Regional Strategies to Collaboratively Measure Affordability

Meredith Roberts Tomasi
HealthInsight Oregon

Katie Dobler
The Portland Clinic

Pamela Mariea-Nason
Providence St. Joseph Health, pamela.mariea-nason@providence.org

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Regional Strategies to Collaboratively Measure Affordability

IHI Learning Lab
Sunday, Dec. 9, 2018
About Us

Meredith Roberts Tomasi

Katie Dobler

Pamela Mariea-Nason

The presenters have nothing to disclose.
Objectives

In this session, you will:

• Understand the terminology, data elements and regional resources already working with quality and cost data across the country, and learn how Oregon uses regional data and multi-stakeholder partnerships to address barriers on the road to affordability
Objectives (cont.)

In this session, you will:

• Identify your key champions for effective multi-stakeholder collaborations, and develop an affordability asset map for your community

• Create ideas to use on your path to a collaborative community approach to understanding and optimizing your use of data
## Table Introductions

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where are you from? Which organization?</td>
</tr>
<tr>
<td>What objectives brought you to this session?</td>
</tr>
<tr>
<td>What do you hope to take home by attending this Learning Lab?</td>
</tr>
</tbody>
</table>
Helpful vocabulary

- **NRHI**: Network for Regional Healthcare Improvement
- **RHIC**: Regional Health Improvement Collaborative
- **MPCD**: Multi-payer claims database
- **APCD**: All-payer claims database
- **TCOC**: Total Cost of Care
About Oregon Health Care Quality Corporation and HealthInsight

We are an independent, neutral nonprofit dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information.

In 2017, Q Corp merged with HealthInsight, a larger nonprofit organization serving Oregon, Utah, New Mexico and Nevada.

In 2018, HealthInsight merged with Qualis Health serving 11 states around the country.
Oregon Data Collaborative

- Fuller picture than any one data source
- Comparisons—between health plans, medical groups, practices and providers
- Follows patients over time, across payers

Aggregated claims data
What is affordability?
We have a problem.

The way we receive healthcare in the United States is broken, and as a result Americans are less healthy while paying more.
We ALL created this problem. We ALL need to be part of the solution.
Regional Health Improvement Collaboratives (RHICs)

Regional Focus

Neutral Conveners

Non-Profit
The role of RHICs

- Patient Education
- Analysis & Reporting
- Quality Improvement
- Paying for What Matters

Regional Focus
Neutral Conveners
Non-Profit

Providers
Purchasers
Payers
Patients

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Major drivers of affordability

Solving one issue in isolation does not achieve the goal.
Addressing the drivers of affordability has systemic benefits—in addition to the positive economic impact

**+ HEALTH**

Healthier populations:
- use fewer resources
- increase productivity
- enhance communities

**- WASTE**

Unnecessary clinical procedures:
- increase clinical harm
- cause emotional distress
- incur financial harm

Administrative burden:
- increases cost
- is burning out providers

**- PRICE**

High prices:
- don’t correlate with quality
- incentivize waste
- misallocate resources

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Multiple stakeholders, varied tactics—one goal

Members engage from positions of particular knowledge, experience and strengths:

- Population Health
- Payment Reform
- Quality Improvement
- Data Analysis

- Cross-pollinate best practices
- Disseminate educational materials
- Lead community dialogue

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RHICs currently work in many regions across the U.S.
State APCDs

Source: APCD Council, https://www.apcdcouncil.org/state/map
NRHI Getting to Affordability (G2A) Program

REGIONAL COMMITMENT.
NATIONAL IMPACT.

The initiative was piloted by NRHI and RHICs in five regions. Their success led to the expansion to fourteen additional regions over the course of the project.

Pilot RHICs
- Center for Improving Value in Health Care | Colorado
- Maine Health Management Coalition | Maine*
- Midwest Health Initiative | St. Louis, Missouri
- Minnesota Community Measurement | Minnesota
- Oregon Health Care Quality Corporation | Oregon

Expansion Regions
- California Healthcare Performance Information System | California
- Greater Detroit Area Health Council | Michigan
- HealthInsight Nevada | Nevada
- HealthInsight New Mexico | New Mexico
- HealthInsight Utah | Utah
- Health Care Improvement Foundation | Philadelphia
- The Health Collaborative | Ohio
- Integrated Healthcare Association | California
- Maryland Health Care Commission | Maryland
- Massachusetts Health Quality Partners | Massachusetts
- The University of Texas Health Science Center at Houston | Texas
- Virginia Health Information | Virginia
- Washington Health Alliance | Washington
- Wisconsin Health Information Organization | Wisconsin

*Phase I and II only participant
What other regions have done
Minnesota Community Measurement

- Distributed data model (work directly w/payers)—payers run measures and send calculated results to MNCM for aggregation
- Public reports of all primary care practices annually
Center for Improving Value in Health Care

- All-payer claims database for Colorado
- Medicare vs. commercial payments by region
Washington Health Alliance

- Voluntary claims database
- Identifying waste in the health care system

This measure identifies use of imaging (X-ray, CT and MRI) in patients with low back pain within 42 days of a diagnosis of low back pain as wasteful.

Only the costs of imaging and professional fees for radiology are included in this measure.

Results from the Health Waste Calculator

In this analysis, a total of 16,673 individuals received imaging for low back pain for an estimated cost of $4.8 million.

83% of these individuals received wasteful and likely wasteful imaging for an estimated cost of $4 million.
What other regions have done: Integrated Healthcare Association

1. **Health Care Cost and Quality Atlas**—public Web tool displaying cost, quality, and hospital utilization at the region/payer/product type level (atlas.iha.org)
3. Public recognition awards (*Excellence in Health Care Award*)—for physician groups; based on the Triple Aim: clinical quality, patient experience and cost
2. Public reporting of the Triple Aim—clinical quality, patient experience, total cost—at the physician group level (reportcard.opa.ca.gov)
4. **Cost savings calculations** if all performed at some benchmark

If all physician groups performed at the level of the Excellence in Health Care Award Winners, $3.9 billion would be saved annually.

If care for all commercially insured Californians represented by the Atlas were provided at the same cost as a relatively high-quality, low-cost region:

- Overall cost of care would decrease by an estimated $2.6 billion annually, or almost 5 percent of the $55 billion total cost of care for the commercially insured.
Understanding and communicating the problem
National perspective

- Alex Azar, Secretary of Health and Human Services, has identified health insurance affordability and availability as a key national priority

- Centers for Medicare & Medicaid Services want to support innovative approaches to improve quality, accessibility and affordability as part of the organization’s strategic goals
State perspective

“Is Oregon’s 3.4 percent cost containment target unsustainable? My answer is yes. It is unsustainable if we continue to deliver care in the way we’ve traditionally delivered it.”

—Pat Allen
Director, Oregon Health Authority
Health plan—problem statement

Amit Shah, MD
Chief Medical Officer, CareOregon

Source: NRHI 2017 National Affordability Summit
“Our clinics are involved in value-based contracts and have to meet contractual obligations. It is impossible to do without understanding cost, and we can’t change our providers’ behaviors without sharing data with them. We need cost transparency across all of our payers to help us meet contract requirements.”
Employer—problem statement

“As employers and as leaders, addressing healthcare is one of the most important things we can do for our employees and their families, as well as for the communities where we all work and live. Together, we have the talent and resources to make things better, and it is our responsibility to do so.”

—Jamie Dimon
Chairman and CEO, JPMorgan Chase

Consumer—problem statement

“No matter what age, gender, or community setting, health/health care is the most unpredictable factor in our lives. If it was just a matter of life or death it would be hard enough. But health/health care can make the quality of your life terrible. And it can and will gobble up any wealth it can, transferring it away from housing, schools, food—the very things we most need to stay healthy. And the folks who should be able to fix it, don’t have the information to do so. Time for patients to take charge.”

—John Santa, MD, MPH
Activity One: Understanding the Affordability Problem in Your Community
It’s about the journey AND the destination

Oregon’s Road Trip to Affordability
A brief history of the Data Collaborative

2000
• Q Corp founded from purchaser’s coalition

2004
• Oregon Chronic Disease Data Clearinghouse pilot

2007
• RWJF Aligning Forces for Quality begins

2008
• Join Network for Regional Health Improvement (NRHI)

2009
• Data Collaborative launches with 10 data suppliers
• First Provider Reports (Quality)
• First Public Reports

2011
• Expanded provider and public reporting to include utilization

2015
• First Cost of Care reports to primary care providers

2017
• Release of first-ever health care cost benchmark report comparing the cost of care in five regions
Oregon’s program is led by stakeholders

In 2009, the Data Collaborative was launched with 10 payers voluntarily submitting data for reporting

- First aggregated quality measures for primary care providers released
- First public reporting of quality measures released
- Improving the patient experience of care (including quality and satisfaction)
Oregon’s program is led by stakeholders

In 2012, Board decided to expand reporting beyond quality & utilization into cost to better address value of health care

- Health plan partners were willing to allow cost reporting based on long history of collaboration on quality & utilization reporting
- Data Use Agreement was updated carefully to ensure protections
- *Reducing the per capita cost of health care*
Oregon’s program is led by stakeholders

Cost of Care Advisory Committee formed in March 2013

- Formed to provide strategic advice and guidance on the development of new products and services related to cost of care
- Committee met for five months to discuss options and develop an implementation plan
Oregon’s program is led by stakeholders

Cost of Care Steering Committee formed in July 2014

- Recruited diverse membership including health plans, primary care and specialty providers, consumers and researchers who are vested in transforming the health care system in Oregon
- Committee spent months discussing data, learning about the measures, and iterating on dozens of report versions
Oregon’s program is led by stakeholders

As organization grew and focus changed, so did stakeholders involved

- Founded by health care purchasers (Employers)
- Data Collaborative launched with data from health plans (Payers)
- Quality reporting (Providers)
- Public reporting (Consumers)
- State APCD (State Agencies)
- Qualified Entity (CMS)
# Cost of Care Steering Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betsy Boyd-Flynn</td>
<td>Executive Director</td>
<td>Oregon Academy of Family Physicians</td>
</tr>
<tr>
<td>Tim Bucy</td>
<td>Manager, Managed Care Contracts</td>
<td>U.S. Oncology</td>
</tr>
<tr>
<td>Susan Clack, MD</td>
<td>President, Pacific Medical Group</td>
<td>President, Portland IPA</td>
</tr>
<tr>
<td>Keith Crowland</td>
<td>NW Director of Analytics and Business Intelligence</td>
<td>KP Insight Northwest</td>
</tr>
<tr>
<td>Scott Conroy</td>
<td>Administrator</td>
<td>Hillsboro Cardiology</td>
</tr>
<tr>
<td>Bill Dwyer</td>
<td>Director, Analysis &amp; Reporting</td>
<td>Moda Health</td>
</tr>
<tr>
<td>Paige Frederick, RN</td>
<td>Quality Assurance Coordinator</td>
<td>Portland Coordinated Care Association</td>
</tr>
<tr>
<td>Robert Gluckman, MD, FACP</td>
<td>Chief Medical Officer</td>
<td>Providence Health Plan</td>
</tr>
<tr>
<td>Jenny Grunditz, M.Sc</td>
<td>Research Associate</td>
<td>OHSU Center for Health Systems Effectiveness</td>
</tr>
<tr>
<td>Doug Koekkoek, MD</td>
<td>Chief Executive Officer, Providence Medical Group &amp; Clinical Services—Oregon</td>
<td>Providence Health &amp; Services</td>
</tr>
<tr>
<td>Sandra Lewis, MD, FACC</td>
<td>Cardiologist, Legacy Medical Group</td>
<td>Past Governor, American College of Cardiology – Oregon</td>
</tr>
<tr>
<td>Steve Mann, DO</td>
<td>President</td>
<td>Adaugeo Healthcare Solutions</td>
</tr>
<tr>
<td>Jennifer Matson</td>
<td>Business Development Manager</td>
<td>Biotronik</td>
</tr>
<tr>
<td>Barry Newman, MD, MBA</td>
<td>Treasurer and Director</td>
<td>Oregon Pediatric Society</td>
</tr>
<tr>
<td>Traci Rieckmann, PhD, MS</td>
<td>Chief Operating Officer</td>
<td>GreenField Health</td>
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<tr>
<td>Deborah Rumsey</td>
<td>Executive Director</td>
<td>Children’s Health Alliance</td>
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<tr>
<td>John Santa, MD, MPH</td>
<td>Director of Dissemination for OpenNotes</td>
<td>Beth Israel Deaconess Medical Center</td>
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<td>Amit Shah, MD</td>
<td>Chief Medical Officer</td>
<td>CareOregon</td>
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<tr>
<td>Divya Sharma, MD</td>
<td>Internist, Mosaic Medical</td>
<td>Medical Director, Central Oregon IPA</td>
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<tr>
<td>Bob Sumner, MBA</td>
<td>Engagement Manager</td>
<td>Provider Partnership Innovations</td>
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<tr>
<td>Michael Whitbeck</td>
<td>Administrator</td>
<td>Northwest Primary Care</td>
</tr>
<tr>
<td>Craig Wright, MD</td>
<td>Chief Medical Officer</td>
<td>The Portland Clinic</td>
</tr>
</tbody>
</table>
How does Oregon address price?

https://vimeo.com/167920308
Steering Committee collaboratively addressed concerns

Members expressed concerns about:
- Disclosure of proprietary information
- Loss/gain of competitive advantage

Committee defined project parameters to ensure protections:
- Reports are based on risk adjusted data at person level—not individual service or procedure rates
- Attributed patient lists were made available
- Cost information is aggregated at the market level (i.e., Commercial). With 5+ plans participating, not possible to back into contractual rates
- Kept attributed patient threshold at 600 for clinics to receive reports

Ultimately decided cost transparency was of benefit to all parties
Source: NRHI 2017 National Affordability Summit
Cost of Care Steering Committee drives direction

- Laid out roadmap:

  Private reporting to primary care clinics x2
  Private reporting to participating payers
  Public reporting

- Healthy tension created by variety of perspectives and priorities
- Steering Committee continues to guide program development and direction
Creating the reports

Professional PMPM by Service Category *
Professional includes all costs for professional services delivered in any setting: inpatient, outpatient, or in a clinic, lab, or imaging center. It also includes ancillary services (lab, radiology, DME, etc.) delivered outside of a hospital facility.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>OR Average</th>
<th>Price Index</th>
<th>RUI</th>
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<tr>
<td>Adj PMPM</td>
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<tr>
<td>Office/Home Visits</td>
<td>$33.42</td>
<td>1.00</td>
<td>1.01</td>
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<td>Office Administered Drugs</td>
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<td>Outpatient Surgery</td>
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<td>1.07</td>
<td>1.08</td>
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<tr>
<td>Pathology/Lab - Office</td>
<td>$7.49</td>
<td>1.11</td>
<td>1.01</td>
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<td>Physical Therapy</td>
<td>$7.22</td>
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<td>0.82</td>
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<td>Office Surgery</td>
<td>$6.27</td>
<td>0.97</td>
<td>1.07</td>
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<td>Outpatient Psychiatric</td>
<td>$6.02</td>
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<td>Preventive Physical Exams</td>
<td>$4.78</td>
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<td>0.98</td>
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<tr>
<td>Inpatient Surgery</td>
<td>$4.56</td>
<td>1.02</td>
<td>1.02</td>
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<tr>
<td>Radiology Office - General</td>
<td>$4.46</td>
<td>0.96</td>
<td>0.92</td>
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<tr>
<td>Maternity</td>
<td>$3.64</td>
<td>1.03</td>
<td>1.04</td>
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<td>Preventive Immunizations</td>
<td>$3.77</td>
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<td>Radiology Office - CT/MRI/PET</td>
<td>$3.57</td>
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<td>1.04</td>
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<td>Preventive Other</td>
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<td>Outpatient Anesthesia</td>
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<td>Miscellaneous Medical</td>
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<td>Inpatient Visits</td>
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<td>ER Visits and Observation Care</td>
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<td>Inpatient Anesthesia</td>
<td>$1.53</td>
<td>0.96</td>
<td>0.92</td>
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<td>All others</td>
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<td><strong>Total</strong></td>
<td><strong>$128.46</strong></td>
<td><strong>1.05</strong></td>
<td><strong>1.00</strong></td>
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Professional PMPM by Service Category

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Clinic PMPM</th>
<th>OR Average PMPM</th>
<th>TCI</th>
<th>RUI</th>
<th>Price Index</th>
</tr>
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<tbody>
<tr>
<td>Evaluation &amp; Management</td>
<td>$24.98</td>
<td>$26.31</td>
<td>0.88</td>
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<td>Surgery &amp; Anesthesia</td>
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<td>Preventive Screenings</td>
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<td>Physical Therapy &amp; Rehab</td>
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<td>Lab &amp; Pathology</td>
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<td>1.24</td>
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<tr>
<td>Oncology &amp; Chemotherapy</td>
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<td>Advanced Imaging</td>
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<td>Echography</td>
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<td>Durable Medical Equipment</td>
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<td>Standard Imaging</td>
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<td>Other Professional Services</td>
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<td>$34.57</td>
<td>1.10</td>
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<td>1.07</td>
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<tr>
<td>Other Services</td>
<td>$13.62</td>
<td>$14.56</td>
<td>0.94</td>
<td>0.91</td>
<td>1.03</td>
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<td><strong>Total</strong></td>
<td><strong>$207.60</strong></td>
<td><strong>$154.45</strong></td>
<td><strong>1.07</strong></td>
<td><strong>0.97</strong></td>
<td><strong>1.10</strong></td>
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</tbody>
</table>

Professional Price vs. Resource Use Comparison by Clinic

[Graph showing comparison of price index versus resource use index (RUI) for different services, with a legend indicating high and low use for each category.]
Oregon Total Cost of Care program timeline

2014
- Cost of Care Steering Committee Formation
- Reporting Template Finalized

2015
- 1st Commercial Clinic Reports Released
- Statewide Cost Information Published for the First Time

2016
- 2nd Commercial Clinic Reports Released
- Health Plan Reports Produced
- Medicare FFS Pilot

2017
- 1st NRHI National Benchmark Report Released

2018
- 2nd & 3rd NRHI National Benchmark Reports Released
- 3rd Commercial Clinic Reports Released
- Medicare FFS Clinic Reports Released
- Public Reporting
- Exploration of expanded service utilization reporting

2019
- Expansion of TCOC program to other HealthInsight states
- 4th Commercial Clinic Reports Released
Activity Two: Stakeholder and Asset Mapping—Part 1
Break—please return by 3 p.m.
Activity Two: Stakeholder and Asset Mapping—Part 2
A case study

How are the reports being used?
Portland Coordinated Care Association (PCCA)—problem statement

“Our clinics are involved in value-based contracts and have to meet contractual obligations. It is impossible to do without understanding cost, and we can’t change our providers’ behaviors without sharing data with them. We need cost transparency across all of our payers to help us meet contract requirements.”
Example report from health plan

HEALTH PLAN

Relative Spending, Based on Allowed Amount as a Percent of Medicare, Inpatient and Outpatient Combined, Based on Dates of Service in 2017, All Health Plan Commercial Business

[Bar chart showing relative spending for Hospitals A to L]
Clinic Comparison Reports—Commercial

Separate Adult and Pediatric reports
Commercial health plan patients

33% commercial population

Data from 7 health plans | 421,000+ covered lives

Cost, quality and utilization are compared to Oregon average

Delivered to 182 practices with 600+ attributed patients

Three rounds of reports—2013, 2014 and 2016—have been sent, with plans for annual delivery going forward.
Clinic Comparison Report Package

• Quality, Cost and Utilization at the clinic level

• Commercial clinic reports sent to 79 medical groups: 166 adult and 47 pediatric reports

• Reports include drilldowns into:
  • Demographics & Cost Overview
  • Professional
  • Outpatient
  • Imaging and ER
  • Inpatient
  • Chronic Conditions
  • Pharmacy
Clinic Comparison Reports

### Overall Summary by Service Category

<table>
<thead>
<tr>
<th>Service Category</th>
<th>clinic Raw PMPM</th>
<th>clinic Adj PMPM</th>
<th>OR Average PMPM</th>
<th>TCI = RUI x Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$203.02</td>
<td>$183.18</td>
<td>$167.12</td>
<td>1.10 0.99 1.11</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$69.00</td>
<td>$62.25</td>
<td>$115.53</td>
<td>0.54 0.60 0.90</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$71.08</td>
<td>$64.13</td>
<td>$72.21</td>
<td>0.89 0.78 1.13</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$73.92</td>
<td>$66.70</td>
<td>$69.20</td>
<td>0.96 0.98 0.98</td>
</tr>
<tr>
<td>Overall</td>
<td>$417.03</td>
<td>$376.26</td>
<td>$424.06</td>
<td>0.89 0.85 1.05</td>
</tr>
</tbody>
</table>

Clinic scores are risk adjusted to account for variations in illness burden.

#### Clinic Risk Score

- **Clinic Risk Score:** 1.11
- **OR Average Risk Score:** 1.00

---

**Resource Use Index (RUI)**

- Other Oregon Clinics
- Clinic

---

**Environment:**

- Resource Use
- Price Index
- High Price
- Low Price
- High Use
- Low Use

---

**HealthInsight OREGON**

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PCCA Data

2016 Price vs. Resource Use Comparison by Clinic Inpatient

- High Price, Low Use
- High Price, High Use
- Low Price, Low Use
- Low Price, High Use

- NW Primary Care Group PC
- Portland Coordinated Care
- The Portland Clinic
- S. Tabor Fam Phy Davies Clinic
## PCCA Data

### Radiology (Outpatient Facility and Professional Services)

<table>
<thead>
<tr>
<th>Service</th>
<th>PCCA Adj PMPM</th>
<th>OR Average PMPM</th>
<th>TCI</th>
<th>RUI</th>
<th>Price x Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>$9.92</td>
<td>$11.15</td>
<td>0.89</td>
<td>1.02</td>
<td>0.87</td>
</tr>
<tr>
<td>MRI</td>
<td>$7.45</td>
<td>$7.90</td>
<td>0.94</td>
<td>1.10</td>
<td>0.86</td>
</tr>
<tr>
<td>CT Scan</td>
<td>$4.00</td>
<td>$4.86</td>
<td>0.82</td>
<td>1.04</td>
<td>0.79</td>
</tr>
<tr>
<td>Therapeutic/Radiation Oncology</td>
<td>$3.96</td>
<td>$3.58</td>
<td>1.11</td>
<td>1.10</td>
<td>1.01</td>
</tr>
<tr>
<td>PET</td>
<td>$0.45</td>
<td>$0.44</td>
<td>1.02</td>
<td>1.22</td>
<td>0.83</td>
</tr>
</tbody>
</table>
PCCA Data

Primary and Specialty Care Utilization:
Evaluation & Management *

Specialist Services, Top Categories *

<table>
<thead>
<tr>
<th>Service</th>
<th>PCCA</th>
<th>OR Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>169</td>
<td>173</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>225</td>
<td>177</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>363</td>
<td>192</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>307</td>
<td>383</td>
</tr>
<tr>
<td>Oncology</td>
<td>624</td>
<td>533</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1,079</td>
<td>622</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>1,459</td>
<td>1,480</td>
</tr>
<tr>
<td>PT/OT/ST</td>
<td>1,004</td>
<td>941</td>
</tr>
</tbody>
</table>

Vists/1,000 patients

Services/1,000 patients

PCCA: [HealthInsight](http://www.healthinsight.org) Oregon
Using the reports—health plan perspective

Bob Gluckman, MD
Chief Medical Officer
Providence Health Plan

Source: NRHI 2017 National Affordability Summit
The power of aggregated data

- Aggregated data informs conversations between health plans and practices, challenging or validating assumptions
Summary and next steps
Starts with an itinerary

• Fellow travelers (Board?) essential
• Listen to the locals and be humble
• Build a successful program
Sharing travel stories

• Expanding beyond Commercial to Medicare and Medicaid

• Supporting practices to make lasting change

• Enabling conversations about improving the affordability of health care in Oregon
Ending the road trip

• Caught the attention of policymakers
• Using data to reduce the cost curve
• Continuing to explore and decide our next “destination”

• Looking to the future:
  – Data is only half the story; how to make the information actionable is the rest
  – How can this work be leveraged to make big change in Oregon? Nationally?
Where we go from here: planned activities to support sustainability

| Expanding beyond commercial population | • Exploring the feasibility of producing TCOC reports using Medicaid claims data  
• Expanding to Medicare FFS in 2018 |
| Attract more payers | • Meetings with several new health plans and existing partners to share value proposition |
| Benchmark reports | • Continuing to participate in NRHI Benchmark reports, allows for increased exposure and potential funding opportunities |
| Public reporting | • Working closely with the Cost of Care Steering Committee to ensure public cost reporting is actionable and consumer-friendly  
• Public release of data in 2018 |
| Develop tools to help stakeholders address costs | • Developing reporting for referral patterns to specialists and facilities |
Activity Three: Assets and Barriers
Report-out and wrap-up

- Key takeaways and report-out
- Final questions/comments
- Reminder of available resources
Regional Health Improvement Collaborative (RHIC)

Patient Engagement

- Patient and Family Advisory Council
- Development and expansion of self-management programs

Data Collaborative Products
- Compare Your Care (public website)
- Practice Reporting Portal
- Statewide Reports

Payment and Delivery System Reform

- Quality Improvement Organization
- Hospital Improvement Innovation Network

- Payment reform projects
- Medicare Quality Payment Program technical assistance
- CPC+ Payer Group facilitation

Training and Assistance in Performance Improvement

Consumers

Providers

Payers

Purchasers

Providers

Performance Measurement and Transparency

Providers

Consumers

Purchasers

Payers

Consumer Information

Providers' Performance Information

Payment and Delivery System Information

Quality Improvement Information

Provider Training and Assistance Information

Patient and Family Information

Payment Reform Projects Information

Medicare QPP Technical Assistance Information

CPC+ Payer Group Facilitation Information

Patient and Family Advisory Council

Development and expansion of self-management programs

Payment and Delivery System Reform

Data Collaborative Products

Training and Assistance in Performance Improvement

Patient Engagement
RHICs currently work in many regions across the U.S.
Contact Us!

Meredith Roberts Tomasi
mrobertstomasi@healthinsight.org

Katie Dobler
KDobler@tpcllp.com

Pamela Mariea-Nason
pamela.mariea-nason@providence.org