Funding Arrangements and Quality Improvement: Is There a Connection?

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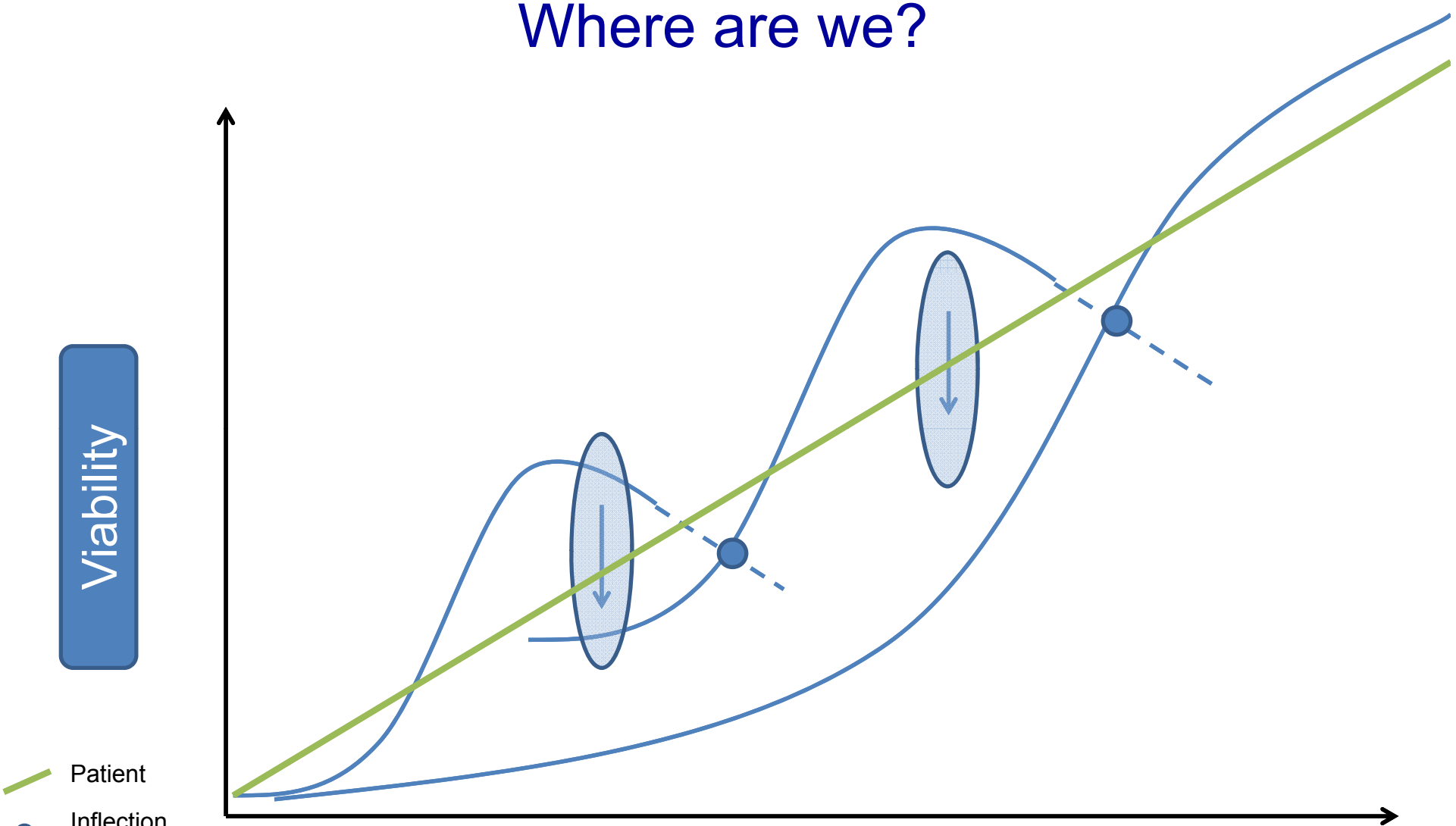
Where are we?



Clinical Model	Episodic Care	→	Coordinated Care	→	Patient Directed Care
Business Model	Fee for Service	→	Bundled Payment/Capitation	→	Disruptive Innovation?
Infrastructure	Segmented	→	Integrated	→	Cloud

Models

Adapted from *The Second Curve*, *Ian Morrison* 1996

Funding Arrangements and Quality Improvement

- Is there a connection?
  - ➢The answer is: *yes*…and *no*

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Some Examples of “Yes”

- Blue Cross Blue Shield of Massachusetts’ (BCBSMA) Alternative Quality Contract (AQC)

- CareOregon’s CareSupport

And Some Examples of “No”

- UPMC hip and knee replacement
- Self hemo-dialysis unit in Jönköping, Sweden
- Bellin Health

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BCBSMA's Alternative Quality Contract

Goals:

- Reduce the rate of increase in health care costs by one-half over five years
- Improve the quality of patient care
- Reward doctors and hospitals for the quality and outcome of care they provide, not just the quantity of services

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AQC: 3 Ways for Providers to be Paid

1. Global payments designed to cover all medical services for a defined population of patients (adjusted for age, sex, and health status); includes primary, specialty, hospital, and pharmacy care

   - creates incentives to work across the continuum

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AQC: 3 Ways for Providers to be Paid

2. Additional payments over term of contract based on annual rate of inflation as determined by Consumer Price Index (in the US, this is rising at less than half the rate of medical inflation)

   - Flexible – adjusts to societal changes

AQC: 3 Ways for Providers to be Paid

3. Potential for substantial bonus payments (up to 10% of total contract) based on quality metrics, both for ambulatory and hospital-based care

- creates clear quality metrics based on process and outcome measures for high-volume conditions / procedures and patient care experiences

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Early Changes for AQC

- Monthly data / feedback and analytical support for the practice
- Organizational leaders formed teams of key physician groups and hospitals to assess quality and cost across the continuum
- Designed systems to share data and to manage clinical variation
- Created clinical teams to manage operational variation

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Early Changes for AQC

- Working with the community to manage out-referrals, to ensure access and quality when services can be provided in system
- Working on changing the culture from “fee-for-service thinking” to evidence-based care
- Focusing on IHI’s Triple Aim

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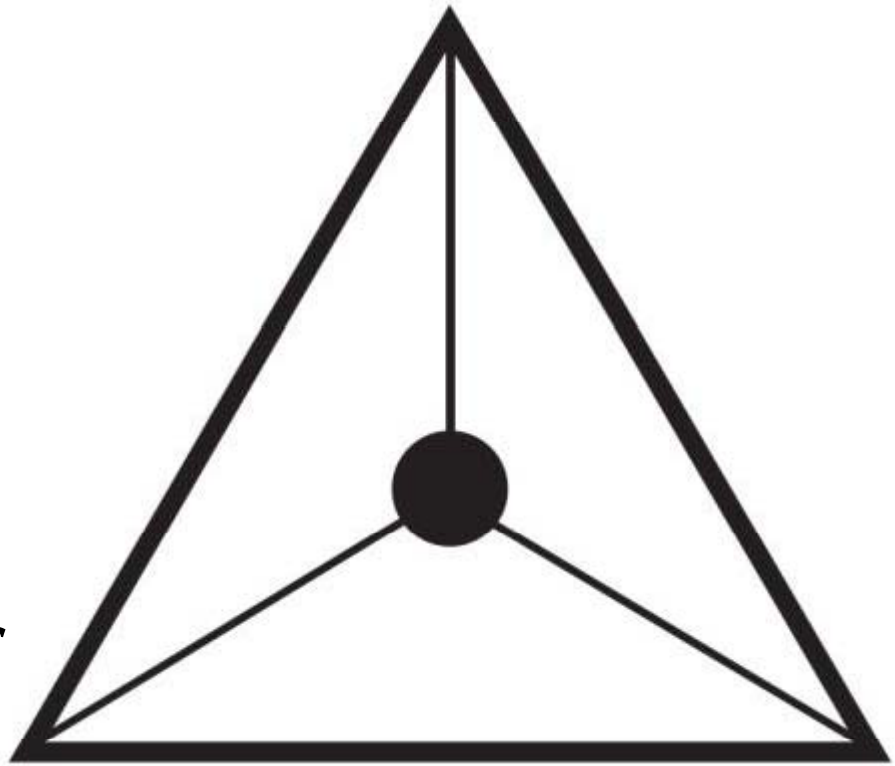
Health of a Population



Experience of Care

Per Capita Cost

The IHI *Triple* Aim

AQC Results

- In the first year of the AQC, improvements in the quality of patient care were greater than any one-year change seen previously, and significantly exceeded rates of improvement prior to the contract, and compared to non-AQC physicians.
- For some clinical outcome measures (e.g., managing chronic conditions), AQC groups have met or are approaching the highest levels of performance believed possible for a patient population.

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AQC Results

- All provider groups have met their budgets, producing surpluses that allow them in invest in infrastructure and other improvements.
- AQC groups outperformed non-AQC groups on all prevention measures.
- No decreases in patient care experience measures.

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AQC Results (Cost)

- All AQC provider groups performed better than their total medical expense budgets.
- AQC positively impacted two major health care cost drivers – hospital readmissions and use of emergency rooms (ER).
  - AQC groups avoided $1.8 million in readmission costs.
  - One AQC group reduced non-emergency ER visits by 22%, which translates into $300,000 in avoided costs.

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Thoughts on Potential

- In the last months, almost all of the major hospitals and systems in Massachusetts have signed on to the AQC. Most recently, Children's Hospital Boston signed on for a 0% rate increase for 2012, and modest increases (below general inflation) for the life of the 3-year contract.

- Requires visionary leadership, new processes, timely and focused data, collaboration with new partners, and a foundation of skills to innovate and improve.

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CareOregon

- Learned about Triple Aim design from Doug Eby at Southcentral Foundation, and redesigned care for a challenging population.

- With local clinicians, designed a new model for care called Primary Care Renewal which emphasized team-based care, proactive panel management, patient-centered care across the continuum and across time, and integrated behavioral health and advanced access.

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CareOregon

- Had some local success with pioneering practices and offered to pay the network $2 per member per month more, but still well below market (“miserable plus $2 is still miserable”).

- Took the funding from individual clinicians and funded collaborative efforts to innovate and learn together.

CareOregon – New Payment Schemes

Phase 1:

- Bonus for provider participation in collaborative
- Quality improvement bonus for improvements in diabetes, hypertension, and prevention
- Bonuses for decreases in hospitalization and emergency department utilization through better control of these diseases

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CareOregon – New Payment Schemes

Phase 2:

- No payment for participation
- More payments for additional quality metrics, including access
- Customized to patient populations

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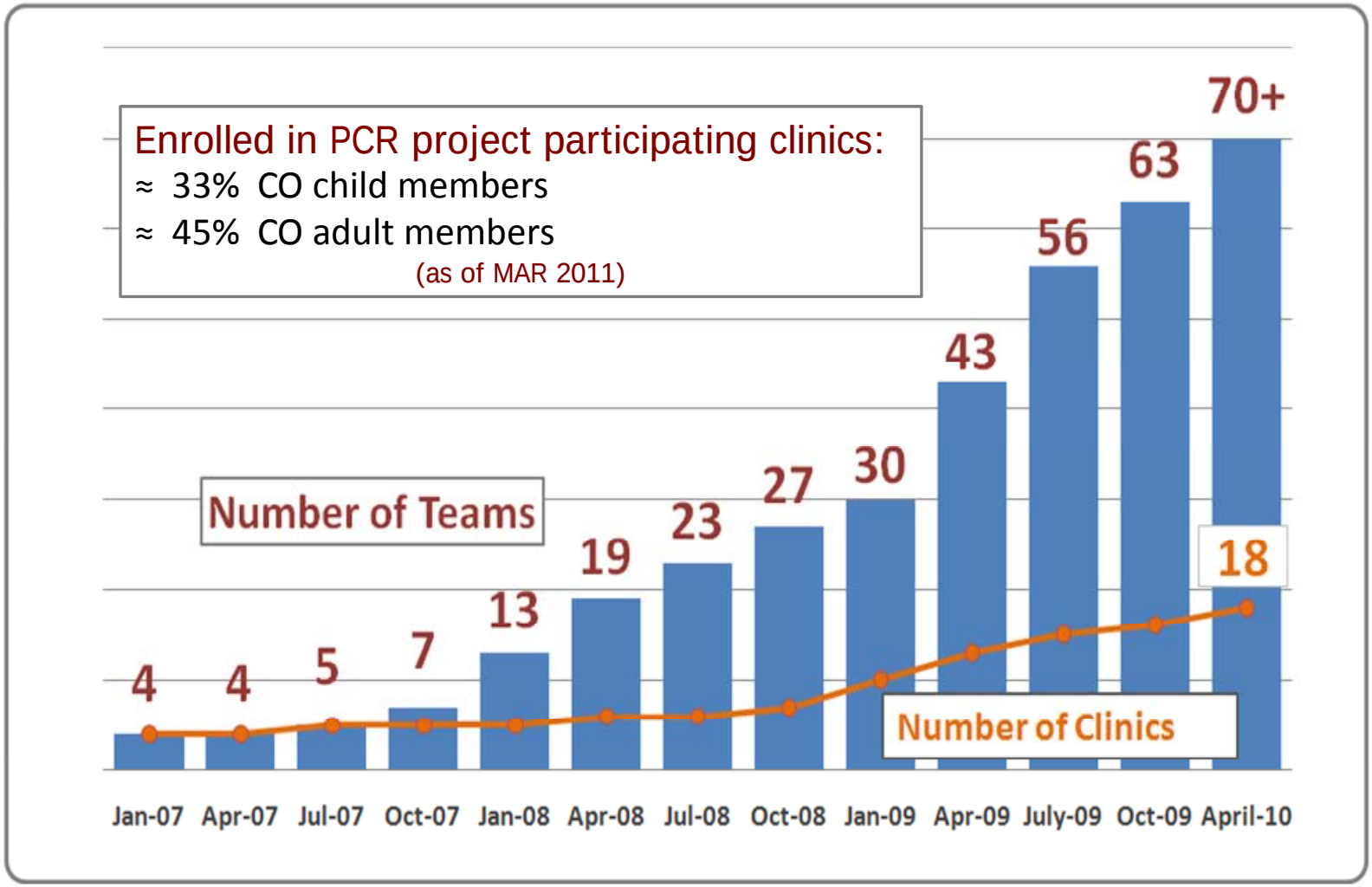
CareOregon – Results

Primary Care Renewal – Pt centered Medial Home



CareOregon – Results

- Decrease in emergency department and urgent care use of over 40%
- Decrease in specialty care use of over 50%
- Decrease in primary care visits of 20%
- Decrease in admissions and inpatient days of 30%

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Boston Sunday Globe
Founded 1872
CHRISTOPHER M. MAYER *Publisher*
MARTIN BARON *Editor* PETER S. CANELLOS *Editor, Editorial Page*
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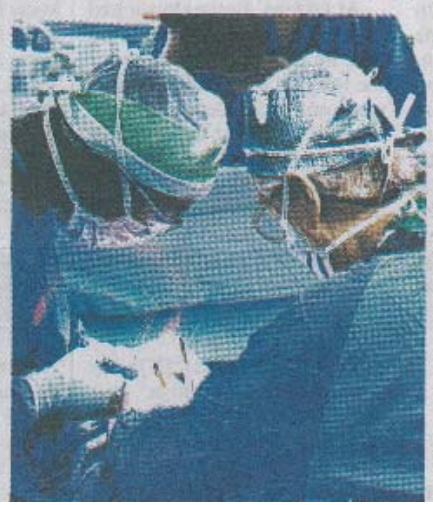
EDITORIALS

Big savings for small business in new, innovative health plans

FOR YEARS now, small businesses have complained about the big annual premium increases they faced for health insurance. Two years ago, state policymakers agreed to let small companies form purchasing cooperatives to bargain for better rates. Now that experiment is paying off. New health plans announced last week will allow members of the first such cooperative to save at least 20 percent, and in some instances double that, on premiums. Those small businesses have every reason to be pleased, but they should share some of the new savings with their employees.

The new, less costly health plans are the result of a partnership between Steward Health Care System, the for-profit provider network run by Ralph de la Torre; Fallon Community Health Plan, the state's fourth-largest insurer; and the Retailers Association of Massachusetts, which was instrumental in winning passage of the



could grow to as much as 42 percent. That plan has a $2,000 deductible for individuals and $4,000 for a family, the maximum allowed under state standards.

Although that's a high threshold, Hurst thinks such a plan will be a good fit for younger workers who rarely see the doctor, particularly since yearly physicals are fully covered with no co-pays. Further, Fallon will administer pre-tax accounts to help employees and employers meet the deductible. The retailers association already uses those; there, employees save pre-tax dollars to fund Flexible Spending Accounts they use to pay the first $1,000 of the deductible; the association funds the next $3,000 from its Health Reimbursement Arrangement plan. Paying $3,000 toward the deductible in those years when a particular employee needs care is cheaper than paying higher premiums every year.

So will small businesses follow that example? "We can't make them, but we will cer-

Funding Arrangements and Quality Improvement

- Is there a connection?
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Some Examples of “No”

- UPMC hip and knee replacement
- Self hemo-dialysis unit in Jönköping, Sweden
- Bellin Health

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A Case Study From University of Pittsburgh Medical Center (UPMC)

- Aims in redesigning care for patients undergoing total joint replacement
  1. Patient and family education
  2. Less invasive techniques
  3. Multimodal anesthesia and pain management techniques
  4. Rapid rehabilitation protocols
  5. Rapid outcomes feedback (from the patients' and the providers' perspectives
  6. Creating a learning environment and culture
  7. Developing a sense of community, competition and teamwork among patients and between patients, caregivers and staff
  8. Promoting a wellness (rather than sickness) approach to recovery

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Tony DiGioia

Dr. Anthony M. DiGioia III, orthopedic surgeon and developer of the patient- and family-centered care program for UPMC, in his office at Magee-Womens Hospital in Oakland

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A Case Study From UPMC

- New Designs:
  - Pre-op testing, teaching
  - Coaching meetings with other patients
  - Pre-surgery discharge planning
  - Strong focus on complete pain management
  - “Wellness” design in orthopedics unit

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Results

- Safe:
  - Mortality rate: 0%
  - Infection rates: 0.3% (0.2% for TKA and 0.7% for THA)
  - Zero dislocations
  - SCIP compliance: 98% for antibiotics within one hour of surgery

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Results

- Effective:
  - 95% of patients discharged without handheld assistance directly to home (national rates: 23-29%)
  - 99% of patients reported that pain was not an impediment to physical therapy, including same-day-of-surgery physical therapy

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Results

- Patient-centered:
  - Press-Ganey mean satisfaction score is 91.4% (99th national percentile ranking) with 99.7% positive responses to “Would you refer family and/or friends?”
- Efficient:
  - Average length of stay:
    - 2.8 days for TKA (national average is 3.9 days)
    - 2.7 days for THA (national average is 5.0 days)
  - One MD able to perform 8 joint replacements before 2:00pm

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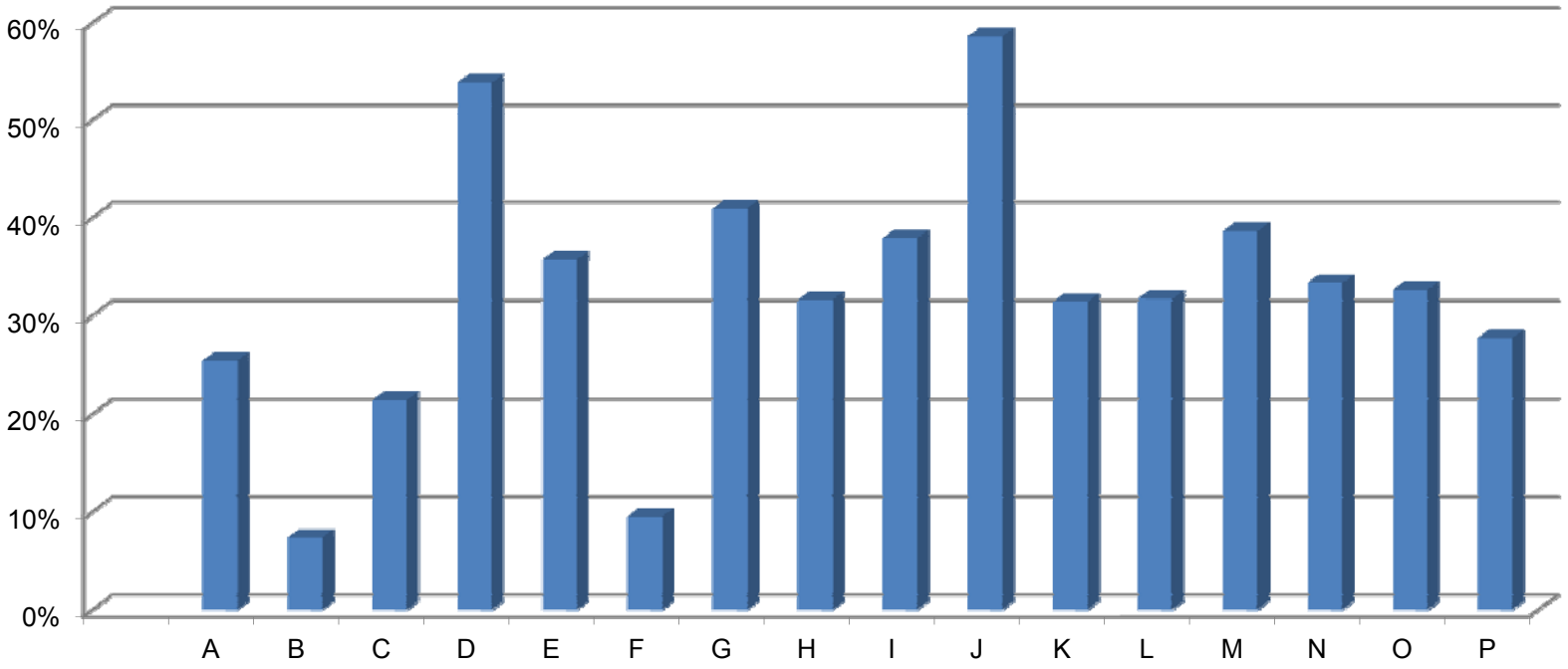
Transfusion Rates for Total Hip Replacements by Surgeon



*Information is based on cases for Fiscal Year 2009

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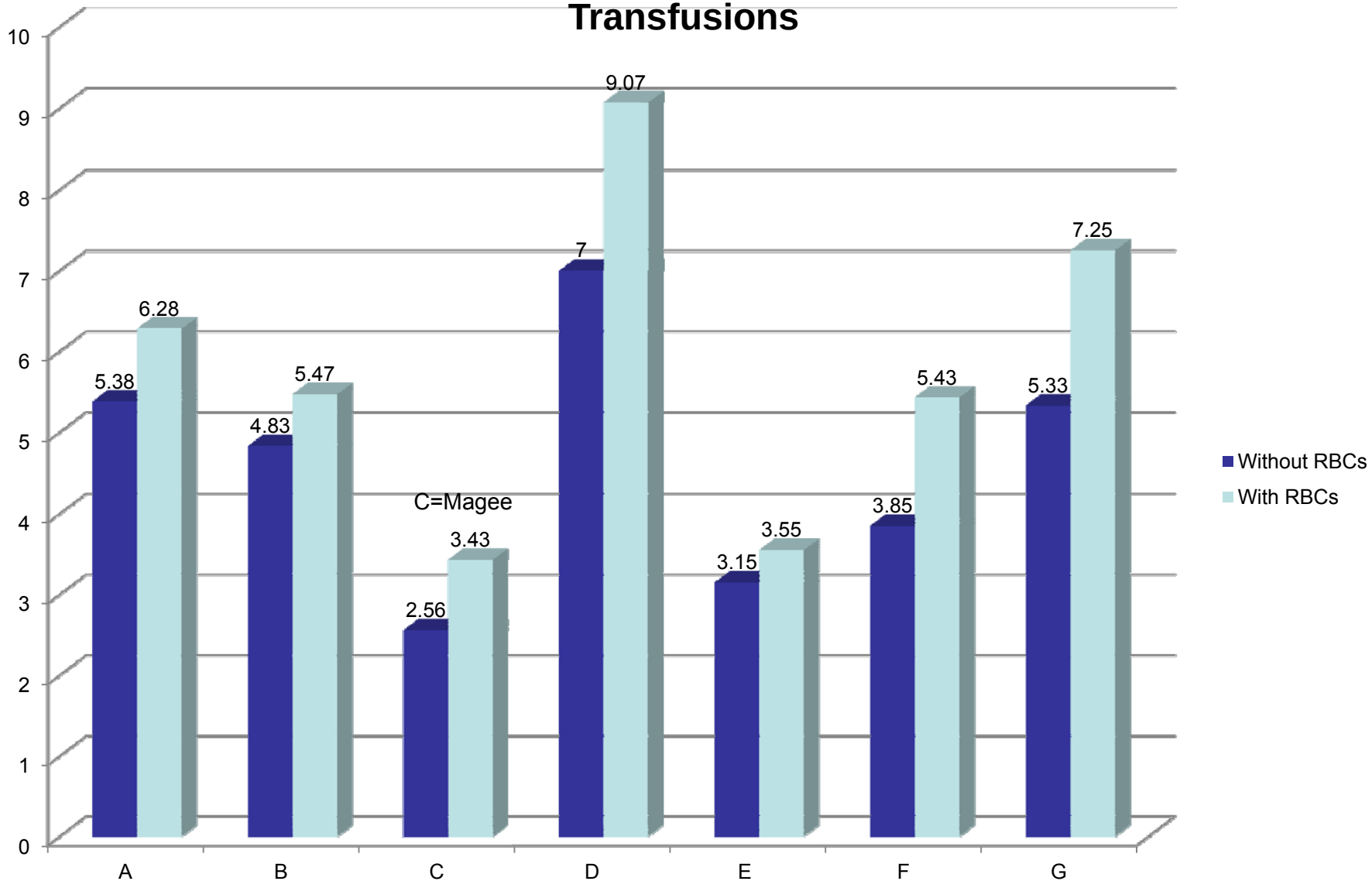
Average Length of Stay Comparison by Hospital for Total Hip Replacement Cases with and without Red Blood Cell Transfusions



Other PFCC Projects at UPMC

- Day of Surgery (UPMC Presbyterian)
- Human Resources – The New Hire Experience (UPMC Corporate)
- Trauma (UPMC Presbyterian)
- Wayfinding / Lobby (Magee-Women's Hospital)
- Rheumatology (Children's Hospital of Pittsburgh)
- Minimally Invasive Bariatric and General Surgery (Magee-Women's Hospital)
- Home Health Rehabilitation (Jefferson Regional)

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UPMC – PFCC Updates

- Tony DiGioia is now working with Michael Porter and Bob Kaplan at Harvard Business School to quantify:
  - Dark green dollars saved per patient on episodes of care
  - Controlled capital costs by increasing efficient utilization of OR and patient bed spaces
  - Impact on productivity of staff (8-11 cases per day)
  - Effect on patient-satisfaction, market share, and retention rates
  - Time to full functionality and impact on patient productivity

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Innovation: Learning from Patients

The Old Way

- Ryhov Hospital in Jönköping had traditional hemodialysis and peritoneal dialysis center.
- But in 2005, a patient, Christian, asked about doing it himself.

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The New Way

- Christian taught a 73-yr-old woman how to do it…

- …and they started to teach others how to do it.

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The New Way

- Now they aim to have 75% of patients to be on self-dialysis
- They currently have 60% of patients

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Lessons to Date

- From Christian (patient):
  - —"I have a new definition of health."
  - —"I want to live a full life. I have more energy and am complete."
  - —"I learned and I taught the person next to me, and next to her. The oldest patient on self-dialysis is 83 years old."
  - —"Of course the care is safer in my hands."

Lessons to Date

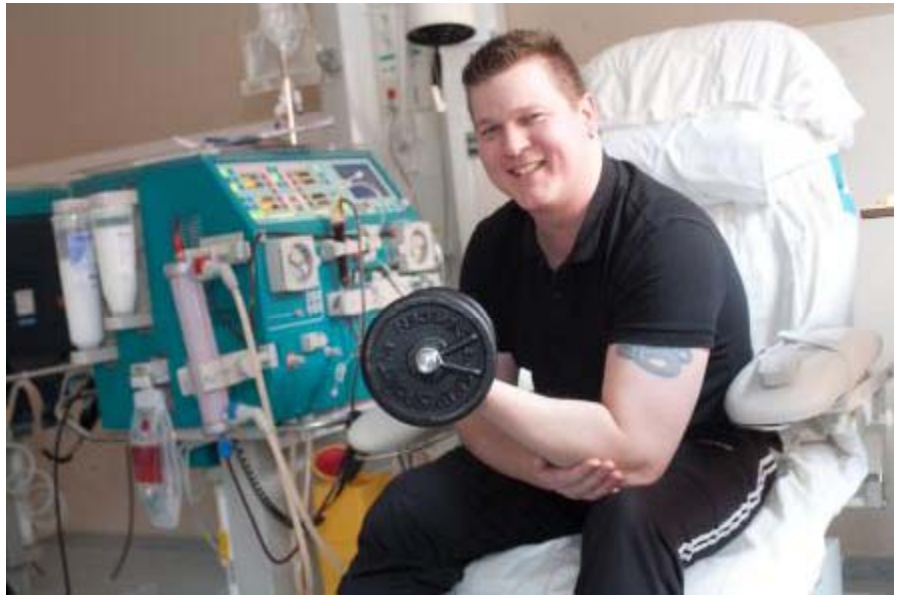
- From Anette (nurse leader):
  - Surprised at design differences between patients, family, and staff
  - Managing at 1/2 – 1/3 less cost per patient
  - Evidence of better outcomes, lower costs, far fewer complications and infections
  - “We brought in the county’s employment, helped the patients make or update the CVs, and trained them for a new career.”

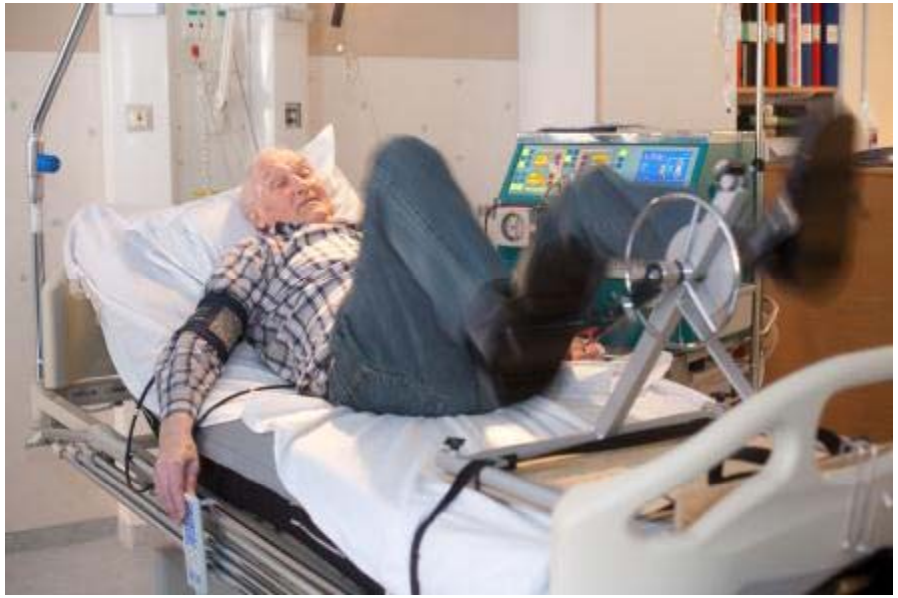
Lessons to Date

- From Britt Mari (nurse and innovator):
  - Found courage to say “yes” in the patient’s face
  - “We used the same training program as I use for new nurses.”
  - “The patients are our partners in designing the unit, buying equipment, teaching, and planning.”

Lessons to Date

- From Ingrid (nurse):
  - —"I got the courage to change (after 40 years) because I saw the patients 'lift up.'"
  - —"I moved from being a technical expert to a coach."
  - —"The patients are so fit, always exercising while they treat."





Update

- Now calculated costs at 50% of costs in other hemo-dialysis units
- Complications dramatically reduced and subsequent expensive care avoided
- Measuring success by “number of patients working”

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Health Navigation: Bellin Health

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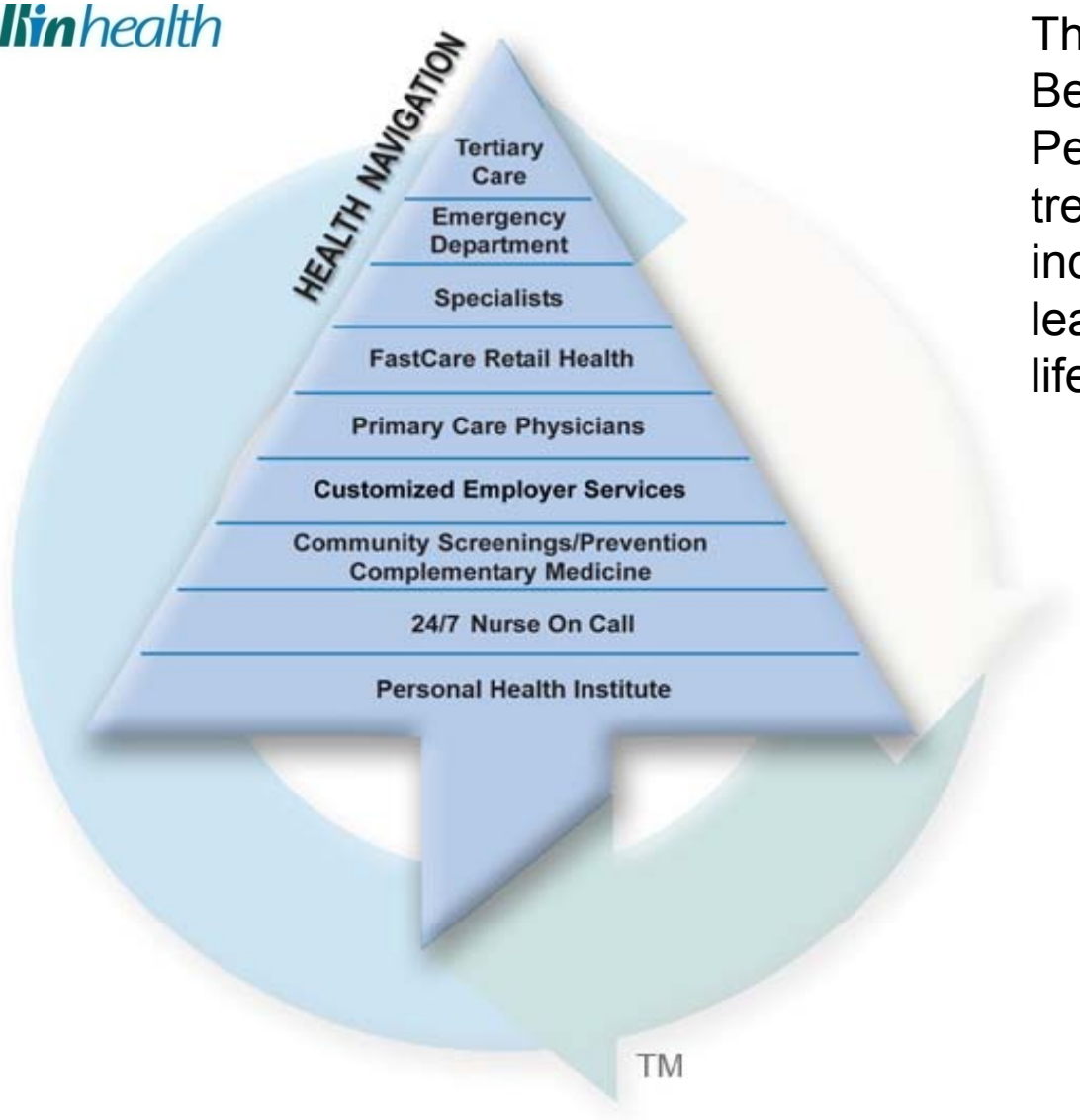

The new gateway to Bellin Health. Personal, tailored treatment to individuals' needs, learning styles and lifestyles.

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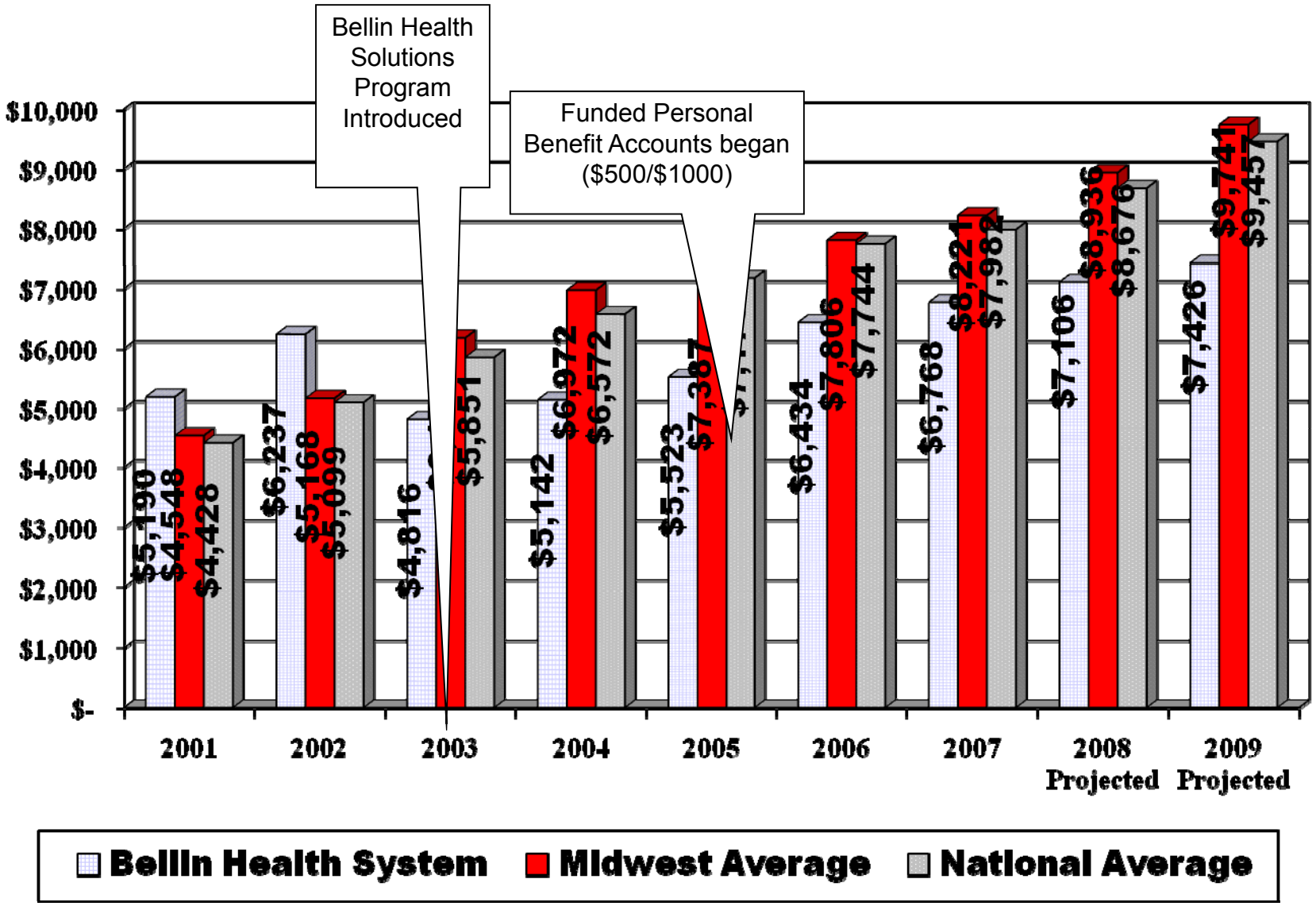
Bellin Health
Cost of Employee Plan vs. Averages



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Results

- Improved aggregate average HRA score from 71.4 to 75.2 on a 100 point scale.

- Decreased high risk scores on HRA (0 to 50) points from 16.3% to 10.6%

bellinhealth

Results

- Lowered employee health costs by 33%
- No increase to Bellin's cost of providing employee insurance
- If adopted on the national level could save employers $63 billion.
- 42 employers are utilizing the THM
- Reporting employers running an average 20% lower health care costs from average

Lessons from Bellin Health

- Worker health is frequently overlooked by measures of organizational vitality, workplace efficiency, and direct costs.
- Building success in improved quality and outcomes internally allows for an expanded view of the market.
- Effective alternative to downsizing in current market and proves best care can cost less and add to market strength.

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The True Disruptor

Christian

Thank You!

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