

**Testimony Presented Before the House Appropriations Labor, Health and  
Human Services, and Education Subcommittee**

**Regarding Fiscal Year 2005 Funding for  
the Agency for Healthcare Research and Quality and  
the Title VII Health Professions Program**

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**On behalf of the Society of General Internal Medicine  
and the American College of Physicians**

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Thank you, Mr. Chairman and members of the subcommittee, for the opportunity to speak with you today. I am Harry Selker, a practicing physician in general internal medicine and health services researcher based in Boston, Massachusetts. On behalf of the Society of General Internal Medicine (SGIM) and the American College of Physicians (ACP), I will focus my remarks on the Agency for Healthcare Research and Quality (AHRQ) and the Title VII Health Professions Program. I want to express our gratitude for your leadership and past support for AHRQ and Title VII, and convey the importance of providing stable funding for both programs in 2005.

SGIM is an association of 3,000 physicians, primarily general internists, and other health professionals who combine treating patients with teaching and conducting research and are dedicated to improving patient care, medical education, and research in primary care and general internal medicine. ACP is the nation's largest medical specialty organization and second largest physician group, whose membership encompasses more than 115,000 internal medicine physicians and medical students.

I will speak first about AHRQ. We are very disappointed that the Administration's budget includes level funding of \$304 million for AHRQ. SGIM and ACP recommend a 2005 appropriation of at least \$443 million for AHRQ. AHRQ provides evidence-based information on health care outcomes, quality, cost, and access. AHRQ plays a major role in translating the promise of biomedical advances into actual practice, benefiting our citizens. AHRQ has made significant contributions to knowledge of patient safety, quality and health disparities, some of the most critical health care issues facing our country. AHRQ is on the forefront of this country's move towards integrating information technology into healthcare practice, which as you know is a goal of this Administration.

As a representative of the ACP and a fellow in the College, I can confidently say that AHRQ's work is considered by most practicing internists as authoritative and vital. To illustrate how AHRQ provides support to organizations to develop information that practitioners need in the field, AHRQ has provided funding for a multi-year, multifaceted initiative of the ACP, "The Other Side of the Quality Equation," to train physicians to provide instruction in their communities to raise physician awareness of quality issues and facilitate physician behavior likely to diminish the occurrence of medical errors. The cornerstone of program is the development of a patient safety curriculum that has educated an estimated 7,000 physicians about patient safety in the ambulatory setting.

To illustrate the vital role of AHRQ research in translating into practice ways to improve the quality and cost-effectiveness of medical care and reduce medical errors, I will describe some of our work at the Center for Cardiovascular Health Services Research (CCHSR) at Tufts-New England Medical Center (Tufts-NEMC).

A central question for the emergency department (ED) physician or emergency medical service (EMS) paramedic is whether a given patient with chest pain or related symptoms is truly having acute cardiac ischemia (ACI: which includes heart attack as well as unstable angina pectoris, which can quickly lead to heart attack). We addressed this by creating a mathematical predictive model, a predictive instrument that provides the 0-100% probability that a given patient is truly having ACI. It aids the physician's or paramedic's decision, just as the probability of rain aids our decision as to whether to carry an umbrella. When the patient has an initial EKG using one of the commonly available electrocardiographs with the predictive instrument for ACI (ACI-TIPI), on the top of the EKG is printed the patient's specific probability of having ACI. This helps identify patients with true ACI who need immediate attention and hospitalization and helps them get the care faster. It helps avoid unnecessary hospitalization of those with chest pain from another non-ACI cause, and thereby saves money. Clinical trials on this supported by AHRQ have shown as much as a 30% reduction in unnecessary coronary care unit (CCU) hospitalization of such patients without ACI, corresponding to 250,000 fewer CCU admissions per year, on the order of \$1 billion saved per year. Another version of the ACI-TIPI that prints out with the standard EKG and provides additional information to avoid mistakenly sending patients

home has been estimated to be able to save \$1.2 billion annually in medical malpractice costs due to missed diagnoses of heart attack. Based on these and other findings, the AHRQ-sponsored ACI-TIPI is generally available in conventional computerized electrocardiographs in hospitals and ambulances in the U.S. and overseas.

Another central issue in emergency cardiac care is the use of emergent coronary reperfusion for a heart attack, with thrombolytic (“clot-buster”) therapy, or coronary angioplasty. Treatment can reduce mortality by 50% if used immediately in the acute phase of heart attack. But in emergency settings, identifying the right patients quickly can be difficult, especially for less obvious candidates, when key physician decision-makers are not on-site. For this situation, we created the EKG-based thrombolytic predictive instrument (TPI), which, when significant an acute heart attack is detected by the electrocardiograph, predictions are automatically computed and printed on the patient’s EKG: 0-100% probabilities for acute (30-day) and long-term (1-year) if and if not treated with thrombolytic therapy, and of thrombolytic therapy-related major bleeding. In a national trial of the impact of the TPI on heart attack care, it increased use of coronary reperfusion, and its use within 1 hour, especially in patients and settings usually associated with under use, or use too late. It increased by 20% for women, both treatment and use within the first hour; by 30% for patients seen where the cardiologist had to be reached by phone; and by 50% those seen in rural hospitals without an on-site ED physician. Reflecting this, the TPI is now available in conventional electrocardiographs for ED and EMS use.

Our work also has looked at the contributing factors to medical errors in ED cardiac care. Malpractice awards for mistakenly sending a patient home with a heart attack is one of the largest costs for malpractice in the U.S. A national AHRQ supported study including 10,700 patients showed the likelihood of missing the ED diagnosis of ACI, including heart attack, and mistakenly sending a patient home, was over twice as high in non-whites; nearly 7 times higher in women under 55 years; nearly 3 times higher in patients with shortness of breath instead of classic chest pain; and over 3 times higher in those with a normal or non-diagnostic EKG. These often-quoted findings have helped generate action to reduce these life-threatening errors, including use of the AHRQ-supported EKG-based predictive instruments described above.

Next I will speak about the Title VII Health Professions Programs, specifically, the Title VII primary care program with which many of my SGIM and ACP colleagues have been involved over the years. Title VII, section 747 plays a critical role in enhancing the training of broadly competent primary care physicians; increasing access to health care among underserved and disadvantaged populations; and promoting diversity in the health professions. We are extremely concerned that Title VII, section 747 is continually zeroed out in the President’s budget and received an almost 12% funding cut in 2004. We recommend an appropriation of \$169 million for these programs in 2005 to continue their successful contribution to training high quality professionals to help meet the needs of the underserved. According to reports of the Advisory Committee on Title VII section 747:

- In 1998, 42-56% of graduates of these programs entered practice in underserved communities, compared to a mean of 10% of U.S. health professions graduates overall.
- In 1998, underrepresented minority or disadvantaged groups comprised 35-50% of graduates of programs supported by Title VII, section 747, compared to a 10% minority representation among the U.S. health professions workforce overall.
- Medical and dental training programs funded by Title VII, section 747 have developed innovative curricula in HIV/AIDS, geriatrics, managed care, domestic violence, genetics, culturally competent care, and rural health. This funding has been perhaps the most important vehicle for structural changes in training programs.

Thank you again for this opportunity. I would be happy to answer any questions.