Testimony of Elizabeth Mitchell

CEO, Maine Health Management Coalition and Foundation
and
Board Chair, Network for Regional Health Improvement
to the
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
February 14, 2013

Key Points:

1. **Change is urgently needed.** Patients, employers, communities and states face unsustainable healthcare cost increases that are hurting job growth, wages, and siphoning needed funds from other priorities including education and infrastructure. They are unable to continue to absorb increases in costs.
2. **High costs do not correspond to high quality.** Though some care is excellent, our current system is inefficient, ineffective and in many cases makes it more difficult for providers to deliver optimal care. Over 30% of care provided in the US today does not improve patient health or is not provided efficiently. Improvement opportunities must be successfully identified to be addressed.
3. **There is no 'one size fits all' solution.** Quality and costs vary dramatically across the country and across communities. This has been documented for over 30 years. Given regional variation, there is no single solution to improving care and reducing costs- improvement opportunities and priorities vary by region.
4. **Data is essential to improvement.** Data plays many critical roles in healthcare improvement including:
    1. **Identifying priority cost and quality improvement opportunities;**
    2. **Enabling performance measurement and public reporting;**
    3. **Establishing cost and quality performance targets;**
    4. **Informing choice by consumers;**
    5. **Engaging physicians and other stakeholders in care improvement; and**
    6. **Managing population health.**
5. **Multipayer data is very difficult to obtain.**
6. **Medicare's Qualified Entity program is an important step toward giving communities and providers the information they need to improve care and value.** CMS should not only continue to enable qualified groups to share data for improvement, but should consider accelerating that work with financial resources and greater flexibility.
7. **Data is valuable only if it is used effectively.** Despite decades of research on unwarranted variation and failures in care, data has rarely been effectively used for improvement.
8. **Regional Collaboratives should be considered key implementation partners in care improvement.** Regional Health Improvement Collaboratives are capable stewards of multipayor data and are experienced leaders using data with physicians and community stakeholders to improve care.

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Mr. Chairman and members of the Subcommittee on Health, my name is Elizabeth Mitchell and I am the CEO of the Maine Health Management Coalition and Foundation. Thank you for the opportunity to speak today because, speaking on behalf of my members and my state, the urgency of the problems you have committed to address could not be overstated. State government and employers cannot absorb ever increasing costs without any corresponding increase in quality and value, employees and unions cannot go additional years without pay increases or even jobs, and our provider members are increasingly burdened in a system that does not reward high performance and creates daily barriers to improving care for patients. In short, we need to dramatically transform care and payment. Thank you for taking on this challenge.

Thank you also for soliciting input from a Regional Health Improvement Collaborative. The Maine Health Management Coalition is an employer-led regional health improvement collaborative whose mission is to improve the quality and value of healthcare services for our members. The Maine Health Management Coalition Foundation is a 501©3 public charity whose mission is to bring the purchaser, provider and consumer communities together in a partnership to

measure and publicly report on the quality and cost of health care and to educate the public to use information on cost and quality to make informed decisions. The Coalition, and collaboratives like us around the country, are solely dedicated to improving the quality and value of healthcare and representing all stakeholders in the community- including employers, unions, health plans, patients and providers. Not unlike serving in Congress, representing diverse stakeholders can be challenging, but in my view, may be the best hope to truly change care through coordinated and aligned changes in care delivery, measurement and payment.

Regional collaboratives are not new. The Maine Health Management Coalition was formed in 1993- 20 years ago this year:

> '(1) To assist the Members in the process of sharing and analyzing data ("Health Data"), related to the provision of health and related services to the Members, and their employees and health insurance plan participants ("Health Services")'; and
>
> (2) To foster research, education and coordination among the Members with regard to Health Services, and to act as a forum to promote solutions to Health Services issues'

Our Foundation was established in 2002 to use data to evaluate the quality, safety and cost of health care services. For over a decade we have used a multistakeholder consensus process to publicly report variations in quality and safety across providers and hospitals to the public free of charge. I am here to talk with you today about the role of data and multistakeholder collaboration in transformation- the role that was recognized by my members over 20 years ago at the Coalition's founding and has only proven more critical over time.

Today the Coalition has over 60 members representing the largest public and private employers in Maine including State Employees, the University of Maine System, Bath Iron Works, Delhaize America and LLBean. Our largest member is a union, the Maine Education Association Benefits Trust. Our members also include large health systems such as MaineHealth and Eastern Maine Health Systems (now a Pioneer ACO) and smaller hospitals including Mercy in Portland and St. Joseph's in Bangor as well as primary care and multispecialty groups from Martin's Point Health Care to Penobscot Community Health Center. Collectively we represent over 40% of the commercial market in Maine and spend well over $1 billion per year on healthcare services. Maine's Medicaid program is also a member of the Coalition. The one notable absence at the table is CMS- who would be a welcome partner.

While we are significant in Maine, our real significance lies in the relevance and replicability of our work nationally. There are strong and effective collaboratives around the country using data with employers, patients and physicians and collectively we may be able to partner with national policymakers to implement change on the ground. We have the tools, abilities and relationships with all stakeholders to do the hard work of transforming care. We may be the 'innovation infrastructure' needed to transform US healthcare.

Change is Urgently Needed

The MHMC's 'value equation' is one of improved quality, improved care outcomes, improved population health and reduced costs. After nearly two decades Maine has achieved some of the best healthcare quality in the nation. We are consistently ranked in the top 3-5 states in the country for our quality as measured for Medicare patients. In 2010, the Agency for Healthcare Research and Quality found that Maine showed the biggest improvement in quality in the country. From our own measurement efforts we know that we have gone from poor medication safety practices to some of the most robust medication safety results nationally. The University of Southern Maine conducted an evaluation of practices participating in our measurement and reporting program that showed higher scores across our measures and qualitative evidence of greater commitment to quality improvement among providers.[1] While MHMC in no way takes full credit for these gains, we know that our work on measurement, data sharing and public reporting has been a key driver of these improvements.

Despite significant quality achievements, significant quality and safety failings continue. More discouraging for us is that quality improvement has not reduced the costs paid by purchasers and patients. After 18 years of focusing almost exclusively on quality improvement, cost pressures on our members have forced us to prioritize cost measurement and cost reduction efforts. Maine employers are struggling to

[1] Jablow, P, Studying Maine's Pathways to Excellence Program: Improving the impact of public performance reports and the quality of primary care, Robert Wood Johnson Foundation 05/20/2011

remain competitive with their national counterparts due in part to very high health care costs. Maine employers, public and private, have been clear that they cannot continue to pay the ever-escalating costs of care that are limiting job growth, expansion and business viability. Key examples of the growing challenges include:

- In 2011 the State employee health plan was flat-funded by the Legislature for two years. In Year One (FY2012), the State Employee Health Commission implemented benefit changes requiring employees to absorb over $13 million in cost sharing. For Year Two (FY 2013), the State Employee Health Commission forecast a $22 million gap between projected expenses and flat funding, due primarily to price inflation.

- The University of Maine System was charged with reducing $24 million in health care spending over five years as budget pressure from soaring health care costs forced several years of salary freezes, layoffs, hiring freezes and began to eclipse academic programming in the budget.

Health care cost growth has implications that extend far beyond health care, including impacts on the US debt, wage growth and unemployment. Excessive growth in health care expenditures has serious economic implications for Maine and the country, with the ultimate burden falling on those who use and pay for health care services.[2] Arnie Milstein, MD, of Stanford University, concluded that ten years of wage growth in the US has been effectively eliminated by the increase in health care costs. Effects are particularly felt by workers in industries where wages tend to be low. Some counter these concerns by noting that the health care sector has been an engine of economic growth and job creation. However, recent research from

[2] Haviland AM, Marquis SM, McDevitt RD, Sood N. Growth in consumer directed health plans to one-half of all employer-sponsored insurance could save $57 billion annually. Health Affairs (Millwood) 2012

RAND Corporation shows that every new job added to the health care sector results in .85 fewer jobs in the rest of the economy.[3] For every job created, the costs of running this health care system grow and eventually 'result in layoffs in other sectors unable to manage the growing burden of the cost of health insurance premiums for employees'.[4] To grow Maine's non-health care economy requires us to address health care costs and reduce the burden of these costs on our businesses and families. The burden on private and public employers, patients and state government is now too great to ignore and we need your support to be successful. Given the urgency of the need for change and the challenge of identifying a single national solution, we need to start accelerating transformation by empowering regions with adequate data and effective measures to identify and address their local priorities.

Cost and Quality Vary by Region as Do Opportunities for Improvement

Health care performance and opportunities vary across the country. Maine is the birthplace of the Dartmouth Atlas where Dr. John Wennberg first observed vast differences in maternity care within Maine with no correlation to demographics, patient acuity, or patient preference. He also noted that his kids would have received vastly different treatment for their tonsillitis if they lived one county away.

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[3] Sood N, Ghosh A, Escarce JJ. Employer-sponsored insurance, health care cost growth, and the economic performance of U.S. industries. *Health Serv Res* 2009 Oct; 44:5, Part I: 1449-64.

[4] Murray R and DelBanco S. Provider Market Power in the US Health Care Industry: Assessing its Impact and Looking Ahead, Catalyst for Payment Reform, November 2012

This 'unwarranted variation' in both cost and quality of care is alive and well- and well documented- 30 years later. Just as there is no single problem facing healthcare, there is no one size fits all national solution. I believe regions are well positioned to not only identify but solve their own healthcare problems.

In 2009, using Maine's All-Payer Claims Database analysts replicated the Dartmouth Atlas work and were able to quantify over $350 million in savings if all regions of the state practiced at the best practice level already achieved within Maine. This level of performance was clearly achievable but it was not consistent. Through reductions in potentially avoidable hospital admissions and in high variation-high cost outpatient services, this study identified savings of over $350 million in annual health care expenditures in Maine.[5] The report went on to quantify savings by service type including savings from potentially avoidable admissions in cardiac care, musculoskeletal, gastroenterology and others. These findings not only make a compelling case for change but make the information increasingly actionable. The Dartmouth Atlas and the profound learnings that have come from it would not have been possible without good data. We must now be equally effective ***using*** data to engage physicians, purchasers and patients in care improvement.

[5] All-Payer Analysis of Variation in Healthcare in Maine *Conducted on behalf of Dirigo Health Agency's Maine Quality Forum and The Advisory Council of Health Systems Development,* Health Dialog, April 2009

Data is Necessary to Identify Regional Improvement Opportunities and Engage all Stakeholders in Improvement

Data plays many critical roles in healthcare improvement:

- **Identifying priority quality improvement opportunities and cost drivers;**
- **Enabling performance measurement and public reporting;**
- **Establishing cost and quality performance targets;**
- **Engaging physicians and other stakeholders in care improvement; and**
- **Managing population health.**

But despite over 30 years of research documenting variations in care, not enough has been done to effect those variations. States and communities face very different challenges related to quality and costs of healthcare. Some states may have much higher rates of readmissions, C-sections or hospitalization for diabetes, or overuse of imaging. To direct physicians to focus their improvement efforts on areas that will not have a significant impact on their patients or the community's costs is not only unnecessary but a sure way to frustrate a physician who is already consumed with patient care and not paid for improvement work. Targeted improvement efforts reflecting population or community need is a much better use of time, energy and resources.

To identify those opportunities in Maine, in 2012 we led a Health Care Cost Workgroup to collectively identify and quantify cost reduction opportunities in the

state. The Workgroup first identified opportunities by soliciting input from members, including clinicians, plans and purchasers. All members had ideas about ways to reduce costs, ranging from reduced administrative costs to improving medication adherence. Providers provided key insights into current practices that are not optimal for patients, are not good uses of resources, but are difficult to change given financial incentives, organizational structures and/or culture. This was reinforced by a separate but related meeting held by the MHMC and the Maine Medical Association with physicians, who identified multiple savings opportunities through practice improvement.

Working with members, Coalition staff then worked to quantify achievable savings related to each area through available data. We then calculated the likely impact of achievable change, keeping in mind that in some cases other costs may increase to reduce unnecessary spending - investment in the medical home pilot to reduce avoidable hospital admissions being an example.

The most notable conclusion of the series was that **significant savings are clearly possible.** As an example:

> **Findings:** Commercially insured people with chronic illness are hospitalized at a rate 3.2 times that of the total commercially insured population in Maine22. According to a recent analysis of MHMC data applying Prometheus algorithms,23 potentially avoidable complication rates for diabetes ranged from 10-40% across providers. These complications should be preventable with optimal care management and if best practice standards are met.
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> • **Potential Savings Opportunity:** Admission and readmission rates and costs were analyzed for MHMC plan sponsor insured members. The portion

> of the inpatient PMPM attributable to members with chronic conditions ranged from 46-77% in this commercially insured population. The workgroup suggested targeting a 20% reduction in admissions and readmissions. **A 20% reduction of hospital admissions and readmissions for people with chronic illness would result in savings of up to $32 million yearly for Coalition employers/plan sponsors and their members.**

The results begin to identify and quantify significant opportunities for reduced health care costs based on best practice in Maine and nationally.

The results were also notable because the series demonstrated that with transparent data, analytic support and neutral facilitation, parties can come together to collectively identify, understand and address health care cost drivers. This is an approach that is both effective and replicable in other communities.

Further, it was concluded that only with all parties at the table will system transformation be achieved. Doctors and other providers must transform how they deliver care to patients, but they need changes in payment, patient engagement and additional data to better manage population health. Patients need more and better transparent and shared information on their care, and different incentives to better manage utilization. These **improvements require coordinated and aligned change from all parties** so that payment can support optimal care delivery, incentives can support optimal utilization and that reliable information is available for all parties to make improvements. A multistakeholder forum where transparent data can be shared with all stakeholders is an important forum to both identify and understand opportunities for improvement, and to work together effectively for its

achievement.

Using Data for Improvement

Access to data is necessary but insufficient. Once opportunities are identified, stakeholders- particularly physicians- must be actively engaged to change current practice. Data is foundational to that work but analysis, technical assistance, measurement and transformation support are also needed. Mechanisms for transparent accountability will be key for sustained change. Fortunately there are examples of this happening across the country.

In addition to using multipayer data to measure and report on the performance of practices and hospitals, and the use of data by ACOs to manage population health, there are several innovative efforts underway in Maine and nationally to use data for improvement. Here I only cite Maine examples though it is important to know that several Regional Health Improvement Collaboratives including the Pittsburgh Regional Health Initiative, Oregon Health Care Quality Corporation, Puget Sound Health Alliance, Minnesota Community Measurement and Institute for Clinical Systems Improvement and many others have innovative programs driving and supporting improved care.

Using Data for Improvement: Examples:

Multipayer Advanced Primary Care Pilot and Learning Collaborative.

In November 2010, Maine was selected as one of eight states to participate in the Medicare Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, Medicare's major PCMH demo. In January 2012, Medicare joined the private purchasers and Medicaid as a payer in the Maine Patient Centered Medical Home (PCMH) Pilot. Within this demo, Medicare is providing Maine PCMH Pilot practices with a new care management fee – estimated to a total up to $28 million over the next three years—for providing medical home services to their Medicare patients. Because of Medicare expectations for budget neutrality, CMS has set an expectation that Pilot practices will demonstrate improvements in clinical care and efficiency; to that end, the Maine PCMH Pilot has targeted decreases in several areas of high-cost utilization that could be reduced as a result of improved coordination of care, including 4-5% decreases in avoidable inpatient admissions, 9% decrease in avoidable emergency department visits, and 5% decreases in specialty consultations and imaging. These targets were set using data made available to Maine by Medicare.

As practices seek to transform to become medical homes, significant technical assistance and support is required. Maine Quality Counts, another Regional Health Improvement Collaborative in Maine provides targeted and intensive support to these practices based on their performance against key metrics. Maine Quality Counts offers outreach, support, and collaborative learning methods to PCPs, helping them transform to a more patient-centered model of care and provides IHI model learning collaborative opportunities for PCPs transitioning to PCMH and MaineCare Health Home status.

Community Care Teams and "Hot-Spotting'

The MAPCP demonstration also provided the Pilot with an opportunity to introduce Community Care Teams (CCTs) as a new component of care for high-needs patients. CCTs recognize that many patients have needs and barriers to care that can reach beyond the capacity of even the most robust

primary care physician practice. CCTs are multi-disciplinary, community-based, practice-integrated care management teams that will work closely with PCMH Pilot practices to provide enhanced services for the most complex, most high needs patients in the practice. Maine has worked with Dr. Jeffrey Brenner of New Jersey whose 'hot-spotting' techniques were highlighted in *The New Yorker* by Dr. Atul Gawande. By identifying and targeting high need patients who utilize disproportionate resources, Dr. Brenner and his team were able to make substantial improvements in utilization and costs through intensive and targeted interventions. Early results are showing as much as 40% decline for some patients in the use of hospital services when appropriate supports are provided. The CCT model had been established and found to be highly successful in other communities and states, like North Carolina, New York and Vermont.

Under the MAPCP demo, Medicare, Medicaid, and commercial payers have agreed to provide payment to a set of eight sites that support the 26 PCMH Pilot practices and patients. CCTs are a vital strategy for improving quality and reducing costs, decreasing avoidable hospital admissions, readmissions and Emergency Department visits.

Practice Reports for Patient Centered Medical Homes and Health Homes

To support the Multipayer Patient Centered Medical Home and Medicaid Health Home pilot practices, the Maine Health Management Coalition has developed practice performance reports using claims based quality, cost and utilization metrics. Not only will the reports be populated with all payer claims data, we intend to integrate clinical data from our Health Information Exchange to track clinical outcomes measures. We developed these reports working directly with physicians to ensure meaningful measurements. After

initial private reporting, a subset of the report will be publicly reported to recognize good performance and facilitate consumer choice.

In 2010 Maine Quality Counts, the Maine Quality Forum and the Maine Health Management Coalition developed and disseminated reports on comparative practice performance across the state and held regional forums with providers to understand and use the data. High levels of participation in the regional meetings and ongoing dialogue with the practices indicate strong demand for this type of information that is otherwise unavailable.

Risk Based Contracts

In some communities across Maine, large public and private purchasers are working directly with practices and health systems to establish risk-based contracts for population health management. The Maine Health Management Coalition and its analytic staff are key participants in these pilots to enable transparent, neutral and reliable data sharing. The MHMC identifies aggregate trends for each employer population and works with the parties to establish appropriate performance benchmarks given demographics and trends. Participating providers can then access identified data on this same population in order to immediately impact areas of care that may need better management. Enabling two parties to use the same data with appropriate, role-based access, enables important transparency and avoids problems of competing, inconsistent data. Even more importantly this enables providers to address priorities by population and enables purchasers to understand- and address – barriers providers face in current payment systems and benefit designs. Purchasers are well positioned to make critical payment and benefit changes to support care redesign when there is common understanding of the need and impact, and there is clear accountability through transparent data sharing.

Assuring that Clinical Coordination is Facilitated by Data

Maine has one of the most robust query-based centralized health information exchanges in the nation (HealthInfoNet). Today, over 90% of all hospital data and 55% of all ambulatory data flows into the exchange. All Maine hospitals will be participating in the exchange by the end of 2013, and 80% of all Maine ambulatory providers will be participating by the end of 2015. This data infrastructure will:

- Make clinical notifications available in real-time when patients enter the health care system;
- Advance the electronic capture of behavioral health and other "high-risk" clinical data
- Give patients access to their statewide clinical information so that they can be better informed when making medical decisions and hold their providers accountable for the care that is delivered

Data and Measurement Must Include Multiple Stakeholders and Reflect Community Priorities

You rightly recognize the central role of measurement in both improvement and accountability. A key barrier to addressing costs in ways similar to our successful work in quality was the lack of cost measures. Until very recently, there were no reliable, nationally endorsed measures of cost and resource use. Without measures endorsed by the National Quality Forum, we found it impossible to identify measures deemed relevant by purchasers and consumers and fair and acceptable to providers. With no ability to measure or report on cost and no visibility into cost drivers, large employers and purchasers have had to accept rates set by providers

and health plans through private negotiations. And we have paid a high price. Maine's commercial premiums are among the highest in the country.

No payment system will be successful without appropriate and transparent measurement. New incentives to reduce costs must be balanced by ongoing measurement of access, patient experience and outcomes to ensure that patients are protected and access is preserved in this transition to new models. Measures that are developed and selected for use in payment systems and programs will drive change. It is essential that this change is towards our collective aims.

While clinician leadership is key to improving care, measurement must also reflect the needs and priorities of consumers, communities and those paying for care- both employers and government. You note that:

- 'physician fee schedule payment updates will be based on performance on meaningful, physician-endorsed measures of care quality and participation in clinical improvement activities (e.g., reporting clinical data to a registry or employing shared- decision making tools).
- Medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process.'

Physician input is critical to the measure development and selection process but measures must reflect all of our values. Multi-stakeholder endorsed measures with a clear standard of evidence are the foundation of care and value improvement. A process that includes physicians, purchasers and patients will identify measures of improvement that meet the needs of all stakeholders. As an example, we know from

extensive consumer research that measures of patient experience are most important to patients but, despite having a nationally endorsed valid patient experience measurement tool (CG-CAHPS) available for many years, providers have not prioritized or widely used this survey. Without the 'healthy tension' that results from bringing the parties together it is unlikely that we would have complete and robust measures for patient experience, outcomes, cost or resource use or other areas important to communities. As those who pay for and receive care, the employer and patient voice are crucial to identifying the right indicators of performance together with physicians.

Data is a Resource that is Only Valuable when it is Accessible and Used Effectively. If Available, Data Can Be Used Effectively By Communities

Not unlike out national peers, in order to meet our mission the Coalition and Foundation together have a broad portfolio of initiatives that include performance measurement and public reporting; consumer engagement; value based purchasing and payment reform to support clinical care redesign. While each initiative is important, it is the combination of these data-driven efforts and the active engagement of all stakeholders that is impactful. None of this work is possible without access to data.

Despite our track record and years of experience working with data, obtaining multipayor data is remarkably difficult- and expensive. Many commercial health

plans view the data as proprietary and many provider-based organizations are reluctant to share data publicly. Many state-based all payer claims databases place such onerous restrictions on data use that its value is dramatically diminished. Dr. David Howes, President and CEO of Martin's Point Health Care, summed up our challenge eloquently, 'The age of competing for market share by controlling access to data is over. Transparent all-payer data should be made widely available and competition should be based solely on performance'.

The Qualified Entity Certification Program is an important step to enable improvement in communities. The Maine Health Management Coalition was the fourth organization in the country to receive Qualified Entity status to receive identified Medicare data to measure and report performance to physicians. We will integrate this into our multipayer claims database including data from commercial insurers and soon to include Medicaid. This will enable physicians to better understand their performance relative to peers and to improve care across their entire patient population. It will also facilitate reporting to inform consumers about provider performance, meeting the needs of multiple stakeholders. This program is an important step to empowering physicians and communities to use data effectively. The Qualified Entity Certification Program is a strong signal of partnership and support for local innovation and an endorsement for use of integrated data. As experience grows with the program, it could be even more

effective with fewer restrictions on data use and resources available to communities to support improvement.

Maine is fortunate that it has the improvement resources it does. Our success is entirely replicable if these resources are more widely available. In our view, to transform care and payment and engage providers, employers, and consumers, communities need the following:

- **A common, shared data source of integrated clinical and claims data for all parties to use** – with appropriate privacy, security and legal safeguards and role-based access – to serve as the foundation for system and payment reform. All approved users should have fair, affordable and equitable access to the data for the purposes of care improvement.

- **Timely access to all payer data** is necessary to support system transformation. Data on a subset of patients is insufficient to facilitate population health management. Data that is not current does not allow for effective and timely interventions to change care.

- **Patient identified data must be included but identifiable only at the patient/provider level** to allow providers to effectively improve care for their patients. Identified data enables the combining of different data sources to allow a meaningful and longitudinal understanding of utilization, care patterns, and outcomes.

- **Resources should be used effectively and care should be taken to avoid unnecessary duplication of data systems** and the resources needed to support them. Current duplication of proprietary data systems drive additional costs to employers and patients.

- **Data users- including consumers- should have input into the structure, design, and purpose** of data systems to maximize use for and by all stakeholders, including the public.

- **Integrated clinical data, claims, health risk, and outcomes data is the optimal source** of information for care improvement and high value.

- **Information created from healthcare data should be made transparent and publically available** in aggregate with the appropriate safeguards, processes, and criteria for reliability.

Once this data infrastructure is established, with leadership and support stakeholders can put the information to work improving care and reducing costs.

Regional Collaboratives May Serve as Key Implementation Partners

With the best data and measurement, care will only be improved if providers lead care transformation and are supported by reformed payment. We share your priorities and urgency for a transformed healthcare system that delivers value for our significant investment. As you take on the challenge of care redesign, measurement and payment reform, use regional collaboratives to truly understand which measures are meaningful to communities, to physicians and to improvement. This cannot be done solely from Washington. National organizations can and must respond to community need for measure development but measures can only be implemented at the community level. Providers must use data to change practice, data must be collected and reported, consumers must understand and engage in change- all of which is facilitated by local relationships and support. As you set the national direction, we can serve as implementation partners.

Thank you again for this opportunity and thank you for addressing these urgent issues.


Maine Health
Management
Coalition