INNOVATIONS IN HEALTH CARE DELIVERY: PROMISE AND PERFORMANCE

Stephen M. Shortell, Ph.D.
Blue Cross of California Distinguished Professor of Health Policy and Management
Dean, School of Public Health
University of California-Berkeley

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Austin, Texas
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Problem

We are not a healthy nation, yet we spend twice as much money as most other countries.

What is going on?
U.S. Health Care Expenditures as a Share of GDP, 1960 – 2021

Source: Centers for Medicare and Medicaid Services.
Source: OECD Health, June, 2011
# Overall Health Status
## Persons Aged 46-64

<table>
<thead>
<tr>
<th>Health Status</th>
<th>NHANES 1988-1994</th>
<th>NHANES 2007-2010</th>
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</thead>
<tbody>
<tr>
<td>Report “excellent” health</td>
<td>32 %</td>
<td>13.2%</td>
</tr>
<tr>
<td>Use walking assist</td>
<td>3.3%</td>
<td>6.9%</td>
</tr>
<tr>
<td>“Limited in work”</td>
<td>10.1%</td>
<td>13.8%</td>
</tr>
<tr>
<td>“Functional limitation”</td>
<td>8.8%</td>
<td>13.5%</td>
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</table>

Source: JAME Internal Med Online, February 4, 2013
# Lifestyle Factors

## Persons Aged 46-64

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Obesity</td>
<td>29.4%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Regular exercise</td>
<td>49.9%</td>
<td>35%</td>
</tr>
<tr>
<td>No regular physical activity</td>
<td>17.4%</td>
<td>52.2%</td>
</tr>
<tr>
<td>Smoking</td>
<td>27.6%</td>
<td>21.3%</td>
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Source: JAME Internal Med Online, February 4, 2013
Two Fundamental Approaches

• Reduce burden of illness
  • Focus on the physical, environmental, behavioral and social determinants of health
  • “Health in All” policies

• Change how care is paid for and delivered

CHANGE = INNOVATION
Changes in Payment

- Move away from fee-for-service to:
  - Bundled payments
  - Episode-of-care-based payments
  - Partial capitation
  - Full capitation
  - Global risk-adjusted budgets

- Create incentives for keeping people well.
It’s About Changing Cultures and Paradigms

• From culture of disease to culture of care to culture of health.

• We need to create “markets” for health, not disease.
For Providers,
It’s About Managing Risk

The co-evolution of new payment models and new delivery models.
Ability to Manage Risk

Payment Form

<table>
<thead>
<tr>
<th></th>
<th>IDS</th>
<th>MSGP</th>
<th>PHO</th>
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<tbody>
<tr>
<td>Full Capitation</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Partial Capitation</td>
<td></td>
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</tr>
<tr>
<td>Episode of Illness</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Payment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fee-For-Service</td>
<td></td>
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</table>

Risk-Reward Relationship
Innovations in Care Delivery
Central Theme:

The co-evolution of new payment models and new organizational delivery models
Caring for Medically-Fragile Patients

- Pro-active monitoring
- 24/7 support using less costly health workers
- Reduce annual total per capita spending by 15 to 20 percent

Source: Milstein and Gilbertson, *Health Affairs*, 2009
Advanced/Serious Illness
End-of-Life Care

• Medicare spends 25 percent of its budget on 5 percent of people who die within a given year.

• Many who die in hospitals prefer to spend their final days at home. Respect patient preferences.

• Increasing evidence that palliative care programs improve the quality of care and lower the costs of care for patients in late stages of serious illness.
Advanced/Serious Illness
End-of-Life Care (cont’d)

• Key is well-trained interdisciplinary teams and flexible scope of practice laws

• Need media and consumer support
Increasing Hospital Patient Flow

- Application of systems engineering tools
- Can increase flow by 15 percent without proportionately adding staff

Source: Boston University Health Policy Institute
Reducing Hospital Admissions

• Care transition programs
  • Medication self-management
  • Patient-centered personal health record
  • Structured follow-up with a primary care physician
  • Alerting patients to certain “red flags” that signal an impending decline

• Need effective partnerships with post-hospital sites.

Sources: Coleman, et al. *Archives of Internal Medicine*, 2006
ACO Tally Sheet

- 30 Pioneer ACOs
- 333 MSSP ACOs
- 116 are advanced payment
- 424 total ACOs in 48 states
ACOs Are Serving Millions

- 21-31 million Americans receive care through ACOs
- 2.4 million are in Medicare ACOs
- 15 million non-Medicare patients of Medicare ACOs
- 8 to 14 million patients of non-Medicare ACOs

People Live in Areas Where ACOs Are Available

- In 19 states, more than 50 percent of residents have access to ACOs
- In 12 states, between 25 and 50 percent of residents have access to ACOs (includes Montana)

ACO Distribution by State

How About Accountable Care Organizations (ACOs)?

Are they more than a guess?
Some Key Issues

- Enrollment size matters – achieve sufficient savings to spread overhead and related costs

- Care management is key:
  - 5/50 stratification
  - Multiple chronic illness, frail elderly, dual eligibles, mental illness
Some Key Issues (cont’d)

• Building new relationships
  • Business model changes most for hospitals
  • Integrating different professional/social identities
  • Collaborative governance

• New tools required:
  • Information exchange across the continuum
  • Predictive risk modeling
Some Key Issues (cont’d)

• Patient activation and engagement

• Agreeing on a common set of cost and quality measures and thresholds, across payer contracts
What is Needed?

A New Care Management Platform
New Care Management Platform

- Reduce office visits
- Expand between-visit at-home care management
- Improve “hand-offs”
- Smoother “glide paths” to health recovery
- Technology enabled within a foundation of continuous improvement.
Some Required Changes

• Inpatient Care Workflow and Redesign

• Care Transition Management
  • e.g. Coleman Care Transition Model

• Physician Referral Patterns

• Interoperable EHRs

• From Inpatient Margin to Total Care Margin
Challenges and Lessons Most Frequently Mentioned by Existing ACOs

- Importance of focusing on high cost/high risk patients
- More attention needs to be given to the post-acute care continuum
- Challenge of engaging specialists
- Difficulty of managing contracts with multiple payers
Challenges and Lessons Most Frequently Mentioned by Existing ACOs (cont’d)

- Dealing with patient choice – can receive care outside the ACO
- Little patient activation/engagement so far
- Continual communication and transparency with all involved are really important
- Big time cultural change
- “It’s like deciding whether or not you are ready to be a parent. At some point, you just decide to have kids”
### Facilitators of ACO Formation and System Transformation

<table>
<thead>
<tr>
<th>Factor</th>
<th>Role and Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facilitators of ACO Formation</strong></td>
<td></td>
</tr>
<tr>
<td>Facilitators of Executive Leadership and Strong Governance</td>
<td>Supports development of shared aims, prioritizes resources and removes obstacles to allow for transformational change</td>
</tr>
<tr>
<td>Strong Payer-Provider Relationship</td>
<td>Facilitates trust and recognition of shared aims to overcome challenges in developing the ACO infrastructure</td>
</tr>
<tr>
<td>Experience with Performance-Based Payment</td>
<td>Develops capability to bear risk, aligns financial incentives and drives performance</td>
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</table>

## Facilitators of ACO Formation and System Transformation (cont’d)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Facilitators of System Transformation</strong></td>
<td></td>
</tr>
<tr>
<td>Robust Health Information Technology Infrastructure</td>
<td>Supports data collection and reporting to identify waste, coordinate care, improve performance, and measure outcomes</td>
</tr>
<tr>
<td>Strong Care Management Capabilities</td>
<td>Provides tools and infrastructure to manage population health and improve care coordination</td>
</tr>
<tr>
<td>Performance Measurement and Transparency</td>
<td>Improves population health, supports care coordination, eliminates waste, and ensures accountability</td>
</tr>
<tr>
<td>Effective Physician Engagement</td>
<td>Perpetuates awareness and support throughout the system and develops physician champions for the model</td>
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</table>

Early ACO Governance
Key Lessons

• Shared goals and incentives
  • Directly linked to performance criteria and individual physician objectives
  • Based on value rather than volume
  • More difficult for hospitals who are not exclusive to specific ACO
• Governance model should reflect function
  • Long history – more formal and integrated
  • Shorter history – more reliance placed on managerial interaction
  • Need to first establish a culture of trust and supportive decision-making processes
  • Need structures that accommodate flexibility
Early ACO Governance Key Lessons (cont’d)

• Align measures and thresholds across payers
  • Reduce the complexity and costs involved

• Credibility and transparency of data
  • Risk-modeling tools for presenting comparative data help
  • Promote physician sense of interdependency for achieving ACO goals

Importance of Managing Social Identities

- Balance organizational identity/socialization with professional identity/socialization

- Use ACOs as a framework or mechanism or vehicle for promoting more integrated coordinated care

ACO’s Are in the Eye of the Beholder

- **An IPA**: it’s about better coordinated care, not integration
- **A medical group**: it’s about integration for employed physicians, but not affiliates
- **A hospital system**: it’s about developing an equal partnership between physicians and the hospital
- **An integrated delivery system**: it’s about a cultural change, not a structural change

Are ACOs More Than a Guess?

Some emerging evidence
Medicare Physician Group Practice Demonstration

• Annual savings per beneficiary/year were modest overall

• But significant for dual eligible population – over $500 per beneficiary, per year

• Improvement on nearly all of 32 quality of care measures

Preliminary Results of Massachusetts Alternative Quality Contract (AQC)

- 2.8% lower costs ($90 per member, per year)
- Savings much larger among groups with no prior experience with risk sharing
- Savings largely from reduced spending for procedures, imaging, and lab tests
- Greatest savings come from patients with highest health risks
- 10 of 11 participating physician groups spent below their targets, earning a budget surplus payment. All earned a quality bonus.

Source: Karen Davis, Commonwealth Fund, July 21, 2012
# Comparison of Accountable Physician Practices Versus Other Practices

<table>
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<tr>
<th>Quality Measures</th>
<th>Crude measures</th>
<th>Adjusted measures</th>
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<tbody>
<tr>
<td>Mammography in women ages 65-69</td>
<td>50.4%</td>
<td>57.9%</td>
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<tr>
<td></td>
<td>53.1%</td>
<td>1.11</td>
</tr>
<tr>
<td></td>
<td>1.12</td>
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<tr>
<td>Completion of all three diabetic tests</td>
<td>53.9%</td>
<td>63.4%</td>
</tr>
<tr>
<td></td>
<td>57.1%</td>
<td>1.12</td>
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<tr>
<td></td>
<td>1.15</td>
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<tr>
<td>ACS admission rate; rate per 100</td>
<td>8.3</td>
<td>6.9</td>
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<tr>
<td></td>
<td>8.4</td>
<td>0.82</td>
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<td></td>
<td>0.92</td>
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<table>
<thead>
<tr>
<th>Cost Measures</th>
<th>Crude measures</th>
<th>Adjusted measures</th>
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<tbody>
<tr>
<td>Standardized MD in 2005</td>
<td>$2,881</td>
<td>$2,764</td>
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<tr>
<td></td>
<td>$3,003</td>
<td>-$239</td>
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<td></td>
<td>-$176</td>
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<tr>
<td>Standardized hospital spending in 2005</td>
<td>$2,405</td>
<td>$2,193</td>
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<tr>
<td></td>
<td>$2,428</td>
<td>-$235</td>
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<td></td>
<td>-$103</td>
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<tr>
<td>Total standardized CMS payments in 2005</td>
<td>$7,406</td>
<td>$7,053</td>
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<td>$7,593</td>
<td>-$540</td>
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<td></td>
<td>-$272</td>
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Sacramento Blue Shield: Dignity-Hill-Calpers Experience

- 42,000 Calpers Members

- Set target premium first – no increase in 2010– and then worked backward to achieve it

- Saved $20 million -- $5 million more than target, while meeting quality metrics

- Package of interventions:
Sacramento Blue Shield: Dignity-Hill-Calpers Experience (cont’d)

- Package of interventions:
  - Integrated discharge planning
  - Care transitions and patient engagement
  - Created a health information exchange
  - Found that top 5,000 members accounted for 75% of spending
  - Evidence-based variance reduction
  - Visible dashboard of measures to track progress
Early Evidence from Primary Care Medical Home Interventions

Group Health Cooperative of Puget Sound (Seattle, Washington)
• 29 percent reduction in ER visits; 11% reduction ambulatory sensitive admissions

Health Partners (Minnesota)
• 39% decrease ED visits; 24% decrease hospital admissions

Geisinger Health System (Pennsylvania)
• 18 percent reduction in all-cause hospital admissions; 36% lower readmissions
• 7 percent total medical cost savings

Source: Karen Davis, Commonwealth Fund, July 21, 2012
Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)
- 20 percent lower hospital admissions; 25% lower ED uses
- Mortality decline: 16 percent compared to 20% in control group
- 4.7% net savings annual

Intermountain Healthcare (Utah)
- Lower mortality; 5% relative reduction in hospitalization
- *Highest $ savings for high-risk patients*

Source: Karen Davis, Commonwealth Fund, July 21, 2012
High Blood Pressure Management

- 67 million Americans

- 36 million not in control
  - Not aware
  - Aware, but not taking medication
  - Aware, treated, but hypertension remains

WHAT TO DO?
KP Northern California Response

- Increased patients under control from 44 percent (2001) to 87 percent (2010)
- Stroke mortality declined by 42 percent
- Heart attacks declined by 24 – most serious by 62 percent
How Did They Do It?

- Hypertension registry
- Used pharmacists to initiate therapy
- Used medical assistants to monitor patients’ progress
- Made it easy for patients to get free blood pressure checks
- Gave doctors feedback on how they compared with others
- 95 percent of patients buy their drugs at KP pharmacies.
Distinguishing Features of Successful Programs

- Frequent face-to-face contacts
- Strong rapport with primary care providers
- Increasing medication adherence
- Early discovery of hospitalizations and facilitating transitions to home
- Communication systems
- Knowing patients’ needs

Source: Randall Brown, Mathematica
Care Managers in Primary Care Practices

- Constant surveillance of frail elderly patients
- 20% decrease in hospitalizations
- 25% decrease in ED visits
- Mortality drop from 20 to 16 percent
- ROI of 2.65/1

Source: Partners Health Care, Boston
Some Ideas to Promote “Spread”

- “Twinning” – organizational mentoring
- “Collaboratories” emphasizing customized technical assistance
- Aligning Forces for Quality (AF4Q) – 16 communities - measurement, QI processes, consumer engagement, public reporting, “community checkup report”
- In-person meetings and team travels
Some Ideas to Promote “Spread” (cont’d)

- HHS Chartered Value Exchange Program
- ONCHIT – Beacon Community Program
- Clinical coaches (Rosenberg) – translate organizational goals to changes in individual physician behavior
  - Face-to-face and phone interaction with physicians
  - 25 MD’s per MD coach
  - Targeted to helping individual physicians achieve quality and cost metrics
Some Ideas to Promote “Spread” (cont’d)

- University of Best Practices – California’s Right Care Initiative
  - San Diego and Sacramento
  - Reduce deaths from heart attacks and stroke by better management of blood sugar, blood pressure, and lipids
Education and Training Recommendation

• Greater emphasis on inter-professional training in:
  • Systems engineering
  • Management science
  • Behavioral sciences
Thank You

“Healthier Lives In A Safer World”