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COMMENTS
on the
United States Senate Committee on Finance Policy Options for Transforming the Health Care Delivery System

The Network for Regional Healthcare Improvement commends the Committee for advancing many important and innovative ideas that can help to create a more value-driven healthcare system in the U.S., and offers the following comments and recommendations.

Implementation of Quality Measurement at the Regional Level

- Support the work of Regional Health Improvement Collaboratives in creating and operating measurement and reporting programs on healthcare quality and cost, and in providing assistance to providers and practitioners to improve the quality and value of healthcare. (See page 2 below for more detail.)
- Enable Regional Health Improvement Collaboratives to use Medicare claims data as part of quality reporting initiatives. (See page 4 below for more detail.)
- Ensure that EHRs and other HIT systems provide the capability for providers to improve their performance on quality measures and to submit data to regional quality measurement and reporting programs. (See page 5 below for more detail.)

Dissemination/Utilization of Comparative Effectiveness Research

- Utilize Regional Health Improvement Collaboratives to disseminate and encourage the utilization of comparative effectiveness research information, and to collect and analyze data needed to support comparative effectiveness research. (See pages 6 and 8 below for more detail.)
- Support research on ways to overcome barriers to efficient utilization of effective treatments and services. (See page 8 below for more detail.)

Medicare Participation in Regionally-Defined Payment Reforms

- Provide the authority and the resources to enable Medicare to participate in locally-defined payment and delivery system reform projects. (See page 10 below for more detail.)

Embedded Decision Support for Reducing Unnecessary Services

- Support the use of embedded decision support tools to reduce unnecessary and inappropriate use of imaging and other services. (See page 11 below for more detail.)

Building a Strong Regional Health Improvement Infrastructure

- Provide funding to support comprehensive strategies for health reform at the local level, developed and coordinated by Regional Health Improvement Collaboratives. (See page 12 below for more detail.)

1. Improving Quality Measurement (pp. 21-23 of Policy Options Report)

We were pleased to see that the Committee recognizes the importance of strengthening and expanding quality measurement and reporting. Measurement is an imperative for reforming health care, since we can't solve problems if we don't know they exist and don't know if solutions are working. Measurement and public reporting on the quality of healthcare are important tools for enabling healthcare providers to improve their care, for helping consumers to choose high-quality providers, and for more effectively engaging both consumers and providers in managing health and improving outcomes. Moreover, as the Committee works to move healthcare payment away from volume-driven fee-for-service systems and toward value-driven structures such as bundled episodes and comprehensive care payment, it will be even more important to have publicly-reported quality measures that can reassure the public that the quality of healthcare is improving.

Needed: Priority for Supporting Implementation at the Regional Level

Although efforts to develop new and improved measures should continue, much more emphasis is needed now on *implementation*: the actual collection and public reporting of measures. It is not enough to develop quality measures; effective mechanisms are needed to collect the data, publicly report on performance, and most importantly, actively use performance measures to improve the quality and value of healthcare.

Moreover, the primary focus for implementation efforts should be at the *regional level* (i.e., in states and metropolitan areas), not the national level. Patients choose healthcare providers in regional markets, not national markets, and initiatives to improve quality are most commonly organized at the state or local level. Indeed, the leadership to date in quality measurement and reporting, particularly public reporting on the quality of physician services, has come from the more than 50 Regional Health Improvement Collaboratives across the country. For example:

- The California Cooperative Healthcare Reporting Initiative collects information on the performance of over 20,000 physicians, including the quality of patient experiences, and issues reports comparing the performance of 148 physician groups and 8 different health plans. (See the *2008 Report on Quality* at www.cchri.org.)
- The Greater Detroit Area Health Council reports quality information on health plans, hospitals, and physician organizations through its Save Lives, Save Dollars initiative. (See www.gdahc.org.)
- The Iowa Healthcare Collaborative publishes comparative reports on quality and patient safety information for over 40 hospitals in the state. (See the 2008 Iowa Report at www.ihconline.org.)

- The Louisiana Health Care Quality Forum has generated reports on unwarranted variation in the quality and cost of healthcare across the state. (See www.lhcqf.org.)
- The Maine Health Management Coalition publishes quality ratings on physician practices, health plans, and hospitals. (See www.mhmc.info.)
- Massachusetts Health Quality Partners publishes ratings of physician groups in the state on 30 different clinical quality measures and 7 measures of patient experience. (See www.mhqp.org.)
- Minnesota Community Measurement produces Minnesota HealthScores[SM], which compares over 50 medical groups and over 300 clinics on 12 measures of clinical quality, and it also issues reports on healthcare disparities in the state. (See www.mnhealthscores.org and www.mncm.org.)
- The Puget Sound Health Alliance produces Community Checkup, which enables comparisons of 50 physician groups in 200 clinics, and over two dozen hospitals on a wide range of clinical quality measures, and it has also issued reports on disparities in healthcare quality between Medicaid and commercially-insured patients within the state. (See www.wacommunitycheckup.org and www.pugetsoundhealthalliance.org.)
- The Wisconsin Collaborative for Health Care Quality publishes comparisons among 20 physician groups on 17 quality and patient access measures, comparisons among 22 hospitals on 37 clinical quality measures, and comparisons among 5 health plans on 17 quality and patient satisfaction measures. (See www.wchq.org.)

Moreover, it is important to note that several Collaboratives have pioneered the collection and reporting of data on *patient experiences and satisfaction*, a challenging but essential element of a comprehensive system for ensuring quality care.

Needed: Funding for Regional Quality Measurement and Reporting Efforts

However, there has been no federal financial support for these regional quality measurement and reporting efforts, which has impeded their ability to initiate measurement and reporting programs, to maintain and improve such programs, and to ensure maximum utilization and effectiveness of the programs. Even though many Regional Health Improvement Collaboratives have been formally recognized and federally chartered by the U.S. Department of Health and Human Services through its Chartered Value Exchange program, and while the Agency for Healthcare Quality and Research (AHRQ) has provided technical assistance to Collaboratives in developing and implementing quality measurement and reporting efforts, there has been no funding to help cover the significant costs of an effective local quality measurement and reporting program.

Expanded efforts to collect and report patient experience and outcome data are particularly critical, but these are the most expensive and challenging measures to

produce, and an area where federal funding is particularly needed. In addition, measures of the cost of care – which are essential if we are to truly measure *value*, not just quality – are critically needed, and resources will be needed to support not only collection of this information, but appropriate analysis and communication of that information to effectively support patient decision-making.

Federal funding needs to be specifically authorized and appropriated to support the work of Regional Health Improvement Collaboratives to collect data on the cost and quality of healthcare, particularly data on patient experiences and outcomes, to publish those data and encourage their use by the public, and to use the data to work with providers and practitioners to improve the quality and value of healthcare.

Needed: Access to Data, Particularly Medicare Claims Data

Although Regional Health Improvement Collaboratives have been playing a lead role in public reporting using quality measures endorsed by the National Quality Forum, most have been forced to do so using only claims data from commercial insurance plans. Current restrictions in federal law prohibit the use of Medicare claims data by Regional Health Improvement Collaboratives, even though the Collaboratives have well-established systems for protecting the confidentiality of patients and providers. As a result, many quality reports cannot provide a complete picture of the quality of health care, particularly for senior citizens. The restrictions in current law exceed those governing private third party payers and state Medicaid programs, which in many regions are sharing their claims data to support these public reporting programs. Recent efforts to provide aggregated Medicare claims data to regional collaboratives have proven to be ineffective in enabling the production of all-payer quality measures for all patients cared for by a provider.

Regional Health Improvement Collaboratives need the ability to access Medicare claims data and permission to publicly share standardized measures of the cost and quality performance of providers and practitioners based on those data for non-commercial uses. Appropriate changes will likely be needed in both HIPAA and the Privacy Act of 1974. In light of the extensive experience Collaboratives have had in using private health plan data for these purposes, we would be happy to help the Committee develop appropriate standards for the release of these data to ensure patient level data are protected from public release, and to ensure that only valid and reliable measures on providers are published using transparent methodologies.

In addition to the contribution of data by Medicare, **there should be a requirement that all healthcare payers and providers contribute quality and cost data to support regional initiatives to measure and report on healthcare value.** Quality data from all sources – Medicare, Medicaid, and private payers – are needed to develop statistically robust measures that can provide meaningful guidance to both providers and consumers on performance differences. Although many regions already are obtaining quality data voluntarily from health insurers, this often requires lengthy and complex negotiations. In addition, there need to be ways of measuring the costs of services across all payers, in order for meaningful comparisons of value to be made.

There are enormous opportunities to improve the efficiency of delivery of healthcare, but in order to identify these opportunities and capitalize on them, measures of cost and value are essential.

Needed: Integrating Health IT into Quality Measurement and Improvement

Although current quality measurement programs are a major advance, their ability to improve care is constrained by the inherently *post hoc* and time-lagged nature of today's measurement systems. Rather than merely telling physicians, hospitals, and other providers how they performed after the fact, the ideal should be to help them identify what should be done *before* the opportunity is missed. Moreover, rather than waiting for data to be processed and reported back to them through periodic comparative quality reports, they should have the capability of continuously analyzing their own performance so that they can make immediate improvements in performance.

Realizing this vision will require the use of information technology, such as electronic health records, but unfortunately, many EHR systems do not have capabilities such as patient registries which enable identification of patients who have not received appropriate care and which enable analyses of performance on quality measures to be easily generated.

Consequently, in addition to the assistance and incentives for healthcare providers to adopt electronic health records discussed in the previous section of the Committee's report ("Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals," pages 19-21), **we would recommend that there be a more explicit goal of ensuring that EHRs and other HIT systems incorporate the capacity to deliver patient-specific reminders on key clinical processes at the point of care, to identify patients who should be proactively contacted to receive care, to enable providers to analyze their own performance on key quality measures, and to enable providers to automatically submit their performance data to regional quality measurement and reporting programs.**

2. Comparative Effectiveness Research (pp. 24-25 of Policy Options Report)

Needed: Dissemination of Comparative Effectiveness Research

The options in the Committee's report focus primarily on the generation of research about the clinical outcomes of alternative therapies or treatment strategies. However, equal or greater attention is needed to the *dissemination* of research. The value of any comparative effectiveness research depends critically on whether healthcare providers and consumers are *aware* of the results, *understand* the results, and are *able to use* the results successfully in making decisions about treatments and services. There is already extensive information available about the effectiveness of many types of treatments and services, but much of it is not being used effectively to improve the quality and efficiency of healthcare. Consequently, **it is critical for the federal government to invest adequately in programs that will successfully disseminate the results of both existing and new comparative effectiveness research.**

Although national dissemination efforts will have some value, it is likely that the most effective approaches will be:

- locally organized and implemented, so that they can tie the information to the specific types of services that are available locally;
- done through a collaborative effort of healthcare providers, payers, consumers, and employers, so that use of the information is endorsed and supported by peers; and
- implemented in conjunction with quality reporting and quality improvement initiatives, so that providers, payers, and consumers can receive the support and assistance they need to make changes in the delivery of care based on the comparative effectiveness information.

Regional Health Improvement Collaboratives are ideally positioned to organize local dissemination activities quickly and to ensure they are designed and implemented in ways that will reduce waste in the healthcare system and improve patient outcomes:

- Doing so is consistent with their core mission, since good comparative effectiveness research that is used by consumers, physicians, hospitals, employers, health plans, and others will support the Collaboratives' goals of improving healthcare quality and reducing costs in their communities.
- Most Collaboratives are already engaged in consumer education about choosing providers and treatments or are planning to implement consumer education and engagement programs in the near future.
- Many Collaboratives provide training and coaching for healthcare providers that have been proven to be effective in eliminating waste and inefficiencies and increasing the providers' ability to consistently and successfully use evidence-based guidelines.

- All Collaboratives develop and implement programs with the active involvement of providers, consumers, payers, and purchasers. Indeed, Collaboratives can serve as a form of "one-stop shop" to help coordinate dissemination activities in their communities by other health-related organizations, ranging from business health coalitions to healthcare provider associations.

Some examples of the kinds of successful dissemination efforts by Regional Collaboratives include:

- Minnesota Community Measurement (www.mncommunitymeasurement.org) has established "The D5: 5 Goals for Living With Diabetes" (www.thed5.org) to make it easier for people with diabetes to manage their condition and to find the healthcare providers who can most effectively help them.
- The Pittsburgh Regional Health Initiative (www.prhi.org) is using research on effective self-management support programs for patients with chronic disease and on effective identification and intervention programs for patients with depression and substance abuse problems to reduce hospital admissions and readmissions, thereby reducing costs and improving patient outcomes.
- The Institute for Clinical Systems Improvement (www.icsi.org) designed guidelines for the use of high-technology diagnostic imaging and helped physicians implement an embedded decision support system for use of imaging that has replaced health plan prior authorization systems and saved millions of dollars.
- Massachusetts Health Quality Partners (www.mhqp.org) has worked with physicians to develop and disseminate evidence-based practice guidelines and quality improvement tools for chronic disease care.
- The California Quality Collaborative (www.calquality.org), HealthInsight (www.healthinsight.org), the Pittsburgh Regional Health Initiative (www.prhi.org), and other Collaboratives work with physician practices to improve the efficiency and effectiveness with which they deliver evidence-based care.
- The Oregon Health Care Quality Corporation (www.q-corp.org) has developed patient-friendly materials to help people select quality healthcare providers and work with them to develop appropriate treatment plans.

However, Collaboratives need more funding to carry out this important dissemination role successfully. Even though the federal government has recognized the important role that Collaboratives play through the HHS/AHRQ Chartered Value Exchange program, there is no federal funding support to help Collaboratives carry out any of their existing programs, much less to implement extensive new dissemination activities related to comparative effectiveness research.

We recommend that funding be specifically authorized and appropriated for grants to Regional Health Improvement Collaboratives to enable them to support the dissemination and utilization of comparative effectiveness research information.

Needed: A Strong, Regionally-Based Data Collection and Reporting Infrastructure

It is impossible to compare the effectiveness of alternative treatments and services, particularly in real-world settings, without a mechanism for collecting and reporting data on the use of treatments and the outcomes achieved when they are used. Moreover, it is impossible to know whether comparative effectiveness research is having an impact on the types of treatments utilized by providers and patients unless there is a system for collecting and reporting such data.

The fastest and most cost-effective way to do this is to build on the extensive quality measurement and reporting infrastructure which has already been developed in a number of regions around the country by Regional Health Improvement Collaboratives such as the California Cooperative Healthcare Reporting Initiative (www.cchri.org), the Greater Detroit Area Health Council (www.gdahc.org), the Iowa Healthcare Collaborative (www.ihconline.org), the Louisiana Health Care Quality Forum (www.lhcqf.org), the Maine Health Management Coalition (www.mehmc.org), Massachusetts Health Quality Partners (www.mhqp.org), Minnesota Community Measurement (www.mncommunitymeasurement.org), the Puget Sound Health Alliance (www.pugetsoundhealthalliance.org), and the Wisconsin Collaborative for Healthcare Quality (www.wchq.org).

We recommend that funding be explicitly authorized and appropriated for use by Regional Health Improvement Collaboratives to expand the number of measures collected; to help establish and enhance registries, data repositories, and health information exchanges and to utilize them to improve data collection and reporting; and to more extensively analyze these data and expand comparative performance reporting for providers, researchers, and the public.

Needed: Research on Ways to Overcome Barriers to Efficient Utilization of Effective Treatments and Services

What really matters is not the effectiveness of a treatment or service under *ideal* circumstances, as is generally the case in clinical trials, but its effectiveness in *actual practice*. If physicians do not recommend the treatment or do not implement it correctly, or if patients do not accept or adhere to the treatment regimen, then its practical effectiveness may be significantly lower than what clinical trials may suggest. For example, although use of long-acting bronchodilators reduces hospitalizations for patients with COPD, studies have shown that 80% of patients with inhalers do not use them properly, and many do not even get their prescriptions for inhalers filled.

Research is needed to identify the technical assistance and coaching programs, educational tools, insurance benefit designs, and provider payment methodologies that most effectively assist and encourage both healthcare providers and consumers to utilize evidence-based treatments and services and to eliminate the use of unnecessary and ineffective services. Regional Health Improvement Collaboratives can serve as important laboratories and partners in carrying out this type of research, and **we urge**

that priority be given to Comparative Effectiveness Research that is done in cooperation with Regional Health Improvement Collaboratives.

Specifically, we would recommend a focus on the following three areas:

a. **Identifying the most effective strategies and consumer-friendly tools that healthcare providers and Regional Health Improvement Collaboratives can use to assist and encourage consumers to improve their health status and adhere to treatment plans.**

b. **Identifying the most effective strategies that Regional Health Improvement Collaboratives can use to assist and encourage physicians to recommend cost-effective treatments and to implement them consistently and efficiently.**

c. **Identifying insurance benefit designs and provider payment methodologies which enable patients and physicians to utilize more cost-effective treatments.**

For example, reducing co-payment levels for existing chronic disease maintenance medications, eliminating "doughnut holes" in pharmacy benefit plans for these drugs, and providing reimbursement to support patient-centered medical home services for patients with chronic disease would likely do more to increase the effectiveness of chronic disease care than any new drug or treatment. A number of Regional Health Improvement Collaboratives are working with health insurance plans and purchasers in their communities to redesign payment systems and benefit designs to achieve greater value in health care.

3. The Medicare Health Care Quality Demonstration Program (p. 19 of Policy Options Report)

A number of Regional Health Improvement Collaboratives are currently working to design reforms to health care payment and delivery systems and to encourage the payers in their region to implement those reforms. However, since Medicare is often one of the largest payers in a region, it is very difficult for health care providers to improve the way they deliver care if private payers improve their payment systems but Medicare does not. For example:

- In Minnesota, the Institute for Clinical Systems Improvement has developed the DIAMOND Initiative to improve the quality of care for people with depression. Under the program, primary care practices hire a care manager to provide education and self-management support to patients with depression, and psychiatrists are paid to providing consulting support to the care managers and physicians in managing the patient's condition. All commercial payers in the community are supporting this new model, and it is already proving effective, but the physicians cannot be reimbursed for the new way of delivering services to Medicare patients under current Medicare rules.
- In conjunction with the Pittsburgh Regional Health Initiative, the Governor's Office of Health Care Reform and the Governor's Chronic Care Commission have developed and are implementing a project to help physician practices implement the Wagner Chronic Care Model to improve the quality of care for patients with chronic disease. All commercial payers have agreed to participate and share the costs of additional services, but because Medicare is not participating, many physician practices may have financial difficulties implementing some of the most important additional services.

Based on experiences such as these, we believe it is important that Medicare be able and willing to "follow as well as lead" on payment and delivery system reforms. Although CMS's current payment reform demonstrations are laudable and should continue, CMS also needs to participate in regionally-defined payment and delivery system reform projects that can present a clear business case for controlling costs as well as improving quality. Moreover, by increasing the probability of Medicare participation in locally-defined reforms, it would reduce the barrier that Medicare payment systems often present to such reforms.

Consequently, we support the proposal to permanently authorize Section 646 of the Medicare Modernization Act. However, we would urge that in addition to providing the *authority* for CMS to participate in locally-defined demonstration projects, CMS should be given the administrative *resources* needed to evaluate and respond quickly to proposed demonstrations, and that there be explicit and relatively short deadlines for both CMS and OMB to respond to such proposals. Furthermore, we would recommend that CMS and OMB clearly define in advance the information that is needed and the standards to be met in terms of budget neutrality, etc. so that regions that wish to make proposals will clearly know what is expected.

4. Promotion of Adherence to Appropriateness Criteria for Imaging Services (pp. 8-9 of the Policy Options Report)

We support the Committee's desire to find ways to reduce the inappropriate and unnecessary use of expensive imaging services. However, rather than examining the use of radiology benefit managers, **we would urge you to support the use of embedded decision support tools, an approach that is already being tested in Minnesota by the Institute for Clinical Systems Improvement (ICSI) and is proving successful.**

ICSI facilitated a collaborative that developed a set of appropriateness criteria for high-technology diagnostic imaging (HTDI) tests based on American College of Radiology and American College of Cardiology standards. But rather than have these criteria used by a radiology benefit manager, and rather than require prior authorization processes, the ICSI collaborative incorporated these criteria into a decision support tool which the physician can use to determine immediately which exam (if any) is most appropriate for each patient. This not only decreases unnecessary exams, which saves time, money and reduces radiation exposure, it improves the physician-patient relationship and increases patient support for the decision, since it enables the physician to discuss the decision directly with the patient, rather than deferring the decision to a third party. Moreover, the system enables the physician to receive direct feedback on compliance with the criteria and to correlate that with outcomes data, which can help to improve the "gray areas" in the guidelines.

This approach has already been piloted in Minnesota and has resulted in a dramatic leveling in the growth of use of HTDI. It has already saved $28 million and is estimated to have the potential to save $60 million per year when it is expanded statewide.

A similar approach could clearly be used in many other areas to reduce the unnecessary use of expensive services.

More information on ICSI's approach is available at http://www.icsi.org/health_care_redesign_/diagnostic_imaging_35952/.

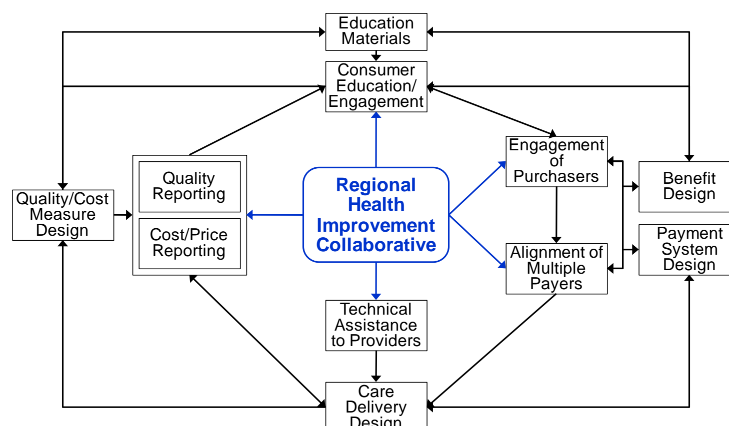
5. Building a Strong Regional Health Improvement Infrastructure (New)

Particularly with the changes recommended above, a number of the payment reform options outlined in the Committee's report could go a long way toward solving the problems of high cost and poor quality in the healthcare system.

However, while payment reforms are necessary to transform healthcare delivery, they are not sufficient. To be successful, *coordinated* changes are needed in *multiple* areas – not only reforming payment systems, but changing benefit designs to reward quality and value, redesigning care delivery systems to be more efficient and better coordinated, creating effective performance measurement and reporting systems, and educating and assisting consumers to take an active role in maintaining their health and choosing high-value healthcare services.

Moreover, there is unlikely to be a single, one-size-fits-all national approach to healthcare reform that will work equally well in all parts of the country. Health care is a fundamentally regional enterprise, since most providers and even most payers operate exclusively or primarily in metropolitan regions or states. Moreover, every region of the country is different in terms of the number, types, and relationships of healthcare purchasers, payers, and providers.

Regional Health Improvement Collaborative Roles in Healthcare Reform



Regional Health Improvement Collaboratives are needed to play the critical planning, coordinating, and support roles that will ensure these many inter-related changes happen successfully. Regional Health Improvement Collaboratives can help to build consensus among healthcare providers, health plans, employers, consumers, and others on the changes needed in their local healthcare systems, and then provide support and coordinate the implementation of those changes.

Fortunately, there are over 50 Regional Health Improvement Collaboratives in the U.S., all working to improve the quality of healthcare services while controlling skyrocketing costs.

Regional Health Improvement Collaboratives design and implement programs ranging from public reports on the quality and cost of physicians, hospitals, health plans, and other healthcare providers, to projects that reduce hospital-acquired infections and improve the health of people with chronic diseases, to fundamental transformations in payment and delivery systems.

However, Regional Health Improvement Collaboratives struggle to obtain the funding needed to support their programs and operations. HHS has recognized the importance of these regional approaches to transparency and quality improvement by chartering twenty-four such efforts as “Chartered Value Exchanges” or CVEs. Yet these regional organizations receive no direct federal funding for their important transformative work.

We urge that federal funding be specifically authorized and appropriated for grants to Regional Health Improvement Collaboratives to support their activities. We also urge that this funding not come at the expense of the other programs that support quality measurement, public reporting, and improvement. We believe that funding for the work of Regional Health Improvement Collaboratives will more than pay for itself through reductions in costs for Medicare and private health insurance facilitated by their programs.