Governor's Work Group on Health Care Quality and Cost—Project Scope

- A coordinated, statewide approach to corralling health care costs
  - Reduce rate of health care cost growth for State government
  - Reduce rate of health care cost growth for businesses in the State

- Look at everything possible that can:
  - Improve quality
  - Lower costs
  - Increase access

- Make specific recommendations that:
  - Can be implemented under current law
  - Call for legislation next session
  - Can be advocated by the Governor—changes in the broader system and federal government

- Charge:
  - Do not cut the number of people covered by State programs
  - Take risks
  - Be innovative
  - Develop public-private partnerships
Cost Pressures—No End in Sight

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits; 2003. Dental work by Dr. Milstein.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
Employer and Government Share Is Increasing

Health and Related Costs*

appropriated state dollars in billions and as percent of all state fund expenditures

*Includes direct health costs such as Medicaid, Basic Health, public health; plus long-term, institutional, and behavioral health costs.

State Health Costs

dollars in billions - includes direct health programs, public health, institutional care, and behavioral health

All Other Expenditures

Health-Related Expenditures

State Funds Only

All Budgeted Funds

GF-state = $3.4 b
HSA = $0.5 b
Other state = $0.3 b

$4.2
28.3%

$10.6

$14.8 billion

$13.9
34.8%

$7.4

$10.6
$14.8 billion
$13.9
$7.4

Washington State Health Expenditures

Growth in Selected Costs versus Growth in General Fund-State Revenue

Note: MAA growth is a combination of medical cost (avg. 6%) and caseload growth (avg. 6%).
The Problem

To this scene, Halvorson and Isham bring to bear unusually powerful and well-informed insight into the causes of these problems, combined with great clarity of exposition. The causes they describe are many and complex. Their list includes:

- many costly medical miracles
- free access to which everyone feels entitled
- an unsafe, error-prone system that, as often as not, fails to deliver effective and appropriate care
- a widespread belief in entitlement to unproven experimental care and care of very low marginal value compared to its extra cost
- a failure to do proper evaluations of new technologies before general use
- irresponsible politicians who pass laws mandating the coverage of extremely costly but unevaluated treatments (some of which turn out to be worthless or harmful)
- local care monopolies created by mergers of most of the hospitals or most of the doctors in town in a single specialty
- a system that creates cost-unconscious demand for new drugs, permitting drug companies to charge ten times the price for the new drug that is only marginally better than the old one
- high, rising, and unrealistic patient expectations
- serious shortages of nurses and other technically trained personnel, the solution to which will have to include large pay increases
- the relaxation of managed care cost controls forced by the anti-managed care backlash and its accompanying lawsuits.

Alain Enthoven, Forward to Epidemic of Care
Large Employer Health Care Strategies

Data Analysis and Diagnosis
Business and HR Priorities
Enrollment, costs and demographics
Cost drivers and savings opportunities

Traditional Tactics
- Plan Design
  - Types of plans
  - Number of choices
  - Cost Sharing
  - Service-related offerings
  - Pay-related designs
  - Pharmacy
  - Savings/spending accounts

- Contributions
  - Percentage of cost
  - Salary stratified
  - Indexed to plan costs
  - Tiered for family size
  - Risk-related
  - Opt-out credits (cash)

- Financing
  - Funding decision – insured, self-insured, minimum premium
  - Gain sharing
  - Employee self-funding – FSA, HRA

- Vendors
  - Vendor selection
  - Performance measures
  - Clinical capability
  - Operational audits
  - Network strategy
  - Renewal negotiation

Advanced Strategies
- Maintain a healthy workforce
  - Identification of health risks
  - Health promotion programs
  - Self-care assistance
  - Health risk management
  - Incentives for health awareness – risk appraisal participation

- Engage employees in behavior change
  - Raise cost awareness through education and cost sharing
  - Education about cost and health conditions
  - Tools about provider cost and quality
  - Availability of savings accounts

- Focus on high cost population
  - Disease management
  - Case management
  - Maternity programs
  - Advocacy programs
  - Incentives for care management compliance
  - Integrate information and/or care management with disability and worker’s compensation

- Purchase Highest Quality and Most Cost Effective Care
  - High performance network
  - Collective purchasing
  - Supply chain purchasing
  - National initiatives for quality improvement

Source: Mercer Human Resource Consulting
Alternatives to Medical Impoverishment, Uninsurance, and Service Rationing:

A. Slow the growth rate of payable provider prices (not rated)
B. Incentivize greater beneficiary stewardship of care spending ★ (Consumer Incentives, Small Business Supports)
C. Reduce intensity of services, especially for “flat-of-curve” care ★★ (Less Unnecessary Utilization)
D. Improve health industry’s production efficiency ★★★ (IT, Safety, Prevention, Disease Management, Collaboration, Medicaid Innovation Waivers)

Note: Linkage to Governor’s 9 priorities are mapped within parentheses. “Other ideas” – evidence-based medicine, dissemination of quality info and improved agency coordination – also link primarily to option D.
A Near-Term Vision that Benefits All Stakeholders

- Performance comparisons for hospitals, MDs & treatments
- Market sensitivity to hospital & MD performance
- Consumerism (Tiered Plans w or w/o Spending Accounts) & P4P
- Clinical re-engineering by MDs, hospitals & hlth risk reductn programs
- Chasm Crossing

Efficiency of Health Benefits Spending (Health Gain / $)

High

- Performance Transparency (Quality & Cost Efficiency)

Low

2002 2012

Evolutionary Path

Americans

Q = % adherence to evidence-based rules

$ = Per capita health care spending. Includes new investment in IT / industrial engineering capability. Excludes impact of inflation, aging and biomedical innovation
A Similar Vision from the Institute of Medicine

CARE SYSTEM RE-DESIGN IMPERATIVES
- Redesigned care processes
- Effective use of information technologies ★★★★★
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time
- Use of performance and outcome measurement for continuous quality improvement and accountability

Supportive (i.e., performance-sensitive) market environment
Organizations that facilitate the work of patient-centered teams
High performing patient-centered teams

EMPLOYERS
GOVT PLANS

BETTER OUTCOMES
- Safe
- Effective
- Efficient
- Personalized
- Timely
- Equitable

Source: Adapted by Arnie Milstein, M.D., from Crossing the Quality Chasm, IOM, 2001
Less Flat-of Curve Care & More Production Efficiency: Specific Vehicles and Their Yields

Estimated Static Savings From Linking Beneficiaries With More Efficient Options

Source: 2002 Mercer Report to Business Roundtable
Incentivizing Robust Re-Engineering of Health “Production” is the Only Infinite Method of Stabilizing Health Care Spending

MD Longitudinal Cost Efficiency Index AKA “TCO”
(total cost per case mix-adjusted treatment episode)

Adapted from Regence Blue Shield
Outswimming the Shark for 12 Months Primarily Via Use of More Efficient MDs Who Use Less “Flat-of-Curve” Care

Per Capita Health Care Spending
(Low Wage Hotel Workers in Nevada)

Source: Arnie Milstein, M.D., Mercer Human Resource Consulting
Goals

1. Reduce State’s health care cost Trend to no more than the State of Washington’s revenue trend

2. Improve the quality and cost-efficiency of health care services

3. Improve the health of Washington residents

4. Increase the number of insured Washington residents by improving the affordability of health care
1. Purchase high quality and cost-efficient care
2. Create an improved market for buying health care
3. Focus on the high health care cost population
4. Support health promotion and health education of State beneficiaries
5. Increase the insured population
Initiatives

- Improve PEBB procurement to improve quality and cost.
- Medicaid Cost Containment
- Centralized, collaborative, evidenced based set system to set priorities and determine what the State will pay for.
- Effectively manage the ‘High Opportunity’ populations insured or sponsored by the State – 5%-50% population
- Promote the transparency of health plan and provider performance.
- Reduce the impact of State administrative impacts on providers
- Improve the insurance market for small employers and individuals
- Prevention and Wellness for State Employees and Beneficiaries
- Encourage technology improvements in patient/provider information
- Explore the creation of an Institute for Clinical Performance Improvement
Key Messages

- Quality problems and Variability are driving Health care costs—this can’t continue
  - **State revenue growth is 4%, health care growth trends are 10%**
    - Health care cost increases take away from education and other priorities
    - Rising health care costs are negatively impacting jobs, wages and employer provided coverage
    - As we pay more for health care, cuts hurt safety nets like clinics and Basic Health
  - **We’re spending more on health care, but the population is less healthy**
    - Children born today face a lower life expectancy than you or I
    - Increases in diabetes, obesity, heart disease
  - **Significant Quality issues drive increased costs**
    - RAND: Americans get evidence-based care only 55% of the time
    - IOM: up to 98,000 Americans die each year due to avoidable medical errors
    - NCQA: up to 79,000 Americans die each year due to quality gaps
    - CDC: 2 million patients acquire infections in the hospital each year => 90,000 die
**Key Messages**

**Priority Actions to Achieve the Goals**

- In State purchasing of health care we can be a force for higher quality and lower costs

- We need to create an improved market for health care
  - We will use State purchasing and collaborative efforts to promote transparency of health plan and provider performance
  - We will promote the use of electronic medical records

- We will develop programs to ensure appropriate utilization by clients of State programs who are high cost patients
  - 5% of the population is responsible for 50% of the costs—we need to be sure their treatment is appropriate, high-quality and cost-effective

- We will provide effective prevention and wellness programs for clients of State funded health care programs
Priority Actions to Achieve the Goals (continued)

- We will reduce the number of uninsured residents by making health care more affordable
  - Make the health care marketplace more affordable for employers
  - Restructure insurance regulations to better address quality and cost-efficient health care
  - Develop small business assistance strategies
Next Steps

**Action Items**

1. Further refine work plan details and develop key strategies
2. Review approach and implications with key stakeholders
3. Plan the details of the Health Care Summit (scheduled for Fall / Winter 2005)
4. Develop a process to monitor progress and link to the legislative calendar
Health Care Quality Defects Occur at Alarming Rates

Sources: modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint; Premera 2004 Quality Score Card; March of Dimes
What’s Wrong? Quality Performance Is Too Low

- RAND: Americans get evidence-based care only 55% of the time
- IOM: up to 98,000 Americans die each year due to avoidable medical errors
- NCQA: up to 79,000 Americans die each year due to quality gaps
- CDC: 2 million patients acquire infections in the hospital each year => 90,000 die
Patients get recommended care only half of the time; consequences are avoidable.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Shortfall in Care</th>
<th>Avoidable Toll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Average blood sugar not measured for 24%</td>
<td>2,600 blind; 29,000 kidney failure</td>
</tr>
<tr>
<td>Hypertension</td>
<td>&lt; 65% received indicated care</td>
<td>68,000 deaths</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>39% to 55% didn’t receive needed medications</td>
<td>37,000 deaths</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>36% of elderly didn’t receive vaccine</td>
<td>10,000 deaths</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>62% not screened</td>
<td>9,600 deaths</td>
</tr>
</tbody>
</table>

Source: Elizabeth McGlynn et al, RAND, 2004
Surgery for Back Pain
Back Surgery

HRRs Benchmarked to Seattle, WA for:
"Back Surgery per 1,000 Medicare Enrollees (2001)"

- 1.33 Spokane, WA
- 1.33 Tacoma, WA
- 1.23 Olympia, WA
- 1.00 Seattle, WA
- 0.97 Yakima, WA
- 0.73 Everett, WA

Ratio to Benchmark

0.5 0.75 1.0 1.25 1.5

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Sample Process Reengineering in Dr’s Office
An Initial “Rebuild” of an Ophthalmology Visit

- **Before**
  “we’re doing everything we can think of…we need more money!”
  - Traditional model
    - 1 assistant/MD
    - Staff poorly trained
    - 2 rooms/MD
  - 22 patients/day/MD
  - 3 month wait for consult
  - Patient Satisfaction = 63%
  - Provider Satisfaction = 90%
  - $60 per visit
  - $22.31 per beneficiary/year

- **After**
  “we’re doing what we didn’t know about before…we need less money!”
  - Engineered model
    - 3 assistants/MD
    - Staff highly trained
    - 4 rooms/MD
  - 50 patients/day/MD
  - No wait for consult
  - Patient Satisfaction = 85%
  - Provider Satisfaction = 94%
  - $43 per visit
  - $14.91 per beneficiary/year
Sample Process Reengineering in Hospital
An Initial “Rebuild” of an ICU Stay

The Bottom Line: 54% reduction in mortality and 21% reduction in costs in average hospital. 20% and 20% in a “top” hospital.
Steve Hill was appointed Administrator of the Washington State Health Care Authority (HCA) in April 2005. A cabinet level agency, the HCA administers health-care benefits to more than 400,000 Washington residents through the Basic Health program for low-income residents, and the Public Employees Benefits Board (PEBB) program for state government workers and retirees. Combined, the two programs administer over $1.2 billion in benefits annually. The HCA also administers the Community Health Services program that provides state funding to community clinics; the Prescription Drug Program (known as Rx Washington) designed to reduce state spending on drugs; and the Uniform Medical Plan, a preferred provider plan utilized by more than a third of PEBB enrollees.

In announcing his appointment, Governor Christine Gregoire named Hill to lead a team of public and private sector health-care leaders to make specific recommendations to contain health-care costs. The group will investigate effective uses of technology, consumer incentives, wellness promotion, and other avenues to reduce health care’s increasing impact on the state’s budget.

Hill retired from Weyerhaeuser Co. where, as senior vice president of human resources, he led wellness efforts for thousands of employees and worked to contain the company’s health-care costs. He helped form, and served as president, of the Health Care Purchasers of Puget Sound, a group representing employers who sponsor health-care insurance. He also has served on the state’s Hospital Rate Setting Commission.

A former Regent for Washington State University, Hill received a bachelor of science degree in forest management from the University of California at Berkeley in 1969. In 1971, he received a master of business administration degree from the University of California at Los Angeles. He is a member of the first class of the American Leadership Forum Chapter for Tacoma-Pierce County, and on the board of directors for the Seattle Symphony, Hilltop Artists in Residence, and the Washington Public Affairs Network (TVW). He was elected a member of the National Academy of Human Resources in the Class of 2000. In 1978, he was appointed a White House Fellow and served as a staff assistant in the Office of the Secretary, U.S. Department of Energy. He is past president and board member of the White House Fellows Association.

Hill lives in Tacoma, Washington with his wife Sandy. They have two adult daughters.