Section I Demographics:
Organization Type: Association
Organization Type (if Other):
Organization Name: Network for Regional Healthcare Improvement
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Designated Point of Contact
First Name: Elizabeth
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Related Experience: The Network for Regional Healthcare Improvement is the national organization of leading Regional Health Improvement Collaboratives. We have over 30 members across the US covering over 40% of the US population. The large majority of our members support clinical practice improvement through a range of strategies including cost and quality measurement, private and public reporting, leadership training, data management and reporting, education, technical assistance and best practice sharing. NRHI members lead and/or are lead partners in multiple initiatives including State Innovation Model awards, HIEs and Regional Extension Centers, MAPCP and PCPI, Hospital Engagement Networks, QIOs, APCDs and other national projects to drive practice transformation. Elizabeth Mitchell is President and CEO of the Network for Regional Healthcare Improvement and previously led a statewide Regional Health Improvement Collaborative in Maine after working in quality improvement, employer engagement and public policy for an integrated health system.

Section II. The name and contact information of the organization whose views are represented in the submission, if that contact information differs from that provided in Section I.

Organization Type: Please Select...
Organization Type (if Other):
Organization Name:
Mailing Address:

Designated Point of Contact
First Name:
Last Name:
Email:

Phone Number:
Fax Number:
Related Experience:

A. Practice Transformation Strategies, Resources and Opportunities

1. Based on your organization's experience and understanding, what does a transformed clinical practice look like?

A transformed clinical practice is completely oriented around its patients' needs and preferences, is responsible for patient individual and population outcomes and accountable for costs. This is demonstrated in terms of (1) access- open access scheduling, phone, text and email contact options, and evening and weekend hours; (2) data and integrated health information technology to support improved communication with and for patients, and to inform providers of utilization, quality and cost including real time notifications and comparative outcome information for benchmarking (3) transparency- publicly reported quality, cost and patient experience scores; (4) connection to community resources and social supports- including community care teams, social services and public health; (5) integrated behavioral and physical health services; (6) team-based approach to care with integrated care management; (7) partnerships with patients and families including community and home-based support; (8) referrals for secondary and tertiary care informed by valid cost and quality information; (9) demonstrated leadership with providers visibly championing a commitment to improve care; and (10) time available for patients as needed, when needed.

2. Clinical practice transformation can occur through many forms and avenues. When you think about clinical practice transformation, what forms and avenues do you think it should take? Which avenues would you find most valuable and would maximize quality and outcomes?

A considerable amount of practice transformation support is not high-tech but about communication, leadership and culture. This can take a variety of forms- one on one coaching, peer mentoring, and learning collaboratives. In some cases creating a neutral forum for provider communication can have an important impact on transformation. In Maine we brought physicians together from across a health system who had not had the opportunity to talk directly with colleagues about practice patterns and ways to improve care. With expert facilitation and a neutral forum - and endorsement from system leaders- they identified multiple opportunities for improvement in both quality and cost. As examples: a radiologist asked the PCPs to order fewer films and the PCPs shared that they thought it was an expectation of the radiology department. An oncologist asked PCPs and other specialists to help him manage patient expectations and support him when he decided to pursue less aggressive- but more realistic- treatment options. All acknowledged that there were multiple ways to improve care and reduce waste if they had their colleagues' cooperation. This is a first step toward transformation and with follow up, support and measurement can generate a range of improvements. All payer and clinical data systems will be required to take efforts to scale but are not a prerequisite for engagement. On site QI assistance to help practices assess current performance, develop their team and formulate their improvement plans will maintain momentum. Practice transformation is inherently about improving relationships and as such are best done in local, trusting, personal forums.

3. What are the existing sources of national, state and local expertise available to assist with leadership development, clinician engagement and overall transformation? What gaps can CMS help to close to build upon these efforts?

There are a range of excellent resources e to support practice transformation efforts including the following: (1) National resources, available at no cost: Health Care Communities, HRSA (www.healthcarecommunities.org/Home.aspx); Safety Net Medical Home, Commonwealth Fund/ GroupHealth (www.safetynetmedicalhome.org/); AHRQ Effective Health Care Program (http://effectivehealthcare.ahrq.gov); (2) National resources, with fees for some services: Institute for Healthcare Improvement (IHI) (www.ihi.org); TransforMED (www.transformed.com/); provider professional organizations – e.g. AAFP; AAP; ACP, including ACP Practice Advisor online tool; (2) State resources: These are available in most states, though levels of expertise and local engagement can vary widely: CMS-designated QIOs; Area Health Education Centers (AHECs); state medical societies; universities, colleges, and community colleges; (3) Local resources: Regional Health Improvement Collaboratives (RHICs): the Network for Regional Healthcare Improvement (NRHI) defines RHICs as “non-profit organizations based in a specific geographic region that are governed by a multi-stakeholder board composed of healthcare providers, payers, purchasers of health care, and consumers... that help stakeholders in their community identify opportunities for

improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities" . Over the past two decades, over 40 RHICs have been established across the country, many of which focus on providing QI services for transformation. Many of these have significant expertise in offering QI support to local providers and serve as national exemplars, most notably Institute for Clinical Systems Improvement (ICSI); Maine Quality Counts; Iowa Health Collaborative; and the Wisconsin Collaborative for Healthcare Quality. CMS could support RHICs to help fill gaps in existing QI infrastructure.

4. What should CMS consider if it were to organize a program of technical assistance to support the transformation of clinician practices and to prepare for effective participation in value based payment? What should CMS consider to ensure local "on-the-ground" support to practices? In such a program, what if any role by the state would you find useful?

CMS should first avoid disrupting strong local organizations with existing relationships and a recognized quality improvement role in their communities. Displacing or creating competition for effective QI programs is unnecessarily disruptive and can derail community progress already underway. Strong regional presence, trusted leadership and access to data by local organizations should be built on, not undermined or duplicated. Leveraging a network of regional QI organizations- like the Network for Regional Healthcare Improvement- could accelerate change and ensure some level of appropriate standardization while preserving strong relationships and responding to local needs. CMS could further support this work by ensuring access to all payer claims data at a state/regional level and clinical data across populations in each region. This could be built on the QECP, HIEs and/or other multi-payer claims data resources. Population data is essential for providers to manage population health. It is also important to engage all stakeholders because transformation is only possible with change from all parties. Providers alone cannot change the system- purchasers must change how they pay for care to enable delivery system change, plans and vendors must share data freely, benefit designs must incent appropriate utilization and patients need to be supported by the practice and in the community to manage their own health and effectively partner with providers. Regional Health Improvement Collaboratives bring all o the stakeholders to the table to coordinate change from all sectors. Practices need transformation support but more importantly they need the existing barriers to payment change and data access effectively addressed.

5. What key areas of practice transformation require attention?

We would suggest that the areas for practice transformation that require QI support and attention are defined by the key elements of a transformed practice i.e.(1) Leadership capacity and skills; (2) Team-based approach to care, including professional training for enhanced roles in the practice such as up-skilled medical assistants, EMR scribes, health coaches, population health managers, and nurse care managers; (3) Population risk stratification and management; (4) Practice-integrated care management; (5) Ensuring enhanced access to care; (6) Behavioral-physical health integration; (7) Partnering with patients and families to improve care: (8) Connecting to community resources and social supports; (9) Reducing avoidable healthcare spending and waste; (10) Integrating and optimizing health information technology and the use of data to improve patient-centered care. Additionally, many practices, particularly small and independent organizations, could benefit from building skills to assess and manage efficient financial practices; this is a significant need as many of those practices struggle to maintain financial viability and are often not able to address issues of transforming practice until their fundamental business structures are stabilized. Homer and Baron also offer a useful framework for considering the critical elements for practice transformation , including the following (1) Leadership; (2) Resources to support practice investments in new personnel, space, and systems; (3) Skills to establish and maintain relationships; (4) Patient and family engagement; (5) Competent management and finances; (6) Quality improvement techniques; (7) Expert and facilitated QI assistance; (8) Health IT; (9) Capacity to deliver care coordination; and (10) Professional and staff roles and training.

6. What policies or standards should CMS consider adopting to ensure that groups of solo, small practices and rural providers have the opportunity to actively participate in practice transformation?

A key barrier to participation by small practices is lack of financial resources to support data systems and dedicated QI staff and the inability to access integrated data for populations. This may require them to join large systems to access this capacity but they may find that they not only relinquish autonomy and culture but that systems to not distribute improvement resources intended for practices. This integration may also contribute to higher prices from purchasers. A shared community non-profit resource with data and QI staff could reduce the cost burden and redundancy of multiple improvement systems while helping to preserve small practice independence and physician leadership. Payment reform is also essential to enable greater flexibility of time and staff to work towards transformation.

7. What practice transformation strategies, resources, and tools are most needed to prepare smaller practices to successfully participate in private and public sector pay for value arrangements?

One of the key strategies for engaging smaller practices in practice transformation and pay for value arrangements is the need to change payment models to allow these practices to innovate, and to reward them for investing in practice transformation to become more efficient and patient-centered. Additionally, CMS should support the ability of local QI organizations (or Regional Health Improvement Collaboratives) to offer a range of QI support services for small and rural practices that is responsive to their particular needs (e.g. supporting mentoring to develop leadership skills; on-site QI assistance; and distance-based learning), and regularly solicits feedback from these providers to monitor the effectiveness of QI methods being offered. CMS should also support the data needs of small practices since, unlike practices that are part of larger health systems and provider groups, many of them do not have the resources to build their own systems for accessing data feedback and reporting and lack critically important data to identify high-risk patients, or monitor their progress in impacting cost and resource use.

8. Are there private sector organizations interested in providing practice transformation support if matching federal dollars were available?

There are over 40 Regional Health Improvement Collaboratives across the country, all of which are neutral, non-profit conveners and many of which focus on providing QI services for transformation. These include the Pittsburgh Regional Health Initiative, Wisconsin Health Quality Collaborative, Oregon Quality Corporation, Maine Quality Counts, the Institute for Clinical Systems Improvement and many more. Many practice transformation consultants are often cost prohibitive and unable to provide customized assistance that small practices need. Practice transformation should occur in conjunction with other national and local initiatives and adapt to practices' current status and readiness. This is best provided by a local entity that can align other efforts. Some private foundations are also making significant investments in quality improvement that should be leveraged if federal investments are made.

9. What should CMS consider as it relates to beneficiary and caregiver experience of care when practices transform?

Transformed practices should improve patient experience. CAHPs tools should be broadly used to measure and monitor patient experience of care over time and to inform transformation efforts. Subsidies may be required for broad adoption of CAHPs and less expensive, technology supported survey methods should be expanded. Many RHICs have extensive experience administering CG-CAHPs including Massachusetts Health Quality Partners, Minnesota Community Measurement and Maine Quality Counts some with statewide survey efforts. Their experience implementing these surveys, working with physicians and practices to understand the results and developing standardized approaches should inform CMS' approach. Other NRHI members, including HealthInsight are assisting practices and groups of practices to create patient and family advisory committees. These committees can be used to better understand how patients experience care in a practice and can serve as critical input for new transformational activities prior to their implementation.

Models like the ones developed by the Patient and Family Centered Care Partners should be considered. CMS should also promote tested, effective patient engagement models (motivational interviewing, etc) and promote open notes access.

10. Which existing educational and assistance efforts might be examples of "best in class" performance in spreading the tools and resources needed for practice transformation? What evidence and evaluation results support these efforts?

Many NRHI member Regional Health Improvement Collaboratives have designed, operated and sustained best in class QI support in their regions. Pittsburgh Regional Health Initiative (PRHI) developed PA SPREAD, a quality improvement and Patient Centered Medical Home educational and support initiative in the Penn State College of Medicine with funding from AHRQ to lay the foundation for a Primary Care Extension Service to support ongoing primary care transformation and quality improvement. In 2011 and 2012, PA SPREAD and the Northwest and South Central AHEC offices led regional PCMH-focused learning collaboratives and provided practice facilitation support for 15 primary care practices. Participating practices made statistically significant one-year quality gains on a range of measures. These accomplishments are notable because practices received no financial incentives for their PCMH and improvement work. More than 7 have now attained Level 3 NCQA PCMH recognition. Members of the PA SPREAD team also supported PCMH implementation in the 150 primary care practices in PA's Chronic Care Initiative. PRHI provides a formal yet customized curriculum to effectively convey practice transformation change concepts and provide leadership, management, providers and staff with the work flow and QI methodologies required and also provides access to on-line environments which support self-directed learning, remote coaching, inter-practice collaboration and sharing of quality data. PRHI received a 3 year $10.4 million award from CMMI to create a series of six hospital based Primary Care Resource Centers to address readmission reduction and the interface between the hospital and primary care settings. Other RHICs including HealthInsight and Maine Quality Counts serve as QIOs and/or lead Regional Extension Centers that have successfully moved practices through transformation. RHICs help align programs across the community and decrease facilitation costs.

11. How useful is the rapid sharing of results in facilitating practice transformation and improving health outcomes?

Rapid data sharing at the provider, practice and community level is key to practice transformation. There must be a transparent methodology tied to risk adjustment, cost, utilization and clinical outcomes to support actionable data. Payer data must be timely (monthly or quarterly) to ensure value as feedback. Private physician dashboards within practices or systems can provide rapid quality data to guide panel and population health management Practice transformation works best when staff and patients see rapid results generated in real time from their own EHRs. Using practices' own data is most useful; accurately comparing with internal and community peers is motivating. Internal benchmarking to identify and compare best practices and to compare QI efforts over time is crucial to transformation. Ideally a community HIE could be used for peer comparisons but only if interfaced to EHRs. Competitive or external benchmarking, using comparative data between organizations and community peers is critical to judge performance and identify improvements. Many NRHI member Regional Health Improvement Collaboratives provide data, private and public reports and support to practices to use multipayer data. The participation of CMS in these kinds of regional data and improvement efforts is critical to providing rapid results and data sharing to accelerate transformation.

12. What general quality improvement strategies should practices employ to build a sustainable continuous quality improvement program (e.g., programs that rely on input and involvement from patients and staff, proven improvement processes and performance measures)?

13. How are practices using Health Information Technology (HIT) and Electronic Medical Record (EMR) technology to improve patient health outcomes? How have various organizations supported HIT integration in practice transformation?

HIT and EMR technology is helping practices to improve patient health outcomes by allowing providers to obtain more detailed data on their population. This information allows providers/practices to identify high risk and vulnerable populations, manage cost and improve care. As is being demonstrated by NRHI members, including the Louisiana Health Care Quality Forum, HIT and EHR's provide tools and resources for patient education and can improve continuity of care and communication between provider and patient through the use of portals. However, while many practices report using HIT/ EMRs in some capacity, a majority report limited use of EMR to track patient care and support population health management or to optimize outcomes as measured by the ability of practices to meet "meaningful use" criteria. In Maine Quality Counts' experience, many practices are using EMRs and have developed registry functionality to identify and track patients with a limited number of chronic conditions, but most acknowledge gaps in optimizing HIT in terms of maximizing efficiencies and the ability to track only a limited number of conditions in the EMR; limited use of the statewide HIE; limited use of clinical decision support and electronic prescribing; suboptimal clinical quality reporting, and limited use of patient portals. HealthBridge in Cincinnati working with Summit Family Physicians in Ohio demonstrated that the transformation process -- from using paper records to being an electronically connected, high performing PCMH ready to participate in a payment innovation project – can happen in just over a year. Because of their RHIC efforts (AF4Q, HIE, REC, Beacon, and CPC) they have had the ability to form teams across organizations to combine a High Tech/High Touch service and product line that combines in-practice support, webinar facilitation, EHR/HIE/HIT implementation and maximization, along with QI improvements for a facilitated practice support plan.

14. How are practices addressing race, ethnic, primary language, and disability status health disparities in their work to improve patient health outcomes? How have organizations leveraged practice transformations to support reduced racial and ethnic disparities?

15. How are practices using population-based strategies to improve patient health outcomes? How have organizations supported population-based strategies in practice transformation?

Many practices have developed population-based strategies to improve patient outcomes using data sources to identify patients by levels of need, and then directing care management resources to provide additional outreach and support to high-needs patients. In Maine, practices participating in the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demo have direct access to two payer portals: first, Medicare has contracted with RTI to create a beneficiary portal that identifies high-risk patients assigned to each practice and provides reports that stratify patients based on utilization to identify those at high need or high cost. Second, Maine's Medicaid program has developed a portal that identifies members identified as high need or high cost, and allows practices to drill down on reports of high utilization or care gaps. Practices then assign population health and/or nurse care managers to conduct outreach and education for patients with care gaps or those needing additional support. Additionally, the Maine Health Management Coalition has used its multi payer claims database to generate reports on practice performance in cost and quality across payers with statewide performance benchmarks. Leveraging SIM funding these reports are being made available to all practices statewide with analytic support to interpret the reports and inform improvement.

B. Challenges and lessons learned in Practice Transformation engagement.

16. What are the most significant clinician challenges and lessons learned related to transforming a practice and what solutions have been successful in addressing these issues?

In considering the challenges in working with clinicians to transform primary care practices, it is clear that the majority of these fall into the category of "adaptive change" as described by Heifetz and others who propose that complex changes can be characterized as having components of both technical and adaptive change. Adaptive changes are those that include complex challenges; require transformation of long-standing habits and deeply held assumptions and values; trigger perceptions and feelings of loss; and require solutions that

require new learning, relationships, and ways of thinking – all characteristics of the complex changes required for practice transformation. Comprehensive practice transformation can require two to three years of intensive work. Therefore, practices need support to build the skills needed to succeed over this extended period of time. Regional collaboratives allow for shared learning and accountability alongside expert facilitators and experienced leaders who can help practices overcome progressive challenges along the journey. Among the most significant challenges for clinicians is the interim effect that the process change effort has on the bottom line. The short-term learning curve and rapid-cycle process improvement process temporarily decreases provider productivity. Without funding to offset this intensive work, providers can face the dual challenge of higher costs and lower revenue. Advising providers and their office managers about the likely decrease in productivity allows the clinicians to make adjustments in their work schedules.

17. What are the operational challenges, lessons learned, and successes in developing an infrastructure to support transformation?

The current payment system and data ownership models create significant barriers to practice transformation. Practices are not paid to communicate with patients outside of the office or electorinically, they are not paid flexibly to allow time with patients beyond short visits, QI work is not paid for, transformation support is often cost-prohibitive, and fragmentation of care is incented. Busy and undertrained clinicians require comprehensive technical assistance to help them assess workflow, processes and baseline measures to develop an appropriate improvement plan. Practices seeking to transform will require changes in payment to avoid significant financial penalties for changing care. This may require additional spending for the primary care practice but is likely to reduce overall spending in healthcare. The NUKA primary care system in Alaska spends 10x what most practices pay for their primary care model but their total costs are 25% below average- as a result of fewer hospitalizations and reduced need for secondary and tertiary care. Current data access is limited by business models that treat claims and clinical data as proprietary and limit the ability to aggregate and use the data for improvement. Fragmented data from individual payers does not enable population health management. Aggregated data without the ability to identify individual patients does not enable targeted improvement. The cost of aggregating and analyzing data is frequently prohibitive when done by for profit consulting companies. These two barriers are among the most significant obstacles to transformation.

18. How can physician/clinician affinity groups be leveraged to strengthen the care process and for improve patient outcomes?

Physicians and their teams can benefit from forums to share learnings and experience with colleagues. However, informal affinity groups without skilled leadership and structure will not generate change. These forums are most effective with multi-specialty participation, targeted and sequenced priority initiatives informed by data to understand results, a commitment to transparency with peers and a commitment to eventual public reporting, and with external stakeholders appropriately involved to ensure accountability to community needs. Varying levels of skillsets and education among clinic staff could be offset by supporting a standardized but tailored curriculum to address knowledge and skill deficits among clinical professional, clerical and administrative staff. Organizing clinicians, particularly providers from small and rural practices who may not otherwise be part of larger provider groups, could offer important opportunities for peer networking and valuable interactions for providers engaging in these efforts.Providing free education and training at times and locations convenient for clinicians would also improve the collective knowledge and practices across groups. Many NRHI members host, facilitate and lead physician and mutlistakeholder forums to support improvement. Wisconsin Collaborative for Healthcare Quality as an example serves and the facilitator and convener of collaborative learning events. Leveraging performance metrics and a scorecard, they are focusing initially on three conditions where clear opportunity for improvement exists and are forming a partnership with their QIO and State Department of Health Services to align efforts.

19. What are the essential lessons learned from other industries where best practices on systems transformation and learning culture have been adopted?

The recurring essential lesson learned from other industries is involving customers, users, workers, managers and leaders in the transformation process. Many lessons can be learned from other industries that can help to inform the work of practice transformation. These include manufacturing and the use of lean production and six sigma management principles to eliminate waste and improve value: There are many excellent examples of health care organizations that have adapted the lessons of lean workflow analysis and redesign from industry to streamline care and improve efficiencies. The concepts of lean design and six sigma can and should be offered as part of practice redesign efforts. Pittsburgh Regional Health Initiative has led LEAN work in healthcare across Pennsylvania with dramatic improvements in care.

20. What challenges that have not been successfully addressed to date need to be addressed to achieve desired outcomes in health, healthcare, and more affordable care?

21. What information privacy challenges are anticipated or have been experienced in the transformation of practices? How have these challenges been addressed? What specific local, state or federal requirements presented these obstacles?

C. Engagement, Partnership and Continuous Learning in Practice Transformation.

22. What should CMS consider when spreading innovations through learning systems?

There are several issues that CMS should consider when spreading innovations through learning systems: (1) All health care is local: Efforts must be made to support transformation efforts in each state and community, and to identify and engage trusted sources of QI support for practice transformation. While CMS can be helpful to these efforts to by communicating a clear vision for transformation, setting policy, establishing standards, and catalyzing supportive payment reform, practice change ultimately occurs at the local level, and must be supported and led by trusted leaders in each community (potentially at the state level). 'Tool kits', webinars and presentations will not transform care. CMS should respect and build on local work already underway and not disrupt successful quality efforts. Requirements to re-bid successful initiatives can undo any progress made. CMS should address the legal and business barriers to data access in communities that will serve as the foundation for improvement. Competing data sources generate more noise than improvement. CMS should also recognize that the current number of initiatives can create cacophony and burn out in the field. There is momentum and readiness to change in multiple regions but even the most dedicated leaders can get discouraged when the goalposts continue to move or support is not sustained. A deliberate, coordinated and targeted approach plus follow through support to take identified innovation to scale are needed. Janet Yellen recently called for a community 'quarterback' for change- RHICs can play this role in health. (2) Payment systems must be changed to support practice transformation.

23. What should CMS consider regarding how QIOs, Regional Extension Centers, States and other existing entities can support practice transformation?

To be successful, practice transformation must occur among all payer types and patient types. To ensure multistakeholder perspective, representation and buy-in, this may be best done through Regional Health Improvement Collaboratives. It’s crucial that CMS be open to sharing strategies and co-developing processes

and incentives with other payers and self-insured employers. Meshing the nuances of local markets and initiatives with national improvement efforts offers the best opportunity to achieve meaningful practice transformation. Payers, purchasers and providers are all challenged to think both nationally and locally. But there is still a strong need to let local communities use local data and partnerships in ways that will solidify transformation. QIOs will play a critical role in practice transformation and should be fully supported. Future funding should invest in the existing infrastructure rather than building new mechanisms. CMS should understand that state governments do not do quality improvement. States have an important role and should be at the table as purchasers, as experts, as funders, and as regulators and policymakers but the work of practice transformation happens through different relationships. Sustained trusting relationships fare best outside of a politicized environment and, with rare exceptions, few practices think of state government as their preferred partner in QI. Even states who establish successful programs are subject to complete turnover with each election.

24. What should CMS consider when working with private payors in practice transformation?

Even large private employer purchasers do not have the needed market leverage to transform care and payment alone. They need alignment and partnership with CMS. Alignment of initiatives in measurement and target outcomes is essential. Practices waste time trying to address multiple demands and are frustrated by the lack of access to private payer data regarding provider performance and costs of services provided, and often disagree with reports payers provide. While many private employer purchasers have implemented innovative benefit designs and employee engagement strategies, new approaches to measurement and technology use that may be transferrable and relevant to other populations, multipayer alignment is necessary to change the payment system to enable practice transformation. Private health plans are not trusted physician partners and, despite significant financial resources, rarely invest in practices to enable them to lead change. As an example, care management programs that are most effective embedded in the primary care practice and communities, are often considered key features of the health plan product that they are unwilling to 'unbundle' or discontinue- regardless of patient and/or provider preference. Health plan products also need to be geared to population health across all payers.

25. What should CMS consider as it works with States in practice transformation?

Practices distrust states as improvement partners. Given their role as regulators and partisan politics, many states are not seen as a neutral and credible source of support. Bringing the complexities of healthcare transformation into a politicized environment like a state Legislature increases the difficulty of change, highlights organizational interests, and undermines collaboration. The state's role should be to align Medicaid efforts and endorse an appropriate framework to ensure community engagement and provide flexible rules and regulations. CMS should also note the lack of capacity and resources in many state governments that could cause efforts like SIM to suffer from wide variation in states' ability to effectively undertake healthcare improvement work. States do, however, have regulatory powers that can enable change where voluntary efforts fail. States also often have leaders dedicated to the public good with the authority to enforce accountability. States are also, typically, one of the largest purchasers of care in any state and should be expected to lead innovative payment and benefit design strategies as purchasers.

26. What should CMS consider when aligning public and private clinical transformation efforts?

CMS should recognize the need to align and coordinate efforts across agencies, public and private entities and between national and local work. CMS should support RHICs and other efforts that bring public and private efforts together at a state or regional level and should join regional efforts as partners.

27. How has the use of knowledge management systems facilitated effective communication in learning environments (i.e., through sustainable sharing of improvement results, providing virtual technical assistance, interactions amongst large communities of practice, and the provision of on-line resources and tools)?

28. What would motivate clinicians to participate in any potential future initiatives relating to practice transformation and value-based purchasing?

The wording of this question belies a belief that physicians are not motivated to change. While this may be true of a minority, it is our experience that most physicians want to lead, want to deliver the best possible care and want to be at the table to help direct change in policy and practice. NRHI members like the Iowa Health Collaborative have seen dramatic reduction of medical errors and associated costs facilitated by skilled physician engagement and sustained transformation support. CMS would see a much greater return if it focused on removing the barriers to those who want to change than focus on motivating those who do not. These barriers – as noted above- are primarily payment systems, data and knowledgeable, trusted support to implement new delivery models. The continuation and/or development of community forums- such as Regional Health Improvement Collaboratives to identify targeted goals and meaningful measures and to facilitate coordinated change in payment and benefit design will strengthen these efforts.

29. What would motivate new partners to enter the field of practice transformation as a prime contractor, subcontractor, or consultant?

Funding, sustained support, and clarity of role and purpose.

30. Are there other successful mechanisms that support engagement in practice transformation that could be considered?

D. Current Engagement in CMS Models.

31.What is your current relationship with CMS initiatives related to practice transformation (e.g., Accountable Care Organizations (ACOs) participating in the Shared Savings Program or the Pioneer ACO model, and the State Innovations Models (SIM)?
Most NRHI member RHICs participate in at least one CMS initiative related to practice transformation including SIM, MAPCP, QIO, HIE, REC, PCPI, ACO, etc.

32. In your transformation efforts, have you seen any program integrity issues and if so what strategies did you use to assure that your transformation efforts did not foster program integrity problems?

In both the Beacon program and with some HIEs, despite being publicly funded programs, the organizations have used their 'favored status' and/or resources developed through the program for market leverage to benefit their organizations or stakeholders at the expense of others. In many cases private employer purchasers have faced market consolidation and higher prices as a result. Governance has been a key challenge when defining who should benefit from these public investments and how. The SIM program has created numerous challenges in several states by concentrating resources and authority in state government challenging successful collaborative forums and leading to redundant development of resources already established in the community.

33. Even if you did not see any program integrity problems or issues during your transformation efforts, did you actively design strategies to mitigate any such issues? What were the mitigation strategies?

34. Are there particular program integrity issues that you think you need to address as you pursue transformation? What are these issues? What barriers do they pose to successful transformation?

35. How could CMS possibly use patient satisfaction surveys or report cards regarding practice transformation?

Transparency and accountability are an integral part of transformation. But it has been noted that data can be used as a 'weapon or a tool'. The punitive use of data to publicly shame lower performing practices will not achieve the aims of improved care. Practices and providers should be held publicly accountable for performance, but a fair and inclusive process with providers at the table will be far more effective to drive change. Physicians who are given a meaningful role in public reporting can bring critical insights to the work and champion the results more credibly than any other stakeholder. RHICs have developed processes to enable fair and reliable participation while continuing to progress towards a shared goal. Several examples were included in a recent GAO report reviewing provider feedback mechanisms. These include multiple opportunities for input, designated data review periods and processes to resolve conflicts. These processes are replicable and can and should be leveraged to meet federal objectives.

Optional Attachments:

$(Upload)

RFI Notes and Information

Agency/Office: Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Type of Notice: Request for Information

Title: Request for Information: Transforming Clinical Practices

Response Date: Tuesday, April 8, 2014

SUMMARY: The Center for Medicare & Medicaid Services (CMS) seeks information about large scale transformation of clinician practices to accomplish our aims of better care and better health at lower costs. CMS seeks responses to questions listed in the "**QUESTIONS**" section of this Request for Information (RFI). CMS may use this information collected through this RFI notice to test new payment and service delivery models.

DATES: Submit comments through the website listed in the "RESPONSE FORMAT" section by 11:59 pm Eastern on April 8, 2014.

RESPONSE FORMAT: Responses to this RFI must be provided via on-line submission at the following website here**.** Submissions are **due no later than 11:59 pm Eastern on April 8, 2014**. CMS will not accept hard-copy responses or other formats. CMS will consider only those responses that contain the information described below. Submitted responses must follow the format listed below, with responses divided into three sections. CMS will not consider additional information submitted beyond these three sections.

CMS is interested in opportunities to help promote the transformation of clinical practices to improve health and health care across the country.With the passage of the Affordable Care Act in 2010, came renewed efforts to improve our health care system. Guiding these efforts has been the CMS focus on better health, better health care, and lower costs through quality improvement and the six national priorities of the National Quality Strategy, which map to the six goals of the CMS Quality Strategy. CMS is considering initiatives to encourage practice transformation. The questions in this RFI specifically would address strategies to improve health and make quality care more affordable for individuals, families, and employers, through the development, implementation and spread of new health care delivery and value-based purchasing models. The result would be transformed clinical practices characterized by the delivery of high quality care, population-based care, cost-savings, and improved workflow.

There are nearly 50,000 providers participating in Center for Medicare and Medicaid Innovation (Innovation Center) models and over one million physicians and other clinical professionals affected by other CMS payment policies. While Innovation Center models may include technical assistance for multiple provider types, many clinician practices need assistance in developing their capacity to successfully participate in an Innovation Center model or other alternative value-based payment models (e.g., state or Medicaid models). To begin the process of transforming clinical practice, the leadership and staff of these practices must assess their success in improving patient health outcome and systems of care. They must also understand the benefits and the capabilities necessary for entering value-based payment arrangements. Then, the clinical practices would need to commit to transforming their practices and processes to adapt to those new business models. Providers who want to transform their care delivery system must then acquire the data, knowledge and skills that support high value care, and be prepared to make the infrastructure investments in systems, staffing and practice work flows and process redesign necessary to be successful.

The literature on practice transformation notes that there are identifiable characteristics of a transformed organization. (Such characteristics include patient-centered interactions, engaged leadership and a robust quality improvement strategy.) (The Commonwealth Fund Report: *Guiding Transformation: How Medical Practices can Become Patient-Centered Medical Homes;* Edward H. Wagner, M.D., M.P.H., Katie Coleman, M.S.P.H., Robert J. Reid, M.D., Ph.D., M.P.H., Kathryn Phillips, M.P.H., and Jonathan R. Sugarman, M.D., M.P.H. *February 2012*) This is recognized in the CMS and private sector models that are currently underway. Recognizing the challenge of transforming practices across the nation, CMS seeks information about strategies that could be the catalyst for transformation supporting the participation of large numbers of providers in a redesigned healthcare system via the pathway that makes the most sense for their practices.

Your responses to this RFI will help inform CMS' continued efforts to improve our healthcare system through transformation of clinical practices.

QUESTIONS: This Request for Information (RFI) seeks responses to the questions from Clinicians, Clinician Practices, Quality Improvement Organizations, Regional Extension Centers, Patient Advocacy Organizations, Health Plans, Employers, Purchasers, Consumers, Professional Associations and other members of the public about large scale transformation of clinician practices, to generate better care and better health at lower costs. The feedback from this RFI may be used to develop future Requests for Proposals and test new payment and service delivery models to assist practices in their work to prepare for participation in new value-based payment programs.

CMS asks that respondents address the following questions. Please respond to those questions that are germane to your experience and expertise.

SPECIAL NOTE TO RESPONDENTS:

Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses. CMS is particularly interested in the lessons learned from improvement programs in the areas of transformed clinical practices, health services delivery, public policy and/or the administration of complex policy programs, innovation diffusion, knowledge management, change management, community organization/mobilization, industrial engineering or manufacturing, operations research, and other disciplines that can inform the quality improvement of services delivered in health care systems or the promotion of health through community-based organizations. CMS will draw upon the responses in designing the Transformation of Clinical Practice model.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this requirement.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become Government property and will not be returned.

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