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Network for Regional Healthcare Improvement

Getting to Affordability

National Physician Leadership Seminar Summary Report

Total Cost of Care & Resource Use

August 4-5, 2016

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ABOUT THE NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT (NRHI)

The Network for Regional Healthcare Improvement is a national organization representing over 35 regional multi-stakeholder groups working toward achieving the Triple Aim of better health, better care, and reduced cost through continuous improvement. NRHI and all of its members are non-profit organizations, separate from state government, working directly with physicians, hospitals, health plans, purchasers, and patients using data to improve healthcare. For more information about NRHI, visit www.nrhi.org.

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"The National Academy of Sciences consistently reports 30-40% waste in healthcare services and spending. As healthcare consumes $3-trillion annually – 18% of our economy - this is the single biggest financial threat to America. We have to make progress and data is a critical tool."

— Arnold Milstein, M.D., MPH, Director, Clinical Excellence Research Center, Stanford University

INTRODUCTION

The drive by Congress, states and the marketplace to transform healthcare in a timely, multi-faceted way leaves providers facing unprecedented pressure to cut costs while simultaneously improving quality and access to care. Many feel demoralized and overburdened with demands to not only provide excellent, accurate diagnoses and treatment for their patients at the lowest possible cost but to also electronically record each diagnosis, each point of contact with the patient and an explanation for each decision - often for several different measurement platforms or tools.

In an effort to support and energize clinicians, and to share emerging best practices for measurement, reporting and utilizing data as a tool for transformation, the Network for Regional Healthcare Improvement (NRHI) brought together physician leaders, healthcare measurement experts and nationally recognized leaders in provider communication from across the country for the second National Physician Leadership Seminar at Stanford University on August 4 and 5, 2016. Together, the group of about 50 participants from 11 regions across the country looked at comparative health care cost reports and analyzed their

usefulness in identifying cost variations, interventions and how they can be used to influence and energize teams around clinical transformation. The seminar is just one example of how NRHI coordinates efforts by 35 regional health improvement collaboratives (RHICs) through multi-stakeholder partnerships and data sharing to address national issues.

The meeting was funded with support from the Robert Wood Johnson Foundation as part of NRHI's Getting to Affordability initiative. Presentations drew on the research of Arnold Milstein, M.D., MPH, Clinical Excellence Research Center Director at Stanford University, physician communication experts Jay Want, M.D., Chief Medical Officer with the Center for Improving Value in Healthcare of Colorado (CIVHC) and Michael van Duren, M.D., Vice President of Variation Reduction with Sutter Health of California and the measurement and reports of five RHICs: Center for Improving Value in Healthcare, Maine Health Management Coalition, Midwest Health Initiative (St. Louis), Minnesota Community Measurement and Oregon Health Care Quality Corporation. The two-day seminar explored:

- The technical aspects of data collection and how to build a credible system of reporting
- How to effectively use measurement to address healthcare cost and quality
- How to build on providers' core values so they see data collection and measurement as tools for transformation
- How to communicate with providers so they engage in improvement and behavior change
- How to leverage the provider instinct to problem solve

Participants included doctors, data analysts, chief medical officers, leaders from state agencies, researchers, a chief operating officer, a data scientist and leaders from RHICs around the country.

Through interactive table exercises, participants tackled challenges associated with data collection and communicating it to clinicians, and learned best practices for both. This report provides a summary of common themes emerging from this dialogue, as well as key action steps for physician leaders and regional collaboratives moving forward.

BACKGROUND

In November 2013, with support from the Robert Wood Johnson Foundation, NRHI launched a multi-regional initiative with five RHICs to measure Total Cost of Care and Relative Resource Use (TCOC). Phase I of the project was successful at initiating transparency conversations among stakeholders in each community, in addition to producing and sharing TCOC reporting with local providers.

Now near the completion of Phase II, the Getting to Affordability project has expanded to include two new regions for implementation and four additional regions for future reporting of these measures. The RHICs continue to work toward a standardized approach to reporting, sharing, and using information about the total cost of care to identify instances of potential overuse and opportunities for more efficient and effective care at a lower cost. As RHICs share this data privately and publicly, physician leaders have an opportunity to utilize the results to influence and energize teams around practice transformation.

CONVINCING PROVIDERS TRANSFORMATION IS POSSIBLE AND DATA IS ESSENTIAL: LESSONS FROM BRIGHTSPOTS

An essential element of engaging providers in transformation is making sure they understand the urgency behind the drive for transformation and that they can make a difference. Dr. Milstein suggests making sure providers are aware that healthcare overuse and wasteful spending is a national crisis. "About 5 years ago, we reached the watershed moment when state Medicaid obligations caused a higher percentage of American

"After I review performance information with providers, I feel like I have daggers in my back all the time. I now know techniques for how to engage physicians differently."

— Seminar Participant

state government budgets to be allocated to Medicaid than to K-12 education."[1]

To address this crisis, the likes of the Congressional Budget Office and the National Academy of Sciences have identified three overarching goals for the national healthcare system – a three-point Call to Action:

- 1% growth per year in quality
- Reduce wasteful spending by 30%
- 2.5% point growth annually

"Providers need to understand the work they are doing in the context of the wellbeing of the nation – both medical and financial," says Dr. Milstein. To learn how to best connect the everyday work of providers with these overarching national goals, Milstein and his team at Stanford University have spent the last three years identifying and studying what they call "Brightspots" – practices that are "positive deviants" in that they consistently rank higher in quality and lower in spending. Milstein and his team found that the characteristics that distinguish "positive deviants" cluster into three broad categories:

Voices From The Field:
America's Most Valuable Care

Stanford University's Clinical Excellence Research Center (CERC) spent three years studying 15,000 Primary Care Practices across the country. They carefully reviewed quality and cost data and identified 11 that are delivering exceptional value to their patients in that they:

- *Scored very high on patient quality measures*
- *Scored low on total health insurance spending.*

Hear providers from one Brightspots practice, Family Physicians Group in Orlando, FL, describe their approach in their own words:

https://www.youtube.com/watch?v=2MnVN_sOMkc&app=desktop

1 Source: NASBO State Expenditure Report, December 2012 — P2

You've got to have enough alignment of purchasing influence to balance the amount of influence on the other side. Providers are now very large systems. Health care payers are now very large systems. Purchasers must work together to represent the interests of society and their own employees. These are complicated relationships, but we need to make them less complicated.

— David Lansky, CEO
Pacific Business Group on Health

- **Heart:** Building patients' trust in the primary care physician (PCP)
- **Head:** Extending the PCPs' stewardship of value to patient interactions with other parts of the healthcare system
- **Heft:** PCP investment in building and maintaining a reliable in-office support team

Milstein says by sharing the best practices common in Brightspot practices, organizations can help all physicians understand that success is attainable and that by adopting these practices, they are significantly more likely to substantially improve quality and lower healthcare spending, therefore bringing more value to both patients and payers.

In order to institute these practices, providers need reliable data to measure their current state, set goals for success and establish a roadmap for improvement.

BUILDING A CREDIBLE DATA REPORTING SYSTEM

Once providers understand the national need for transformation, comprehend the framework of what works in Brightspot practices and are convinced that data is an essential tool for success in both, they still need to trust that the information is accurate.

Gunnar Nelson, Health Economist with Minnesota Community Measurement (MNCM) describes TCOC and how MNCM calculates this measure:

Total Cost of Care (TCOC)[2] is a measure of all costs for a patient over a 12 month period adjusted for diagnostic risk and assigned to a single medical group. The base calculation is the average of all the medical groups case mix adjusted costs divided by the average for all patients in the measure. The patients are attributed to the group with the highest number of unique dates of service for primary care office based activity. The results are risk adjusted using the Johns Hopkins adjusted clinical groupings (ACG) algorithm. Cost is defined by the amount that the health plans paid and the patient responsibility for copays and deductibles.

This measure is limited to commercial patients who are enrolled in a single health plan for at least nine of the twelve months. It does include both fully and self-insured patients and group and individual plans.

Since cost is a product of price and utilization, in order to understand these main price drivers, we need a way to separate price from utilization.

Voices From The Field:

Over the course of two years, Minnesota Community Measurement (MNCM) built and tested their Total Cost of Care measurement tool, ensuring clean and complete data despite a $300 to almost $900 variance in total commercial cost of care across the practices they studied.

MNMC used the following criteria:

- *Data from commercial claims*
- *Provider-designed with input from health plans*
- *Data is pulled directly from health plan warehouses instead of an APCD. Summary files are merged by MNCM*
- *This distributed model delivers highly accurate results at a low administrative overhead but requires extensive cooperation from the health plans.*
- *Patient attribution is based on volume of activity.*
- *All costs per patient are included*

2 **Total Cost of Care** is a comparison of clinics and medical groups if all clinics had the same level of patient illness.

"This is the application of science to real problems. This enables us to apply an economic model needed to institute change at an individual level and at the broader level. TCOC can create the broader picture so we can create strategies around what we do together to effect change. It is our assumptions that are often the barrier we need to overcome."

— Seminar Participant

The HealthPartners Total Care Relative Resource Value (TCRRV)[3] algorithm accomplishes this by using the same patients and the same claims and converting the TCOC to a standard payment model. In this model, all providers get "paid" the same and therefore the only difference between providers is the amount of resources. This is done by using the national, usually Medicare, relative value units.[4, 5]

The patient attribution (assignment) process needs to be very transparent. MNCM worked with medical groups and health plans to design and test the assignment process. In addition, attribution is essential to accruing accurate data. With a goal of identifying the PCP with the most influence, MNCM uses the following criteria for assigning patients:

- Assign patients only when a medical group had the majority of primary care events
- Follow a repeatable, reliable and affordable process
- The actual patient rosters are made available to the medical groups and clinics

3 **TCRRV Relative Resource** is a comparison of clinics and groups if all clinics had the same level of patient illness AND got paid the same amount.

4 **Price Index** is a comparison of clinics and groups if all clinics had the same level of patient illness and used the same amount of resources. All that is left is price.

5 The details of the NQF endorsed process can be found at HealthPartners https://www.healthpartners.com/hp/about/tcoc/index.html.

Even so, points out Nelson, not all patients can be assigned. MNCM found:

- 55% met an obvious attribution
- 25% could not be attributed
- 20% were dependent on local market assignments

USING DATA TO EFFECT HEALTHCARE COST AND QUALITY

You've heard the famous quote from Tip O'Neill, the late Speaker of the US House of Representatives, "All politics are local." The same is certainly true of health and healthcare. For data to be truly instructional and actionable, physician leaders must be able to gain a clear picture of their practice as a whole, and how each individual provider is contributing to the aggregate. This in turn is the basis of what is reported publicly and how data informs the patient, who is now expected to shop around, compare costs and quality and choose the way they would for a house, a car, a daycare provider or any other service.

Drilling down to the local and individual level

One approach to practice/provider specific measures comes from Oregon Healthcare Quality Corporation (Q Corp) where Meredith Roberts-Tomasi is Senior Director of Programs and Operations. "Shared Clinic Comparison Reports are one way to show clinics their TCOC performance - they show how the measure can roll up and drill down," says Roberts-Tomasi.

Q Corp maintains that reporting cost in conjunction with quality is critical. Early findings show very little, if any correlation, between cost and quality.

Voices From The Field:

Q Corp: Drilling Down to the Practice Level

Q Corp studied quality, cost and utilization across Oregon and compiled 143 adult and 44 pediatric clinic-level Clinic Comparison Reports for 79 different medical groups. Each report detailed how the clinic compared to others in:

- *Demographics and Cost*
- *Professional services*
- *Outpatient services*
- *Imaging and ER*
- *Inpatient services*
- *Chronic Conditions*
- *Pharmacy*
- *Year over Year*

For more information, visit: q-corp.org/our-work/costofcare

"The reports point to variation and then opens the door for conversations about performance improvement at the clinic, medical group, or clinical affiliates. The more transparent groups are, the more improvement can happen."

PUBLIC REPORTING AND CONSUMER TOOLS

In terms of public reporting and providing a consumer tool, Seminar participants heard from Lorrie Marquis, former Director of Pathways to Excellence with Maine Health Management Coalition (MHMC). "The balance between statistical difference and consumer ability to understand results is a difficult solution," says Marquis. "Discussion with representatives, particularly consumers, to weigh in on how to publicly report the information is critical."

Voices From The Field:
MHMC: Public Reporting

MHMC turned two years of Total Cost of Care data into a public, online consumer tool. It includes a measure entitled, "Provides care at a Reasonable Cost". The tool is used increasingly by Maine residents and payers to locate and sign up with a primary care provider. MHMC's key criteria:

- *Provider understand what numbers they need to report, what numbers they don't*
- *Survey public to ensure they understand what is being measured*
- *Words matter – vet terms and ranking designations with consumers*

For more information, visit: http://www.getbettermaine.org/

MHMC has found that bringing TCOC to the public realm is a long and arduous process. People that were present for the early discussions are not necessarily the same as those in the middle or end of the journey. Staff suggests emphasizing from the outset the need for consistent participation from member representatives, and to have plans in place for the inevitable transitions in staff/representation to bring new participants up to speed.

"Physicians are thoroughbreds. If you continue to feed and water them regularly and carefully, they've got a good shot."

— Seminar Participant

CREATING TRANSFORMATIONAL CHANGE WITH DATA

Reliable data and commitment to transparency will bring a community a long way on the road to transformation, but success will also require provider behavioral change. As Michael van Duren, M.D., Vice President of Variation Reduction for Sutter Health in California puts it, "There is 'waste' in the health care system, also termed overutilization, or provision of 'low value' services. This contributes to the total cost of care and is a modifiable factor, by addressing clinician behavior." He adds that other factors, such as patient behaviors, might be harder to modify quickly.

A good portion of the seminar was dedicated to methods and leadership approaches to managing provider performance by presenting data in ways that will not put providers on the defense, but rather encourage them to improve and innovate.

Dr. Van Duren says focusing on and building from providers' core values is key to behavioral change. Doctors are highly motivated to "do the right thing" for patients. To change their behavior, he says, "you don't need to resort to financial incentives or public blame/shame. Just gentle, respectful, guidance that alerts them to the possibility that perhaps they were not doing the right thing – by exposing them to the 'positive deviants' amongst their peers - leads to rapid behavior change." Using this approach yielded $11-million in healthcare cost savings over a 24 month period. To accomplish this, physician leaders should share performance data in three key ways:

- Peer comparisons with unblinded data about local peers
- Share in a face-to-face group meeting that is facilitated by someone who knows how to create safety in a group
- The data shared has to be rates of specific behaviors that are considered actionable

Van Duren defines actionable as: "something that tells me exactly what specific behavior I can change tomorrow". He goes on to emphasize that,

"Being right is almost worthless. Being trusted is priceless."

— Jay Want, M.D., Chief Medical Officer, Center for Improving Value in Healthcare (CIVIC)

"Providing actionable data will be welcomed as helpful and respectful. Providing non-actionable data will be experienced with frustration and resentment."

UTILIZING AND COMMUNICATING DATA TO ENGAGE PROVIDERS IN IMPROVEMENT AND BEHAVIOR CHANGE

Behind every data point on a chart is a human life, whether it is a patient or a physician being measured on performance. It is one thing to show a provider a dense graph with statistics ... and quite another to tell them the story of how the care provided to one patient in crisis changed or even saved a life, and quite possibly improved the lives of their entire family. Or how one "Brightspot" practice tackled resource use and improved morale and performance as a result. This is because it connects the provider to the data on an intimate, human level, and reminds them of why they come to work every day.

Jay Want, M.D., Chief Medical Officer with the Center for Improving Value in Healthcare (CIVIC), says when sharing data about performance, it is essential to do it in a bi-directional, conversational way that ensures the provider feels respected and supported. In most cases, this is contrary to what medical school and all of their traditional training has focused on and requires a new social contract:

"Try to walk the walk, not talk 'at' providers"

— Seminar Participant

Old Way

- Infinite power for infinite responsibility
- Lack of data to measure performance so use of outlier whack-a-mole as regulatory mechanism
- Guilt, fear and shame as cultural regulatory mechanisms
- Discourage inquiry, experimentation and requesting help from others

New Way:

- Contribute expertise within a shared responsibility
- Present individual data as it compares to whole
- Team performance outweighs individual performance

By approaching performance conversations as a partner with the provider, the physician leader not only earns their trust, but their buy-in to transformation efforts. Dr. Want says this holds true because providers are people, too, and despite all the training they react and make decision like anyone else:

- Most important decisions for humans are emotional. Logic is necessary, but mostly insufficient to change human behavior.
- Humans filter relationships with homophily, the tendency to associate with similar others, which is a powerful force for change, and especially prevalent in physicians.
- Successful transformations invoke all three human motivations: financial, social and ethical.

Leadership is disproportionately important to major change, as it is a major determinant of culture. Physician leaders have some added challenges in that they must help the provider see beyond their natural tendencies to be

autonomous, errorless and a strong sense of being isolated from the rest of society by nature of their profession. It all starts with establishing a mutually supportive and respectful relationship.

"Presenting data and performance feedback in the context that the work you are doing is essential to the wellbeing of the nation is key. What we are asking doctors to do differently can't be adamant, it must be flexible. Nor can it be broad. We must connect their individual, every day work to the whole in a meaningful way."

— Arnold Milstein, M.D., Clinical Excellence Research Center Director, Stanford

KEY ACTIONS

Participants spent the last session of the Seminar sharing their key takeaways and many voiced commitments to next steps:

- Utilize the techniques learned here to motivate providers
- Engage providers differently
- Take home a much better understanding of where we are with data and how to include quality data
- Search out the Brightspots and rising stars in my organization and leverage their example
- Work from the assumption that physicians are motivated by the right thing and try to feed that
- Challenge data analysts to provide additional information: We have this, how do we get to that?

- Language matters
- Center all conversations and efforts around patient
- Identify what we can do together to effect change and DO IT
- Reporting data only once is not going to get us where we need to be – need to track it over time
- Partner with providers and the community when designing data collection and reporting systems
- Commit to the art of not only collecting data but how you present it

For more information about the Getting to Affordability initiative, visit our website at www.nrhi.org/work/multi-region-innovation-pilots/tcoc or email us at gettingtoaffordability@nrhi.org.