PREMIER

Care Transformation and the Journey to Population Health Management

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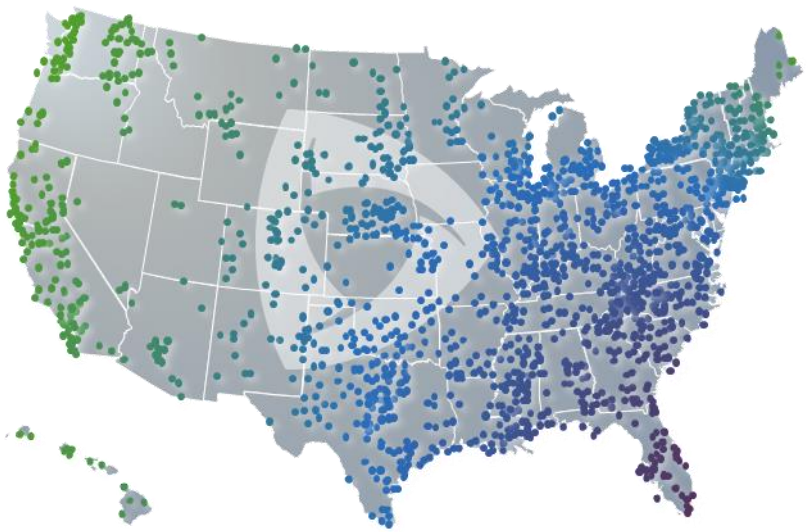
AMGA Institute for Quality
September 26, 2013

Premier: the largest healthcare alliance in the U.S.

Our mission: to improve the health of communities



- **Owned by health systems**
- Uniting more than **2,800** hospitals – 57% of U.S. community hospitals– and over **100,000** alternate sites of care
- **$40+ Billion** in group purchasing volume – saving **$5 Billion** through collaboration, integrated data, and sharing of best practice
- Database representing **1 in every 4** U.S. hospital discharge
- **2.5 Million** real-time clinical transactions per day

MAKE HEALTHCARE SUPPLY CHAIN EFFICIENT AND EFFECTIVE

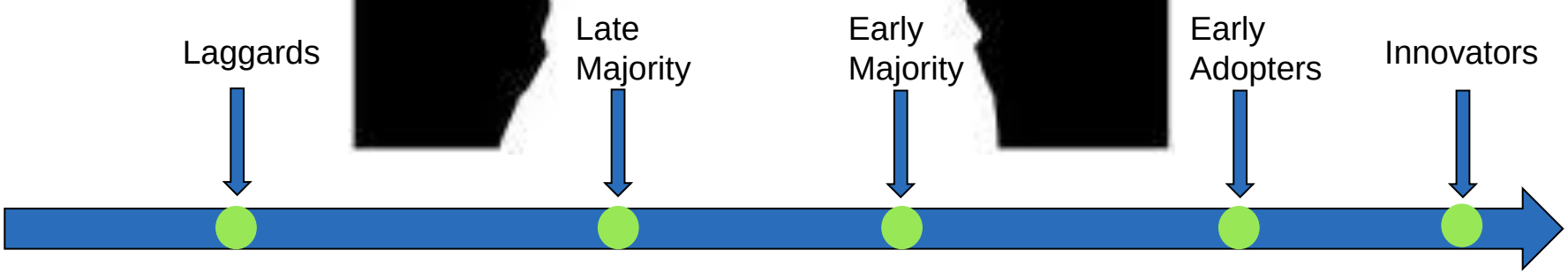
DELIVER CONTINUOUS IMPROVEMENT IN COST AND QUALITY TODAY AND ENABLE SUCCESS IN NEW HEALTHCARE DELIVERY / PAYMENT MODELS

INTEGRATE DATA AND KNOWLEDGE TO CREATE MEANINGFUL BUSINESS INTELLIGENCE THAT DRIVES IMPROVEMENT

Transitioning to population health means having a foot in more than one camp

- Pay for volume
- Fragmented care
- FFS
- Treating sickness
- Adversarial payors
- Little HIT
- Duplication & waste

- Pay for value
- Accountable care
- Global payment
- Fostering wellness
- Payer partners
- Fully wired systems
- Right care, right setting, right time



Four stages in the Journey to Population Health Management

- Education
- Assessment
- Gap analysis
- Operational plan

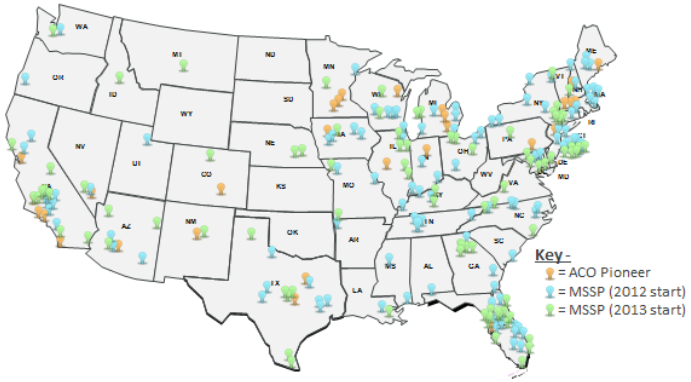
- Primary care
- Patient Centered Medical Home
- Clinical integration
- Care management
- Network development
- Health informatics

- Defined population
- Payor partner

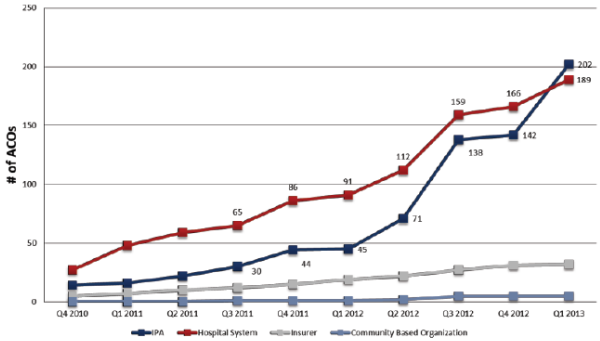
- Employee health plan
- Commercial arrangement
- Medicare
- Medicaid
- Employer contracting
- Uninsured

Growing number of ACOs nationwide

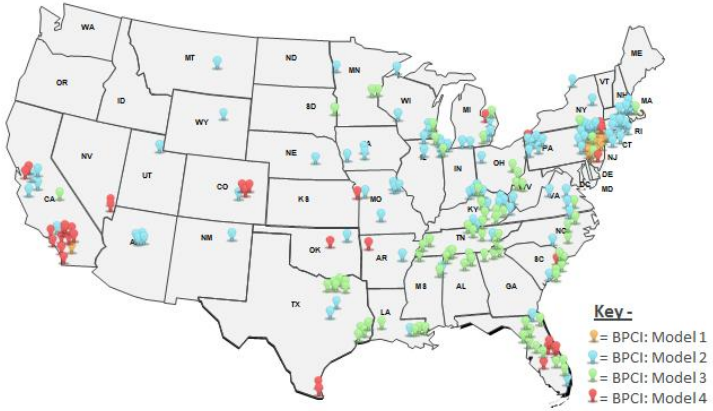
250 Medicare ACOs in 43 states



Over 480 Medicare and Commercial ACOs

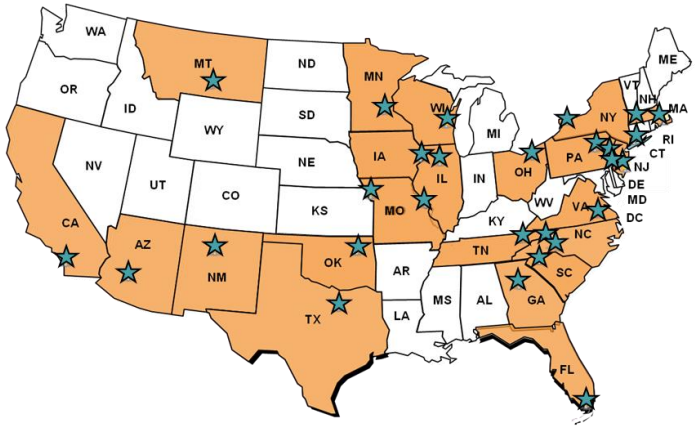


500 providers in CMS Bundled Payment initiative



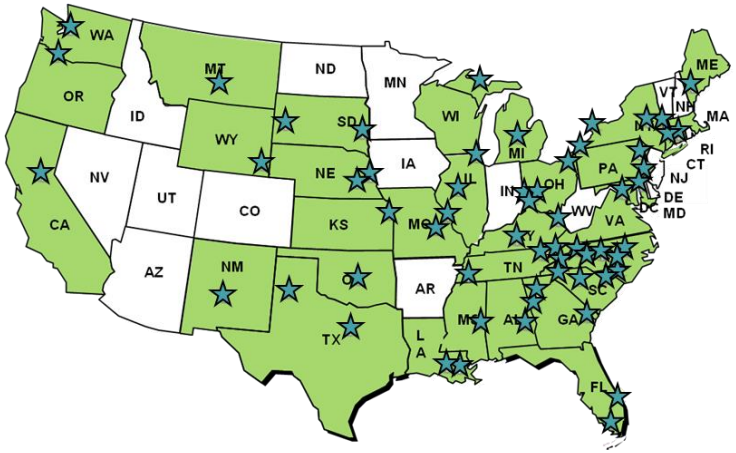
Key Insights from alliance members for Population Health

PACT Implementation



29 markets | 23 systems | 100+ hospitals | 5,000+ MDs, 1.5M accountable care covered lives

PACT Readiness



86 markets | 67 systems | 300+ hospitals | 12,000+ MDs

- Primary Care network development
- Patient Centered Medical Home
- Physician-led / professionally managed
- Clinically Integrated Network
- Care Management programs
- Population Health Analytics
- Aligned Payer arrangements

Total Cost of Care: Exploring Payment Models

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AMGA – Scottsdale, Arizona – 9/26/2013

Reducing Total Health Burden From 2001 to 2009

An Employer Counter-Trend Success Story and Its Implications for Health Care Reform

Harris Allen, PhD, William H. Rogers, PhD, William B. Bunn III, MD, JD, MPH, Dan B. Pikelny, MA, MBA, CEBS, and Ahmad B. Naim, MD

Objectives: To examine total health burden for an employer whose health-related focus is direct and indirect costs. To explore implications for the Final Rule for Accountable Care Organizations recently issued by the Centers for Medicare and Medicaid Services, whose focus includes direct but not indirect costs. **Methods:** Used 42 claims and survey-based measures to track this employer's continental US workforce burden in the aggregate and by healthy and selected disease designations from 2001–2002 to 2008–2009. **Results:** Starting from equivalent baselines, this employer's aggregate total direct costs decreased 16% (8.5% adjusted) whereas comparable US per capita expenditures rose 22.1%. Even larger decreases were recorded in total indirect costs. The healthy and disease designations replicated this pattern. Minimal employee cost shifting occurred. **Conclusions:** Attention to direct and indirect costs helped put this employer's health care investment on a markedly more sustainable path than comparable national cost trends. Fully tapping the applicable lessons this and other purchasers have learned will be facilitated by amending the Final Rule to include measures of indirect costs.

The necessity for substantial and sustainable progress in bending the health care cost curve continues to mount with each annual report of the percentage of the US gross domestic product devoted to health care spending— up a full point to 17.6% from 2008 to 2009.[1] Arguments over the various approaches that have been proposed for cost control are as contentious now as when the Affordable Care Act was passed 2 years ago.

The 2010 Patient Protection and Affordable Care Act (H.R. 3590) and the amendments to it in the 2010 Health Care and Education Reconciliation Act (H.R. 4872)—together herein referred to as the 2010 Affordable Care Act (ACA)—contain far-reaching provisions for systemic reform. The Congressional Budget Office has underscored the promise of these acts by estimating that their combined impact will be $124 billion in net reductions to the federal deficit deriving from their health care and revenue provisions over the 2010–2019 period.[2]

This legislation, however, evidences neglect of an increasing priority for purchasers: the need to measure and manage lost productivity, workers' compensation (WC), disability, and related indirect costs and their drivers. A burgeoning literature has laid out the need to attend to indirect costs along with direct costs when grappling with the total burden of health.[3–7] Yet, indirect costs have been all but absent as a priority in the infrastructure that has been rolling out to enact this legislation.

Can focusing on the drivers of indirect and direct costs that comprise total burden in fact bend the health care cost curve? This article examines a recent study about trends in total health burden at Navistar, Inc (Lisle, Illinois), a leading corporate practitioner of the use of direct and indirect cost measures in the field. This study was undertaken with two main objectives. One was to assess the overall bottom line impact of the strategy Navistar has taken to manage workforce health and productivity. In this capacity, this article sets the stage for two papers that will follow in next month's issue,[8,9] which hone in on recent steps the company has taken to measure and manage the burden of specific diseases that have presented unique challenges to this strategy.

The second objective was to tap the Navistar experience as a case study with implications for health care reform. To anticipate, the trends reported herein attest to the success of the strategy orchestrated by Navistar in collaboration with its health plan, vendor, and research partners and its use of indirect cost measures to supplement direct cost measures to manage workforce health and its impacts. The lessons learned suggest implications for improving the prospects for steps now being taken under H.R.s 3590 and 4872 to reform health care.

Purchasers and H.R.s 3590 and 4872

The extent of buy-in and participation of private sector purchasers has often played a key role in the success or failure of systemic initiatives to affect change in health care. For example, employer support has been pivotal to the evolution of the National Committee for Quality Assurance's Healthcare Effectiveness Data Information Set (originally, the Health Plan Employer Data and Information Set) as the standard by which health plan performance is now measured.[10] Conversely, efforts to set up regional health information centers across the United States to promote the exchange of clinical data across independent parties have stalled in part because employer financial support has fallen far short of expectations.[11,12]

This precedent seems to have been overlooked in the deliberations for H.R. 3590, H.R. 4872, and the rollout activities that have followed, given their lack of attention to certain priorities that employers are increasingly cultivating as stewards of health care for their beneficiary populations. Nowhere is this disconnect more obvious than the measurement of indirect costs. On one hand, these employers are complementing their focus on transaction-based direct costs with much attention to measures of presenteeism (impaired performance while at work), absenteeism, WC, and disability, and related indirect costs.[13–18] Such measures capture losses that these employers and their employees incur, relative to the gains they hope to achieve with their expenditures for health care—gains that are increasingly seen as vital, both to the quality of life of individuals and their capacity to be productive at work as well as to the capacity of organizations to survive and thrive in the marketplace.

On the other hand, there is scant recognition of indirect costs in the legislation and the accompanying public discussion that has

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This study was funded by an unrestricted educational contract to the Harris Allen Group from Janssen Scientific Affair, LLC, and Navistar, Inc. Dr. Allen has received consulting fees from Janssen Scientific Affairs, LLC and Navistar.

No conflicts of interest have been declared for any of the authors.

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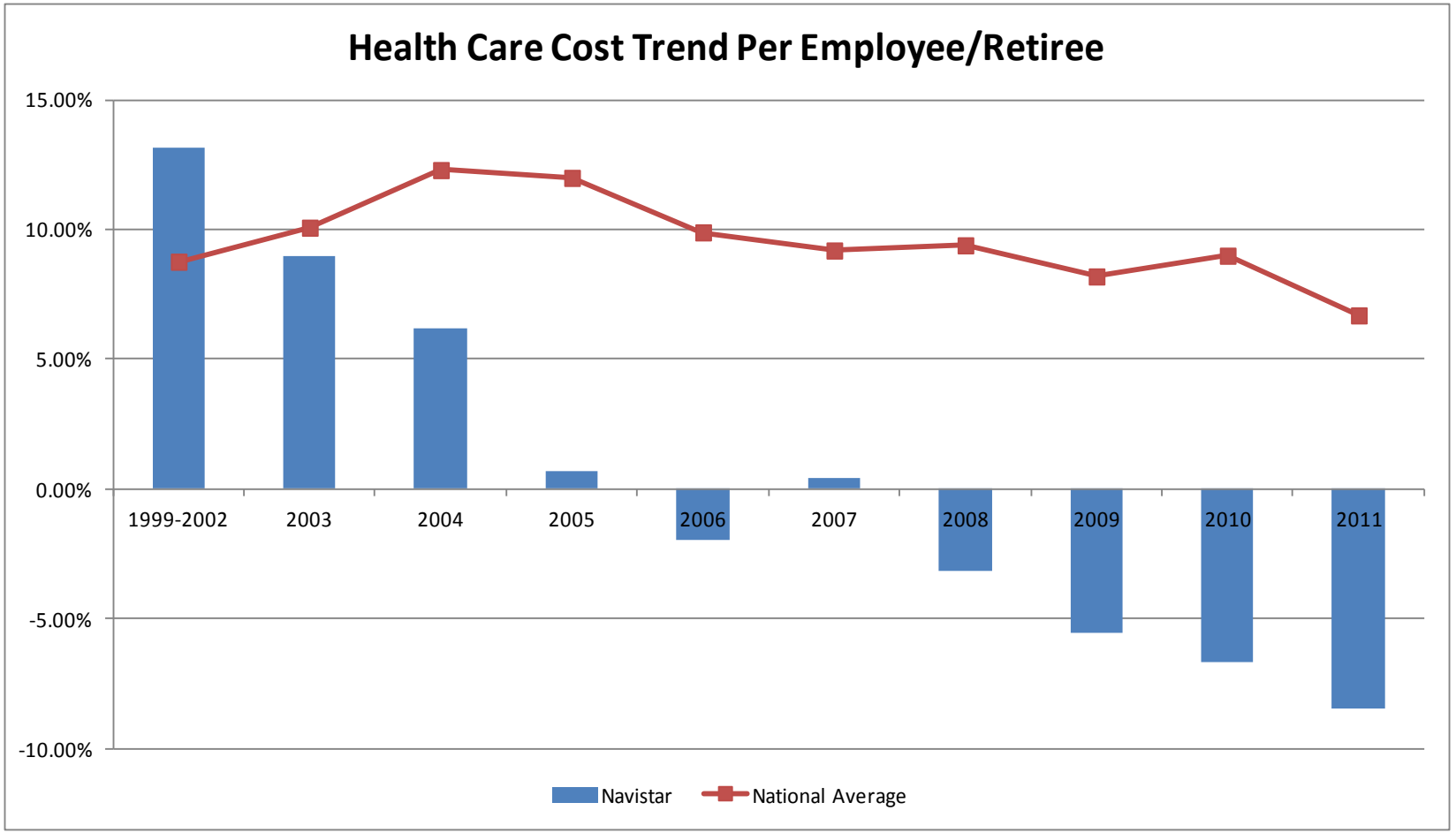
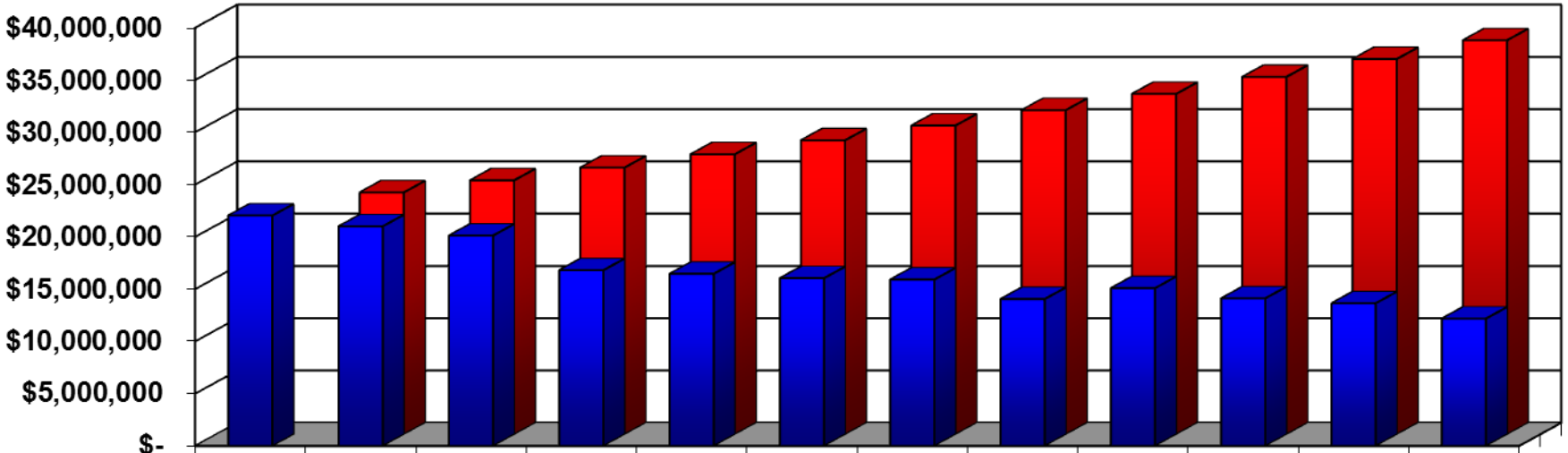
DOI: 10.1097/JOM.0b013e318267f1b1

Health Care Cost - National Trends vs. Navistar Actual



Combined Workers Compensation and Disability Cost - National Trends* vs. Navistar Actual

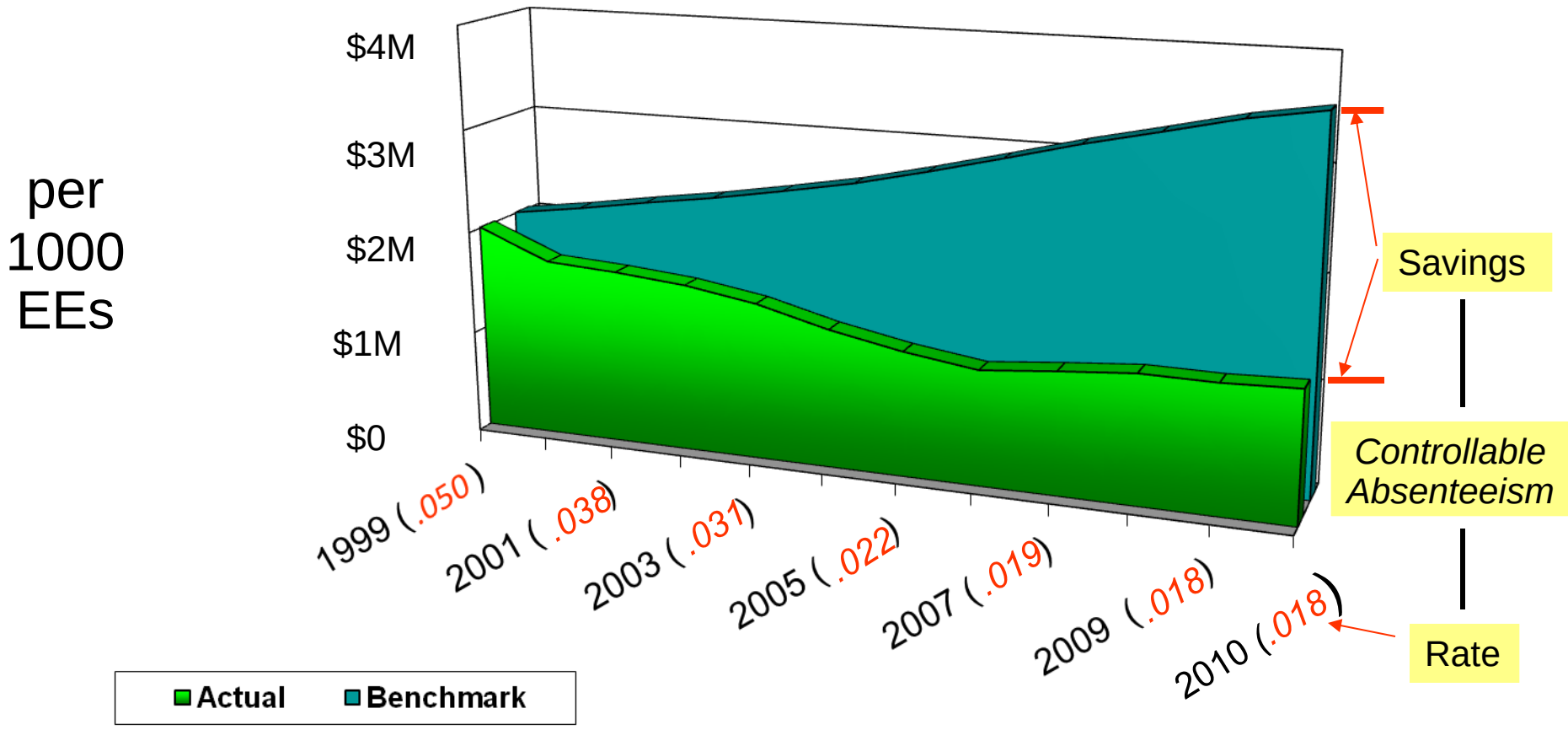


	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012**
Actual Cost	$22,039,33	$21,008,21	$20,123,11	$16,809,73	$16,464,03	$16,049,03	$15,915,00	$14,051,53	$15,091,23	$14,117,81	$13,644,42	$12,178,37
Cost With Trend		$23,141,30	$24,298,37	$25,513,29	$26,788,95	$28,128,40	$29,534,82	$31,011,56	$32,562,14	$34,190,24	$35,899,76	$37,694,74

*Assumes only 5% annual combined increase in WC and Disability costs

**Estimated through May

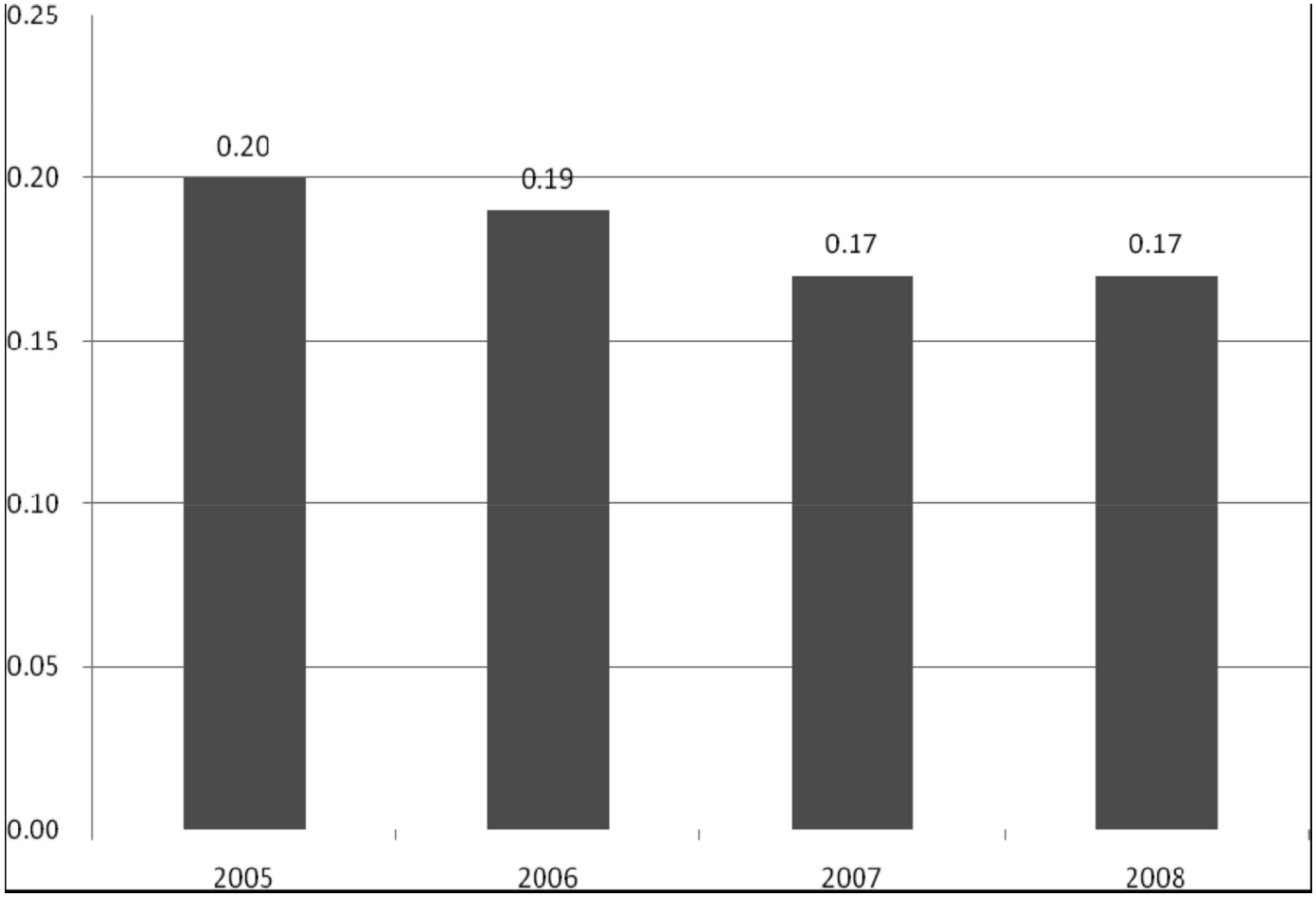
Controllable Absenteeism Cost Savings: Navistar, 1990-2010 In constant 2005 Dollars Per 1000 Employees



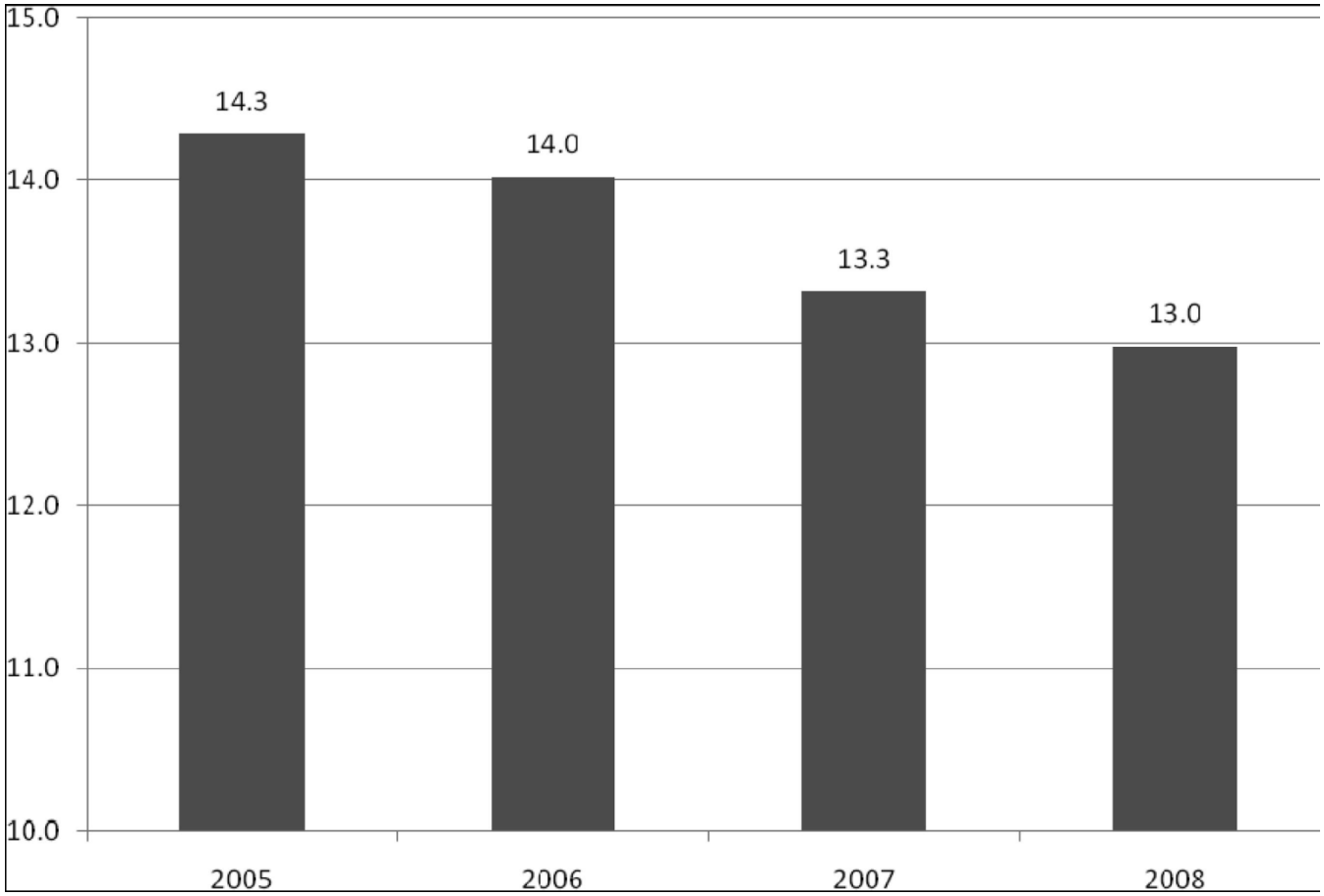
Conclusion

From 1999-2010, Navistar's controllable absenteeism rate dropped from 5.0% to 1.8%. Treating 1999 as benchmark, its annual savings now exceeds $2 million per 1000 EEs.

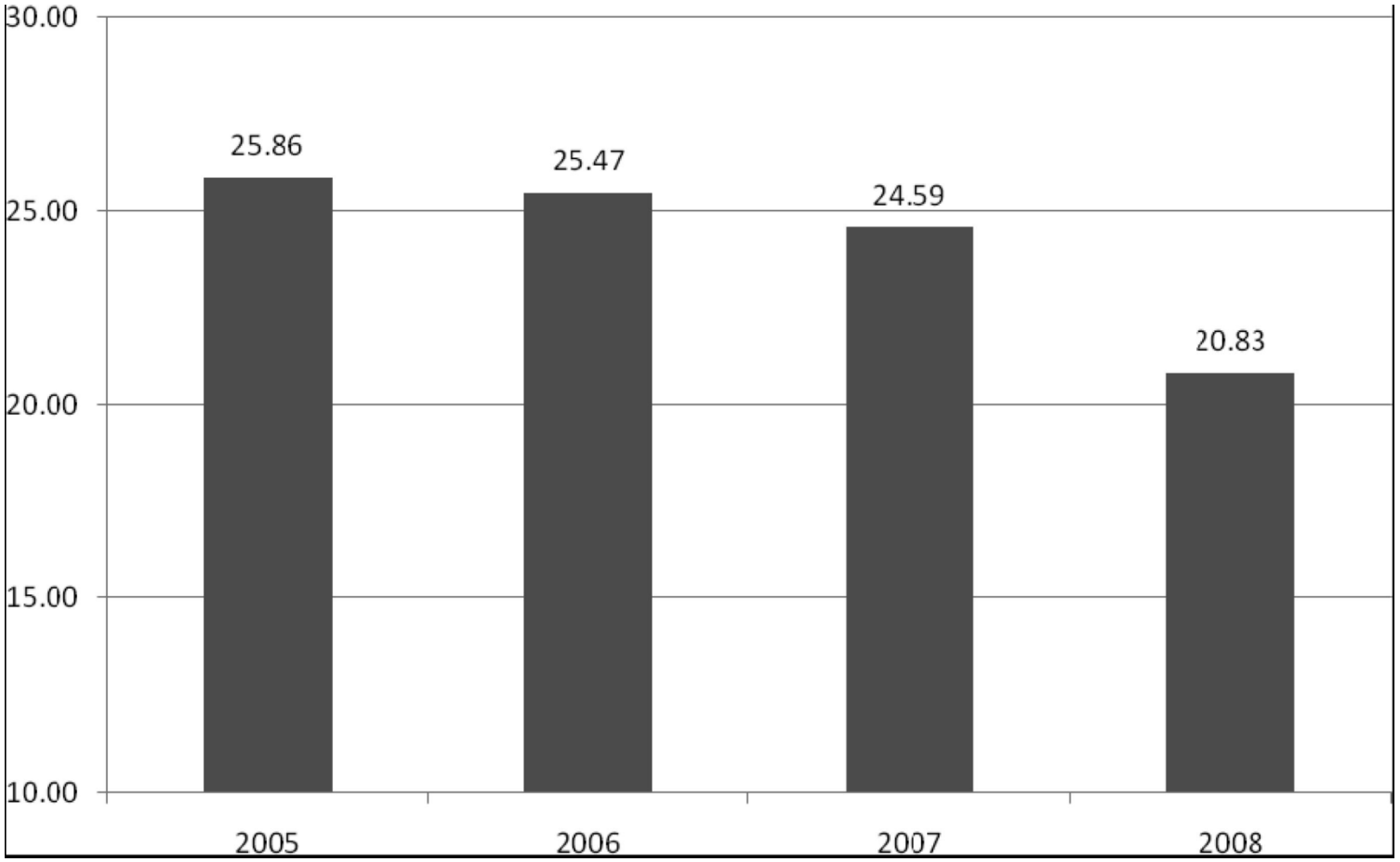
Hospital Admissions per Employee



Outpatient Visits per Employee



Pharmaceutical Prescriptions per Employee



Measures Taken

- Monthly measurement and management of costs / quality
- Plan and payment design
- Preventive care
- Case management
- Disease management
- Special analyses
- Physician selection
- Health and Productivity