

## **Briefing Paper: Health Care Innovators and Health Care Reform**

Over the past year, politicians of all stripes, academics, think tanks, and journalists have engaged in a vigorous debate over whether health reform legislation before Congress will truly rein in the skyrocketing costs. Reform proponents have pointed to quality leaders like Mayo Clinic and Intermountain Health, while opponents have questioned whether their successes can be replicated. But these health care leaders are not the only model for reform or the only test of its potential to reduce costs and improve quality. Hundreds of other health care innovators have adapted their own path toward high-value care in their own communities. In addition to national leaders like Mayo, a myriad of hospitals, health centers, provider groups, businesses, and community coalitions have pioneered cost-saving, quality-enhancing initiatives like chronic disease management, health IT, quality initiatives, bundled payments, evidence-based medicine, and new approaches to care coordination.

U.S. Public Interest Research Group (U.S. PIRG) researchers have contacted health care innovators in several areas of the country. The accounts below were developed based on interviews with the leaders who have helped drive successful reform initiatives. After each case study, we explore the provisions of health reform legislation before Congress that would encourage or replicate that reform.

Each of the case studies below demonstrates an innovative approach to delivering quality health care at a lower cost. In each case, we find these models of care could be scaled up significantly through provisions already included in the health care bills before Congress.

### **1 - St. Louis, Missouri - St. Louis Area Business Health Coalition**

The St. Louis Area Business Health Coalition unites over thirty-nine local employers in an effort to reduce health care costs and improve quality in the St. Louis region. They have recently started a program to improve care quality by encouraging providers to adhere to evidence-based standards of care. Their efforts to improve the quality and effectiveness of care have already resulted in over 400 physicians receiving a National Committee on Quality Assurance certification in care for one of the conditions most responsible for higher health costs: diabetes. Together these initiatives are intended to ensure that members' employees and all St. Louis patients receive higher quality, more efficient health care.

Employee wellness is another area where the coalition has been active. While many local employers lack the capacity to design and run the best workplace wellness programs themselves, the Coalition connects area employers with an outside organization that specializes in the delivery prevention and wellness services for their employees. This program allows area employers to invest in the chronic disease management and prevention activities which would be difficult to provide themselves but can have significant impact on the cost of coverage.

### Current Legislation Being Considered Addresses Quality and Workplace Wellness

Both the House and Senate health care bills call for significant expansion of the development of health care quality.<sup>i</sup> Through an approach known as value-based purchasing, the Senate bill would adjust Medicare's payment system for hospitals to reward hospitals which excel at meeting those standards.<sup>ii</sup> Senate legislation also requires that physicians' payment rates be adjusted based on the value of the care they deliver.<sup>iii</sup>

The House legislation establishes a grant program to help small employers mount strong employee wellness and prevention programs, similar to those which the St. Louis Area health Coalition is trying to encourage.<sup>iv</sup>

### **2 – Muncie, Indiana - Care Teams and Workforce Retention at the Open Door/BMH Health Center**

Open Door/BMH Health Center is a non-profit, federally qualified community health center that acts as the safety net for the uninsured and underinsured in east central Indiana. ODBMH accepts Medicaid, Medicare, and private insurance, and has a sliding fee scale for those without insurance.

According to Tori Estep, CEO of ODBMH, the patients coming to her facility tend to have worse health problems than patients at private practices because people who go to private practices tend to have been receiving care longer. Because each patient has more difficult medical problems, physicians need to spend more time with each patient. But when they do, they seldom achieve the number of visits needed to financially sustain a primary care practice.

To deal with this problem, ODBMH developed "care teams." Each care team has a physician, a nurse practitioner, a medical assistant (to put patients in examining rooms), a nurse to do phone triage and prescription drug refills, a nurse educator, and a behavioral therapist. There is also a nutritionist on staff who is shared by two care teams. The Center presently has three care teams and expects to add two in the near future. In each team, the nurse educator has the time to provide the sort of health care information to patients which results in the patients not needing to return to the doctor so often.

Use of the care teams has resulted in physicians being able to see more patients while still managing to deliver better care to the patients. This has improved the morale of the physicians and is expected to result in the physicians staying in their jobs longer.

Allowing the nurse educator to now deliver vital patient education at a much lower cost has helped financially. Estep estimates that the doctors see at least five more patients per day under the new system and that the savings in the range of \$1,000 per day.

### Current Legislation Being Considered Encourages Care Coordination and Workforce Development

Health reform legislation now before the Senate includes a provision encouraging these community health teams.<sup>v</sup> Other elements of the bill invest in loan forgiveness and scholarships that would encourage more providers, both doctors and nurse practitioners, to commit themselves to work with community health centers like Open Door/BMH.<sup>vi</sup>

### **3 – Rockford, Illinois - PROMETHEUS: Employers Unite Behind Bundled Payments**

In Rockford, Illinois, over 100 employers have banded together in an effort to transform how medical care is paid for in their community. Working with local hospitals and providers, they use a new payment system entitled PROMETHEUS for its lengthy acronym – **Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability and Sustainability**. The program seeks to pay good doctors more, improve quality, and save money overall by paying doctors to not make mistakes. The aim is to seriously reduce the resources wasted on avoidable medical errors while providing patients with better care.

The program works like this: An expert panel establishes an evidence-informed case rate (ECR) for a particular illness or condition. This is a calculation of the resources needed to deliver all the care by all providers and institutions to correctly treat an individual with a particular condition. The rate is arrived at by looking at previous treatment records, good clinical practices, science, and research by qualified doctors. ECRs are adjusted for severity and other factors, and exist only for conditions where robust, agreed-upon national clinical guidelines or expert opinion have been established. (Thus far, 17 ECRs exist, including ones for several of the nation's most expensive and prevalent conditions.) Funding for the development of ECRs was provided by the Commonwealth Fund and the Robert Wood Johnson Foundation

Then providers are paid through a bundled payment equal to the ECR. For example, a patient with chronic obstructive pulmonary disease might have a total calculated ECR of \$15,000, which includes a \$2,000 allowance for potentially avoidable complications. If a provider successfully treats a patient for chronic obstructive pulmonary disease for \$13,000 and there are no avoidable complications, the \$2,000 goes to the providers' profit margin. In the event of complications, the provider will still only receive \$15,000 for addressing the needed care. At the end of the year in the PROMETHEUS system, incentive payments are paid to providers based on whether mistakes occurred and whether providers followed good clinical protocol. By contrast, in the fee-for-service payment system currently prevalent across most American communities, the doctor would be paid for every test and procedure used to treat any complications that arise.

PROMETHEUS works because it encourages doctors, hospitals, and labs to coordinate the care they provide. Thus they avoid the types of poor management that add significantly to health care costs: repetitive tests, prescriptions of contraindicated drugs, communication breakdowns among providers.

Because the project is new, a final assessment of its effectiveness has not yet been completed. But anecdotal reports from local business leaders are positive. Jim Knutson, risk manager and human resources director for Aircraft Gears Corporation in Rockford, Illinois, helped launch the Prometheus effort in Rockford, and he reports that the quality improvements in his employees' care have left his company better off financially. "It's a real game changer," said Knutson. "Prometheus gives us data that show which groups and institutions are delivering value. We'll be able to negotiate our contracts accordingly."

#### **Current Legislation Being Considered Fosters Bundled Payment Systems**

Both the House and Senate versions of health reform legislation call for bundled payment pilot programs that would test PROMETHEUS-style payment approaches in Medicare.<sup>vii</sup> If the pilot projects demonstrate lower costs while improving or maintaining quality, the Secretary of Health and Human Services would be authorized to broaden the model to more communities and health conditions. Supporters believe that a program as large as Medicare has the market strength to drive the adoption of bundled payments throughout the health care system.

#### **4 – Washington State - Group Health Reduces Avoidable Hospital Readmissions**

Group Health Cooperative is one of America's oldest and largest consumer-governed health care organizations. Founded in Seattle in 1947, Group Health integrates coverage and care for more than 600,000 people. Members get care from 900 physicians and 1,600 nurses in Group Health Medical Centers around the greater Puget Sound region and in Spokane and Coeur d'Alene, Idaho. But Group Health is not immune to the problem of high rates of avoidable hospital readmissions.

Nationally, nearly a fifth of Medicare patients are back in the hospital within thirty days of an admission. At Group Health, readmission rates trend somewhat better at about 16 percent. But just in the past year, they've launched a comprehensive effort to bring Medicare readmits below 10 percent in 2010—and sustain those rates. The goal is to contribute to saving \$50 million in unnecessary hospital costs per year.

Group Health's plan to reduce readmissions has several elements. It includes better coaching and care coordination for patients with complex needs as they transitioned from hospital stays to home or other care settings, a focus on consistent follow-up care for these patients in their next care setting, and improved access to alternative care settings like non-hospital extended observation or urgent care for patients who do not require hospital or emergency care.

The initial stage of implementation in seven hospitals where Group Health physicians and care management nurses personally manage inpatient care was completed November 12, 2009. Statewide roll-out to all other contracted hospitals will be completed by the end of the year. And while the process is still ongoing, early results are very promising. Virginia Mason Hospital & Medical Center, a flagship hospital in the region and hospital partner for this readmission initiative, is already showing a lower rate of readmission compared to the same time period in 2008. And during the week ending Nov. 13, Virginia Mason observed for the first time that the number of readmissions within seven days after discharge from the hospital was zero.

#### **Current Legislation Being Considered Includes Incentives to Reduce Readmissions**

The House and Senate health reform bills attack the problem of avoidable readmissions within Medicare by reducing Medicare payments to hospitals with high rate of avoidable readmissions.<sup>viii,ix</sup>

#### **5 – Dover-Foxcroft, Maine - Mayo Regional Hospital: Aligning Physicians Payment Incentives for Care Coordination and Quality**

Much has been made of the successes of Mayo Clinic and the successes it has had in Rochester, Minnesota. But innovation in health care delivery can also be seen at a small 46-bed regional hospital in central Maine that shares a name, but no organizational affiliation with the famed Mayo Clinic.

For the past sixteen years, this Mayo Regional Hospital in Dover-Foxcroft Maine has taken its own journey toward higher quality care, due in no small measure to the leadership of Dr. David McDermott, M.D. When McDermott joined the hospital in 1993, virtually every physician in the state was in private practice model. Mayo had never hired a physician outright, but made exception for McDermott.

The experiment worked, and from that point forward, every physician at MRH has come on as an employee. In addition, several prior physicians have become employees of the hospital. Now 21 out of 25 physicians employed and 2 of the other 4 have a contract so they have certain attachments to the hospital.

Under the salary compensation model, each doctor is paid a salary with some incentives based on performance. This stands in contrast to the prevalent fee-for-service payment system which rewards quantity and complexity of care delivered not quality. As McDermott states, "Models based on the volume of care administered are risky because they can be gamed, and may not encourage cooperation among physicians from which we have benefited."

Another element of delivery reform at MRH has been a consistent focus on measuring and disclosing performance on quality of care measures. Several years ago, the hospital invited a Medicare sponsored Quality Improvement Organization, Vermont Northeast Healthcare Quality Organization, to examine the care delivered at primary care offices associated with the hospital and measure on the effectiveness of their diabetes care. Their report showed that the doctors had different strengths and weaknesses. McDermott himself relates that he was cited for failing to take not cholesterol levels into account.

But the physicians at the hospital decided to post each doctor's individual results so they could all learn from each other. McDermott credits this decision for "allowing changes and improvements in our practices to happen almost overnight, as we learned from one another."

The progress at MRH has made a real difference. The Maine Employers Association ranks the state's hospitals by tiers. Today, MRH now sits in the top tier of that ranking. But the real difference can be seen in patient care. "At Mayo there is a close alignment between physicians and the hospital," says McDermott, "Our system does wonders to align incentives, putting everyone on the same page, so we can coordinate care."

#### *Current Legislation Being Considered Expands Quality Incentives and Will Encourage Hospitals to Experiment with Salaried Medical Staffs*

As noted above, the House bill calls for significant expansion of the development of measures of health care quality, while the Senate bill would adjust Medicare payment of hospitals and providers based on their performance on those measures.<sup>x,xi</sup>

Both measures authorize a new Center for Innovation within the Department of Health and Human Services to develop, test and extend new models for provider and hospital payment such as salaried medical staffs.<sup>xii,xiii</sup> The Senate bill explicitly lists that model as one of several payment reforms that may be developed.<sup>xiv</sup>

### **Conclusion**

For communities around America struggling with rising costs and uneven delivery of health care, the innovators discussed above offer something truly valuable. They offer a path to lower costs, by improving, not sacrificing, quality of care. These health care innovators have demonstrated that reforms like quality measurement, workplace wellness, bundled payments, salaried hospital medical staffs and team-based approaches to care can lead to better quality at lower cost. Legislation now before Congress would accelerate the adoption of these important reforms throughout the country.

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<sup>i</sup> Section 1441-1445, Affordable Health Care for America Act of 2009 downloaded from [http://energycommerce.house.gov/Press\\_111/health\\_care/hr3962\\_Section\\_by\\_Section.pdf](http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf).

<sup>ii</sup> Section 3001, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

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<sup>iii</sup> Section 3007, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

<sup>iv</sup> Section 112, Affordable Health Care for America Act of 2009 downloaded from [http://energycommerce.house.gov/Press\\_111/health\\_care/hr3962\\_Section\\_by\\_Section.pdf](http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf).

<sup>v</sup> Section 3502, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

<sup>vi</sup> Sections 5201-5210, and Sections 5301-5313, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

<sup>vii</sup> Section 1152, Affordable Health Care for America Act of 2009 downloaded from [http://energycommerce.house.gov/Press\\_111/health\\_care/hr3962\\_Section\\_by\\_Section.pdf](http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf).

<sup>viii</sup> Sections 3025, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

<sup>ix</sup> Section 1151, Affordable Health Care for America Act of 2009 downloaded from [http://energycommerce.house.gov/Press\\_111/health\\_care/hr3962\\_Section\\_by\\_Section.pdf](http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf).

<sup>x</sup>Section 1441-1445, Affordable Health Care for America Act of 2009 downloaded from [http://energycommerce.house.gov/Press\\_111/health\\_care/hr3962\\_Section\\_by\\_Section.pdf](http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf).

<sup>xi</sup> Sections 3001 and 3007, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

<sup>xii</sup> Section 1907, Affordable Health Care for America Act of 2009 downloaded from [http://energycommerce.house.gov/Press\\_111/health\\_care/hr3962\\_Section\\_by\\_Section.pdf](http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf).

<sup>xiii</sup> Section 3021, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.

<sup>xiv</sup> Section 3021, Patient Protection and Affordable Care Act of 2009, downloaded from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act.pdf>.