PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

The Engaged Provider Response to the Current Health Care Policy Environment

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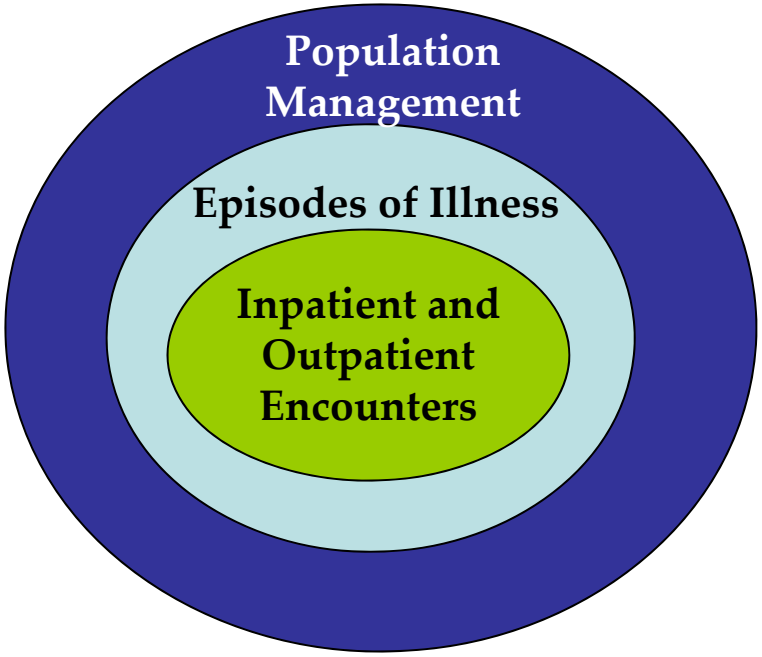
Timothy G Ferris, MD, MPH
Mass General Physicians Organization, Medical Director
Associate Professor, Harvard Medical School

The Engaged Doctor's Dilemma

- **Health care costs are rising too rapidly**
- **We have been through this before**
  - Healthy skepticism that the next big idea from an insurance company is actually going to solve this problem.
- **Physicians remain unsure of what reform will bring**
  - Multiple approaches in commercial, state, and federal payers
  - Uncertainty in payment reforms leaves the engaged provider with little direction regarding how to get started



- **So what is the engaged provider to do?**
  - Whatever the new payment system, there are some clear directional indicators:
    - Change focus - from units to episode and populations
    - Move forward - move forward with the things that I know have been shown to improve outcomes and/or reduce costs.
    - Always improve - create incentive structure that rewards continuous innovation

Engaged Provider Tactics

<table>
<tr><th></th><th colspan="2">Longitudinal Care</th><th colspan="2">Episodic Care</th></tr>
<tr><th></th><th colspan="2">Primary Care</th><th colspan="2">Specialty Care</th><th>Hospital Care</th></tr>
<tr><td rowspan="3">Access to care</td><td colspan="3" rowspan="2">Patient portal / physician portal</td><td>Optimize site of care</td></tr>
<tr><td rowspan="2">Reduced low acuity admissions</td></tr>
<tr><td colspan="3">Extended hours / same day appointments</td></tr>
<tr><td rowspan="6">Design of care</td><td colspan="5">Expanded virtual visit options</td></tr>
<tr><td colspan="5">Defined process standards in priority conditions
(multidisciplinary teams, registries)</td></tr>
<tr><td colspan="2" rowspan="2">High risk care management</td><td colspan="2" rowspan="2">Required patient decision aids</td><td>Re-admissions</td></tr>
<tr><td>Hospital Acquired Conditions</td></tr>
<tr><td colspan="2" rowspan="2">Provide 100% preventive services</td><td colspan="2" rowspan="2">Appropriateness</td><td>Hand-off standards</td></tr>
<tr><td>Continuity Improvements</td></tr>
<tr><td colspan="5">EHR with decision support and order entry</td></tr>
<tr><td colspan="5">Incentive programs (recognition, financial)</td></tr>
<tr><td rowspan="3">Measurement</td><td colspan="5">Internal variance reporting / performance dashboards</td></tr>
<tr><td colspan="5">Publicly reporting of quality metrics: clinical outcomes, satisfaction</td></tr>
<tr><td colspan="2">Costs / population</td><td colspan="3">Costs / episode</td></tr>
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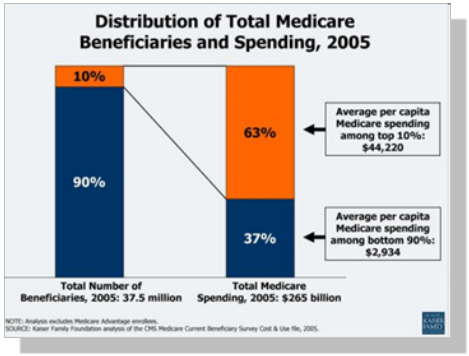
Chronic Conditions – MGH Medicare Demo

MGH Demo

- Medicare selected MGH to participate in a 3-year demonstration project focusing on high-cost beneficiaries in 2006
- Success validated in 2010 (RTI evaluation)
- Contract renewed through 2012
- Expanded to Brigham and Women's and North Shore Medical Center

Opportunity

10% of Medicare patients account for nearly 70% of spending



COST SAVINGS FROM MANAGING HIGH-RISK PATIENTS

Timothy G. Ferris, M.D., M.P.H., Eric Weil, M.D., Gregg S. Meyer, M.D., M.Sc., Mary Neagle, M.P.H., James L. Heffernan, M.B.A., and David F. Torchiana, M.D. Massachusetts General Hospital[2]

- Enrolled 2,500 highest cost Medicare patients with total annual costs of $68 M
  - Average number of medications = 12.6
  - Average annual hospitalizations = 3.4
  - Average annual costs = $24,000
- Payment model similar to proposed shared savings for ACOs
  - Paid monthly fee based on number of enrolled patients
  - Required to cover costs of program +5%
  - Gainsharing if savings greater than cost +5%
  - Success determined using prospective matched comparison group

http://www.massgeneral.org/about/newsarticle.aspx?id=2531

Chronic Conditions – MGH Medicare Demo

Results from Independent Evaluator (RTI)

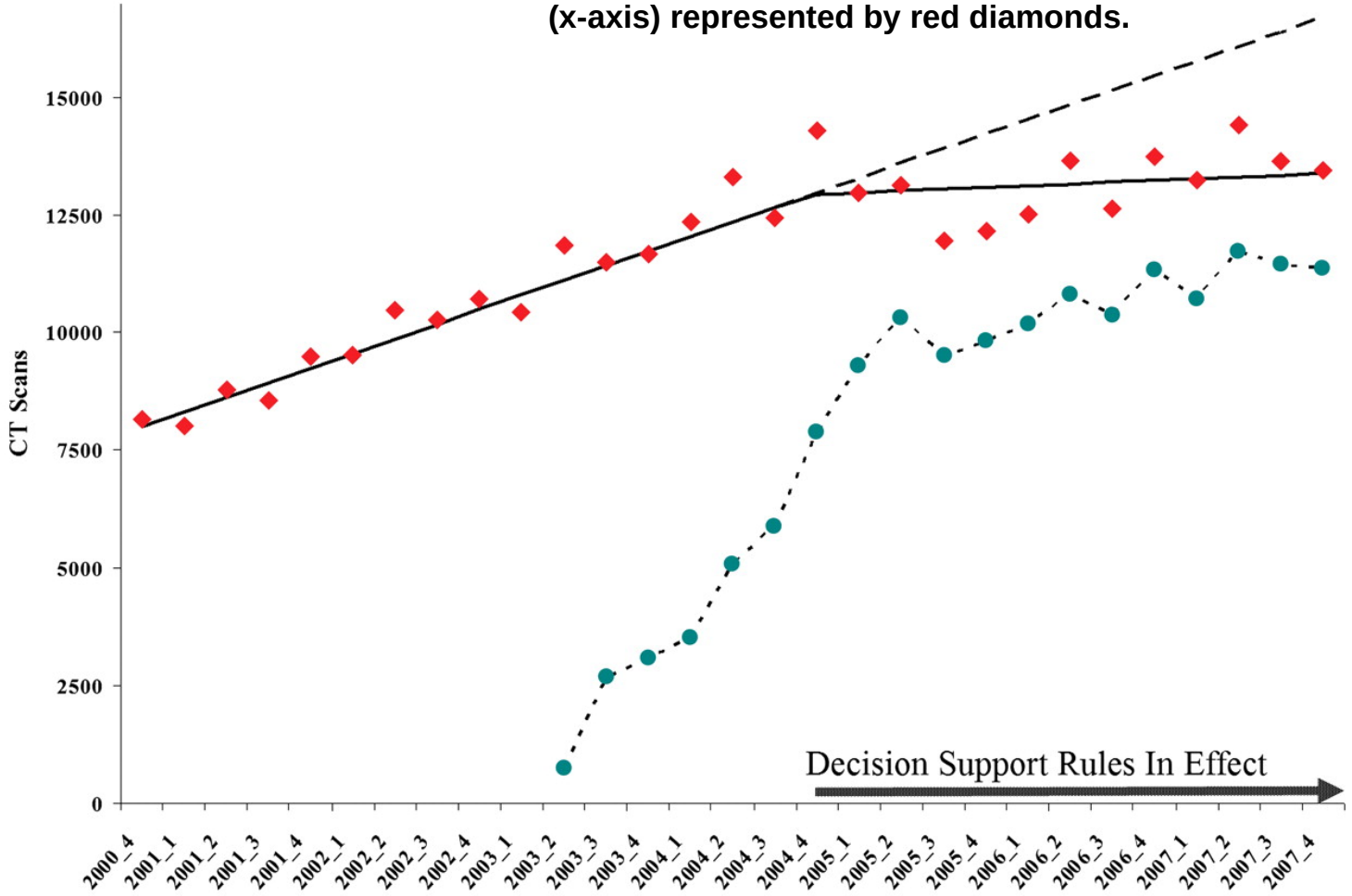
- 12 care managers embedded in primary care practices
  - Coordinate care; point person for acute issues
  - Identify patients at risk for poor outcomes
  - Facilitate communication when many caregivers involved
- Key characteristics
  - Care managers have personal relationships with patients
  - Care managers work closely with physicians
  - All activities supported by health IT (universal EHR, patient tracking, home monitoring)
- Successful Outcomes
  - Hospitalization rate among enrolled patients was 20% lower than comparison*
    - ED visit rates were 25% lower for enrolled patients*
  - Annual mortality 16% among enrolled and 20% among comparison
- Successful Savings
  - 7.1% annual net savings (12.1% gross) for enrolled patients
  - For every $1 spent, the program saved at least $2.65

*Based on difference in differences analysis

Health IT – Integrated Decision Support for Imaging

- Radiology utilization management systems

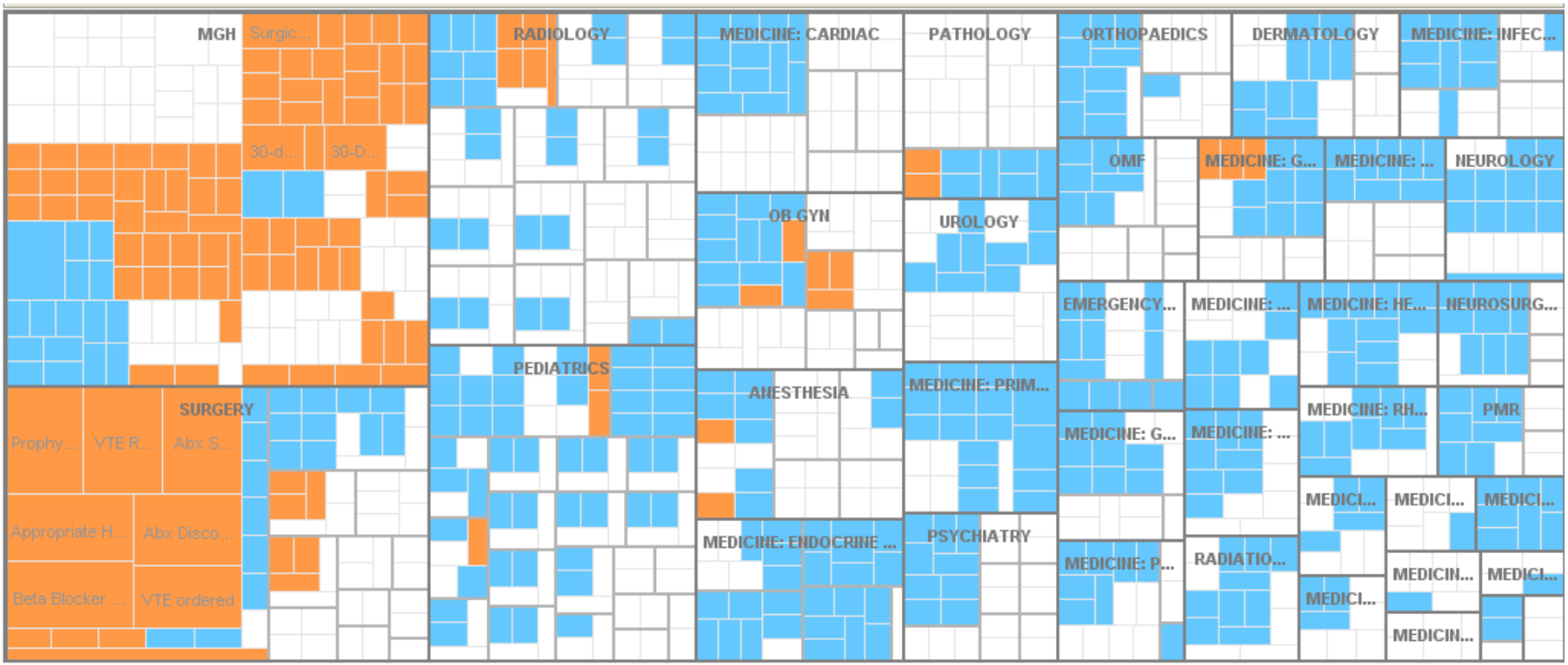
Scatterplot of outpatient CT examination volumes (y-axis) per calendar quarter (x-axis) represented by red diamonds.



Sistrom C L et al. Radiology 2009;251:147-155

Radiology

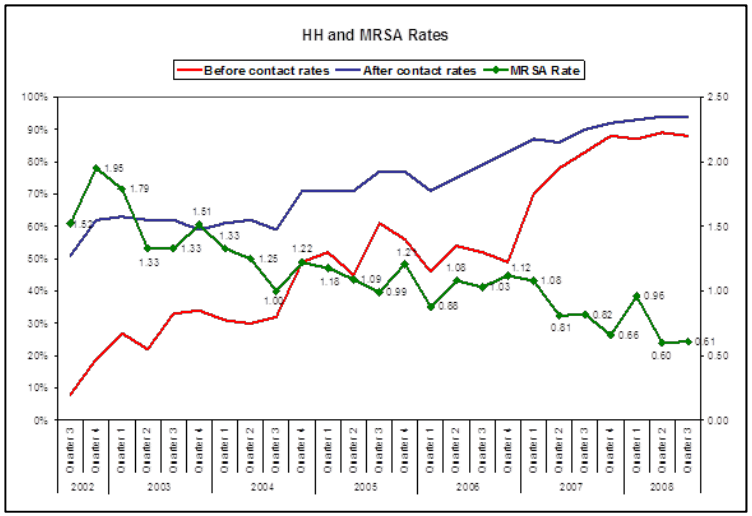
MGH Internal Physician Quality Measures



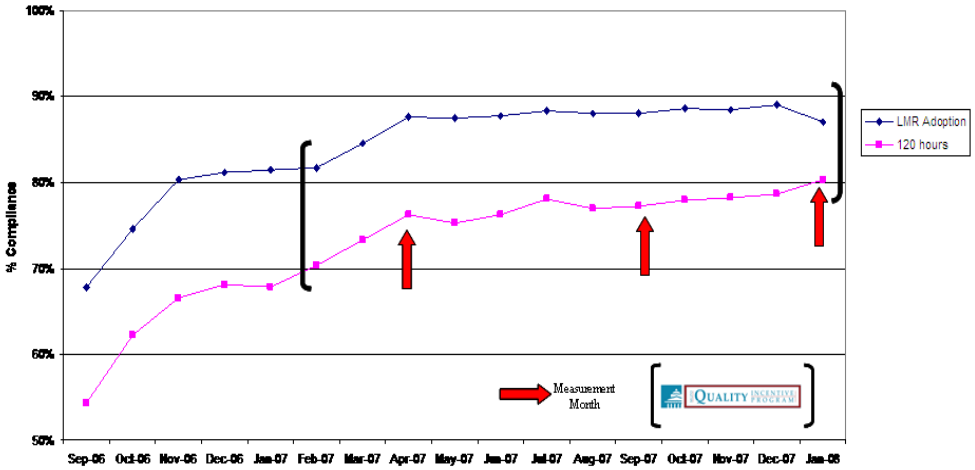
http://www-958.ibm.com/software/data/cognos/manyeyes/visualizations/mgh-quality-meas-overview-1209

MGH Internal Quality Incentive Measures

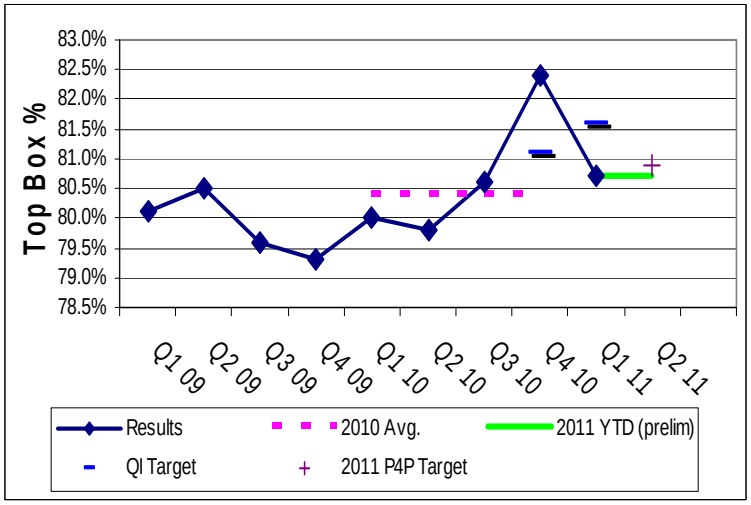
Hand Hygiene / MSRA



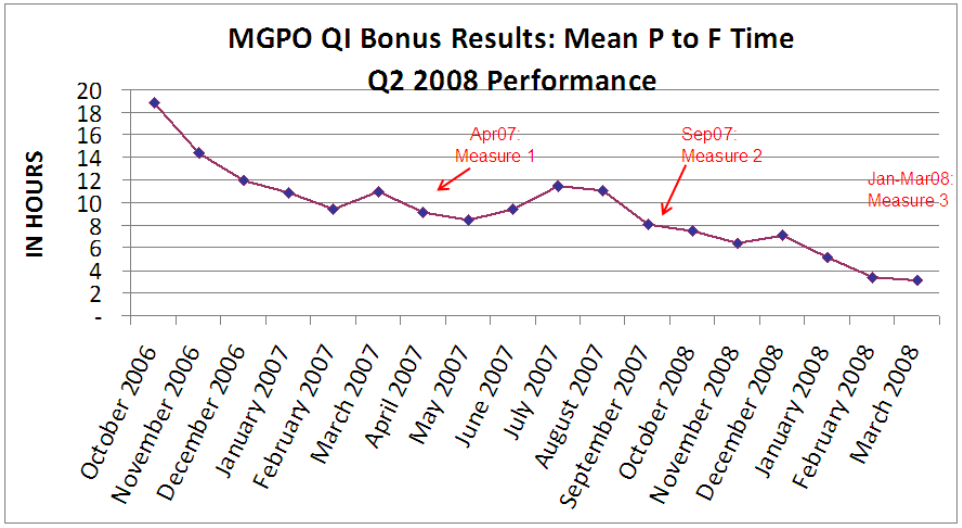
EMR Use (for Notes)



H-CAHPS Performance



Radiology Turn Around Times



Closing Thoughts

- Doing all this will take quite a while – the stakeholders will need to be a little patient
- How do we incent providers to do these things?
  - Shared savings
  - Pay for performance
  - Gold card status for engaged providers resulting in lower administrative costs for payers and providers
- This presentation addressed only the engaged provider side of a two party relationship:
  - Incentives for patients to be judicious consumers of health care would be a powerful complementary set of policies
- Types of innovation
  - Adopting and implementing ideas known to be effective (i.e. “new” processes)
  - Development and testing of new technology and processes not yet known to be effective