The Better Care Plan for Continuously Improving the U.S. Healthcare System

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Where We're Going

The Problem

Blueprint Pillars

Seven Design Principles

Seven Team Based Care Criteria

Recommendations

Conclusion

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We Underperform

WE DO WELL ON SOME PREVENTION MEASURES BUT ARE LAST AMONG 11 HIGH INCOME COUNTRIES ON…

- Access to Care
- Administrative Efficiency
- Equity
- Healthcare Outcomes
- Overall Ranking

For example: Our premature excess death rate is over twice that of the U.K.

The Commonwealth Fund, 2021

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Underperformance Continued…

- Our maternal mortality is 3x that of France - 23.8 to 7.6 per 100k births
- High variability in maternal mortality by state - Arkansas 49.5 per 100k births vs. California 11.7 per 100k
- We rank 33rd out of 36 industrialized countries for highest infant mortality rate - 95.4 per 1000 live births
- Hospital mortality can vary by 3 to 1
- Hospital complications vary by 6.2 to 1

Source U.S. National Center for Health Statistics and OECD, Amory Associates, CMS Database

We Are Costly

Nearly 20% of our GDP spent on healthcare - over 4 trillion

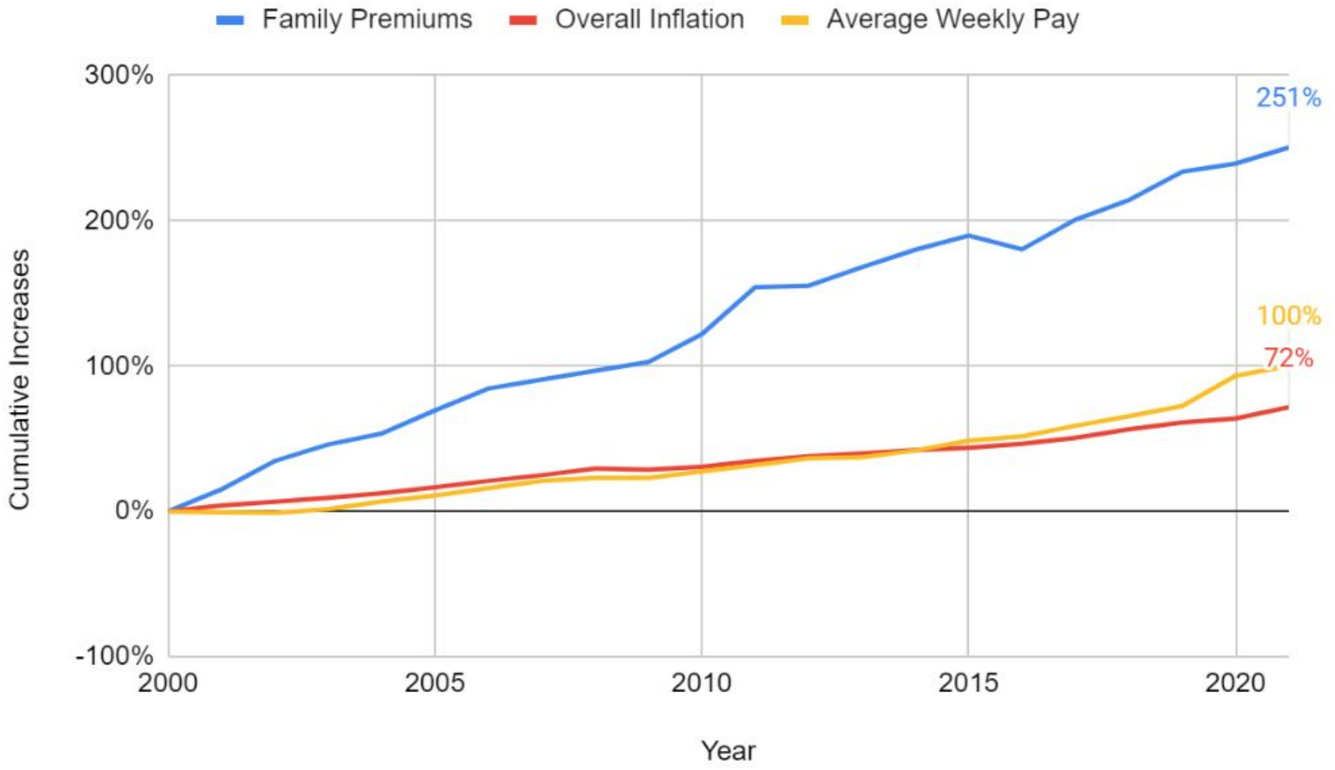
$405 billion spent on healthcare in California

California has exceeded the $10,299 per person U.S. average for the first time since 1991

California's annual rate of increase has grown faster than the U.S. since 2010 - 4.7% vs. 3.6%

2023 Edition, California Healthcare Spending – Wilson Analytics

Premiums, Inflation, and Weekly Pay in California, 2000-2021



Notes: Petris Center analysis of data from MEPS-IC (family premiums), the California Department of Finance (inflation), and the California Employment Development Department (average weekly pay).

Affordability

- 52% OF CALIFORNIANS REPORTED THEY SKIPPED OR POSTPONED CARE BECAUSE OF COSTS

- 36% REPORTED HAVING MEDICAL DEBT

- HALF OF PEOPLE WITH LOWER INCOMES REPORTED MEDICAL DEBT VS 30% OF THOSE WITH HIGHER INCOMES

- LATINOS (52%) AND BLACKS (48%) REPORTED MEDICAL DEBT VS 28% FOR OTHER POPULATION GROUPS

Source: LR Bailey et al. The 2023 CHCF Health Policy Survey, California Healthcare Foundation

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Three Major Pillars for Improvement

CHANGE HOW WE PROVIDE CARE	CHANGE HOW WE PAY FOR CARE	CREATE NATIONAL TRANSPARENCY AND ACCOUNTABITY
Proactive not reactive; relational not transactional	Risk adjusted prospective payments	In terms of patient safety and quality of care outcome reporting

Seven Design Principles

INTEGRATED, COORDINATED, TEAM-BASED, TECHNOLOGY-ENABLED PATIENT-CENTERED PRIMARY CARE

CONTINUOUS IMPROVEMENT OF CARE

CONTINUOUS EFFORTS TO ELIMINATE INEQUITIES IN CARE

RISK-ADJUSTED PROSPECTIVE PAYMENT TO PROVIDER ORGANIZATIONS

PATIENT ACCESS TO PERSONAL HEALTH RECORDS AND INFORMATION ON PLAN/PROVIDER ORGANIZATION PERFORMANCE

TRANSPARENCY AND ACCOUNTABILITY OF PATIENT SAFETY AND QUALITY OF CARE OUTCOME PERFORMANCE MEASURES TO BE USED BY CONSUMERS, PURCHASERS AND THOSE HELD ACCOUNTABLE FOR CONTINUOUSLY IMPROVING CARE

COMPETITION BASED ON PATIENT SAFETY AND QUALITY ACCESS, AND PRICE.

Advantages of Team Based Care

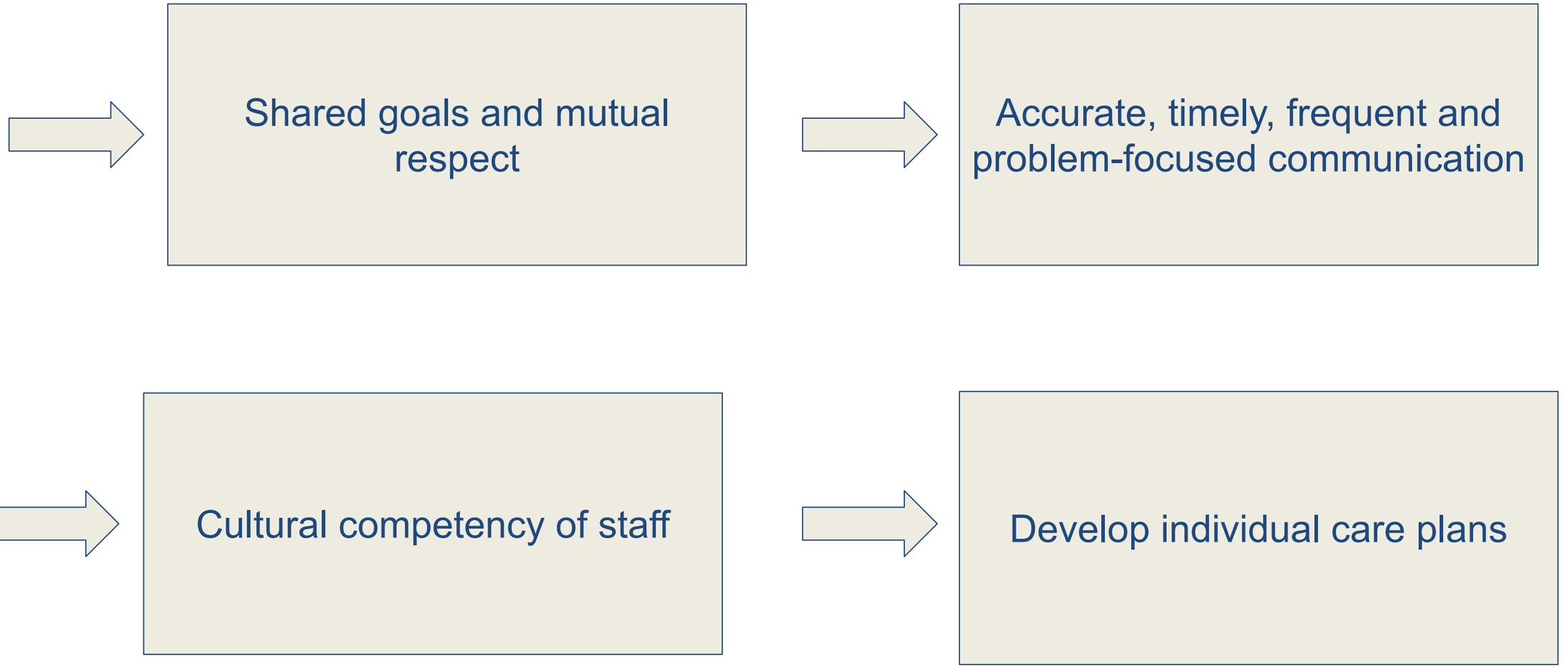
- Needed to manage patients with complex chronic illnesses
- Patients experiencing care with poor teamwork are 5 times more likely to have complications or death from surgery compared to patients with better functioning teams (Pubmed.ncbi.nlm.nih.gov/10929993/)
- A review of 31 studies found well-functioning teams performed better on multiple performance measures including postoperative complications and blood-stream infections

  (Pubmed.ncbi.nlm.nih.gov/15586830/)
- Many new innovative care models are based on team-based care

Seven Team-Based Criteria

1. **Collaborate** with patients in setting goals and developing care plans
2. **Coordinate** and arrange for all needed care (speciality, behavioral, etc.) across sites and providers over time
3. **Be accountable** for patient safety, health outcomes, and cost of care
4. **Continuously improve care** – central to the group's culture
5. **Provide access** to point-of-care performance data by those providing care
6. **Use every team members competencies** to the fullest – practice at "top of license"
7. **Identify** high risk patients and allocate resources based on need and patient preferences and eliminating disparities and inequities in care

Additional Elements of Team Based Care



Continuous Quality Improvement - Operational Excellence

- Continuous Learning
- Team Based And Data Based
- Plan, Do, Study, Act (PDSA) Cycles
- Develop Problem-Solving Skills Of Everyone
- Alignment At All Levels Of The Organization

Evidence of Impact

- National study of 1200 hospitals found positive associations with higher patient experience scores, lower adjusted inpatient expense per admission, lower 30 day unplanned readmission rates, and less use of low value care without a negative impact on overall mortality *(Shortell, Rundall, Blodgett, et al, Joint Commission Journal, 2021)*

- Significant declines in heart attack mortality *(healthgrades.com/umass-memorial-medical center-hgstd4d52386220163)*

- Improved patient flow during the pandemic *(Xenophon and Toussaint , New England Journal of Medicine Catalyst, Nov-Dec, 2020, 1(6)*

- Marked decline in sepsis death rates from 20% to 3% *((Crawford, Skeath, and Whippy, Critical Care, 2012, 16 (suppl 3);12)*

Risk Adjusted Prospective Payment

- Per member per month payment creates “health budgets” for provider organizations
- Incentive for prevention, keeping people well, and continuously innovating to improve care
- Predictable revenue stream for provider organizations
- Need to move all payers/plans to risk adjusted prospective payments to provider organizations

Evidence of Impact

- Organizations that have more risk-adjusted prospective payment have generally higher clinical quality of care and lower total cost of care (Agarwal et al., Health Affairs, June, 2021,40(6)

- Medicare Advantage uses risk-adjusted prospective payment to pay providers - clinical quality performance is higher for these patients than those in traditional Medicare (Landon et al., Health Affairs, April, 2023, 42:4)

Risk Adjustment Important

Audited Encounter Data

Incorporate Social Determinants Of Health

Area Deprivation Index

Patient Safety and Outcomes Data Reporting

- Define what will be measured – selected risk adjusted outcomes by race/ethnicity

- Mandate reporting with national laws and regulations

- Reduce reporting burden- take advantage of artificial intelligence (AI) technology

- Test and refine

- Easy to interpret and read – numerical grades like FICO credit scores

Central Recommendation

1. Certify health plans and provider organizations that meet the better care plan principles and criteria

2. Create an entity or entities that will do this

Recommendations to Increase Primary Care Capacity

- Medical schools/health science professional schools assure students have content on teamwork, CQI processes, and completion of improvement projects. same for continuing medical education (CME) programs
- Expand incentives for students to choose careers in primary care
- Support Senate bill s. 834 to increase the number of residency slots in rural areas and health professional shortage areas. also training sites for other health professionals
- Create a national healthcare professional licensing body to define common nationwide competency standards for professional practice for nurse practitioners, physician assistants, pharmacists, and other healthcare professionals to fully utilize their training in providing team-based care

Recommendations to Make Risk Adjusted Prospective Payment the Norm for Paying for Care

- Hospitals/health systems should accept risk adjusted prospective payments from all payers
- Medicare should move all of Medicare to risk adjusted prospective payment following the lead of the Medicare advantage program
- All state Medicaid plans should use risk adjusted prospective payment
- Medicare special needs plans (SNPS) should be made available to all beneficiaries who are eligible for both Medicare and Medicaid
- Employers of 50 or more employees should offer at least one health plan to their employees based on the better care plan design principles and criteria
- Medicare and Medicaid beneficiaries should be able to compare their plan choices side by side on enrollment information sites
- States should ensure that price data is organized, understandable, and available to employers, patients, and related groups.

Recommendations to Establish National Patient Safety and Health Outcomes Reporting

- Congress should direct DHHS to establish a data reporting protocol to be used by all electronic health record vendors to enable the reporting of health outcomes by all payers
- CMS should establish a national committee convened by the National Quality Forum (NQF) or the National Committee on Quality Assurance (NCQA) or similar entity to define a small number of high priority clinical outcomes that can be captured electronically and reported on a daily basis broken out by race/ethnicity and used to continuously improve care and facilitate plan and provider organization comparisons
- The NQF or NCQA or similar entity should convene experts to develop relevant, reliable, valid measures of diagnostic errors and recommend how these can be identified and reported on by provider organizations and clinical sites of care – overall and by race/ethnicity
- House Bill HR 4377 creating a national patient safety board should be supported to create a national repository of the best safety practices
- An accreditation body such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO) should be charged with overseeing the patient safety practices are being implemented and improved and that each organization is complying with safety reporting requirements

Implementation Challenges

- LONG ENTRENCHED FEE-FOR-SERVICE PAYMENT SYSTEM
- A CENTURY OF HABITS INSTILLED IN MEDICAL AND HEALTHCARE PROFESSIONAL EDUCATION AND TRAINING
- HIGH DEGREE OF VARIANCE ACROSS AND WITHIN STATES
- A COMBINATION OF POLICY “CARROTS AND STICKS” WILL BE NEEDED

Conclusion

1. **All three pillars are needed- changing how we pay for care, deliver care, and are accountable for care delivered**

2. **Need to spread current "pockets of excellence" throughout the country**

3. **Everyone deserves accessible, continuously improving, equitable and affordable care**

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