The Future Is Now: The Successful Medical Enterprise In Challenging Times

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CHOIR CENTER FOR HEALTHCARE ORGANIZATIONAL + INNOVATION RESEARCH

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Outline

- Understanding the Challenge and the Opportunity
- The Essential Elements of Integrated Care Delivery Models
- The Role of Value-Based Payment Models in Incenting Continuous Improvement in Care
- Highlighting the Evidence to Date
- Defining and Incorporating Health Equity Under the Capitated, Integrated Care Model

The Challenge and the Opportunity

- Most Costly Healthcare System in the World – 18% GDP
- Estimated 25-30% Waste
- Yet. Some of the Poorest Outcomes
- Highly Variable Quality of Care

California Advantages/Opportunities

- Innovative Health Insurance Exchange – Covered California
- History of Organized Medical Groups/IPAs Working Under the Delegated Model
- Integrated Healthcare Association (IHA)-Pay for Performance

Essential Elements of Integrated Care Delivery Models

- Stratifying patients by level of severity
- Pro-active coordinated team-based care
- Use of specially trained nurse care mangers to work with complex high needs patients
- Actively engage patients in pre-visit planning, mutual goal setting, and shared decision-making
- Wide use of evidence-based standardized care guidelines and clinical pathways
- Integrated information systems
- A performance management system
- A continuous improvement learning-oriented culture with strong leadership

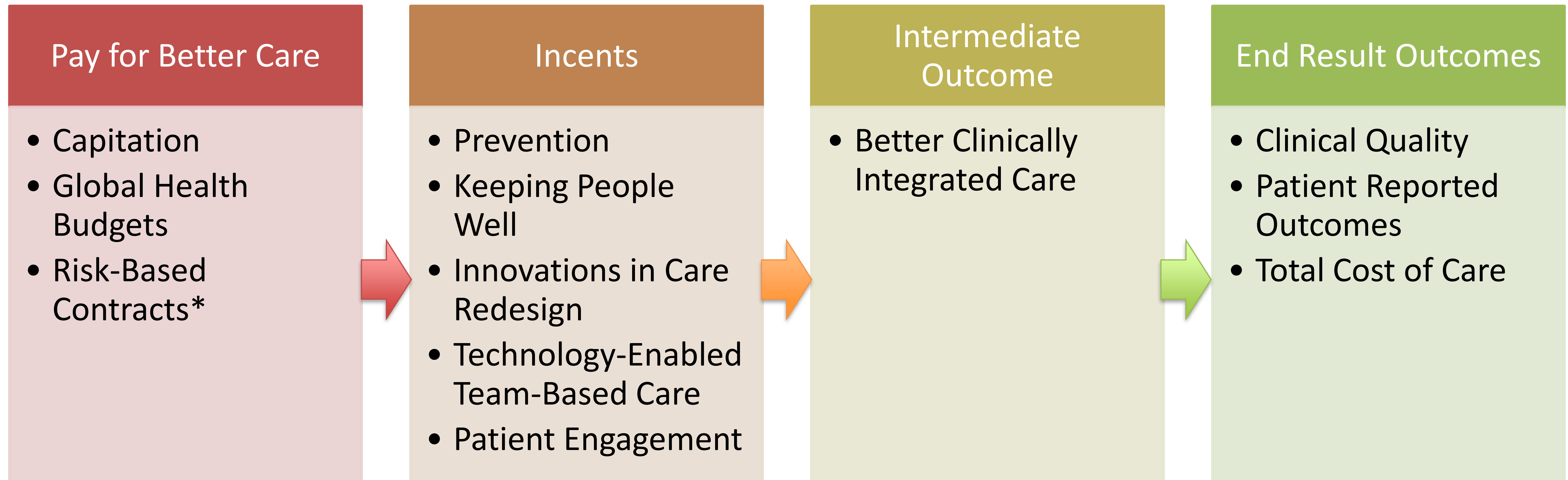
Team-Based Care Criteria

1. Clinicians working with patients and their families to make care decisions together
2. Resources and capacity to provide or arrange for all needed care
3. Actively coordinate patients' care across providers and sites, over time
4. Assume responsibility for the health outcomes and cost of care
5. Every team member uses their competencies and practices at the "top of their license"
6. Access to point-of-care data on performance with systems and training to continuously improve care
7. Receive timely feedback on the quality of care that they are providing
8. Patients always have ready access to their claims and electronic record data
9. Can identify high-risk patients requiring special care needs
10. Have access to relevant resources to address patients behavioral and social needs

Some Evidence on Better Care Teams

- Patients receiving care with poor teamwork almost five times more likely to have complications or die from surgery
- Teams that are more patient-centered and that have "champions" make more in-depth changes to improve chronic illness care
- RAND study found that PCMHs using team-based care had better quality care for patients with diabetes, and reductions in hospital admissions and costs non team care -based PCMHs
- A recent study of primary care practices found that teams provided better care and outcomes than solo providers for patients with diabetes, hyperlipidemia, and hypertension
- A recent meta-analysis of 31 studies of teams found statistically significant "medium-size effects" on performance across multiple tasks, including postoperative complications and blood stream infections

Logic Model of Value-Based Clinically Integrated Better Care



* ”Groups With a Larger Share of Revenue From Risk Contracts are more likely to have salaried physicians, advanced data management capabilities, preferred relationships with efficient specialists, and formal programs to coordinate care for high-risk patients”

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Mechanic R. and Zinner DE, Health Affairs, September, 2012 3!(9)! 1994

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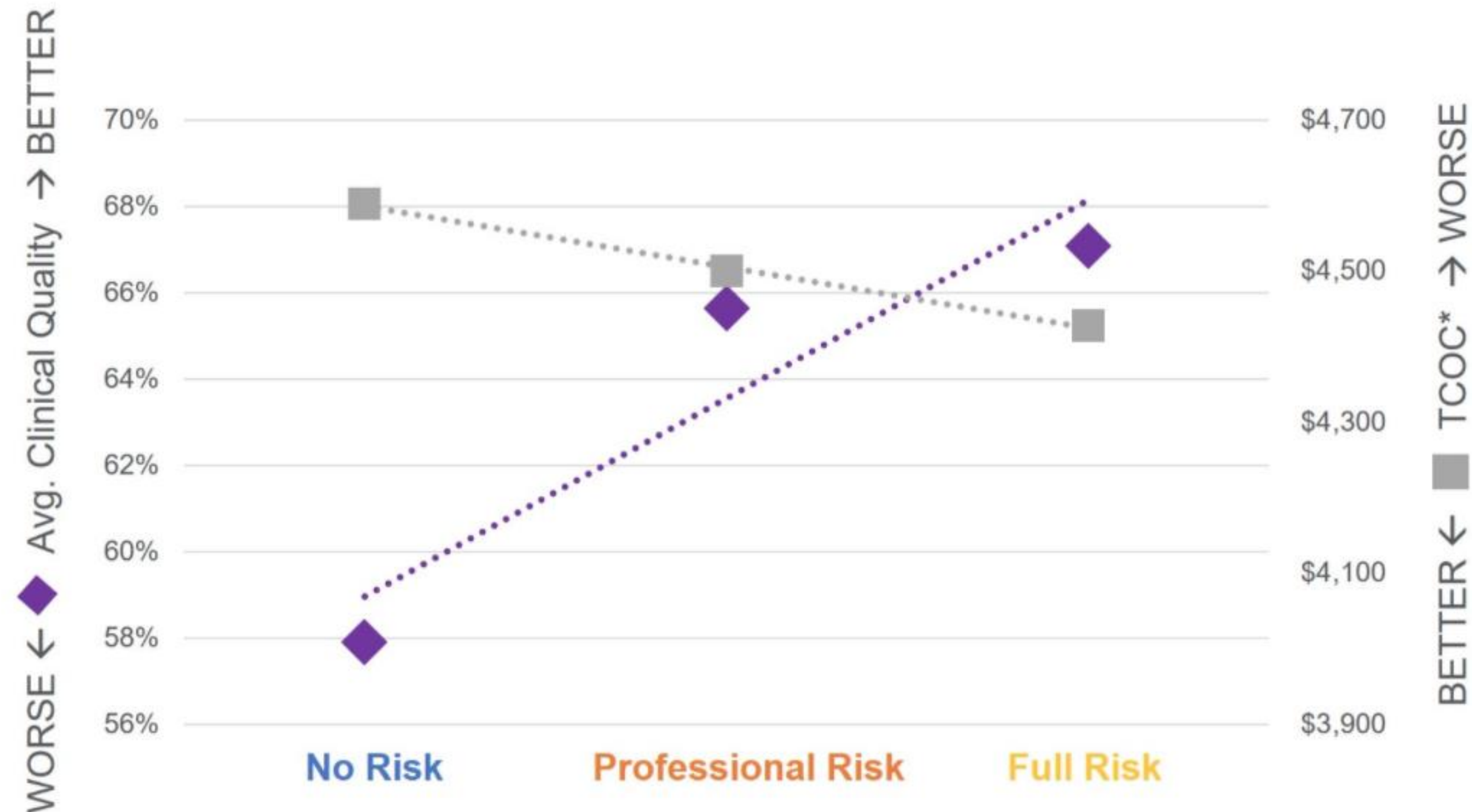
Importance of All Payers Moving Toward Capitation

- MGMA Study of Nearly 1,000 Primary Care Practices
  - Shifting to team-based care for low complexity chronically ill patients
  - If 63% of annual payments were capitated, 95% of the practices would have a financial gain
  - But if below 20% of payments were capitated 95% of the practices would lose money
- Underlying difference in how the practices treated chronically ill patients under capitation versus fee-for-service payments
- Yet, fee-for-service reimbursement still accounts for over 70% of healthcare expenditures in the state

Increasing Evidence for Higher Quality, Lower Cost from Risk-Adjusted Prepaid Per Member Per Month Payment

- ACO experience – 1-2% savings; better quality. New models such as REACH
- Medicare Advantage Experience – better quality, lower cost, growing in popularity; Coding concerns and related to be addressed
- California IHA Experience with Pay for Performance – Full risk and professional risk had better quality and lower cost than fee-for-service
- Medicaid managed care – Oregon Coordinated Care Organizations

Cost and Quality by Risk-Sharing Arrangements in California



Source: California Regional Health Care Cost and Quality Atlas, Integrated Healthcare Association, April 12, 2019. Used with permission.

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Implementing Innovations in Care Management Processes (0 to 100 scale)

	California Practices (N = 219)	Rest of the Country (N = 1971)	P-value
Care of complex/high need patients	46%	39%	0.0001
Shared decision-making with patients	49%	42%	0.0001
Use of EHRs for decision support	63%	55%	0.0001
Use of evidence-based guidelines	73%	60%	0.0001
Use of registries	63%	49%	0.0001

Source: Analysis of National Survey of Healthcare Organizations and Systems (NSHOS) – Dartmouth, Berkeley, High Value Health Care Collaborative Center of Excellence, April, 2019

Degree of Participation in Payment/Delivery System Reforms (0-9)

(N = Over 2,000 practices)

Measure	Correlation
Care of Complex, High Need Patients	.28*
Participation in Quality-Focused Payment Progress	.19*
Screenings for Clinical Conditions	.14
Screenings for Social Needs	.18*
Use of Evidence-Based Guidelines	.22*
Use of EHR-Based Decision Support	.19*
Use of Patient-Engagement Strategies	.24*
Use of Quality-Focused Information	.23*
Support of Care Transition	.28*

* = statistically significant

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Source: National Survey of Physician Practices, Dartmouth, Berkeley, Harvard Center of Excellence, Health Systems Performed, funded by the Agency for Healthcare Research and Quality

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Percent of Patients Covered By ACO Contracts

(N = Over 2,000 practices)

Measure	None/Some (mean score)	Most/All (mean score)
Care of Complex, High Need Patients	.40	.46*
Participation in Quality-Focused Payment Programs	.26	.28
Screenings for Clinical Conditions	.81	.82
Screenings for Social Needs	.34	.39*
Use of Evidence-Based Guidelines	.57	.66*
Use of EHR-Based Decision Support	.53	.58*
Use of Patient-Engagement Strategies	.46	.53*
Use of Quality-Focused Information	.40	.44*
Support of Care Transition	.38	.44*

* = statistically significant

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Source: National Survey of Physician Practices, Dartmouth, Berkeley, Harvard Center of Excellence, Health Systems Performed, funded by the Agency for Healthcare Research and Quality

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Percent of Revenue With Cost of Care Incentives

(N = Over 2,000 practices)

Measure	Bottom Third Mean	Middle Third Mean	Top Third Mean
Care of Complex, High Need Patients	.41	.46	.43
Participation in Quality-Focused Payment Progress	.26	.28	.28
Screenings for Clinical Conditions	.80	.82	.82
Screenings for Social Needs	.32	.33	.38*
Use of Evidence-Based Guidelines	.53	.63	.64*
Use of EHR-Based Decision Support	.48	.55	.57*
Use of Patient-Engagement Strategies	.44	.52	.52*
Use of Quality-Focused Information	.40	.44	.43*
Support of Care Transition	.38	.45	.41*

* F Test statistically significant

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Source: National Survey of Physician Practices, Dartmouth, Berkeley, Harvard Center of Excellence, Health Systems Performed, funded by the Agency for Healthcare Research and Quality

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Physician Practices With Robust Capabilities Spend Less On Medicare Beneficiaries Than More Limited Practices

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Abstract

No research has considered a range of physician practice capabilities for managing patient care when examining practice-level influences on quality of care, utilization, and spending. Using data from the 2017 National Survey of Healthcare Organizations and Systems linked to 2017 Medicare fee-for-service claims data from attributed beneficiaries, we examined the association of practice-level capabilities with process measures of quality, utilization, and spending. In propensity score–weighted mixed-effects regression analyses, physician practice locations with "robust" capabilities had lower total spending compared to locations with "mixed" or "limited" capabilities. Quality and utilization, however, did not differ by practice-level capabilities. Physician practice locations with robust capabilities spend less on Medicare fee-for-service beneficiaries but deliver quality of care that is comparable to the quality delivered in locations with low or mixed capabilities. Reforms beyond those targeting practice capabilities, including multipayer alignment and payment reform, may be needed to support larger performance advantages for practices with robust capabilities.

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The Practice Capabilities

- Care of Complex Patients
- Use of Evidence-based Guidelines
- Use of EHR Based Decision Support
- Use of Registry Functions
- Learning Oriented/Team Culture
- Capacity for Innovation
- Depression Care Management
- Patient Engagement Activities
- Patient Responsiveness
- Patient-reported Outcomes

Key Findings

- Robust Practices had $615 per beneficiary less spending than mixed capability practices and $505 per beneficiary less spending than practices with limited capacities. With no differences in the quality of care provided.
- Most of it was accounted for by lower spending for evaluation and management services and outpatient spending.

Defining Health Equity

- "Everyone has a fair and just chance to be as healthy as possible" - Paula Braveman
- Need to remove obstacles - poverty, discrimination, barriers to safe environments, affordable housing, education and health care
- Health care should be provided according to need and not based on personal characteristics or economic and social position

See: RM Scheffler and O Shane, "Health Equity: Califronia Style", The Milbank Quarterly, December 6, 2021

Some State Initiatives

- California Healthy Places Index (HPI) used during Covid - based on 25 community attributes
- Proposed Health Equity Fund (AB 1038) - $60 million per year over three years. Targeted to communities most affected by the pandemic
- Cal-Aim Medi-Cal waivers - “Whole Person Care”

Adjusting Payments for the Social Determination of Illness

- Area Deprivation Index (ADI)
  - Based on neighborhood characteristics at the census block level - income, quality of housing, food insecurity etc
  - RAND algorithm based on zip codes

Components Needed to Achieve Clinically Integrated Better Care

Strategic	• Must be an ongoing true North priority of the organization
Structural	• Must be aligned out all levels • Organization-wide • Department, division • Inclined Patient – caregiver interaction
Cultural	• Beliefs, values, norms, behaviors of continuous improvement
Technical	• Actionable information, training,, and skills of the workforce

What Happens When Just One is Missing?

Strategic	Structural	Cultural	Technical	Result
0	1	1	1	No or little impact on anything
1	0	1	1	Inability to capture the learning and spread it throughout the organization
1	1	0	1	Small, temporary effects; no lasting impact
1	1	1	0	Frustration, false starts, underperformance
1	1	1	1	Continuously improving clinically integrated better care

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Integration is Difficult Work

“Creating integrated health systems that function seamlessly to optimize care for patients is devilish hard. It requires strong, consistent, talented, and courageous leadership to overcome the huge barriers to making integrated systems work at the frontlines where it matters.”

David Blumenthal, President of the Commonwealth Fund, Health Services Research, 2020

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Thank you

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