Physicians and Patients: Natural Partners in Identifying the Right Care

NRHI Total Cost of Care Pilot Findings
Elizabeth Mitchell
President & CEO
Network for Regional Healthcare Improvement
Today's Goals

- Share regional experience producing and sharing cost data with physicians
- Consider implications in current policy environment
- Discuss next steps for cost transparency and physician engagement
What is a Regional Health Improvement Collaborative?
NRHI is a non-profit, non-governmental and national organization representing over 30 member Regional Health Improvement Collaboratives (RHICs)

Established in 2004 by seven RHICs who recognized the need for a national membership to support RHIC efforts by:

- Increasing awareness of the key role RHICs play
- Providing technical assistance to RHICs
- Facilitating the ability for RHICs’ to share practical knowledge
- Advocating for the role of RHICs in improving population health and higher value healthcare
NRHI Member Regional Health Improvements Collaboratives (RHICs)

NRHI has over 30 members across the U.S. collectively serving more than 40% of all Americans.

California  New Jersey
Colorado    New Mexico
Iowa        New York
Kentucky    Ohio
Louisiana   Oregon
Maine       Pennsylvania
Massachusetts Tennessee
Michigan    Texas
Minnesota   Utah
Missouri    Washington
Nevada      Wisconsin
Why are we here today?
We have a problem.

Health Spending Share of GDP in the United States, 1962 to 2022

- 1962: 5.3%
- 1972: 7.3%
- 1982: 10.0%
- 1992: 13.1%
- 2002: 14.9%
- 2012*: 17.2%
- 2022P: 19.9%
We know the reasons.

- Lack of Data Access
- Medical Error Rates
- Fragmented Delivery System
- Wrong Incentives
- Poor Health Outcomes
- Lack of Cost Transparency
#1: People Need to Know Where The Opportunities To Improve Are

Quality/Cost Analysis & Reporting

TRIPLE AIM
- Improve Health
- Improve Care Quality
- Reduce Costs
#2: Providers Need to Change the Way They Deliver Care

**Quality/Cost Analysis & Reporting**

**TRIPLE AIM**
- Improve Health
- Improve Care Quality
- Reduce Costs

**Value-Driven Delivery Systems**
#3: Payment & Benefits Need to Support Higher-Value Care

**Quality/Cost Analysis & Reporting**

**TRIPLE AIM**
- Improve Health
- Improve Care Quality
- Reduce Costs

**Value-Driven Payment Systems & Benefit Designs**
#4: Patients Need to Be Educated and Engaged

**Patient Education & Engagement**

- Quality/Cost Analysis & Reporting
- Value-Driven Delivery Systems
- Value-Driven Payment Systems & Benefit Designs

**TRIPLE AIM**
- Improve Health
- Improve Care Quality
- Reduce Costs
Transformation Must be Founded on Reliable Data and Information

- Patient Education & Engagement
- Quality/Cost Analysis & Reporting
- Value-Driven Delivery Systems
- Data, Analytics and Effective Use
- Value-Driven Payment Systems & Benefit Designs

Value-Driven
We have a force for change...

Secretary Burwell Announces HHS Quality Payment Goals, Introduces Timeline For Shifting Medicare Reimbursements From Volume to Value

Payment Reform Taxonomy

1. Fee for Service
   - No link to quality

2. Fee for Service
   - Link to quality

3. Alternate Payment Models
   - Built on Fee for Service

4. Population-Based Payment
...an opportunity to change care for the better...

Practice Transformation
Interoperability Roadmap

...consensus on a starting point...

Transparency
Connecting Health and Care for the Nation:
A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure

Overview

The U.S. Department of Health and Human Services (HHS) has a critical responsibility to advance the connectivity of electronic health information and interoperability of health information technology (health IT). This is consistent with its mission to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. This work has become particularly important as it addresses the national priority of Healthy People 2020, which aims to empower individuals, customize treatment, and accelerate cure of disease.
All the Pieces Have to Be Coordinated…

Patient Education & Engagement

Value-Driven Delivery Systems

Quality/Cost Analysis & Reporting

Value-Driven Payment Systems & Benefit Designs
Where does this all come together?
Measuring Total Cost of Care Across Regions

Total Cost of Care Phase II Project Team Sites are well distributed among the National NRHI Membership.
Total Cost of Care Pilot
November 2013 – April 2015

Project Goal

To develop and produce information to enable communities to reduce the total cost of care in multiple regions with replicable, multi-stakeholder driven strategies.
TCoC Pilot Project Overview

Funded by the Robert Wood Johnson Foundation

- Based on NQF endorsed HealthPartners Total Cost of Care and Resource Use framework
  - Represents all healthcare costs of patients, attributed to PCP
  - Population, person-centered measurement approach using regional multi-payer data
  - Adjustments for patient illness burden allows for meaningful comparisons across practices
  - Separate out cost from relative resource use for identification of variation and potential overuse

- Standardized across 5 regions
  - Considered impact of required data fields, market representation, attribution method, risk adjuster, and quality control timing and techniques

- Identify best practice for sharing cost information with key stakeholders in local communities; goal to identify drivers of and reduce healthcare cost

- Conduct focused work with physicians to help them use cost information to adopt practices that reduce cost, and encourage them to serve as leaders in their communities
TCoC Pilot Project

RHICs who participated in the Original Pilot

- Center for Improving Value in Health Care (CIVHC)
- Maine Health Management Coalition (MHMC)
- Midwest Health Initiative (MHI)
- Minnesota Community Measurement (MNCM)
- Oregon Health Care Quality Corporation (Q-Corp)
TCoC Pilot is extended to Phase II

May 2015 – October 2016

Two additional Team Member sites

Technical Advisor

Again funded by Robert Wood Johnson Foundation

HealthInsight Utah

Maryland Health Care Commission (MHCC)

Compass Health Analytics, Inc. (Compass, Inc.);

Technical Advisor

Robert Wood Johnson Foundation (RWJF)
Lessons Learned

Available at www.nrhi.org
Alignment & Standardization

- Common vision and aligned mission
- Commitment to multi-stakeholder engagement early and often
- Locally tailored to market
- Neutral forum, trusted data
- Private sharing before public release
Pilot Goals Achieved

- Each region produced *and distributed* attributed practice level reports in their respective communities.
- A benchmarking approach across five regions was developed and tested.
- Each Regional Collaborative shared reports with community stakeholders.
- Participating physicians were supported to lead change both locally and nationally with a reporting framework, strategy and practical approaches to affect change.
Detailed Report – Total Cost: Adults

This display helps you compare the care quality and cost of care ratings for up to three medical groups. If a medical group has no HealthScore rating for a specific measure, it has no reportable information. This could be due to not offering that type of care; having too few patients who received that care; not submitting information; or recently being renamed or closed.

Use the back button in your browser to return to the full list of medical groups and change your selections to compare.

Don’t see a health topic you’re looking for? It may be a clinic or hospital measure.

SEVEN DAY CLINIC
MOORHEAD, MN

ST. CLOUD MEDICAL GROUP NW,
SO., COLD SPRING, CLEAR
WATER - IHN
ST. CLOUD, MN

WEST SIDE COMMUNITY
HEALTH SERVICES
SAINT PAUL, MN

TOTAL COST: ADULTS

LOWER THAN AVERAGE $313
AVERAGE $436
HIGHER THAN AVERAGE $646
**Maine Primary Care Practice Report**

<table>
<thead>
<tr>
<th>Practice</th>
<th>BM(^2)</th>
<th>Raw PMPM</th>
<th>Adj PMPM*</th>
<th>PMPM</th>
<th>TCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Fac.</td>
<td></td>
<td>$82</td>
<td>$77</td>
<td>$98</td>
<td>0.78</td>
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<tr>
<td>Outpatient Fac.</td>
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<td>$175</td>
<td>$164</td>
<td>$196</td>
<td>0.84</td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td>$152</td>
<td>$142</td>
<td>$146</td>
<td>0.97</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>$94</td>
<td>$88</td>
<td>$93</td>
<td>0.94</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>$503</td>
<td>$470</td>
<td>$533</td>
<td>0.88</td>
</tr>
</tbody>
</table>

\(^2\) BM = Peer Benchmark  
Note: Retrospective Risk Score for Practice = 1.07  
Displayed as an index to protect information while being transparent with relative performance.
...and Resource Utilization (RUI)

2 BM = Peer Benchmark
Retrospective Risk Score for Practice = 1.07
Displayed as an index to protect information while being transparent with relative performance.
Key Lessons Learned

• **First Step – Know Your Data**
  - Integrity of data, QC and validation checks, external examinations are critical – trust but verify EVERYTHING
  - Don’t underestimate time and resources

• **Assume Nothing**
  - Be specific, detailed, confirm understanding
  - Validate everything – if it doesn’t seem right, investigate

• **Don’t go it Alone**
  - Working together provides a jumpstart, new learning opportunities, and project efficiencies

• **Engage Stakeholders Early**
  - Builds buy-in, adds to validation of results

• **Precision Directly Proportional to Use**
  - Keep the intended purpose in mind
So You Want to Try This at Home? What Does it Take?

Michael DeLorenzo, PhD, Director of Health Analytics
Maine Health Management Coalition

Jonathan Mathieu, PhD, VP for Research & Compliance & Chief Economist, Center for Improving Value in Health Care

Meredith Roberts Tomasi, Program Director
Oregon Health Care Quality Corporation

Mary Jo Condon, Senior Director Partnerships & Projects, Midwest Health Initiative
What Does It Take?

• Ability to substantiate **validity** and **reliability** to your stakeholders

• Demonstrate **meaning**, what affects (or not) results

• Example: More variable year to year than expected
  ▪ Determine causes
    o Not the usual suspects
    o Interaction of data, clinical & payment facts, and measure methodology
  ▪ Find solution/modify methodology
  ▪ Complete **transparency** with all stakeholders
Data Quality Considerations

• Bottom Line:
  – Reality – There is no perfect data
  – Question – When is the data “Good Enough”
  – Answer – It depends on…

• Intended Use of Results and Associated Risks:
  – Reporting to Primary Care Physician Practices
  – Public and other Stakeholder Group Reporting
  – Support Pay for Performance – Moving Money

• Desired Comparisons:
  – Statewide
  – Regional
  – National
Data Quality Considerations

• Trade Offs:
  – Completely standardized and clean claims data
  – Representative of target population
  – Adequate n’s to support intended purpose

• Validation:
  – Cannot validate a claims data set, per se
  – Can validate and establish appropriateness of a claims data set to support a specific use case
  – Data determined to be valid for one purpose will not necessarily be valid to support other uses

• All of this can be thoughtfully addressed!
A relationship without trust is like a phone with no service. And what do you do with that phone? You play games.
Engaging Varied Perspectives Around Improving Health Care Value

**Goal:** We sing the same tune, hand holding optional

**Challenges/Opportunities:**

- True differences in lens
- Environmental Factors
- Moral Imperative
- Financial Interests
“It’s time to change the culture of responsibility for the Triple Aim”.

“Understand the value in physician partnership. Physicians are really your best partner in the healthcare system for this work. Physicians, on a day to day basis, are the most aligned with the needs of their patients.”

Choice and quality in healthcare are concepts that have entered the consumers’ mind. Understanding value will get patients closer to realizing a true marketplace. This is a responsibility the patients are taking on, and providers need to be prepared to respond to new questions of cost and quality when making decisions with patients.
Pilot Results

Available at www.nrhi.org

Cost Transparency from the Ground Up
Findings from the Regional Total Cost of Care Pilot
Executive Summary

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President & CEO
Network for Regional Healthcare Improvement

Ellen Gagnon
Senior Project and Operations Director
Network for Regional Healthcare Improvement

This summary was prepared with support from the Robert Wood Johnson Foundation.
April 30, 2015
Physician Leadership Seminars

National Model – Stanford University, CA
August 2014

Regional Model – Minnesota
June 2015
National Physician Leadership Seminar

- August 2014; Stanford University, CA
- Agenda and Objectives
  - Hosted by Dr. Arnold Milstein
  - Shared understanding of development and results of 2012 TCoC and Resource Use benchmarks, community and practice level reports
  - Physician feedback on cost and resource use information, including content, presentation and usefulness for identification of cost drivers and interventions
  - Develop skills and strategies to engage and lead their community physicians in implementation of efforts to reduce health care costs and improve quality
  - Define role of Physician Champion in accelerating efforts locally; moving from ‘advisors’ to ‘ambassadors’
  - Discuss follow up forums for continued support and learning
Stanford Seminar Approach

• National forum with local connections
  o Recruited up to four emerging physician leaders from 5 participating regions

• Balanced curriculum centered on Total Cost of Care
  o Burning platform for change and the role physicians can play
  o Sufficient technical training to establish familiarity, credibility and usefulness of measures
  o Why change is so difficult for humans and more so for physicians
  o Practical examples of how to reduce variation in practice patterns leading to cost savings
  o Tools and techniques to identify and solve vs pre-packaged solutions

• Group interactions and regional break out sessions

• Pre-seminar homework
Regional Physician Leadership Seminar

- June 2015; Minnesota
- Two sessions offered
- Agenda and Objectives
  - Hosted by Minnesota Community Management and the Institute for Clinical Systems Improvement
  - Call to action by Dr. Arnold Milstein
  - Overview of Total Cost of Care reporting in Minnesota
  - Creating transformational change through data, trust, and relationships
  - Strategies for reducing healthcare cost variation, including case studies
  - Discuss follow up forums for continued support and learning
Regional Approach

- National thought leaders and success stories
- Conversational atmosphere
- Customized for current community knowledge
- Target physicians below the senior leadership
- Share real data
- Map TCOC reporting to the local initiatives already underway by local RHICS
# National vs. Regional Approach

<table>
<thead>
<tr>
<th>Stanford University</th>
<th>Minnesota</th>
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<tr>
<td>August 2014</td>
<td>June 2015</td>
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- 1 ½ days
- Multi-regional
- Audience
  - Total 40; 40% Physicians
  - Future Physician Champions
  - TCoC RHIC Project Teams
- Sample TCoC Reports
- No CME credits

- 1 day curriculum x 2 days
- Single region
- Audience
  - Total 52; 77% Physicians
  - Medical Groups, Health Plan Leadership, Vendors
- Actual TCoC Reports
- 5.75 CME
Role of Physician Champions in Reducing Variation

Michael van Duren, MD, MBA
VP Clinical Transformation,
Sutter Medical Network
Clinical Variation Reduction Process

Sutter Medical Network

- A face-to-face, facilitated meeting with a department where un-blinded, individual clinician data is shared in a safe environment
- Variation Reduction Standard(s) are developed by the clinicians at this meeting
- A Variation Reduction Standard is a specific clinical decision or behavior at the point of care that clinicians develop together
- The Variation Standard becomes a project and clinicians change their behavior as soon as the next day

Some examples:
- prescribe generic instead of a brand medication
- order or not order diagnostics
- perform or not perform a procedure
The Results

Sutter Medical Network

In the last 24 months, 105,883 patients were touched by Variation Reduction through the involvement of 712 clinicians.

Since inception, savings from variation reduction projects has totaled over $30 million across the medical network.
“Everyone thinks they do a good job, but do they really?”

“I think the concept of total cost of care should be as common as any other concept and that physicians should recognize this as a way of medical decision making”

“Having total cost index and RUI are extremely important measures but ensuring that appropriate quality measures are also being tracked in association with those cost/resource measures is also very important.”
How familiar are you with the following measurement terms and concepts?

- TCI
- RUI
- Combo TCI/RUI
- Condition Specific Utilz
- Condition Specific Cost

![Bar chart showing familiarity levels pre and post seminar](chart.png)
Seminar Ratings

**Overall**, how would you rate this seminar?

- Excellent: **80%**
- Good: **20%**

How likely are you to **attend another** national NRHI Seminar?

- Very Likely: **70%**
- Somewhat Likely: **30%**

How likely are you to **recommend** a NRHI seminar to a colleague?

- Very Likely: **90%**
- Somewhat Likely: **10%**
Questions?
Special Thanks
TCoC Pilot and Phase II Team Members

Mary Jo Condon
Senior Director, Partnerships and Projects
Midwest Health Initiative (MHI)

Doug Rupp
Senior Health Care Analyst
Oregon Health Care Quality Corporation (Q-Corp)
Thank You

www.nrhi.org
#healthdoer(s)
twitter: @RegHealthImp