Transforming Health Care Delivery in Mendocino County

HIT: The Promise of Better Care and Lower Cost

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Where would you want to get your care?

% Adverse Outcome Rate

18%
16%
14%
12%
10%
8%
6%
4%
2%
0%

$4 $8 $12 $16 $20 $24 $28

Total Hospital Cost (thousands $)

Low Variation Hospital
High Variation Hospital
Average LV
Average HV

Source: MPA

Does this distribution of physicians look like a well-managed supply chain?

Quality Percent vs. Average Cost per Episode

Average Cost per Episode	
$1,000	
$500	
$0	

Quality Percent axis: 52%, 62%, 72%, 82%, 92%

Quality Percent (# of Positives / # Eligible Occurrences)

BTE-Mercer 2006

There are two main ingredients to increasing the value of HC $ spent

Current Landscape – Payers and Purchasers

- Numerous reports confirm substantial gap between best possible and actual care.
- Research has demonstrated that public reporting of performance leads to improvements.
- There are increasing demands from purchasers that providers demonstrate better performance, and initiatives that link payment with performance have proliferated in the private sector, and HHS is deeply engaged in the process (e.g. www.hhs.gov/valuedriven).
- Consumer-directed approaches require valid information on quality and cost of care. President Bush has issued an Executive Order to that effect, and efforts to aggregate data across payers are blossoming (e.g. Value Exchanges).

Current Landscape – HIEs

Health Information Exchanges are emerging as an important nexus to improve "productive efficiencies" and add value as a health information intermediary.

HIEs can be sustainable businesses if they focus on the right set of value-added transactions for their "customers" in the community (see full report at http://toolkits.ehealthinitiative.org/value_creation_and_financing/VSMhome.mspx)

An HIE's social and economic place in the community can help it be the trusted intermediary for transmittal of de-identified data to secondary data users (e.g. health plans, public health)

BTE is a not-for-profit company that designs programs for plans and employers

- **Physician Office Link** – Based on NCQA's Physician Practice Connections (PPC v2), or the QIO Practice Assessment, practices that go through the recognition process successfully are rewarded up to $50pmpy
- **Diabetes Care Link** – Based on the NCQA's Diabetes Physician Recognition Program (DPRP), eligible physicians can qualify for $80/diabetic/y
- **Cardiac Care Link** – Based on the NCQA's Heart-Stroke Recognition Program (HSRP), eligible physicians can qualify for up to $160/cardiac/y
- **Spine Care Link** – Based on the NCQA's Back Pain Recognition Program (BPRP), eligible physicians can qualify for up to $50/back pain/y

Why Physicians Participate in BTE

- 89% Improve Patient Care
- 70% Indicate Quality to Patients
- 43% Indicate Quality to Peers
- 37% Indicate Quality to Purchasers
- 93% “Very Likely” They Will Maintain Certification

Barriers to Participation

- No staff to do chart pulls
- Not enough patients from participating employers

What we proved in our pilot stage

Incentives work and can lead to practice reengineering, but practices need help to reengineer

Better quality can cost less, but you need to focus on the right measures

Self-assessment of performance leads to focused quality improvement, but it's resource-intensive to pull charts

Employers banding together can create enough critical mass to impact physician behavior, but you need the plans to really make it work

BTE-recognized physicians show significant reduction in variation

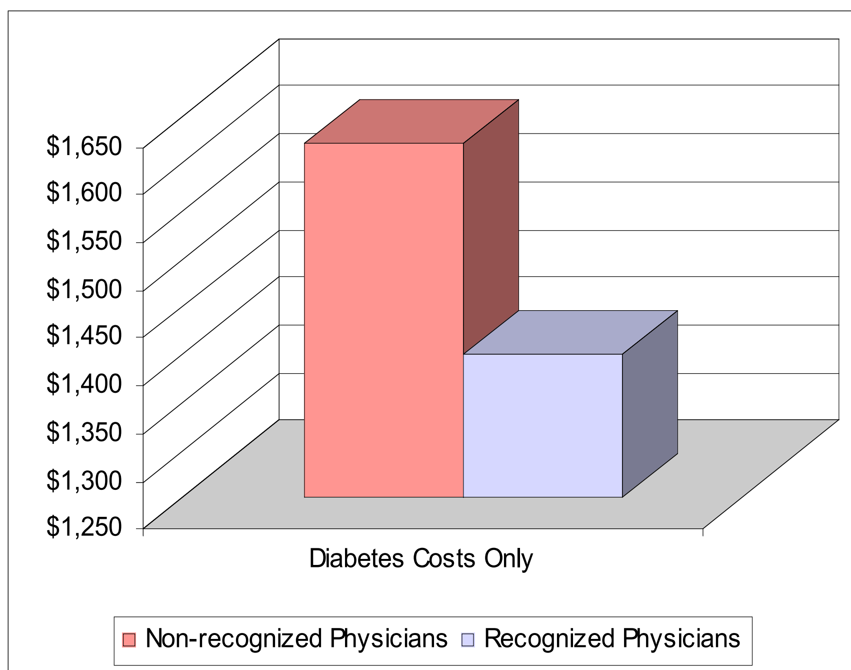
20
15,000
10,000
5,000
0

ENDO NO | ENDO YES | PCP NO | PCP YES

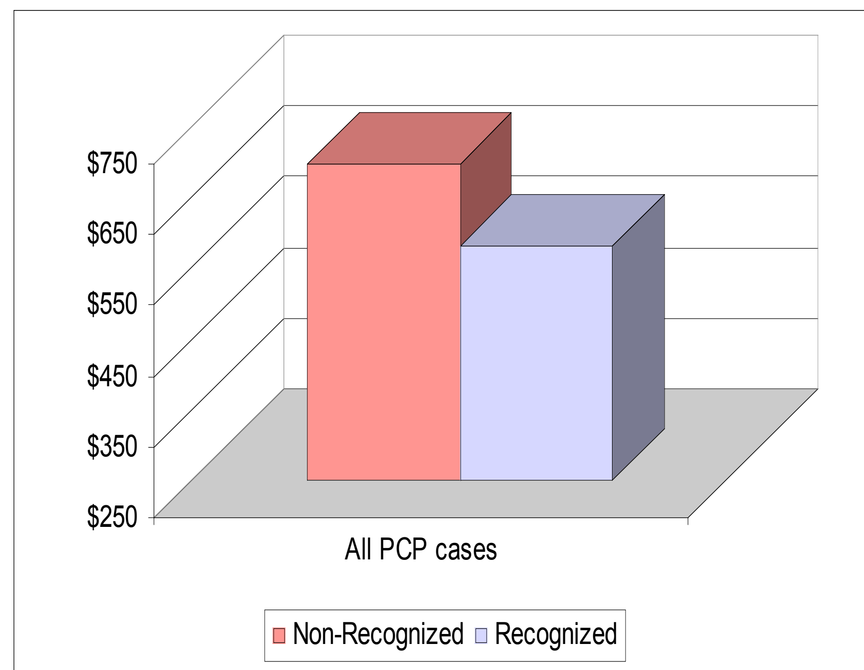
Source: Ingenix

Which also leads to lower costs of care

Diabetes Care Link



Physician Office Link



Average episode costs of care for recognized and non-recognized physicians

Source: Ingenix, Medstat, Mercer

And lower costs are highly correlated to a handful of ambulatory care measures

Measure	Score*
BP<140/90	33
SBP<140	33
DBP<90	27
BP<140/90	27
HbA1c>9%	27
HbA1c<7%	27
LDL<100	27
LDL<130	27
LDL<100 after discharge for AMI, CABG, PCI	27
LDL<130 after discharge for AMI, CABG, PCI	27
LDL<100 any CAD	27
LDL<130 any CAD	27
Weight reduction	23
BetaB in heart failure	23
ACE/ARB in patients with LVSD	23
BetaB post MI with prescription 7 days after discharge	23
BetaB post MI with prescription 6 months after discharge	23
Anti-platelet therapy in CAD—ASA ONLY	23

Scores are the combination of clinical impact (scale of 1 to 7) and cost savings impact (scale of 1 to 5)

The important measures come from medical records, not claims

These measures are critical to all stakeholders

Consumers – health status is good/bad/improving

Public Health – community activities are helping/ hurting/indifferent

Medical device manufacturers – our equipment is having a positive/negative/neutral impact on patients

Life sciences/pharmaceutical companies – our treatment regimens/therapies are having a positive/ negative/neutral impact on patients

Providers – my interventions are having a positive/ negative/neutral impact on patients

HIEs can create feedback loops at multiple levels of the system

Health Information Exchange

Payers

Providers

Patients

Policy-makers

Producers