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Moving Toward A High Performance Health System in Ohio

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The Commonwealth Fund

Ohio Health Quality Improvement Summit

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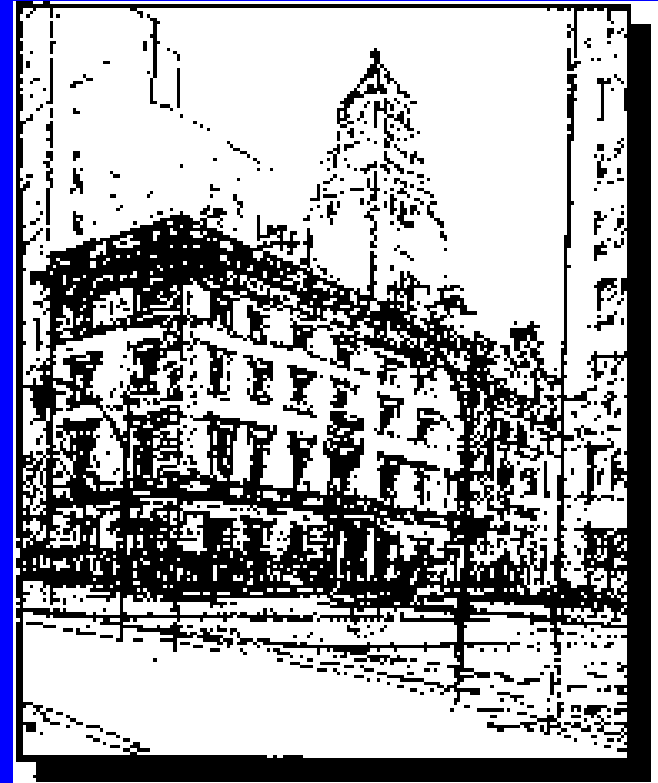
Presentation Overview

- Commission on a High Performance Health System
- Key Commission Recommendations
- What Can States (Ohio) Do?



The Commonwealth Fund

Established in 1918, The Commonwealth Fund (www.cmwf.org) is a private, not-for-profit foundation that aims to promote a high performing health care system by supporting and conducting independent research on health care issues and making grants to improve health care practice and policy.



Commonwealth Fund Commission on a High Performance Health System

Established in July 2005

Chairman: James J. Mongan, MD,
President and CEO, Partners
HealthCare System, Inc.
(Boston, MA)

Objective: Move the U.S. toward
a higher-performing health
care system that achieves
better access, improved
quality, and greater efficiency,
with particular focus on the
most vulnerable due to
income, gaps in insurance
coverage, race/ethnicity,
health, or age



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Five Key Strategies for High Performance

1. Extending affordable health insurance to all
2. Aligning financial incentives to enhance value and achieve savings
3. Organizing the health care system around the patient to ensure that care is accessible and coordinated
4. Meeting and raising benchmarks for high-quality, efficient care
5. Ensuring accountable national leadership and public/private collaboration

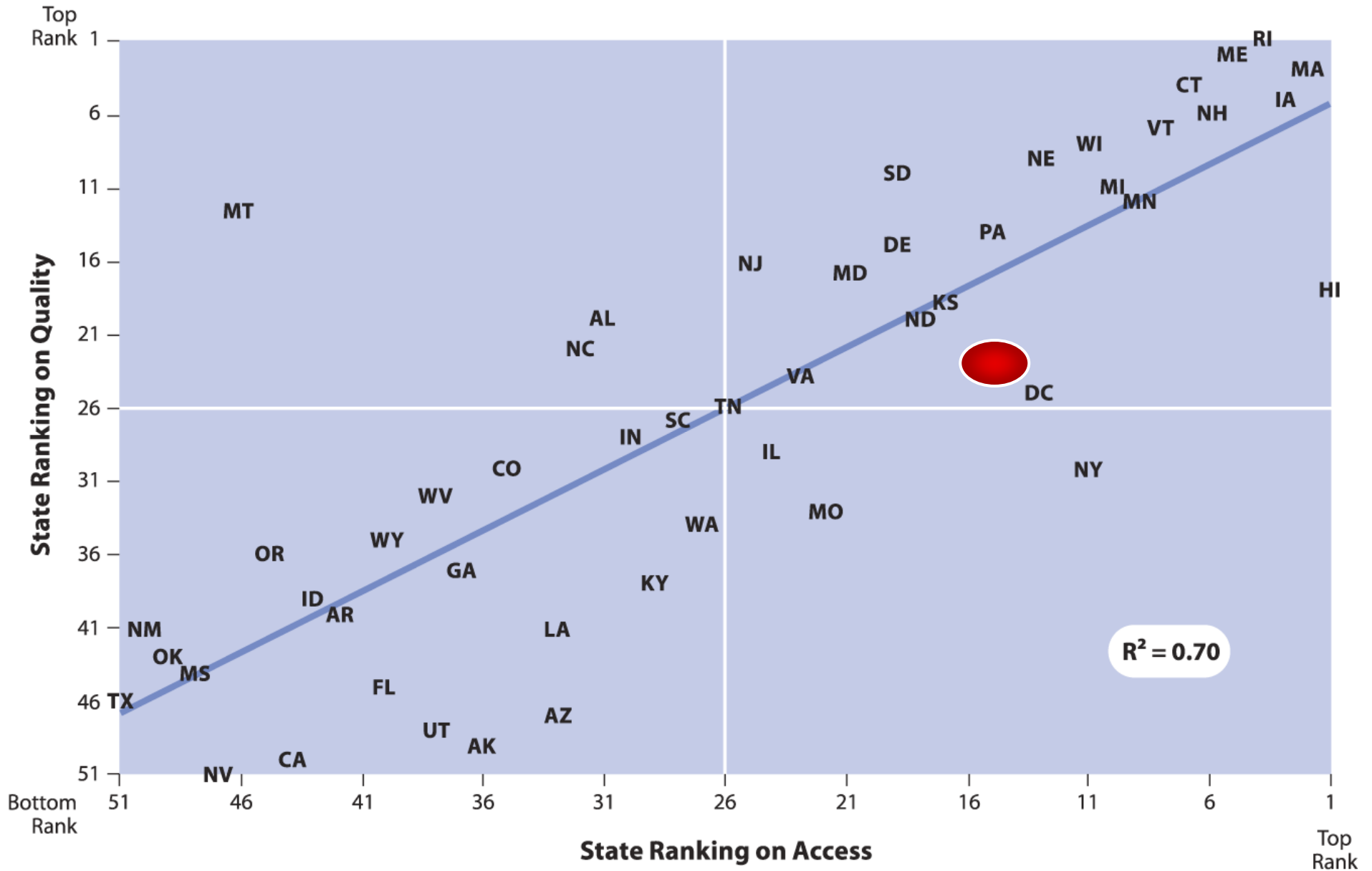
Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007



2008 National Scorecard Findings: Overall Score is 65 Out of 100

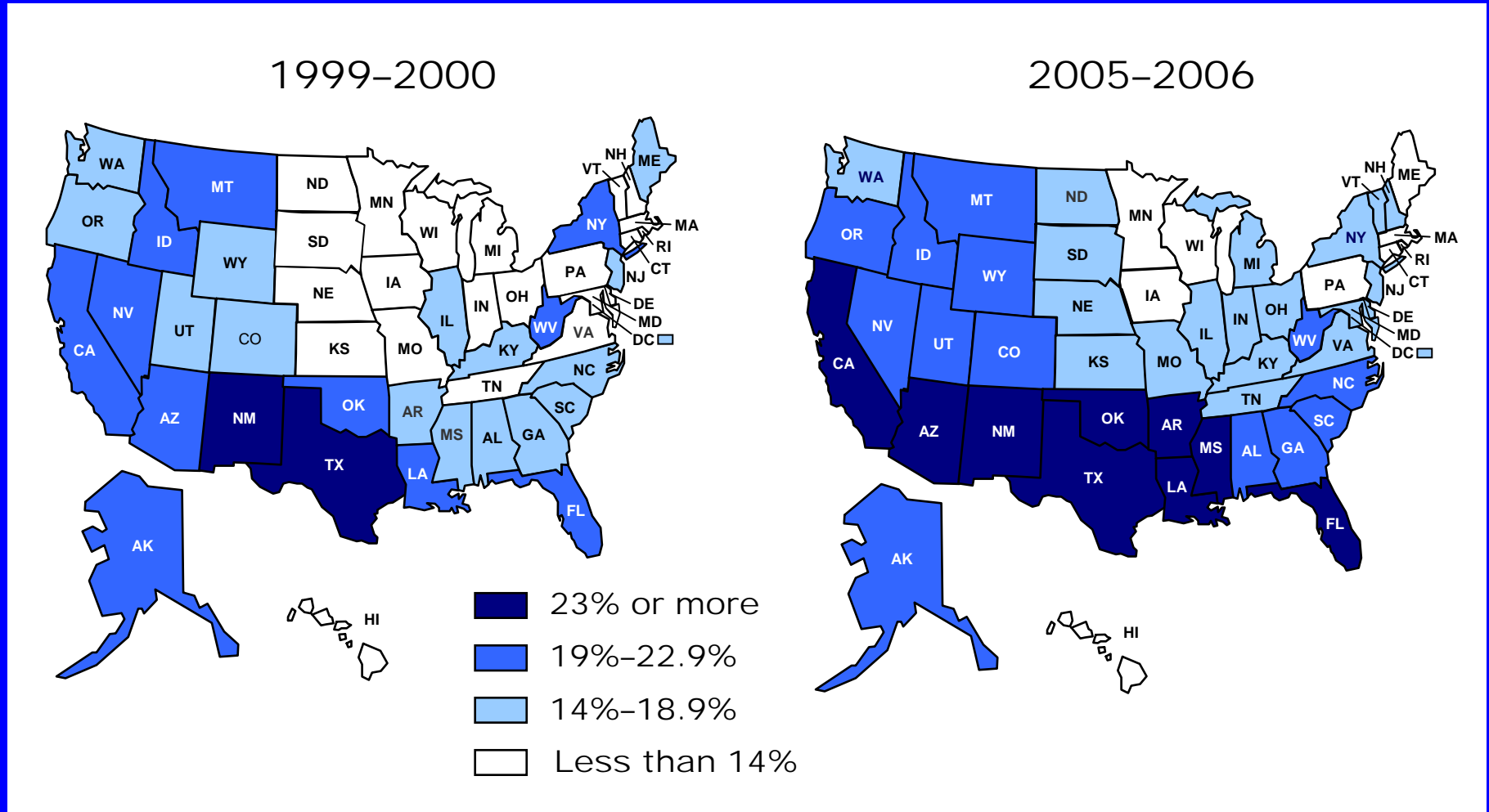
- Overall U.S. health system performance relative to benchmarks failed to improve between 2006 and 2008
 - Steep declines in access and affordability
 - Gains in U.S. health outcomes fell far behind other countries
 - Uneven performance on quality, yet encouraging pockets of improvement
 - Broad evidence of fragmented and inefficient care: efficiency scores especially low
 - Wide disparities by income, race/ethnicity persist
- Substantial variation across the U.S., with as much as fivefold spread between top and bottom regions, states, plans, or providers
- Highest costs in world -should expect higher value in return.
 - Reaching benchmarks could save 100,000 lives and \$100 billion annually

State Ranking on Access and Quality Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

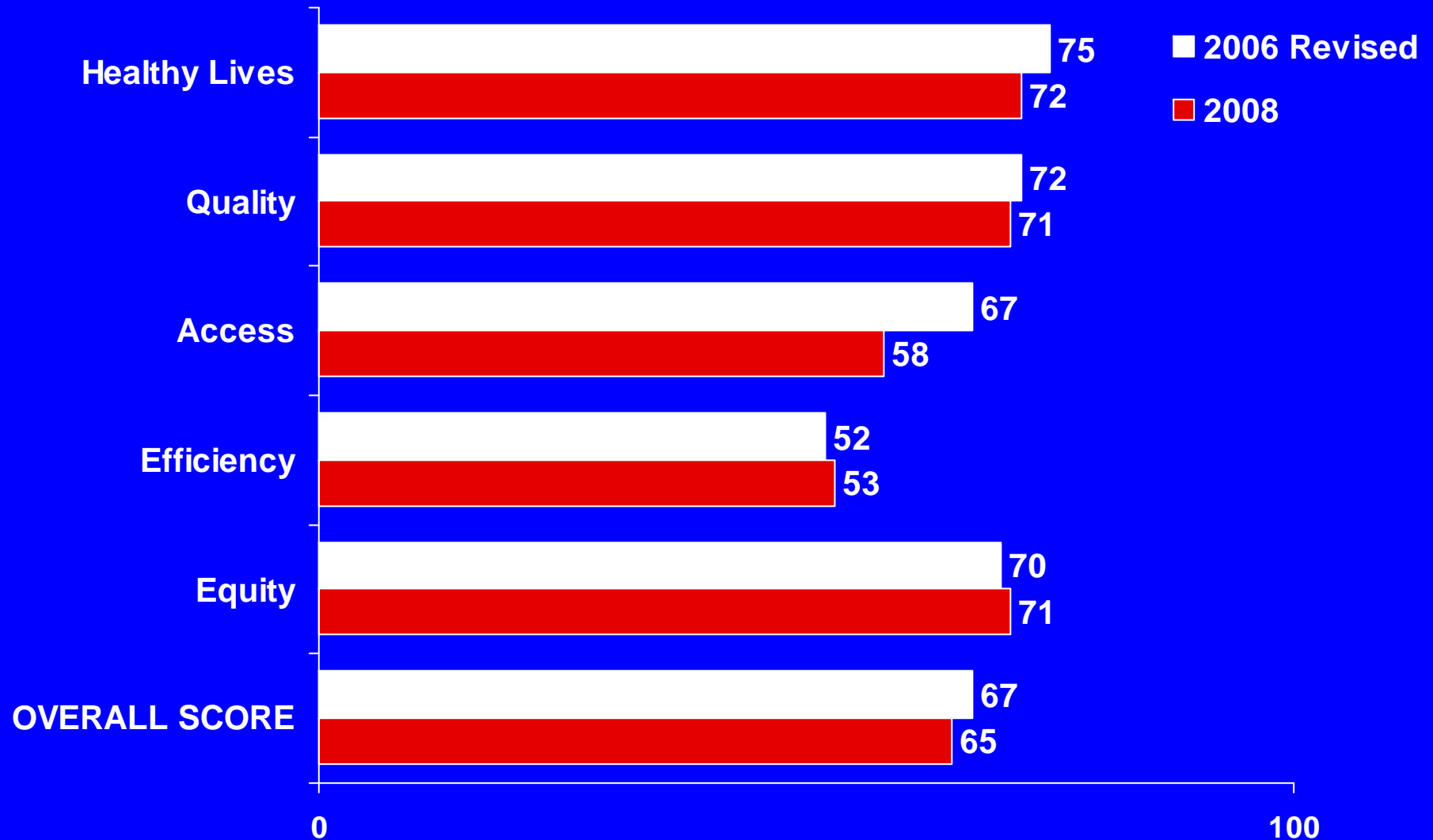
Percent of Adults Ages 18–64 Uninsured by State



Data: Two-year averages 1999–2000, updated with 2007 Current Population Survey correction, and 2005–2006 from the Census Bureau’s March 2000, 2001 and 2006, 2007 Current Population Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

Scores: Dimensions of a High Performance Health System



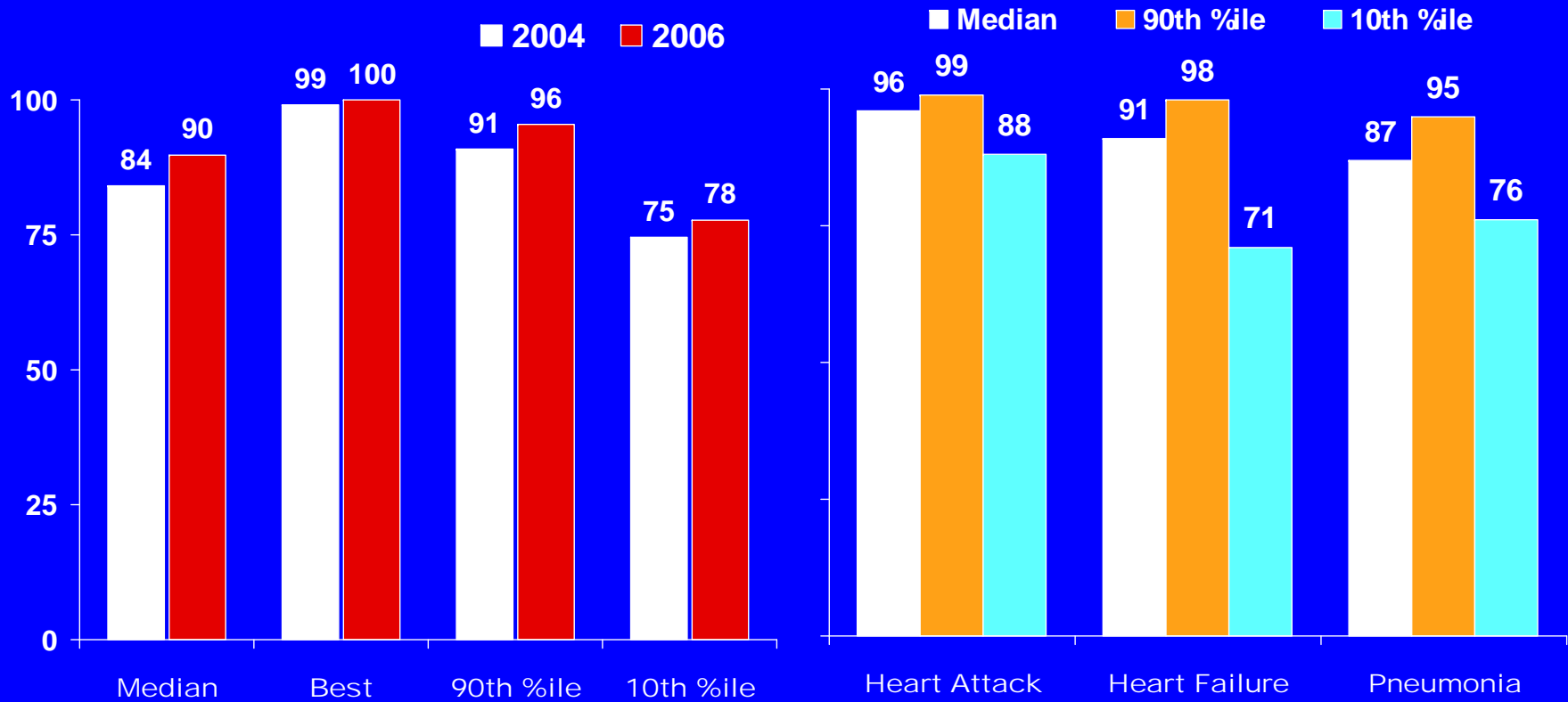
Hospitals: Quality of Care for Heart Attack, Heart Failure, and Pneumonia

Overall Composite for All Three Conditions

Percent of patients who received recommended care for all three conditions*

Individual Composites by Condition, 2006

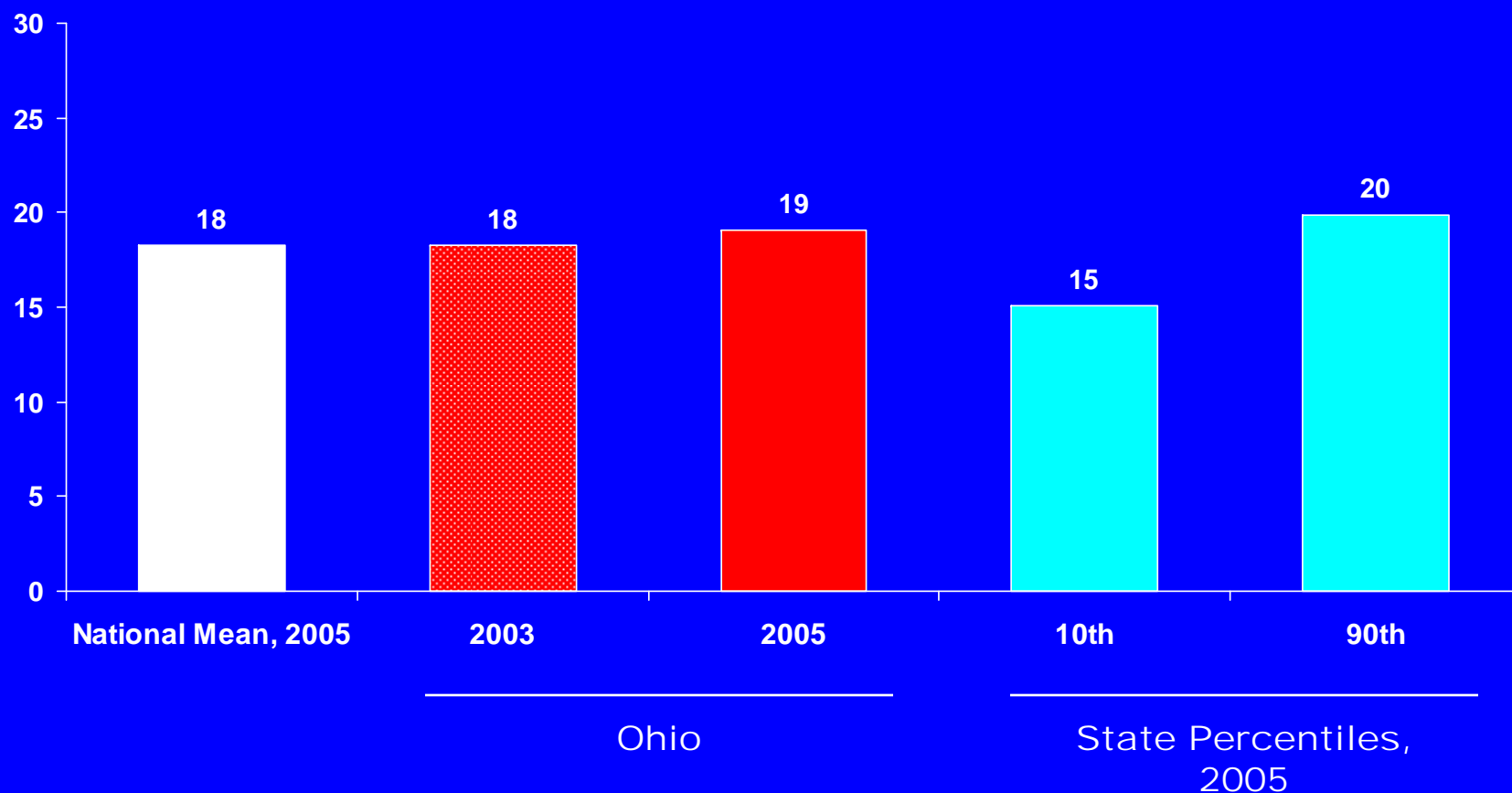
Percent of patients who received recommended care for each condition*



* Composite for heart attack care consists of 5 indicators; heart failure care, 2 indicators; and pneumonia care, 3 indicators. Overall composite consists of all 10 clinical indicators. See report Appendix B for description of clinical indicators. Data: A. Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare.

Medicare Hospital 30-Day Readmission Rates ¹¹

Percent of Medicare beneficiaries admitted for one of 31 select conditions who are readmitted within 30 days following discharge*

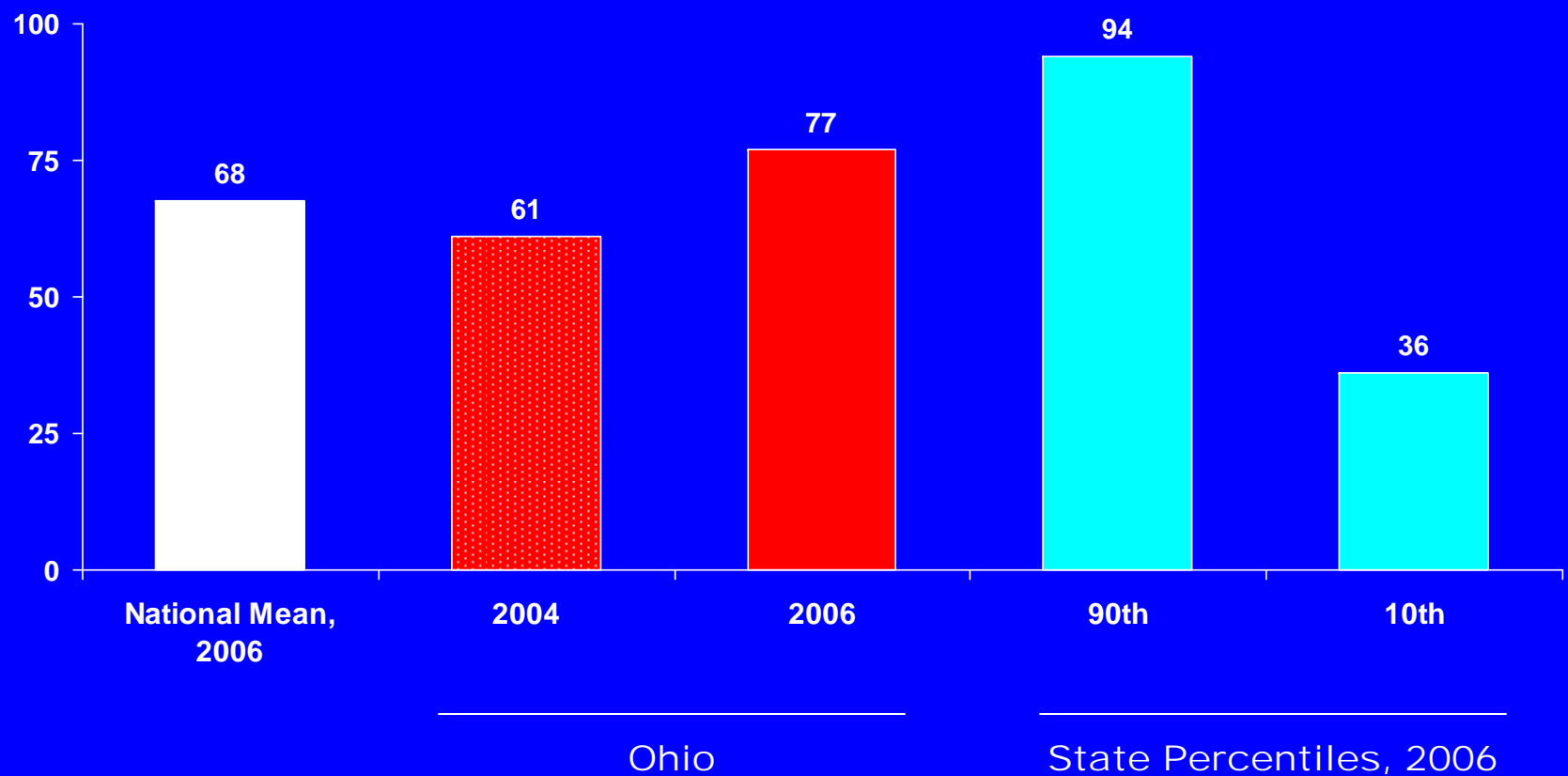


* See report Appendix B for list of conditions used in the analysis.

Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

Transition Care: Hospital Discharge for Heart Failure Patients, 2006

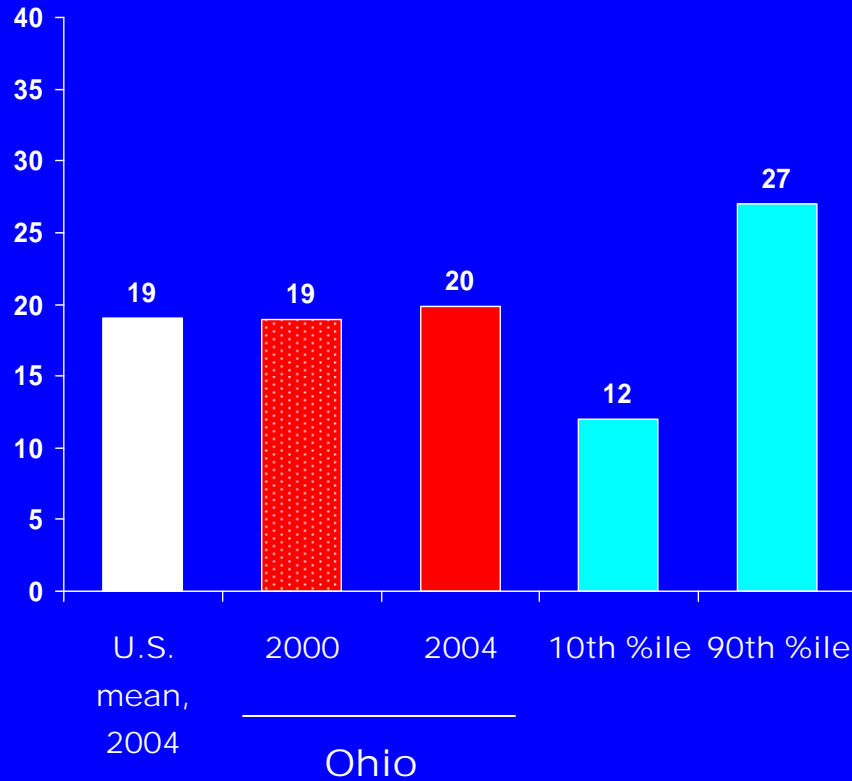
Percent of heart failure patients discharged home with written instructions*



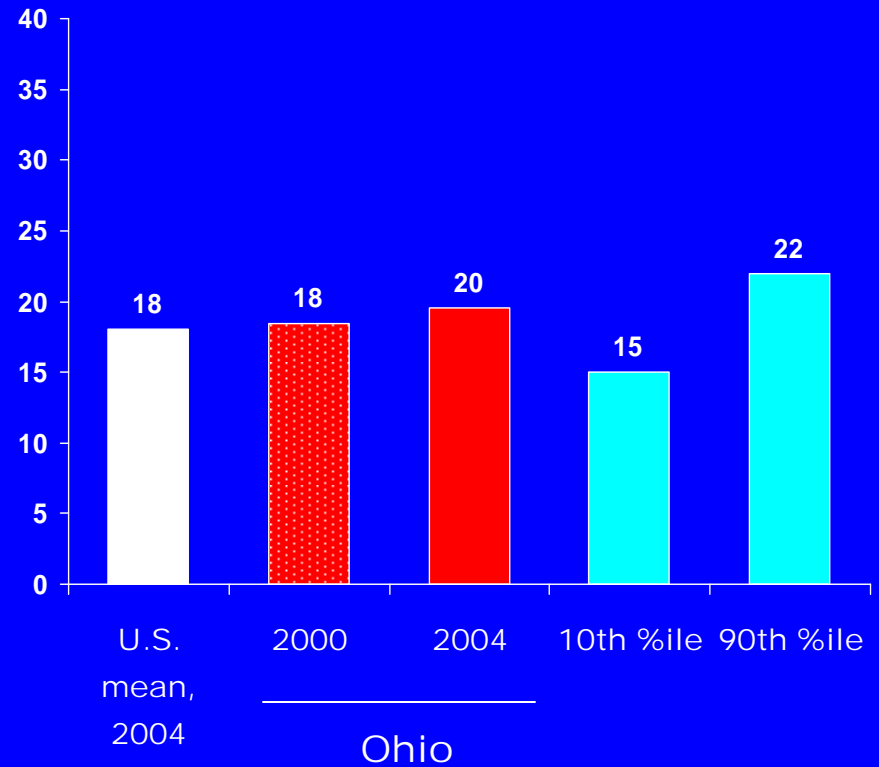
Data: Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare.

Nursing Homes: Hospital Admission and Readmission Rates Among Nursing Home Residents

Percent of long stay residents with a hospital admission

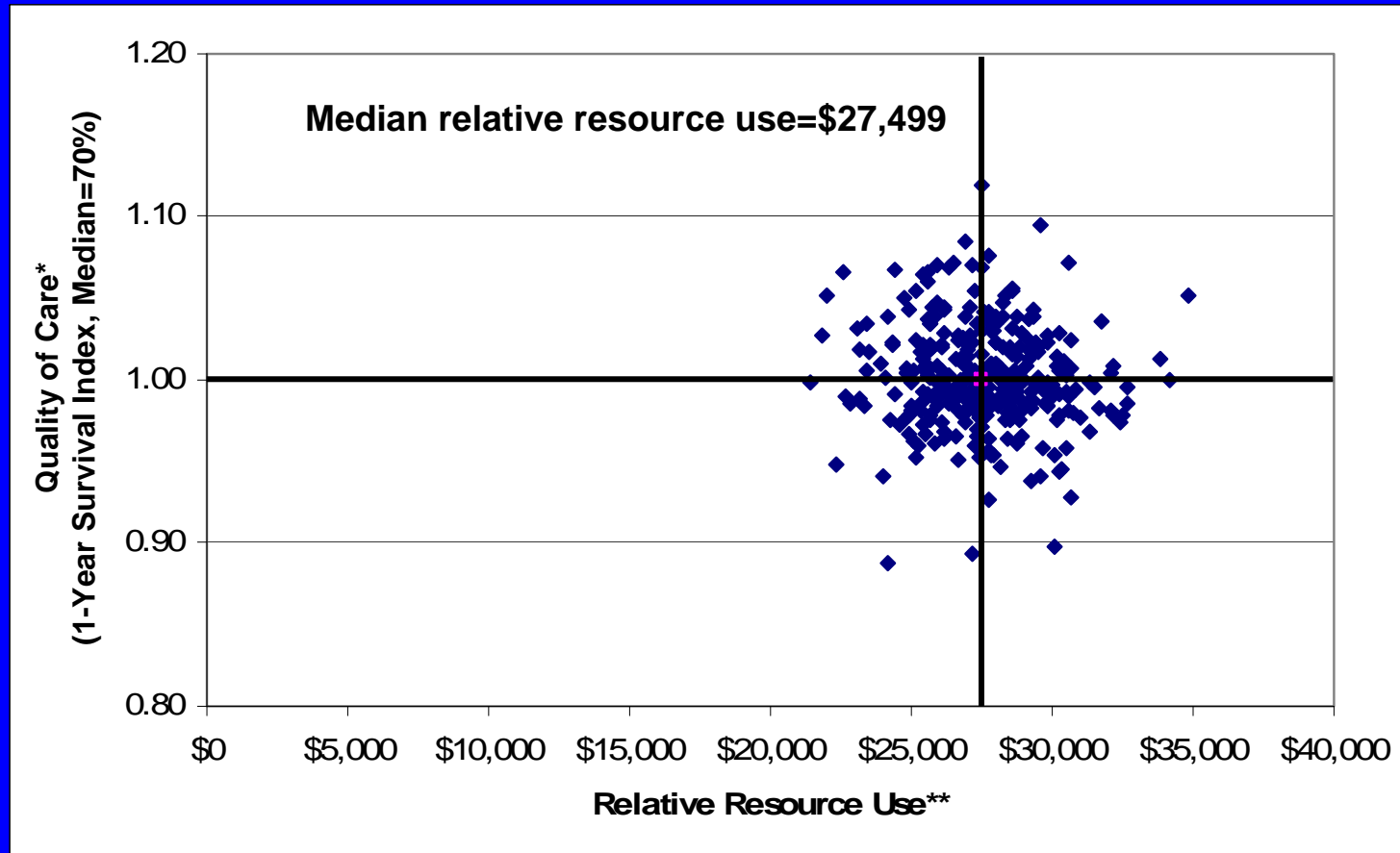


Percent of short-stay residents re-hospitalized within 30 days of hospital discharge to nursing home



Data: V. Mor, Brown University analysis of Medicare enrollment data and Part A claims for all Medicare beneficiaries who entered a nursing home and had a Minimum Data Set assessment during 2000 and 2004.

Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004



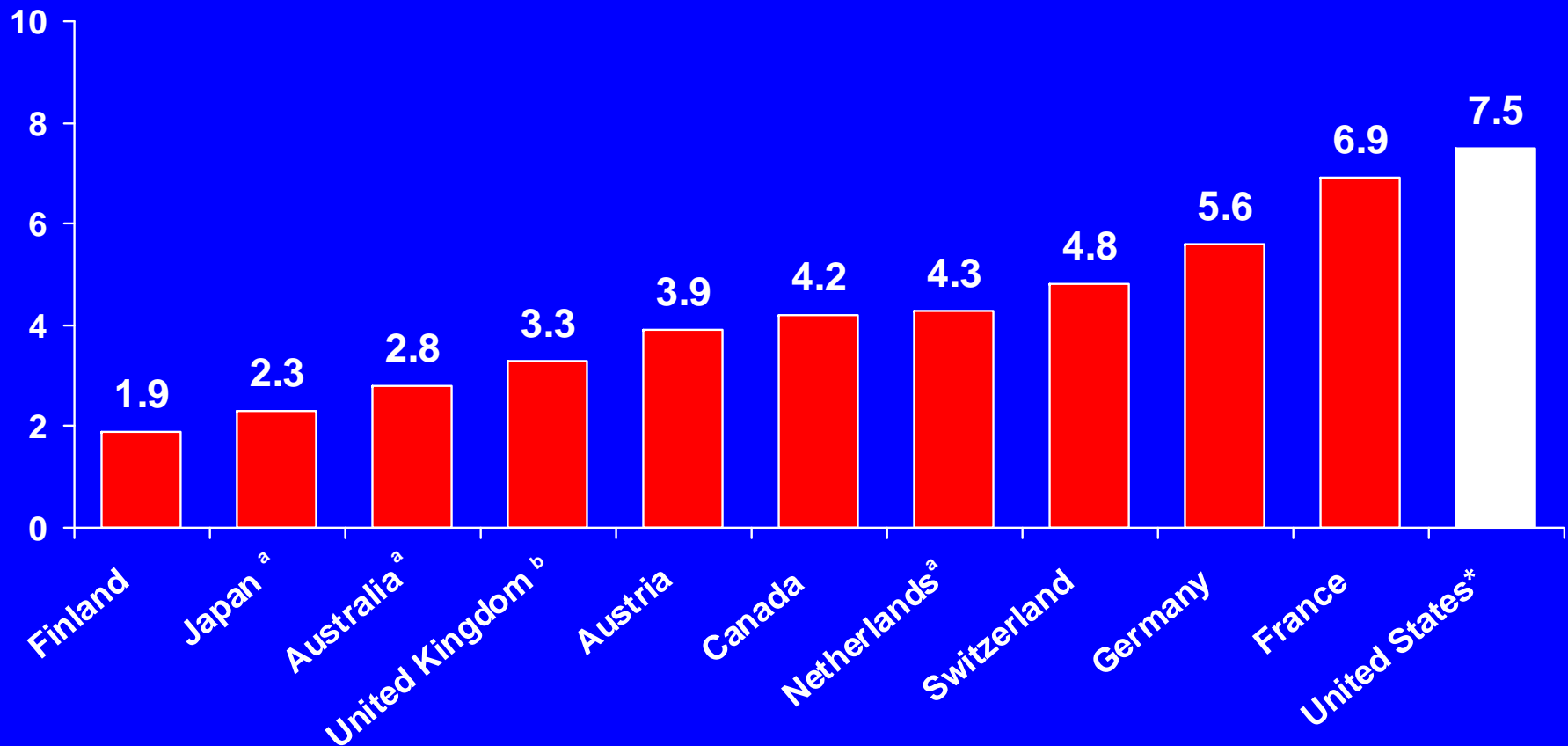
* Indexed to risk-adjusted 1-year survival rate (median=0.70).

** Risk-adjusted spending on hospital and physician services using standardized national prices.

Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare beneficiaries.

Percentage of National Health Expenditures¹⁵ Spent on Insurance Administration, 2005

Net costs of health insurance administration as percent of national health expenditures



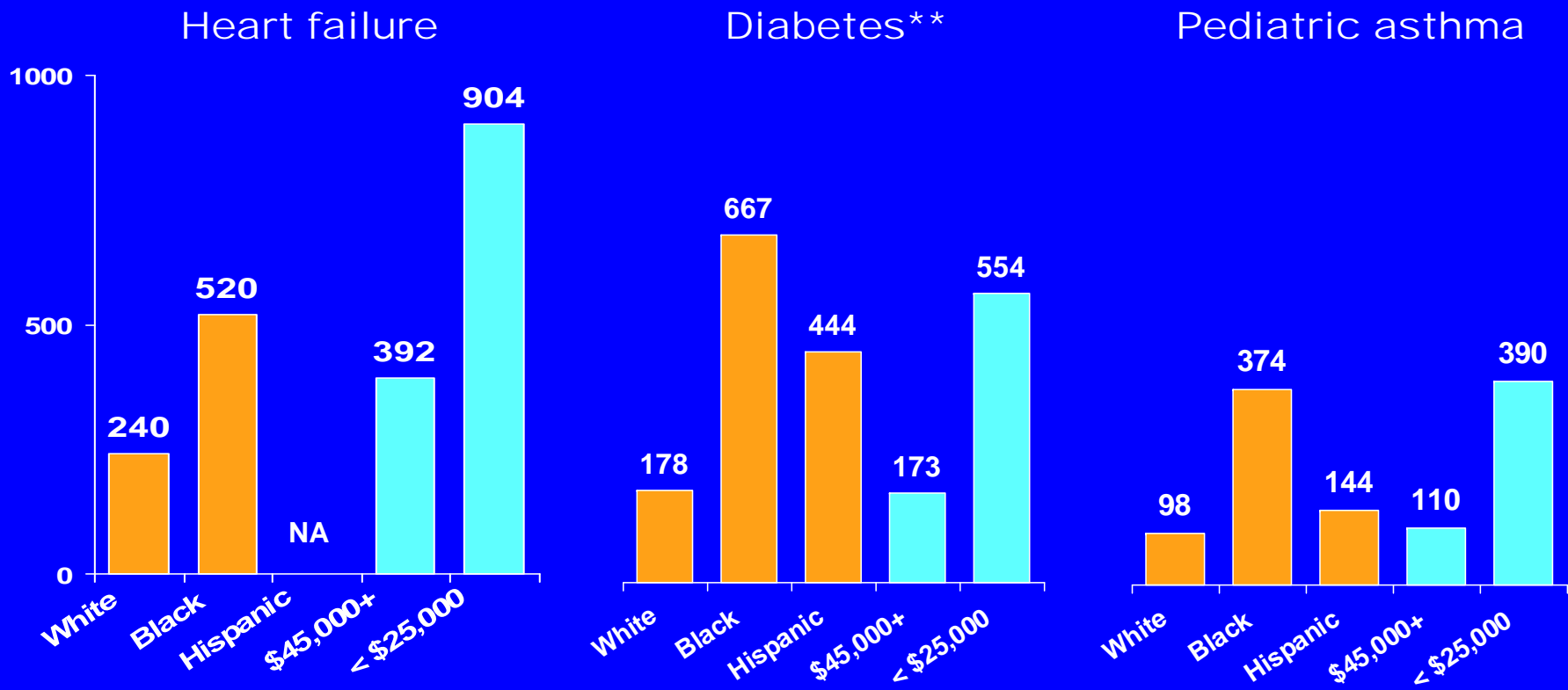
^a 2004 ^b 2001

* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

Data: OECD Health Data 2007, Version 10/2007.

Ambulatory Care–Sensitive (Potentially Preventable) Hospital Admissions, by Race/Ethnicity and Patient Income Area, 2004/2005*

Adjusted rate per 100,000 population



* 2004 data for diabetes and pediatric asthma; 2005 data for heart failure. ** Combines 4 diabetes admission measures: uncontrolled, short-term complications, long-term complications, and lower extremity amputations.

Patient Income Area=median income of patient zip code. NA=data not available.

Data: Race/ethnicity—Healthcare Cost and Utilization Project, State Inpatient Databases and National Hospital Discharge Survey (AHRQ 2007); Income area—HCUP, Nationwide Inpatient Sample (AHRQ 2007, retrieved from HCUPnet at <http://hcupnet.ahrq.gov>).

Five Key Strategies for High Performance

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Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007



Organizing the System: How Should Health Care be Delivered?

6 Key Attributes

1. Patient's clinically relevant information is available to all providers at the point of care and to patients through EHRs
2. Patient care is coordinated among multiple providers, and transitions across care settings are actively managed
3. Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care
4. Patients have easy access to appropriate care and information including after hours; there are multiple points of entry to the system; and providers are culturally competent and responsive to patients' needs
5. There is clear accountability for the total care of patients
6. The system is continuously innovating and learning in order to improve the quality, value, and patients' experiences of health care delivery

What Do We Know About Organization and Performance?

Literature Review:

- Organization is associated with higher quality
- Organized delivery systems may be more efficient
- Evidence on patient experience is mixed

Although an optimal degree of “organization” may be required to achieve the key attributes, the way in which a system is organized may vary according to environmental context

Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008.



Policy Recommendations: Organizing the Delivery System for High Performance

Key Principles:

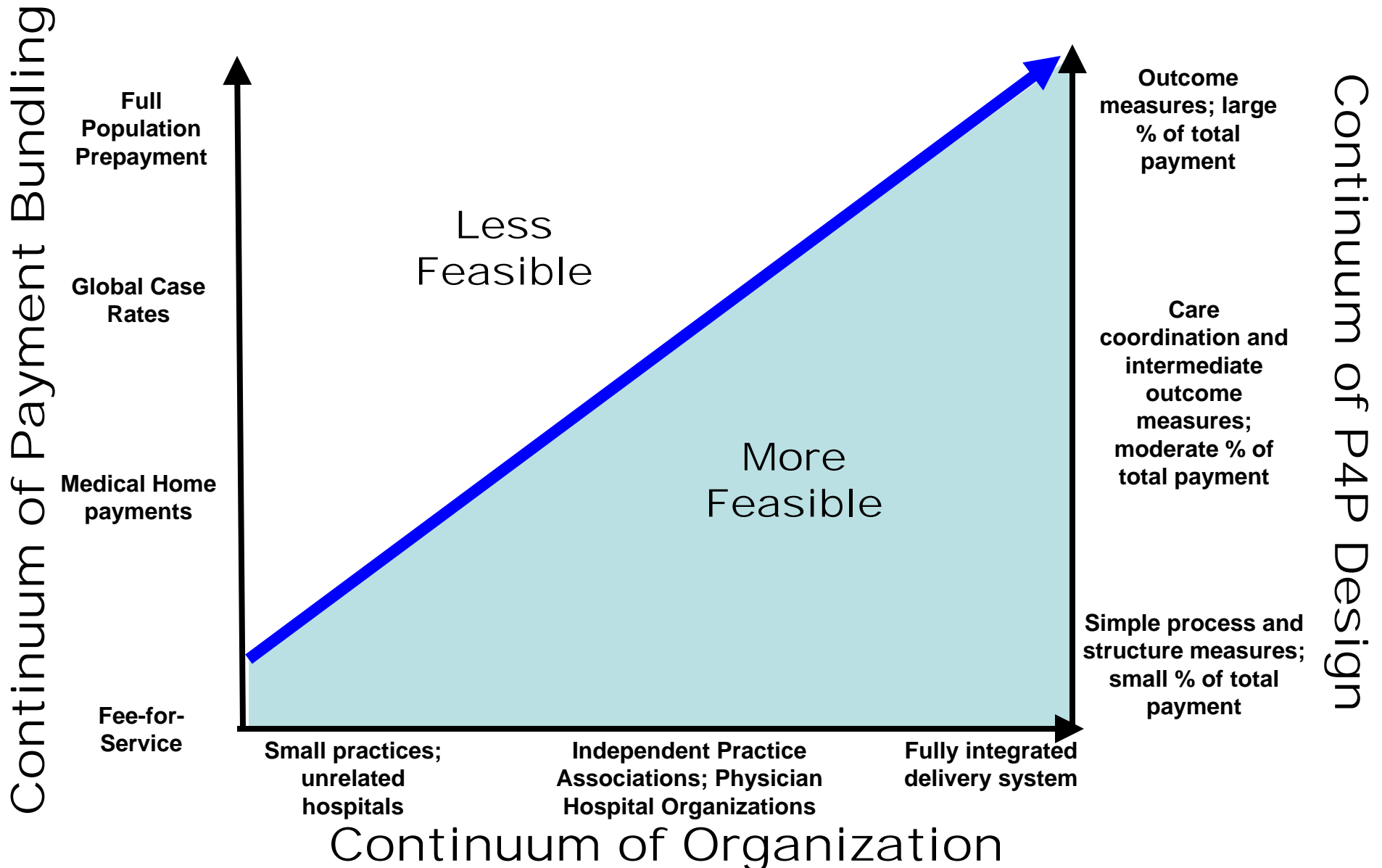
- Policies should move the healthcare system toward achievement of the 6 key attributes of the ideal “organized” delivery system
- Policies should allow for diverse models of organization to achieve these attributes, explicitly recognizing that different regions of the country may require different arrangements

Policy Recommendations: Organizing the Delivery System for High Performance

- Provider payment reform offers the opportunity to stimulate greater organization as well as higher performance
- Patients should be given incentives to choose to receive care from high-quality, high-value delivery systems
- The regulatory environment should be modified to facilitate clinical integration among providers
- Accreditation programs should exist focusing on the six attributes of an ideal delivery system
- Provider training programs should be required to teach systems-based skills and competencies and include clinical training in organized delivery systems
- Providers should be required to implement and utilize certified electronic health records that meet functionality, interoperability, and security standards and to participate in health information exchange across providers
- Government should play a greater role in facilitating or establishing infrastructure for an organized delivery system



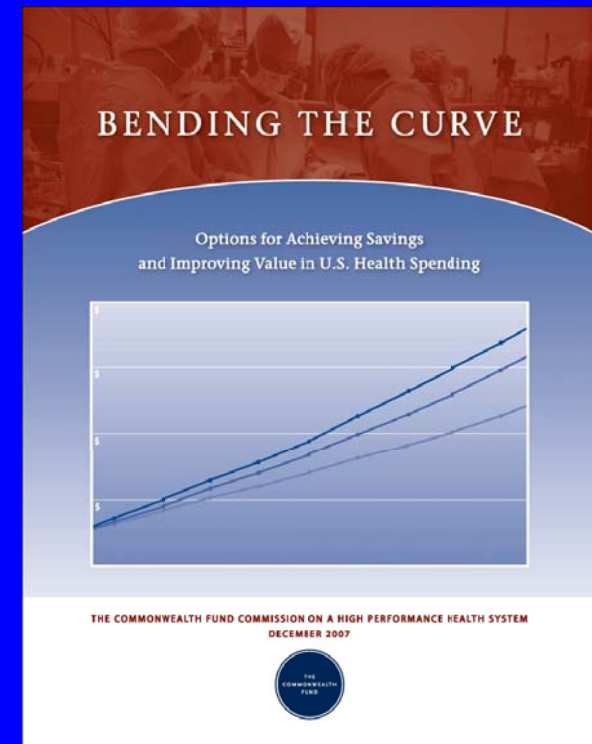
Organization and Payment Methods



Source: The Commonwealth Fund, 2008

Bending the Curve

- Goals
 - To illustrate that it is possible to reduce national health expenditures while also improving access, quality, and population health
 - To spur and inform debate and stimulate action to address national health care costs in a manner that would yield greater value
- Strategic Approaches for Improving Value
 - Producing and Using Better Information
 - Promoting Health and Disease Prevention
 - Aligning Incentives Quality & Efficiency
 - Correcting Price Signals in the Health Care Market



Source: *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2007.

What Can States Do?



In Addition to Moving to Universal Coverage, What Can States Do to Promote a High Performance Health System?

FOCUS ON QUALITY AND EFFICIENCY

- Use better information to guide and drive improvement, such as reporting and using evidence-based medicine
- Reward excellence; transparency on quality, patient-experience, and cost
- Provide incentives for improved performance, e.g. value-based purchasing
- Provide incentives for reduced hospital readmissions
- Invest in information technology
- Join collaborative improvement initiatives
- “Continuous Improvement” around data, techniques, and processes
- Promote better organization/integration
- Encourage development and selection of a medical home
- Promote transitional care post-hospital discharge
- Promote health and wellness through chronic care management



State Quality Improvement Institute

Objective: to provide technical assistance to states that are ready to improve their quality indicators from the *State Scorecard*

- Joint project: The Commonwealth Fund and AcademyHealth
- Ohio chosen as 1 of 9 states to participate: Colorado; Kansas; Massachusetts; Minnesota; New Mexico; **Ohio**; Oregon; Vermont; and Washington
- States receive ongoing technical assistance from conference calls and in-person meetings with expert faculty as well as instructional cyber seminars
- State teams stay connected:
 - Bi-monthly all team calls
 - Monthly email updates from team leaders
 - Interactive website with project information and deliverables and TA resources



State Quality Improvement Institute: Ohio Seeks to Improve State Rankings

Data from the Commonwealth Fund's State Scorecard on Health System Performance:

- Percent of adults age 50 and older received recommended screening and preventive care
 - Ohio ranked 34th with a rate of 38.1 percent (best state 50%)
- Percent of adult diabetics received recommended preventive care
 - Ohio ranked 35th with a rate of 39.2 percent (best state 65%)



State Quality Improvement Institute: Ohio's Action Plan

What are the top 10 strategies that could transform Ohio's health care system into a high quality, cost-effective, high performing system that optimizes the health of Ohioans by 2013?

- Proposed strategies and tactics center around four strategic focus areas:
 - Improving patient safety and reducing errors
 - Promoting health through personal responsibility and disease and injury prevention
 - Improving chronic care management
 - Improving efficiency and decreasing cost

- Ohio HQII participants to consider specific tactics for each strategy that relate to the following cross-cutting themes:
 - Health information technology
 - Payment reform
 - Value purchasing
 - Leveraging partnerships
 - Impact on end of life and other transitions of care
 - Public policy/legislation



Other State Models: Improving Quality and Efficiency



- Vermont – Blueprint for Health
- North Carolina – Community Care of North Carolina
- Massachusetts – Massachusetts Health Quality and Cost Council
- Minnesota – Quality Care and Rewarding Excellence (QCare)
- Minnesota – Baskets of Care
- Delaware – Delaware Health Information Network (DHIN)

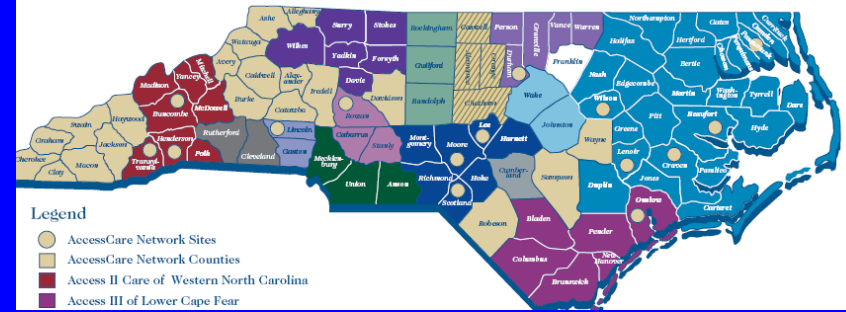


Vermont Blueprint for Health

- The state's mandated standard for chronic care management across all payers and all providers
- Pursuing change in broad areas
 - patient self-management
 - provider practice change
 - community development
 - information system development
- Information, tools and support that patients and providers need to successfully manage chronic conditions
 - Coordination of care across the multiple programs working with the same providers and patients
 - Standardization of best practices for all chronic diseases
 - Use of a consistent health risk assessment
 - Use of consistent metrics for provider measurement
 - Coordination of IT initiatives (web-based chronic care patient information system free to providers)
 - Changing and aligning payer fee structures to provide reward quality (e.g. pay for performance , payment reforms)
- Goal to reduce cost per case for chronic illness by:
 - Reducing hospitalizations, complications, and specialist visits
- Broad support for program from primary care providers



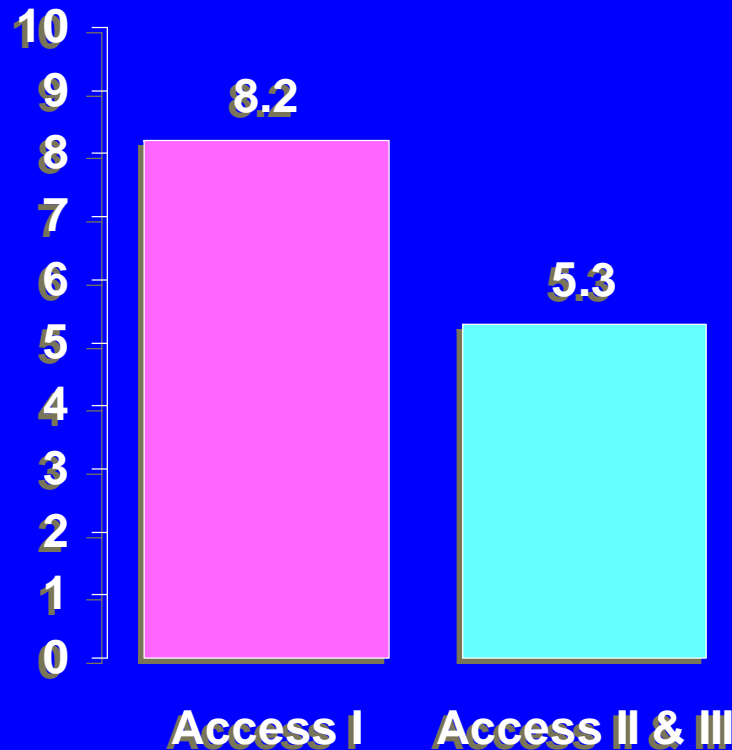
Community Care of North Carolina: Medical Homes Can Save Health Care Costs



Asthma Initiative: Pediatric Asthma Hospitalization Rates

(April 2000 – December 2002)

In patient admission rate per 1000 member months



- 15 networks, > 4,000 MDs, >900,000 patients
- \$3 PMPM to each network
- Hire case managers/medical management staff
- \$2.50 PMPM to each PCP to serve as medical home and participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- From July 1, 2003 through June 30, 2006, actuarial studies conducted by Mercer documented that CCNC saved the state over \$473 million dollars [September 2007].

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Massachusetts Health Care Quality and Cost Council

- Vision: By June 30, 2012 MA will consistently rank in national measures as the state achieving the highest levels of performance in care that is safe, effective, patient centered, timely, efficient, equitable, integrated, and affordable
- Goals
 - Lower or contain the growth of health care costs while improving quality and reducing racial and ethnic health disparities
 - Disseminate through a website and other media, comparative health care cost, quality, and related information for consumers, providers, health plans, employers, policymakers, and the public
 - Address: health care cost control, patient safety, chronic care management and prevention, end of life care, racial and ethnic disparities, and transparency



Chapter 305: An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care

- Sets up the Special Commission on the Health Care Payment System
- Goal: Recommend common payment method for all payers, Including Medicare



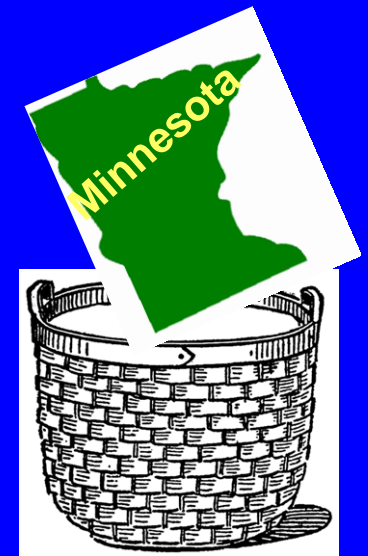
Minnesota: Quality Care and Rewarding Excellence (QCare)

- Started as an effort to link measurement with improvement and practice and income; created by governor executive order in July 2006
- Objective: accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting
- All contracts for MinnesotaCare, Medicaid, and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining greater overall accountability
- Initial focus on four areas:
 - Diabetes
 - Hospital stays
 - Preventive care
 - Cardiac care
- Private sector health care purchasers and providers will be encouraged to adopt QCare through the Smart Buy Alliance
- Ultimate goal: Make sure payers, in the context of business of the state and patients and physicians, are all working from the same page



Minnesota Baskets of Care

- In May 2008 Governor Tim Pawlenty signed into law a health reform bill including the concept of "baskets of care"
- It seeks to bundle payments for a set of health care services together to create incentives for health care providers to cooperate and innovate on ways to improve health care quality and reduce cost
- July 1, 2009 - Commissioner of Health must establish uniform definitions for at least 7 baskets of care with input from work groups comprised of health care providers, health plan companies, and organizations working to improve health care quality
- December 31, 2009 - Commissioner must establish standard quality measurements for the baskets of care
- January 1, 2010 - health care providers offering baskets of care will be able to establish their own prices for the baskets. This will make it easier for consumers to find and compare cost information on the baskets of care.
- Quality information on the baskets will be publicly available beginning July 1, 2010



Source: Minnesota Health Reform Initiative, *Baskets of Care*, <http://www.health.state.mn.us/healthreform/baskets.html>

Delaware Health Information Network



- Created in 1997 to advance the creation of a statewide health information and electronic data interchange network among all health care providers
- Mission: To improve patient outcomes and patient-provider relationships, while reducing service duplication and the rate of increase of health care spending
- Enrollment: 100 practice sites, 284 physicians, and 625 users with 8 additional practices comprised of 45 physicians in line for enrollment and training
- Benefits: Saves time, improves care, reduces costs, and enhances privacy

Source: Paula K. Roy, Robert White, Gina B. Perez, *The Nation's First Statewide Health Information Exchange: DHIN*, State Coverage Initiative Summer Workshop for State Officials, July/August 2008

Ohio: Why Not the Best?



Thank You!



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