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INSTITUTE FOR HEALTHCARE IMPROVEMENT

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Where Knowledge Informs Change

How Physicians Can Help Achieve Health Reform: A Commonwealth Fund/Institute for Healthcare Improvement/Dartmouth Webinar

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May 22, 2009

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Donald Berwick, MD, MPP
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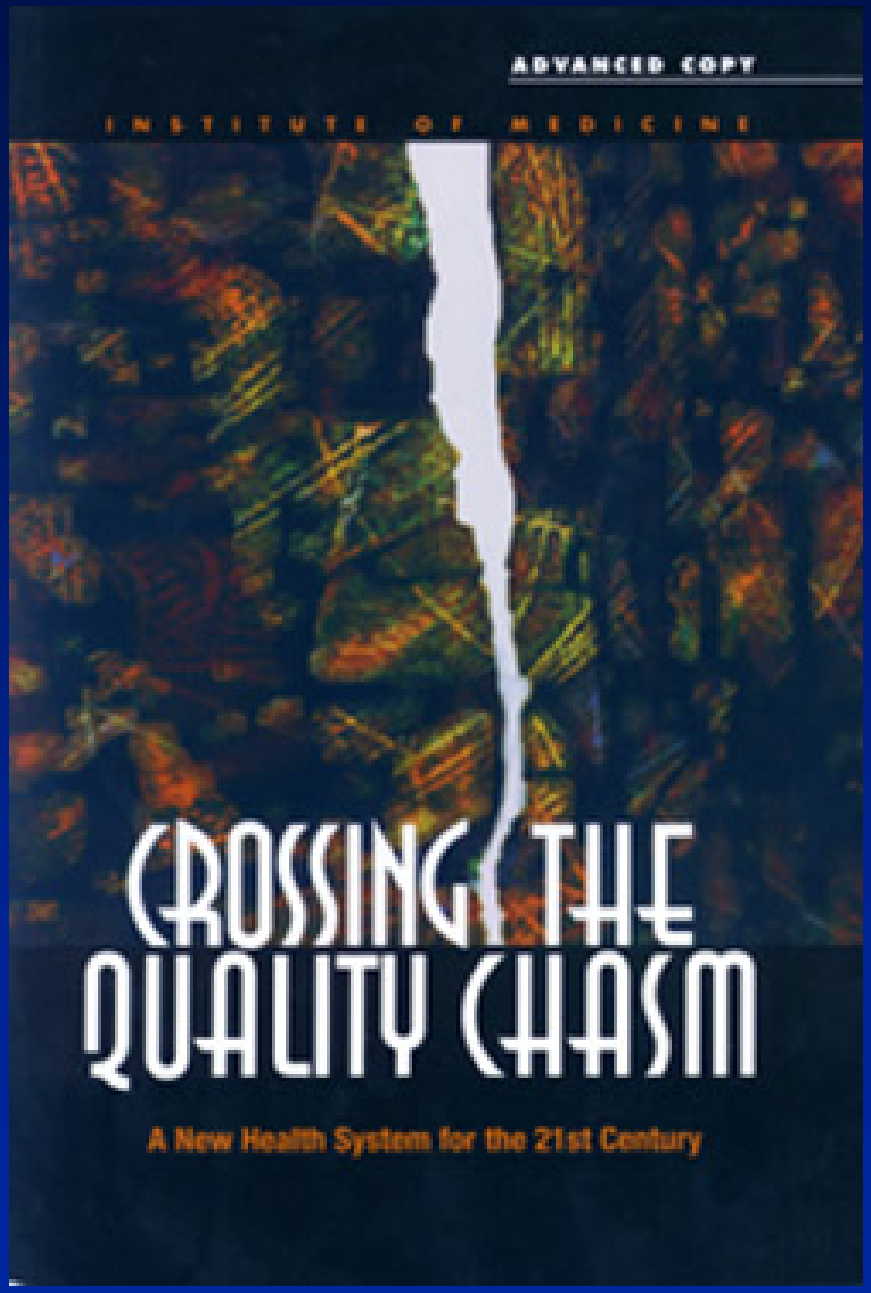
May 22, 2009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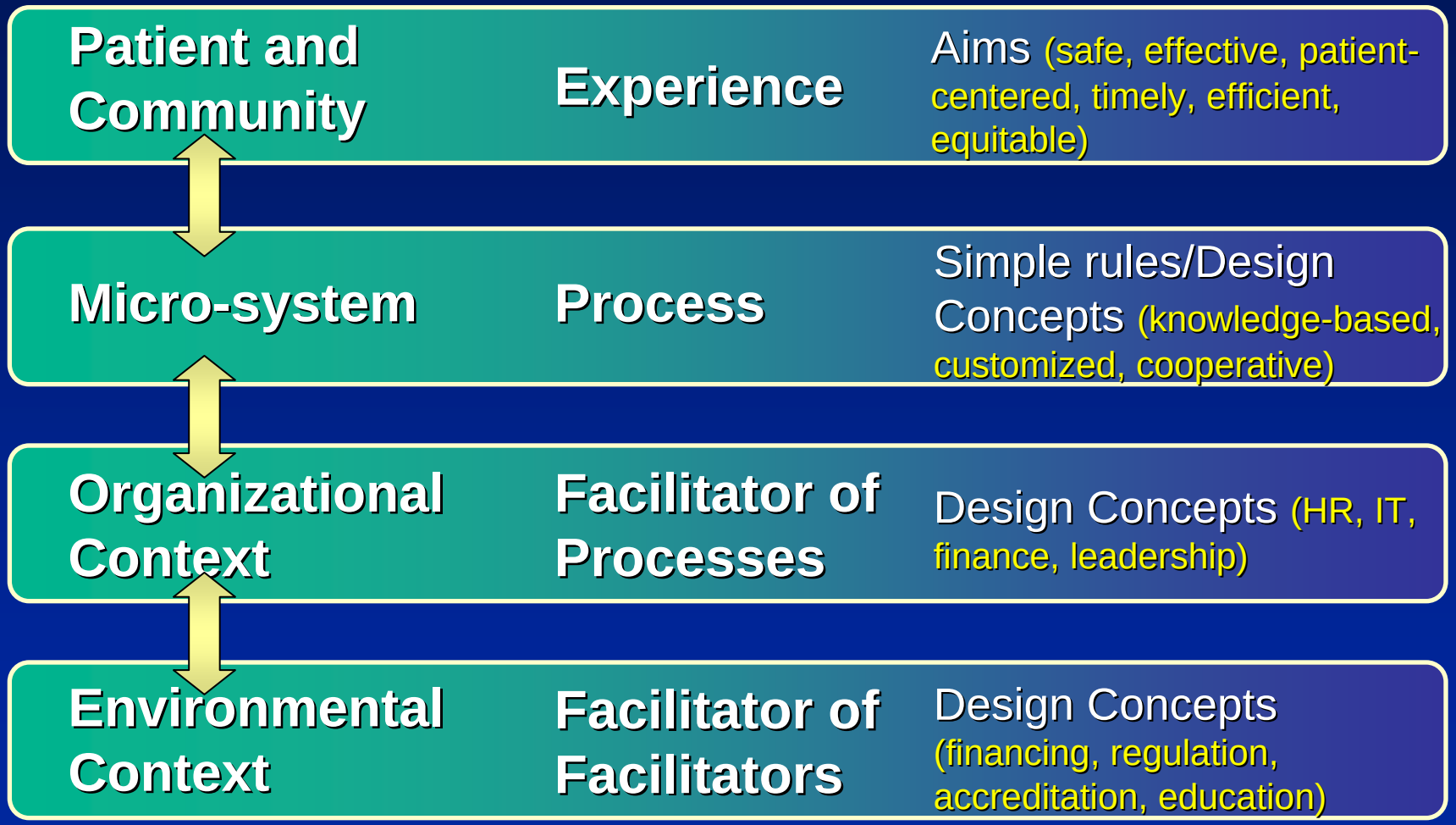
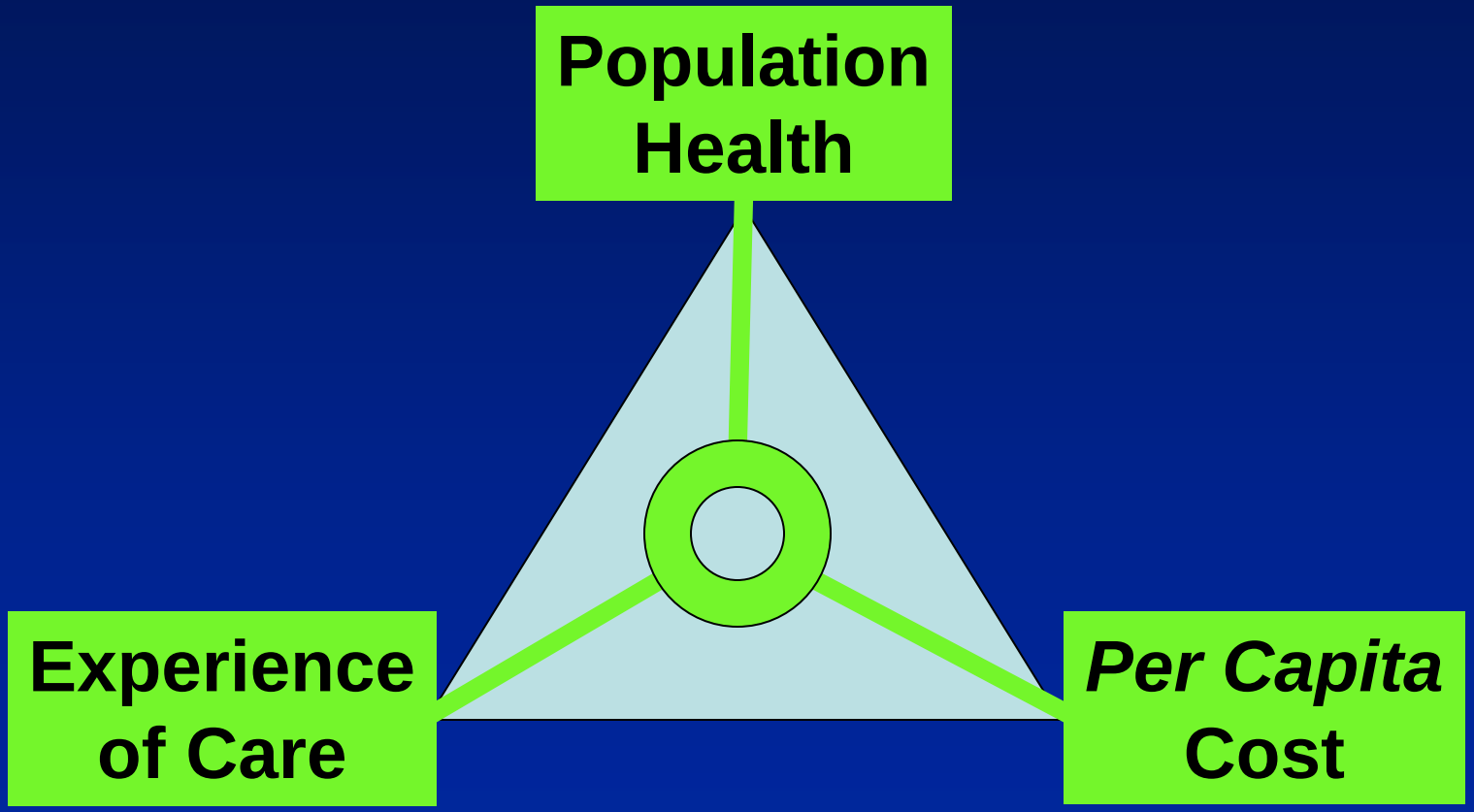
INSTITUTE OF MEDICINE
CROSSING THE QUALITY CHASM
A New Health System for the 21st Century

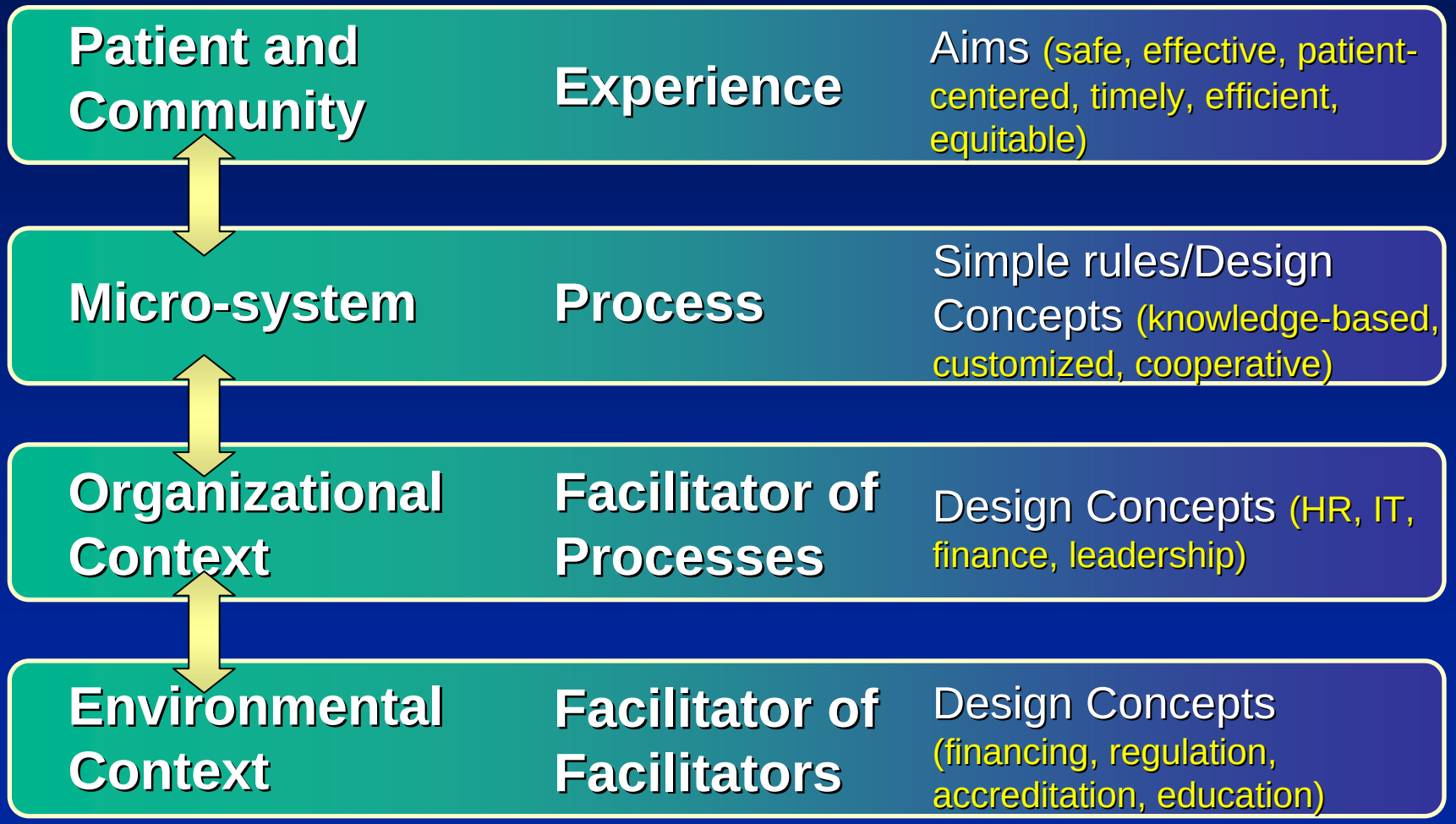
The Chain of Effect in Improving Health Care Quality



The “Triple Aim”



The Chain of Effect in Improving Health Care Quality



The Cost Threat

- Congress may conclude that expanding coverage to all the uninsured is unaffordable.
- Can integrated care save enough money to offset the cost of coverage expansion?

National Quality Forum
National Priorities Partnership Goals

1. Engage Patients and Families in Care
2. Improve the Health of the Population
3. Improve Safety and Reliability
4. Ensure Well-Coordinated Care
5. Guarantee Appropriate and Compassionate End-of-Life Care
6. Eliminate Overuse

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Policy Solutions: Physicians Must Lead

- The Triple Aim
  - Better experience of care
  - Better health for the population
  - Lower total per capita costs
- Quality Improvement Activities
- Accountable Care Organizations
- Physician advocacy
  - Payment reform and coverage for all

Physicians as Leaders

Defending the status quo is a bankrupt plan.

Physicians can lead change to see beyond it.

Health Reform: Getting to Yes

- Acknowledge that delivery system reform offers a win-win
  for providers
- Recognize that achieving savings will not impose hardship
- Guarantee savings through legislative targets
- Link savings to coverage for all and delivery and payment
  system reform

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"Slowing Spending Growth: A Win-Win"

Karen Davis, Ph.D.
The Commonwealth Fund

Bending the Curve in Health Care Expenditures

- **Need to bend the future health care cost growth curve to achieve savings to help finance coverage of the uninsured**
- **Will also ease the nation's financial crisis and provide much needed financial relief to struggling businesses and workers by slowing the rise in health insurance premiums**
- **The commitment by health leaders to slow the growth in National Health Expenditures by 1.5 percentage points is a major positive development**
- **Even assuming the effort takes time to implement it promises substantial savings over the next decade -- $3 trillion over 2010-2020**
- **The savings to the federal government could "close the deal" on financing health insurance for all**

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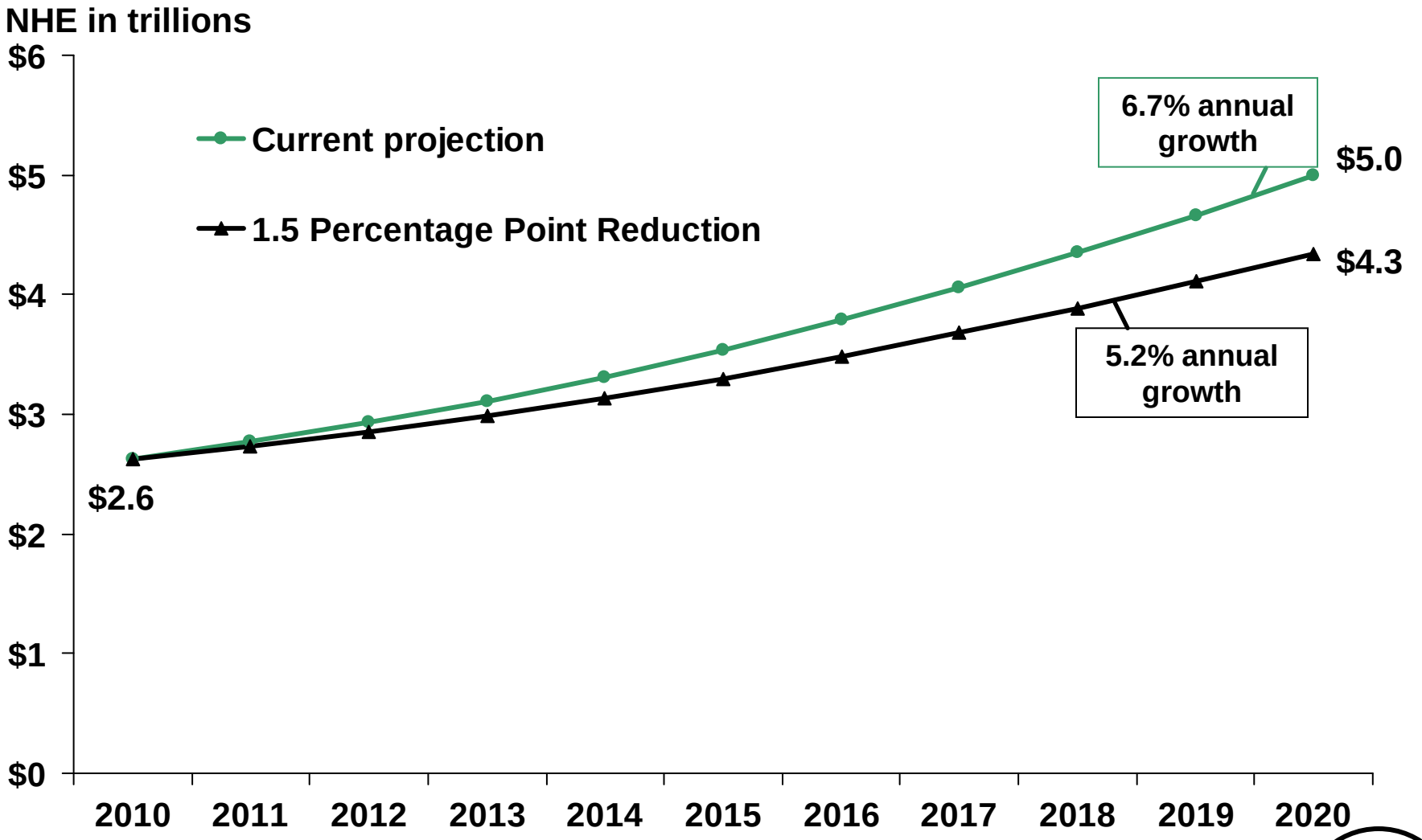
What Would a 1.5 Percentage Point Reduction in Cost Growth Achieve?



Note: GDP = Gross Domestic Product.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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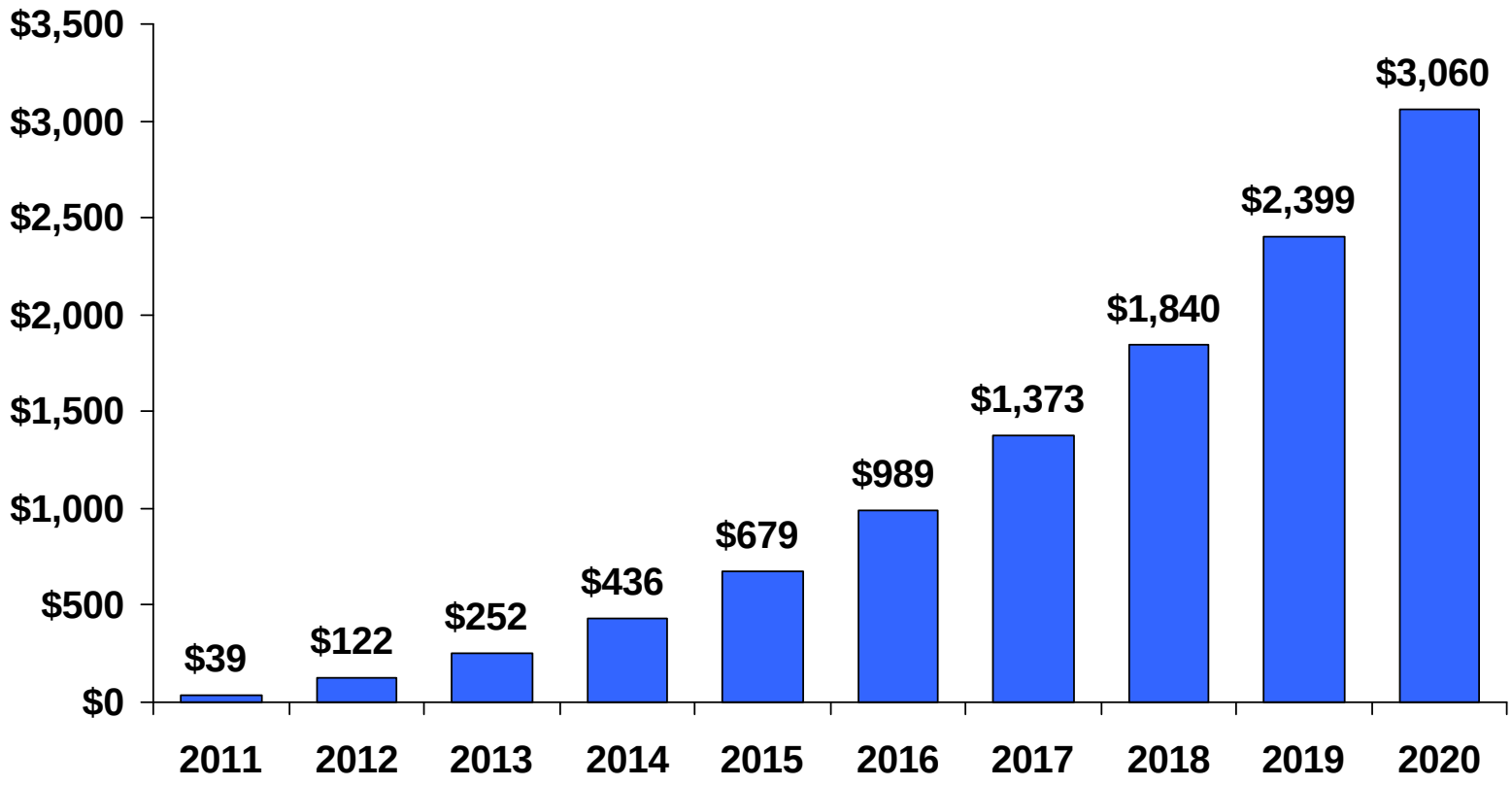
What Would be the Cumulative Savings of Reducing Growth Rate by 1.5 Percentage Point, 2010–2020?

Dollars in billions



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Data: Estimates by The Lewin Group for The Commonwealth Fund.

What Would be the Savings to Government, Businesses, and Families over 2010–2020?

Dollars in billions

	Total NHE	Net federal government	Net state/local government	Private employers	Households	Other
Total Savings	**$3,059**	**$1,066**	**$529**	**$497**	**$671**	**$296**

Data: Estimates by The Lewin Group for The Commonwealth Fund.

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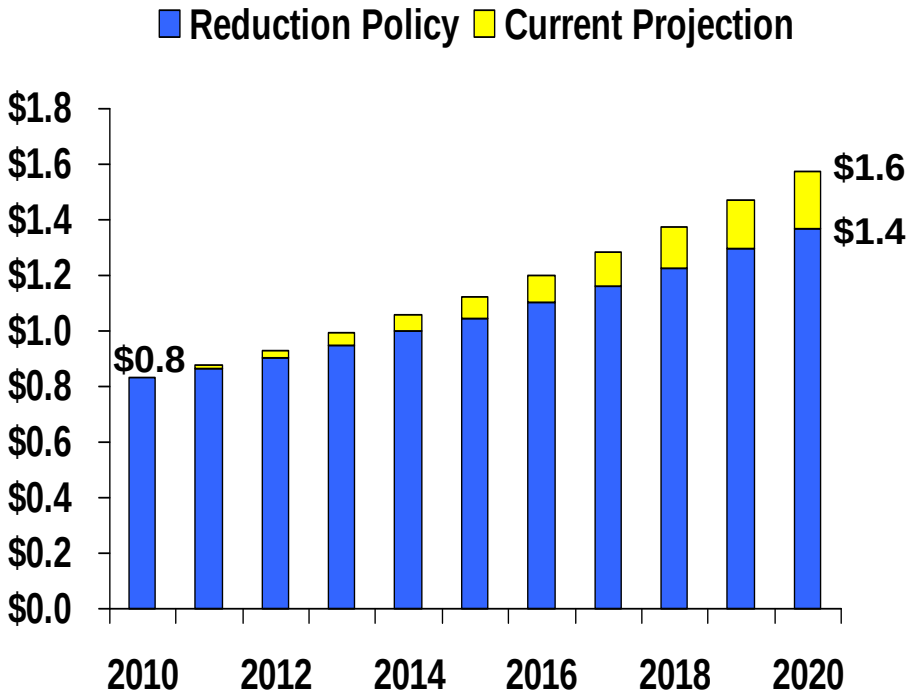
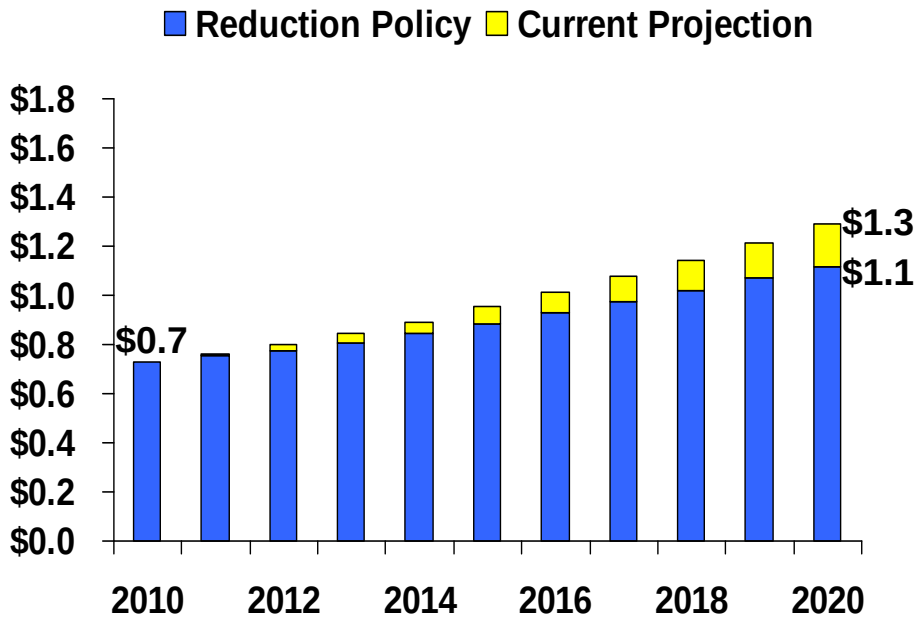
Bending the Cost Curve Would Still Permit Provider Incomes to Grow, 2010–2020

Hospital Expenditure (trillions)



Physician Expenditures (trillions)



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Data: Estimates by the Lewin Group for The Commonwealth Fund.

A Voluntary Commitment is Not Enough

- Congressional Budget Office will not score savings from a voluntary commitment alone
- Voluntary efforts in the past have failed
- Proposed mechanism:
  - Setting a expenditure target on total Medicare outlays
  - Voluntary restraints on provider charges to private plans until Medicare payment rates catch up
- Interim cost measures would be replaced by fundamental payment reform that encourages accountable care organizations and bundled payment that rewards value not volume of services

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Question-and-Answer Session

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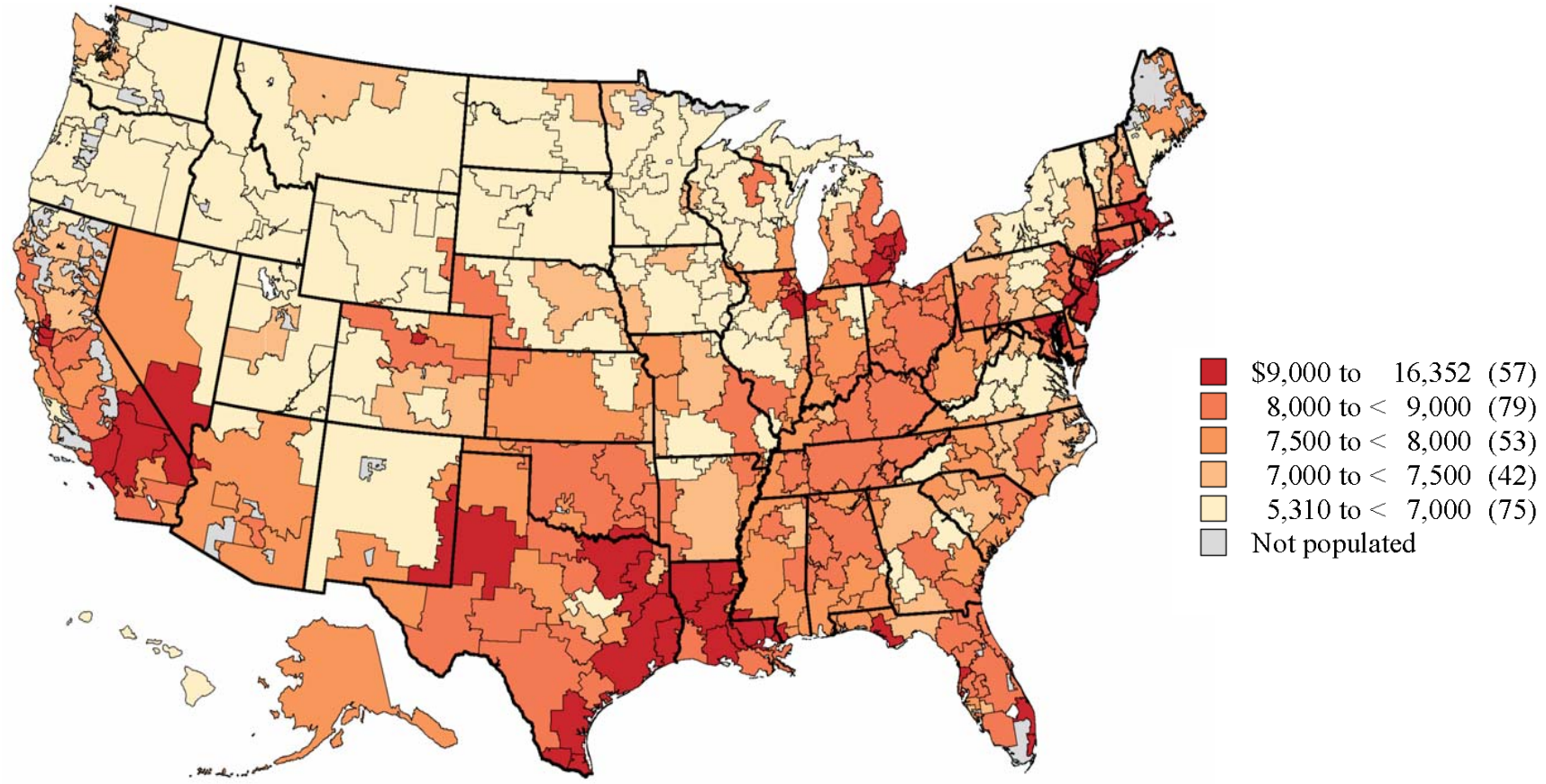
Elliott S. Fisher, M.D., M.P.H.
Dartmouth Center for Health Policy Research

Healthcare Reform Cannot Wait

- **The Problems:**
  - **Cost: Total health spending projected to rise from 17.7% of GDP to 21.3% of GDP absent reform**
    - **Tremendous variation in spending without improvements in quality**
  - **Coverage: Number of uninsured Americans projected to rise to 61 million in 2020**
  - **Quality: Millions of lives lost each year due to inadequate care**
- **Slowing the Growth in Expenditures: A Win-Win**
- **The Solutions:**
  - **IOM's "Chain of Effect"**
  - **Physicians Must Lead**
  - **Getting to Yes –**

Total Rates of Reimbursement for Noncapitated Medicare per Enrollee, by Hospital Referral Region, 2006



Source: E. Fisher, J. Bynum, and J. Skinner, *The Policy Implications of Variations in Medicare Spending Growth*, (Hanover: The Dartmouth Institute for Health Policy and Clinical Practice, February 2009).

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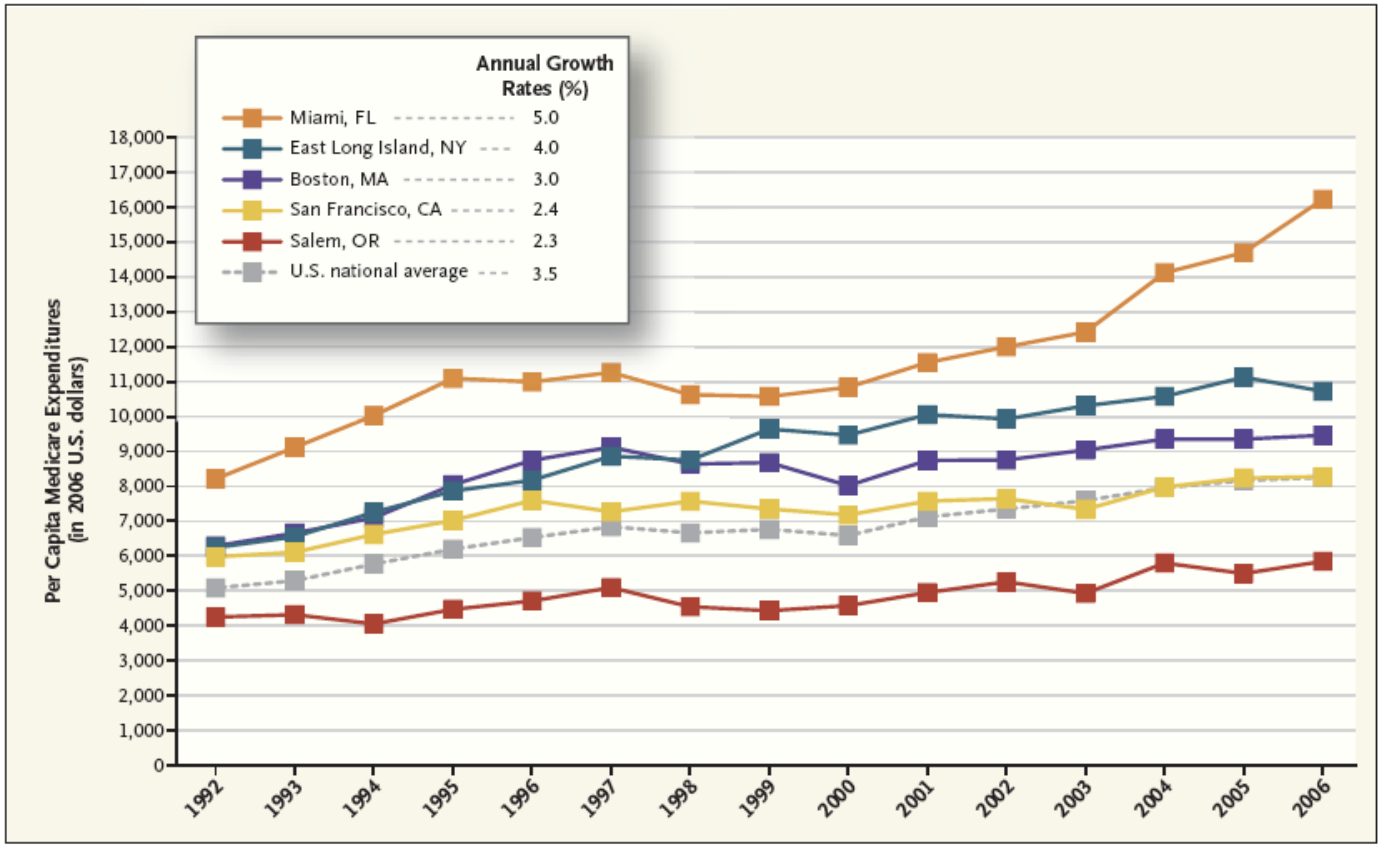
Variations in per-capita *growth* in Medicare spending (non-capitated)



Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992–2006.

Data are in 2006 dollars and were adjusted with the use of the gross domestic product implicit price deflator (from the Economic Report of the President, 2008) and for age, sex, and race. Data are from the Dartmouth Atlas Project.

	Annual Growth Rate
US Avg	3.5
Miami	5.0
E. Long Island	4.0
Boston	3.0
San Francisco	2.4
Salem, OR	2.3

Source: Slowing the Growth of Health Care Spending: Lessons from Regional Variation
Fisher, Skinner, Bynum, New England Journal of Medicine, February 26, 2009

What does higher spending buy?

More discretionary "supply-sensitive" services

	Rate of Avoidable Admissions[1]	Physician Visits[2]	Per-beneficiary spending on imaging	Ratio Primary Care to Specialist visits[2]	Percent seeing 10 or more MDs[2]
Miami	95	106	$1434	0.72	51
E. Long Island	75	91	$1388	0.97	50
Boston	81	59	$864	1.20	39
San Francisco	52	64	$687	1.12	32
Salem	44	38	$512	1.30	18

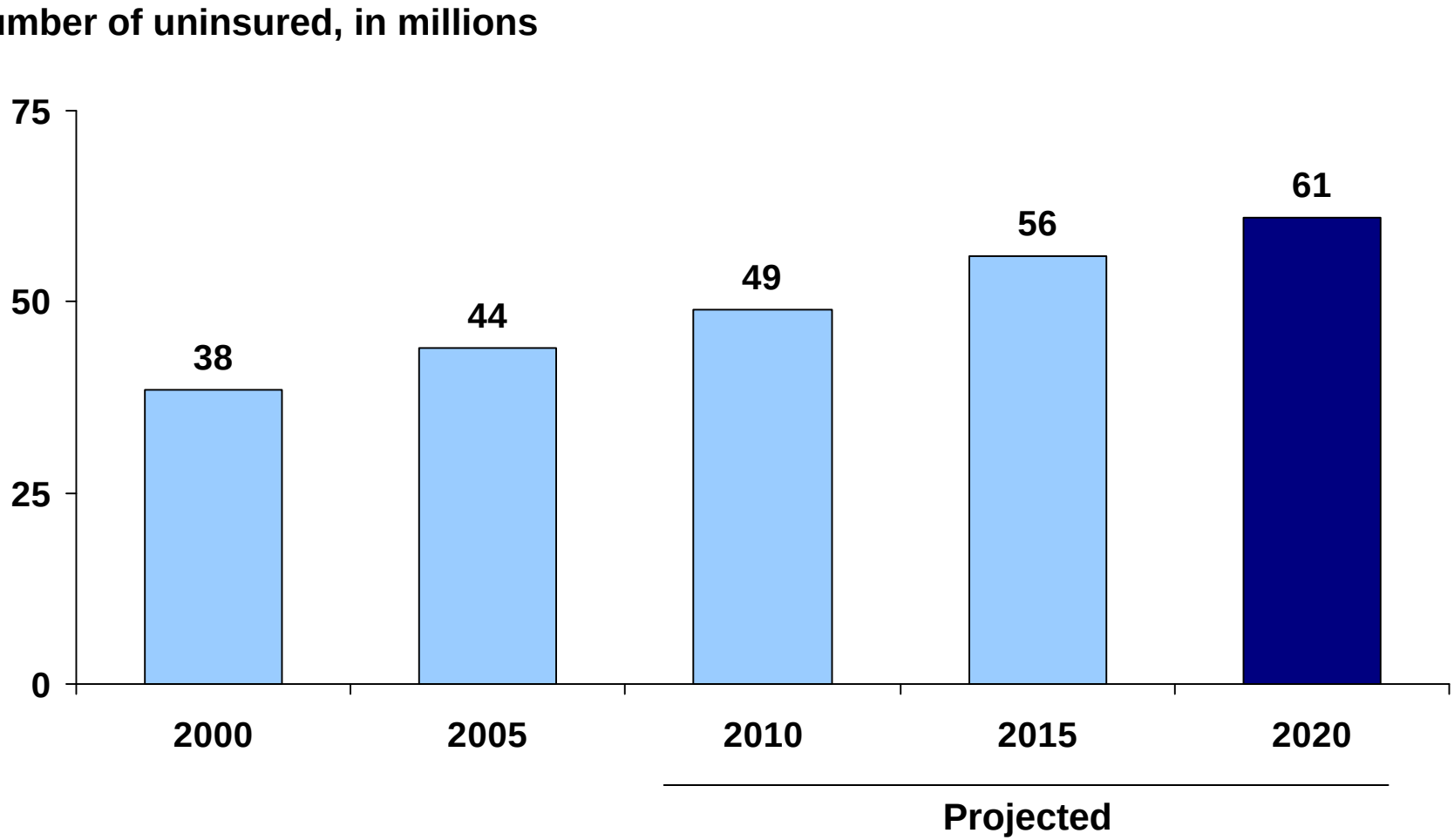
Notes

1. Ambulatory Care Sensitive Hospitalizations per 1000 Medicare beneficiaries
2. Utilization during last 2 years of life, Medicare beneficiaries with serious chronic illness.

And more isn't better

(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(5) Sirovich et al Ann Intern Med: 2006; 144: 641-649
(6) Fowler et al. JAMA: 299: 2406-2412

Uninsured Projected to Rise to 61 Million by 2020 Not Counting Underinsured or Part-Year Uninsured



Data: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2001 and 2006;
Projections to 2020 based on estimates by The Lewin Group.

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Moving forward

Address the underlying causes of rising costs, poor quality
Focus on the triple aim:

Underlying cause	Key principles
Failure to recognize key role of local system (capacity, local social norms) as a driver of cost and quality	Integrated systems of care: Foster the development of local systems accountable for the overall cost and quality of care
Assumption that more is better Equating less care with rationing	Measurement: (1) Comparative effectiveness (2) comprehensive performance measures
Payment system that rewards more care, increased capacity, high margin treatments, entrepreneurial behavior	Payment reform: foster accountability for capacity – and behavior : capitation or global shared savings

Fisher, MClellan et al. Fostering Accountable Health Care: Moving Forward in Medicare *Health Affairs 28, no. 2 (2009):* w219–w231 (published online 27 January 2009.

Integrated care

Foster Accountable Care Organizations (Systems)

Essential attributes of an Accountable Care Organization

- Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system
- Sufficient size to support comprehensive performance measurement

Potential Accountable Care Organizations

- Integrated delivery systems
  - (Mayo Clinic, Intermountain Health Care)
- Physician-Hospital Organizations / Practice Networks
  - (Middlesex Health System, Academic medical centers)
- Regional Collaboratives
  - (Rochester, NY; Indianapolis, IN)

Would entail little disruption of practice

- All physicians practice within easily defined “Physician-Hospital Networks”, which provide 70% or more of the care to their patients.

Fisher, MClellan et al. Fostering Accountable Health Care:
Health Affairs 28, no. 2 (2009): w219–w231.

Payment reform
The critical element

Current payment system has two effects

- Fosters commercial behavior in some; drives increased costs
- Presents serious barrier to aligning care with our values

Long-term goal: reward triple aim

- Population-based accountability for total per-capita costs
- Performance measurement

Transition period:

- Payment models that reward integration: bundled payments, episodes;
- Global shared savings models --
  - Set target for total costs; reward ACOs that achieve spending growth below target (if quality benchmarks met)
- Simulations suggest real savings possible – scored positively by CBO

Fisher, MClellan et al. Fostering Accountable Health Care:
Health Affairs 28, no. 2 (2009): w219–w231.

Why would anyone want this?

Reforms must meet interests of key parties

Physicians and hospitals

- Offers alternative that allows realignment of work and values
- ACO model allows adaptation of private practice to integration
- Allows personal incomes to be preserved while total revenues fall (achieving savings for patients and payers)
- *Better than the threatened alternative of draconian price cuts*

Patients and consumers

- No lock-in required (but incentives to choose PCP would help)
- System-level measurement allows more rapid implementation
- Offers possibility of real savings (maybe more than capitation)
- *Better access to care*: if unnecessary "revenue-driven" visits eliminated, access to both specialists and primary care physicians should improve (preliminary evidence from medical home pilots highly relevant)