

**Statement of Steven D. Pearson, MD, MSc, FRCP  
President  
Institute for Clinical and Economic Review  
Massachusetts General Hospital and Harvard Medical School**

**Hearing on “Implementing Best Patient Care Practices”  
Senate Committee on Health, Education, Labor, and Pensions**

**February 5, 2009**

Thank you, Senator Mikulski, and Members of the Committee for the invitation to testify today. My name is Steven Pearson. I am a general internist and the Founder and President of the Institute for Clinical and Economic Review, or ICER. ICER is a research group in the Institute for Technology Assessment at the Massachusetts General Hospital which works with patients, clinicians, manufacturers, and health insurers to evaluate the comparative effectiveness of medical tests and treatments.

In my oral testimony today, I want to cover two questions:

- 1) What is the connection between the concepts of comparative effectiveness and “best practices?”
  
- 2) What are the mechanisms and the requirements for effective implementation of comparative effectiveness findings?

The term “best practice” is usually meant to refer to *systems* for delivering care, systems such as Dr. Pronovost’s fabulous surgical checklist, that produce optimum patient outcomes. Comparative effectiveness, on the other hand, is a newer term that has generally referred not to research on systems of care but to evaluations of specific treatment options – for example, trying to determine which patients with coronary artery disease do better with medication, and which do better with cardiac stents.

So “best practices” and comparative effectiveness can be viewed as feeding in to different approaches to improve the quality and value of care, but they can also be quite complementary: comparative effectiveness helps figure out what the right care is; and “best practices” research helps us learn how to get that right care delivered as safely, effectively, and efficiently as possible.

What are the mechanisms by which the results of comparative effectiveness research can be implemented? The ideal framework is for the findings to be able to support tools and policies that can be used by different stakeholders and that all reinforce each other.

Implementation strategies include the following, some of which, but not all, are also options for the implementation of “best practices”:

- 1) Patient information

- 2) Clinical guidelines
- 3) Physician group compensation incentives
- 4) Tiered benefit designs, in which patients would pay different amounts out of pocket depending on the evidence of benefit and value; and
- 5) Value-based coverage and reimbursement policies

There are two key points I want to make about this list. First, insurance coverage decisions are not the sole, nor even the primary mechanism for implementing comparative effectiveness results. Sometimes concerns are raised that comparative effectiveness will only be translated into all-or-nothing, one-size-fits-all coverage decisions. In fact, comparative effectiveness assessments are expressly designed to hunt out any evidence that specific types of patients may benefit more or less from certain treatment options. These findings can then be used to support benefit and coverage policies that are flexible enough to recognize these differences.

The second point I want to make about implementation is that in order for assessment results to be useful to patients and clinicians, and for results to be linked in a transparent way to coverage and reimbursement, some kind of common “language” about the evidence is necessary. To meet this need at ICER we have developed a rating system that assigns a capital letter to grade the degree of clinical effectiveness of

whatever it is we're evaluating, and a separate lower-case letter indicating our assessment of the comparative value. These ratings can be looked at in isolation, or they can be put side-by-side to form an integrated evidence rating. In a demonstration project in Massachusetts, we are now working with a coalition of employers, health plans, and provider groups to assess prostate cancer treatments. The ICER integrated evidence ratings arising from these assessments will then be used to generate patient materials and new medical policies. The goal is to give patients' better evidence to use in shared decision-making and to align that process with coverage and reimbursement policies that can help shift patterns of care to high value options.

In conclusion, I believe that comparative effectiveness research and efforts to implement "best practices" are complementary and mutually supportive efforts. Finding out what works best, and getting it done right – left and right hands – will both be needed to help us achieve a high quality, affordable health care system. Thank you.