nrhi Network for Regional Healthcare Improvement

Patient-Centered Primary Care Collaborative National Briefing

July 30, 2015

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?

Network for Regional Healthcare Improvement (NRHI)

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)

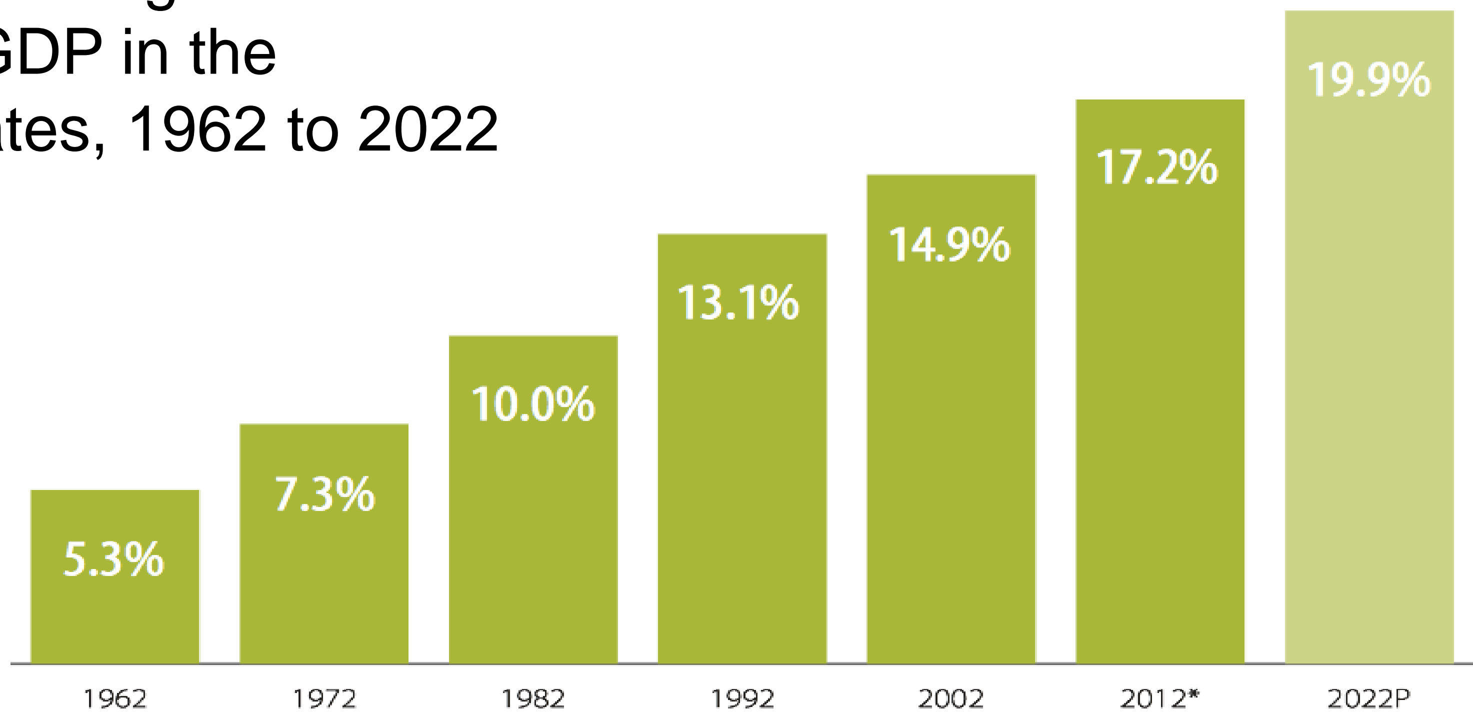
NRHI has over 30 members across the U.S. collectively serving more than 40% of all Americans.

- California
- Colorado
- Iowa
- Kentucky
- Louisiana
- Maine
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Nevada
- New Jersey
- New Mexico
- New York
- Ohio
- Oregon
- Pennsylvania
- Tennessee
- Texas
- Utah
- Washington
- Wisconsin

Why are we here today?

We have a problem.

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



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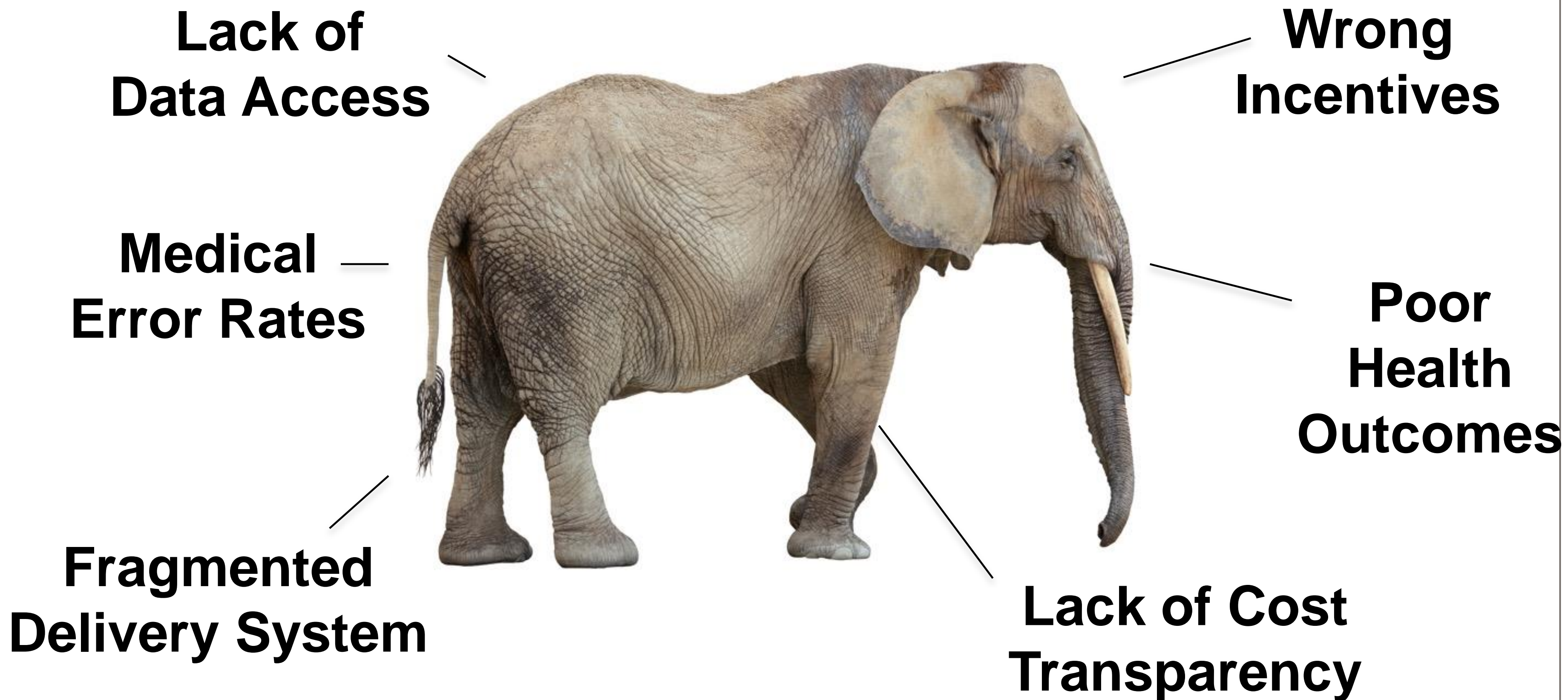
We know the reasons.



#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

Value-Driven Delivery Systems

#4: Patients Need to Be Educated and Engaged

Patient Education & Engagement

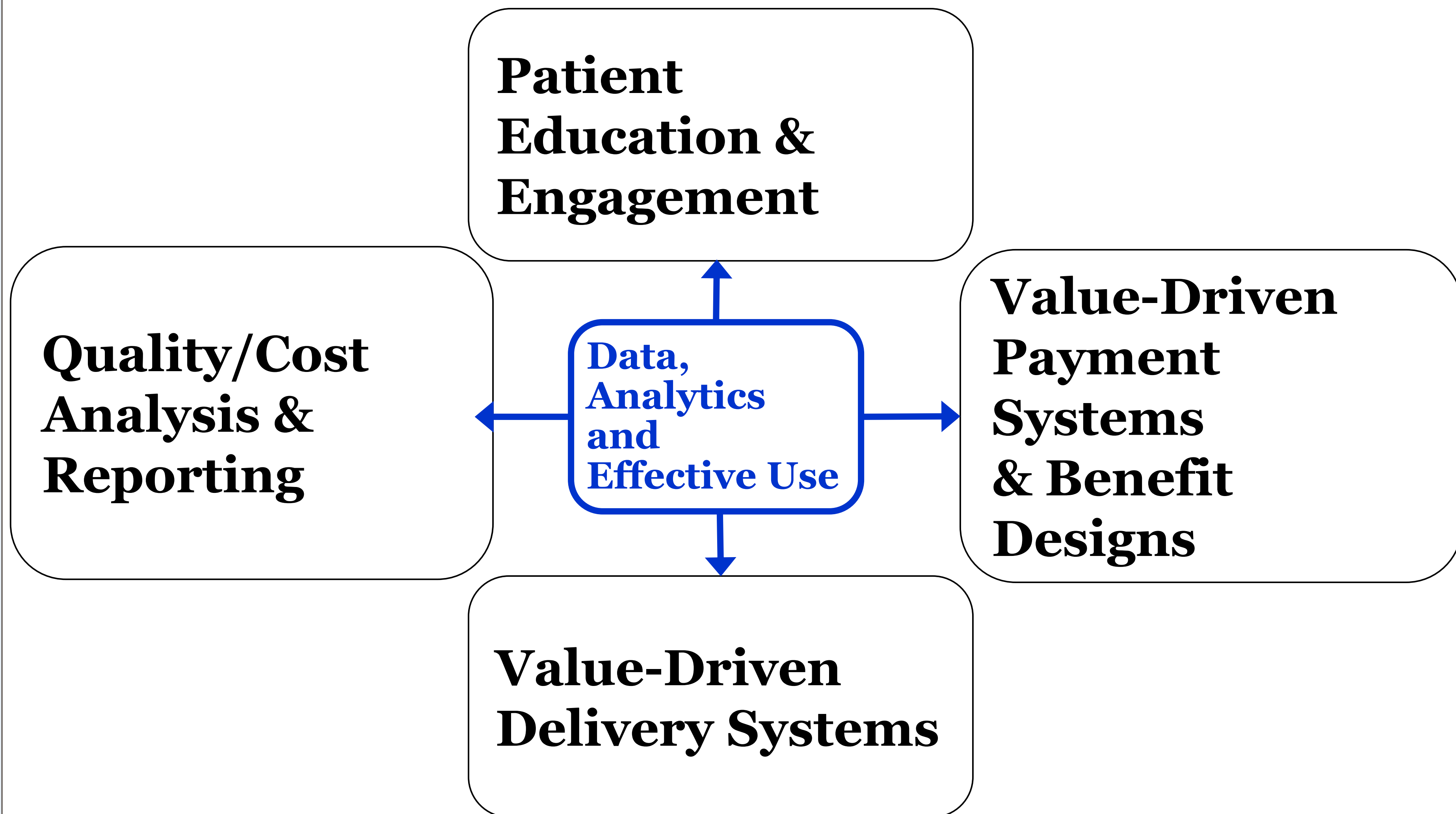
Quality/Cost Analysis & Reporting

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

Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems

Transformation Must be Founded on Reliable Data and Information



We have a force for change…

January 27, 2015

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

Payment Reform Taxonomy

1	2	3	4
Fee for Service	Fee for Service	Alternate Payment Models	Population-Based Payment
No link to quality	Link to quality	Built on Fee for Service	

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…an opportunity to change care for the better…

Treatment Room

Practice Transformation

…consensus on a starting point…

Transparency

...and a roadmap.

Health Information Technology

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

Interoperability Roadmap

empowers individuals, customizes treatment, and accelerates cure of disease.

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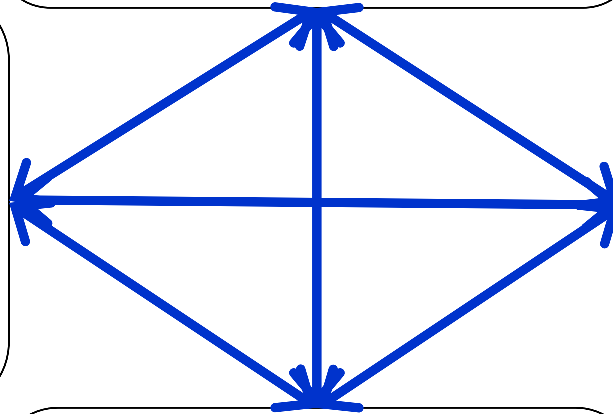
All the Pieces Have to Be Coordinated…

Patient Education & Engagement

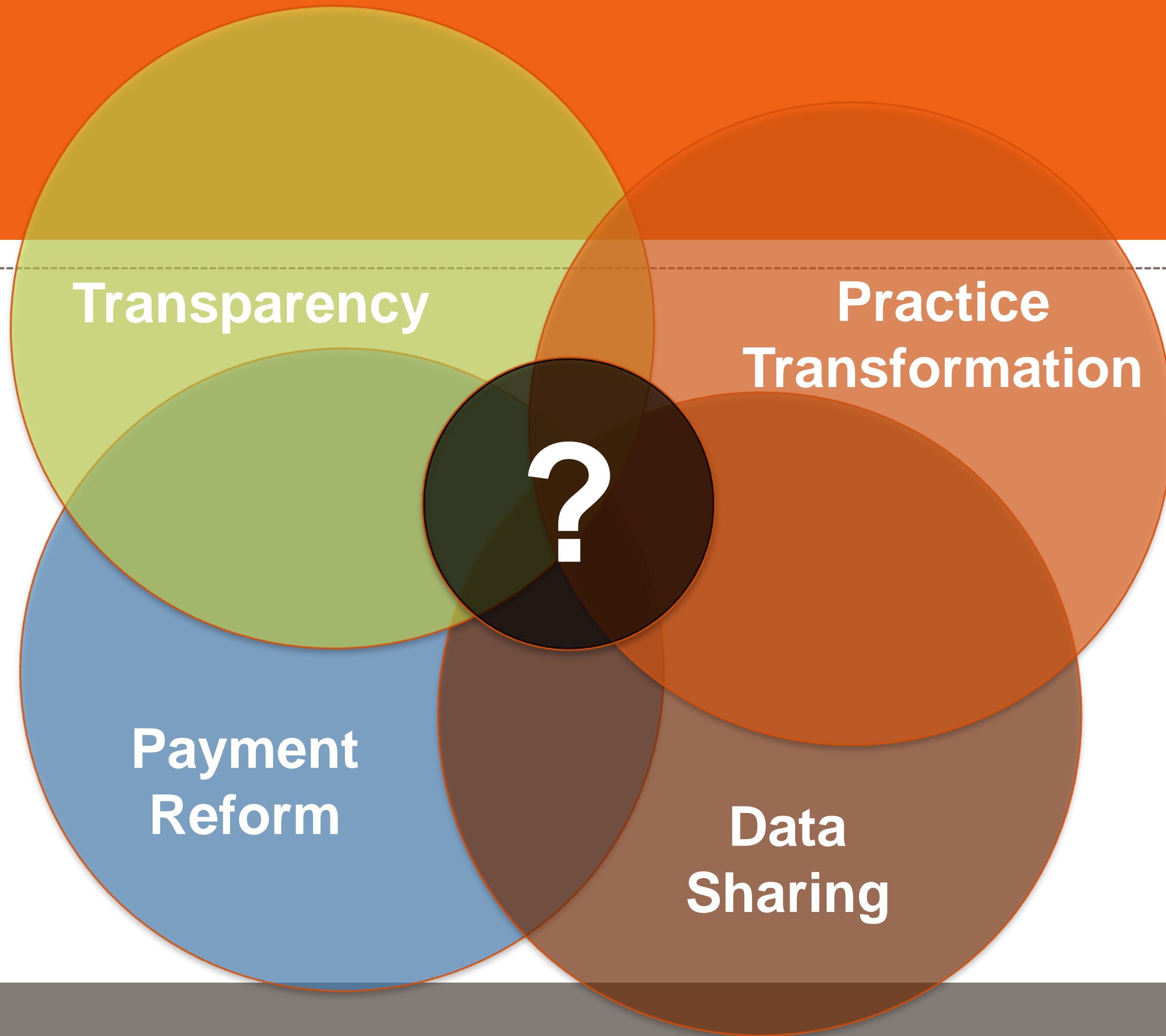
Quality/Cost Analysis & Reporting



Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems

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

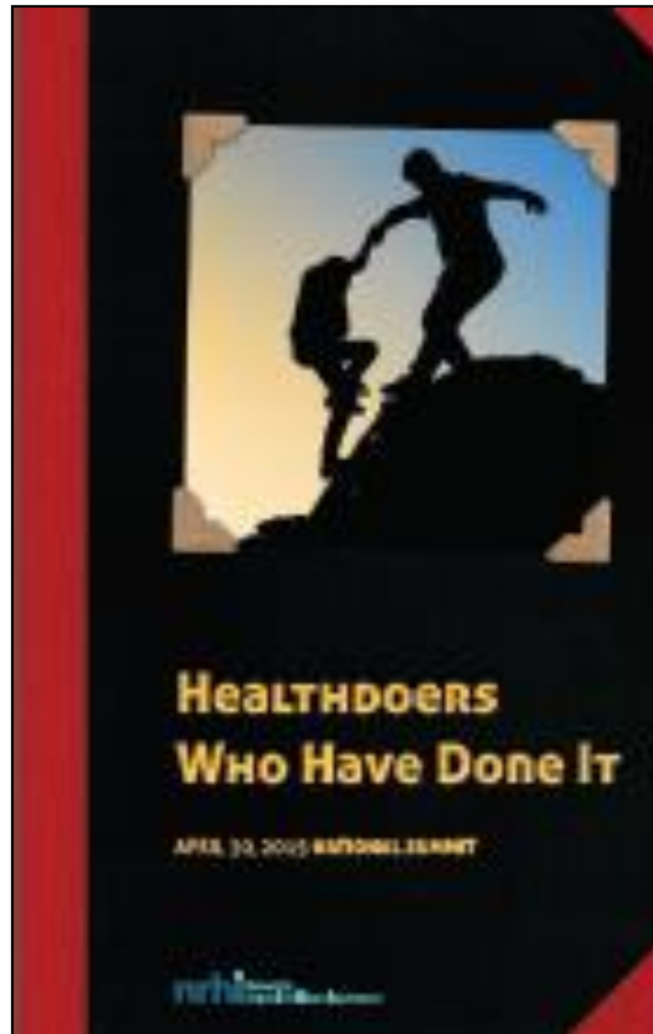
Maryland Health Care Commission (MHCC)

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

Robert Wood Johnson Foundation

Robert Wood Johnson Foundation (RWJF)

Lessons Learned



Available atwww.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.

TCoC Publically Reported at the Medical Group Level

MINNESOTA HealthScores
When Health Care Improves, Everyone Wins.

TRANSFORMING HEALTH | MEASURING QUALITY | MANAGING COST | ADVANCING THE FUTURE

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.

Go back to Detailed Report

STANDARD VIEW | DETAILS VIEW | LEGEND

	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

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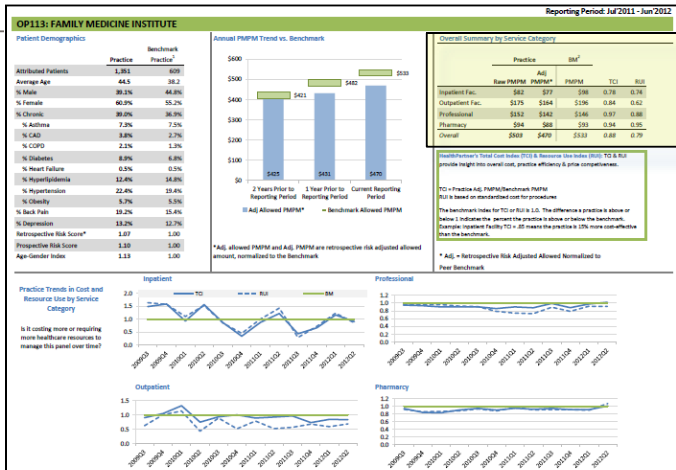
Maine Primary Care Practice Report



Reporting Period: Jul'2011 - Jun'2012

OP113: FAMILY MEDICINE INSTITUTE

Patient Demographics

	Practice	Benchmark Practice[1]
Attributed Patients	1,351	609
Average Age	44.5	38.2
% Male	39.1%	44.8%
% Female	60.9%	55.2%
% Chronic	39.0%	36.9%
% Asthma	7.3%	7.5%
% CAD	3.8%	2.7%
% COPD	2.1%	1.3%
% Diabetes	8.9%	6.8%
% Heart Failure	0.5%	0.5%
% Hyperlipidemia	12.4%	14.8%
% Hypertension	22.4%	19.4%
% Obesity	5.7%	5.5%
% Back Pain	19.2%	15.4%
% Depression	13.2%	12.7%
Retrospective Risk Score*	1.07	1.00
Prospective Risk Score	1.10	1.00
Age-Gender Index	1.13	1.00

Annual PMPM Trend vs. Benchmark

*Adj. allowed PMPM and Adj. PMPM are retrospective risk adjusted allowed amount, normalized to the Benchmark

Overall Summary by Service Category

	Practice		BM[2]		
	Raw PMPM	Adj PMPM*	PMPM	TCI	RUI
Inpatient Fac.	$82	$77	$98	0.78	0.74
Outpatient Fac.	$175	$164	$196	0.84	0.62
Professional	$152	$142	$146	0.97	0.88
Pharmacy	$94	$88	$93	0.94	0.95
Overall	*$503*	*$470*	*$533*	*0.88*	*0.79*

HealthPartner's Total Cost Index (TCI) & Resource Use Index (RUI): TCI & RUI provide insight into overall cost, practice efficiency & price competiveness.

TCI = Practice Adj. PMPM/Benchmark PMPM
RUI is based on standardized cost for procedures

The benchmark index for TCI or RUI is 1.0. The difference a practice is above or below 1 indicates the percent the practice is above or below the benchmark. Example: Inpatient Facility TCI = .85 means the practice is 15% more cost-effective than the benchmark.

* Adj. = Retrospective Risk Adjusted Allowed Normalized to Peer Benchmark

Practice Trends in Cost and Resource Use by Service Category

Is it costing more or requiring more healthcare resources to manage this panel over time?

	Practice		BM[2]	
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Inpatient Fac.	$82	$77	$98	0.78
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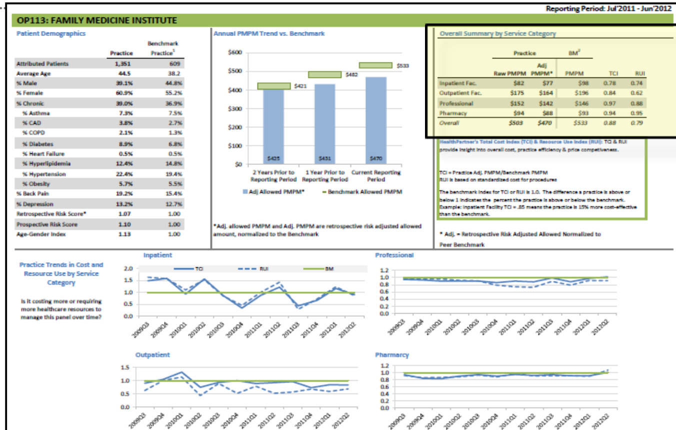
[2] BM = Peer Benchmark
Note: Retrospective Risk Score for Practice = 1.07
Displayed as an index to protect information while being transparent with relative performance.

…and Resource Utilization (RUI)



	Practice		BM²		
	Raw PMPM	Adj PMPM*	PMPM	TCI	RUI
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[2] BM = Peer Benchmark
Retrospective Risk Score for Practice = 1.07
Displayed as an index to protect information while being transparent with relative performance.

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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 <u>validity</u> and <u>reliability</u> to your stakeholders
- Demonstrate <u>meaning</u>, what affects (or not) results
- Example: More variable year to year than expected
  - Determine causes
    - Not the usual suspects
    - Interaction of data, clinical & payment facts, and measure methodology
  - Find solution/modify methodology
  - Complete <u>transparency</u> with all stakeholders

Data Quality Considerations

CIVHC

- 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

CIVHC

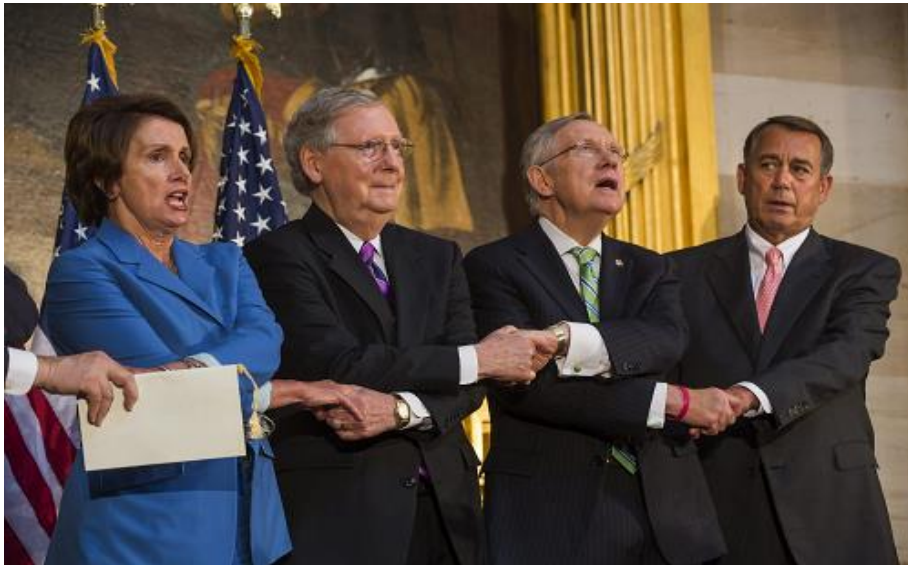
- Trade Offs:
  - Completely standardized and clean claims data
  - Representative of target population
  - Adequate n's to support intended purpose
- Validation:
  - Cannot validate a claims data set, per se
  - Can validate and establish appropriateness of a claims data set to support a specific use 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!

Trust

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**

MIDWEST HEALTH INITIATIVE

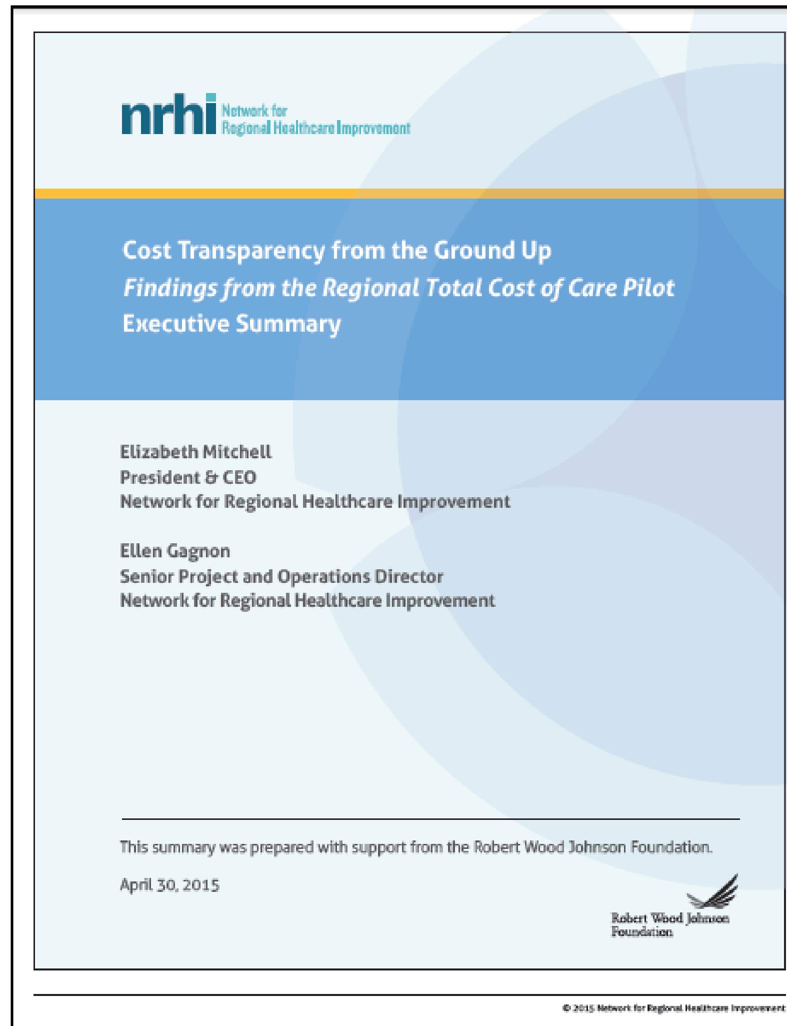
What are physicians saying? They have a key role to play…

"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


nrhi Network for Regional Healthcare Improvement

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

Robert Wood Johnson Foundation

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Available atwww.nrhi.org

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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
  - Recruited up to four emerging physician leaders from 5 participating regions
- Balanced curriculum centered on Total Cost of Care
  - Burning platform for change and the role physicians can play
  - Sufficient technical training to establish familiarity, credibility and usefulness of measures
  - Why change is so difficult for humans and more so for physicians
  - Practical examples of how to reduce variation in practice patterns leading to cost savings
  - 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

Stanford University August 2014	Minnesota June 2015

Stanford University

August 2014

- 1 ½ days
- Multi-regional
- Audience
  - Total 40; 40% Physicians
  - Future Physician Champions
  - TCoC RHIC Project Teams
- Sample TCoC Reports
- No CME credits

Minnesota

June 2015

- 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

Sutter Health
Sutter Medical Network
We Plus You

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

Sutter Health
Sutter Medical Network
We Plus You

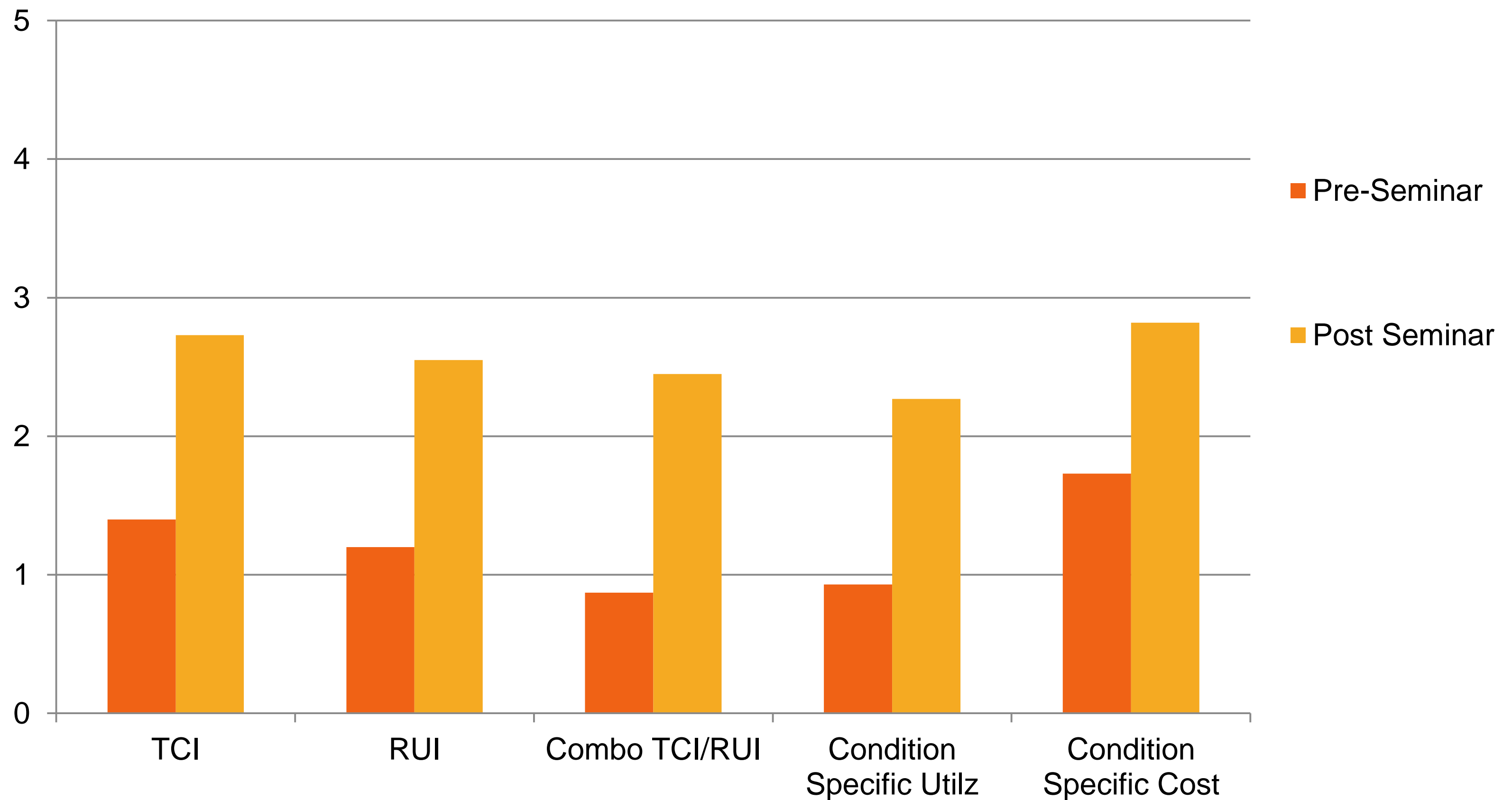
What Physician Leaders are Saying…

"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?



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

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