Kentuckiana Health Collaborative

A Competitive Advantage Through Better Health, Better Care & Lower Cost

Craig Osterhues
Manager, Health Services
GE Aviation

3/11/14
Agenda

- Global Health Comparison
- US Health Care
- The Cincinnati Story
- Q&A
Global Comparison – Better Health?

Prevalence of insufficient physical activity*, ages 15+, age standardized
Both sexes, 2008

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.
Global Comparison – Better Health?

Prevalence of obesity*, ages 20+, age standardized
Both sexes, 2008

Prevalence of obesity (%)
- <10
- 10–19.9
- 20–29.9
- ≥30
- Data not available
- Not applicable

*BMI ≥30 kg/m²

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Data Source: World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization
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Global Comparison – Better Health?

Prevalence of raised fasting blood glucose*, ages 25+, age standardized
Both sexes, 2008

Prevalence of raised blood glucose (%)
- <5
- 5–7.4
- 7.5–9.9
- 10–12.4
- ≥12.5
- Data not available
- Not applicable

* ≥7.0 mmol/L or on medication for raised blood glucose

Data Source: World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization
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Global Comparison – Better Care?

Source: WHO World Health Statistics 2013
Global Comparison – Lower Cost?

Source: WHO World Health Statistics 2013

*2010
Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2013

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

Overall quality ranking

1

11

21

31

41

51

Annual Medicare spending per beneficiary (dollars)

3,000  4,000  5,000  6,000  7,000  8,000


NOTE: For quality ranking, smaller values equal higher quality.
Employer’s Health Care
by the Numbers

80% of $ Outside the fence-line

70% of $ related to Chronic disease

50% of time Primary Care uses EBM

33% of $ that is waste

30% of ER visits are Non-emergent
The Cincinnati Story: Improving Healthcare Quality and Value

How GE Aviation Helped Drive Regional Change Through Multi-Stakeholder Collaboration

IBI 2014 Forum, San Francisco
March 4, 2014
Managing the Supply Side of Employee Health: Fundamental Choices Facing Employers

In the face of increasing benefit costs, employers can choose to...

1. **Retreat:** Reduce the employer role—e.g., via health exchanges

2. **Engage:** Drive market change through value-based purchasing

3. **Wait and see….**

Which of these choices has the greatest potential for delivering sustainable value to employers?
The Answer Depends on How You Define “Value”

1. Near-term savings (discounts) + ease of administration

   — OR —

2. Sustainable cost control + positive impact on human capital

\[
\text{Greater Value} = \frac{\text{Better Employee Health, Productivity and Engagement Outcomes}}{\text{Lower Cost Trend}}
\]
High-Performing Employers Are Choosing Engagement

Employers generally move through a spectrum of strategies as they strive to control costs and improve health & productivity—with high-performing employers leading the way.

“Reactive”
- Provider and drug discounts
- Cost shifting to employees

“Cost Management Tactics”
- Basic wellness programs
- Simple incentives
- Consumer-directed health plans

“Health Management Strategies”
- Population health management
- Integrated programs and benefit design

“Quality and Value-Driven Strategies”
- Value-based purchasing
- Provider engagement and alignment

“Culture is good—but impact is limited. We need to engage with the supply chain, where the rubber meets the road…”

“Tactics aren’t enough. Let’s improve our health culture.”

“We need to do something to impact costs.”
Benchmarking the Best Performing Employers That Have Demonstrated Sustained Success

Best Performers vs. Median: Annual Cost Trend Comparison

- 246 eligible companies
- 45 Best Performers (18%)
- Every major industry represented
- Similar to other employers in demographics and coverage
- One difference = size
  - 51k vs. 28k employees

The Long-Term Impact of Better Performance

Cumulative 15% Cost Trend vs. 53% over 7 Years (Illustrative)

Total PEPY Spending Difference Over 7 Years = $11,792
## Findings: Best Performers Are Early Adopters of Value-Based Purchasing

### Tactics That Are More Widely Adopted Among the Best Performers vs. Low Performers

<table>
<thead>
<tr>
<th>Employee Health Benefit Tactics</th>
<th>Differential 2013 Adoption Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt new payment methodologies that hold providers accountable for cost of episode of care, replacing fee for service</td>
<td>38% vs. 13% [+25%]</td>
</tr>
<tr>
<td>Offer incentives (or penalties) to providers to improve quality, efficiency and health outcomes (performance based payments)</td>
<td>47% vs. 28% [+19%]</td>
</tr>
<tr>
<td>Contract directly with physicians, hospitals and/or ACOs</td>
<td>31% vs. 13% [+18%]</td>
</tr>
<tr>
<td>Offer incentives (or penalties) to providers for coordinating care and using emerging technologies or evidence based treatments</td>
<td>38% vs. 21% [+17%]</td>
</tr>
</tbody>
</table>

Pursuing a Continuum of Value-Based Purchasing Strategies

Individual vs. Collective Action
Number/Range of Stakeholders Involved

- Narrowly Targeted
  - Direct 1 on 1 Engagement
  - Onsite Primary Care Clinics
  - Intensive Outpatient Care
  - Value-Based Networks
  - Risk-Based Payments
- Broad-Based
  - Multi-Stakeholder Initiatives
  - Payer- or Coalition-Mediated
  - Promoting Medical Homes
  - Promoting Transparency
  - Centers of Excellence

Population Impact
Share of Employees Impacted

Cincinnati Regional Healthcare Transformation Initiative
Helping to Build a Common Vision and Agenda for the Community

Craig Osterhues, Manager, Health Services GE Aviation
What’s Different in Cincinnati?

- Leadership
- Health Info Exchange
- Collaboration
- Payment structure

The Mission: Make health & health care a competitive advantage for the Region
Participating Stakeholders
Community Planning Process

Process: Inclusive, Open, Transparent
Strategic Framework

Better Care
Improve the patient experience of care, including quality and satisfaction

Better Health
Improve population health

Lower Costs
Reduce the per capita cost of health care

Triple Aim Goals

Primary Care Information Technology Quality Improvement Consumer Engagement Payment Innovation

Cincinnati’s Five Pillars
The Promise of PCMH

- **COST REDUCTIONS**
  - $26.37 PMPM (Michigan)
- **FEWER ED VISITS**
  - 19% Reduction in ED Visits (GE)
- **INPATIENT ADMISSIONS**
  - 31% Decrease in Inpatient Admissions (20 study average)
- **FEWER READMISSIONS**
  - 13% Decrease in Readmissions (20 study average)

Source: [www.pcpcc.org](http://www.pcpcc.org)
The Promise of PCMH (cont.)

Source: [ww.pcpcc.org](http://ww.pcpcc.org)
Move from pilot projects to production
How We Got Here…

Health Information Exchange

1997

Medical Home Pilot

Multi payer claims data

2008

2009

2010

2011

2012

2013

2015

Comprehensive Primary Care (CPC) Initiative

Qualified Entity

CPC data

State Innovation Model

All payer claims data

Public Reporting (Bethesda)

Electronic Medical Record (REC)

Data/Information (Beacon)

Community Quality Improvement (AF4Q)

27
Impact at GE

IMPROVING PRIMARY CARE THROUGH PCMH

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Visits per 1000 Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PCMH PILOT</strong></td>
<td>119</td>
<td>106</td>
</tr>
<tr>
<td><strong>NON-PCMH MATCHED COHORT</strong></td>
<td>132</td>
<td>139</td>
</tr>
<tr>
<td>Hospital Admissions per 1000 Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PCMH PILOT</strong></td>
<td>54</td>
<td>36</td>
</tr>
<tr>
<td><strong>NON-PCMH MATCHED COHORT</strong></td>
<td>54</td>
<td>67</td>
</tr>
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</table>

QUALITY IMPROVEMENT IN THE CARE OF ADULT DIABETES

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Diabetes Patients with Complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CINCINNATI</strong></td>
<td>1.4%</td>
<td>0.8%</td>
</tr>
<tr>
<td><strong>NON-CINCINNATI</strong></td>
<td>1.3%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Percentage of Diabetes Patients with HbA1c Tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CINCINNATI</strong></td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td><strong>NON-CINCINNATI</strong></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>74%</td>
</tr>
</tbody>
</table>
Impact at GE (cont.)

QUALITY IMPROVEMENT IN THE CARE OF PEDIATRIC ASTHMA

<table>
<thead>
<tr>
<th>Percentage of Pediatric Asthma Patients with Complications</th>
<th>Percentage of Pediatric Asthma Patients with ER Visits</th>
<th>Hospital Admissions per 1000 Pediatric Asthma Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CINCINNATI</strong></td>
<td><strong>NON-CINCINNATI</strong></td>
<td><strong>CINCINNATI</strong></td>
</tr>
<tr>
<td>4.7%</td>
<td>4.1%</td>
<td>44</td>
</tr>
<tr>
<td>2.7%</td>
<td>3.6%</td>
<td>13</td>
</tr>
</tbody>
</table>

| **CINCINNATI**                                             | **NON-CINCINNATI**                                   | **CINCINNATI**                                        |
| 6.6%                                                      | 3.2%                                                 | 51                                                   |
| 4.2%                                                      | 3.6%                                                 | 33                                                   |

[Greater Cincinnati Health Council Logo]
Next Step: Scale & Spread

- Leverage – Patient-Centered Medical Home
- Align – payment strategies
- Demand – comprehensive data-driven care
- Engage – make your voices heard
PCMH + Payment Reform

Greater Cincinnati
1 of only 7
chosen sites nationally

75 practices and 261 providers

Multi-payer:
9 health plans + Medicare

300,000 estimated commercial, Medicaid and Medicare enrollees

65 miles from Williamstown, KY to Piqua, OH
CPC Markets

The Participating Practices

There are 500 primary care practices participating in the CPC initiative. ([List](#) | [Map](#))

This represents 2,144 providers serving an estimated 313,000 Medicare beneficiaries.

Source: Centers for Medicare & Medicaid Services
Measuring and Paying for Value

Need for Neutral “Source of Truth”

- No payer has the whole picture of any one provider
- No provider organization has data outside of their walls
- Payers lack Quality data; Providers lack Cost data
- Payment moving from “fee for service” to “pay for value”
- With money at stake, a high degree of statistical credibility is needed
- Without aggregation of data, practice level measurement will always have a “numbers” problem
- A consistent and continuous methodology is needed to monitor year over year progress
Benefits of All-Payer Claims Database

- Community-wide view of cost and utilization
- Evaluation at the practice level
- Benchmark performance
- Transparency for consumers seeking high quality care
Pay for Value Not Just Visits

Ohio Governor’s Office of Health Transformation

80%-90%

Have 80-90 percent of the state’s population in some value-based payment model within five years.
Questions?