

Building an accountable health system: *High-value health care for chronic illness*

CCA Forum 11

September 8, 2011

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Pacific Business Group on Health



The Pacific Business Group on Health

- The Pacific Business Group on Health helps employers improve the quality of health care and limit health care cost increases for their employees.
- Our 50 members spend 12 billion dollars annually to provide health care coverage to more than three million employees, retirees and dependents in California alone.

PBGH Members



Purchasers' views of health care today

- Health reform will not moderate costs
- Quality of care only fair, extremely variable, with little transparency
- Price of care unrelated to value
- Delivery systems and plans show little motivation to seek efficiencies, improve quality
- Current tools – HMOs, P4P, quality measurement – having little impact
- Market trends are unfavorable – consolidation of plans, consolidation of provider systems, pricing patterns
- Little employer willingness to expand employee cost-sharing
- Hoping for plans to do the right thing has faded
- Hoping that managed care principles will lead to cost stabilization has faded

Purchasers reassessing their role

- Growing interest in direct contracting with providers and ‘accountable’ systems
- Early consideration of the role of Exchanges and possible ‘exit’ from employer-sponsored benefits

Meanwhile, what are purchasers looking for?

- Improved health outcomes at sustainable costs
 - Accountability for outcomes & costs
 - Transparent outcomes & costs
- Infrastructure that supports continuous improvement
 - Coordinated care
 - Evidence-based medicine
 - Reduced errors
 - Increased diagnostic and treatment appropriateness
- Engaged patients and consumers

PBGH 2015 Vision

A health care system transparent about the quality, cost and outcomes of care, where consumers are motivated to seek the right care at the right price and providers are incentivized to offer better quality, more affordable care.



Strategies, Goals and Metrics

Program & Organizational Metrics – Level One – 2015 Metrics



<p>Engaging Consumers</p> <p>ALL national health plans publicize physician fee schedules and tie to benefits.</p> <p>30% of consumers report using patient ratings of doctors when choosing a physician</p> <p>25% more consumers report participating in a decision making process when considering treatment</p>	<p>Paying for Value</p> <p>20% of health plan payments to providers are based on quality and efficiency ratings</p> <p>Bend member purchaser cost trend to CPI+1</p>	<p>Redesigning Care Delivery</p> <p>PBGH dashboard is adopted and results published</p> <p>7% increase in overall satisfaction rating of routine and chronic care</p> <p>25% increase in proportion of routine and chronic care patients who receive "right care"</p> <p>25% reduction in preventable hospital and ER admissions</p>	<p>Advancing Policy</p> <p>Legislation and policies that support our other goals are successfully advanced.</p>
<p>Engaging Consumers</p> <p>Consumers have necessary information about total cost and quality to make informed decisions about, plans, providers and/or treatment options</p> <p>Patients use consumer reported satisfaction of doctors online</p> <p>Patients are active participants in treatment decisions</p>	<p>Paying for Value</p> <p>Payment reform motivates providers to partner with high quality and cost efficient specialists</p> <p>Financial incentives are aligned toward managing total cost of care</p>	<p>Redesigning Care Delivery</p> <p>Uniform measurement tool for redesigned care delivery models and their effectiveness</p> <p>Newly redesigned care programs have improved how care is delivered and are demonstrating better outcomes</p> <p>PCPs are partnering with cost efficient and high quality specialists to deliver care</p>	<p>Advancing Policy</p> <p>To be a recognized expert and advocate for policies that advance Value Based Purchasing goals including: influencing federal payment policy; ACO rules; spending of HIT incentives; quality measures used to pay for value</p> <p>Private/public partnerships drive policy solutions that redesign care delivery and payment reform</p>

Four Strategies

✓ Engaging consumers:

- ✓ Benefit design & transparency

✓ Paying for value

- ✓ Episodes, advanced medical home, global budgets

✓ Redesigning care

- ✓ Accountable care organizations
- ✓ Specialty services bundling (registries, SDM, appropriateness criteria)

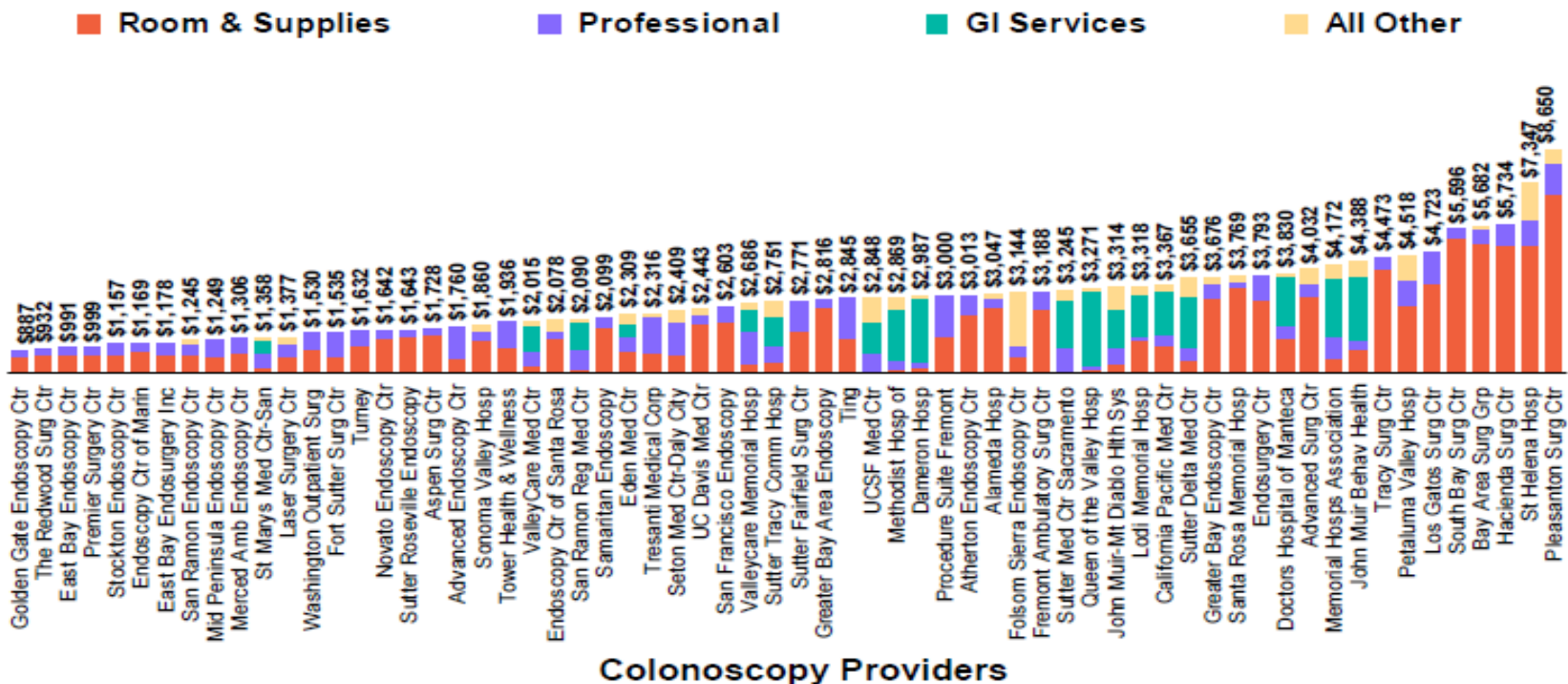
✓ Advancing policy

- ✓ Information infrastructure (measurement and health IT)
- ✓ Transparency
- ✓ Aligning public and private payment

Engaging Consumers: Safeway's approach

Colonoscopy

Cost Per Procedure (\$) – Greater SF Bay Area MSA





[Hospital](#)

[Clinic](#)

[Same Day Surgery Center](#)

[Medical Equipment & Supplies](#)

[Radiology](#)

[Pharmacy](#)

[View All Procedures & Conditions](#)

Sort facilities by:

Cost Range Key:

Lower Cost

Medium Cost

Higher Cost

MRI - Knee

[Learn more about this procedure](#)

Facility Name	Average Cost Range How were these costs calculated?
Abbott Northwestern Hospital	\$901.00 - \$1,650.00
Albany Area Hospital	\$1,651.00 - \$2,800.00
Altru Hospital	\$1,651.00 - \$2,800.00
Amery Regional Medical Center (WI)	\$1,651.00 - \$2,800.00
Baldwin Area Medical Center (WI)	\$1,651.00 - \$2,800.00
Buffalo Hospital	\$901.00 - \$1,650.00
Burnett Medical Center (WI)	\$1,651.00 - \$2,800.00
Cambridge Medical Center	\$901.00 - \$1,650.00
Center For Diagnostic Imaging	\$650.00 - \$900.00
Community Memorial Hospital	\$1,651.00 - \$2,800.00
Consulting Radiologists Ltd	\$650.00 - \$900.00
Cuyuna Regional Medical Center	\$901.00 - \$1,650.00
Dakota Clinic Ltd	\$650.00 - \$900.00
Douglas County Hospital	\$901.00 - \$1,650.00
Duluth Clinic	\$901.00 - \$1,650.00

Engaging Consumers: CalPERS

- Hip and knee replacement costs are skyrocketing
- Price varies from \$15,000 to \$110,000 (commercial PPO population)
- Anthem Blue Cross and CalPERS have established a threshold of \$30,000 – reference price – for a standard inpatient hip/knee replacement procedure.

Cost to the member








	Designated Prudent Buyer hospital	In-network Prudent Buyer hospital	Out-of-network hospital
Hospital billed	\$60,000	\$60,000	\$60,000
Negotiated rate/C&R	\$30,000	\$40,000	\$50,000
Provider write-off	\$30,000	\$20,000	\$0
Member coinsurance/ annual OOP	\$3,000	\$3,000	\$20,000
Paid	\$27,000	\$27,000	\$30,000
Member obligation	\$3,000	\$13,000	\$30,000

Paying for Value: Ambulatory Intensive Care Unit

Boeing IOCP pilot, ran from January 2007 through July 2009.

IOCP Boeing Pilot results as published on Health Affairs blog 2009.10.20:

Measure compared to baseline	Result
Health care costs of pilot participants versus control group	- 20.0% 
Hospital admissions	- 28% 
Improvement in mental functioning of pilot participants	+ 16.1% 
Participants feeling that care was "received as soon as needed"	+ 17.6% 
Average number of patient-reported workdays missed, 6 months	- 56.5% 

Redesigning Care: ACOs

PBGH Principles for ACOs:

- ACOs must be transparent at provider level.
- ACOs must be outcomes-focused.
- ACOs must be deploy patient-centered care models and measure performance in ways that are relevant for and available to patients, and include cost and patient-experience.
- ACOs must pay providers for quality, not quantity.
- ACOs must address affordability and contain costs, such as managing the cost trend increase to Consumer Price Index (CPI) plus one percent.
- ACOs must support a competitive marketplace.
- ACOs must demonstrate meaningful use of health information technology, for clinical decision support, clinical integration, and information exchange among providers and with m

Advancing Policy (Reforms where health IT matters)

- ONC programs – *(obviously)*
- Accountable care organizations - 2012
- Health insurance exchanges - 2014
- PQRS and Physician Compare - 2013
- Hospital value-based purchasing
- Physician value-based purchasing
- Episode payment
- Medical homes & “hotspotting”
- Private sector P4P
- Quality designations for tiered networks

PPACA & National Quality Strategy

- The Affordable Care Act on the Secretary of the Department of Health and Human Services (HHS) to establish a national quality strategy and a comprehensive strategic plan and to identify priorities to improve the delivery of health care services, patient health outcomes, and population health.
 1. **Better Care:** Improve the overall quality, by making health care more patient-centered, accessible, and safe
 2. **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care
 3. **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government

The Strategy adopts six priorities

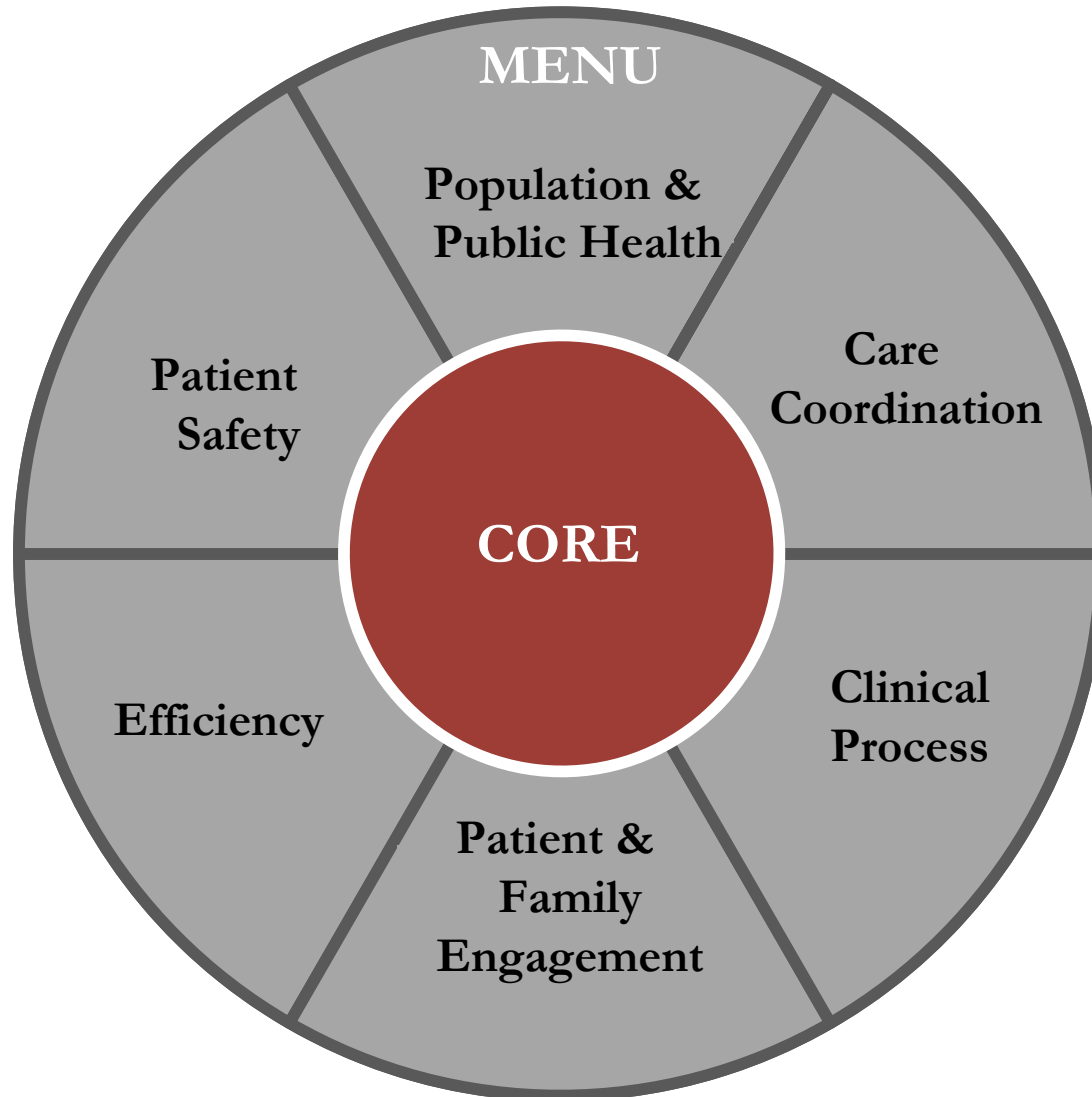
These priorities, based on research, input from a broad range of stakeholders, and examples from around the country, suggest that there is a great potential for rapidly improving health outcomes and increasing the value and effectiveness of care for all populations. They include:

1. **Making care safer** by reducing harm caused in the delivery of care
2. Ensuring that each person and family are **engaged as partners** in their care
3. Promoting effective communication and **coordination of care**
4. Promoting the most **effective prevention and treatment practices** for the leading causes of mortality, starting with cardiovascular disease
5. **Working with communities** to promote wide use of best practices to enable healthy living
6. Making quality care **more affordable** for individuals, families, employers, and governments by developing and spreading new health care delivery models

The role of Health IT in driving system redesign

- The information foundation for:
 - Evidence-based practice and clinical decision support
 - Clinical improvement and feedback
 - Care coordination across settings, across time
 - Recognition and payment
 - Comparative effectiveness research
 - Informed and engaged patients
 - System navigation

Translating the Quality Strategy into Meaningful Use: The Quality Measures Menu – Stage 2



Emerging Measures

Patient and Family Engagement New Measures

- ✓ Patient experience of care & HIT connection with providers
- ✓ Measurement of functional status & health risk
- ✓ Patient activation and self-management skills

Clinical Appropriateness and Efficiency New Measures

- ✓ Lipid Control using Framingham risk score
- ✓ Measure assessing the appropriate use of diagnostic imaging procedures, with measures for redundancy, cumulative exposure, and appropriateness
- ✓ Measure assessing appropriate medication treatments, including overuse and/or underuse

Emerging Measures

Population and Public Health New Measures

- ✓ Patient experience of care & HIT connection with providers
- ✓ Measurement of functional status & health risk
- ✓ Patient activation and self-management skills

Care Coordination New Measures

- ✓ Measure assessing adherence to a comprehensive care plan
- ✓ Measure of patient and family experience of care coordination across a care transition
- ✓ Measure of an advance care plan as a product of shared decision making
- ✓ Composite measure assessing receipt by both care team members and the patient/caregiver of a comprehensive clinical summary after a transition

Bringing the IT agenda to life...

- Aggressively support EHR adoption *consistent with policy objectives*
- Send clear signals about Stage 3 of meaningful use
- Think through the needed technology architecture
- Build shared vision of financing and policy infrastructure in both public and private sectors
- Demonstrate successes to public and policymakers
- *Don't slow down!!!!*

What purchasers are looking for

- An infrastructure that supports care coordination
- An infrastructure that provides accountability and better measures of the performance of providers
- An infrastructure that better engages patients (and consumers) in their health care decisions
- A health system that encourages innovation for improved outcomes at a sustainable cost