THEDACARE
CENTER FOR
HEALTHCARE VALUE

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HEALTHCARE DELIVERY REFORM POLICY

Demanding More from Healthcare Reform

The purpose of this policy statement is to detail what the Center believes are the core components of healthcare reform related to the delivery of care. We will also suggest the core components of payment reform that will support the needed delivery reform.

President Obama recently announced his $3 trillion-plus budget, which includes more than 600 billion dollars in healthcare spending that will be financed through increased taxes and Medicare payment cuts. The president and congress for the most part are focused on insurance coverage for Americans and are not addressing what we consider to be the actual problem.

What is the problem? We believe the underlying problem is there is a trillion dollars of waste in healthcare. The waste includes defects, over utilization, poor care coordination, overcapacity and much more. We have a lack of a comparative measurement system to determine who might be delivering more efficient care, and we have a financing system that rewards low quality and high cost. Politicians are focused on insurance coverage for all, which is a laudable goal, but lack of insurance coverage is not the cause fundamental problem. If the problem is high cost and poor quality designing a care system dedicated to delivering better value to the customer is where we need to focus. In addition to providing insurance solutions, we need to identify the waste in the system and develop plans to remove it.

If one of the core components of a redefined delivery system is better value for the patient, we must put the patient at the center of the redesign. In order to remove hundreds of billions of dollars of waste in care delivery we need to organize in a way that minimizes this waste. The new organizational design should deliver an entire efficient "value stream" which is a set of steps that deliver specific value or products to people. If we map out processes in care delivery we find that the majority of the steps involved in that delivery are waste in the eyes of the patient. Value is only created when the patient's entire condition is treated at once and there is measurable improvement.. The patient is looking for a provider or group of providers who can meet their needs in the management of their condition such as diabetes or chronic hip pain. The patient is looking for an "accountable" process owner for the episode of care. We are suggesting this process owner be named an "Accountable Health Organization". The purpose of this process owner or "AHO" is to deliver all the components of care necessary for the patient to have a good outcome. An episode of care is like a DRG (diagnostic related group) for an entire condition. The episode of care for a diabetes patient, for example, would include all tests, office visits, ancillary services and education required each year to manage the disease. Quality and cost should be measured on each episode and compared across providers. This can be done now using episode treatment groupers, which can aggregate claims for a given condition longitudinally. And global

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payment rates could be established for individual conditions like diabetes or breast cancer. These global payments would cover all the services necessary to deliver any one episode.

The AHOs would involve collaborations between primary care and specialty care physicians, between hospitals and physicians, between outpatient surgery centers and physicians, and among any other combination of providers that can most effectively deliver care. The patient condition is the level at which competition would occur between AHOs, not at an insurance company, hospital level or network level. In other words, competition should occur at the level that value is created for the customer.

Encourage Transparent Comparisons Between Providers

It is critical that patients have data on the AHOs they want to access. They need accurate information to make good choices as to where they should seek care. The doctors, hospitals and others once aggregated into AHOs, by market forces not government forces, would be measured using claims and clinical data reported by accountable regional measurement organizations like the Wisconsin Collaborative for Healthcare Quality (www.WCHQ.org) or the Minnesota Community Measurement (www.mnhealthscores.org). Government insurance claims data should be released to regional authorities like WCHQ or the Minnesota Measurement Group. These groups would be responsible for publicly reporting the performance of AHOs using de-identified patient data and meeting all HIPPA requirements. No individual patient data would be reported. This way, patients could see which AHOs were doing the best job. The performance would be reported at the level of patient condition such as diabetes, heart failure etc., so patients could determine who was best at delivering the care they were looking for.

Physicians Should Keep Patients Well

We have a sickness care system today so not enough resources are focused on improving health. Physicians see many patients in the office each day in a "production" mindset. This has led to little focus on the overall outcomes of the population of patients they care for. Most physicians get little feedback on how they are actually doing in managing that population and many aren't doing well at all. In addition, the physicians don't have time or resources. to track down patients who choose not to come in for a visit or who repeatedly do not take care of themselves. Similarly, there are no disincentives for the patient besides poor health.

If we want to achieve a healthier population, we must design a system that rewards doctors for keeping patients well. We know that if A1C scores, a measure of blood sugar control, are below seven, patients experience fewer complications. We also know that keeping the disease under control requires a combination of education, intensive outpatient therapy and good social networks. Most of this is not adequately reimbursed in today's healthcare system. We pay the most for hospitalization and the least to prevent hospitalization. This payment process has to be reversed.

Patients must sign up with a primary physician so that their care can be attributed to one doctor or clinic. The primary physician is the coordinator of the "medical home," where the data and coordination of each episode is housed, no matter which AHO is involved. Obviously, the primary care physician will help patients decide which AHO is best for their condition and will

most likely be part of the management of the condition as well. The goal is to encourage patients to use the primary office as a hub of information and consultation without jeopardizing their choice of providers for more specialized care.

The medical home will be more effective if it is supported by an electronic platform. All providers and hospitals should be working toward an electronic platform. However, if electronic health records are used to implement the same poor processes of care that exist today in a paper format then little will be gained. It is very important that providers be focused on improving the care delivery process as well as implementing I.T. platforms. For example ThedaCare, McLeod Health, Denver Health, Virginia Mason and many others have proven the use of Toyota Production system principles work in health care. Education regarding these quality practices is critical because most health care workers have very little understanding of them. A major part of the health reform platform needs to be focused on assuring that these principles be instilled into daily activities of providers. If they are not, I.T. and other technology will only increase the cost of care.

Patients must take individual responsibility

Americans must take some responsibility for their improved health. The doctor and his/her team are not 100 percent responsible in this system. Those who use government insurance would be required to complete a confidential HRA (health risk assessment). This would allow the primary care physician to create a plan, in partnership with the patient, to improve their health. Those who didn't complete the HRA would incur a financial penalty but could opt out.

This plan should remove drug compliance barriers for patients with chronic disease. No co-pays for primary care services or appropriate drugs should be put in place. Generic drug use should be encouraged whenever possible and once the cost barrier is removed compliance with medication use should improve.

So how do we get started?

We need the data on performance. We need to aggregate all the claims and clinical data that exist for Medicaid, Medicare and commercial insurers and begin to report the clinical and cost performance of physician groups. This should not be done at the federal level but instead at the regional or state level by existing organizations. In Wisconsin it would be The Wisconsin Collaborative for Healthcare Quality and the Wisconsin Health information organization. In Minnesota it should be the Minnesota Measurement Community, in Seattle it would be the Puget Sound health alliance. These organizations can do this more efficiently and better than any federal bureaucracy. The reports should be focused on physician groups not individual physicians and the data should be publicly reported in a way that consumers can understand and use it to make decisions on care.

Since the real issue on the delivery side is redesigning care to remove waste which increases quality and reduces cost there needs to be incentives and expectations developed by the government and other payors to promote improvement. Most clinical organizations do not know how to radically improve yet improvement and redesign are critical if we are going to remove waste. Improvement cannot and should not be regulated by the government because more regulation reduces the chance of innovation and change. Instead <u>significant</u> incentives should be

implemented that encourage providers to change. For example, rather than 2% of Medicare spending being available for performance bonuses 10-20% of the total spend should be redirected to high value providers.

Payment should be reduced for providers that aren't able to lower cost and improve quality. In today's pay for performance world quality is incented but efficiency isn't. It must be both or it doesn't make any difference on the total cost of care. In other words quality can be delivered at many different cost levels. We now have the ability to measure efficiency across "episodes" of care and compare these episodes provider by provider. By using bundled payments we encourage doctors and hospitals to work together to think about reducing waste

In addition to the episode treatment measurement and management we need to move from sickness care to improved health. This can be accomplished by establishing a primary care doctor for every patient. Patients who routinely access their primary care physician are more likely to be educated and to take medications appropriately. This coordination role of the primary physician is critical to improving health outcomes. But the delivery model at the primary care level needs to change. The necessary resources for appropriate education and management of chronic disease are not available to the patient. Whether it's pharmacists, social workers diabetic educators or others most payment processes don't reimburse primary physicians to deliver these services. If improved health outcomes are the goal then we need to stop paying physicians for doing procedures and start paying them to manage a population of patients with those health outcomes as the measuring stick. This may involve shifting some of the payment which is skewed to specialists today back into the primary care office to help encourage more physicians to choose this specialty.

If we are to reduce health expenditures dramatically we don't need a new insurance system but rather a new delivery system. Producing that is much harder but is the critical component missing from the dialogue in the U.S. around health reform. The model outlined above is one attempt at trying to tackle the core problem. We invite others to contribute to this discussion so that we get it right.