspecialist, as you're mentioning, if that person makes sure that all of the care is delivered. If an immunologist is willing to provide—make sure that the immunizations are given to the patient, that family counseling is given to the patient, that all of these things are done, absolutely, that can be.

Senator MIKULSKI. What about the community health teams, the community health team concept in the bill, and what do you think about it?

Dr. PALFREY. The medical homes also include community outreach and are community-based, and we have some very good examples, for instance Community Care Alliance in North Carolina, which have saved enormous amounts of money using community health as a component of this because we have to be able to get out to the homes. We have to be able to coordinate care. It is a full concept, as you're talking about.

Senator MIKULSKI. Very good. John, did you want to comment?

Mr. ROTHER. Senator, I just recently was in Vermont to look at some of the community health team innovations that they are sponsoring and it looks very promising and the experience in North Carolina equally promising.

I think these are innovations worthy of support. I don't know if they're the complete answer, I doubt it, but they certainly are adding value at a very reasonable cost.

Senator MIKULSKI. Anybody else?

Dr. JONAS. There's an educational network within HRSA that does an excellent job of looking at innovations like this in the community health teams and then disseminates the ones that have been shown to work out and I think looking at that and supporting that would be an ideal way and an adequate way that you could actually begin to roll out these areas.

Senator MIKULSKI. Well, first, I want to come back to Dr. Palfrey. We have been talking about the North Carolina model and various examples related to prevention and wellness.

See, what we don't want at the end of the day is to just give lip service to prevention and wellness. It is like everybody talks about it but nobody does it. Everybody thinks it is swell and then they kind of want it to be an afterthought.

It was the goal of Senator Kennedy, when he established these working groups, to make sure there was quality and that there was a whole working group just on prevention and I am very proud of what my colleague has done, but it wasn't separated from coverage. We have all been working together under Senator Dodd's inspiration and perspiration.

Now, though, we are at the point where we are actually drafting language and, quite frankly, we are on new territory because this will be the first time we are trying to move from volume medicine to value medicine in what we are doing in our two working groups and at the same time establishing concepts that have been recommended. We are making them 21st Century concepts and we need to have those who are in the area of practice and who really study the policies to give us feedback because, quite frankly, I worry at times we are in a little over our head and we have to make sure we don't inadvertently create unintended consequences where we lock people in, I mean a variety of things.

So we are asking you to really look at the definition, give us advice, and also look at the community health team and also make sure that guidance is not rigid gate-keeping and be able to proceed from there.

Dr. PALFREY. We will be happy to help and follow the Garrett Sisters model.

Senator DODD. Thank you very much. I have one additional question, Dr. Palfrey.

We have written a provision for the bill very similar to the best pharmaceuticals for children provision in the follow-on biologics regarding children with the 6-month exclusivity. You may recall, the best pharmaceuticals for children produced a stunning number of new safety information about drugs used in children that came out as a result of that effort and I just would call for a similar 6 months of exclusivity for pediatric testing for biological products.

I don't know if you had any comments about that. Are you familiar with this?

Dr. PALFREY. I want to thank you for what you've done with it. I personally am not as familiar to give you the answer to that, but it is so important for children to be included in these trials because so many of our drugs actually literally say we shouldn't be using them.

Senator DODD. No. I appreciate——

Dr. PALFREY. Thank you.

Senator DODD [continuing]. It very much. Additional comments. You've been a terrific panel. I regret that not more of my colleagues were here but I do understand how that can happen and so it has been tremendously valuable and we are going to leave the record open because I think there will be questions for you from additional members over the next few days.

We want you to stay very much in touch with us, if you could, in these coming days and particularly the ideas and suggestions that I mentioned at the outset, if you could submit to us—and Senator Mikulski just pointed out some very specific suggestions, for instance, on the medical home definition. If we are going to expand it, to what degree are we expanding it? What are the add-ons you'd recommend for us? That's a good example of what we are talking about.

So with that, I thank you all for being here today, and we have a very big job in front of us and, Dr. Palfrey, I appreciate you mentioning Senator Kennedy because obviously he'd be the one in this chair and he is in so many ways, even though he's not physically here. It has been his inspiration for four decades to try and get a national healthcare plan in place that is accessible and affordable and is value-based, quality-based, again principles and concepts that have been talked about for years and years and years, and as I've said over and over again, the present situation is no longer not only unacceptable, it is unsustainable.

Just from a financial standpoint, we can't continue the path we are on and that has got to change. So your participation today has contributed significantly to our discussion and we thank you very, very much for it and look forward to hearing from you again.

The committee stands adjourned.

[Additional material follows.]

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ADDITIONAL MATERIAL

PREPARED STATEMENT OF CHIP KAHN, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

I. QUALITY

• The 1,000 hospitals of the Federation of American Hospitals (FAH) strongly supports the expansion of health coverage to uninsured Americans, as well as health care delivery, and congratulates this committee and its leadership in forwarding that process.

• We are gratified with the committee's appropriate focus on prevention and our health care workforce as part of reform. Today, I am going to focus on the quality components of the legislation, which we find particularly important to achieving the goals of health reform.

Stand For Quality

• The FAH has long worked with other stakeholders to develop a quality infrastructure to enable hospitals and clinicians to improve patient care.

• We deeply appreciate the leadership of Chairman Kennedy, Senator Dodd, and Senators Enzi and Mikulski for including in the bill a strong quality title which recognizes the need for a cohesive Federal infrastructure, essential for effectiveness research, that is built on the foundation of a strong public-private, multi-stakeholder partnership.

• The FAH is an active member of Stand For Quality, a broad multistake-holder coalition that includes more than 190 major organizations nationwide from consumers, labor, employers, purchasers, to clinicians and hospitals, and we appreciate the committee's recognition of the six key functions we believe are necessary to strengthen and improve quality:

1. Setting national priorities to guide reporting and improvement activities and assess progress.
2. Endorsing and maintaining measures for national use through multistake-holder consensus process.
3. Developing measures to fill identified gaps in priority areas.
4. Strengthening a public-private stakeholder consultation process.
5. Providing a national strategy for the collection, aggregation and public reporting of quality measures.
6. Identifying, developing, testing and disseminating innovative methodologies for improvement in quality of health care.

Delivery Reforms

• Additionally, the committee bill includes a section that would have insurers implementing quality programs. We would encourage the committee to ensure that quality programs developed by insurers are linked to those quality programs you included in title II (2).

II. GENERAL HEALTH CARE REFORM

• As I wrap up my remarks, I would like to mention three key points that we view as critical for reform to work:

- Ultimately, health reform must work to strengthen—not weaken—the hospitals that so many Americans rely on for their care.
- Therefore, we need to be very careful that the bill does not arbitrarily reduce hospital revenue. That would undermine the ability of hospitals to meet the expectations of expanded access for Americans to quality patient care.
- Medicare and Medicaid are critically important programs that so many Americans depend on; however, we must acknowledge that both chronically underpay hospitals for services. So, tying payments under expanded coverage to these programs will weaken not strengthen hospitals.

• We all support delivery reforms that will improve care and its efficiency, but if sufficient funding is not there, we could very well defeat the goals of the bill.

• Thank you for the opportunity to address the committee today.

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AMERICAN ASSOCIATION OF COLLEGES OF NURSING (AACN),
WASHINGTON, DC 20036,
June 19, 2009.

Chairman EDWARD KENNEDY,
Senate Health, Education, Labor, and Pensions Committee,
428 Dirksen Office Building,
Washington, DC 20510.

Ranking Member MICHAEL ENZI,
Senate Health, Education, Labor, and Pensions Committee,
835 Senate Hart Office Building,
Washington, DC 20510.

DEAR CHAIRMAN KENNEDY AND SENATOR ENZI: I am writing on behalf of the American Association of Colleges of Nursing (AACN) to amend our written and oral testimony provided on June 12, 2009. In the testimony, we incorrectly asked that the 10 percent cap on the availability of funds for doctoral students under the Advanced Education Nursing Grant program be lifted by striking section 296j(f)(2) of the current Title VIII authority of the Public Health Service Act. We were unaware that the *Affordable Health Choices Act of 2009* does indicate the removal of this provision. This was an oversight and unintentional error by AACN, and we would like both to apologize and to correct our comments to reflect that the legislation does indeed include the removal of this cap. It was not our intent to mislead the Senate Health, Education, Labor, and Pensions Committee, and we sincerely apologize for this error.

AACN is grateful for the tireless efforts of you and your staff to move forward this momentous piece of legislation. An accessible healthcare system that provides quality and affordable care nears reality under your leadership. We offer our strong support for your efforts to see reform passed swiftly and effectively.

We appreciate your commitment to healthcare reform and nursing education. If AACN can be of any assistance with your efforts, do not hesitate to contact me or Dr. Geraldine Bednash, Chief Executive Officer and Executive Director at *pbednash@aacn.nche,edu* or (202) 463–6930.

Sincerely,

C. FAY RAINES, PH.D., RN,
President.

cc: Senator Christopher Dodd (D–CT); Senator Tom Harkin (D–IA); Senator Barbara A. Mikulski (D–MD); Senator Jeff Bingaman (D–NM); Senator Patty Murray (D–WA); Senator Jack Reed (D–RI); Senator Bernard Sanders (I–VT); Senator Sherrod Brown (D–OH); Senator Robert P. Casey, Jr. (D–PA); Senator Kay Hagan (D–NC); Senator Jeff Merkley (D–OR); Senator Judd Gregg (R–NH); Senator Lamar Alexander (R–TN); Senator Richard Burr (R–NC); Senator Johnny Isakson (R–GA); Senator John McCain (R–AZ); Senator Orrin G. Hatch (R–UT); Senator Lisa Murkowski (R–AK); Senator Tom Coburn, M.D. (R–OK); Senator Pat Roberts (R–KS)

[Whereupon, at 11:59 a.m., the hearing was adjourned.]

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