

**Ohio Health Quality Improvement Summit Planning Committee
Improving Efficiency and Decreasing Cost in the Healthcare System**

Caveats:

Suggested tactics and metrics for each strategy are examples only, derived from a general literature review and survey of other states’ initiatives and policy brainstorming. Further work is needed to (1) determine the extent to which these tactics and metrics are already under development or being used in Ohio, (2) probe the merit and viability of these tactics and determine whether there are better tactics for achieving the desired goals, (3) assess which mix of tactics would work best for Ohio, and (4) determine appropriate timeframes and targets for achieving the indicated metrics.

Additionally, our committee wishes to emphasize the importance of the seven cross-cutting “areas” reflected in the fourth column. In many ways, each of the seven topics in this column could form its own “strategy,” and it is our hope that when the work of the November conference is done, the tactics in all 7 areas can be mapped and tracked across all four focus areas of the conference (cost and efficiency, patient safety, chronic disease management, and prevention).

Finally, not all committee members supported every strategy or tactic and indeed, some members opposed certain strategies and tactics. Also, not every strategy or tactic currently being supported or pursued by each of our committee members is listed in this chart. Nonetheless, the strategies and tactics listed in this chart had sufficiently broad support among our committee’s members to warrant further consideration at the November summit.

Proposed strategy	Rationale (with citations, and estimated return on investment)	Possible supporting tactics (general)¹	Possible supporting tactics in the areas of (1) health information technology; (2) payment reform; (3) addressing and reducing disparities²; and (4) workforce development³	Metrics for measuring progress
Transform healthcare delivery by promoting use of patient-centered medical homes.	A growing number of policy analysts, consumer groups, physicians, and other observers believe that American healthcare is unbalanced, with inadequate resources going to primary care and excessive resources going to procedurally oriented specialty care – with no one managing the ‘whole person’ to optimize health outcomes in a cost effective manner. Inadequate resources go to prevention and early treatment; excessive resources are spent on the delivery of end-stage	<ul style="list-style-type: none"> Through a new agency or an existing one (ODH, ODJFS, EMMA, or other), issue an RFP for regions to submit proposals for creating patient-centered medical home pilots in their regions. Grants could provide seed money to individual regions in the range of \$2 to \$6 million per year so they can have a 	<ul style="list-style-type: none"> Health IT: one way of promoting development of Health IT – while incenting adoption among primary care providers – would be to develop (as a condition of reimbursement in public programs, for example, or as a requirement for insurance contracts) transferrable 	<ul style="list-style-type: none"> Number of NCQA certified patient-centered medical homes in the state. Annual cost/patient, medical home pilots v. state average in other settings as well across pilots Health disparity data,

<p>care. This imbalance causes a lack of coordinated, cost-effective care, many times resulting in redundant services, delayed delivery of services as well as frustration to both the providers and patients. More importantly, the imbalance results in under-treatment of early disease, leading to unnecessary morbidity and mortality and resulting in high overall healthcare costs.</p> <p>MedPAC, the advisory commission to Medicare, recognizes the seriousness of this problem. In its June 2008 Report to Congress, <i>Reforming the Delivery System</i>, it recommends “two new initiatives for promoting primary care. The first initiative increases fee schedule payments for primary care services furnished by clinicians focused on delivering primary care.... The second initiative is to establish a medical home pilot program in Medicare.”⁴The pilot was funded at \$100 million in July 2008.</p> <p>The lack of coordinated care impairs health for all Ohioans, including those who suffer from mental illness, substance abuse, or co-occurring disorders. The National Association of State Mental Health Program Directors (NASMHPD) found that 3 of 5 persons with serious mental illness die due to a preventable health condition. They have significantly higher rates of diabetes, hypertension, heart disease, and asthma. The NASMHPD study estimated that people with serious mental illnesses die 25 years prematurely.</p> <p>Many experts cite patient-centered medical homes as a promising solution to the lack of care coordination in our current system. Definitions of the medical home concept vary, but the NCQA has developed a set of criteria for defining patient-centered medical homes that is gaining consensus.</p> <p>Can medical homes live up to their promise of streamlining costs and improving care delivery?</p>	<p>transformative effect, with flexibility to use funds for start-up purposes and/or for operational expenses to defray the costs of uncompensated primary care until new reimbursement models are in place.</p> <ul style="list-style-type: none"> • Promote expansion of federally qualified health centers (FQHCs) as medical homes in under-served areas. • Support, measure, and improve existing healthcare home initiatives such as those currently occurring, for example, in ODJFS’s Medicaid healthcare home initiative with the CFC and ABD population. • Promote the expanded use of cost-effective, qualified and competent medical professionals charged with coordinating care, such as advanced practice nurses). • Promote use of clinical effectiveness information to reduce overuse of ineffective care and underuse of clinically effective treatments • 	<p>electronic health records for Ohioans, and vest responsibility for building such records (along with funding for doing so) with primary care physicians or other front-end providers. Patients could be the “owners” of their records, and the records would need to have adequate privacy protections, but primary care physicians and other front-end care coordinators could be empowered and funded to “build” the records for patients, thus reinforcing their coordinating function and providing them with the background and tools needed to fulfill it. In investigating this tactic, attention should be given to the e-health record development efforts of Google, Microsoft, the Cleveland Clinic, and others who are already working on electronic health record platforms. Additionally, to incent rapid adoption of e-prescribing, electronic health records, and other IT improvements, consider requiring use of these tools as a condition for reimbursement through public programs like Medicaid (as some other states have done).</p> <ul style="list-style-type: none"> • Payment reform: empower ODJFS and other state payors to make upward adjustments in reimbursements for primary care and other structural changes that promote care integration, such as allowing payment to behavioral health providers for consultations 	<p>medical home pilots v. state average in other settings as well as across pilots</p> <ul style="list-style-type: none"> • Longer-term, various chronic disease indicators, medical home pilots v. state average in other settings.
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	<p>The concept is a new one, and accordingly there is little U.S. data evidencing return on investment. In international comparisons, Barbara Starfield of Johns Hopkins has consistently found lower cost for equivalent outcomes in nations with stronger primary care sectors.⁵ Mercer Consulting showed that Community Care of North Carolina achieved a reduction of several hundred dollars per capita per year in Medicaid CFC spending through paying an extra per member per month fee to patient centered medical homes. Geisinger reported a “20% reduction in all-cause admissions and a 7% total medical savings” with the initial PCMH pilot in two sites.⁶</p> <p>The American Academy of Family Physicians TransformMED two-year pilot project on medical homes completed data collection in May 2008 and will report findings in 2009.</p> <p>Up to one-fifth of all Medicare spending nationally could be saved if providers in high cost regions practiced in the same fashion as those in low cost regions.</p> <p>A recent study found that patients received care that professional standards recommend barely half the time (45 percent of heart attack patients received recommended beta-blockers, 38 percent of adults were screened for colorectal cancer.</p>		<p>rendered on the same day their patients receive medical services.</p> <ul style="list-style-type: none"> • Leveraging partnerships: patient-centered medical homes depend on effective partnerships between groups of physicians and other healthcare services; incentivizing their development through a regional RFP process will incentive those hoping to pilot such homes to effectively leverage partnerships up-front. • Cultural disparities: it is essential that care coordination be culturally competent, and special education campaigns for primary care physicians should be considered. By coordinating care through the primary care system, however, such cultural competence education can be focused and targeted – at least initially – on those having the most interaction with patients. Additionally, initial pilots of patient-centered medical homes could be focused on vulnerable populations, and if such a focus were adopted, the effect on reducing healthcare disparities should be measured to assess whether the new delivery model can effectively bridge healthcare gaps. Pilots should engage in efforts to increase ethnic and cultural diversity in the health care work force to reduce disparities in care and outcomes. • Workforce development: a substantial shift to patient-centered medical homes will 	
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<p>Decrease the rate of preventable rehospitalizations.</p>	<p>Preventing unnecessary hospital readmissions is a goal lauded by many health policy advocates as representing among the most achievable opportunities to “lower health care costs, improve quality, and increase patient satisfaction at once.”⁷ “If there is such a thing as low-hanging fruit,” observes Urban Institute Senior Fellow Robert Berenson, M.D., “this is low-hanging fruit.”⁸</p> <p>Moreover, this is an opportunity that holds substantial promise for a short- to medium-term return on investment. A 2007 MepPac report to Congress examining 2005 data found that 17.6 percent of Medicare patients were readmitted to hospitals within 30 days of discharge, accounting for \$15 billion in spending.⁹ An Agency for Healthcare Research and Quality study of patients admitted to hospitals with preventable admissions found that 19.4 percent had at least one preventable readmission within six months. The cost of those readmissions – measured over 4 states in 1999 dollars – was \$729 million, or \$7,400 per readmission.¹⁰</p> <p>This is also an area where hospital performance varies substantially. For example, PacifiCare Health Systems Inc.’s review of its enrollees’ 2005 and 2006 discharge data found hospital readmission rates ranging from as low as 0 percent to as high as 44 percent.¹¹</p> <p>Many readmissions can, in fact, be prevented through process improvements. Research has demonstrated, for example, that specific hospital-based initiatives to improve communication with beneficiaries and their other caregivers, coordinate care after discharge, and improve the quality of care during the initiation admission can avert many readmissions.¹² The analysis of 2005 Medicare discharge claims cited earlier determined that a significant number of potentially preventable hospital readmissions could be avoided, generating billions of dollars in</p>	<p>The following are example tactics only, drawn from a general literature review and survey of other states’ initiatives; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio, through, for example, the quality collaboratives of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.</p> <ul style="list-style-type: none"> • Develop recommended pre- and post-discharge checklists and guidelines for medication protocol, follow-up intervals.¹⁹ • Provide narrowly crafted favorable evidentiary presumptions against medical malpractice claims relating to deficient follow-up care or discharge instructions for physicians who comply with recommended pre- and post-discharge checklists and guidelines. • Create an Ohio-specific Healthcare Compare (modeled on Hospital Compare) website that makes it easy for employers, payors, and consumers to access and evaluate performance on readmit metrics (among other metrics). Perhaps this resource could be co-developed/co-branded with OHA, which already maintains some data tools for comparing hospitals on its website and may already have data for readmissions. Note, however, that if malpractice or other voluntary incentives are not enough to incent reporting of 	<p>The following are example tactics only, drawn from a general literature review and survey of other states’ initiatives; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio, through, for example, the quality collaboratives of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.</p> <ul style="list-style-type: none"> • Payment reform: (a) provide for cost recapture/gainsharing through public payment systems. Several possible payment incentives are possible, but some examples to consider would be to calculate an average cost per preventable readmission figure, and then for hospitals that reduce their readmissions below a target threshold, provide bonus payments equal to half of the captured savings. If a certain preventable readmission category had a target readmission rate of 15%, for example, a hospital that achieved a 13% rate could receive a bonus payment equal to half of the 2% differential multiplied by the average readmission cost for the particular readmission category; (b) collaborative among Ohio’s largest insurers and employers who agree to a similar bonus system. Regardless of whether the state system is modeled on the 	<p>More research is needed to determine reasonable target percentages and timeframes, but these metrics could serve as benchmarks for measuring progress on a systems level:²⁰</p> <ul style="list-style-type: none"> • All-cause readmissions within 30 days of discharge (possible target: 18%). • Readmissions for any cause within 30 days of discharge among patients with a primary diagnosis of heart failure upon admission. (Align with CMS reporting) • Readmissions for any cause within 30 days of discharge among patients with a primary diagnosis of chronic obstructive pulmonary disease. • Same metrics reported by long-term care facilities: readmission referrals to hospitals – all cause, heart failure, and chronic obstructive pulmonary disease.
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	<p>savings.¹³ The study determined that 84 percent of 7-day readmissions, 78 percent of 15-day readmissions, and 76 percent of 30-day readmissions were potentially preventable.¹⁴ Medicare spending on these potentially preventable readmissions was substantial: \$5 billion for cases with 7-day readmits, \$8 billion for 15-day readmits, and \$12 billion for cases readmitted within 30 days.¹⁵</p> <p>Locally, at least one Ohio system has reported substantial improvements as a result of its own initiative aimed at curbing readmission rates. Catholic Healthcare Partners (CHP) implemented its initiative in part based on a 2000 AHA statement advocating the use of team care for heart failure management. In addition to tracking readmit rates and other performance criteria at its hospitals and clinics, some CHP hospitals began using specially trained nurses that they called "heart failure advocates," who were used to educate patients about their disease, coordinate their care, and follow-up with them after discharge.¹⁶ Over the first four years of the initiative, CHP's hospitals dramatically improved their performance on four Hospital Compare heart failure measures, and aggregate all-cause heart failure readmissions decreased system wide from 22 percent in 2002 to consistently below 20 percent between 2004 and 2006.</p> <p>CHP's effort begs the question of whether a preventable readmissions strategy should be more narrowly tailored to heart failure or certain other chronic diseases. In fact, one study comparing hospital readmission rates and related utilization in New York, California, and Washington demonstrated that diagnoses such as chronic obstructive pulmonary disease and congestive heart failure were the two major causes of hospital readmission rates – suggesting these two areas could serve as effective foci for a preventable hospital readmissions strategy.¹⁷ But many caution against such a narrow focus at the</p>	<p>readmit metrics or ensure quality control and lack of manipulation in reporting, consider adding readmit metrics to state-imposed disclosure mandates.</p>	<p>private bonus system or vice versa, the two systems should adopt similar incentives and benchmarks to reduce the reporting and monitoring burden on hospitals and other healthcare facilities eligible to receive bonus payments.</p> <ul style="list-style-type: none"> • Leveraging partnerships: OHA and the Ohio Association of Health Plans are obvious candidates to collaboratively develop metrics and payment incentives that could be adopted by enough payors to incentivize widespread adoption throughout Ohio's health system. The Ohio Business Roundtable and/or the Employers Health Coalition of Ohio are candidates for convening larger employers toward the same end. • Leveraging state medical assistance and retirement programs: see above comments under payment reform. 	
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	<p>outset of such an initiative, warning that while patients with these chronic diseases have higher readmission rates, the actual causes for their readmission vary substantially. Moreover, some policy analysts believe that care coordination and other solutions that could positively impact avoidable readmissions are best examined by hospitals on a global basis.¹⁸</p>			
<p>Improve transparency and data collection</p>	<p>Unlike almost every other component of the American economy, the price and quality of health care services are not readily distinguishable to the average health care purchaser or individual consumer. As a result, purchasers of services are not able to compare either the price of care or the quality of the services provided.</p> <p>Many states have recently created – or are in the process of creating – public agencies responsible for mandating, collecting, and publishing price, quality, and even cost data. An agency dedicated to this mission could result in information-driven decision-making about health care policy and purchasing in both the public and private sectors. Examples of this type of work in other states include a review and recommendation process regarding current laws or proposed legislation that calls for mandating certain health insurance benefits (Pennsylvania) and coupling its duty “to develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain growth in health care costs while improving the quality of care” with cost/benefit analysis of recommendations for improving quality and reducing cost (Massachusetts). Such neutral analyses should allow decision-making to be data-driven rather than based on unproven assumptions.</p> <p>Data should not be collected for collection’s sake, however, and it is important that data reporting requirements be limited to data that is actually used. Moreover, such requirements should impose the minimum administrative</p>	<ul style="list-style-type: none"> • Create, as a number of other states have already done, Ohio should establish a “Health Care Cost and Quality Council.”²¹ The Council could collect, once and in a central place, the necessary data to analyze spending and outcome patterns in Ohio, distribute its analyses, and make recommendations to state policymakers for how to improve efficiencies and outcomes. Such a council could be housed in one of the state’s existing agencies (e.g., ODI), with members appointed by the Governor and the General Assembly, should be funded through legislative allocations, and should be empowered to collect necessary information from health care entities (providers, insurers) in Ohio. Such a group could play a key role in: <ul style="list-style-type: none"> • establishing common quality metrics across all health care consumer and provider types that conform with NCQA, URAC, HEDIS, HIPAA and other national quality measures. By assuring a single standard within the state, the council would reduce duplicative reporting; • establishing common cost and payment metrics across 	<ul style="list-style-type: none"> • Health IT: a Health Care Cost and Quality Council could be the implementing body for the recommendations expected out of the Ohio HIT Advisory Group; • Payment reform: the analysis and recommendations of the Council could also include recommendations for payment reform; • Value purchasing: by identifying more highly valued outcomes and health care strategies, the Council’s work would be key to advancing value-based purchasing strategies; • Cultural disparities: with appropriate data available, the Council could perform analysis to provide rigorous data on disparities, including identifying reasons for disparities and suggesting ways to remedy; • Workforce Development: if desired, the Council could undertake unbiased analysis of workforce issues, including developing an Ohio provider/practitioner index. 	<p>Process measures:</p> <ul style="list-style-type: none"> • Creation and passage of authorizing legislation. • Appointment of council members & hiring of staff. • Data collection. • Data analysis and dissemination. <p>Outcome measures:</p> <ul style="list-style-type: none"> • Longitudinal studies of quality measures in Ohio; • Comparative studies of efficiency and cost growth in comparison to national statistics

	<p>burden needed to accomplish the desired policy objective, utilize consistent definitions, be as uniform as possible, and, without usurping regulatory authority of existing health-related regulatory bodies, be “transferrable” across – or at a minimum collated across – state agencies so as to avoid duplicative reporting.</p>	<p>all health care provider types, including defining common case mix definitions and payment methodology definitions for comparison purposes</p> <ul style="list-style-type: none"> • collecting and distributing to all necessary agencies financial, utilization, enrollment, and process data from insurers and providers; • monitor utilization and cost trends, enabling forecasting of future health care cost drivers and identifying areas for improvement, (which could, e.g. be in the form of an Ohio-focused Dartmouth atlas); • developing focused analyses on topical areas of interest to the council, policymakers, and stakeholders; • making its findings available to consumers, stakeholders and policymakers; • making its resources (i.e., data) available for interested parties to undertake further analysis – either in the form of grants sponsored by the Council or for self-funded projects; • undertaking custom analyses for commercial & non-commercial purposes on a contract basis; • highlighting successful strategies, perhaps even establishing “best practices” recommendations, for benefit plan design, contracting strategies, consumer 		
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		<p>education and provider care improvement strategies.</p> <ul style="list-style-type: none"> • serving as coordinating body for SQII recommendations overall and potentially other cross-cutting group recommendations, such as the Ohio HIT Advisory Group, provided that taking on such responsibilities does not detract from its transparency-promoting activities. 		
<p>Improve end-of-life care</p>	<p>Both the Robert Wood Johnson Foundation and the Dartmouth Atlas Project have documented that aggressive care provided at the end stage of life does not correspond to improvement in the quality or length of life. The Robert Wood Johnson Foundation, for example, points out that often little thought is given to the goals of treatment when these interventions are ordered, and that restructuring care for dying patients should be a priority.</p> <p>The impact of such reform could be substantial. In 2003, Ohio had 18,300 deaths in the aged, blind, and disabled population. The average cost of care per individual for this group in the year prior to their death was \$6,230 for professional services, \$4018 for outpatient hospital services, \$3787 for pharmacy benefits, \$33,683 for hospital inpatient services, \$34,087 for nursing facility services, and \$4,219 for hospice services. Additionally, the amount of services consumed increased disproportionately as death approached. In the last three months of life, the percentage of total services consumed was 38% for professional services, 30% for hospital outpatient services, 30% for pharmacy benefits, and 47% for inpatient hospital services. 40% of the hospital admissions were through the emergency department; the most common diagnosis was “no family to care;” and 32% of the patients died in the hospital.</p>	<ul style="list-style-type: none"> • Review and implement Unified Long Term Care Budget recommendations. • Educate providers, patients, and families regarding illness and prognosis; encourage discussions regarding comfort measures. • Provide CME web events for end-of-life case management provider education; make end-of-life CME a requirement of licensure renewal (Pennsylvania does this with patient safety and risk management). • Develop alternatives to inpatient hospital care when “no family to care” is the real issue. • Expand awareness, availability, and utilization of hospice care. • Join other states in streamlining end-of-life documentation through, for example, adopting legislative changes needed to put in place “5 Wishes” reforms. 	<ul style="list-style-type: none"> • Health IT: provide enhanced web services and information regarding end-of-life care oriented to providers, with a separate site for patients, covering topics such as comfort care, alternative sites of care/hospice, explanations of tests/interventions/types of medications, and others; electronic health records would also improve coordination issues that inflate end-of-life spend. • Payment reform: for patients with diagnoses of terminal diseases, increase prior-authorization/utilization management of emergency department, inpatient hospital, and high-cost laboratory services; consider caps on funds available for end-of-life care; consider limiting hospital stay reimbursement; incent alternative sites of care. • Value purchasing: develop discount purchasing/rebates on comfort medications (long-acting narcotics, mood- and appetite stimulants). • Leveraging partnerships: work 	<ul style="list-style-type: none"> • Cost/patient in year prior to death. • Utilization rates for non-tradition/hospice care.

			with hospitals and other providers (and their associations) to assist in providing alternative sites of care, limiting inpatient stays, training hospitalists and other hospital-based providers in end-of-life care.	
<p>Streamline, coordinate, and better manage costs associated with prescription drug use and delivery.</p>	<p>Ohio’s prescription drug costs, like the nation’s, are escalating at an unsustainable rate – without corresponding improvements in patient health. Experts offer many different explanations for this trend. Some, for example, point to what they argue are excessive and unduly influential marketing tactics. By two 2005 estimates, pharmaceutical companies spent \$7- \$12 billion nationally in marketing to physicians (approximately \$13,000 per physician), including provision of free samples.²² Additionally, approximately \$2.5 billion is spent annually on direct-to-consumer pharmaceutical advertising, making many medications household names and popular with patients.²³ A different study points out that, “[o]f the drugs responsible for the nearly 19% rise in spending on pharmaceutical in 2001, the four top sellers were among the top ten most heavily marketed drugs.”²⁴ Sometimes, this marketing is misleading. Notes one recent article, “Warner Lambert promoted the epilepsy medication Neurontin for unapproved uses. The Massachusetts Attorney General joined with the Department of Veterans Affairs and the federal Department of Justice to successfully sue the company for a total of \$430 million in damages for losses the Medicaid programs suffered as a result of Warner-Lambert’s fraudulent drug promotion and marketing misconduct.”²⁵</p> <p>Not everyone agrees marketing is the root cause of our excessive prescription drug spend. Other experts highlight inefficient purchasing decisions. For example, some studies estimate that the U.S. could save more between \$7-20 billion with increased use of generics.²⁶</p>	<ul style="list-style-type: none"> • Education campaign for prescribers on the benefits of formulary compliance – explaining what is in it for them and their patients. • Develop and provide prescribers with copies of formularies for placement in exam rooms and/or patient files. (If academic detailing is supported, these professionals could place the formularies in the patient files to assist the prescriber). • Implement an academic detailing program leveraging the creation of prescriber and consumer education materials with other states who have adopted the Academic Detailing model, resulting in increased quality of prescribing, reduced complications from inappropriate medications and decreased effectiveness in pharmaceutical manufacturers’ marketing of name brand drugs.³¹ Also consider how to promote use of academic detailers in a broader capacity to assist, for example, in prevention of chronic diseases.³² • Develop a generic educational program for prescribers and consumers to increase the use of generic medications, including, for example: (1) a state-wide ‘Generics First publicity 	<ul style="list-style-type: none"> • Health IT: (1) encourage/ incentivize – use of electronic hand-held tool(s) to assist in formulary look-ups, access current research on prescription efficacy, safety and cost-effectiveness, as well as cross-reference brand to generics; (2) encourage/ incentivize/ mandate use of e-prescribing; (3) develop and implement an electronic system to provide access to patient information to all providers to minimize opportunity for medication interactions and reduce overprescribing. • Payment reform: (1) coordinate and implement an evidence-based pharmaceutical purchasing and prescribing program for all state programs. • Value purchasing: (1) consider standardizing/streamlining the creation of different formularies across state programs and health plans with a view toward reducing the administrative costs and increased prescriber compliance concerns that can result from prescriber confusion around multiple formularies; (2) enter longer-term commitments to minimize the number of PDL and formulary changes annually, resulting in less 	<ul style="list-style-type: none"> • Growth rate of prescription drug costs • Average drug costs cost per patient • Patients deaths resulting from adverse drug events • % of generic substitution, including in therapeutic classes • Success rate of Academic Detailers, rate of substitution, success rate of coordinated treatment protocols, etc.

	<p>Whatever the cause, there can be little debate that Ohio’s health system underperforms when it comes to overall prescription drug spending. Ohio spends 25.4% more than the U.S. average on pharmacy.²⁷ Reinforcing the hypothesis that inefficient purchasing decisions help to explain this trend, in 2005 approximately 800,000 prescriptions were filled in Ohio for Nexium, which at \$240 per script amounted \$19.2 million in overall costs. The generic omeprazole can frequently be substituted at \$5-6 per script – resulting in an overall cost of \$4M.²⁸</p> <p>This is not just a cost issue, however. Better use of drugs can help improve quality. Notes one recent report, “Vioxx, the heavily marketed Merck pain killer, may have caused tens of thousands of avoidable heart attacks and strokes before it was removed from the market. This occurred even though the drug was no better for the vast majority of patients than older, less expensive drugs.”²⁹</p> <p>Reform is possible. Better results can be achieved. For example, the Department of Veterans Affairs (VA) has held per capita spending flat over the past decade, while improving health care access and quality—especially with regard to prescription drugs. “VA has used several tools to improve the drug purchasing and prescribing process including a formulary design based on evidence-based information; communication with physicians to encourage adherence to recommended therapies; restrictions on the access of pharmaceutical sales reps to physicians at VA hospitals; and the use of electronic medical records in order to provide physicians easy access to preferred drugs and treatment options, as well as safety information.”³⁰</p>	<p>campaign’; (2) creating a cross-reference brand name to generic equivalent comparison for prescribers’ easy reference; (3) a generics sticker program to assist prescribers with names/spelling of generic medications; (4) a generics sampling program to acclimate prescribers and consumers to prescribing and use of generic medications; (5) educate consumers on the safety, effectiveness and cost-savings/affordability of generic drugs, through community-based outreach; and (6) educate consumers to research generics using tools like those on www.consumerreports.org and to question prescribers on generic substitution, potential side-effects as well as alternative non-drug treatments.</p> <ul style="list-style-type: none"> • Develop and pass legislation to limit pharmaceutical company marketing practices; require public reporting of marketing expenses; and ban the sale of individual prescriber information to the pharmaceutical industry, unless used as part of a patient’s care.³³ 	<p>prescriber confusion.</p>	
<p>Align and streamline, and create</p>	<ul style="list-style-type: none"> • Ohio’s health system is complex, but it is made more complex by the number and sometimes competing missions of the 	<p>The following are example tactics only, aimed at provoking thought; a great deal more work would be needed</p>	<ul style="list-style-type: none"> • Health IT: a consolidated agency, coordinating commission, or advisory body 	<p>Realignment/consolidation metrics could include (1) process metrics (timetables</p>

<p>coordination across the healthcare sector</p>	<p>governmental entities responsible for regulating or administering different aspects of our healthcare system. Today’s tight budget climate presents an opportunity to critically examine the extent to which health-related agencies and programs can be streamlined and consolidated.</p> <ul style="list-style-type: none"> In Ohio’s current system, multiple agencies across various levels (state, county, local) oversee various aspects of the system with varying degrees of independence and responsibility. Fragmentation has historically led to communication gaps, zero-sum budget disputes between agencies and health programs, and overall system inefficiencies. Some argue this fragmentation also promotes excessive costs and high complexity for patients and providers as well as challenges to policy reforms seeking to expand access, extend coverage, improve quality, and restrain the growth of costs. <p>A variety of institutions in Ohio currently oversee separate components of the health care delivery system, yet no agency exists with the authority to oversee all of it. Cooperation and coordination between public and private sectors could more easily occur if a new entity – or a newly empowered existing entity – could facilitate all health-related agencies to streamline and consolidate their organizations.</p> <p>Health care leaders in almost every sector of the health care delivery system have argued for a transformation to a higher performance system in Ohio, and by creating an entity with the responsibility to coordinate all of Ohio’s health-related infrastructure, that common goal may become more reachable.</p>	<p>to (1) determine the extent to which these tactics are already under development or in progress in Ohio; (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.</p> <p>Two alternative approaches to consider – and address across each level of government (state, count, and local):</p> <ul style="list-style-type: none"> Consolidate health-related agencies and programs into a re-engineered Department of Health or, alternatively, create a new cabinet-level department responsible for overseeing all or the vast majority of the State of Ohio’s health system – ranging from health insurance regulation to Medicaid to public health programs and everything in between. Alternatively, create a coordinating commission or body responsible for aligning priorities, programs, standards, and most importantly, budgets across the spectrum of Ohio’s health system. <p>Note: these recommendations differ in scope from, but are complementary to, the transparency strategy recommendation to form a Cost and Quality Council. This infrastructure realignment recommendation is intended to extend beyond transparency to purchasing and other aspects of the health system, although the Cost and Quality Council recommended in the transparency strategy could provide a platform for developing the alternative recommendations set forth above in the second bullet.</p>	<p>could be responsible for establishing Health IT standards and using the State’s public spending programs (Medicaid, and the state’s own health plan expenditures) to incent adoption of these standards by providers.</p> <ul style="list-style-type: none"> Payment reform: a consolidated agency, coordinating commission, or advisory body could be responsible for pooling the State’s purchasing power across multiple health plans and public spending programs; such a purchasing collaborative should be better able to leverage favorable purchasing discounts. Leverage partnerships: a new entity would not only leverage partnerships, but it would also help to create them. It should provide a venue through which Medicaid and state employee retirement programs would devise policies that harmonize with other public and private payers. Workforce development: a new coordinating entity could be a logical home for the analyses of need for workforce development for all categories of professional, paraprofessional, and nonprofessional health care workers. 	<p>for consolidation or establishment of a coordinating body), as well as (2) reduction in overall rate of growth in health care spend among merged or coordinated health programs and agencies.</p>
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¹ Note: suggested tactics are examples only, derived from a general literature review and survey of other states' initiatives and policy brainstorming; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio through, for example, the quality collaborative of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.

² Note: disparities could include, but are not limited to, the following examples: age, culture, disability, ethnicity, gender, geography, race, religion, and sexual orientation.

³ Note: suggested tactics are examples only, derived from a general literature review and survey of other states' initiatives and policy brainstorming; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio through, for example, the quality collaborative of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.

⁴ Available at www.medpac.gov.

⁵ Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.

⁶ Paulus, RA, Davis, K, Steele, D, Continuous Innovation in Health Care: Implications of the Geisinger Experience, *Health Affairs* 27(5), 2008, 1235-1245.

⁷ S. Klein (March 2008). In Focus: Preventing Unnecessary Hospital Readmissions, *Quality Matters* 29, excerpted online at www.commonwealthfund.org/publications.

⁸ Id.

⁹ Report to the Congress: Promoting Greater Efficiency in Medicare. June 2007

¹⁰ B. Friedman and J. Basu (2004). The Rate and Cost of Hospital Readmissions for Preventable Conditions. *Medical Care Research and Review* 61, 225–240.

¹¹ B. Friedman and J Basu (2004).

¹² Report to the Congress: Promoting Greater Efficiency in Medicare. June 2007

¹³ Note that readmissions rates vary substantially by diagnosis and a hospital's specific mixture of cases will impact its overall readmission rate.

¹⁴ Report to the Congress: Promoting Greater Efficiency in Medicare. June 2007

¹⁵ Report to the Congress: Promoting Greater Efficiency in Medicare. June 2007

¹⁶ The Commonwealth Fund. *Quality Matters: Hospital Readmissions*. March 20, 2008. Volume 29.

¹⁷ G. Westert. An international study of hospital readmissions and related utilization in Europe and the USA. *Health Policy*. 2002. Volume 61, Issue 3: 269.

¹⁸ See, e.g., S. Klein (March 2008). In Focus: Preventing Unnecessary Hospital Readmissions, *Quality Matters* 29, excerpted online at www.commonwealthfund.org/publications.

¹⁹ Attending to patients' medication needs at discharge and addressing potential complications has been shown to reduce postdischarge complications. One nonrandomized before and after study – conducted in the 10 largest hospitals in the Utah-based Intermountain Health Care system – compared patients hospitalized before (1996–1998) and after (1999–2002) implementation of a discharge medication program. The study followed patients for up to 1 year and specifically upon discharge of cardiovascular patients, physicians and nurses referred to a checklist of indications and contraindications for five medications known to prevent complications and save lives (i.e. prescriptions for beta blockers, which can help prevent heart attacks, increased from 57 percent of patients who needed them to 98 percent, and prescriptions for warfarin, which can help to prevent certain patients from stroke, increased from 40 percent of patients who needed it to about 90 percent) (Lappe, J.M., J.B. Muhlestein, D.L. Lappe, et al. 2004. Improvements in 1-year cardiovascular clinical outcomes associated with a hospital-based discharge medication program. *Annals of Internal Medicine* 141: 6. September 21: 446-453). Moreover, this discharge medication protocol significantly improved mortality rates after discharge and after 30-day admission rates, particularly for patients with chronic heart failure and for cardiovascular patients without chronic heart failure. This initiative did not require additional funding for staff as Utah's existing medical informatics infrastructure integrated the program into its system.

²⁰ We recommend vetting all metrics through OHA, which can provide insight on the metrics hospitals already collect and report and can also help refine metrics to calibrate for patient risk and possible data exclusions (such as discharges against medical advice).

²¹ Examples include the Massachusetts Cost and Quality Council and the Pennsylvania Health Care Cost Containment Council (PHC4). After more than 20 years of operation, PHC4 was not reauthorized under the state's budget in June 2008 as a result of budget wrangling, despite widespread support; the entity is operating under executive authority.

²² Goldfield, Norbert, et al, "A Consumer-Driven Health Care Cost Control Agenda for Massachusetts: 17 Legislative Proposals," *Health Care for All*, March 2007 www.hcfama.org, at p. 18. See also The Prescription Project, Policy Brief, Control Pharmaceutical Marketing to Improve Health Care Quality and Cost Control Recommendations for State Policymakers at 1 (Sept. 7, 2007).

²³ National Conference of State Legislatures, *Health Programs, Marketing and Direct-to-Consumer Advertising of Pharmaceuticals* at 1 (Aug. 2008).

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- ²⁴ The Prescription Project, Policy Brief, “Control Pharmaceutical Marketing to Improve Health Care Quality and Cost, Recommendations for State Policymakers, September 2007
- ²⁵ MidAmerica Healthcare Venture Forum, “Up & Coming,” Ceuticare LLC, 2008.
- ²⁶ http://www.fda.gov/oc/oms/ofm/budget/2009/Execsum/6_Generic_Drug.pdf, p. 2. See also *Annals of Internal Medicine*, Potential Savings from Substituting Generic Drugs for Brand-Name Drugs: Medical Expenditure Survey Panel, 1997-2000, 7 June 2005, Vol. 142, Issue 11, p. 891-97.
- ²⁷ “Achieving Health System Reform in Ohio,” Ohio Business Roundtable, 2008, at 41.
- ²⁸ “Achieving Health System Reform in Ohio,” Ohio Business Roundtable, 2008
- ²⁹ MidAmerica Healthcare Venture Forum, “Up & Coming,” Ceuticare LLC, 2008.
- ³⁰ MidAmerica Healthcare Venture Forum, “Up & Coming,” Ceuticare LLC, 2008.
- ³¹ These tactics have resulted in proven cost savings in addition to prescribing the ‘right drug at the right time cost effectively’ to effect a positive health care outcome. Goldfield, Norbert, et al, “A Consumer-Driven Health Care Cost Control Agenda for Massachusetts: 17 Legislative Proposals,” *Health Care for All*, March 2007 www.hcfama.org,
- ³² One study has indicated outcomes for diabetics are seven times better than the national average and the cost of treatment is 24-36% less. MidAmerica Healthcare Venture Forum, “Up & Coming,” Ceuticare LLC, 2008.
- ³³ Several states, such as Minnesota, Vermont, Maine, West Virginia and the District of Columbia have addressed some or all of these issues in a variety of ways. MidAmerica Healthcare Venture Forum, “Up & Coming,” Ceuticare LLC, 2008.