PROMETHEUS NEWSLETTER: ISSUE 6 June 2010

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE INC

Robert Wood Johnson Foundation

From the Board Chair

Dear Readers:

With the passage of the *Patient Protection and Affordable Care Act* (PPACA), it is a whole new dawn for those of us working in the world of payment reform and PROMETHEUS Payment. From our partners and pilot sites to the provider organizations and stakeholders we interact with, now that health reform has finally been signed into law everyone is talking both about paying for value with a new seriousness – and thinking about how they can get ahead of the coming wave of regulation.

Here at PROMETHEUS the level of inquiries we are receiving is well beyond what we have ever experienced. Suddenly everyone is coming to the realization that there are few tested, replicable, scalable and fair payment systems out there that can meet the requirements laid out by Congress – and that PROMETHEUS Payment fits the bill. It is this interest that makes me even more comfortable saying proudly that we, PROMETHEUS Payment, *are* payment reform!

During the excitement of the last few months, the teams here at PROMETHEUS and Bridges to Excellence have been burning the midnight oil to keep this initiative shining bright for all to follow. And in this issue of the newsletter, you will read about the fruits of our labors, including the latest on PROMETHEUS Payment and payment reform in the news, updates from our pilot site in Minnesota and the stories of Ted and Michael, two fictitious patients in our latest series of vignettes comparing PROMETHEUS Payment against traditional fee-for-service systems.

Amidst all this activity, I truly believe this innovative payment model remains one of the most important things happening in health care today. It is very exciting.

Sincerely,

Alice G. Gosfield, Esq.
Chairman of the Board
Health Care Incentives Improvement Institute

The Latest from PROMETHEUS

June 23 PROMETHEUS Payment Webinar

Join the PROMETHEUS Payment team, pilot sites and partners on June 23rd from 1:00 – 3:00 pm ET for an interactive webinar on the latest from this revolutionary initiative to reform payment. Hear and talk to those on the frontlines of this effort about their experiences in contracting for episodes, re-engineering and quality improvement.

Space is limited. Reserve a spot online at:

https://www2.gotomeeting.com/register/761251130

Speakers on the call will include:

- Chad Heim, *Sr. Director Health Informatics, HealthPartners*
- Chris McTiernan, *Sr. Director, Provider Reimbursement, Independence Blue Cross (IBC)*
- Kevin M. Fosnocht, *MD, FACP, Assistant Vice President Quality and Patient Safety, Crozer-Keystone Health System*
- Marty Michaels, *Director, Professional Services Network Management, HealthPartners*
- Paul Brand, *Executive Director, Employer's Coalition on Health (ECOH)*
- Richard Freeman, *CMO & Sr. VP., Medical Affairs, Spectrum Health*


Slate

BRIEFING NEWS & POLITICS ARTS LIFE BUSINESS & TECH SCIENCE PODCASTS & VIDEO BLOGS

HOME / PRESCRIPTIONS / HOW TO FIX HEALTH POLICY

Little Bundles of Joy

Why do insurers ignore the most promising way of cutting health costs

By Darshak Sanghavi

Posted Thursday, April 29, 2010, at 9:47 AM ET

Now that a national health reform bill passed, it's time to get to work on the reforms themselves. To illustrate the big challenges, and also a practical way forward, let's consider asthma in children. A leading cause of misery, the disease accounts for one in six pediatric emergency room visits and is the most common cause of inpatient hospitalizations in many urban areas. And yet, most experts agree, asthma is eminently treatable and most of these hospitalizations are preventable.

Treating asthma requires a sophisticated algorithm. Frequently, parents must try three or more combinations of medications before finding the one that works best. Guidelines to prevent subsequent attacks also advise that schools receive written asthma "action plans" for the child; allergists evaluate and treat specific asthma triggers; homes be treated for insect pests.

Last November, researchers from Children's Hospital Boston reported interim results from a community-based asthma program that used case managers, home health aides, and outreach to coordinate the proper steps for children with severe asthma. Within six months, emergency-room visits dropped by 60 percent. Hospitalizations fell by 80 percent and stayed down for a year. And yet, according to a legislative liaison from the hospital, "in the current traditional health care system, these kinds of workers"—such as home-visiting nurses

PROMETHEUS and Bundled Payments Featured in *Slate*

PROMETHEUS Payment and the cost-cutting potential of bundled health care payments were the focus of a piece by *Slate* magazine's health care columnist and the chief of pediatric cardiology and assistant professor of pediatrics at the University of Massachusetts Medical School, Darshak Sanghavi. Looking at the history of attempts to do so, and deeming bundling payments to be the "most promising way of cutting health costs," Darshak calls PROMETHEUS Payment the best way of structuring the complex and wonky deals. But asking the same questions we do all the time, he questions why more insurers don't turn to what is the most promising payment reform model in existence.

Read the article: http://www.slate.com/id/2252221/

Annals of Internal Medicine: Pay for Performance Through the Lens of Professionalism

A May *Annals of Internal Medicine* piece co-authored by PROMETHEUS Payment board chair Alice Gosfield board member Keith W., Michl, MD – reporting on an expert panel convened by the American College of Physicians (ACP) – analyzes the potential conflicts between pay for performance and medical professionalism. Among newer efforts to improve quality in the U.S. health care system, pay for performance has been proposed to propel better results, but many observers are concerned that it is at odds with medical professionalism.

Examining how such a payment structure meshes with the goals of the Physician Charter on Professionalism, the report finds that properly designed pay-for-performance models are indeed compatible with professional objectives, can strengthen the relationship between physicians and patients and can increase the likelihood that physicians will deliver the best possible care. At its core the PROMETHEUS Payment engine aligns brilliantly with the philosophy of pay-for-performance and these findings should give further support to providers and systems considering implementation.

Read the article: http://www.annals.org/content/152/6/366.abstract

PROMETHEUS PACs Under Consideration at the National Quality Forum

Following a call for outcome measures by the National Quality Forum (NQF) and series of promising meetings with its Technical Advisory Panel and Steering Committee, a batch of PROMETHEUS Payment Potentially-Avoidable Complications (PACs) for AMI, pneumonia, stroke and six chronic conditions (Diabetes, CHF, HTN, COPD, Asthma, CAD) are nearing completion of approval as comprehensive measures of complications of care. Now undergoing public comment, if all goes as expected, these PROMETHEUS PACs will soon gain the cache of being NQF-endorsed and, through that, wider-spread uptake from stakeholders across the country.

Setting a New Standard: Pilot Site HealthPartners Data Shows PAC Rates Among Best in Country, Expands Involvement and Agrees to Set Benchmark for Others

Since launching early last year, the pilot team at HealthPartners in Minnesota has been a shining star in PROMETHEUS Payment – and their success continues. As will be officially announced on the webinar later this month, their implementation of the ECR for Acute Myocardial Infarction (AMI), which has included actively paying providers for it, has yielded phenomenal results. The numbers from HealthPartners will show that they have PAC rates that are among the lowest and best in the country, and that patient care in the pilot is being very well coordinated and managed. Because of this success, the team in Minnesota has agreed to serve as the national benchmark for PACs, setting a new standard for care among PROMETHEUS Payment pilots, partners and followers.

CMS RFP Issued for the Construction of a Public Domain Episode of Care Logic

In response to the recently passed Patient Protection and Affordable Care Act (PPACA) the Centers for Medicare & Medicaid Services (CMS) has issued a request for proposals for the construction of an episode of care logic that would be fully in the public domain. This is the essential building block for any payment model based on episodes of care and will finally give the country what it needs to launch broad-based episode of care payment – a standard definition of episodes. The work is slated to be completed at some point in 2012. So while we at PROMETHEUS Payment have developed 21 ECRs, there will soon be far more courtesy of the federal government.

CMS Centers for Medicare & Medicaid Services

Learn more about the RFP:
https://www.fbo.gov/index?s=opportunity&mode=form&id=24f02e746a259f484efc4010c91e5cbd&tab=core&_cview=1

PROMETHEUS PAYMENT IN ACTION

The Tale of Ted and Michael

HEALTH CARE PAYMENT AND ACCOUNTABLE CARE: Improving Information and Incentives

The following vignette contrasts two worlds, one depicting the healthcare experience as we now know it and another that is built on new systems of "Accountable Care."

Imagine two people sharing largely identical medical characteristics in terms of age, gender, lifestyle habits and underlying maladies; in other words, one patient type describing two different people. In this case, we have **Ted** and **Michael**, two 53-year old males, who have recently moved to new locations because of work. While both are excited about the prospects of their promotions, they feel run down, have difficulty catching their breath and concentrating, and – more alarming – both have begun to notice a tingling in their legs neither has experienced before.

Ted and Michael love football and beer, smoke a pack and half of menthol cigarettes a day (though neither readily admit it to coworkers) and have seen their midriffs expand generously over the past 20 years. Neither has much use for daily exercise. Although they both have the same cavalier disregard for seeing doctors, their wives are concerned over their recent complaints and are pushing them to seek care. With time, Ted and Michael relent and decide to take advantage of their new health insurance; and here's where the differences occur.

Ted: The Traditional Fee-for-Service Experience

Ted uses the internet to find the nearest practice to his home that accepts his employer-sponsored benefits. Valley Medical is a traditional fee-for-service practice with five primary care providers. He calls and, after some time navigating the automated phone system, Ted speaks to a receptionist who gives him the earliest available appointment, three weeks out.

Valley Medical has modern facilities yet has decided that Electronic Medical Records are not worth the investment, content that their referral patterns are more than adequate; and they view the new payment arrangements that reward performance as "just another fad."

Ted sees Dr. Andrews at Valley Medical who, according to his new neighbors, is an excellent doctor and has been practicing with his partners for over 25 years. From Ted's medical exam and patient history, Dr. Andrews is concerned that he is most likely suffering from adult onset diabetes, has high blood pressure, and is very likely suffering the early stages of heart disease and perhaps lung disease

brought on by years of smoking. Dr. Andrews orders a variety of lab tests and asks Ted to return in two weeks.

When Ted comes back, Dr. Andrews confirms the bad news. After examining Ted's eyes and feet, he tells Ted that he is suffering from out-of-control Type 2 Diabetes (HgBA1c level is 11), dangerously high blood pressure (190/110), advancing emphysema (FEV1 is less than 60% normal) and very high LDL cholesterol (level of 210, twice normal).

If things persist, Dr. Andrews stresses, Ted stands a good chance of having a heart attack, a debilitating stroke, vision impairment, and limb loss. He advises Ted that he must quit smoking, gives him a pamphlet on dietary changes to lower weight and blood sugar, and writes Ted prescriptions for blood sugar monitoring equipment and for three medications needed to treat his hypertension and high cholesterol.

Dr. Andrews also tells Ted he needs to start exercising, measure his blood sugar every day and come back in three months to check on his progress. Dr. Andrews then quickly moves on to his next patient – he sees an average of 40 patients a day.

Michael: Results-Based Health Care Payment

Michael's experience couldn't be more different. He starts by checking his employer-sponsored health benefits' website where he learns that the company is part of a larger coalition of employers and health plans participating with select area care providers to promote this new notion of "accountable care."

Although Michael doesn't really understand what "accountable care" means, he does see that several local practices have been recognized as delivering superior care by reputable national healthcare quality organizations like the National Committee for Quality Assurance (NCQA), American Academy of Family Physicians (AAFP) and American College of Physicians (ACP). Moreover, he sees that if he goes to any of them, he may see his co-pay costs waived and enjoy potential breaks on his monthly health plan contributions. As this sounds like a good deal, Michael makes arrangements for a visit to Medical Partners, one of the provider groups highlighted.

Medical Partners is a multi-specialty practice that made a decision five years ago to embrace new technologies like EMRs, clinical messaging, electronic prescribing, and clinical practice guidelines – "best practices" – software. It has also committed itself to establishing a culture where physicians, specialists and nurse practitioners work in patient-centered teams, where outreach programs are available and where care coordination, particularly for hospitalized patients, is safe and efficient. Most importantly, Medical Partners is dedicated to working in a data-rich environment, shared across the organization and allied healthcare providers, to ensure a process of continual care measurement and improvement.

Fortunately, Medical Partners was able to find employers and plans that wanted to encourage these types of progressive healthcare changes for their beneficiaries and agreed to implement *Bridges to Excellence* performance measures and the PROMETHEUS Payment® system to redirect reimbursement from volume-based payment to results-based payment. Although some of these concepts were foreign to Michael, he could relate to the goal of better, safer care at lower cost.

Unlike Ted, Michael was able to make his own appointment on Medical Partners' website – the same day. His first visit included an examination with Dr. Sanchez and testing that was similar to Ted's, and he returned two weeks later for a follow-up visit to hear the same bad news: out-of-control blood sugar and pressure, poor lung function and arterial problems.

Like Dr. Andrews, Dr. Sanchez explained the same dire conditions and potential consequences; but unlike Dr. Andrews, Dr. Sanchez used Medical Partners' EMR to help care for Michael more efficiently and save time by electronically ordering his prescriptions during the office visit. She then explained to Michael that a Certified Diabetes Educator would be assigned to him to follow up on how he is doing over the next month and to answer questions on things like dietary changes.

Dr. Sanchez highly recommended a new and powerful way to improve diabetes care – the Diabetes Group Visit – that would involve monthly group meetings with other diabetics in the Medical Partners clinical setting for support and education. She further explained to Michael that if he signed a diabetes care compact and actively participated in the Medical Partners diabetes management program, Michael's employer would waive his co-pays *and* give him a break on his monthly contribution – if he achieved certain goals within three months (like getting his HgBA1c down to eight and blood pressure to 140/80). A care compact is an agreement signed by a patient and clinician emphasizing their partnership in care and outlines the patient's responsibility for his or her own health. The compact lays out the patient's commitment to communicate with health care team members; involve his or her family in care; complete important care steps, including medication adherence; and undertake appropriate follow up and preventive care.

"Michael," said Dr. Sanchez, "you're in bad shape, and it's up to you. We are here to work hard with you as teammates and can help make your life much better. Otherwise, I am afraid things will only get much, much worse." Michael agreed.

The Continuum of Care

Time passed. Even though it was difficult for Michael to quit smoking, start exercising, come to meet with his fellow diabetics, lose weight and always take his medications, his condition steadily improved – and he was satisfied that Dr. Sanchez's promise to be proactive, to help Michael feel he can make a difference in his own health – was true.

In the course of the following year, Michael's condition improved a lot (his HgBA1c level dropped from 11 to eight; blood pressure fell from 190/110 to 130/90 and LDL level stabilized at 110). While not perfect, it was going in the right direction. More pointedly, Michael just plain felt better. Seeing his improvements and being able to share them with

his wife, diabetic group and coworkers, Michael's confidence grew and he was convinced he could do even better. At work, he noticed that climbing stairs in the office wasn't so taxing, and his focus had significantly improved. Similarly pleased, Dr. Sanchez recommended that Michael's company reimburse him for the past 12 months of co-pays and reduce his monthly contribution, and that going forward, he would have no co-pays for future visits. For Michael, things were looking up.

Ted, in contrast, had a very different experience. When he got home from his second visit with Dr. Andrews, discouraged with the bad news, he promptly set his prescriptions on a corner table, where they gathered dust for several months. He made a brief attempt to stop smoking, but pressures from his new job got the best of him. He once ate a salad instead of a Big Mac for lunch, but there his dietary change ended, and he still managed to swallow three or four bottles of his favorite lager every night. Instead of losing weight, Ted actually gained another 11 pounds.

With no call, outreach or support from Valley Medical, Ted was lost in the "Fee for Service purgatory" and went on with life as he had been doing for the past two decades. Although didn't know it, he was a walking time bomb.

One night, while watching TV with his wife, Ted became woozy and then unresponsive. His wife tried to rouse him, but without success. In a panic, she called 911, and Ted was rushed to the hospital, where the ED doctors diagnosed a diabetic coma and heart failure. Having no records of Ted, his hospital physicians performed not only all the tests that Dr. Andrews had ordered just months earlier, but other expensive tests as well.

After two weeks in the hospital, Ted's condition stabilized, and he was sent home – although without an update from the inpatient physicians to Dr. Andrews. Scared that he had had a close call, Ted did go back to see Dr. Andrews, and did make a greater effort to change his life…but much damage had already been done.

Costs

Looking over their medical cost data, Ted's health plan may have felt that before his admission Ted was being managed well and that his care was cheap – only two office visits that totaled $165. But the bill from the hospital was $52,678, an amount that could have been avoided had Ted been cared for in a better care environment, one that was designed to deliver demonstrably better and more efficient, cost effective care.

In contrast, Michael's care occurred in an "accountable care organization" committed to quality, patient experience and reduced cost. Medical Partners works with several plans and employers in the PROMETHEUS Payment program where providers receive half of dollars saved from avoiding the expensive – and harmful – event that Ted's traditional though poorly managed care incurred.

And while re-engineering care and managing patients in a team-based way may be more expensive upfront than traditional Fee-for-Service primary care, the downstream effects of better outcomes and reducing potentially avoidable costs are far less expensive. With Medical Partners, not only does Michael's company see their medical trend rate improving, but in return they get a happier, healthier Michael, all because payer and provider are now cooperating to align information, outcomes and incentives. ■