

# Making Health Care Work for American Families: Improving Access to Care

Presented by Risa Lavizzo-Mourey, RWJF President and CEO

March 24, 2009



Robert Wood Johnson Foundation



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TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE  
ON ENERGY AND COMMERCE  
U.S. House of Representatives  
Washington, D.C.

Chairman Pallone, Ranking Member Deal, and members of the subcommittee, thank you for this opportunity to testify about strategies for improving access to care for America's families.

I am Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of the Robert Wood Johnson Foundation (RWJF), the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Today, we are in the middle of *Cover the Uninsured Week*, which RWJF has supported since 2003, in cooperation with a diverse coalition of national partners and supporters. This week, communities across the country are organizing hundreds of events to raise awareness about the fact that too many Americans are living without health insurance, and to demand solutions. Our health care system is at the brink. We must reform it: Make it better, cheaper and more inclusive. Inaction is not an option.

Assuring that everyone in America has stable, affordable health care coverage is central to our Foundation's mission, and expanding coverage must be a priority as Congress considers opportunities for health reform this year. We know that going without health insurance has serious consequences, not only for the uninsured person's physical, mental and financial health, but also for the community. This subcommittee heard a couple of weeks ago from Jack Ebeler about the new RWJF-supported Institute of Medicine report on the consequences of uninsurance.<sup>1</sup>

The report shows that insured adults in communities with high rates of uninsured residents are less likely to be satisfied with the quality of their care and their choice of health care providers. Clearly, when millions of Americans are uninsured, everyone is affected.

But expanding coverage alone will not be sufficient. Meaningful health reform must also include efforts to improve the quality, value and equality of care; address health care costs and spending; strengthen the public health system's capacity to protect our health; address the social determinants of health; and prevent disease and promote healthier lifestyles. I am delighted that the subcommittee is considering all of these important elements through this series of hearings on Making Health Care Work for American Families.

In our more than 35 years of work to improve health and health care, RWJF has learned many lessons about making health care work, about what constitutes high-quality, patient-centered care, and about the factors that facilitate or impede meaningful access to care and services.

Critical to implementing these transformations are our nation's nurses. In my testimony today, I'll focus primarily on the critical role that nurses play in ensuring high-quality care and some of the challenges and opportunities for addressing the nation's shortage of nurses and nurse faculty.

## The Value of Nurses

I hope none of you have ever had to be hospitalized or had a loved one hospitalized, but if you have, you know that it's the nurses who make the difference when it comes to high-quality, patient-centered care.

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<sup>1</sup> Institute of Medicine (IOM). *America's Uninsured Crisis: Consequences for Health and Health Care*. Washington, D.C.: The National Academies Press, 2009. Available at <http://www.nap.edu/catalog/12511.html>

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And the evidence supports that anecdotal experience: the Institute of Medicine report *Keeping Patients Safe: Transforming the Work Environment of Nurses* found that nurses, as the largest segment of the health care workforce and the professionals who spend the most time providing direct care to patients, are indispensable to patient safety and health care quality.

Indeed, the new data hospitals across the country are submitting to CMS on patient satisfaction show that nursing is the single most important factor in how patients rate their hospital experience and whether they would recommend their hospital to a family member or friend.

Nurses' vigilance keeps bad things from happening to patients such as medication errors, patient falls, and pressure ulcers.

Nurses provide vital care and services not only in hospitals and in nursing homes, but in the community, as well. That's a key piece of ensuring access to meaningful care and services. We talk a lot about the importance of patient-centered care, and part of patient-centered care is meeting people where they are—sometimes literally. For example, schools present an important opportunity for increasing access to care for children and families. Fifty-six million children attend an elementary or secondary school in the United States<sup>2</sup>, and schools offer a prime opportunity to reach kids where they spend most of their time. RWJF has a long history of investing in school-based health centers, many of them nurse-led. Today, there are more than 1,500 school-based health centers across the country that provide critical health care, mental health and dental care services to vulnerable children and, in some cases, their families.

Nurses also play a vital role in ensuring that children get a healthy start in life through an innovative, proven, cost-effective program called the *Nurse-Family Partnership*. Supported by a range of public and private funding sources—including RWJF—the program works in 28 states to pair young, low-income pregnant women and first-time mothers with nurses who provide home visits during pregnancy and through the child's second birthday. Nurses counsel their clients about the importance of prenatal care, proper diet and avoiding cigarettes, alcohol and illegal drugs and help parents develop skills and strategies for caring for their babies responsibly. In addition, they work with the moms to develop a vision for their own future, including plans to continue their education and find work.

The program has now served nearly 100,000 families. A 15-year study found that participants have positive outcomes in reducing child abuse and neglect, reducing behavior and intellectual problems among children, reducing arrests among children by age 15, and reducing emergency room visits for accidents and poisoning. A 2005 analysis by the RAND Corporation also found a \$5.70 return for every dollar invested in the program.<sup>3</sup>

## The Nursing Shortage

The value and importance of nurses is clear, but as we all know, our nation faces a critical shortage of nurses and nurse faculty. As Congresswoman Capps noted at the White House Forum on Health Reform earlier this month, there is a projected shortage of 500,000 nurses by 2020.<sup>4</sup>

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<sup>2</sup> Upcoming *Statistical Abstract of the United States: 2009*, Table 211. Available online at <http://www.census.gov/compendia/statab>

<sup>3</sup> Karoly LA, Kilburn MR and Cannon JS. *Early Childhood Interventions: Proven Results, Future Promise*. Santa Monica, Calif.: RAND, 2005. Available online at [http://www.rand.org/pubs/monographs/2005/RAND\\_MG341.pdf](http://www.rand.org/pubs/monographs/2005/RAND_MG341.pdf)

<sup>4</sup> Buerhaus P., Staiger DO, Auerbach DI. *The Future of the Nursing Workforce in the United States: Data, Trends and Implications*. 2008.

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Despite the growing need for new nurses, a survey from the American Academy of Colleges of Nursing shows that nursing schools turned away more than 40,000 qualified applicants to baccalaureate and graduate nursing programs in 2007. More than 70 percent of nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into nursing programs. During this current academic year, there are 814 faculty vacancies at 449 nursing schools across the country, with most of those vacancies in doctoral-level positions.<sup>5</sup>

More recently, the situation has become even more dire, as state budget cuts force schools of nursing to suspend enrollment or cut faculty positions.

As the job market tightens, many part-time nurses are increasing their hours to full-time, and retired nurses are re-entering the workforce to make up for a spouse's lost income. More than half of the nation's hospitals, according to a recent American Hospital Association survey, are making or at least considering layoffs. All of these effects of the economic downturn may create an artificially low demand for nurses, masking the prolonged, persistent shortage of nurses and nurse faculty. When the economy recovers, the impact of this temporary, apparent stabilization could further exacerbate the nurse shortage. There continues to be significant vacancies across health care and community health settings: in hospitals, in community health centers, in nursing homes and within home health agencies.

The last statistics I'll note on the problem are related to the demographics of the aging nursing workforce; by 2010, it's expected that 40 percent of the nursing workforce will be over the age of 50. The average age of a full professor of nursing, with a doctoral degree, is 59.1 years; the average age of nurse faculty retirement is 62.5 years.

## Promising Solutions to the Nurse Shortage

RWJF has supported research and programs that lead us to conclude that solving the nursing shortage is within our reach. Of course, we are not doing this alone, and we can't do it alone. We have many partners, and although we are committing significant resources to develop and evaluate models and approaches, solving this problem will require action at the national level and the commitment of significant resources.

As we work together to address the shortage of nurses and nurse faculty, the results of our grantees' and partners' work suggest the following steps be taken:

- First, increase the number of nurses with baccalaureate degrees to create a larger pool of nurses who qualify to pursue teaching careers in nursing.
- Second, increase graduate education financial assistance to enable more nurses to attend graduate school and obtain teaching qualifications.
- Third, encourage the private sector to adopt evidence-based best practices, including better use of technology, to improve the retention of nurses in clinical care roles.
- And finally, support research to gather the evidence of how nursing care links to high-quality patient care and outcomes.

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<sup>5</sup> See the "Special Survey of AACN Membership on Vacant Faculty Positions for Academic Year 2008" available online at <http://www.aacn.nche.edu/IDS/pdf/vacancy08.pdf>

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I want to highlight more specifically a few promising programs and strategies for addressing the shortage of nurses and nurse faculty.

RWJF has awarded more than 700 scholarships to students entering one-year postbaccalaureate nursing programs at 58 schools. These scholarships support accelerated nursing degrees for students who already have a degree in a discipline other than nursing, and who as non-first-time students typically are ineligible for federal aid programs.

A recent summit here in Washington, D.C., included participants from 47 states and D.C., to discuss best practices to expand nursing education capacity. State partnerships of nurses, educators, consumers, business, government and local philanthropy are working collaboratively on a wide range of projects to improve nursing education. They're exploring practical and creative solutions like using shared curriculum, providing online education and using simulation centers for training. They also are exploring opportunities to improve students' transitions from associate to baccalaureate programs, and to increase the diversity of the nursing workforce.

I'm also pleased that RWJF is supporting an innovative program in our home state of New Jersey to ensure that we have a well-prepared, diverse nursing faculty and workforce. In partnership with the New Jersey Chamber of Commerce, we are currently supporting two nursing collaboratives, one at the master's level and one at the Ph.D. level, that will support the development, implementation and evaluation of new model curricula that prepare students for the nurse faculty role. In addition, we are currently providing career development awards to 15 outstanding junior nurse faculty across the country, through our national Nurse Faculty Scholars program, and will have another 15 scholars named this spring.

Finally, we've just launched a program that will support evaluations of models, programs and innovations that have demonstrated potential to increase enrollment and teaching capacity; improve nurse faculty work-life and satisfaction; and/or enhance nurse faculty recruitment and retention. Even as we and our partners experiment with creative ideas to address the problem, we want to be sure that we build the best evidence to understand which strategies will be most effective for expanding nursing education and attracting and retaining nurse faculty.

As we consider the critical task of fixing the pipeline issue – ensuring that the education system can graduate new nurses—we also must be attentive to the number of nurses who are reluctant to stay in their jobs.

A tracking survey of newly-licensed nurses by researchers at New York University and the University of Buffalo found that 18 percent of new nurses had changed jobs within one year, and more than a third said they felt ready to leave their jobs. Nurses also reported that it was not salary or even benefits that topped their list of the most important work characteristics; it was having the support, resources and ability to do the job well. Perhaps not surprisingly, then, the top reasons cited for leaving a nursing position were poor management and job-related stress.<sup>6</sup>

A vicious circle surrounds the nursing profession. Fewer people are entering nursing, which has led to a shortage. Because of the shortage, nurses who remain in hospital work must care for more patients under increasingly difficult working conditions. Because of these strained working conditions, more

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<sup>6</sup> Kovner CT, Brewer CS, Fairchild S, Poornima S, Kim H and Djukic M. "Newly Licensed RNs' Characteristics, Work Attitudes, and Intentions to Work." *American Journal of Nursing*, 107(9), pp.58–70, 2007. Available online at <http://www.rwjf.org/pr/product.jsp?id=20712>

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nurses leave the hospital workforce, thereby worsening the shortage and making recruitment of new nurses more difficult.

One program that has been successful in reducing turnover on medical/surgical units—an area of the hospital with generally high rates of turnover—is an initiative developed with the Institute for Healthcare Improvement, called *Transforming Care at the Bedside*, or TCAB.<sup>7</sup>

We know that medical/surgical nurses spend only about a third of their time delivering direct patient care—much of their time is spent filling out paperwork, tracking down medication or supplies, or doing other kinds of administrative tasks.

The idea behind TCAB is to identify, test and evaluate nurse-led innovations to improve nursing processes, which in turn can improve both nurses' satisfaction and the quality of care that patients receive.

It's as much about putting nurses in the driver's seat—identifying problems, brainstorming solutions, and having the authority to implement them—as about the innovations themselves. But some simple changes, like keeping supplies at the bedside rather than in a central storage area, or identifying patients at risk of falling by outfitting them with ruby-red socks, have on many units increased morale, increased the time that nurses are spending in direct patient care, reduced accidents and errors, and decreased nurse turnover.

Ultimately, a three-pronged strategy—to address the faculty shortage, increase the pipeline of new nurses and retain experienced nurses—is what it will take to solve the nursing shortage.

## Primary Care Workforce

In addition to the nursing shortage, we recognize that there is also a shortage of primary care physicians, with a predicted shortfall of as many as 40,000 primary care doctors by 2025. I know that one of the other panelists today will speak to the primary care workforce issue more broadly, but I want to say a few words about the role of the nurse practitioner as we think about access to care in underserved areas.

Nurse practitioners are the fastest-growing group of primary care professionals in the country, with more than 120,000 practicing nurse practitioners currently practicing, and close to 6,000 new nurse practitioners prepared each year.<sup>8</sup>

However, nurse practitioner graduations are no longer growing fast enough to meet escalating demand. Too few nurses can afford the additional training to become a nurse practitioner because of declining financial support for program development and inadequate student scholarships and loans. The tuition benefits hospitals have provided their nurse employees in the past to pursue nurse practitioner training are disappearing in the current economic downturn. Health reform will be seriously hampered if we do not support expansion of nurse practitioner training.

Nurse practitioners are able to prescribe medication, including controlled substances in most states, and nearly 40 percent have hospital admitting privileges. In 23 states, nurse practitioners can practice independently of physicians. In a randomized trial, the quality of patient care—both health outcomes and

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<sup>7</sup> See The Transforming Care at the Bedside (TCAB) Toolkit available online at <http://www.rwjf.org/qualityequality/product.jsp?id=30051>

<sup>8</sup> See *Why Choose A Nurse Practitioner as your Healthcare Provider* available online at <http://www.aanp.org/NR/rdonlyres/5C81057B-9C87-4C88-AD6D-6F78BDC55207/0/FAQsWhatisanNP31408.pdf>

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service utilization—were comparable between physicians and nurse practitioners.<sup>9</sup> It has long been established that using nurse practitioners is also cost-effective—nurse practitioners in a physician practice can decrease the cost per patient visit by as much as a third.<sup>10</sup>

Nurse practitioners also are essential to the nation's network of community health centers. More than one-third of ambulatory visits are now provided by non-physicians, including nurse practitioners. Nurse practitioners have staffed the recent largest expansion of community health centers since the Great Society Program; the centers now serve more than 16 million mostly underserved patients in more than 7,000 sites. The rapid growth of retail clinics to approximately 1,000 sites that provide 3 million ambulatory visits annually are staffed largely by nurse practitioners. The reforms in primary care, prevention and management of chronic illness being considered as part of health system reform will not be possible without thousands more nurse practitioners.

Yet barriers remain to using nurse practitioners as widely and as wisely as seems reasonable. Current Medicare rules allow nurse practitioners to certify people for admission to long-term care facilities, but not for home health or hospice care. As Congress addresses both the shortage of primary care physicians and the need to control health care spending, I encourage you and your colleagues to think about opportunities to use nurse practitioners, who provide vital health care services in rural and other underserved areas, much more widely and more effectively.

## Disparities in Health Care

Of course, it's not only in rural areas where disparities in access to health care exist. I was vice-chair of the Institute of Medicine committee that produced the 2002 *Unequal Treatment* report. We reviewed hundreds of research studies documenting gaps in care between black and Hispanic and white patients, and it was sobering. We found that racial and ethnic disparities in care persisted, even when other factors such as health insurance and income level were equal.

An essential step is increasing the quality and availability of health care language services for patients with limited English proficiency. Poor communication can lead to devastating, even deadly consequences for patients. A study by the Joint Commission examined the difference in the impact that adverse events had on people with limited English proficiency, compared to English-speaking patients. Nearly half of the patients with limited English proficiency reporting adverse events experienced some degree of physical harm, compared with less than a third of English-speaking patients; the rate of permanent or severe harm or death was more than 2.5 times higher for patients with limited English proficiency.<sup>11</sup> Language can affect care quality and outcomes.

With nearly 20 percent of the nation's population speaking a language other than English at home, our health care system needs to do a better job of ensuring that all patients, regardless of the language they speak and understand, receive high-quality, culturally competent care. The patient-provider relationship is so essential to good health care, and when the two can't communicate, the quality of the interaction and the quality of care suffers.

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<sup>9</sup> Mundinger, MO, et al. "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *Journal of the American Medical Association*, 283(1), pp.59–68, Jan. 2000.

<sup>10</sup> Office of Technology Assessment *The Cost and Effectiveness of Nurse Practitioners*. Washington, D.C.: U.S. Government Printing Office, 1981.

<sup>11</sup> See *What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety*, 2007. Available online at [http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving\\_health\\_literacy.pdf](http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving_health_literacy.pdf)

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I'll never forget a story that Glenn Flores M.D., F.A.A.P., from Wisconsin told me. In one of his studies, he taped and translated exams of 70 Spanish-speaking children in several Boston emergency departments and clinics. He found dozens of dangerous translation errors. In one instance, a nurse ordered an oral antibiotic to clear up a 7-year-old's ear infection. The mother spoke no English—and a bystander pulled in to translate told her to pour the drug directly into the girl's ear. We don't all have to be doctors to know that pouring an oral antibiotic into a child's ear isn't going to cure the ear infection. What can we do to change this?

An RWJF program called *Speaking Together* helped hospitals demonstrate effective ways to help patients get the care they need by weaving language services into the fabric of clinical practice. That means making sure that all patients with limited English can communicate with their health care team through a bilingual provider or a trained medical interpreter. Even a few small changes can make a big difference: asking patients their preferred language; ensuring clinical staff know how to find an interpreter when they need one; or placing a sign over a child's bed to indicate that she doesn't speak English.

Patients who have access to trained medical interpreters when they need them—particularly at critical points in a health care encounter, like admission and discharge—are more likely to use preventive services and experience greater satisfaction with their care.<sup>12</sup>

What does it take to provide high-quality language services? Here's what the Speaking Together hospitals have learned:<sup>13</sup>

- **Language services should be included in every discussion about improving quality.** Communication is essential to quality; language services need to be included in improvement efforts in the organization.
- **Meaningful improvement is possible.** The Speaking Together hospitals demonstrated that quality improvement techniques can be applied to language services for the purposes of measuring and improving performance.
- **The power is in the data.** Hospitals can report data on language services performance and use this data to engage clinicians and leadership in making change in the organization.
- **Clinician involvement is key.** Clinicians are ultimately responsible for making sure that the language needs of their patients are met. Without clinician involvement, an organization cannot ensure that all patients are receiving quality care.
- **Language services cannot “go it alone.”** The language services department can work to improve the quality and accessibility of services, but it takes a multidisciplinary team to measure and improve the quality of language services delivery—including, but not limited to clinicians, front-line staff, registration and scheduling staff, quality improvement departments and senior leadership.

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<sup>12</sup> See Jacobs EA, Lauderdale DS, Meltzer D, et al. “Impact of Interpreter Services on Delivery of Health Care to Limited English-Proficient Patients.” *Journal of General Internal Medicine*, 16(7), pp.468–474, July 2001. Kuo D and Fagan MJ. “Satisfaction with Methods of Spanish Interpretation in an Ambulatory Care Clinic.” *Journal of General Internal Medicine*, 14(9), pp.647–650, Sept. 1999.

<sup>13</sup> See the Speaking Together Web site at [www.speakingtogether.org](http://www.speakingtogether.org)

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- **Investment is necessary to achieve quality.** Like many services in health care, some investment of time and financial resources is necessary to improve the quality of language services. Individuals responsible for allocating resources in an organization need to make a commitment to language services in order to improve overall quality of care.

## Improving Health Care Quality

The lessons and strategies from programs like TCAB and Speaking Together are now being integrated into RWJF's signature initiative to improve the quality of health care in the United States, called *Aligning Forces for Quality*. Aligning Forces aims to lift the overall quality of care in targeted communities and, at the same time, close racial and ethnic gaps. The initiative aligns the key players—those who give care, those who get care, and those who pay for care—within 14 geographic regions across the United States, representing about 11 percent of the nation's population. The 14 Aligning Forces community teams<sup>14</sup> have committed to collecting and publicly reporting on measures of health care quality (for example, the percentage of patients with diabetes who receive regular eye exams, or the percentage of patients who receive appropriate preventive screenings) by the end of 2009; they also will collect patient data by race and ethnicity.

Physicians and other health care providers want to provide the best possible care for their patients, and most think that they're performing well. Yet we know that Americans receive only about half of recommended treatment.<sup>15</sup> Collecting data about the gaps in care allows providers to understand where they're falling short, and to make improvements in those areas. Through Aligning Forces, we're not simply showing the providers their data and saying, "Hey, you're doing a terrible job; good luck with that." We and our grantees are providing assistance to help them do a better job, to apply the lessons learned over the years about what it takes to improve the quality of care for all patients and to close the gaps in care.

It's important that providers be part of the solution. Sometimes, the solutions are simple once you have the data and ask the right questions. For example, RWJF's *Expecting Success* program—another model that is being incorporated into the Aligning Forces work—supported 10 hospitals across the country in their efforts to improve cardiovascular care, with a particular emphasis on improving care for African-American and Latino patients.

We focused on this area because there is strong evidence of racial and ethnic gaps, both in care and outcomes, in treatment for heart disease. Heart disease is a leading killer of African Americans. And cardiac care is an area of medicine where the standards of care are well-established.

The hospitals generated and reviewed data that told them about the overall quality of care they were provided, as well as whether there were gaps between different racial and ethnic groups. And oftentimes, just by asking the right questions, and just by virtue of collecting the data and paying attention, they were able to improve. Suddenly, some hospitals saw that there was a poor level of compliance with discharge instructions among Hispanic patients, just like Glenn Flores saw in his research. And it hit them like a ton of bricks: all of their written materials were in English.

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<sup>14</sup> The 14 Aligning Forces communities: Cincinnati; Cleveland; Detroit; Humboldt County, Calif.; Kansas City, Mo.; Maine; Memphis; Minnesota; Seattle; South Central Pennsylvania; West Michigan; Western New York; Willamette Valley, Ore., and Wisconsin.

<sup>15</sup> McGlynn EA, Asch SM, Adams J, et al. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine*, 348(26), pp.2635–2645, June 2003. Available online at <http://www.rwjf.org/pr/product.jsp?id=14090>

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These steps are seemingly so straightforward and simple: measure the quality of care delivered in each group, implement interventions designed to improve the quality of care for each group, and measure again. Through this process, the Expecting Success hospitals made impressive progress: At one hospital, counseling for smoking cessation jumped from 71 percent to 100 percent; at another, heart attack patients receiving an angioplasty balloon within 90 minutes increased from 17 percent to 100 percent during the two years of the program. Across the 10 Expecting Success sites, the percentage of patients receiving all recommended care for heart failure improved 37 percent over two years.<sup>16</sup>

This notion of “Making Health Care Work for American Families” really is about putting the patient at the center of the relationship, ensuring that our health care system provides access to good care and preventive services for everyone in this country.

Thank you for the opportunity to testify today, and for your attention to these issues that include but reach beyond ensuring health care coverage as we strive for comprehensive, meaningful health reform.

*Review Risa Lavizzo-Mourey’s presentations, commentaries, interviews and media briefings at the President’s Corner of the RWJF Web site at [www.rwjf.org](http://www.rwjf.org).*

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<sup>16</sup> See the report, *Expecting Success: Excellence in Cardiac Care: Results from Robert Wood Johnson Foundation Quality Improvement Collaborative* available online at <http://www.rwjf.org/files/research/expectingsuccessfinalreport.pdf>