2015

FIRST STEPS:

A Journey to Developing a Shared Understanding of Health Care Costs and Utilization in the St. Louis Area

MIDWEST
HEALTH
INITIATIVE

About the Midwest Health Initiative

The Midwest Health Initiative (MHI), St. Louis' regional health improvement collaborative, supports physicians, employers, hospitals, health plans and consumers in improving the health and the quality and affordability of health care in its region. MHI stewards a large commercial data asset and serves as a neutral, trusted forum for diverse health care stakeholders to determine shared priorities for action and work collaboratively to achieve their goals.

The mission of the Midwest Health Initiative is to provide a forum where trusted information and shared responsibility are used to improve health and the quality and affordability of health care. Its vision is a community where committed partners share trusted information to enable all who use, provide and pay for health care to make informed decisions.

Acknowledgements

MHI would like to thank The Robert Wood Johnson Foundation, the Network for Regional Healthcare Improvement and the technical advisors, the Maine Health Management Coalition and HealthPartners. It would also like to thank the MHI Physician Leadership Council members, its attendees at the National Physician Leadership Seminar and the St. Louis area physician groups who provided insight and guidance to this process.

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Introduction

Government economists estimate health care spending will hit more than $3.21 trillion in 2015, as steeper cost increases resume (Services, 2015). Already, American workers have lost a decade of wage growth which has been consumed by rising health care spending (Fund, 2014). The costs creep beyond our paychecks and copays into higher taxes, more expensive goods and services and less money for education, transportation and defense. If we believed every dollar spent improved health or extended life, these costs might be deemed an unfortunate but necessary investment. To the contrary, evidence suggests one-third to one-half of health care spending could be avoided. The challenge is finding where these opportunities hide and building shared, collaborative action to drive improvement.

The Midwest Health Initiative (MHI), St. Louis' regional health improvement collaborative, uses its claims data asset and diverse stakeholder partnerships to gain a deeper understanding of health care quality, cost and utilization in the region. The goal is to foster ongoing, honest dialogue about how local stakeholders can work together to improve care quality, lower costs, improve the appropriate use of resources and position the St. Louis region as a national leader in health care quality and affordability.

Pilot Overview

The Healthcare Regional Cost Measurement and Transparency Project brings together MHI and four other regional health improvement collaboratives from around the nation to report ***Total Cost of Care*** and ***Relative Resource Use*** in each region using standardized measures developed by Health Partners of Minneapolis and endorsed by the National Quality Forum in 2012. This report was developed as an additional means of keeping our partners and community in the loop as we progress on a journey of learning how to best measure and report these metrics.

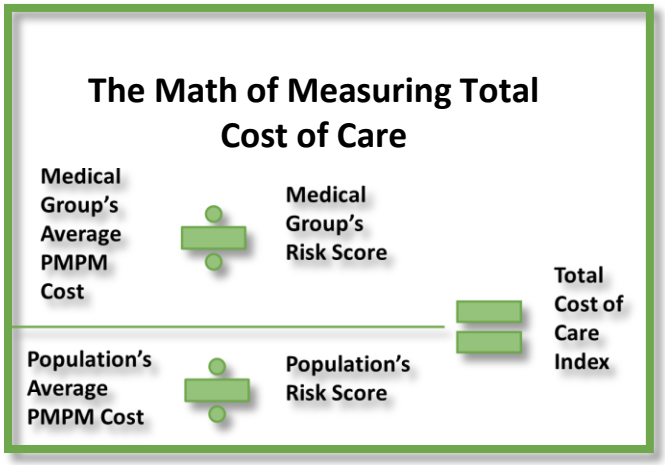
Pilot Goals

1. Contribute to shared learnings and comparisons with other Regional Health Improvement Collaboratives via data sharing, National Physician Leadership seminar and other forums
2. Share 2013 measure results with large medical groups and provide comparisons to community and blinded peers
3. Publish report to inform community about the project and share early findings

The 18-month pilot project, which began in November 2013, has been led by the Network for Regional Health Improvement with funding from the Robert Wood Johnson Foundation. Thanks to the continued support of these organizations, the work will continue for another 18-month period. Prior to this project, comparative data on health care costs has been elusive. This data has been particularly difficult

to obtain for the commercially-insured population. This project brings together medical and pharmacy cost data from the St. Louis region's three largest health plans, self-insured employers and unions to provide a better understanding of differences in the cost of care and how resources are being used across the community and among physician practices. The MHI data asset includes information on the health care services provided to more than 1.2 million commercially insured people, who are nearly all residents of the St. Louis region. The Total Cost of Care and Resource Use measure results were developed using a subset of the MHI data asset. Quality results are based on the full data set.

Measure Background: To ensure consistent results, MHI and the other pilot sites agreed to measure total cost of care and resource use using the same measures. The sites chose measures developed by HealthPartners, a Minnesota health plan. Both measures have been endorsed by the National Quality Forum. For more information on the measures, visit www.healthpartners.com/public/tcoc.



The HealthPartners Total Cost of Care measure sums the cost of care for all medical and pharmacy services provided to all individuals in a population and divides by the number of member months in the population. This per-member, per-month cost is then divided by an average risk score for the population. The Health Partners Total Care Relative Resource Use Value measure replaces the allowed amount for a service with a standardized price in order to remove the impact of price and focus on utilization. Application of this measure set provided a foundation for the work of the five partnering RHICs.

Measure Specifications

Measurement Period:	12 months + 3 month run out *(2013 +Q1 2014)*
Ages:	>1 to 64 (all commercial)
Enrollment Criteria:	Minimum of 9 months enrollment during performance measurement period
Truncation:	Costs over $100,000 per person are removed
Risk Adjuster:	The Johns Hopkins Adjusted Clinical Groups (ACGs); national weights used
Attribution:	One office visit with a primary care provider in 24 months

HealthPartners served as a valuable technical advisor on the pilot project, supporting MHI in developing a better understanding of the measures and possible applications for the St. Louis community.

Working Together: MHI was founded on the belief that collaborative partnerships armed with meaningful data can produce valuable change. Participation in this project reaffirmed that belief. Peer learnings from other RHICs strengthened MHI's data collection and aggregation processes. The experience of others informed MHI as it considered how to present early findings to its partners and community.

The technical process of measuring and reporting total cost of care is tedious. Standardizing decisions about attribution and risk adjustment across multiple regions with differing local experiences and market dynamics is even more challenging.

For this project, MHI and the four other pilot sites agreed to use the same risk adjuster, the Johns Hopkins Adjusted Clinical Groups System (ACGs). This was the chosen risk adjuster because it is the risk adjuster used by HealthPartners, the measure developer. Locally, some MHI partners use the Adjusted Clinical Groups methodology for risk adjustment. Others are using products developed by Optum or other vendors. MHI is interested in better understanding whether and how the choice of risk adjuster impacts results.

Attribution is a process by which a patient is linked to a health care provider. Pilot sites chose different rules for attribution. With input from its Physician Leadership Council and data vendor, MHI chose to attribute patients to primary care providers if they had one office visit with the provider during the previous 24 months. This resulted in approximately 67% of all patients being attributed. Attribution is important and complex. As such, MHI's attribution decisions may evolve over time.

Total Cost of Care Pilot Partners

Regional Health Improvement Collaboratives (RHICs)

- Center for Improving Value in Health Care (Colorado)
- Maine Health Management Coalition
- Midwest Health Initiative (St. Louis, MO)
- Minnesota Community Measurement
- Oregon Health Care Quality Corporation

Technical & Funding

Technical Advisors

HealthPartners®

Maine Health Management Coalition Foundation

Support

Robert Wood Johnson Foundation

During the next phase of work, MHI will continue to explore how decisions about applying the measure, such as choosing a particular attribution or risk adjustment methodology, impact results.

Measuring total cost of care and resource use were new endeavors for MHI and it benefited greatly from the experience of the other RHICs in the project. Minnesota and Maine already had reported these measures privately to physicians and MHI appreciated the opportunity to learn from their experiences. This shared learning would not have been possible without the technical support and leadership of the Network for Regional Healthcare Improvement and funding from the Robert Wood Johnson Foundation.

Physician Engagement:

Physicians are patients most trusted source of information when it comes to making health care decisions. Therefore, they must be given actionable information about the cost and quality differences of treatments and providers. With this in mind, developing strong physician engagement was a key component of the pilot project and will only grow as work continues.

National Physician Leadership Seminar on Measuring Total Cost of Care and Resource Use Physician Participants

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Associate Program Director,
Internal Medicine Residency Training Program
Saint Louis University School of Medicine

Bryan Burns, DO
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St. Anthony's Medical Center

Bernard Eskridge, MD
Medical Director, Well Baby Nursery
Assistant Professor of Child Health
University of Missouri's University Hospital and Women's and Children's Hospital

Rajiv N. Patel, MD
VP of Medical Affairs/CMO
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The project included a National Physician Leadership Seminar held at Stanford University in August 2014. Through informative presentations and discussion, physicians from the five communities learned about the nation's health care cost crisis and the efforts to provide meaningful cost and quality information.

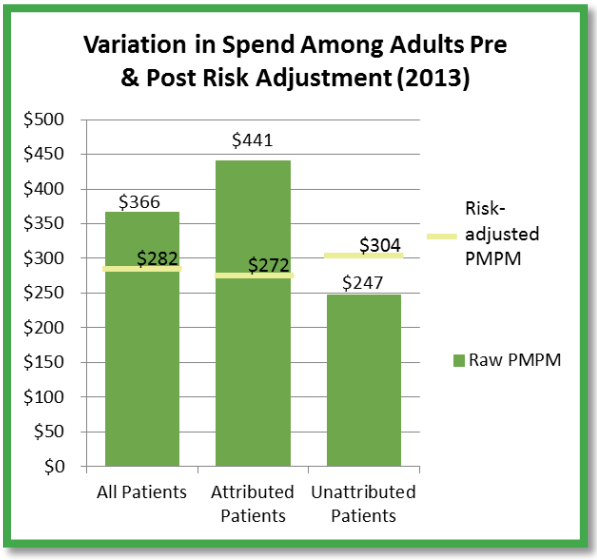
The MHI Physician Leadership Council suggested primary care physicians apply to represent MHI at the Seminar. In their applications, physicians from across the community expressed their desire to better understand health care costs and share their learnings with colleagues.

In follow-up conversations about their experiences, St. Louis' physician representatives shared that they felt better positioned to accelerate change in their own organizations and nationally. The participating physicians returned to St. Louis to share learnings with their organizations, the MHI Physician Leadership Council and other peers. Rajiv Patel, MD and Bryan Burns, DO presented at NRHI's National Summit: *Cost Transparency from the Ground Up* on April 30, 2015. MHI also hosted an April 2015 meeting with local physician leaders to share information on the project and early findings on cost and utilization. Participating physicians confirmed the usefulness of the data in their ongoing efforts to provide higher value care and provided meaningful insights into how the data might be made even more useful for their practices and the St. Louis community.

Early Findings

A Starting Point for Analysis: As with any data analysis project, it is impossible to provide reliable findings or trend information with only one data point. However, this pilot project provides a starting point to better understand variation in cost and utilization among patients with commercial insurance coverage in the St. Louis region.

Figure 1



The three graphs accompanying this section show early findings. Please note these data represent one point in time. They may be subject to fluctuation from period to period and may change with future refinements in attribution and risk adjustment. MHI offers them as a starting point in developing shared understanding of the nature of the analysis and work being undertaken.

Figure 1 above shows the average per-member, per-month spend of adults in the MHI pilot population.

Figure 2 below shows risk-adjusted, average per patient spending for six large St. Louis area primary care groups compared to a risk-adjusted average for all attributed patients in the MHI data set. For example, patients that were attributed to Group E spent $84 more than average. Patients attributed to Group C spent $18 less than average. Figure 3 below shows the spending patterns of patients attributed to primary care physicians. The "Professional" category represents fees to physicians and other health care professionals.

Figure 2

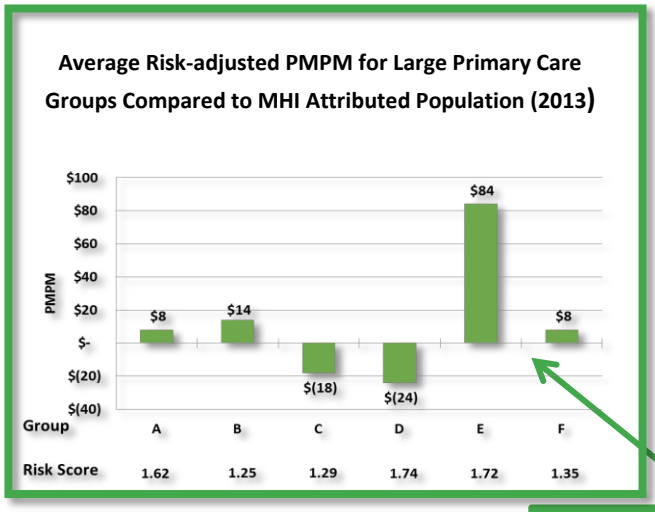
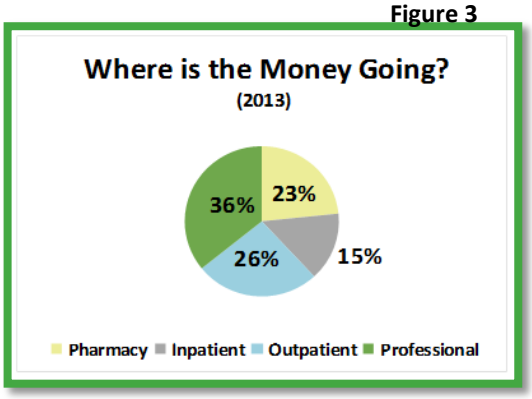


Figure 3



Quality, the Other Half of Value:

MHI is meeting with physician groups individually to share information on the cost and resource use incurred by their patients compared to patients attributed to peer groups. High-quality care is essential to high-value care. With this in mind, MHI is providing these groups early information on variation in care quality along with their cost and utilization results. This next level of reporting makes the total cost of care and resource use results more actionable for physician groups. Not surprisingly, the data suggests that all of the physician groups highlighted had instances where they excelled and areas of opportunity. A sampling of findings is provided on the next page.

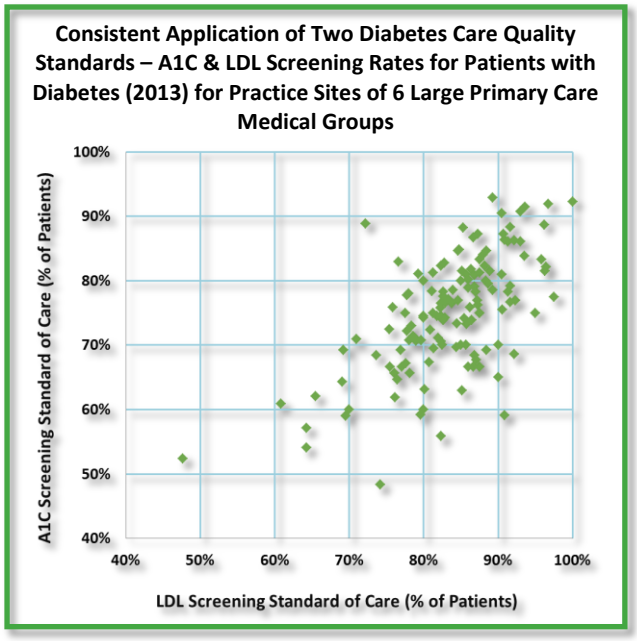
In the coming months, MHI plans to launch a portal by which primary care physicians will have the opportunity to access information on how frequently their patients receive care in line with standardized measures, such as those endorsed by the National Quality Forum.

Examples of Cost, Utilization and Quality Metrics Shared With Physician Groups During the Total Cost of Care Pilot:

- **Total Cost of Care by all patients, adults, healthy adults, chronically-ill adults, and adults with specific chronic conditions such as diabetes and hypertension.**
- **Resource use at the full population-level using the Health Partners measure and more granularly rates of hospital admits and days, advanced imaging and emergency department utilization. The proportions of patients receiving generic medications for certain high-opportunity drug classes of drugs and the ratio of PCP to specialist visits are also included.**
- **Quality measures include diabetes care and appropriate emergency department use.**

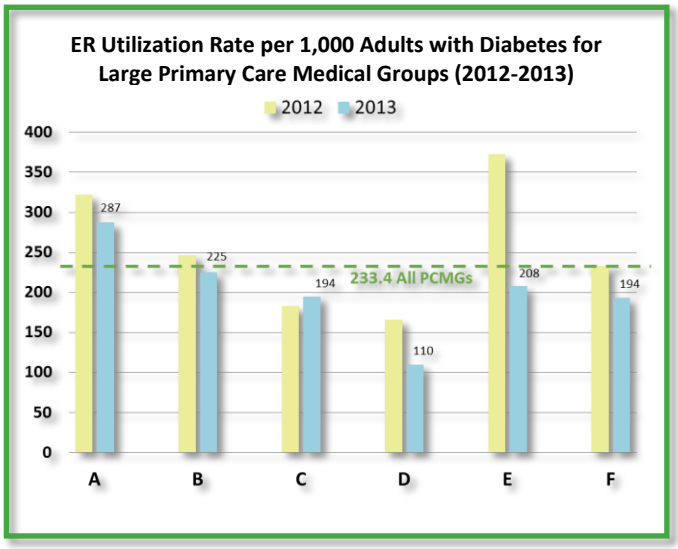
Comparable practice sites' scores on two common measures of high-quality diabetes care are shown below. The results point out those with the most opportunity to improve and offer a goal for practices on their quality improvement journey.

Figure 4



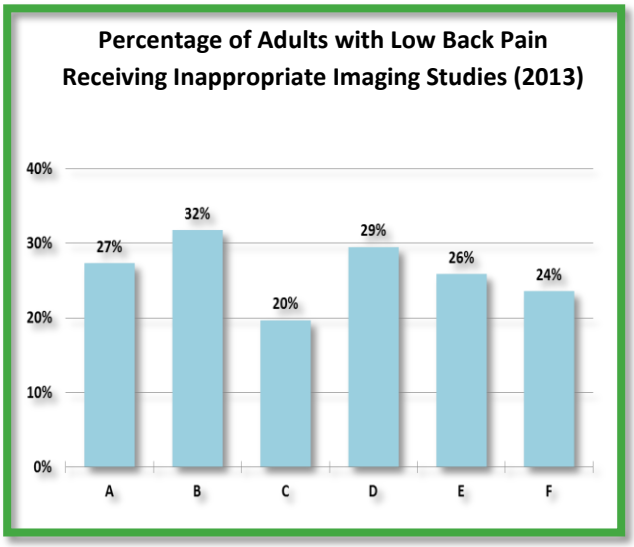
In receiving their groups' results, several physicians have noted they want to better understanding how they are supporting their patients with chronic conditions. The graph below shows fewer adults with diabetes sought care in the emergency department in 2013 than in 2012.

Figure 5



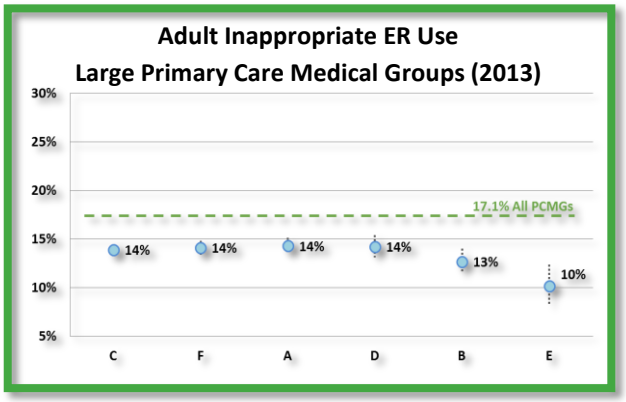
Most of the time, low back pain subsides on its own without surgery. The graph below shows the percent of patients who received an MRI or other imaging study of the low back within 28 days of the initial complaint, a nationally-standardized, NQF-endorsed quality measure.

Figure 6



The graph below shows how often adults attributed to one of six large St. Louis area medical groups visited the emergency department for a diagnosis that likely could have been treated in a physician office or at home. The list of approximately 200 diagnoses deemed to not require ED care was developed by the California Department of Health Care Services. When this same measure was run for the state of Oregon by the Oregon Health Care Quality Corporation, the average for the adult population was 10%.

Figure 7



Next Steps:

MHI is fortunate to have the opportunity to continue to learn from others nationally and support efforts to achieve standardized reporting of quality, utilization and cost data across private and public sector health care purchasers.

Over the next 18 months, MHI will develop results for additional points in time. Further, it will work with its partners to understand which primary care sites are most comparable, whether its current process for attribution reflects the community's preferences and practices and how to provide meaningful companion data to make information on cost and utilization actionable. As noted above, MHI is early in its efforts to measure, understand and share information on cost and utilization. It looks forward to gaining the input of many as to how the data can be most useful to the community.

MHI will host a Community Summit this summer to spread knowledge of this project and facilitate honest, collaborative dialogue on cost and utilization. MHI hopes this forum will add knowledge and perspectives to the ongoing community conversation on these topics. St. Louis' physicians, patients, employers, health plans and hospital leaders best understand how to work together to balance our community's health care needs with its limited resources. MHI looks forward to convening them around these important topics.

Sources:

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Gagnon, E., & Mitchell, E. (2015). *Cost Transparency from the Ground Up: Findings from the Regional Total Cost of Care Pilot Executive Summary.* Portland, Maine: Network For Regional Healthcare Improvement.

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