Total Cost of Care and Affordability Summit

October 25, 2018
Framing Affordability: Welcome, Challenges, Opportunities, and Goals
GDAHC is Southeast Michigan’s Regional Health Care Improvement Collaborative (RHIC)

- A cross-sector, multi-stakeholder, non-profit, non-governmental membership organization
- Partner with those who get care (patients), give care (providers), pay for care (purchasers and plans), and make policy decisions
Founded in 1944, GDAHC has served as Southeast Michigan’s RHIC for almost 75 years

- Collaborate with the community to improve health, transform health care delivery, manage costs, and preserve the joy of practice (achieve the Health Care Quadruple Aim)

- Working to “blur the lines” to seamless, whole-person care: integrating social determinants of health; bridging health and health care delivery
An old adage says that “all health care is local,” yet GDAHC is stronger with national membership in NRHI.

GDAHC is not alone--RHICs work in many regions across the country.
This chart shows the roles that RHICs play in facilitating value in health care delivery and improving health outcomes.
Mylia Christensen, COO of HealthInsight says it best ...

“Regional Health Improvement Collaboratives are key to our communities’ ability to deliver higher quality and more affordable healthcare, serving many critical roles.”
One year ago, the NRHI Board voted unanimously to work together across the country to address health care affordability.

Affordability Context
Health | Price | Waste

Achieving affordability requires focused efforts on three major drivers: health, price, and waste.

The campaign builds on RHICs’ multi-stakeholder efforts to address one or more of these drivers, and collectively, create greater awareness.
Affordable Care Together represents the commitment of multiple stakeholders using varied tactics focused on one goal

Members engage from positions of particular knowledge, experience and strengths:

- Population Health
- Payment Reform
- Quality Improvement
- Data Analysis

- Cross pollinate best practices
- Disseminate educational materials
- Lead community dialogue
Now recruiting national partners to join forces and reach a broader public audience on why affordability matters.
Thanks go out to . . .

- NRHI for funding today’s event
- Robert Wood Johnson Foundation for underwriting
- GDAHC Staff—especially Nicki Gabel
- Featured speakers
- Reactor panelists
- Facilitators
- All of you
Our guest speakers are GDAHC’s friends from Minnesota and Maine—we work with them on national projects.
The path to affordable healthcare

Role of regional collaboration
Health spending as a share of U.S. GDP, 1963 to 2023 - selected years

We have an unsustainable problem. Harder choices are coming.

*2013 figure reflects a 3.1% increase in gross domestic product (GDP) and a 3.6% increase in national health spending over the prior year. See page 27 for a comparison of economic growth and health spending growth.

Notes: Health spending refers to national health expenditures. Projections shown as P.


© 2015 CALIFORNIA HEALTHCARE FOUNDATION
We have an unsustainable problem. Harder choices are coming.

Between 2006 to 2016 premiums are up 77%

Healthcare costs will consume half of household income by 2021


Value is LOWER today than six years ago.

Higher cost

Poorer quality

Source: National Council of State Legislatures
Percent change in middle income households’ spending on basic needs (2007-2014).

Source: Brookings Institution, Wall Street Journal
Medicaid crowds out education.

Source: National Association of State Budgets Officers
Healthcare costs for typical American family hit record high.

Source: Fiscal Times, *Health Care Costs for Typical American Family Hit Record High*, May 23, 2018
We ALL created this problem. We ALL need to be part of the solution.

Patients  Payers  Providers  Purchasers  Policymakers
Understanding the problem
The major drivers of affordability.

Solving one issue in isolation does not achieve the goal.
Addressing the drivers of affordability has systemic benefits — in addition to the positive economic impact.

**+ HEALTH**

Healthier populations:
- use fewer resources
- increase productivity
- enhance communities

**- WASTE**

Unnecessary clinical procedures:
- increase clinical harm
- cause emotional distress
- incur financial harm

Administrative burden:
- increases cost
- is burning out providers

**- PRICE**

High prices:
- don’t correlate with quality
- incentivize waste
- misallocate resources
"Rational common interests and rational individual interests are in conflict. Our failure as a nation to pursue the Triple Aim meets the criteria for what Garrett Harden called a “tragedy of the commons.” As in all tragedies of the commons, the great task in policy is not to claim that stakeholders are acting irrationally, but rather to change what is rational for them to do."

- Don Berwick, Health Affairs, May/June 2008
What would it take to fix all this?

Transparency
Data & Information
Aligning Incentives
Community Engagement
Collaboration Across Sectors
New Payment Models
Informed Consumers

Who could do all this?
There is hope.

In many regions across the country we are coming together to untangle complexities and find a path to affordability.
So, what are we doing about it?
Using SDoH data to reduce ambulatory care-sensitive hospitalizations

Combined SDoH (e.g., insurance type, race/ethnicity, language preference, education, household income) with clinical data for increased care coordination and improved primary care.

Outcomes:

- Hospitalization rates decreased by 106 more per 100,000 adults than they did in comparative counties
- 5,764 hospitalizations for ambulatory care-sensitive conditions were averted between 2009-2014

Graph source: Health Affairs, Association Of A Regional Health Improvement Collaborative With Ambulatory Care–Sensitive Hospitalizations, February 2018
This study highlights how regional collaboration among healthcare competitors can improve population health and benefit health care purchasers and payers. ""

- Don Berwick, former Administrator of the Centers for Medicare and Medicaid Services
Summary

Route 66 Accountable Health Community

Leverages technology to **address gaps in clinical services and health-related social needs** of Medicare and Medicaid beneficiaries.

- Program **screens for five SDoH with patients** - food, shelter, transportation, domestic violence, & public utility access
- Program **documents measures and integrates information** into HIE and provider EHRs
- Testing positive for SDoH measures triggers **program to coordinate services** and inform clinical sites as to whether those services were delivered

*Program went live May 1, 2018 – outcomes to be determined*
Summary

Care coordination/Medical Neighborhoods

Creating medical neighborhoods for increased care coordination lead to improved health.

- Improved referral pattern allowed for EDs to identify primary care providers for high-utilizers
- Reduced variation across systems; enabled adopting/spreading best practices
- Tracked patient history to avoid duplication of services and error
Improving end-of-life care

NJHCQI developed a plan that shares **tactical solutions to improve end-of-life care** for New Jersey adults.

This plan was developed in response to a poll: 60% of New Jersey adults had no written documents expressing their wishes for care at the end of their lives.

The plan calls for improved:
- Technology
- Payment reform
- Education
- Culture
Background

Supporting providers in Caring for ME

2016: Maine passed legislation enacting comprehensive and aggressive limits on opioid prescribing. MQC partnered with Maine Medical Association to create:

Caring for ME – an effort to bring together a wide set of partners to promote shared messages, educational resources, and practical tools for healthcare providers

Goals:

- Support prevention efforts
- Maintain compassionate/trauma-informed approach to chronic pain management
- Improve safety of opioid prescribing
- Appropriately diagnose addiction
- Improve access to effective treatments
Maine has seen the largest decrease in the country in opioid prescribing over the year.
Summary

Supporting practices in addressing the opioid epidemic

Employs pharmacists/technicians to help ensure Montanans get the right medicines at the right time, for the right reasons.

Supports physicians and practice teams by:
• Building community partnerships for resource sharing
• Managing databases and providing customized reporting
• Identifying and developing sustainability strategies
• Creating educational materials about prevention, treatment, and recovery
• Connecting with telehealth networks
• Giving clinical support (e.g., patient navigation program)
Summary

Utilizing the Louisiana Emergency Department Information Exchange (LaEDIE)

Collects/routes utilization data from hospital EDs across the state to Managed Care Organizations (MCOs); MCOs use data to contact members and:

- educate patients on appropriate ED use
- identify causes that sent them to ED
- implement case management strategies to reduce readmissions
- assist in finding a Primary Care doctor for follow up care

Value:

- Reduce avoidable ED visits
- Redirect to appropriate/less costly care
- Develop care plans for managing chronic disease
- Focus on preventative care
- Improve health status of patients
Reducing preventable diseases

Cost burden of four preventable adult diseases is $15 billion per year. Aim of program is to increase education and work toward Healthy People 2020 goal of 90% of adults 65 and older being immunized.

Partnering with Immunization Action Coalition and working with providers to ensure patient immunization status is addressed in a clinical encounter.

Cost Burden of 4 Adult Vaccine-Preventable Diseases in Persons Age 65 Years and Older, United States, 2013

<table>
<thead>
<tr>
<th>Vaccine-Preventable Disease</th>
<th>Estimated # of CASES</th>
<th>Estimated COSTS (Medical &amp; Indirect) (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>4,019,759</td>
<td>8,312.8</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>440,187</td>
<td>3,787.1</td>
</tr>
<tr>
<td>Zoster</td>
<td>555,989</td>
<td>3,017.4</td>
</tr>
<tr>
<td>Pertussis</td>
<td>207,241</td>
<td>212.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15,329.8</td>
</tr>
</tbody>
</table>

Additional $11.2 billion in costs if ages 50 – 64 years included.


Improved immunization rate for 65 years and older in NM from 58.4% to 65% between 2013-2017.
Summary

Data driven improvement for population health

Developing comprehensive primary care by practicing learning and diffusion of skills, deploying an all payer claims database (benchmarking), and convening to discuss results.

Strategy:
- Neutral, Trusted, Local Convener
- Sustainable Prospective Care Management Payments
- Claims Data Aggregation Capability: The “Five C’s”
- Physician/Provider/Practice Culture
- HIE and EHR: Ability to Effect Change

Initial results:
- PRIMARY CARE TREATABLE CONDITIONS: 540 fewer CHF and 460 fewer COPD admissions (45%)
- OVERALL HOSPITAL ADMISSIONS: 8,500 fewer trips to the hospital (33%)
- SPECIALIST VISITS: 128,000 fewer trips to a specialist provider (24%)
- EMERGENCY DEPT. VISITS: 11,000 fewer trips to the emergency room (17%)
- TOTAL COST: $112 Million reduction in total cost (9%)
Summary

Blazing the path for healthier, more active children

Working for the last decade with multi-sector leaders to advocate for policy, systems, and environmental changes in Monroe County, NY.

Agenda:

• better school food
• safer play areas
• 60+ mins of in-school physical activity
• healthy food in neighborhoods
• walkable, bikeable & accessible communities
Summary

Electronic data flows improve patient care

Partnered with the Humboldt County Department of Health and Human Services Social Services to reduce ED utilization among high-need, “super-utilizer” populations.
Summary

Expanding practice transformation efforts to decrease waste

Support provider members in transformation to value-based reimbursement environment by improving quality, reducing cost, and therefore, increasing the value of healthcare.

This will be achieved by:
1) Using clinical and claims data to create a measure set that shows progress on both quality and the delivery of cost-sensitive care
2) Develop a coalition comprised of payers, purchasers/employers, providers, and stakeholder organizations

Goals:
• Accelerate the value proposition in Wisconsin
• Improve quality, increase affordability
Bringing the higher than average cost states highlighted above down to the average of the participating states *could potentially save over $1 billion.*
Comparison reports show variation in healthcare cost and resource use for commercially insured patients attributed to individual clinics, as compared to other clinics in the same state.
Background

Using total cost of care and quality data to inform policy makers

Comparing ratings on the quality and cost of healthcare in Minnesota and neighboring areas can drive better care.

There is a large variation in medical groups in the amounts that are paid for the same procedure.

For example:

<table>
<thead>
<tr>
<th>Service</th>
<th>Average Cost</th>
<th>Range: low to high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit: 15 min</td>
<td>$146</td>
<td>$84-193</td>
</tr>
<tr>
<td>Strep test</td>
<td>$22</td>
<td>$8-104</td>
</tr>
<tr>
<td>Knee x-ray</td>
<td>$64</td>
<td>$24-191</td>
</tr>
<tr>
<td>Lower extremity MRI</td>
<td>$664</td>
<td>$253-3,510</td>
</tr>
</tbody>
</table>

Quality varied widely - there were significant disparities in quality of care by insurance type, race, ethnicity, language, and country of origin.
Summary

Making cost and quality information public

*Wear the Cost* campaign provides cost and quality information for consumers.

Goals:

- Patients/providers become more aware of variation among hospitals statewide
- reduce costs
- help patients make high-value choices.

Empowering consumers to get involved in their own healthcare, with numerous ways to take action.
“The price difference can’t always be attributed to quality; sometimes prices are just higher, and consumers are entitled to know that.”

- Ben Steffen,
  Executive Director, Maryland Health Care Commission
Summary

**Benchmarking & hot-spotting to improve care**

Created second version of California Regional Health Care Cost & Quality Atlas – state’s largest improvement measurement tool that tracks:

- Clinical quality
- Hospital utilization
- Cost of care

Data gathered from 29M insured Californians showed wide variation of costs and quality across state (2013 & 2015).

**Outcomes:**

- Clinical quality varied by **average of 25%** across 19 areas in 2015
- Clinical quality improved modestly from 2013-2015, while costs increased **3.85% annually**

*IHA plans to update Atlas with 2017 data by end of 2018.*
Summary

Making it easy for consumers to shop for imaging services

Developed website database where consumers can select an imaging service, and compare prices/patient experience at CO healthcare facilities.

Results:

• Significant increase in hits to website
• Media coverage

In the process of adding more procedures to expand consumer shopping options
Summary

Shining a light on waste in Washington state

Overuse of low-value services introduces the unnecessary risk of adverse physical and financial harm for patients, drives up costs for purchasers and insurers, and strains the system.

Outcomes:

• This report examined 47 common treatment approaches known by the medical community to be overused

• More than 45% of the healthcare services examined were determined to be low value

• Approximately 1.3 million individuals received one of these 47 services; among these individuals, almost one-half (47.9%) received a low value service

• 36% of spending on the healthcare services examined went to low value treatments and procedures - this amounts to an estimated $282 million in wasteful spending
Outcomes:

- Common Standard Measure Set used for P4P
- Single set of results used by health plans for rewarding healthcare systems and providers for delivering high value care
- Healthcare providers benefit from reduced administrative waste and can apply comprehensive interventions across all patients

Of **89 measures** across 9 programs’ sets, only 4 were in all sets, while 60 were in only 1 or 2 sets.
PRHI aims to remove unnecessary services and pay for what matters, with a focus on perinatal care.

The maternal mortality rate in the U.S. is 3x higher than any other developed country.
Paying for what matters

Waste

We can reinvest in:

Services That Add Value

If we remove:

- Preventable Complications
- Unnecessary Treatments
- Inefficiencies
- Errors

Choosing Wisely

An initiative of the ABIM Foundation

©NRHI 2018
Summary

Reducing unnecessary Medicare patient readmissions

Established a standard set of quality measures to improve rural hospital care and reduce unnecessary admissions.

Goal: identify and field test measures for rural, community-based programs that reflect clinical quality, patient and family experience, and resource utilization as a metric of financial impact.

- Data used to standardize and coordinate processes in providing palliative care
- Emphasized important role standard measures play in supporting integration and communication
- Worked to connect patients with community resources

Resulted in 7,168 fewer unnecessary hospital readmissions.
Summary

Building a common measure set

Led a committee that researched and selected 32 unique comparative measures.

Chose measures that were aligned across payers and could be reported reliably.

Goals:
- Improve quality/value of care
- Reduce provider reporting complexity
- Align healthcare organizations
Summary

Enabling patients to be active participants in their healthcare

Patient Engagement Electronic Resource Guide will include articles on self-management and tools for shared decision-making, insurance education, and medical record access.

Goals:
• Allow patients to evaluate potential cost trade-offs for different treatment options
• Engage patients in their own care to improve outcomes
• Avoid unnecessary services

Community stakeholders currently evaluating for 2019 release.
Primary care practices can improve patient participation, expand staffing, and ensure accurate billing by focusing on four things:

- Increase provision of under-used, high value services (e.g., annual wellness visit, chronic disease management, etc.)
- Increase primary care clinical staffing
- Support ongoing process improvement
- Ensure accurate billing for wellness services

Launching this campaign across New Mexico, Nevada, Utah, and Oregon.
Summary

Expanding practice transformation efforts to decrease waste

Supporting provider members in transformation to value-based healthcare by focusing on increasing value through cost & quality.

- Plan: 1) use data from patients/payers to create measure set for both clinical and intermediate outcomes, 2) propose development of coalition made up of payers, purchasers/employers, providers, and stakeholder organizations.
- Goals: 1) accelerate value through collaboration and coordinated improvement, 2) reduce unnecessary care.
Waste

Integrating Choosing Wisely into EMRs

Summary

Overuse decreased by an average of 70%

Partnered with local health systems, purchasers, health plans, and medical society to reduce x-rays for lower back pain, antibiotic prescriptions for respiratory illness, and vitamin D screenings.

Reached 8 million individuals nationally through public services announcements with "what to do" messaging.

Implemented Choosing Wisely best practice alerts in the Henry Ford Physician Network's Epic EMR.
What do all these initiatives have in common?
They’re bringing together all parties for safer, higher quality, more affordable care that works better for everyone.
Regional Health Improvement Collaboratives (RHICs)

Regional Focus
Neutral Conveners
Non-Profit

Providers
Policymakers
Payers
Purchasers
Patients
While practices struggle with MACRA, value-based payment systems past due, expert says

by Joanne Finnegan | Dec 4, 2017 12:30pm

Although many physician practices struggle to get on board with the new Medicare payment system implemented by MACRA, physicians are finding ways to improve their practices and reduce costs.

JAN 25, 2017

Health Plans Spend $1,000 More Per Patient Depending On Region

Bruce Japsen, CONTRIBUTOR

The Road To Affordability: How Collaborating At The Community Level Can Reduce Costs, Improve Care, Leverage HIEs, and Transform Practice

Elizabeth Mitchell

NOVEMBER 14, 2017

Greater access to shared data requires the move to alternative payment models, but it also requires the buy-in of providers and the lack of interoperability and data.
The Path to Affordable Healthcare

We have a problem.

The way we receive healthcare in the United States is broken, and as a result Americans are less healthy while paying more.

Regional Health Improvement Collaboratives

We all created the situation. It will take all of us working together to solve it.

HEALTH

Affordability

The drivers of affordability are: Health, Waste, and Price. Solving one issue in isolation does not achieve the goal.

PRICE

WASTE

What does it take to address the problem?

- Transparency
- Data & Information
- Aligning Incentives
- Community Engagement
- Collaboration Across Sectors
- New Payment Models
- Informed Consumers

Who could do all this?

Patient Education  Paying for What Matters  Analysis & Reporting  Quality Improvement

©NRHI 2018
Do your part to make healthcare more affordable

Network for Regional Healthcare Improvement
Choosing Wisely work is a perfect example of GDAHC’s role as trusted convener improving community health

• Three key target areas:
  • Reducing antibiotics prescribing for respiratory illness, bronchitis
  • Reducing imaging for low back pain
  • Reducing the number of Vitamin D tests; making sure ordered tests are the correct type

GDAHC’s Roles and Responsibilities

• Trusted convener
• Program management
• Project facilitation
• Measurement and assessment
• Public reporting

An initiative of the ABIM Foundation

Healthy people. Healthy economy.
All partners made positive strides in advancing Choosing Wisely concepts and protocols

- Decreased inappropriate use by 70% in 3 targeted areas
- Henry Ford now includes over 80 CW guidelines in their EHR (Epic) system
- Blue Care Network developed interactive social media quiz on antibiotics; top performing post
- UAW Retiree Medical Benefits Trust updated and relaunched their website with dedicated CW section; site over 7,000 unique hits in week one
- Developed 2 screensavers on antibiotics with Henry Ford & Consumer Reports; they run on 26,000 computers system-wide
- MSMS developing targeted messaging for providers highlighting clinical performance successes to encourage provider participation
Soon GDAHC will launch its 12th Physician Organization Performance report on myCareCompare.org

Compare Your Care

Is your family getting the best care possible?

GDAHC’s PO Performance Report:
• Reports on performance of the 14 major POs in Southeast MI
• The only report of its kind in MI
• POs and health plans voluntarily participate
• Enables GDAHC to sustain Qualified Entity status
GDAHC leads the Michigan Patient Experience of Care initiative, tracking and reporting patient experiences

**Vision**

Statewide initiative to *measure, report and improve* patient experience of care in primary care provider setting

**Status**

- **Over 1,050 providers** in **235 practices** and **13 POs** currently participate
- 2016 survey results by PO posted on myCareCompare.org in late 2017
- 2017 survey results to be published by practice at the end of 2018
- At least 70% of funding for survey costs was provided by health plans based on market share
- Unfortunately funding is no longer available and this initiative is suspended
Goals for today

• Learn about the challenges to health care affordability
• Learn about national efforts
• Assess national efforts for applicability to Southeast Michigan
• Formulate an array of initiatives we may champion
• Agree on 2-3 projects and ideate funding sources
• Identify goals for each project—how will we prove it works
• Commit to support
Guest Speaker

Julie Sonier
President
MN Community Measurement

“Health Care Cost Transparency in Minnesota”
Health Care Cost Transparency in Minnesota

Julie Sonier, President
MN Community Measurement

October 25, 2018
MN Community Measurement: Who We Are and What We Do

Multi-stakeholder collaborative

- Physicians
- Hospitals and health systems
- Health plans
- Employers
- Consumers
- State government

Activities

- Develop
- Collect
- Analyze
- Report

Types of data

- Quality
- Cost
- Patient Experience
- Disparities
MNCM grew out of the idea that **everyone** benefits from:

- Working together to agree on measurement priorities
- Reducing fragmented, conflicting, and duplicative efforts
- Combining data to get more reliable and stable results
- Creating a common, trusted source of information
- Making data transparent
What is Being Measured?

• Quality
  • Clinics and hospitals
• Patient Experience
• Cost
  • Total cost of care
  • Drivers of cost: resource use and price
  • Average prices for common services
• Disparities
  • Variation by race, ethnicity, language, and country of origin
Area of Focus: Cost

• **Total cost** of care, by medical group

• **Drivers of cost**: overall resource use and prices by medical group

• **Prices** by medical group for 118 common services (e.g., office visit, imaging, lab tests)
Three Types of Cost Information

1. **Total Cost of Care** – average per person cost for patient population (commercially insured only)
   - All care over 12-month period, regardless of where the care was delivered
   - Total amount paid: insurance + patient
   - Risk-adjusted, and adjusted for high-cost outliers

2. **Factors driving variation in total cost of care**

3. **Prices for common services**
Total Cost of Care Variation, 2017

*Excludes outlier costs above $125,000 for any individual patient..
Price vs Resource Use, 2017

Results are risk adjusted and exclude outlier costs above $125,000 for any individual patient.
Growth and Cost Drivers

Growth from Previous Year*

Share of Spending 2017*
- 16.7%
- 16.7%
- 42.8%
- 23.6%

Share of Growth, 2013-17*
- 24.9%
- 5.5%
- 24.2%
- 45.3%

*Before removal of outlier costs above $125,000 for any individual patient.
Examples of Variation in Prices for Specific Services

2017 Dates of Service, Commercial Insurance

<table>
<thead>
<tr>
<th>Service</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee X Ray</td>
<td>$29</td>
<td>$72</td>
<td>$378</td>
</tr>
<tr>
<td>MRI – lower extremity</td>
<td>$195</td>
<td>$851</td>
<td>$3,050</td>
</tr>
<tr>
<td>Strep Test</td>
<td>$8</td>
<td>$22</td>
<td>$96</td>
</tr>
<tr>
<td>Office Visit 15 min</td>
<td>$62</td>
<td>$150</td>
<td>$202</td>
</tr>
</tbody>
</table>

- Actual allowed amounts, not billed charges (averaged across 4 largest commercial payers)
- Specific information on average prices by medical group is available at mnhealthscores.org
Public Reporting

Compare ratings on the quality and cost of healthcare in Minnesota and neighboring areas.

Get started by selecting one of the following categories:

- Clinic Quality and Patient Experience
- Medical Group Quality and Cost Ratings
- Hospital Quality and Patient Experience
- Cost of Services and Procedures

Clinic Quality and Patient Experience
Use our clinic quality and patient experience ratings and resources to improve your health and health care.

SELECT A HEALTH TOPIC FOR DETAILED RATINGS
Select

View all Clinic Quality of Care Ratings
View all Clinic Patient Experience Ratings
Public Reporting – Cost *and* Quality

<table>
<thead>
<tr>
<th>Medical Groups</th>
<th>Total Cost</th>
<th>Diabetes: Adult</th>
<th>Vascular Care</th>
<th>Depression: Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Lake Pediatrics, Minnetonka, MN</td>
<td>$401</td>
<td>Not Reportable</td>
<td>Not Reportable</td>
<td>Not Reportable</td>
</tr>
<tr>
<td>Essentia Health St. Mary’s, Detroit Lakes, MN</td>
<td>$400</td>
<td>Below Average 33%</td>
<td>Average 49%</td>
<td>Average 9%</td>
</tr>
<tr>
<td>France Avenue Family Physicians - Minnesota Healthcare Network, Edina, MN</td>
<td>$399</td>
<td>Top 50%</td>
<td>Average 56%</td>
<td>Average 8%</td>
</tr>
<tr>
<td>North Memorial, Robbinsdale, MN</td>
<td>$398</td>
<td>Above Average 42%</td>
<td>Average 51%</td>
<td>Below Average 4%</td>
</tr>
<tr>
<td>Entira Family Clinics (formerly Family Health Services MN), St. Paul, MN</td>
<td>$398</td>
<td>Top 52%</td>
<td>Top 64%</td>
<td>Top 17%</td>
</tr>
<tr>
<td>Central Pediatrics, Woodbury, MN</td>
<td>$396</td>
<td>Not Reportable</td>
<td>Not Reportable</td>
<td>Not Reportable</td>
</tr>
<tr>
<td>HealthPartners Clinics, Minneapolis, MN</td>
<td>$392</td>
<td>Top 46%</td>
<td>Top 59%</td>
<td>Below Average 5%</td>
</tr>
</tbody>
</table>

Public reporting display on MNHealthScores.org – Cost and quality side-by-side
## Analysis By Claim Type for attributed patients

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Expected</th>
<th>TCRV™</th>
<th>Price Ratio</th>
<th>Expected based on all reported groups and adjusted for risk mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$1,837,886</td>
<td>$1,731,033</td>
<td>1.062</td>
<td>0.993</td>
<td>1.069 UB claim form with room and board codes.</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$2,923,818</td>
<td>$2,961,713</td>
<td>0.987</td>
<td>0.955</td>
<td>1.034 UB claim form, non inpatient.</td>
</tr>
<tr>
<td>Professional Rx</td>
<td>$4,414,419</td>
<td>$5,013,195</td>
<td>0.884</td>
<td>0.907</td>
<td>0.955 All CMS-1500 claim form claims.</td>
</tr>
<tr>
<td>Rx (Prorated for missing Rx data)</td>
<td>$1,500,190</td>
<td>$2,117,442</td>
<td>0.737</td>
<td>0.764</td>
<td>0.905 Pharmacy claims prorated for Rx paid by different PBM</td>
</tr>
<tr>
<td>Total</td>
<td>$10,736,372</td>
<td>$12,019,374</td>
<td>0.893</td>
<td>0.907</td>
<td>0.985</td>
</tr>
</tbody>
</table>

## Utilization Metrics 2016 Totals

### 2016 totals for all patients attributed to Sample Medical Group

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Expected</th>
<th>Difference</th>
<th>Actual</th>
<th>Expected</th>
<th>Difference</th>
<th>Ratio</th>
<th>Market Wide Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>111</td>
<td>106</td>
<td>5</td>
<td>52.4</td>
<td>49.8</td>
<td>2.59</td>
<td>1.05</td>
<td>55.1</td>
</tr>
<tr>
<td>Days</td>
<td>419</td>
<td>415</td>
<td>(4)</td>
<td>157.5</td>
<td>210.1</td>
<td>(12.47)</td>
<td>0.94</td>
<td>206.7</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>3.77</td>
<td>4.22</td>
<td>(0.45)</td>
<td>3.77</td>
<td>4.22</td>
<td>(0.45)</td>
<td>0.89</td>
<td>3.75</td>
</tr>
<tr>
<td>Surgical Admits</td>
<td>44</td>
<td>36</td>
<td>8</td>
<td>20.8</td>
<td>16.9</td>
<td>3.81</td>
<td>1.23</td>
<td>16.2</td>
</tr>
<tr>
<td>Surgical Days</td>
<td>152</td>
<td>152</td>
<td>0</td>
<td>71.7</td>
<td>71.5</td>
<td>0.15</td>
<td>1.00</td>
<td>61.2</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>3.45</td>
<td>4.22</td>
<td>(0.77)</td>
<td>3.45</td>
<td>4.22</td>
<td>(0.77)</td>
<td>0.82</td>
<td>3.79</td>
</tr>
<tr>
<td>Medical Admissions</td>
<td>67</td>
<td>70</td>
<td>(3)</td>
<td>31.6</td>
<td>32.8</td>
<td>(1.23)</td>
<td>0.96</td>
<td>36.9</td>
</tr>
<tr>
<td>Medical Days</td>
<td>267</td>
<td>294</td>
<td>(27)</td>
<td>125.9</td>
<td>138.5</td>
<td>(12.57)</td>
<td>0.91</td>
<td>145.4</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>3.59</td>
<td>4.22</td>
<td>(0.63)</td>
<td>3.99</td>
<td>4.22</td>
<td>(0.23)</td>
<td>0.94</td>
<td>3.74</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>332</td>
<td>345</td>
<td>(13)</td>
<td>156.6</td>
<td>162.6</td>
<td>(6.01)</td>
<td>0.96</td>
<td>164.2</td>
</tr>
<tr>
<td>High Tech Imaging in ER</td>
<td>59</td>
<td>83</td>
<td>(24)</td>
<td>27.8</td>
<td>35.9</td>
<td>(12.07)</td>
<td>0.70</td>
<td>38.9</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>207</td>
<td>273</td>
<td>(96)</td>
<td>97.5</td>
<td>128.5</td>
<td>(30.90)</td>
<td>0.76</td>
<td>129.9</td>
</tr>
<tr>
<td>Office Visits</td>
<td>8,524</td>
<td>8,865</td>
<td>(341)</td>
<td>5,256.3</td>
<td>4,087.2</td>
<td>(1,169.0)</td>
<td>0.96</td>
<td>4,158.8</td>
</tr>
<tr>
<td>Primary Care</td>
<td>5,157</td>
<td>4,497</td>
<td>700</td>
<td>2,451.3</td>
<td>2,121.4</td>
<td>329.95</td>
<td>1.16</td>
<td>2,183.3</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>3,127</td>
<td>4,168</td>
<td>(1,041)</td>
<td>1,474.9</td>
<td>1,965.8</td>
<td>(490.85)</td>
<td>0.75</td>
<td>1,975.5</td>
</tr>
<tr>
<td>Lab</td>
<td>10,637</td>
<td>12,757</td>
<td>(2,120)</td>
<td>5,017.3</td>
<td>6,017.2</td>
<td>(999.91)</td>
<td>0.83</td>
<td>6,377.5</td>
</tr>
<tr>
<td>Radiology</td>
<td>1,528</td>
<td>1,783</td>
<td>(255)</td>
<td>720.7</td>
<td>840.9</td>
<td>(120.17)</td>
<td>0.86</td>
<td>949.0</td>
</tr>
<tr>
<td>High Tech Imaging ‡</td>
<td>451</td>
<td>500</td>
<td>(49)</td>
<td>212.7</td>
<td>236.0</td>
<td>(23.27)</td>
<td>0.90</td>
<td>231.8</td>
</tr>
<tr>
<td>Standard</td>
<td>1,077</td>
<td>1,282</td>
<td>(205)</td>
<td>508.0</td>
<td>604.9</td>
<td>(96.91)</td>
<td>0.84</td>
<td>717.21</td>
</tr>
<tr>
<td>Pharmacy - Count of scripts</td>
<td>23,049</td>
<td>24,647</td>
<td>(1,598)</td>
<td>12,771</td>
<td>13,656</td>
<td>(885.24)</td>
<td>0.94</td>
<td>14,192.2</td>
</tr>
</tbody>
</table>

### Generic prescribing rate

- **Average**: 88.1%
- **Minimum**: 87.4%

© 2018 MN Community Measurement. All Rights Reserved.
What Does It Take To Accomplish Price And Cost Transparency?

• Commitment
  • Consensus on value of doing the work
  • Momentum/determination to keep moving forward

• Collaboration
  • Need to build consensus about details like attribution, level of detail reported

• Persistence
  • It takes time to get everyone on the same page and bought in to methodology – providers need more detail
  • It is a good idea to publish results privately to providers first
    • MNCM is currently the only region publishing by medical group
Do We Need An All-Payer Claims Database?

• Surprisingly, NO.
  • MN Community Measurement uses a “distributed model” where participating health plans all run the analysis the same way and provide us the results for aggregation
  • Most other regions doing this analysis do have APCDs
  • There are advantages and disadvantages to each approach – but distributed model can be a testing ground that doesn’t require payers to give up control of their data
Cost and Price Transparency: Things to Consider

• Price transparency has a role to play, especially when consumers face significant out of pocket costs. The best price information is:
  • Easy to find and use
  • Timely
  • Relevant to consumer’s specific health concerns and insurance coverage

• But, be careful not to focus only on price:
  • Total cost of care is affected by variation in use of care and in prices. MNCM analysis finds:
    • 95% variation in resource use
    • 94% variation in price
  • Many consumers think high price = high quality. Must have information on both to make good decisions
Cost and Price Transparency: Things to Consider, Part 2

• Transparency alone is not enough
  • Need to give consumers/employees a reason to use this information
  • Benefit design is an important tool – through its impact on both consumers’ and providers’ behavior. Examples include:
    • Tiered networks
    • Reference pricing
    • High-value networks
Wrap-up/Summary

• There is more than 2.5-fold variation across medical groups in Minnesota in total cost of care
• Pharmacy and outpatient are growing at the fastest rates, but professional services still account for about 45% of growth in total cost – because they are a big share of the total to start with
• Prices for individual services also vary substantially across providers
• Measurement and transparency are important tools in driving improvement
  • Identify opportunities
  • Measure progress/impact
Reactor Panel

Dr. Steve Grant
GDAHC Board Chair
Practicing Physician

Michael Jasperson
Vice President
Provider Network-East Region
Priority Health

Dr. George Kipa
Deputy Chief Medical Officer
Blue Cross Blue Shield of Michigan

Marsha Manning
Manager of Medical Benefits & Strategy
University of Michigan
Networking Break
20 Minutes
Guest Speaker

Jolie Ritzo
Senior Program Manager
HealthDoers Network, Network for Regional Healthcare Improvement (NRHI)

“First Do No Harm”
“First, Do No Harm”
Tackling Waste in Health Care
• In health care, we are doing too much unnecessary stuff to patients.

• People are being harmed\textcolor{yellow}{\textbf{in multiple ways}}.

• It doesn’t matter that the harm is not intentional.

• It won’t stop until we address it directly.

• Employers and labor must work together to “demand” change.

• This will take courage, persistence and a new mindset.
A “culture of more” . . . it’s not just one thing

• Physician training and practice culture
• Inadequate information about the patient at the point of care
• Fee-for-service payment, pressure to “produce” widgets
• Aggressive marketing by developers of tests, drugs, procedures
• Defensive medicine (more a persuasive myth than reality)
• Culture preference for technological solutions
• Lack of health literacy and patients’ minimal understanding of health care, benefits and risks
• Very little transparency on the price of health care, and almost none upfront
Physical Harm
Healthcare acquired infections
Surgical errors
Medication errors
Excessive radiation
False positives resulting in MORE . . .

Financial Harm
Debt
Bankruptcy
Devastating trade-offs: food, medication and other health care, education, housing, employment

Emotional Harm
Worry
Anxiety
Lower productivity
Absenteism

Financial Harm is harm!
Urban Institute: Percentage of people with medical debt in collections (2016)

Nationally:
18% overall, 16% white, 21% nonwhite
Some counties over 50%

Washington:
9% overall, 8% white, 10% nonwhite
Some counties as high as 22%
Financial harm is harm.
In the U.S., we spend more on a per capita basis than everyone else.
Health care spending is outpacing other spending at the federal and state levels.

Source: Congressional Budget Office, 2017 Long Term Budget Outlook

All states, source: NASBO 2013
And for all this spending, quality is lagging.

Compared to many other industrialized nations, in the U.S.:

- Mortality amenable to health care is worse
- Infant mortality is higher
- Life expectancy is lower
- Access is worse
What drives up health care costs?

• Price +
• Utilization
  – Necessary
  – Unnecessary (e.g., tests, procedures when not needed)
  – Potentially Avoidable (e.g., readmissions, inappropriate use of ER, medical errors)
First, Do No Harm
Calculating Health Care Waste in Washington State
February 2018
Medical tests, treatments and procedures that have been shown to provide little or no benefit to patients in particular clinical scenarios and, in many cases, have the potential to cause harm.
What is the Health Waste Calculator?

- Milliman MedInsight tool
- Software that analyzes claims data to identify wasteful services as defined by national initiatives such as Choosing Wisely® and the U.S. Preventive Services Task Force
- Version of the HWC tool used for this report included **47 measures** (there are plans to expand the number of measures in the tool over time).
- Analysis done at claim line level; includes professional and facility
- Situational intelligence creates “degree of waste” (necessary, likely wasteful, wasteful)
Our results from the Health Waste Calculator

• Results based on ~2.4 M commercially insured lives in our data base

• Measurement year: July 2015 – June 2016

• Utilization reflects actual

• Costs estimated based on Milliman’s Consolidated Health Cost Source Database for Washington
  - Unit prices represent the average cost of each service (commercial sector, Washington state)
High level summary – SERVICES

- 1.52 million services were examined (47 measures)
- 45.7% of examined services were determined to be low value (likely wasteful and wasteful)
High level summary – IMPACTED INDIVIDUALS

- **1,298,862** individuals received services (47 measures)
- **622,341 (47.9%)** individuals received low value services (likely wasteful and wasteful)

© 2018 Washington Health Alliance. Proprietary, all rights reserved. This material may not be reproduced or modified without the prior permission of the Alliance.
High Level Summary – SPEND ON LOW VALUE

- An estimated $785 million was spent on services (47 measures)
- $282 million (36%) was spent on low value services (likely wasteful and wasteful)
Targeting key drivers of overuse

- These same 11 measures account for 89% of the estimated spend associated with low value.
- A total of 578,503 individuals received at least one of these 11 services.
11 things to focus on:

• Too frequent cervical cancer screening
• Preoperative baseline laboratory studies prior to low-risk surgery
• Unnecessary imaging for eye disease
• Annual EKGs, cardiac screening in low risk, asymptomatic people
• Prescribing antibiotics for acute upper respiratory, ear infections
• PSA screening
• Population-based screening for OH-Vitamin D deficiency
• Imaging for uncomplicated low back pain in the first six weeks
• Preoperative EKG, chest x-ray and pulmonary function testing prior to low risk surgery
• Cardiac stress testing
• Imaging for uncomplicated headache
Too frequent cervical cancer screening

In this analysis, a total of 166,860* women received annual cervical cancer screening for an estimated cost of $25.8 million.

73% of these women received wasteful (too frequent) cervical cancer screening for an estimated cost of $19 million.
Preoperative baseline lab studies prior to low-risk surgery

In this analysis, a total of 108,037* individuals received preoperative lab studies prior to low-risk surgery for an estimated cost of $105 million.

85% of these individuals received wasteful preoperative lab studies for a total estimated cost of $86 million.
Preoperative EKG, chest x-ray and pulmonary function testing prior to low risk surgery

In this analysis, a total of 41,747 individuals received preoperative EKGs, chest X-rays or pulmonary function tests for an estimated cost of $41.4 million.

20% of these individuals received wasteful preoperative testing for an estimated cost of $6 million.
Annual EKGs or cardiac screening in low-risk, asymptomatic individuals

In this analysis, a total of 416,225* individuals received annual EKGs or cardiac screening for an estimated cost of $199 million.

23% of these individuals received wasteful annual EKGs or cardiac screening for an estimated cost of $40 million.

© 2018 Washington Health Alliance. Proprietary, all rights reserved. This material may not be reproduced or modified without the prior permission of the Alliance.
In this analysis, a total of 40,546 individuals received cardiac stress testing for an estimated cost of $197 million. 18% of these individuals received wasteful and likely wasteful cardiac stress testing for an estimated cost of $33 million.
In this analysis, a total of 104,744 individuals received imaging for eye disease for an estimated cost of $46.4 million.

74% of these individuals received wasteful eye imaging for an estimated cost of $34 million.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Waste Index</th>
<th>Impacted People*</th>
<th>Est. Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging for low back pain during first six weeks</td>
<td>83%</td>
<td>14,000</td>
<td>$4 M</td>
</tr>
<tr>
<td>Imaging for uncomplicated headache</td>
<td>53%</td>
<td>4,900</td>
<td>$7 M</td>
</tr>
<tr>
<td>Antibiotics for URI and earache w/in 7 days of diagnosis</td>
<td>98%</td>
<td>75,000</td>
<td>$2 M</td>
</tr>
<tr>
<td>PSA Screening - asymptomatic men</td>
<td>62%</td>
<td>48,000</td>
<td>$10 M</td>
</tr>
<tr>
<td>Population screening for Vit D deficiency in absence of risk factors</td>
<td>35%</td>
<td>36,000</td>
<td>$12 M</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>177,900</strong></td>
<td><strong>$35 M</strong></td>
</tr>
</tbody>
</table>

*Numbers rounded*
1.52 million services examined,
45.7% determined to be low value

622,341 (47.9%) individuals impacted

Estimated $282 million spent on low value
Call to action in WA

1. Overuse must become central to honest discussions of health care value.

2. Clinical leaders must **lead** provider efforts to incorporate reduction of overuse into local practice culture.

3. The concepts of choosing wisely and shared decision-making must become the bedrock of provider-patient communication.

4. We need purchasers and payers to keep their collective “foot on the gas” to transition fee-for-service to paying for value.

5. Value-based provider contracting must include measures of overuse **as well as** measures of access, underuse, experience and total cost of care.
• In health care, we are doing too much unnecessary stuff to patients.

• People are being harmed in multiple ways, including financially!

• It doesn’t matter that the harm is not intentional.

• It won’t stop until we address it directly.

• Employers and labor must work together to “demand” change.

• This will take courage, persistence and a new mindset.
Find report on the Community Checkup website: www.wacomunitycheckup.org

Nancy Giunto, Washington Health Alliance
ngiunto@wahealthalliance.org
Reactor Panel

Dr. Scott Eathorne
President and CEO
Together Health Network

Dr. Michael Genord
Senior Vice President & CMO
Health Alliance Plan (HAP)

Mary Beth Kuderik
Chief Strategy & Financial Officer
UAW Retiree Medical Benefits Trust
Breakout Session

Facilitators

Breakout #1
Renaissance Room

Roger Panella
Chief Operating Officer
GDAHC

Breakout #2
Oakland Room

Ted Makowiec
Vice President and Health Consultant
Segal Consulting

Breakout #3
Charlevoix Room

Jessica Gubing
President & Founder
The Cortex Group, Inc.

Breakout #4
Petoskey Room

Kim Wixson
Vice President and Health Consultant
Segal Consulting

Healthy people. Healthy economy.
Report Out, Next Steps, Wrap Up
Thank you for your valuable time and input!

Join the conversation... become a member, partner and/or sponsor.

GDAHC
GREATER DETROIT AREA HEALTH COUNCIL