Senate Budget Committee Hearing: *Health Care and the Budget: Information Technology and Health Care Reform*

Testimony of Laura L. Adams, President and CEO, Rhode Island Quality Institute

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Chairman Conrad and Members of the Committee, thank you for the opportunity to appear before you today to testify on this issue of great importance to the future of health care in this country.

My name is Laura Adams and I'm the President and CEO of the Rhode Island Quality Institute, an organization founded six years ago by then RI Attorney General, now US Senator, Sheldon Whitehouse. This multi-stakeholder organization, comprised of hospitals, physicians, nurses, consumers, insurers, government and employers has the singular mission of significantly improving the quality, safety and value of health care in RI. We're not-for-profit and beholden to no one but the people of the State of RI and, to the nation, in so far as we develop models of innovation worth replicating.

My remarks today will reflect the perspective of our broad-based coalition working together to transform the health care system in the state. The Quality Institute serves as Rhode Island's Regional Health Information Organization and we strongly believe in the value of health IT as an essential element in any viable proposal for addressing the problems that plague our health care system. It's our goal to bring the delivery of health care out of the paper-based system, which we recognize as a root cause of significant waste and harm.

But we're under no illusions. We fully recognize that health IT ***alone*** adds little to no value and if developed in isolation from other critical reform initiatives, is likely to be, to borrow a phrase from Don Berwick, the next festival of waste. But we have a clear understanding that health IT undergirds virtually every major health care reform initiative being advanced today.

Whatever you support in terms of health care reforms, whether it's Primary Care's Medical Home model emphasizing patient-centered primary care and prevention, consumer-driven health care, quality improvement and reduction of medical errors, pay-for-performance, population health and disease management, access for all, fraud and abuse detection, transparency and public reporting on quality and costs—none of these can succeed without a constant flow of reliable and timely clinical and administrative information—the kind that is only produced electronically. Therefore, it would be a mistake to regard health IT as merely one idea in a sea of good ideas for reform.

Those that are pioneering efforts to promote adoption and full use of health IT deserve our attention and strong support as a nation. So much is riding on their success or failure of grassroots initiatives. I applaud the efforts of HHS, the Office of the National Coordinator for Health Information Technology and especially the Agency for Health Care Research and Quality, which has been particularly effective in grasping what's needed to prioritize and

fund critically important initiatives in the field. However, our collective approach to funding and supporting these initiatives almost guarantees failure.

To illuminate the point, let's assume for a moment that our goal is to make toast. One idea advanced by bread producing vendors is to put bread in the toaster. Yet credible scientific study suggests that toast-making benefits from efforts to push the lever down to lower the bread into the toaster. Another prominent industry group insists that plugging in the toaster is the key and everyone should work on getting electricity to the toaster. Fund the testing of each of these ideas separately and we'll conclude that there is simply no way to make toast or that reliable toast-making is still decades away. It's only when we combine all three in the same setting that we realize the potential.

Achieving the significant and sustained improvement we need in health care requires the testing of multiple concepts in the field simultaneously. We believe that health IT adoption, work on quality improvement and prevention and reforming the toxic payment system must be tested in aggregate in what is an essential yet virtually non-existent R & D role for health care.

Efforts to test these concepts in real-world settings in which they must prove their worth are crippled by the necessity for local collaborators to cobble together funding and support, almost always with huge gaps for key elements necessary for informing the nation of what truly works and what doesn't. As a result we're learning at an achingly slow pace as a nation. We have some initiatives focused on implementing health IT, others advancing improvement projects and a brave few testing new payment structures—each struggling independently against the gale-force winds of the status-quo. Yet after literally years and years of toil, we have come nowhere near what the architects of these initiatives had envisioned. We're testing these as isolated concepts and not surprisingly, we're having trouble making toast.

Rhode Island is no exception--even as some consider us a candidate for "most likely to succeed". For six years, we've have the CEO-level leadership of every major health care stakeholder required to remake this system at the table and actively participating. We were the birthplace of SureScripts' e-prescribing system and currently rank #2 nationally behind Massachusetts in e-prescribing. We're implementing a statewide health information exchange with the help of a $5 million dollar AHRQ contract, which ignited our state's progress unlike anything else. We've spawned unprecedented collaboration in the work of EMR adoption. In an initiative co-led by our state government and our QIO, Rhode Island is testing a Medical Home model that includes payment reform.

Our Governor championed work that led to The Wellness Councils of America naming Rhode Island as the first "Well State" in the nation as measured by the percentage of the workforce employed in award winning "Well Workplaces". We have every single ICU in every single hospital in the state participating in an improvement collaborative that has lowered deadly and costly central line infections by 57% in 18 months.

Our insurers, most notably Blue Cross and Blue Shield of RI, have stepped up and so have our doctors, hospitals and pharmacies, our consumer advocacy groups, our state

government and our certainly our congressional delegation, all of whom are working non-stop to advance our work.

So yes, we're progressing, but at a far slower pace than the crisis warrants. All of our initiatives are funded on a shoestring and depend heavily on the in-kind contributions of the local participants—and we're wearing them out. The funding sources are fragmented, each with their own set of deliverables and timelines which, while well intentioned, can draw focus and energy away from the critical business at hand.

We're respectfully urging Congress to place more trust and higher levels of aggregated resources in organizations like the Rhode Island Quality Institute and a number of similar organizations across the nation, many of whom would challenge us for the designation of "most likely to succeed". We'd like you to join us in our model of shared responsibility and contribution and then hold us accountable for results, just as our other stakeholders do. We'll deliver.

It isn't a question of whether we can afford to spend the money to do this. We're already spending the money -–the question is what we want to buy with it. Unless we act, the money will be spent on more duplicate tests, avoidable hospitalizations, the care required to mop up after the physical and emotional damage caused by medical errors and the consequences of uncoordinated care when we could be rapidly advancing toward a way out.

On behalf of my colleagues in Rhode Island and across the nation, I'd like to thank you for devoting your time and attention to exploring the value of health IT and its role in reform. We stand ready as energized, committed and capable partners in maximizing its worth for all of our citizens.