

HB 6697
Representative Linda Schofield
Public Health Committee – February 26, 2007

Chairwoman Sayers and Chairwoman Handley, and other members of the Public Health Committee, thank you for having this public hearing of HB6697. For the record, I am Representative Linda Schofield, the introducer of this bill, which would establish an organization to collect claims data and hospital data for the purposes of monitoring the quality performance of providers, providing consumers real comparative information upon which to choose providers, and supporting the establishment of quality improvement initiatives.

I have not had the opportunity to meet all of you yet, and want to give you a little background about myself, because my work experience has shown me the need for this kind of legislation. I started my career as a nurse and eventually got my Master's in Public Health. I worked as CT's Medicaid Director for nearly 6 years, was the executive director of Aetna's health plans in CT as well as Kaiser Permanente's health plans in MA. For the last 7 years I have consulted with physician associations, consumer groups, pharmaceutical companies, health plans, and state governments on health care projects, including many projects related to quality improvement and cost containment.

Some years ago, health plans began trying many different approaches to improve health care, which also results in cost containment. We invested great resources into developing physician and hospital performance profiles, which showed how well they did on a variety of HEDIS measures compared to their peers and to national practice guidelines. We thought that just providing providers data, but not sharing it publicly because of their opposition, would stimulate them to improve their performance. Sometimes it did, but often we found that high performing providers concluded that the data confirmed what they already knew...that they were performing well and needed to make no improvements.. And the lower performing providers discounted the reports as inaccurate because we didn't have an adequate sample size. To some degree they were right...we could only provide a reasonable sample size for performance data by reporting on large group practices. Individual doctors and small groups, where performance can be compromised by a lack of infrastructure to support care, had to be lumped together to get an adequate sample size, and the result was that we couldn't tell how any one doctor within the group was really performing. They each assumed they were doing the right things and the others were the cause of the poor aggregate data. The result was little change in performance.

The next generation of data based quality improvement was to negotiate pay-for-performance or gain-sharing contracts with providers. Again, this initiative was limited to large group practices and hospitals, because of the limitations of sample size that face any single payor vis a vis a small practice and because of the lack of infrastructure in a small practice to support disease registries and other quality improvement initiatives.

No one payor, with the possible exception of Medicare, really has enough members in any physician practice or hospital to have a robust data set....especially if you want to look at relatively uncommon diseases or procedures. Indeed, a health plan is lucky to have 10-20% of any physician's panel of patients.

We did have some real success with the incentivized reimbursement arrangements, when the providers were willing to negotiate such arrangements. But many were not willing or did not have an adequate volume of patients. The volume issue is especially true of specialists.

In Massachusetts, when I ran the Kaiser plan, we had one employer...the GIC...which was ahead of its time. Their benefits manager demanded that all of the health plans they contracted with had to collect and report provider data on specific topics that the GIC selected for quality improvement initiatives. This coordinated approach to having all payers prioritizing the same QI objectives with all the providers made a lot of sense. But once again, the GIC, was only one admittedly very large employer, but sample size in some parts of the state was still an issue. Most employers are not experts in promoting quality and controlling the costs of health care and look to the health plans to do this for them.

In recent years, Medicare has also jumped on the bandwagon of collecting quality data and they are undertaking a massive project to establish codes that can be collected through claims data, so that they can monitor the compliance of physicians in every specialty with nationally approved practice guidelines and metrics. Indeed, my consulting firm has established the quality metrics for three specialty physician groups to be used by Medicare that are in the process of approval by the National Quality Forum, the AMA's Physician Consortium, and AQA.

But the keys to best use of quality data is to have a large sample size, to assure that the metrics reflect national practice guidelines, to assist providers to then use the data to improve their practices patterns, and to provide transparency for the benefit of consumers. Karen Ignani, president of the trade association: Americas Health Insurance Plans said it herself: "We need to look at patients across all insurance plans...the aggregation of data is so important." Thus, the health plans are not likely to oppose making this data available – minus patient identifiers of course.

Transparency not only arms consumers with real information upon which to make choices, but it stimulates competition among providers to improve their quality performance. A study published last year in Health Affairs showed that hospitals were more likely to engage in quality improvement efforts if the results were publicly reported.

You will hear some oppose the publication of data on the basis that some providers treat sicker patients than others and would be penalized by data reporting. Let me debunk that excuse right off. The kinds of data collected are mostly process measures, not outcome measures. So, for example, we would collect data on whether a doctor did appropriate HbA1C testing on their diabetic patients quarterly in accordance with national

guidelines...not on whether the doctor's diabetic patients were sicker or healthier than other doctors' patients. Or we would collect data on whether they prescribed a beta blocker after a heart attack in accordance with national guidelines. It is true that some providers treat sicker patients, though I found in giving provider profiles to many providers, the ones that think they treat sicker patients are often not the ones that really do. And there is no reason that a doctor with a panel of sicker patients should not also be treating them in accordance with evidence based national guidelines....if anything they should be providing these patients even better treatment, not worse.

The cost of poor quality care is enormous. The CDC reported last year that more people in this country (20,000) died of hospital acquired infections than died of AIDs. Two other sources stated that 90,000 a year die of hospital acquired infections, resulting in \$4.5 billion in excess cost. The American Journal of Medical Quality reported that hospitals spent \$27,000 more on patients who acquired infections. Pennsylvania's Cost Containment Commission has focused on this area of quality improvement and had great success in reducing infection rates. The old adage "you can't manage what you don't measure" is no where more true than in health care.

We have the ability to improve care by collecting and using data, we just need to create the infrastructure in CT to do so. Many, many other states have established what are now known as Regional Coalitions for HealthCare Improvement, including all of the New England states except CT. These organizations typically do some or all of the following:

- Collect and analyze insurance claims data and also hospital data
- Public reporting of health care performance
- Develop consensus about the prevention and management of disease
- Provide assistance to delivery systems to improve performance
- Develop payment incentive arrangements
- Serve as a forum for developing electronic connectivity between providers

My bill proposes that we establish such a private non-profit organization to aggregate health plan and Medicaid data, and to collect hospital data – at a minimum on infections. The organization would need only start-up funds from the state, and then would be self-sustaining, as other Regional Coalitions are – based on grants and assessments on members.

Aside from the obvious benefits to quality, there is another benefit from establishing an organization like this. Every health plan now is required by NCQA standards to implement various quality improvement initiatives with their network of providers. IN addition, they may have P4P programs as well. Physicians and hospitals get justifiably annoyed by the lack of consistent priorities between plans for these QI projects. So while one payor wants them to focus on asthma, another is focused on diabetes this year. By having the health plans work collaboratively in a partnership with the providers, one statewide set of priorities can be crafted based on what the aggregate data show as the greatest need. This will make everyone's lives a little easier.

I am honored to have with me Barbra Rabson, Executive Director of the regional coalition for Massachusetts, which is called the Mass Health Quality Partnership. Barbra holds a Masters in Public Health from Yale. She is a national spokesperson on this topic, has published many articles, and just last week addressed Congress on the topic of data reporting to improve health quality. I so appreciate her taking the time to come and share her experience and expertise with you, and I've asked her to tell us a little about the MHQP's successes and her recommendations for how we might proceed.

Testimony of Barbra G. Rabson
Executive Director
Massachusetts Health Quality Partners
Concerning An Act Establishing the Connecticut Quality Partnership

February 26, 2007

Good morning. My name is Barbra Rabson and I am the Executive Director of the Massachusetts Health Quality Partners, an organization founded to provide **trusted** performance information to hospitals, physicians and the public in order to improve the quality of health care for residents of Massachusetts.

The Massachusetts Health Quality Partners (MHQP), which brings together all the key health care stakeholders in MA, was established in 1995. Our members include:

- provider organizations (the MA Medical Society, the MA Hospital Association, and members of MHQP's Physician Council),
- government agencies (MA Executive Office of Health and Human Services and CMS Region 1 administrator),
- employers (Analogue Devices)
- health plans (Blue Cross Blue Shield of MA, Harvard Pilgrim Health Care, Fallon Community Health Plan, Tufts Health Plan, Health New England and Neighborhood Health Plan)
- Consumers (Executive Directors of Health Care for All and New England Serve)
- Academic (Board Chair – Harris Berman MD from Tufts Medical School)

As a broad base coalition, collaboration is key to MHQP's success. There are a number of levels that MHQP collaborates on.

MHQP Aggregates Data Across our 6 member Health Plans

MHQP has over 4.5 million lives represented in our aggregated database. This is out of 6.2 million MA residents. **More data leads to greater validity** because the results are based on a greater number of cases , giving the result more statistical validity. When we report on a doctor's or medical group's performance, we report on that doctor's performance across all their patients that belong to any of these health plans, not just the 20% or so that have any single health plan.

The larger database also **allows us to report on more physicians and at a more granular level.** Methodological standards require that there be a minimum number of cases before we draw conclusions about a physician's or medical group's performance.

If we measure how a physician is caring for their diabetic patients for example, that physician must have enough Diabetic patients to draw a meaningful conclusion.

By aggregating the data, it is more like that a physician will have enough diabetics so that they can get a valid feedback report so more physicians will receive feedback about their performance.

Finally, because we aggregate the data across plans and report a single statewide report comparing physician performance, we **avoid “dueling scorecards” or conflicting/non-comparable data** where physicians and the public are given multiple reports of physician or hospital performance based on the population of each insurer or payer. When physicians get conflicting feedback reports they tend not to believe any of them, so that separate efforts are not productive.

MHQP was recently selected to be one of six quality coalitions across the country to be selected to receive Medicare data to combine with our aggregated Commercial health plan data, so MHQP will have an even more robust database.

MHQP Involves Physicians and Hospitals in Measurement Process

The purpose of our performance feedback work is to change physician and hospital behavior in ways that will improve the quality of care provided. We all know it is extremely difficult to change behavior so we must do all we can to support that behavior change. **MHQP involves those being measured in the measurement process to increase the credibility, acceptance and actionability of end results.** The collaborative process takes longer on the front end, but the performance reports we produce are accepted. **MHQP’s success is based on the fact that we are a trusted source of performance data.** As one of our physician executives put it - “Do it with me, not to me”. MHQP always provides performance reports to physicians and hospital prior to publicly reporting the information.

Engagement Among Members of Broad Based Collaborative

MHQP provides a forum to bring all of the stakeholders together to discuss how to improve the quality of health care. **By bringing the stakeholders together, each party gains a greater understanding of diverse views.** For example, physicians can share their views and concerns about making sure physicians are not hurt by unreliable performance measure side by side with employer and consumer views and concerns about the patients not having adequate information available to make informed health care choices.

MHQP’s Track Record for Public Release (see attached screenshots from MHQP’s website)

Hospital Level Performance of Patient Experiences in Acute Care Hospitals

–Our first report was a statewide hospital survey of patient experiences (public release in 1998) led to every hospital in MA engaging in quality improvement activities and awareness about the importance of improving the patient experience, including the inclusion of patient experience score goals in hospital executive compensation.

Physician Organization and Medical Group Level Clinical Performance Measures for Preventive Care and Chronic Disease Management

-Another report was a statewide report of HEDIS performance measures at the medical group level (150 groups) and physician organization level (public release in 2005 and 2006). This report led to statewide improvements on all measures (18 of 23 measures showed improvements at the statewide level.) We know that there is great variability among practices and many practices use MHQP reports internally to incentivize performance improvements among individual physicians. Most importantly by publicly comparing the performance of medical groups, medical groups accelerated the adoption of electronic medical records once they saw where they needed to be in order to compete with highest performing groups (that did have electronic medical records.)

Practice Site Level of Patient Experiences with their Primary Care Physicians

-Our most recent effort has produced a statewide survey of patient experiences in the primary care physician office for nearly 400 practices (public release in 2006). This led to awareness of the importance of listening to patients about their experience of care. Since this annual report was released, anecdotally patients have reported their physicians have been more responsive to listening to patients and making sure there is better communication between patients and doctors. It is too early to know the full impact. In 2007 MHQP will be repeating the survey and adding a survey of patient experiences with groups of specialists – OB/GYNs, cardiologists and orthopedics.

MHQP's experience mirrors that of the research that public release of performance information motivates hospitals and physicians to improve care and systems in order to be competitive and have a good reputation.

To conclude, MHQP is a regional quality coalition, a model for health care improvement that has been embraced by leading health care markets across the country. **There are over 50 regional quality coalitions across the country**, some statewide and others focused around single markets like Pittsburgh. As Representative Schofield mentioned, there are regional coalitions in every New England State BUT Connecticut. Each coalition has a different catalyst, but for some reason Connecticut until now has not had that catalyst.

These coalitions are increasing in number and have recently been recognized by the federal government that sees the benefit of local health care reform efforts sponsored by a trusted, independent source. These coalitions have reduced hospital infection rates, implemented statewide electronic prescribing, demonstrated that statewide public reporting of quality performance information can improve the quality of healthcare for

the residents and more. It's time for Connecticut to join the other regions of the country and embrace regional healthcare improvement.

Below are the names and websites of the regional coalitions from the other New England states, and a website for the Network for Regional Healthcare Improvement, a new organization working to spread and support regional coalitions.

Thank you and I'd be happy to answer any questions.

New Hampshire Foundation for Healthy Communities
www.healthynh.com

Massachusetts Health Quality Partners
www.mhqp.org

Maine Health Management Coalition
www.mhmc.info

Rhode Island Quality Institute
www.riqi.org

Vermont Program for Quality in Healthcare
www.vpqhc.org

Network for Regional Healthcare Improvement
www.nrhi.org

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