

From Network to Neighborhood: Who is in the neighborhood, what are they doing, and what is my role?



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Patient Centered Primary Care Collaborative
February 10, 2009



Medical Home: Overarching goals.....

Medical Homes: The Information Exchange Challenge

By Myles Maxfield, Hoangmai H. Pham
and Deborah Peikes

Closing the Circuit Among Medical Homes, Patients and Other Providers

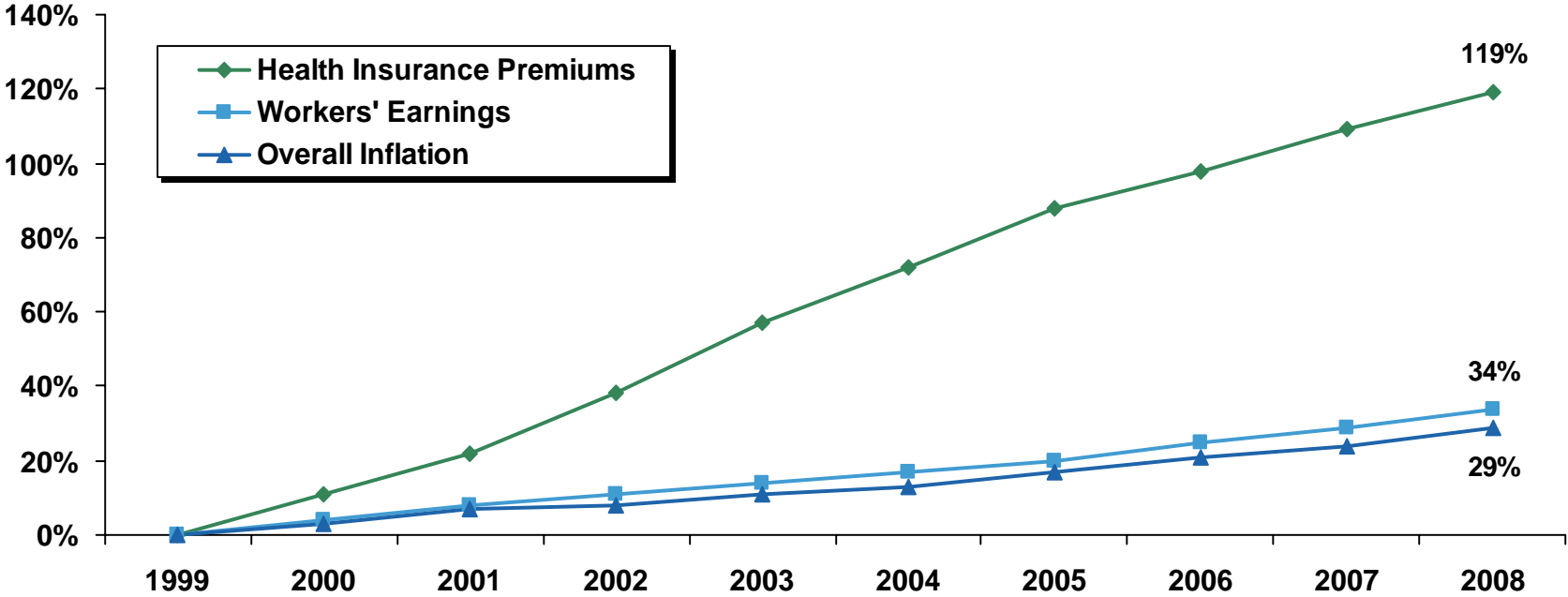
Medical home initiatives typically have two overarching goals—to reduce costs and improve the quality of care.

Outline

- **Market Forces and framing the issues**
- Who is in the neighborhood and what are they doing?
- How do physicians 'influence' care?
- A new role for the primary care team?

The Big Picture:

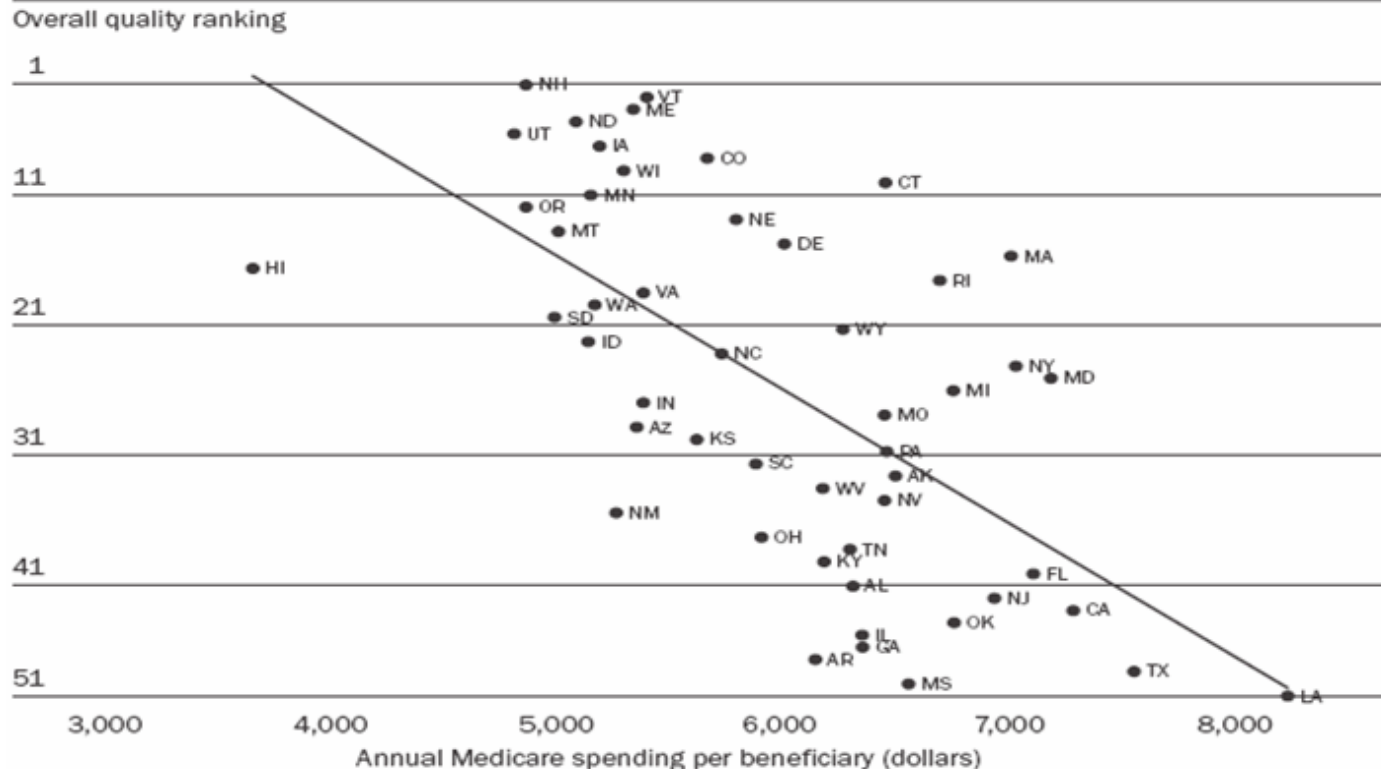
■ Insurance premiums, inflation, earnings



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April).

Relationship Between Quality and Medicare Spending

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

NOTE: For quality ranking, smaller values equal higher quality.

Unwarranted Variation

- Variations that cannot be explained on the basis of illness, scientific evidence or well-informed patient preferences

Effective Care: “Proven effectiveness, no significant trade-offs”

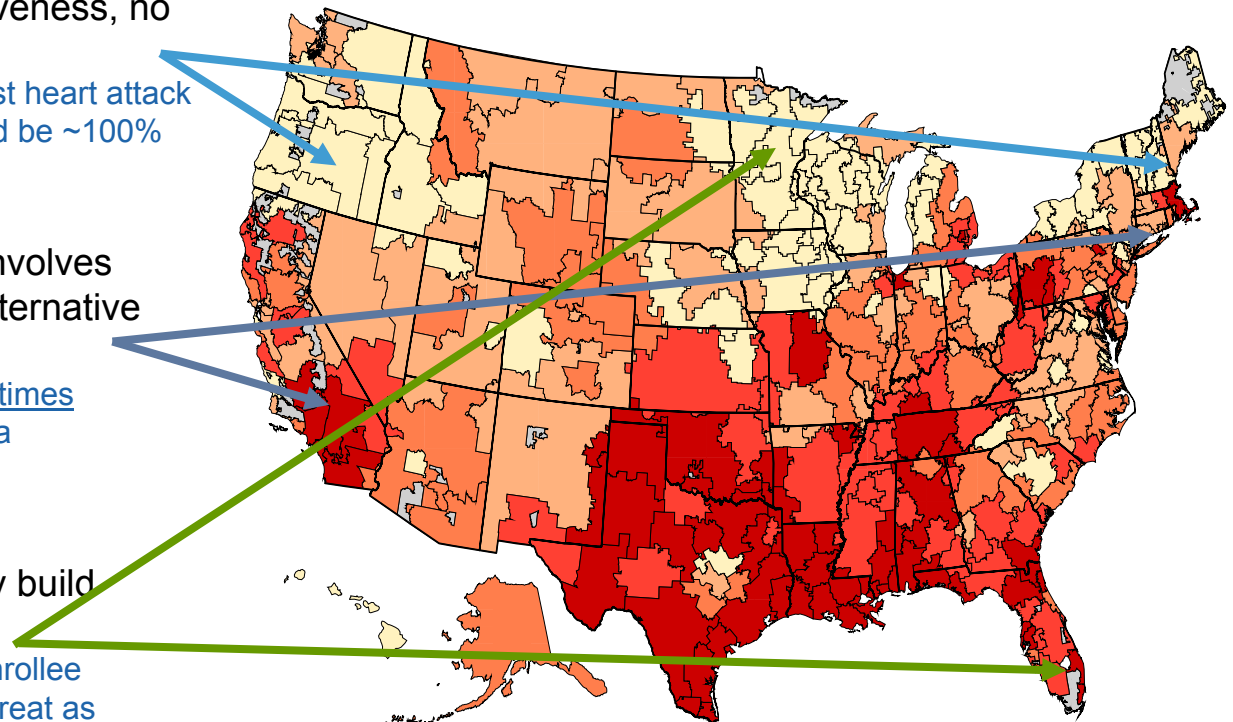
Beta blocker use among patients post heart attack varies from 5% - 92%, when it should be ~100%

Preference-Sensitive Care: “Involves trade-offs, (at least) two valid alternative treatments are available”

In Southern California, a patient is 6 times more likely to have back surgery for a herniated disk than in New York City

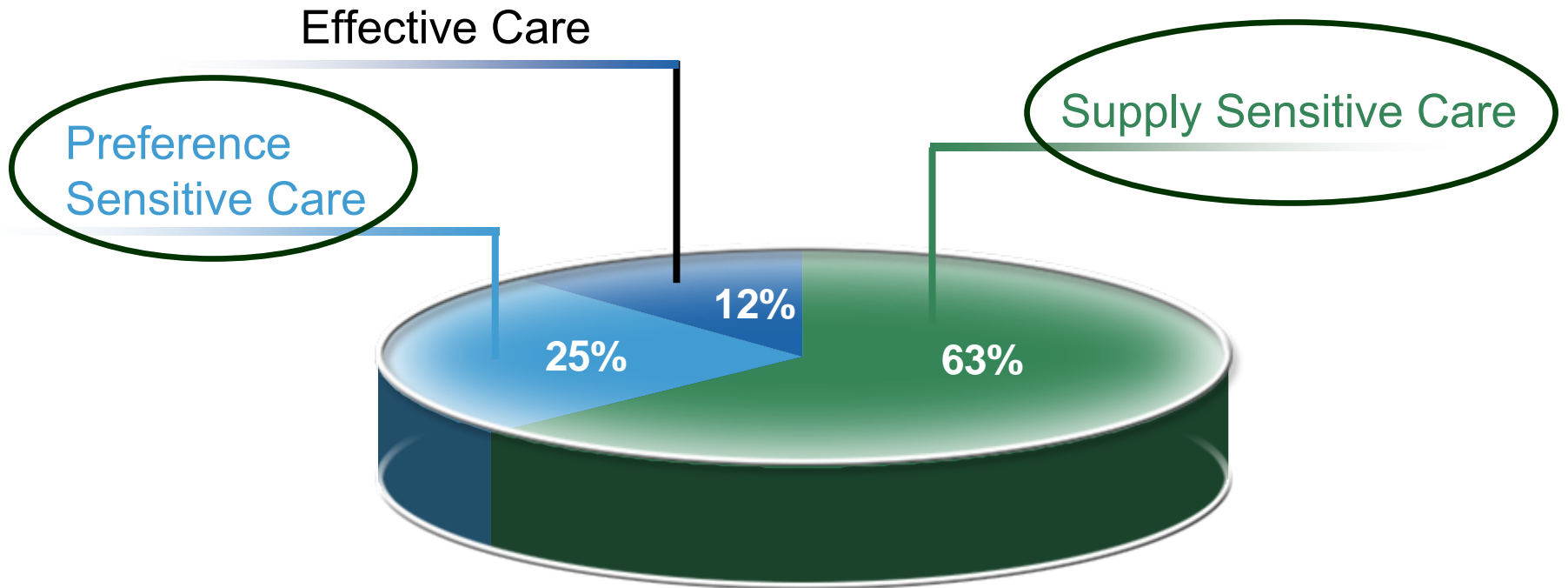
Supply Sensitive Care: “If they build it you will come”

Per-capita spending per Medicare enrollee in Miami, FL is almost 2.5 times as great as in Minneapolis, MN

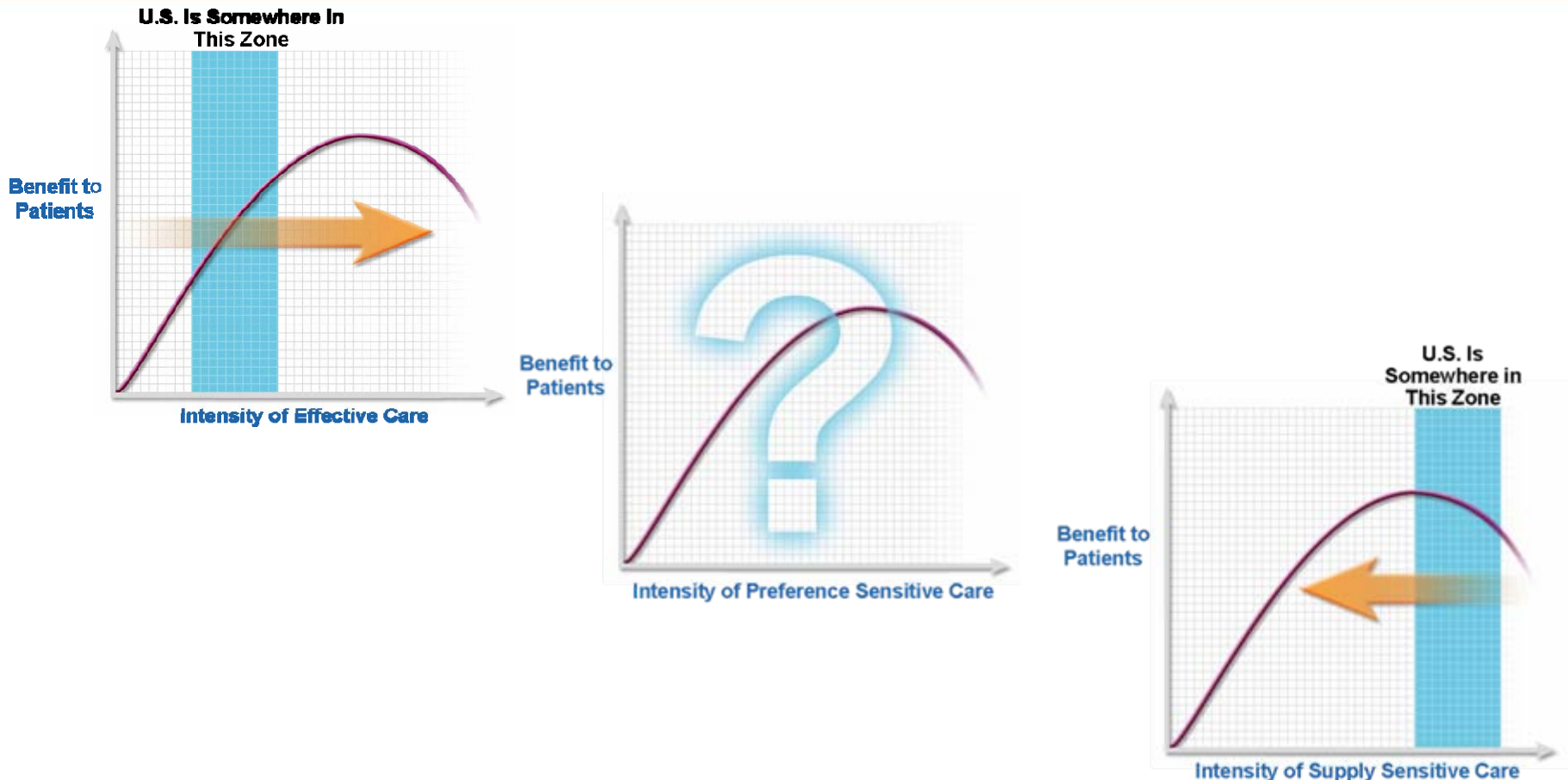


Unwarranted Variations

- Proportion of Health Care Costs Attributed to the three Categories of Care



Causes and goals for reducing Unwarranted Variation differ by bucket



- Addressing Unwarranted Variation and implementing successful Medical Homes are intertwined

Outline

- Market Forces and framing the issues
- **Who is in the neighborhood and what are they doing?**
- How do physicians 'influence' care?
- A new role for the primary care team?

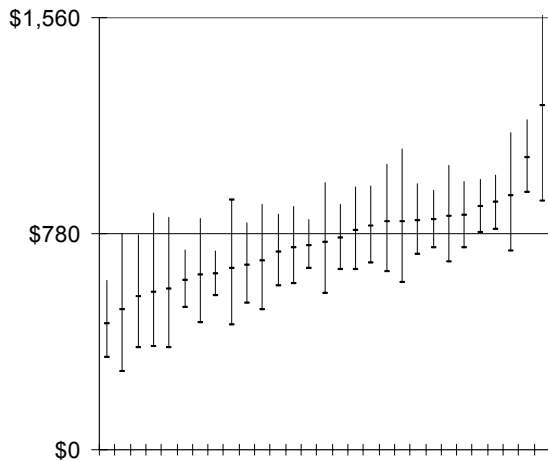
Methods (in one slide....)

- 100% physician, facility and pharmacy data
 - Dominant payor in market (>65% market share)
 - 3 years data
 - One market area
- Patients linked by algorithms
 - Patients to physicians
 - Physicians to groups
 - Groups to hospitals
- Risk and panel size adjusted, price insensitive measures
 - Age, race, income, morbidity
 - Resources measured by RVUs and facility cost weights

In my neighborhood, efficiency varies dramatically....

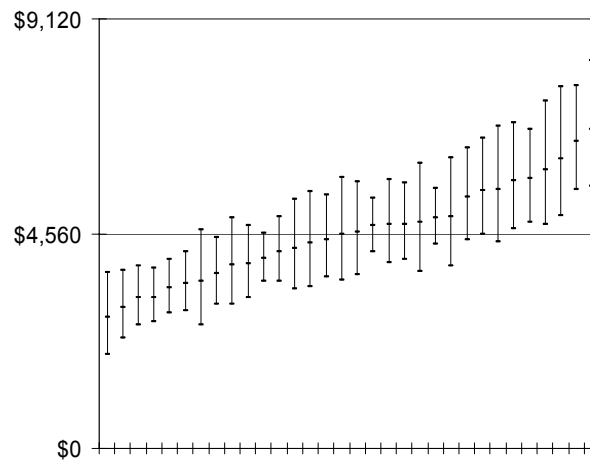
- Efficiency varies at all levels
Medical Home, Neighborhood, Community
- System Efficiency depends on
Efficiency at all levels, Utilization of levels

Primary Care*



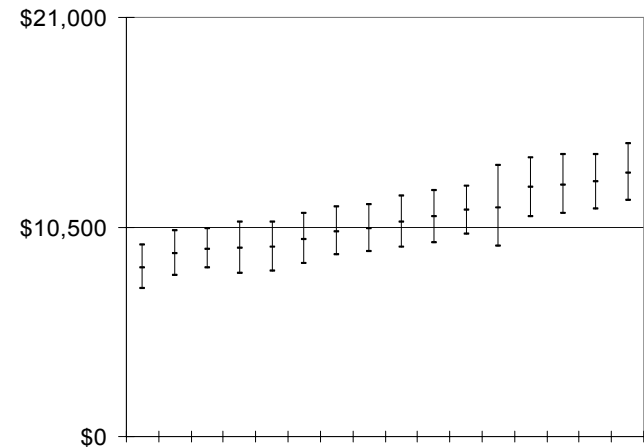
PCP Groups

Secondary Care *



Specialist Groups

Inpatient Care *

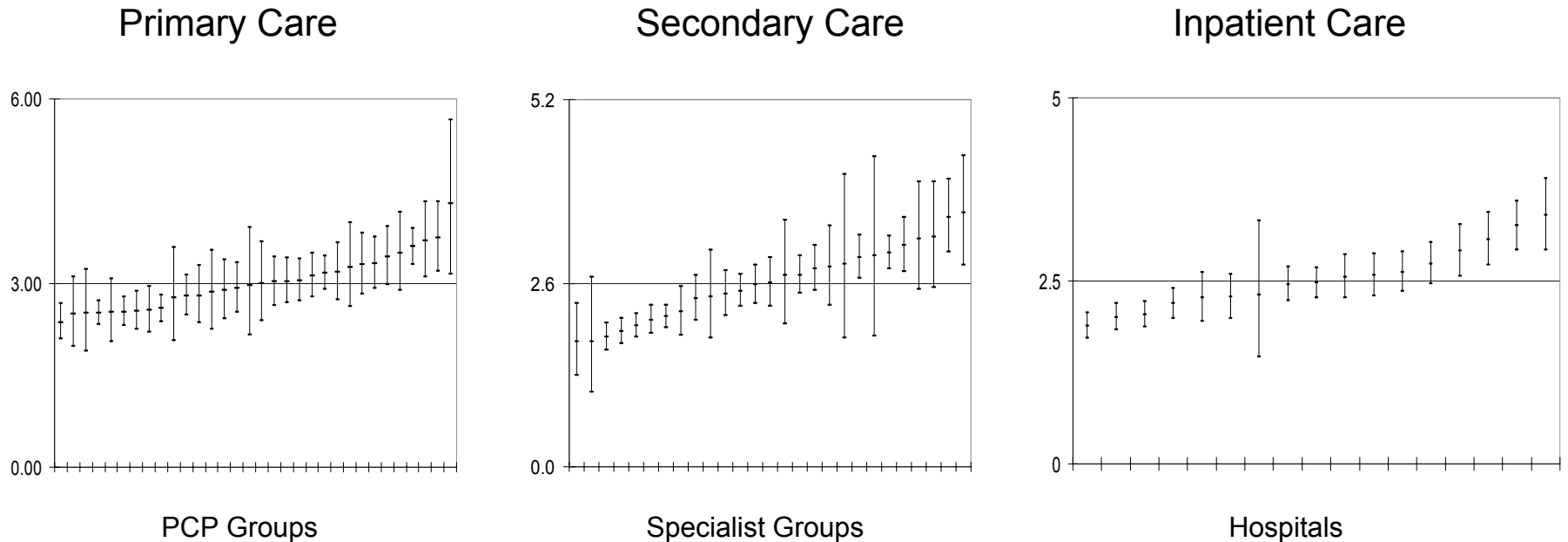


Hospitals

* Risk adjust evaluations, adjusted for sample size.

As does effective care (summary Gap score)

- Quality also varies at all levels
- System Quality depends on quality at all levels



* Risk adjust evaluations, adjusted for sample size.

Preference Sensitive Surgeries

- Rates of preference sensitive surgeries vary widely by primary care group, within a geographic area

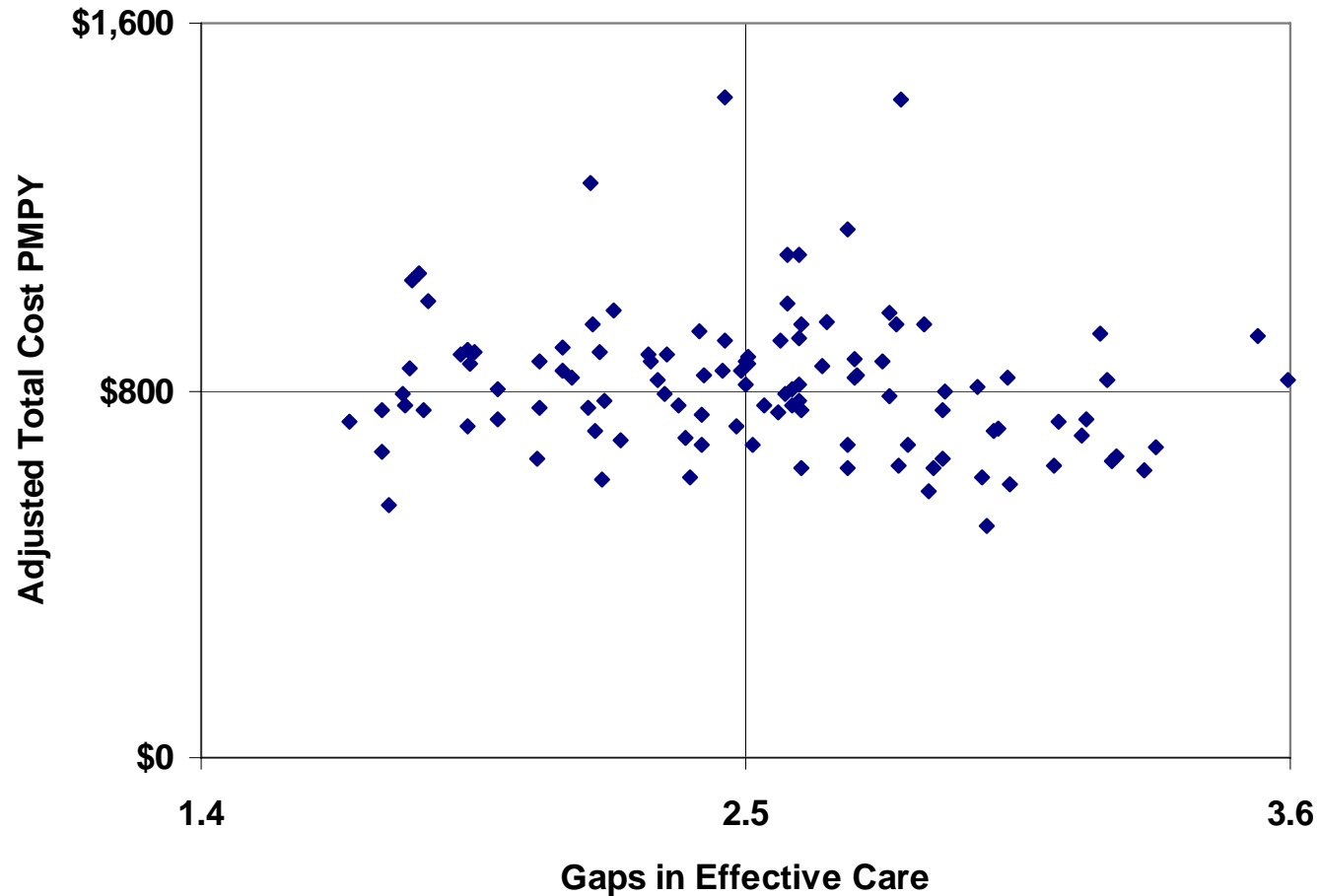
Preference Sensitive*	Min	Median	Max
Hip Repair Surgeries	1.17	1.38	2.04
Knee Repair Surgeries	0.45	0.62	0.87
Lumbar Back Surgeries	1.14	1.38	1.59
Cardiac Revascularization Procedures	1.02	1.30	1.72
Hysterectomy for BUC	1.19	1.68	3.27
Prostatectomy for BPH	1.18	1.89	7.53

* **60 – 600% variation** in rates per 100 members with qualifying conditions, risk adjusted, adjusted for sample size.

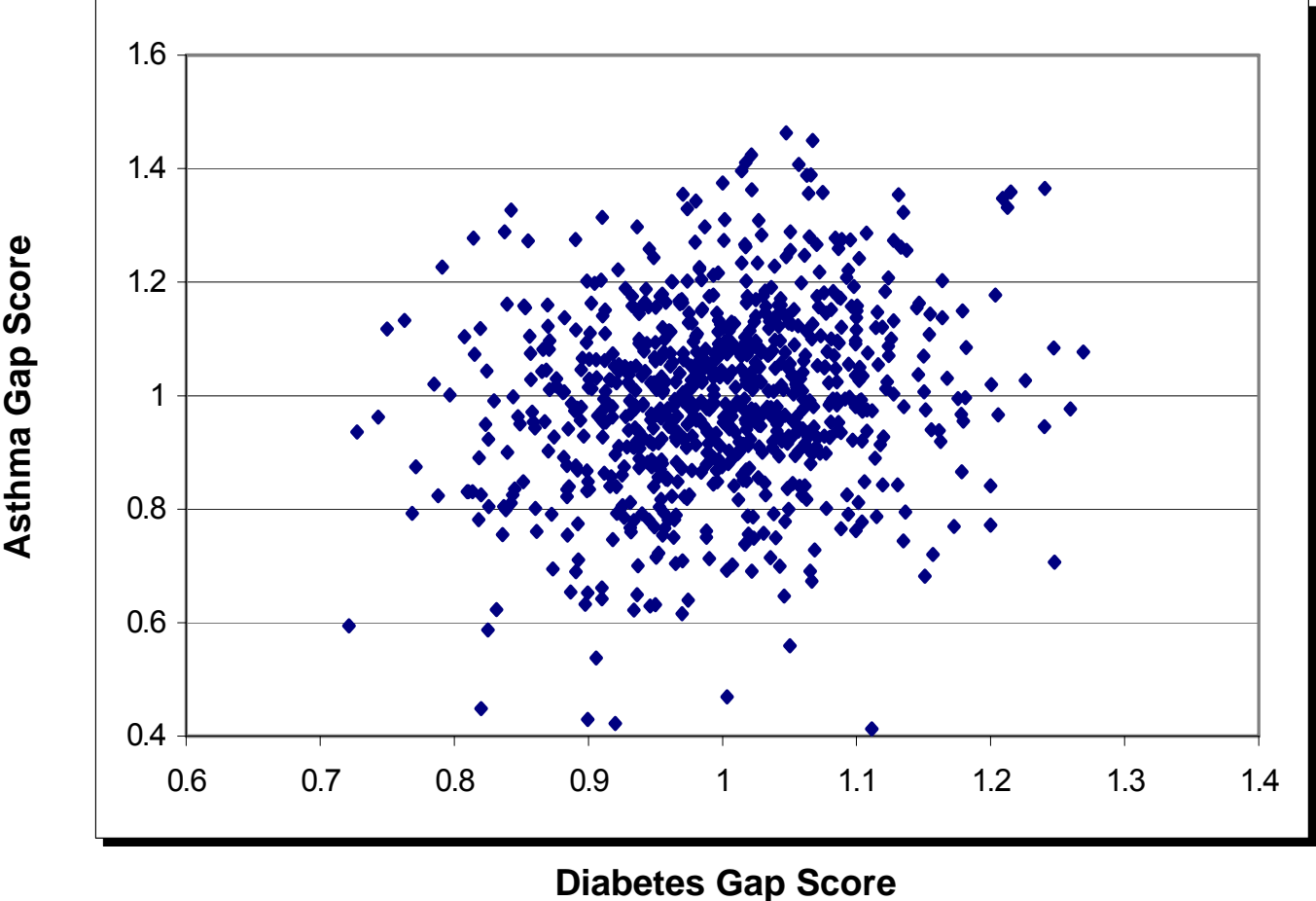
One-hundred eighteen primary care groups in a community.

Unfortunately, efficiency and quality performance are uncorrelated

- No correlation between effective care and efficient care ($r^2=0.02$)



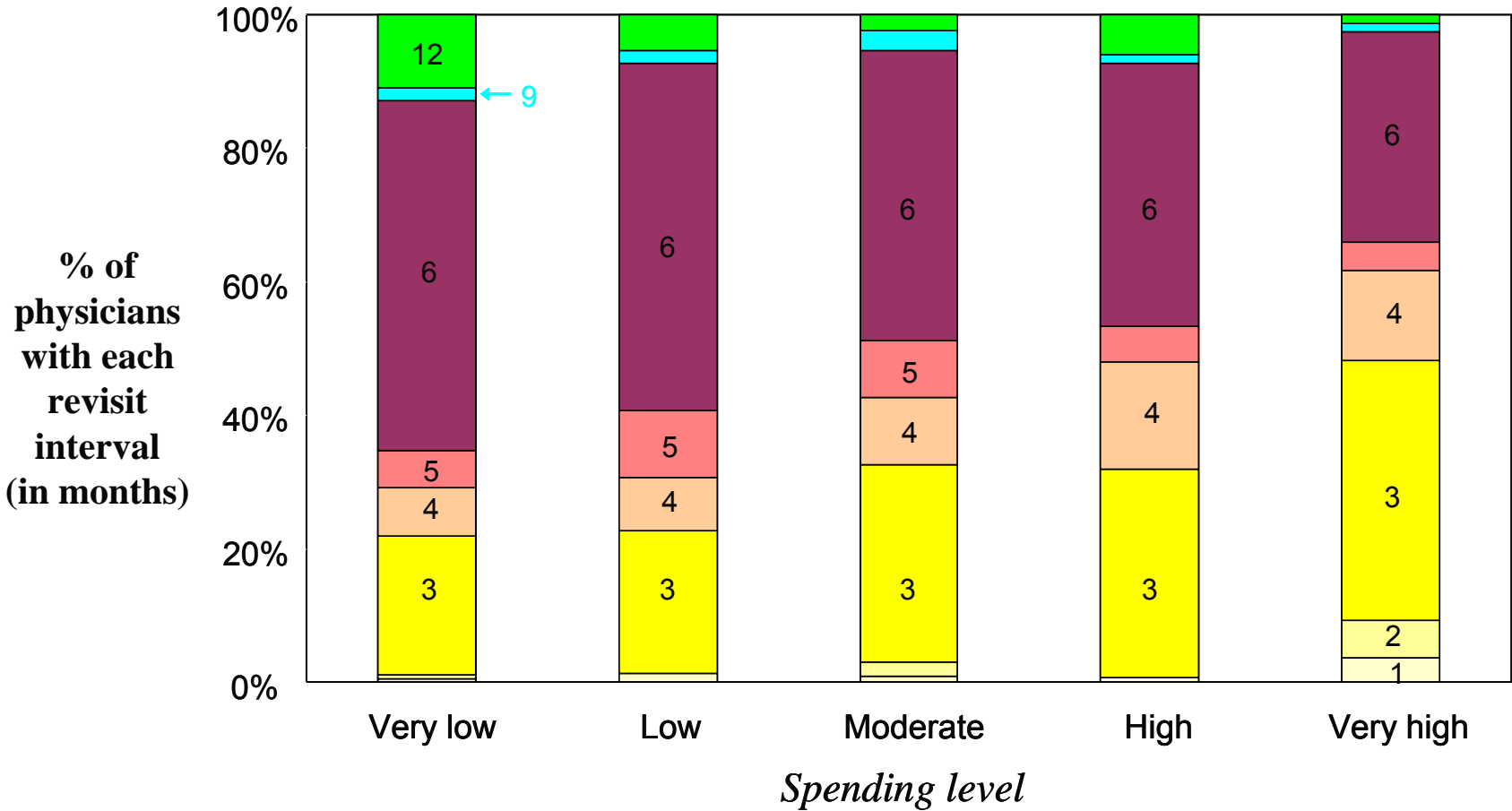
Side bar issue: quality performance in one clinical domain does not predict performance in others



Outline

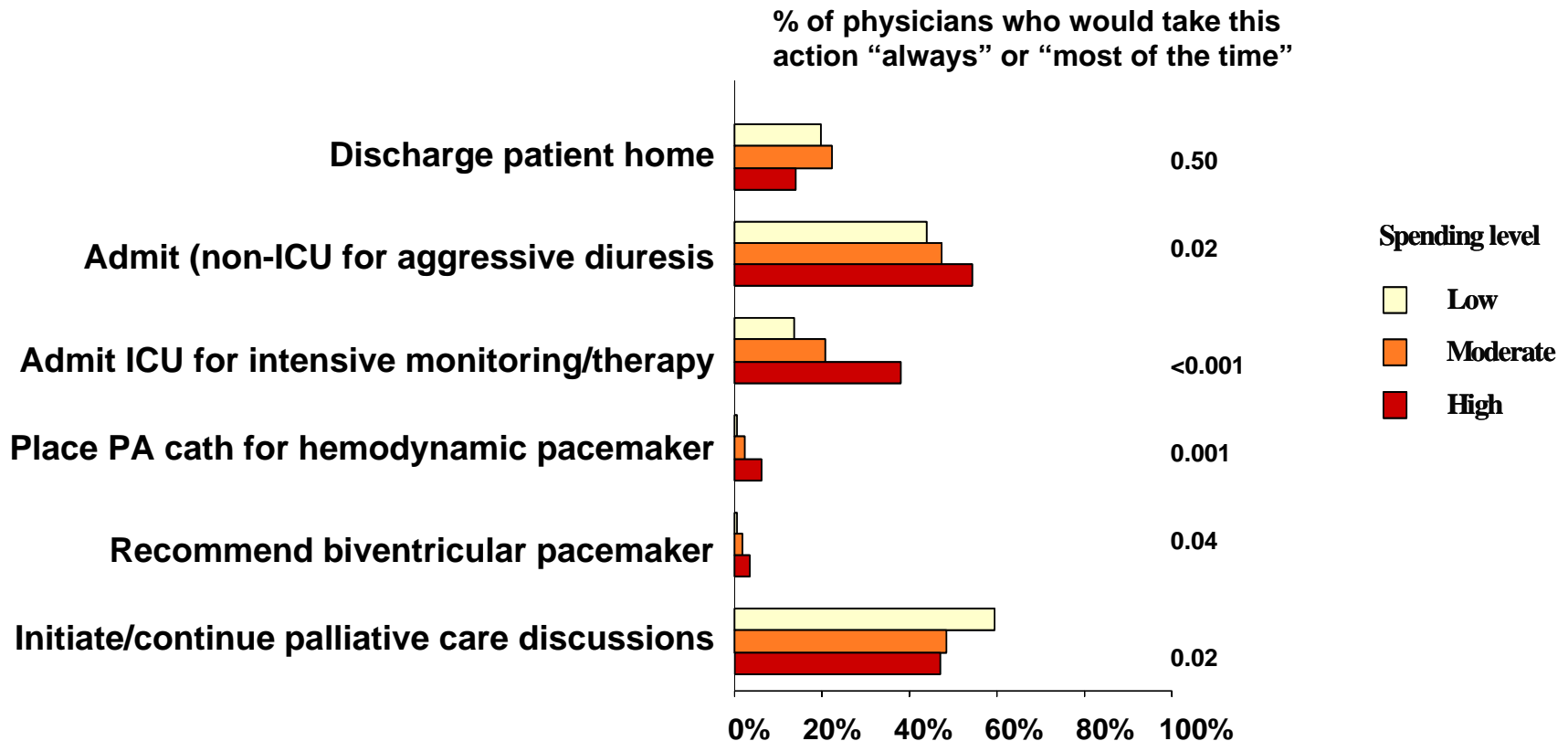
- Market Forces and framing the issues
- Who is in the neighborhood and what are they doing?
- **How do physicians 'influence' care?**
 - **Physicians' roles in use of supply sensitive and preference sensitive care**
- A new role for the primary care team?

Provider decision making for supply sensitive services

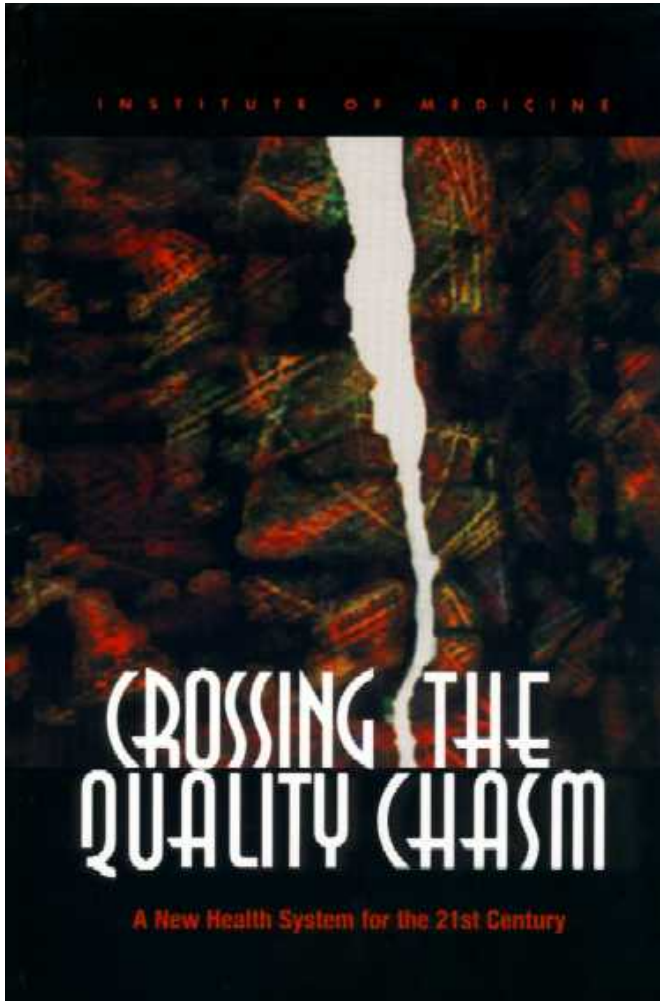


Provider decision making for supply sensitive services

- An 85 year old man with an exacerbation of end-stage congestive heart failure

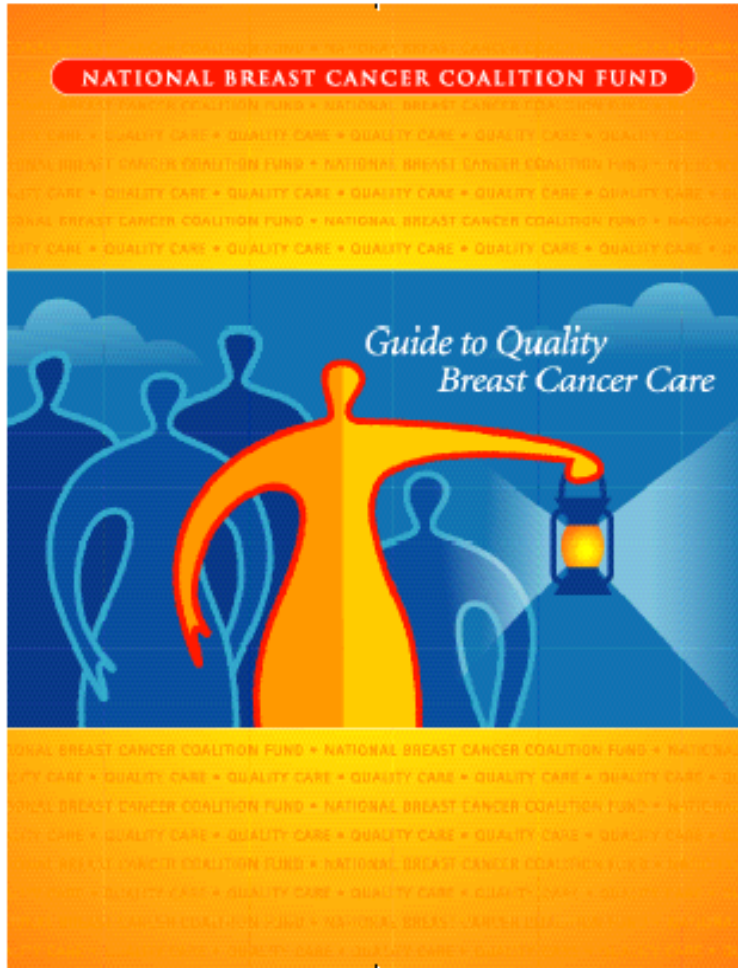


Providers' perspective on patient-centered care (or at least it should be)



“healthcare that establishes a partnership among practitioners, patients and their families (when appropriate) **to ensure that decisions reflect patients’ wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their own care.**”

And patients' perspectives are compatible



“Choice: recommended treatments must offer the best possible outcome consistent with patients personal preferences.”

“Information: Breast cancer patients need to clearly understand the issues they will be facing, and deserve readily available, unbiased, evidence-based information presented from a patient's perspective.”

Policy Support For Patient-Centered Care: The Need For Measurable Improvements In Decision Quality

Documenting gaps in patients' knowledge could stimulate rapid change, moving decisions and care closer to a patient-centered ideal.

by Karen R. Sepucha, Floyd J. Fowler Jr., and Albert G. Mulley Jr.

ABSTRACT: The phenomenon of practice variation draws attention to the need for better management of clinical decision making as a means of ensuring quality. Different policies to address variations, including guidelines and measures of appropriateness, have had little demonstrable impact on variation itself or on the underlying quality problems. Variations

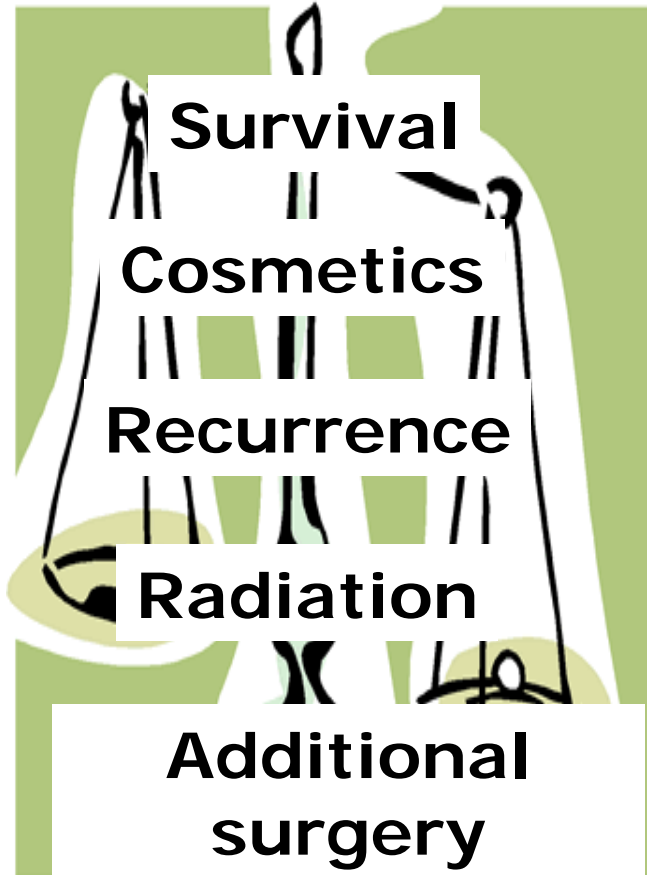
Providers, patients and preference sensitive care

- Karen Sepucha, PhD Principal Investigator
 - Carrie Levin, PhD FIMDM
 - Michael Barry, MD MGH
 - Albert Mulley, MD, MPP MGH
 - Annette O'Connor, PhD Ottawa
- Center for Survey Research, UMass Boston
- Dartmouth Hitchcock Medical Center
- University of North Carolina
- Funding from the Foundation for Informed Medical Decision Making

Bridging perspectives: What are the key facts

Mastectomy

Same
Lose breast
Low (1-5%)
Not common
Rare



Lumpectomy

Same
Keep breast
Slightly higher (5-15%)
6+ weeks
Common 20-50%

Sepucha KR, et. Al.

Decision Quality Instruments

- Preference sensitive decisions
 - What is the core set of information relevant for each decision?
 - What are the most salient goals and concerns upon which patients select treatments?
- Mailed survey to determine accuracy, importance and completeness of items
 - How important was each item?
(Not at all; Somewhat; Very; Extremely)
 - Pick top three.
- Patient responses (n=324)
 - By site: 72-85%
- Provider responses (n=266)
 - Response rate: 76%

Sepucha KR, et. Al.

Top three things patients should know

- Benefits and harms from the survey about Chemo and hormone therapy for breast cancer.

Fact	% top 3 Patient	% top 3 Providers
Chemo reduces recurrence, increases survival	12%	38%
Hormone therapy reduces recurrence, increases survival	12%	33%
Chemotherapy common side effects	12%	0%
Chemotherapy serious side effects	24%	0%
Hormone therapy common side effects	6%	0%
Hormone therapy serious side effects	6%	0%

Sepucha KR, et. Al.

Top three goals and concerns for different breast cancer decisions

Decision: Goal	% top 3 Patient	% top 3 Providers	p
Surgery: Keep your breast	7%	71%	P<0.01
Reconstruction: Look natural without clothes	33%	80%	P=0.05
Chemotherapy: Live as long as possible	59%	96%	P=0.01
Reconstruction: Avoid using prosthesis	33%	0%	P<0.01

Sepucha KR, et. Al.

Is doing what the doctor thinks is best a top priority?

Decision	% top 3 Patient	% top 3 Provider	p
BCA surgery	86%	14%	P<0.01
Hip replacement	84%	40%	P<0.01
Knee replacement	78%	35%	P<0.01
Menopause	60%	21%	P=0.02
PSA	59%	21%	P=0.03
Spinal Stenosis	46%	5%	P<0.01

Sepucha KR, et. Al.

Key differences and conclusions

- Patients feel it is critical to do whatever the doctor thinks is best
- Patients and providers focus on different issues
- Delegation of information provision and decision making to providers is problematic
 - Likely to not get information want and need
 - Likely to not get treatments that best match their individual goals and concerns

Outline

- Market Forces and framing the issues
- Who is in the neighborhood and what are they doing?
- How do physicians 'influence' care?
- **A new role for the primary care team?**
 - **Why variations need to be addressed if we are to deliver true patient centered care**

Do patients get more than they need?

Annals of Internal Medicine

ARTICLE

The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care

Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Daniel J. Gottlieb, MS; F.L. Lucas, PhD; and Éric L. Pinder, MS

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending provide better care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture ($n = 614\ 503$), colorectal cancer ($n = 195\ 429$), or acute myocardial infarction ($n = 159\ 393$) and a representative sample ($n = 18\ 190$) drawn from the Medicare Current Beneficiary Survey (1992–1995).

Exposure Measurement: End-of-life spending reflects the component of regional variation in Medicare spending that is unrelated to regional differences in illness. Each cohort member's exposure to different levels of spending was therefore defined by the level of end-of-life spending in his or her hospital referral region of residence ($n = 306$).

Outcome Measurements: Content of care (for example, frequency and type of services received), quality of care (for example, use of aspirin after acute myocardial infarction, influenza immunization), and access to care (for example, having a usual source of care).

Results: Average baseline health status of cohort members was similar across regions of differing spending levels, but patients in higher-spending regions received approximately 60% more care. The increased utilization was explained by more frequent physician visits, especially in the inpatient setting (rate ratios in the highest vs. the lowest quintile of hospital referral regions were 2.13 [95% CI, 2.12 to 2.14] for inpatient visits and 2.36 [CI, 2.33 to 2.39] for new inpatient consultations), more frequent tests and minor (but not major) procedures, and increased use of specialists and hospitals (rate ratio in the highest vs. the lowest quintile was 1.52 [CI, 1.50 to 1.54] for inpatient days and 1.55 [CI, 1.50 to 1.60] for intensive care unit days). Quality of care in higher-spending regions was no better on most measures and was worse for several preventive care measures. Access to care in higher-spending region

Conclusions: largely explain oriented pattern. Neither quality. Medicare enroll

Ann Intern Med 2003; 138:288-296.
For author affiliations
See related article
347-348, 348-349.

ARTICLE

The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care

Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Daniel J. Gottlieb, MS; F.L. Lucas, PhD; and Éric L. Pinder, MS

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending achieve better survival, functional status, or satisfaction with care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture ($n = 614\ 503$), colorectal cancer ($n = 195\ 429$), or acute myocardial infarction ($n = 159\ 393$) and a representative sample ($n = 18\ 190$) drawn from the Medicare Current Beneficiary Survey (MCBS) (1992–1995).

Exposure Measurement: End-of-life spending reflects the component of regional variation in Medicare spending that is unrelated to regional differences in illness. Each cohort member's exposure to different levels of spending was therefore defined by the level of end-of-life spending in his or her hospital referral region of residence ($n = 306$).

Outcome Measurements: 5-year mortality rate (all four co-

horts), change in functional status (MCBS cohort), and satisfaction (MCBS cohort).

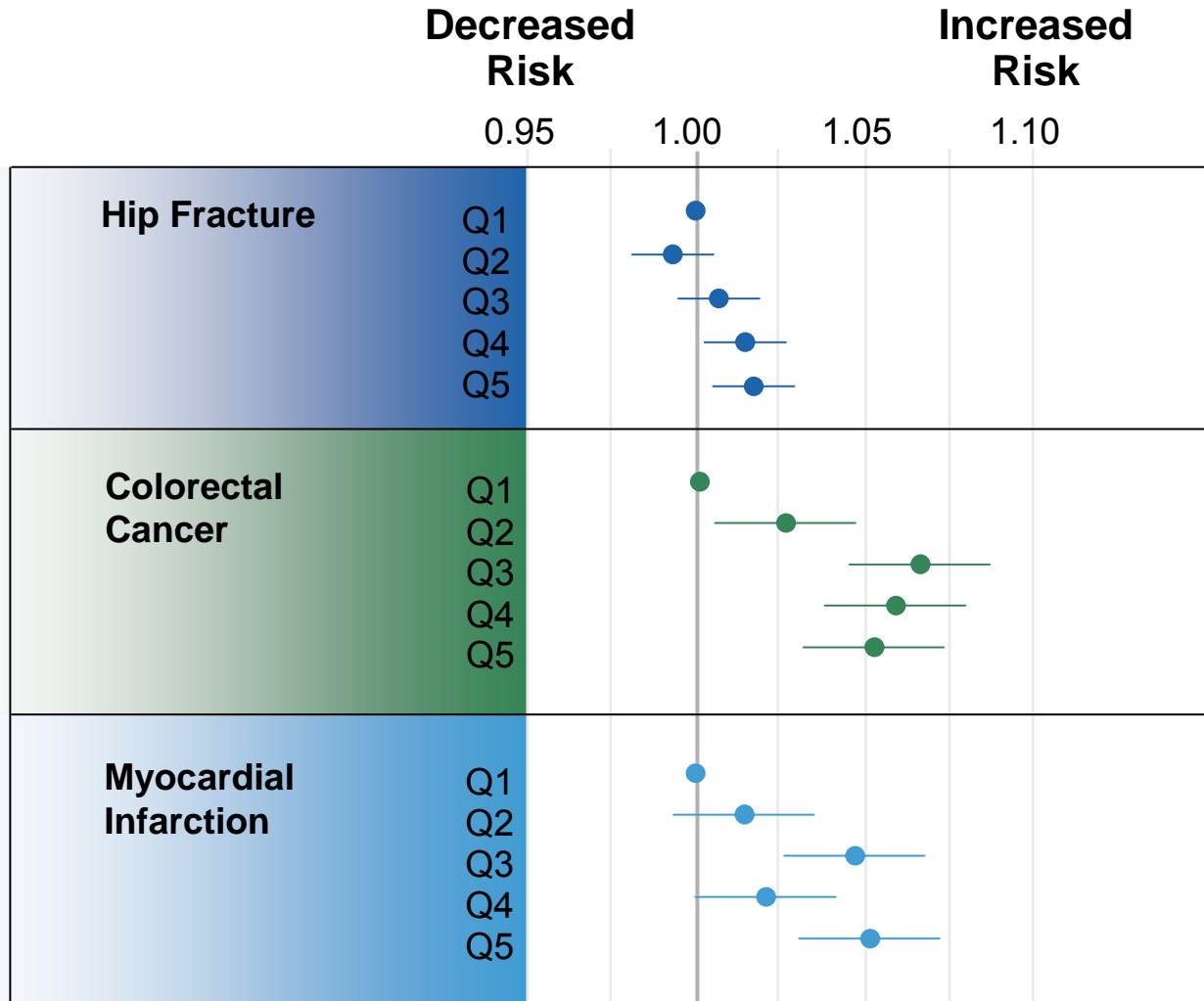
Results: Cohort members were similar in baseline health status, but those in regions with higher end-of-life spending received 60% more care. Each 10% increase in regional end-of-life spending was associated with the following relative risks for death: hip fracture cohort, 1.003 (95% CI, 0.999 to 1.006); colorectal cancer cohort, 1.012 (CI, 1.004 to 1.019); acute myocardial infarction cohort, 1.007 (CI, 1.001 to 1.014); and MCBS cohort, 1.01 (CI, 0.99 to 1.03). There were no differences in the rate of decline in functional status across spending levels and no consistent differences in satisfaction.

Conclusions: Medicare enrollees in higher-spending regions receive more care than those in lower-spending regions but do not have better health outcomes or satisfaction with care. Efforts to reduce spending should proceed with caution, but policies to better manage further spending growth are warranted.

Ann Intern Med 2003; 138:288-296.
For author affiliations, see end of text.
See related article on pp 273-287 and editorial comments on pp 347-348, 348-349, and 350-351.

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Do patients get more than they need?



Do patients get more than they want?

EXHIBIT 1

Effect Of Patient Decision Aids (PtDAs) On Elective Surgical Decisions: Preference For More Aggressive Surgery Relative To Conservative Options

Decision	Decision aid group		Comparison group		Relative risk (RR) (95% CI) ^a
	Number	Percent choosing option	Number	Percent choosing option	
CAN: Coronary revascularization for angina ^b	86	52.3	95	66.3	0.79 (0.62, 1.01)**
US: Coronary revascularization for angina ^c	61	41.0	48	58.3	0.70 (0.48, 1.03)
UK: Hysterectomy for menorrhagia ^d	253	32.4	244	41.4	0.78 (0.62, 0.99)**
US: Mastectomy for breast cancer ^e	30	23.3	30	40.0	0.58 (0.27, 1.28)
US: Back surgery ^f	171	25.7	173	32.9	0.78 (0.56, 1.09)
US: Prostatectomy for BPH ^g	103	7.7	116	13.8	0.56 (0.25, 1.26)
UK: Prostatectomy for BPH ^h	54	11.1	48	2.1	5.33 (0.67, 42.73)

Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids

A review of the evidence base for shared decision making.

by Annette M. O'Connor, Hilary A. Llewellyn-Thomas, and Ann Barry Flood

Outline

- Market Forces and framing the issues
- Who is in the neighborhood and what are they doing?
- How do physicians 'influence' care?
- **A new role for the primary care team?**
 - **Coordination will require information**

How am I doing?

ABOUT YOUR PATIENTS

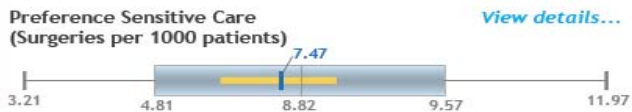
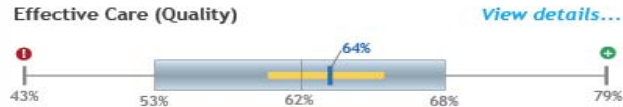
Adult PCP Patients

	You	Peers
Patients	345	275
Average Age	33	35
% Male	49	47
% Chronic	8.4	7.5
% Asthma	1.2	1.2
% CAD	1.6	1.3
% COPD	1.8	1.5
% Diabetes	1.8	2.0
% Heart Failure	2.0	1.5
Risk Index	1.05	1.0

Click > Go to...
to learn more about your performance scores

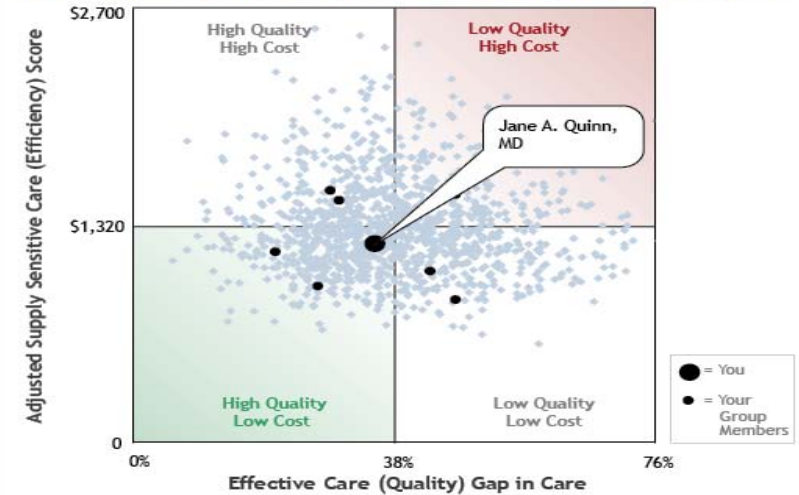
PERFORMANCE SUMMARY

Your overall performance compared to your peers.



QUALITY AND EFFICIENCY

Your composite quality and efficiency scores compared to your peers.



KEY RISK ADJUSTED UTILIZATION MEASURES

> Go to ...

Your use of services compared to your peers.

	You	Peers	Significantly Different from Peers
(PER 1000 PATIENTS)			
Admissions	73	59	!
Hospital days	293	289	
Emergency Dept visits	159	188	
Prescriptions	9	12	

	You	Peers
(OTHER)		
# of PCPs seen per patient	1.4	1.9
# of Specialists seen per patient	2.7	3.8
Physician Visits per patient	8.9	11.8
% Generic Prescriptions	73	68

! = Your performance on this measure is significantly worse than your peers
 ● = You performance on this measure is significantly better than your peers

PERFORMANCE IMPACT

> Go to ...

The impact of your performance compared to your peers.

Effective Care (Quality)	Patients	Rate	Peers	Diff	Opportunity for Change
Breast Cancer Screening (%)	125	73	81	8	10 (Patients)
Diabetes - HbA1c Testing (%)	27	80	87	7	2 (Patients)
CAD - Beta Blocker Post MI (%)	14	92	98	6	1 (Patients)

Supply Sensitive Care (Efficiency)

Advanced Imaging Cost (Dollars)	345	45	28	17	5,693
Outpatient Visit Cost (Dollars)	345	346	305	41	14,007
Specialist Visits (Visits)	345	5.8	4.7	1.1	380

Preference Sensitive Care (Surgeries per 1000 patients)

Cardiac Revascularization	45	22	19	2.4	1 (Patients)
Lumbar Back Surgery	98	14	11	2.6	1 (Patients)
Knee Surgery	75	9	6	2.4	1 (Patients)

How are others doing?

GROUP PERFORMANCE SUMMARY REPORT: INTERNAL MEDICINE

Adult Patients (18 and over) for Year Ending Dec. 31, 2007

ABOUT THE PLAN

Adult PCP Patients

	2007	2006
Groups	561	550
Doctors	3,450	3,426
Patients	724,256	739,581
Average Age	33	33
% Male	49	49
% Chronic	8.4	8.6
% Asthma	1.2	1.2
% CAD	1.6	1.7
% COPD	1.8	1.8
% Diabetes	1.8	1.8
% Heart Failure	2.0	2.1

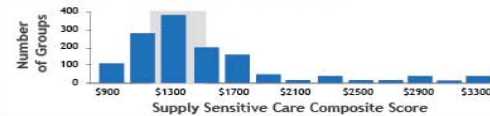
PERFORMANCE SUMMARY

Distribution of Groups in this Report.

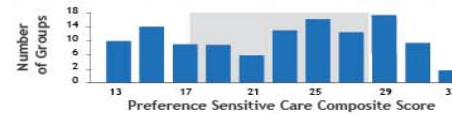
Effective Care (Quality)



Supply Sensitive Care (Efficiency) in Dollars

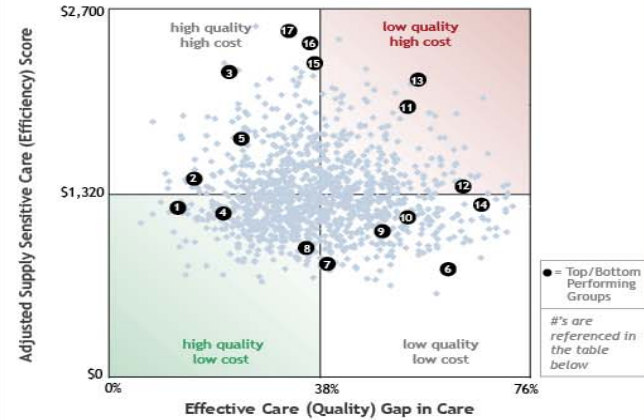


Preference Sensitive Care (Surgeries per 1000 patients)



QUALITY AND EFFICIENCY GROUPS

Distribution of Groups' Quality and Efficiency Performance.



KEY RISK ADJUSTED UTILIZATION MEASURES

Use of services among Groups in this Report.

	Min	25th%	Median	75th%	Max
(PER 1000 PATIENTS)					
Admissions	53	62	73	79	88
Hospital days	171	224	289	352	402
Emergency Dept visits	98	125	189	192	205
Prescriptions	6	8	9	10	12
(TOTAL)					
# of PCPs seen per patient	1.1	1.3	1.4	1.5	1.9
# of Specialists seen per patient	2.2	2.4	2.7	3.1	3.5
Physician Visits per patient	5.7	6.2	8.9	9.2	9.4
% Generic Prescriptions	52	62	73	84	90

TOP/BOTTOM PERFORMING GROUPS

The groups in the Plan with top and bottom overall quality and efficiency scores.

EFFECTIVE CARE

Top Performance

1. Eastham Medical Group	92%
2. Meadow Internal Medicine	88%
3. Hill Physician Group	87%
4. Hobson Medical Associates	87%
5. Downtown Doctors	85%

PLAN MEAN

78%

Bottom Performance

6. Chinatown Medical Group	61%
11. Mercer Medical Associates	60%
12. Coopertown Doctors	59%
13. London Medical Group	53%
14. Eastlake Associates	53%

SUPPLY SENSITIVE CARE COST

Top Performance

6. Chinatown Medical Group	\$1,095
7. Davidson Place Associates	\$1,106
8. Western Hills Medicine	\$1,125
9. Southeastern Corner Group	\$1,189
10. Georgetown Medical Group	\$1,199

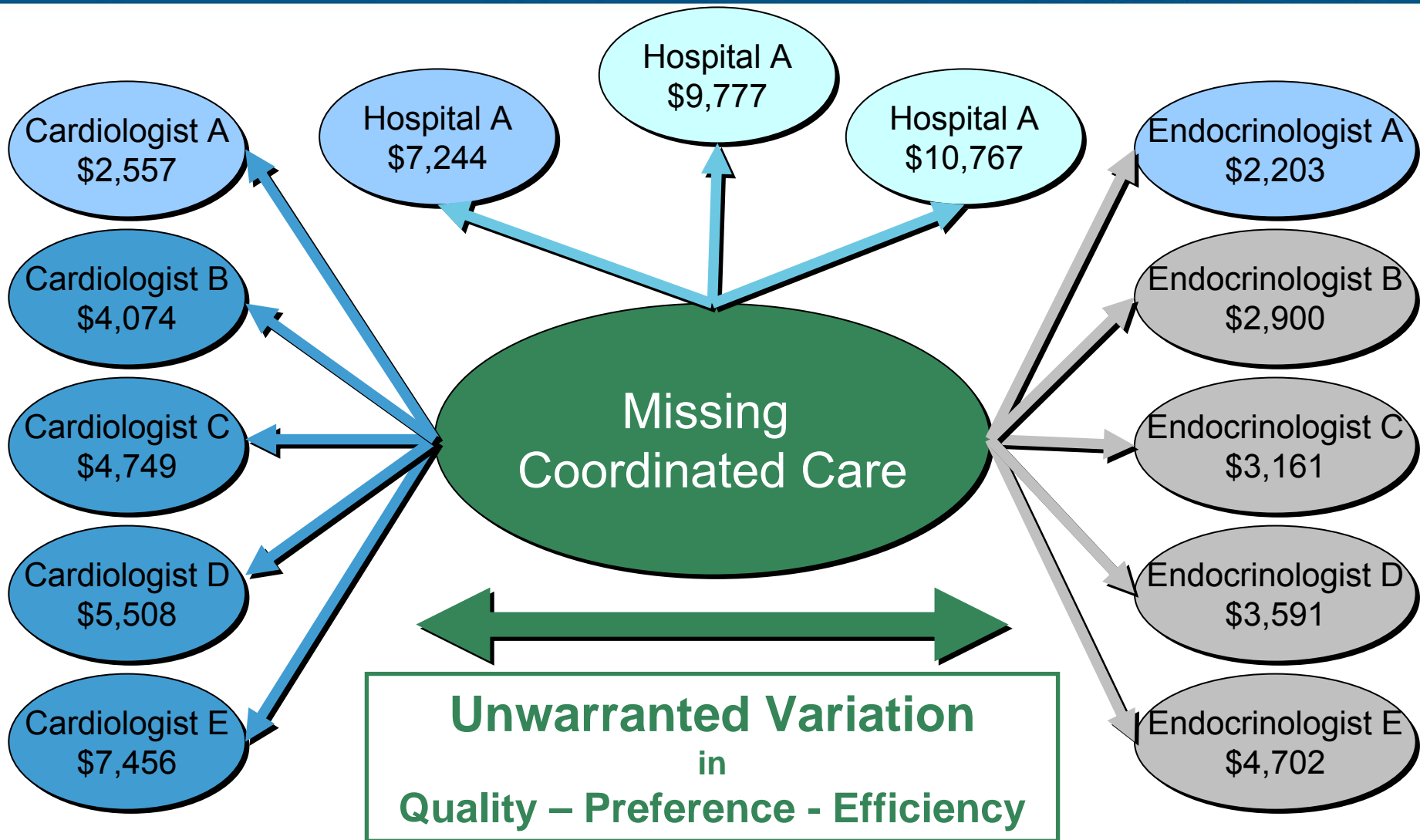
PLAN MEAN

\$1,675

Bottom Performance

3. Hill Physician Group	\$2,012
13. London Medical Group	\$2,311
15. Browns Medical Associates	\$2,315
16. Stanford Associates	\$2,478
17. Colfax Medical Group	\$2,563

Variation in quality and efficiency can identify best practice within the neighborhood



Or as a method to identify who we would like on the extended team.....

High Performing Community

Cardiologist A
\$2,557

Hospital A
\$7,244

Endocrinologist A
\$2,203

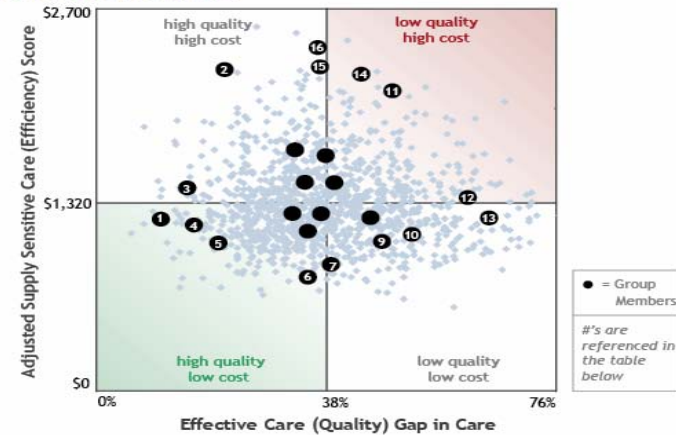
Medical Home

Primary Care
Coordinated Care

- High Quality
- Patient preferences
- Efficient care
- No more than necessary

QUALITY AND EFFICIENCY

Composite quality and efficiency scores for Group Physicians compared to their peers.



TOP/BOTTOM PERFORMING PHYSICIANS

The physicians in the group with top and bottom overall quality and efficiency scores.

EFFECTIVE CARE

Top Performance

1. Sam Jones	92%
2. Peter Smith	88%
3. Jill Howard	87%
4. Ed March	87%
5. David Downs	85%

GROUP MEAN 78%

Bottom Performance

9. Kerry Hamill	61%
10. Roland Katz	60%
11. Elaine Cooper	59%
12. Ella Baff	53%
13. John Badanes	53%

SUPPLY SENSITIVE CARE COST

Top Performance

6. Pat Abercrombie	\$1,095
7. David Kimball	\$1,106
5. David Downs	\$1,125
9. Kerry Hamill	\$1,189
10. Roland Katz	\$1,199

GROUP MEAN \$1,675

Bottom Performance

2. Peter Smith	\$2,012
11. Elaine Cooper	\$2,311
14. Aubrey Reinbolt	\$2,315
15. Fred Meyers	\$2,478
16. Lynn Fontaine	\$2,563

Medical Home: Overarching goals.....

Medical Homes: The Information Exchange Challenge

By Myles Maxfield, Hoangmai H. Pham
and Deborah Peikes

Closing the Circuit Among Medical Homes, Patients and Other Providers

Medical home initiatives typically have two overarching goals – to reduce costs and improve the quality of care. Medical homes are expected to reduce costs directly by avoiding redundant or unneeded tests, imaging, procedures and medications, hereafter generically called unnecessary services.

Outline

- Market Forces and framing the issues
 - Who is in the neighborhood and what are they doing?
 - How do physicians 'influence' care?
 - **A new role for the primary care team?**
 - Identifying the true preferences and values of patients.....and making sure they are honored
 - It will require new roles and responsibilities on the team
 - It will require new tools and processes
 - It would be a transforming role for the medical home
 - **Helping patients get the care they need and nothing less, want and nothing more *across the full continuum of care***
- (maybe that is the medical home mission?)**

Thank You

Thank you for your participation in today's event. A recording will be posted to the PCPCC and Health Dialog websites later this week.

Any further questions or comments about today's presentation or Health Dialog may be directed to:

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