
Health System Transformation Team

February 9, 2011

Toward a Vision for Accountable
Health In Oregon

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font positioned above the word "Health". "Health" is written in a large, blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font. A thin blue horizontal line is positioned just above the "Authority" text, extending from the left side of the "H" in "Health" to the right side of the "y" in "Authority".

Oregon
Health
Authority

Purpose of the presentation

This presentation will offer some examples of health care innovation

- To catalyze our thinking – not to offer all the answers
- To help us identify the essential elements for a successful Oregon model of accountable integrated care and services

Essential elements for pursuing the Triple Aim*

- Target population
- Capped total spending with strict year-over-year budget targets
- “Integrator” that accepts responsibility for all components of the Triple Aim – improving population health, improving the experience of care (quality), and reducing per capita cost
 - Delivering person-centered care and services
 - Redesigning care: strengthening primary care and improving coordination between primary and specialty providers and community supports
 - Targeting the needs of particular subpopulations
 - Driving annual initiatives to reduce waste
 - Paying providers and allocating resources to support Triple Aim goals
 - Budgeting cautiously for capital investment (e.g., technology & infrastructure)
 - Monitoring performance using evidence-based quality & cost measures
 - Using provider agreements that align incentives to support the Triple Aim

*Extracted from materials of the Institute for Healthcare Improvement

Let's Try it Out Using Some Real-World Examples...

- *PACE - full integration of Medicare/Medicaid/LTC services for a select population of voluntary enrollees*
- *Minnesota Senior Health Options Program - full integration of Medicare/ Medicaid/LTC services in a managed care model for all enrollees in pilot counties*
- *Arizona Long-Term Care System (ALTCS) – full integration of Medicaid health and LTC services in a managed care model for all enrollees*
- *Geisinger Health System –collaborative, cross-silo system improvement efforts with supporting provider payment systems*
- *Jonkoping, Sweden – regional government responsibility for all aspects of health care services for an entire community of 330,000*
- *Grand Junction community effort – community collaborative involving most providers and major plans*

PACE – The Program for All-Inclusive Care for the Elderly

- Sponsored by Medicare – A program built on the OnLok model developed in San Francisco’s Chinatown
- Target population: Medicare beneficiaries with need for nursing facility level of care who choose a PACE plan
- Plans receive both Medicare and Medicaid capitation payments to provide all health and long-term care support and services, including prescription drugs
- PACE plans must follow a prescribed model of care delivery
 - Team approach to care and service planning with individualized service plans
 - Non-institutional living arrangements
 - Day center-based services, including nurse and physician, therapy, meals, and recreation
 - Support services, including services not covered by traditional Medicare and Medicaid programs

Results from PACE programs

- Experience of care (compared to traditional home & community-based services)
 - Higher rates of preventive care
 - Lower rates of difficulties with pain, activities of daily living
 - Higher rates of life satisfaction
 - Lower rates of hospitalization
- Cost - Savings expectations have been neither demonstrated nor refuted
- Population health
 - No demonstrated difference in health status for enrollees
 - Does not address health of non-enrollee except to the extent it facilitates caring for frail elderly in a way that supports families
- Growth - The model has grown slowly.

Minnesota Senior Health Options

- Pilot sponsored by Minnesota Medicaid and CMS, beginning in 1997
- Target population: Persons eligible for Medicare and Medicaid health, especially those needing long-term care services
- Plans receive both Medicare and Medicaid capitation payments to provide all Medicare and Medicaid services – 17 plans in 7 counties
- Plans must provide care coordination
- Plans must develop a person-centered plan for each long-term care eligible beneficiary
- Plans contract for the array of services, using sub-capitation in some cases
- State and plans collaborate on quality assurance and performance improvement, use of chronic care protocols, and developing best practices and encouraging their use for providers

Results of Minnesota Senior Options Pilot

- Experience of care
 - Improved patient/family satisfaction especially for nursing home population
- Cost
 - Not available.
- Population health
 - No significant difference in health status has been demonstrated between pilot population and a comparable population
 - Program does not address broader community health issues

Arizona Long Term Care System (ALTCS)

- Sponsored by Arizona Medicaid, which has contracted with plans to provide both long-term care and health services since the state Medicaid program began in 1989
- Target population: Medicaid eligibles at risk for institutionalization
- Managed care plans provide all Medicaid-provided physical health and long-term care services for the target population (behavioral health is carved out)
- Medicaid Managed care participation is mandatory
- Medicare Managed care participation is voluntary, but many beneficiaries choose Medicare plans operated by ALTCS contractors
- Managed care plans must develop individual care plans

Results of ALTCS

- Experience of care
 - High participant satisfaction
 - Highest rate of non-institutional care of individuals with nursing home level of need in the country
 - Difficult to measure quality of health services because there is no Arizona comparison group
- Cost
 - Early studies showed Arizona's Medicaid long-term care population had lower rates of utilization of acute care services (except for Evaluation and Management services) than a comparable New Mexico population
 - Early studies showed Arizona's LTC population in nursing homes used fewer acute care services than those in home & community based services
- Population health
 - Unknown

Other states are experimenting with integration of health and long-term care services

These include:

- Tennessee
- Wisconsin
- Washington (Snohomish Co. pilot)

Geisinger Health System

- Sponsored by Geisinger Health System, an integrated delivery system that serves individuals enrolled in its own health plan as well as others (more like Providence than Kaiser)
- Target population: Primarily commercial
- Strategies:
 - Primary Care Home initiative
 - Enrollees with chronic conditions have a primary care home and personal health navigator
 - Providers develop bundles of care for chronic conditions
 - Up to 20% of provider payment is at risk for compliance with best practices and patient satisfaction
 - ProvenCare Acute Care initiative
 - Bundled payments go to clinical groups for acute episodes (guarantee: no additional charges for 90 day period)
 - Providers develop best practice elements of care to improve quality
 - Patient agrees to take steps to improve care
 - Supported by a strong electronic health record system

Geisinger Results

- Experience of care
 - Coronary Artery Bypass Graft (CABG): Increased adherence to best practices increased from 59% to 100%, complications reduced by 8%, and readmissions reduced by about 50%
 - Primary care home: Reduced admissions by 20%, improved outcomes
- Cost
 - Primary care home: 7% over-all cost savings
- Population health
 - Not measured broadly although control of diabetes improved
 - No responsibility for community as a whole
- Next steps
 - Goal is to bundle 50% of all services as flat-rate packages

Jonkoping, Sweden

- Sponsored by county of Jonkoping, Sweden (population 330,000)
- Since 1982, Sweden has assigned responsibility for providing health care (including dental and public health) to its counties, which levy taxes and fix budgets for health care
- Goals: patient-centered, evidence-based, effective, efficient, safe, and equal
- Strategies:
 - Three geographic units are given a population and a budget
 - Each unit has an anchor hospital and primary care centers
 - Quality improvement efforts are addressed to broad issues of access, collaboration, clinical processes, patient safety, and medication
 - Quality Improvement projects address specific issues targeted for improvement such as nutrition for the elderly; care coordination and integration of services for the elderly; preventing falls, ulcers, and pain; and eliminating waits for visits.
 - Performance is measured at all levels. Measures include cost, clinical outcomes (C-section rates, recovery from stroke, readmissions, patient satisfaction), and financial performance

Jonkoping Results

- Experience of care
 - Reduced rate of hospital admissions for pediatric asthma from 20 to 7 per 10,000 with pediatric asthma (compared to 30 in the US)
 - Reduced wait times for primary and specialty care appointments and telephone consultations
 - Reduced hospital admissions for the elderly by 20%
 - Reduced hospital days for heart failure by 30%
 - Best quality in Sweden by far on a composite index including measures of access (eg., 7-day access, number of visits), quality (readmissions, depression after stroke, C-section utilization), and cost (per capita cost)
- Cost
 - Lower per capita cost than the average in Sweden
- Population health
 - Higher rates of psychological well-being than Swedish average

Grand Junction, Colorado

- Sponsored by a community collaborative that involves an IPA with 85% of the region's physicians, the single dominant hospital, a safety net clinic, HMO, and social service providers
- Target population: Entire community
- Goals:
 - Improve primary care and coordination of care
 - Limit supply and use of expensive resources
- Strategies:
 - Providers share responsibility for Medicare, Medicaid, and commercial patients
 - Physician peer review using plan data
 - Health information exchange
 - Collaborative efforts to address issues like low birth weight babies, chronic disease, end of life care
 - HMO puts 15% of provider payment at risk for cost and quality performance

Grand Junction Results

- Patient Experience of Care
 - Hospital scores in the top 10% for quality
 - Fewer hospitalizations, shorter hospitalizations, and lower hospital mortality
 - Population spends 40% less time in the hospital during the last six months of life than the national average
- Cost
 - Medicare cost substantially below national average in all categories except outpatient physician care, which is average
- Population
 - County as a whole ranks #1 in Colorado on clinical care indicators in RWJF's County Health Rankings (% uninsured, primary care provider rate, preventable hospitalizations, diabetics screenings, and hospice use)

What can we learn?

- Targeting a population
 - Jonkoping and Grand Junction focus on an entire community, which encourages public health approaches and a focus on equity and social services supports
 - PACE focuses on fragile elderly, thinking about all of their needs
 - Geisinger targets a subset of patients that are high needs/high cost
- Capping total spending with strict year-over-year budget targets
 - Jonkoping, PACE, Minnesota pilot , and ALTCS MCOs all operate on fixed budgets
 - Jonkoping 's budget is set by community leaders whereas PACE , ALTCS, and Minnesota pilot rates are linked to Medicare and Medicaid capitation rates
 - Geisinger's bundled payment system encourages elimination of preventable complications (costs related to defects in care) but fails to address technology-driven utilization or price of care to the purchaser

What we can learn?

- “Integrator” that accepts responsibility for all components of the Triple Aim – improving population health, improving the experience of care (quality), and reducing per capita cost
 - Only Jonkoping has a powerful integrator
 - Patient-centered care and services – Geisinger, PACE, and Jonkoping all focus new efforts on patient engagement
 - Redesigning care
 - Arizona and Minnesota capitated systems reduce high cost institutional care
 - Conscious focus on discrete health issues is required to make change that both improves quality and lowers cost (Geisinger, Jonkoping)
 - Targeting sub-populations – Geisinger works to identify high needs subpopulation and addresses efforts toward their needs.

What we can learn?

- Driving annual initiatives to reduce waste –
 - Geisinger’s bundles drive this focus on reducing waste from failure to follow evidence-based protocols
 - Jonkoping focuses improvement activities on both social and strictly medical issues and on workforce strategies for reducing cost
- Paying providers and allocating resources to support Triple Aim goals – Geisinger physician and provider payment systems support its goals
- Cautious capital budgeting – Jonkoping with its power over the budget for an entire community best-positioned to address over-utilization related to excess medical capacity
- Monitoring performance using evidence-based quality & cost measures – All examples are focused on measurement, although they vary how they use information to drive changes
- Using provider agreements to align incentives – Geisinger seems to have given most attention to this issue.