Improving Health Care Value through Shared Accountability

Bert Zimmerli

Rising costs and increasing demand for health care services requires a broader approach to health care reform than the insurance mandates incorporated in the Affordable Care Act. At Intermountain Healthcare, an approach focused on "Shared Accountability" was designed to increase the effectiveness and lower the cost of health care by emphasizing the "Triple Aim" of better care, better health, and better cost management.

Introduction

The health care system in the United States is facing staggering challenges of rising costs and wide variation in both clinical quality and access to care. Recent health care reform legislation—which focuses more on insurance mandates than on improvements in care delivery—is unlikely to significantly alter the fundamental trends of growing demand, growing utilization, and rising costs.

But there is good news, if we as a nation choose to embrace it: We know how to provide excellent care at a lower cost. It's already being done by organizations in different parts of the country, including Utah, where Intermountain Healthcare is the leading provider. If Utah were a country, by many measures, it would rank as having the most effective health care in the world.[1]

Intermountain's approach—called Shared Accountability—is designed to achieve the "Triple Aim" goals of better care, better health, and better cost-management.[2] To understand our approach, it's useful to understand the factors causing health care utilization and costs to rise.

Drivers of Health Care Utilization and Costs

Health care expenditures are rising at a rate that's disproportionate to the growth rates in other sectors of our economy because people are using more care—and more expensive types of care. Utilization is driven by a number of factors:

- **An Aging Population**
  Aging is the first of a number of demographic changes fueling health care expenditure increases. According to the 2010 census, a growing percentage of seniors (age 65 and older) now constitute about 13 percent of the U.S. population (compared to 12 percent in 2000 and 1990 and just 5.4 percent in 1930).[3]

  As more and more of the 77 million baby-boomers turn 65, the percentage of seniors is increasing and will account for 19 percent of the population by 2030.[4] Moreover, the "oldest old"—those 85 and older—are growing as a group, from 15 percent of seniors today to more than 20 percent of seniors by 2050.[5]

  Since per capita spending rises with age,[6] health care expenditures will increase as increasing numbers of seniors require increasing amounts of care.

- **A Sicker Population**
  A much more troubling demographic change is the rising incidence of obesity in our population. According to the Centers for Disease Control and Prevention, 63 percent of Americans have a body mass index (BMI) greater than 25, which is considered

overweight, and 31 percent have BMIs greater than 30, which is considered obese.[7]

These percentages have increased rapidly in the last two decades. The prevalence in children is especially alarming, because it has nearly tripled since 1980.[8]

The health risks of obesity are well-documented and numerous; they include a greater risk of Type 2 diabetes, cardiovascular disease, cancer, hypertension, dyslipidemia, stroke, joint disease, and other health problems.[9]

The annual medical care costs of obesity are estimated at $147 billion.[10]

- **Incentives for Physicians and Hospitals**
  Current financial incentives in the dominant fee-for-service payment model encourage physicians and other health care professionals to do more tests and procedures—and especially reward them for doing expensive tests and procedures. This is one of the main differences between the U.S. health care system and the systems in other countries.

  As a result, America excels at "rescue care": trauma care, cancer care, cardiac care, transplantation, etc. By contrast, most other nations place a greater emphasis on preventive and primary care, such as immunizations, prenatal and well-baby care, and the treatment of chronic illness.[11]

  Similarly, our fee-for-service payment model pays on the basis of services provided rather than on outcomes or effectiveness, rewarding the quantity rather than the quality of care. And fear of litigation causes physicians and hospitals to err on the side of providing extra services.

  Many caregivers take the course of least resistance and order additional tests and services, even though their medical judgment tells them these extras aren't needed.[12]

- **Technology**
  In addition, technology has been a mixed blessing in health care. Americans place such a high priority on technological innovations that we often rush to implement new tools before we have fully evaluated their effectiveness. While advances in technology have dramatically reduced costs in other fields—such as data processing, consumer electronics, and communications—technological advances in health care have almost always added costs.[13]

  New breakthroughs in health care, unlike other fields, often require additional human resources, and these so-called advances have not always improved outcomes, even as costs rise.

  The options for the definitive treatment of prostate cancer, for example, now include radical prostatectomy, robotic prostatectomy, brachytherapy (radiologic seed implant), radiation therapy, intensity-modulated radiation therapy, and proton beam therapy.

  While there are not demonstrably significant differences in outcomes between these various modalities, the costs of these interventions vary by a factor of nearly five.[14]

- **Incentives for Patients**
  Patients tend to view more care—and newer modes of care—as better care. In the decades after World War II, Americans benefited enormously from greatly expanded access to employer and government health insurance.

  But an unintended consequence of this insurance was an almost unchecked incentive for patients to desire—and for caregivers to provide—access to every sort of care, effective or not, with consumers largely insulated from the true cost of care. While Americans have been sharing in more of the costs of care and coverage in the last decade, the view that "more is better" persists.[15]

It should be noted that health care organizations like Intermountain have been very successful through the years in improving efficiency and in reducing the unit costs of care materials and processes.

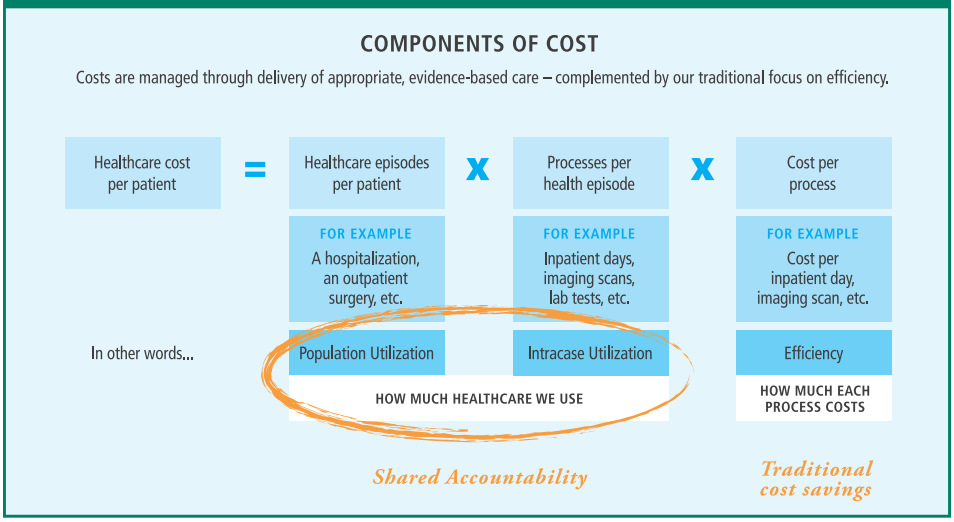
We've done this through innovations in supply chain, revenue cycle, information systems, and other initiatives that enhance operational effectiveness. As a result, the unit costs of care have tended to remain stable and in some cases have even declined.

But unit costs are only one component in the overall cost of care. As shown in Figure 1: Components of Cost, the other two components are as follows:

1. The number of episodes of care ("population utilization" or demand for care)
2. The number of processes used within each episode or case ("intracase utilization")

Demand for care can be affected by prevention, wellness, and care management programs that help people stay as healthy as possible. Intracase utilization can be affected by physicians and hospitals when these providers follow evidence-based best practices in delivering care.

Figure 1
Components of Cost



The Crucial Value of Evidence-Based Medicine

The solution, then, to the problem of rising health care expenditures is to focus on all three components of cost through the following:

1. Efficiency, as we have traditionally done, to address unit costs
2. Evidence-based best practices, which address both population utilization and intracase utilization
3. Wellness programs and patient engagement, which address demand or population utilization

While the focus on efficiency needs to be continued and the focus on wellness needs to be expanded, the largest challenge lies in defining and implementing best practices—reducing the amount of unwarranted variation in how we care for patients. To redesign care delivery, we need to change the behavior of all parties involved, especially hospitals, physicians, and patients.

In changing behaviors, the parties can rally behind a shared goal: higher quality care and better medical outcomes. If we do this, cost growth will naturally tend to be restrained. We may call this the "health care quality paradox": in health care, higher quality tends to result in lower overall costs to a population.

While this may be a counter-intuitive notion, especially to consumers, it has been demonstrated by Intermountain Healthcare, Mayo Clinic, Cleveland Clinic, and other organizations.[16]

The evidence shows that when care is delivered in the right way in the right place at the right time—all the time—patients experience fewer complications, fewer readmissions, and better outcomes overall.

That is our thesis at Intermountain Healthcare: that evidence-based best practice produces higher quality and lower cost. Our journey into evidence-based medicine received a boost about 25 years ago, when Brent James, MD, returned to Utah from Harvard University and started to work on clinical quality improvement studies at Intermountain.

Dr. James was one of a group of researchers around the country who helped launch a movement to identify and implement best practices in health care. These researchers included Dr. John Wennberg, Dr. Elliott Fisher, and others at the Dartmouth Institute for Health Policy and Clinical Practice, as well as Harvard School of Public Health professor Dr. Donald Berwick, who founded the Institute for Healthcare Improvement.

Dr. Wennberg's studies of variation in the delivery of care to Medicare patients began in the late 1960s and developed into the project called *The Dartmouth Atlas of Health Care*, of which he is the founding editor.[17]

The clinical quality improvement process represents an evolution of clinical science: a shift away from a "cottage industry" model, in which apprentice physicians learn solely from mentors or "master" physicians, to a "system" model, in which physicians also study process and outcomes data to determine the types of care that are most effective.[18]

Physicians work as part of teams with nurses and other clinicians, administrators, and data analysts to review opportunities for clinical improvement. Data are measured and analyzed, best practice protocols are implemented, and outcomes are measured again to see if improvements occur. Physicians are

always free to override the guidelines if they deem it necessary, although they are asked to document the reasons for using another pathway. This helps improve processes and protocols, as the team learns what works best.

In the 1990s, Intermountain created clinical programs to serve as a foundation for quality improvement efforts. We now have eight such programs: cardiovascular, oncology, intensive medicine, women and newborns, pediatric specialties, surgical services, primary care, and behavioral health. Intermountain's board of trustees sets annual clinical quality goals for the clinical programs and other areas to ensure progress is made.

In one example, as a result of our goal to ensure heart failure patients were discharged with the proper ACE inhibitors, compliance increased from 65 percent to 95 percent in one year, and readmissions within 12 months decreased from 47 percent to 39 percent (551 fewer readmissions). And, we estimated 331 lives were saved compared to historical controls.

Not insignificantly, this represented a $2.5 million reduction in health care charges to payers in our communities in one year.[19]

In another example, we saw that the risk of having to put a newborn on a ventilator was significantly higher when the baby was delivered prior to 39 weeks of gestation. By reducing the number of elective inductions prior to 39 weeks, we spared many babies the risk and discomfort of beginning life on a ventilator, and we estimate savings of $1.7 million for the period from 2009 through 2010.[20] An added benefit was that the C-Section rates in Intermountain hospitals declined.[21]

Recent data show that Utah has ranked lowest in the nation in per capita health care expenditures.[22] Health insurance premiums in Utah are also among the lowest.[23] Yet clinical outcomes in Utah are among the best in the world. Dartmouth researchers have cited Intermountain as a national benchmark for high-quality affordable health care.

In a recent white paper on health care quality and costs, adjusted for age and overall population health, these researchers wrote:

> How much could the nation save . . . ? Using the Mayo Clinic as a benchmark, the nation could reduce health care spending by as much as 30 percent for acute and chronic illnesses; a benchmark based on Intermountain Healthcare predicts a reduction of more than 40 percent.[24]

More and more, health leaders and policymakers have been awakening to the promise of evidence-based medicine in addressing our nation's health care challenges. It will need to become a national focal point, if we as a country are to succeed in providing excellent care at a lower cost.

Shared Accountability Approach

At Intermountain, our Shared Accountability approach is built upon the concepts of evidence-based medicine and continual quality improvement. Another core premise is that great health care is the responsibility of all those involved: physicians, hospitals, and payers, but also patients and the community as a whole.

As noted, Shared Accountability is designed to achieve the Triple Aim goals:

- Better care (for patients). Create a more robust mechanism to deliver the most effective, appropriate, evidence-based care. This will occur in large part through our Clinical Programs and Services, as well as through other initiatives and programs.
- Better health (for the population we serve). We seek to engage patients in prevention and wellness programs and in decisions about their care.
- Better management of cost. We seek to align financial incentives so that all those involved in health care—including patients—are motivated to seek high-value care. Not only does the current fee-for-service payment model incentivize providers to deliver more care rather than best care, it also, in many cases, financially penalizes caregivers who try to deliver highly effective care.

We are developing a new physician payment model to pay physicians not only based on the amount of care they provide but also on their meeting quality, service, and cost-management goals. (See "Valuation of Physician Contracts and Structuring Physician Compensation" in this *Insights* issue.)

Our commitment to evidence-based care means supporting physicians and other caregivers in their efforts to provide the right care personalized for each patient. By "right care" we mean treatments likely to be most effective, based on the latest studies and the body of medical knowledge and evidence.

This also means avoiding the three types of substandard care identified by the Institute of Medicine: over-treatment (doing too much), under-treatment (doing too little), and misuse of resources (making mistakes).[25]

Patient involvement is another key component of Shared Accountability. Patients are typically unaware of the relative risks, benefits, and costs of different treatment options, and their health insurance benefits often do little to encourage them to be more discriminating consumers of care. We are also committed to providing greater transparency as to treatment options, so that patients and clinicians can make more informed decisions together.

At the same time, we will continue to look at ways to incentivize and reward employees and patients who take advantage of programs that encourage healthy behaviors. We're also providing extra counseling and preventive resources to help patients stay healthy, comply with their doctors' treatment plans, and manage any chronic health problems (like diabetes, heart disease, asthma, and behavioral health issues).

Intermountain's integrated structure helps us address the Triple Aim goals of Shared Accountability. Our health services division includes 22 hospitals, a continuum of care services, and a medical group with 1,100 employed physicians based in more than 185 clinics. We also have affiliations with 4,000 independent physicians.

In addition, we have a health insurance division called SelectHealth that covers about 550,000 commercial plan members, plus other members covered by our Medicare Advantage and Medicaid products. Beyond covering members in Utah and southeastern Idaho, SelectHealth is also now covering members in central and western Idaho through a partnership with St. Luke's Health System.

Our health insurance division is of critical importance in helping us deliver care. For example, it allows us to work with members on health and wellness issues before they become patients, and it provides data about the effectiveness of care that informs our clinical programs and services and the development of best practices.

Each area within Intermountain plays a role in Shared Accountability. One example is Intermountain Personalized Primary Care (our version of the patient-centered medical home concept), through which the Intermountain Medical Group is providing enhanced primary care services, including expanded care management.

Another example is our Telehealth program, which is allowing patients to interact with caregivers across distances. In addition to facilitating consultations among specialists, Telehealth promises to have a transformative effect on access to primary care and care management, significantly improving the patient experience.

At Intermountain, more than 20 teams are working to realize our vision of Shared Accountability. By 2016, we expect to have most of the pieces in place and showing significant results. Revenue and expenses will continue to grow as the demand for care grows. But, Shared Accountability will help Intermountain bend the cost curve, saving hundreds of millions of dollars compared to what costs would have been if they had continued on their earlier trajectory.

These savings will be returned to the community in the form of lower premiums. By 2016, we expect to be able to offer our commercial clients average annual premium increases close to the rate of general inflation.

Shared Accountability offers an alternative to rationing techniques—such as restricted benefits, exclusionary pricing, and eligibility requirements, or service delays—that might otherwise be the norm in American health care. It retains the best of American health care, while tackling the problems of rising costs and wide variation in both clinical quality and access to care.

The unsustainable trends in health care will not be significantly altered by the current health care reform legislation. The health care field needs to reform itself by improving the way care is delivered. Our greatest opportunity is to focus on improving the effectiveness of care: to consistently do the things we know are beneficial and to avoid doing things that aren't valuable.

And, as health care providers do their part, patients and other payers (both private and government) need to do their part to adopt healthy behaviors, use benefits wisely, and avoid care that isn't effective. With evidence-based medicine at its core, Shared Accountability offers a strategy for doing exactly that.

Notes:

1. Intermountain analysis of World Health data, Nolte and McKee studies, and Rutgers Center for State Health Policy studies. Standardized for age (1998), Utah data from 2003, normalized for general U.S. change from 1998. See also The Commonwealth Fund, National Scorecard on U.S. Health System Performance, 2008; http://www.commonwealthfund.org/Charts/Testimony/Insurance-Design-Matters-Underinsured-Trends-Health-and-Financial-Risks-and-Principles-for-Reform/Mortality-Amenable-to-Health-Care.aspx. See also E. Nolte and M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* 27, no. 1 (January 2008): 58–71.
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3. U.S. Census Bureau, "2010 Census Shows Nation's Population Is Aging," Release CB11-CN147 (26 May 2011); http://2010.census.gov/news/releases/operations/cb11-cn147.html.
4. Linda A. Jacobsen, Mary Kent, Marlene Lee, and Mark Mather, "America's Aging Population," *Population Bulletin* 66, no. 1 (February 2011): 2-3; http://www.prb.org/pdf11/aging-in-america.pdf. See especially Figure 2.
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6. CMS. See especially https://www.cms.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf. See also Micah Hartman et al., "U.S. Health Spending By Age, Selected Years Through 2004, *Health Affairs* 27, no. 1 (January 2008): w1-w12; http://content.healthaffairs.org/content/27/1/w1.full.pdf
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9. Ibid.
10. Ibid. See also E.A. Finkelstein, et al., "Annual Medical Spending Attributable to Obesity: Payer- and Service-specific Estimates," *Health Affairs* 28, no. 5 (May 2009): w822-w831.
11. Organisation for Economic Co-operation and Development (OECD), "OECD Health Data," *OECD Health Statistics* (database, updated 30 Jun 2011). See http://www.oecd.org/health/healthdata. Also reported on the Kaiser Family Foundation website. See http://www.kff.org/insurance/snapshot/OECD042111.cfm.
12. Jerome Hoffman, interview as part of "More Is Less" radio story, Episode 391, *This American Life* radio program (Chicago: Chicago Public Media [WBEZ], October 9, 2009); http://www.thisamericanlife.org/radio-archives/episode/391/more-is-less.
13. Bruce Leff, MD, and Thomas E. Finucane, MD, "Gizmo Idolatry," *JAMA* 299, no. 15 (April 2008).
14. Charles W. Sorenson, MD, *Healthcare in the United States and Utah*, presentation at Intermountain Healthcare Trustee Conference (March 2011).
15. Kristin Carmen et al., "Evidence That Consumers Are Skeptical about Evidence-Based Health Care," *Health Affairs* 29, no. 7 (July 2010): 1400-1406; http://content.healthaffairs.org/content/early/2010/06/03/hlthaff.2009.0296.full.pdf.
16. John Wennberg, Elliott Fisher, et al., *An Agenda for Change: A Dartmouth Atlas White Paper* (Hanover, N.H.: The Dartmouth Institute for Health Policy and Clinical Practice, Dec 2008). See especially pages ii and 5.
17. *The Dartmouth Atlas of Health Care in the United States*, http://www.dartmouthatlas.org/. See also Wikipedia, s.v. "John Wennberg," http://en.wikipedia.org/wiki/John_Wennberg.
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