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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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TABLE OF CONTENTS

**A Message from Lilly:
Ensuring Access to New Technology
in Accountable Care Organizations**
By Derek L. Asay 2

**Accountable Care 2013: Are
We There Yet?**
By Robert I. Field, JD, MPH, PhD 3

**Creating a Framework for
Accountable Care: Ensuring
Product Value**
By Rita E. Numerof, PhD 5

Moneyball for Health Care
By Brian Silverstein, MD 7

**Redefining Care Management
to Address Increasing
Fragmentation in Health Care**
By Michael Kobernick, MD, MS 10

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Editorial

A Remedy for Blame – Accountability

By David B. Nash, MD, MBA
Editor-in-Chief

The sultry summer day on campus belied the atmosphere inside as the proceedings of an expert panel meeting, titled *Creating a Framework for Accountable Care*, unfolded. The conveners – Jefferson’s School of Population Health and the team from Eli Lilly and Company – and panelists were enthusiastic about the Affordable Care Act’s (ACA) emphasis on accountability and expressed optimism about the sea change already under way in US health care delivery.

Fast forward to early November, several weeks after the rocky launch of Healthcare.gov. True, the electronic enrollment technology fell woefully short. True, some of us will not be able to continue buying insurance plans that fail to provide coverage that meets the ACA’s minimum standards. But, as with any large, complex initiative, fits and starts are to be expected – the real danger lies in focusing too narrowly on the glitches.

To my mind, this first installment of our new *Prescriptions for Excellence in Health Care* series could not come at a more opportune time because it takes a broad

view of another important aspect of the law (ie, accountable care), celebrates some early successes, and explores new approaches to future challenges.

The first article, “Accountable Care 2013: Are We There Yet?,” describes the journey to “there” by exploring manifold paths to potential failure or imminent success. In “Creating a Framework for Accountable Care: Ensuring Product Value,” we delve into an often ignored aspect of accountability – the need for manufacturers of health care devices and pharmaceuticals to demonstrate clinical and economic effectiveness relative to comparable alternatives.

My personal favorite title is “Moneyball for Health Care.” The premise of the article is that US health care should follow American baseball’s example

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(continued on page 2)

and begin to look at data in different, smarter ways that will impact the bottom line. Last but not least, “Redefining Care Management to Address Increasing Fragmentation in Health Care” is a compelling reminder

that integration is an essential ingredient in accountable care.

The “blame games” now playing out at all levels of government and in the media make a clear case for building

more accountability into our systems. Accountability leaves no room for blame.

As always, I welcome feedback from our readers at david.nash@jefferson.edu.

A Message from Lilly

Ensuring Access to New Technology in Accountable Care Organizations

By Derek L. Asay

This issue of *Prescriptions for Excellence in Health Care* focuses on a number of important aspects of Accountable Care Organizations (ACOs) and what it will take to make them successful in the United States. Without question, we have opportunities to improve the quality of our health care system while better managing costs. Accountable care in the United States shows promise, but we must be mindful to implement those incentives that will lead to the outcomes and costs that we all want.

At the end of 2013, more than 360 Medicare ACOs had been established, serving more than 5.3 million Medicare beneficiaries.¹ Although it has been less than 4 years since the ACA was signed into law, almost 10% of the Medicare population now receives health care from an ACO.

As noted in the Centers for Medicare & Medicaid Services’ (CMS) Medicare Shared Savings Program (MSSP) Proposed Rule (2011), in risk-based arrangements wherein “providers of services and suppliers have an increased motivation to control spending and achieve efficiencies, it would be reasonable to anticipate an

increase in negative incentives such as incentives to stint on care or undersupply services, [and] shift costs,” among other things.² ACO metrics, particularly within the MSSP, may create misaligned incentives relative to innovative technologies. Specifically, new technology costs likely are not included in the benchmark cost and any potential savings associated with the new technology may not be realized within the relevant time window of measurement.

Ensuring access to innovative new technologies is critical to the long-term success of our health care system. It follows that ACO metrics should not disincentivize the appropriate use of new technologies. The range of options available to ensure beneficiary access to new technologies includes:

- Creating reimbursement carve-outs for new technologies.
- Monitoring ACO adoption of new technologies.
- Encouraging ACOs to address new technologies in their clinical guidelines.

- Fostering adherence to compendia guidelines to ensure appropriate beneficiary access to new technologies.

Carve-Outs

One way to ensure that patients continue to have access to innovative medical technologies is to carve them out of both the benchmark and performance year expenditures for ACOs. When the decision to use such therapies is removed from the calculation of the ACO’s expenditures for purposes of determining shared savings, there is no incentive to lower costs by denying patients access to them.

Quality Assessment

The development and implementation of quality measures to assess an entity’s adoption of new technologies is another approach to ensuring appropriate beneficiary access to innovative technologies. Monitoring adherence to new technology quality measures as well as ACO access levels for new technologies will help reduce inappropriate restrictions on medical innovation.

Practice Guidelines

Development of evidence-based medical practices is important

for any ACO, regardless of its participation in the MSSP. CMS' MSSP final rule requires Medicare ACOs to develop evidence-based medical practices or clinical guidelines for delivering coordinated care, especially for diagnoses with potential for significant quality improvements and cost savings.³ Beneficiary access to new technologies should be addressed in these guidelines and processes.

Compendia Guidelines

ACOs' evidence-based clinical guidelines should adhere to recognized compendia guidelines for the use of drugs and biologics. A drug compendia guideline lists appropriate uses of drugs and biologics as defined in clinical practice guidelines based on the evaluation of evidence from scientific literature, integrated with expert judgment in a consensus-driven process.

The incentive to reduce costs that is inherent in any risk-based arrangement may lead to negative consequences with regard to decisions about the care beneficiaries receive and their access to specific procedures and new technologies. Therefore, steps must be taken to ensure that ACO-generated "savings" reflect real quality and efficiency gains. Most importantly, we must ensure that the best interest of the patient is at the forefront when all clinical decisions, including treatment recommendations and prescribing decisions, are made.

Paramount to the integrity of any ACO program is monitoring how savings are generated (eg, identifying and understanding any changes in coding patterns). Details regarding savings generated and other pertinent information concerning an ACO's operation and performance should be made publicly available. Transparency will help ensure against inappropriate

cost-saving practices (eg, cost-shifting), facilitate the sharing of best practices, and hold ACOs accountable for producing savings through quality-driven changes.

ACOs are viewed as leaders in health care reform for their use of innovative service delivery models. They also should be seen as leaders in evaluating and adopting innovative medical technologies. By doing so, they will keep patients at the center of everything that is done in health care.

Derek L. Asay is Senior Director, Government Strategy, Federal Accounts and Quality for Lilly USA, LLC, the U.S. affiliate of Eli Lilly and Company.

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Accountable Care 2013: Are We There Yet?

By Robert I. Field, JD, MPH, PhD

Accountable care is an idea whose time has come. Or is it? Initiatives are under way on several fronts to build health care systems that are accountable for their outcomes and costs, but we have been here before. Will accountable care finally transform American health care, or are today's efforts just another chapter in a long-running saga?

The Vision of Accountable Care

At its core, the call for accountable care is a response to 2 fundamental

and interrelated shortcomings in the American health care system. One is the relentless rise in costs. The other is a pervasive inconsistency in quality.

In terms of costs, the United States has the most expensive health care system in the world. We spend at least 50% more per capita on health care than any other developed country, and almost twice as much as several of them.¹ Moreover, our rate of spending growth is accelerating faster

than anywhere else. Health care now consumes more than 17% of the American economy.² It is expected to exceed 20% within the next few years.³

Despite this level of spending, our health outcomes are no better and, in some regards, are worse than those in much of the developed world. The United States trails several other developed countries on numerous

(continued on page 4)

measures including life expectancy, infant mortality, and mortality attributable to health care.⁴ Clearly, we are doing something wrong.

In terms of quality, the American health care system is plagued by errors that injure and kill thousands of patients every year, causing as many as 100,000 deaths annually by one estimate.⁵ Medical practice varies widely across regions of the country and even within regions, producing dramatic disparities in costs without discernible differences in outcomes.⁶ The obvious conclusion is that good medicine is practiced inconsistently at best.

The vision of accountable care is to address these problems by restructuring relationships among providers,⁷ thereby eliminating incentives that promote inefficient and ineffective care and replacing them with rewards that encourage accountability for the costs incurred and outcomes produced. This, it is hoped, will rid the system of clinical behavior that inflates costs and ignores evidence of effectiveness.

Accountable Care Initiatives of the Past

The movement for accountable care first took root on a wide scale in the 1990s with the creation of what were known as “integrated delivery systems” or IDSs. These collections of different providers within a single organizational structure typically included hospitals, physicians, and providers of ancillary services. They tried to align incentives and oversee care to promote efficiency and effectiveness.⁸

Versions of IDSs had existed for decades, with some led by hospitals (eg, the Mayo Clinic, the Cleveland Clinic, Geisinger Health System) and others by insurance companies (eg, Kaiser-Permanente). The new iterations of the 1990s tried to integrate care with

more dispersed provider networks. Although some of these systems made major strides in coordinating care, the vision of true provider accountability remained largely unfulfilled. Too often, incentives were inconsistently and inappropriately aligned, and many constituent providers continued to be compensated based on the volume, rather than the quality, of services they rendered.⁹

Reasons Why Accountable Care May Succeed This Time

The movement for accountable care has reemerged in the last few years with renewed vigor. Will it turn out differently this time? There are several reasons to think that it will.

First and foremost, information technology has advanced tremendously since the 1990s and is now more capable of supporting care coordination and oversight. Medical record systems are more advanced and new technological capabilities, such as home monitoring of clinical indicators, have emerged.¹⁰ The Internet, which was just developing as a commercial tool in the 1990s, has greatly expanded the horizons of electronic communication.

Coupled with these advances is an increased willingness of physicians and other clinicians to use technology. The relative comfort with electronic records and other technological applications can be attributed to more hands-on experience among providers in general and greater technological savvy among a new generation of physicians.

New physicians also are more accustomed to alternative compensation plans that reward outcomes rather than volume of services. Their expectations are less likely to be linked to the old way of

doing things. At the same time, a growing number of large payers have taken active roles in crafting innovative reimbursement plans.¹¹

Finally, today’s movement for accountable care is supported by major new government initiatives. The Health Information Technology for Economic and Clinical Health Act (2009) offers physicians significant financial incentives for adopting electronic records and using them in a meaningful way.¹² The Affordable Care Act (2010) promotes the formation of accountable care organizations – alliances of hospitals, physicians, and other providers that build on the IDS concept of the 1990s to enhance quality and control costs.¹³

Reasons Why Accountable Care May Still Fall Short

Although these developments are cause for optimism, clouds still linger on accountable care’s horizon. A major threat is the lack of sufficient primary care capacity.¹⁴ Through their role in overseeing all aspects of care, primary care providers serve as linchpins for care coordination in many accountable care systems.¹⁵ However, the number of American physicians entering primary care remains low and shows no signs of increasing. Allied health professionals (eg, nurse practitioners, physician assistants), who could fill some of the need, require years of training.

Accountable care also faces some of the same social and professional resistance that has stymied it in the past. The American health care system is huge and, like most massive enterprises, resistant to change. Many physicians continue to cherish their autonomy and resent the oversight that care coordination can impose. Although a new generation of physicians may be more accepting of alternative practice

paradigms, they do not yet dominate the profession.

Finally, fee-for-service reimbursement remains the norm for much of American health care.¹⁶ Innovations abound, but many large payers, including Medicare, continue to pay physicians largely based on the number, rather than the quality, of services they render. It is difficult for a provider system to restructure its incentives when the external funding environment remains mired in the past.

The Bottom Line: Cause for Cautious Optimism

What should we expect from the latest movement for accountable care? Has its time finally arrived? Although challenges remain, the balance of positive factors suggest that it has.

Information technology has grown in sophistication and now offers many of the capabilities necessary for coordinating care systems. Providers are more accepting of accountability and the limits on clinical autonomy that it can impose. Many major payers, including insurance companies, large employers, and Medicare, are

testing innovative approaches to reimbursement. And government policy is more actively supporting and encouraging accountable care than it has at any time in the past.

The dream of accountable care is getting closer to reality every day. It may take longer to reach fruition than many had hoped, but its widespread implementation is within reach. Even the most obstinate of systems can eventually change its antiquated ways, and American health care is no different.

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Creating a Framework for Accountable Care: Ensuring Product Value

By Rita E. Numerof, PhD

The US health care system is currently undergoing what ultimately will be a radical transformation driven by unsustainable cost increases, increasing regulation, and shifting power relationships among payers, providers, physicians, and patients. Technology advances are accelerating the pace of innovation, while rising costs and demands for affordable health care and

greater transparency are challenging the economics and traditional business assumptions of the industry.

At the same time, health policy shifts brought about by the Patient Protection and Affordable Care Act are placing increased accountability and cost pressures on providers to improve patient safety, quality of care, and consistency

of care delivered. In response, payers (government and private) are actively engaged in changing the way physicians and hospitals are paid. These changes include greater emphasis by payers and other stakeholders on requiring value for payment (eg, pay for performance, bundled payment initiatives).

(continued on page 6)

In the broader context of constrained resources, all those who pay for care – including providers, payers, and consumers/patients – have become more focused on the “value” they receive. In addition, an increasingly educated and information-driven generation is demanding – and receiving – more data about the quality and outcomes associated with specific institutions, procedures, and individual doctors. Providers, payers, and consumers alike are escalating their demands for improved economic and clinical value.

In addition, the trend of health care provider consolidation and physician employment has gained momentum over the past several years. Integrated systems and Accountable Care Organizations likely will further reduce suppliers’ access to physicians as they join larger group practices or become employed by hospital-based organizations.

Collectively, these pressures are causing providers to impose more structure on care delivery in an effort to reduce cost and improve quality – in effect, improving their organizations’ ability to provide “accountable care.” As a practical matter, hospital leaders must focus on understanding the actual cost of care and how their organizations will charge and be paid for services. As new payment systems are implemented, there is more emphasis on links between payment and quality; for example, Medicare’s refusal to reimburse hospitals for services associated with “never events.” As payment is increasingly linked to quality, administrative and clinical leaders must find new ways to reduce unnecessary variation in medical practice and streamline operations, including the supply chain, both to improve care and manage costs more effectively.

The push for accountability in delivering higher quality care at lower

costs has significant implications for manufacturers; for instance, the diminished role of individual physicians in decision making about products. Going forward, committees will make decisions about which products to use. There will be fewer but larger provider customers, requiring more sophisticated sales capabilities on the part of manufacturers. With greater transparency and more links between payment and outcomes, there also will be increased pricing pressure on product companies.

Product selection will not simply be focused on price; rather it will be on selecting products with clearly demonstrated benefits over competitor products. Manufacturers should anticipate that providers will engage in aggressive formulary management and give preference to those products that demonstrate value in terms of safety, efficacy, and cost. In short, *manufacturers must be able to demonstrate the economic and clinical value of their products compared to alternatives.*

To demonstrate a product’s clinical value, manufacturers must have the ability to provide data on the value of a new product in terms of its potential to improve patient outcomes, patient management, and overall treatment costs. This perspective requires a broader view of a product in the context of clinical use, and its potential impact on economic and clinical outcomes.

Fully identifying the potential value of products requires looking beyond product attributes such as physician ease of use or a specific product attribute. Focusing narrowly on individual physicians’ interests often leads to head-to-head comparisons with similar products and, at times, overemphasis on single attribute superiority. Instead, new products should be evaluated on how they potentially improve current treatment regimens for

the condition addressed, save costs, and improve outcomes.

Example: For comparative purposes, determining the potential of a new drug as a substitute for multiple drugs in a current therapeutic regimen could be of great value. Demonstrating equivalent efficacy (vs. superiority) may be sufficient if the product has an improved dosing frequency and improved patient adherence, or a reduction in the number of medications or physician visits required for treatment.

Such an approach requires the integration of a broader relevant stakeholder perspective on value wherein every market need and product benefit is evaluated through the lens of “What is it worth?” This is especially true when comparing a new product to generics and other products that already exist in the marketplace. Strengthening a value proposition to providers – and payers – requires data that demonstrate reduced costs and/or improved clinical outcomes compared to alternatives. Successful manufacturers must demonstrate the value of their products in efforts to achieve accountable care.

As manufacturers become more sophisticated in presenting economic and clinical value data to providers, hospitals will need to adopt processes for evaluating new products. Because the health care delivery team will be tasked with managing the internal decision-making process regarding product decisions, they must understand what value a new product will add to an existing treatment regimen and effectively evaluate the evidence on products. Having such processes in place may create new opportunities for hospitals to partner with manufacturers.

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Moneyball for Health Care

By Brian Silverstein, MD

Everyone agrees that US health care is expensive and that there must be a better way. However, there is considerable uncertainty regarding the actual root cause of the problems and no clear solutions. Perhaps there is an opportunity to use data differently to implement strategies that can move the system forward one piece at a time.

By any measure, we spend more on health care than any other country, and yet the outcomes we achieve are disappointing. Confounding variables, including our unhealthy lifestyles, social and environmental factors, and malpractice issues, cloud the degree to which the health care system itself is producing suboptimal health outcomes. At the same time, we hear anecdotes about the world's elite flying to the United States because of our superior outcomes for acute care. How can we make sense of this?

Reconciling these paradoxical statements is confusing; however, a resolution may be found by using a different frame of reference. We have the best acute care system in the world but we fall woefully short at managing chronic disease and delivering preventive care. Because ours is chiefly an acute care system, our models fail to address the behavioral, social, and economic determinants that affect our health and result in additional cost. Our focus on services and procedures rather than the total patient has made us proficient at delivering high volume irrespective of total value.

An unlikely source may provide some insights for a path forward. I believe that baseball has something to teach us about using data to improve value. A recent evolution in the data elements

used to predict wins in baseball has fundamentally transformed how teams value players. The innovative concept known as "moneyball" uses the data and information differently to assemble winning baseball teams for less money. When applied to health care, the concept would lead to our using data differently to take better care of patients for less money.

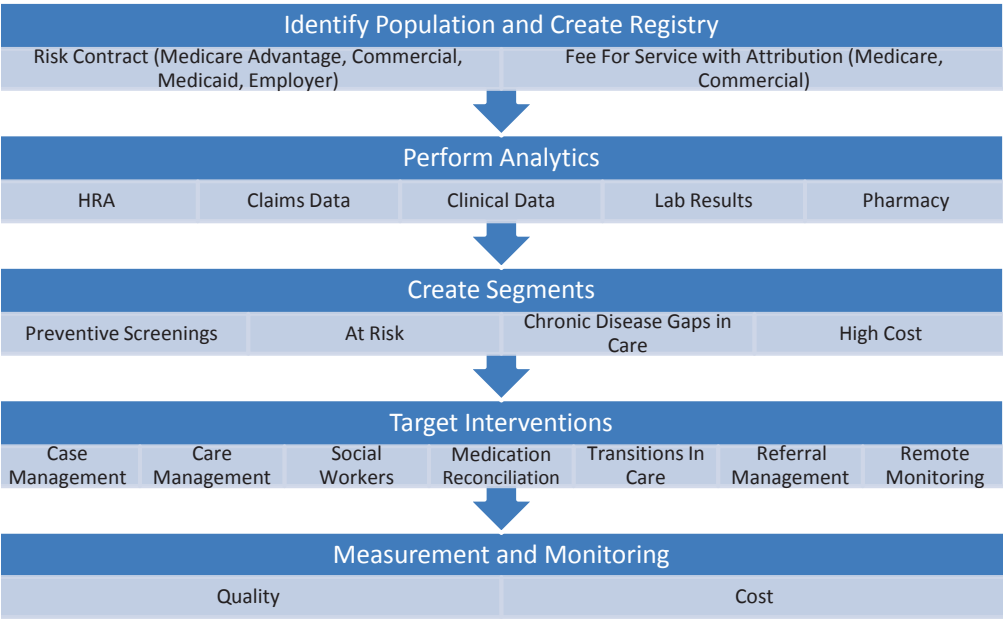
Today, much that we do in acute care is based on flawed assumptions, similar to the way in which baseball players were valued. "Moneyball" for health care takes a different approach, using data and novel care models to ensure that patients get what they need when they need it (or even before they know they need it) (Figure 1), and resulting in better outcomes for a lower total cost.

The key is delivering the right health care in the right amount at the right

time. Today's system is designed to deliver an abundance of acute care with insufficient attention to care coordination. For example, there is clear evidence that patients receive too many cardiac interventions that range from the rare criminal case (ie, stents placed in normal cardiac vessels) to the more common examples of stents placed in patients when the evidence suggests that medical management and lifestyle modification will result in similar outcomes.¹ Although less acute care can produce better total outcomes, it is very challenging in our current environment to implement these changes.

A Framework for "Moneyball": Population Health
To break out of the current mode, the starting point is having a population to manage. This is more important than building infrastructure and capabilities.

Figure 1. Moneyball for Health Care



HRA, health risk assessment

(continued on page 8)

There must be a financial opportunity to improve care for this population and data must be available to make this possible. Self-insured employers already are well situated in this regard, and providers are seeking ways to acquire a population through risk-based contracts and, more commonly, attribution in a fee-for-service contract.

Once there is accountability for a population, the next step is to analyze and segment the population with an eye toward improving value. Some examples include identification of:

- (1) Gaps in care wherein patients' needs for screening and their existing conditions can be improved (eg, vaccines, screening tests, checking HbA1C in all patients with diabetes).
- (2) Opportunities to improve outcomes through better care management (eg, implementing programs to avoid unnecessary emergency department visits and hospital admissions, assessing the value proposition for specific providers for a given clinical condition).

Each of these interventions must be evaluated carefully to ensure that:

- The segment has been correctly defined.
- An opportunity exists for implementing the intervention in the defined population segment.
- There is sufficient time to achieve positive results.

Typically, it takes 5 to 10+ years to see a positive impact from screening programs whereas initiatives that target transitions of care often yield results in a few months.

Figure 2. Population Health – A Different Business

	Fee-for-Service Business	Population Health
Customer	People who are admitted (or use outpatient services)	Everyone who pays for coverage or is enrolled in a plan/program
Revenue	Paid per unit of service	Monthly fixed amount
Expenses	Primarily labor and facilities	Health care services
Data Systems	Cost accounting and billing	Predictive models and care management
Key to Success	Keep occupancy high and expenses low	Increase management and monitoring to reduce unnecessary care

Value-Driven Solutions and Interventions

The earliest adopters of health care “moneyball” are employers. They focus on prevention and wellness and typically manage a population for a sufficient period of time to benefit from the investment. Because insurers and providers have been unable to manage cost increases, employers are shifting their focus to near-term opportunities that may make a large financial impact. For instance:

- Creating care coordination benefits (eg, Boeing provided resources and created financial incentives for providers to deliver high-value health care).
- Modifying benefit design to substantially increase cost sharing (eg, reference pricing) to drive patients from low-value to high-value providers.
- Creating programs that overlay benefits (eg, domestic travel benefits that enable patients to travel to a destination center for evaluation and treatment – at no charge to the employee – thereby reducing their variation in spend and outcomes).

Providers may desire to play “moneyball” for population health, but success requires a distinct business model and different competencies than fee-for-service care (Figure 2). The small number of providers with “risk” contracts have built systems to win in this model.

Most providers are exploring ways to coordinate fee-for-service populations through innovative efforts that reap rewards for total value. Examples of these programs include bundled payments, comanagement agreements, patient-centered medical homes, and accountable care organizations (ACOs) (Figure 3). Although ACOs often are viewed as monolithic, there are factors that differentiate them – from the populations they serve (eg, Medicare, Medicaid, specific employers, commercially insured) to program operations (eg, attribution to benchmarks, provider networks). Although some ACOs assume financial risk (and have been doing so for many years before they were called ACOs), most are contracting fee-for-service with a shared savings based on reduction in total expenses (upside-only shared savings).

There are various models, but the bottom line is that the most profitable

option for high-volume providers is the least desirable – ie, the current one with unnecessary care. The math on shared savings will yield less aggregate revenue than the status quo.

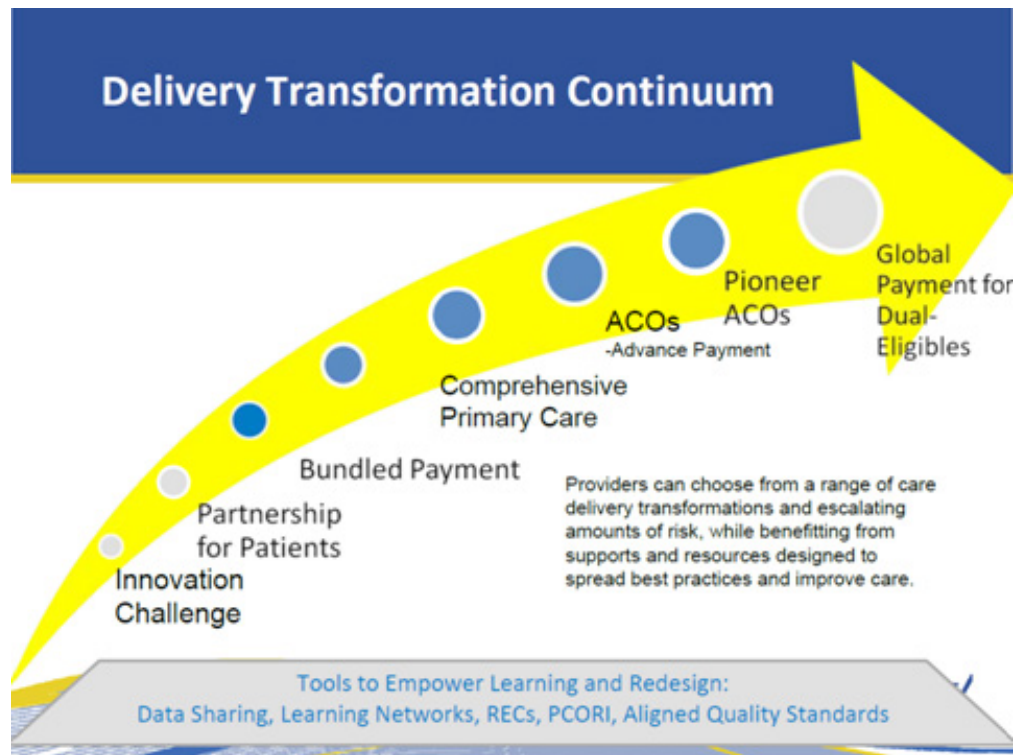
Half of the nation's ACOs do not include a hospital partner – these organizations stand to benefit from a reduction in acute care volume without a reduction in their revenue. In addition, the technological and operational infrastructure required to fully implement the population health model is fundamentally different from volume health care.

Providers must consider how to operate their core businesses as efficiently as possible while determining whether to make the substantial investments necessary to create a population health management business. The popular strategy of becoming a population health manager at the expense of your core business is a certain road to failure. Although there will be pressure on the acute care system, there is and will be value associated with better care. There is no bridge from volume to value as they are separate business models.

The allure of population health also can lead to a desire to assemble components under a single umbrella organization. This is practical in the absence of willing partners in a market, but what happens when your hospital is more expensive and doesn't deliver as high quality? Do you compromise the performance of the ACO at the expense of the system to keep the volume "in the family"?

Having patients in high-deductible health plans plays an important

Figure 3. Care Delivery Transformation



Source: Centers for Medicare & Medicaid Services. Updates from CMS: value-based purchasing, ACOs and other initiatives, March 19, 2012. http://www.ehcca.com/presentations/pfpsummit7/thompson_1.pdf. Accessed November 25, 2013. ACO, accountable care organization; PCORI, Patient-Centered Outcomes Research Institute; REC, Regional Extension Center

supportive role in the success of provider value models. Although seemingly unrelated, patient engagement and malpractice liability are being addressed as patients with "money on the line" take more active roles in making decisions. Often, patients with high-deductible plans become engaged and seek appropriate rather than maximum utilization. This helps providers to make sound recommendations without fear of litigation for avoiding a test or procedure.

Conclusion

Most health care is local, and each market will evolve differently depending on supply and demand as well as the insurance market. There is a big opportunity today to play "moneyball." Markets are moving rapidly as patients enroll in new insurance

products and employers change benefits or create new programs. Providers can enter into shared savings arrangements and focus on care management and patient engagement and be rewarded for their results. Be ready to play the game differently if you want to win.

Brian Silverstein, MD, is President of HC Wisdom. He can be reached at: brian@silverstein.biz.

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Redefining Care Management to Address Increasing Fragmentation in Health Care

By Michael Kobernick, MD, MS

A patient presents at a physician's office with chest pain. On the basis of a chest X-ray, the physician believes the patient has a pneumothorax (collapsed lung) and calls the emergency department (ED) to notify the triage nurse that the patient is coming. The physician does not send the X-ray with the patient so, after assessment in the ED, the patient is taken for a second X-ray to confirm the diagnosis.

While in the radiology department, the patient's heart stops. Assuming that the referring physician's diagnosis is correct, the emergency physician places a chest tube into the patient's lung. When the patient's condition does not improve, an electrocardiogram is performed revealing a myocardial infarction. The patient is referred to a cardiologist for an intervention but, because a history of allergies was not elicited in the ED, the patient has an allergic reaction to the contrast dye necessitating the administration of steroids. The steroids cause a stomach ulcer to hemorrhage. Eventually the patient goes home with many physical limitations and is unable to return to work.

Although the foregoing scenario is hypothetical, this pattern of expensive care and poor outcomes – the result of care delivery fragmentation – is prevalent in the US health care system. Shih and colleagues summarize the issue well in their article for the Commonwealth Fund¹:

"The fragmentation of our delivery system is a fundamental contributor to the overall performance of the US health care system.

• Patients and families navigate unassisted across different providers and

care settings, fostering frustrating and dangerous patient experiences;

- Poor communication and lack of clear accountability for a patient among multiple providers lead to medical errors, waste, and duplication;*
- The absence of peer accountability, quality improvement infrastructure, and clinical information systems foster poor overall quality of care; and*
- High-cost, intensive medical intervention is rewarded over higher-value primary care, including preventive medicine and the management of chronic illness."*

The result is that "the United States spends more than any other country on health care but still ranks in the bottom half of industrial countries in outcomes like life expectancy and infant mortality."² Enthoven defines fragmentation as "the systematic misalignment of incentives, or lack of coordination, that spawns inefficient allocation of resources or harm to patients. Fragmentation adversely impacts quality, cost, and outcomes."³

A variety of health care services have been developed in the areas of wellness, disease management, and complex case management to address specific medical needs and reduce fragmentation. Wellness programs classify individuals into risk groups and apply educational interventions designed to help them stay "healthier," be more engaged in their own health, and incur reduced costs. Disease management focuses on groups of individuals with a particular diagnosis and provides broad programs targeted to the condition. Complex case

management addresses the individual needs of the sickest individuals. Because each of these programs has been developed in isolation from the others, they inadvertently have contributed to the fragmentation of health care described.

With this in mind, a new definition of care management (CM) is apropos. CM is the integration of traditional wellness, disease management (also known as "care gap closure"), complex care management, and care transition programs into a series of patient-centered interventions that use elements from each as appropriate. CM recognizes that services are simultaneously "horizontal" and "vertical." "Horizontal" refers to the natural progression of disease along a continuous time line, generally from healthy to sick. At any given point along the continuum, there are associated interventions from any or all of the care management groups. Many interventions are "vertical," reflecting the severity of disease, from low-risk primary care to complex specialty care.

In a practical sense, the CM coordinators who interact with patients must be educated in the natural history of the disease and the interventions traditionally applied to each group. At any given time a patient may need guidance in all of the groups. For instance, a patient with congestive heart failure may require:

- Wellness advice about a pap test and immunizations.
- Disease management services for hypertension and obesity.

- Complex case management services to help with medication reconciliation, daily weights, and regular physician appointments to avoid admissions.

Integrating the education and services provided by a CM coordinator is the best way to improve outcomes and reduce costs.

The effectiveness of the CM coordinator is dependent on the ability of our health care system to aggregate patient information in electronic health records and to make this information available to all providers at any time. In the example presented, such information sharing could have prevented many of the errors. The chest X-ray would have been available to the emergency physician, who would have noticed an artifact masquerading as air in the chest. A detailed history of allergies would have avoided the allergic reaction.

In addition to personal health data, aggregate information from

populations must be collected in a format that allows for group analysis, the generation of targeted population interventions, and the ability to measure the success of such programs. Data collection and reporting are essential elements in curing the problem of fragmentation in delivering care to individuals in the population.

Poor communication with the individual and family is another source of fragmentation. Who among us has not experienced confusion and concern when told we need certain serious health care services? People frightened by the lack of empathetic communication often seek reassurance in settings that add to the fragmentation of care. Integration of CM includes attention to the relationship of the care team with the individual patient and his or her family. Beyond clinical protocols, CM coordinators need help in acquiring the skills necessary for developing a trusting relationship with the patient. The essence of any healing relationship hinges on the balance

between the clinical science and personal interaction.

The next iteration of health care reforms must seek to cure the fragmentation that exists in our current system. This requires that we understand the natural history of disease, matching interventions to the course of the illness with compassionate understanding.

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