

TESTIMONY
to the
Institute of Medicine
Committee on Comparative Effectiveness Research Priorities
from
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Mr. Chairman and Members of the Committee, thank you for the opportunity to provide input as you work to develop recommendations to Congress and the Secretary of Health and Human Services regarding the priorities for use of the comparative effectiveness research funds appropriated in the American Recovery and Reinvestment Act of 2009 (ARRA).

I represent the Network for Regional Healthcare Improvement (NRHI), the national coalition of Regional Health Improvement Collaboratives across the country. Regional Health Improvement Collaboratives are *non-profit organizations* that work to *improve healthcare quality and value* in a *specific geographic region* of the country (typically either a metropolitan region or state), *through a collaborative effort of multiple healthcare stakeholders* (providers, payers, purchasers, and consumers).

There are over 50 Regional Health Improvement Collaboratives in the U.S., all working to address the most important challenge facing healthcare today – how to improve the quality of 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 readmissions and improve the health of people with chronic diseases. A number of these Collaboratives have been designated as Chartered Value Exchanges by HHS.

Regional Health Improvement Collaboratives in the U.S.



We would urge that in your report, you include the following items as priorities:

- 1. Identification of Treatments and Strategies That Successfully Prevent Avoidable Hospitalizations and Readmissions, Particularly for People With Chronic Disease.**

Most of the public attention and controversy regarding comparative effectiveness research has been about identifying health care treatments and services that should be reduced

or eliminated because they are not effective or not cost-effective. However, of potentially greater importance and impact is identifying and encouraging use of treatments and services that will prevent or reduce the need for other, more expensive treatments and services.

In your report to Congress and HHS, we would urge that priorities for comparative effectiveness research should include:

a. Treatments and Services That Reduce Hospital Readmissions

A clear priority should be identifying treatments and services which can cost-effectively reduce the high rate of hospital readmissions and many of the initial admissions. Analyses conducted by the Pittsburgh Regional Health Initiative, MedPAC, and others have shown that among patients who are discharged from the hospital, 15-25% are readmitted within 30 days, and the largest volume of readmissions occurs among patients with chronic disease. The President is budgeting \$2.5 billion in savings for Medicare over the next 5 years from reduced payments to hospitals for readmissions, but achieving these savings will require programs and strategies for successfully reducing these readmissions in a cost-effective manner.

A variety of studies have shown that 30-50% of these readmissions can be prevented for many patients through simple, low-cost interventions, such as patient education and self-management support. But this research has not been systematically assembled into an action agenda for healthcare providers. Moreover, it will be important to encourage the rapid development and implementation of new models for reducing hospital readmissions and quickly evaluating their impact. For example, the Pittsburgh Regional Health Initiative (www.prhi.org) is carrying out several innovative projects to reduce hospital readmissions for patients with chronic disease and patients with depression through collaborations between hospitals and primary care physicians. Research will be needed to determine which elements of these projects are most critical to success so they can be replicated more broadly.

b. Treatments and Services That Prevent Disease and Hospitalization

Although finding ways to reduce hospital readmissions will likely have the most immediate impact in improving quality and reducing costs, attention is also needed to identifying effective strategies for reducing the incidence and severity of chronic disease. It is likely that success here will require community-based interventions, in addition to or instead of healthcare “treatments.” For example, the Greater Detroit Area Health Council (www.gdahc.org), the Louisiana Health Care Quality Forum (www.lhccf.org), the Healthy Memphis Common Table (www.healthymemphis.org), and other Regional Health Improvement Collaboratives have organized broad-based community efforts to reduce the growth and severity of chronic disease. Comparative effectiveness research on these types of interventions should be done in conjunction with these Collaboratives.

c. Treatments Affecting Large Numbers of Patients and Amounts of Spending

Most media attention focuses on decisions about the use of very high cost treatments, but in many cases, these decisions affect relatively small numbers of patients and a small proportion of total spending. In light of the urgent need to control healthcare expenditures, the priority should be on assessing the effectiveness of alternative treatments that affect large numbers of patients and have the greatest potential for reducing healthcare spending without negatively affecting patient outcomes. Clearly, as suggested above, this implies (1) a focus on patients with chronic disease, and (2) a focus on low-cost treatment options (such as patient self-management education) that can avoid or reduce the use of high-cost treatment (such as hospitalization).

2. Identification of Barriers to Utilization of Cost-Effective Treatments and Services, and Strategies for Overcoming Those Barriers

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.

In your report to Congress and HHS, we would urge that priorities for comparative effectiveness research should include:

- 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.**

For example, 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 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.

- 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 effectively.**

For example, 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, and 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.

- c. **Identifying benefit designs and provider payment methodologies that 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 healthcare.

3. Support for Regional Approaches to Education and Engagement of Consumers and Physicians in Making Value-Based Choices

ARRA makes it clear that the funding for comparative effectiveness research is to be used not just for *development* of research, but the *dissemination* of research. Just as the real effectiveness of a treatment or service depends on whether it is actually used, the value of comparative effectiveness research depends on whether it is used successfully to influence treatment decisions.

Although national dissemination efforts will have some value, it is likely that the most effective approaches will be locally organized and implemented, particularly when done in conjunction with quality reporting and quality improvement initiatives. Regional Health Improvement Collaboratives are anxious to assist in the dissemination role, 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 are already engaged in consumer education about choosing providers and treatments.

However, Collaboratives need more funding to carry out this 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 them carry out their programs.

In your report to Congress and HHS, we would urge you to reinforce the very important role that Collaboratives do and can play in the dissemination and utilization of comparative effectiveness research. In addition, a portion of the funding for research should be used to compare the effectiveness of alternative methods of dissemination, using Collaboratives as natural laboratories.

4. Support for 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 unless there is a system for collecting and reporting such data.

ARRA calls for funding to be used to “encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.” A priority here should be 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.qdahc.org), the Iowa Healthcare Collaborative (www.ihconline.org), the Louisiana Health Care Quality Forum (www.lhcgf.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.wchg.org).

In your report to Congress and HHS, we would urge you to recommend that additional resources be provided to Regional Health Improvement Collaboratives to enable them 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.

In summary, we urge a very pragmatic focus to the priorities you recommend for use of comparative effectiveness research funding, and we urge close coordination with and increased support for the important health improvement activities being undertaken by Regional Health Improvement Collaboratives across the country.

We commend you for taking on this critically important and challenging task in such a short period of time. NRHI and its member Collaboratives would be happy to assist you in any way we can.

Sincerely,

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