How Comparative Effectiveness Research Informs Value-based Purchasing Decisions

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President – QuadMed
Sept 2009
Learning Objectives

• Define Comparative Effectiveness Research
• Define Value-based Benefit Design
• Explore Principles of Personalized Medicine
• Explore QuadMed Model of Prospective Medicine
• Explore Concepts of the Patient-centered Medical Home and Accountable Care Organizations
• Explore the Above Concepts Within the Context of Health-care Reform
“Hi! My name is Kevin, and I’ll be your doctor today.”
About Dr Zastrow

• Family Physician
• President - QuadMed
  – Practice at Sussex and West Allis Clinics
• EVP - Center for Health Value Innovation
• Instructor MCW / MSOE Masters in Medical Informatics Program
• Former Partner Advanced Healthcare, SC
• Former Vice President Medical Affairs
  – St. Michael Hospital – Wheaton Franciscan Healthcare
• Former Medical Director Informatics WFSI
Clinical Effectiveness Research is the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels.
CER – Funding Legislation – ARRA 2009

• $1.1 billion appropriation to fund additional CER administered by
  – the Agency for Healthcare Research and Quality (AHRQ) $300B
  – the National Institutes of Health (NIH) $400B
  – the Secretary of the Department of Health & Human Services (HHS) $400B

• “to conduct or support research to evaluate and compare clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition” as specified in the Conference Report concerning the CER provisions.

• Emphasis on clinical outcome-based research and analysis (as opposed to research driven by cost analysis and cost containment)

• The Conference Report “recognizes that ‘a one-size-fits-all’ approach to patient treatment is not medically appropriate.”
New Federal Body

*Federal Coordinating Council for Comparative Effectiveness Research*

- Authority and responsibilities limited
- Coordinate CER among federal agencies
- Reduce “duplicative efforts”
- Encourage “coordinated and complementary use of resources”

\*explicit language that the advisory council does not have the authority to mandate coverage, reimbursement, or other polices for any public or private payer\*
So What Exactly is Subject to CER?

- Procedure
- Device
- Drug
- “Approach”
- Facility
- Provider
Why CER? Why Now?

• Isn’t the Scientific Method the basis for Medical Decision Making?
• Haven’t we been doing CER all along??
USPTF Level of Evidence Taxonomy

- **A** for services that are *strongly recommended* on the basis of *solid evidence* that the benefits of improved outcomes outweigh the risks of harm
- **B** for services that are *recommended* on the basis of *reasonable evidence* of net benefits
- **C** for services with *no recommendation* because the balance of benefits and risks is *too close*
- **D** for services that *should not be routinely provided* because the evidence indicates the services are ineffective or that the risks outweigh the benefits
- **I** for services that do *not* have *sufficient evidence* on which to base a recommendation

United States Preventive Task Force
“Perhaps the most compelling evidence of those opportunities involves the significant geographic differences in spending on health care within the United States, which do not, on average, translate into higher life expectancy or substantial improvements in other health statistics in the higher-spending regions.”

– Peter Orszag, Director, CBO, December 2007
Medicare Spending per Capita in the United States, by Hospital Referral Region, 2003

- $7,200 to $11,600 (74)
- $6,300 to < $6,800 (55)
- $4,500 to < $5,800 (72)
- $6,800 to < $7,200 (45)
- $5,800 to < $6,300 (60)

Not Populated
THE COST CONUNDRUM

What a Texas town can teach us about health care.

by Atul Gawande

JUNE 1, 2009

It is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks. McAllen is in Hidalgo County, which has the lowest household income in the country, but it’s a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. “Lonesome Dove” was set around here.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much
Per CBO - Four Major Core Categories of Endeavor:

- Research
- Human and Scientific Capital
- CER Data Infrastructure
- Dissemination and Translation of CER
Research

- includes activities or investments in primary research or meta-analysis. Organizations involved in this group of activities may be funding research, conducting research themselves, or helping to establish a common set of research priorities to create momentum around the most critical research topics.
• includes activities or investments that enhance the United States’ capacity for CER by expanding and strengthening relevant research skills or by advancing CER approaches and methodologies. Organizations involved in this group of activities may be directly involved in training and workforce development, developing new CER methods, validating results of CER, or driving consensus on valid approaches to CER.
• includes activities or investments that develop, build, or maintain data infrastructure, systems, or tools. These investments could include the creation of new research data sets and repositories, aggregation of existing data sources, development of new tools to query and analyze existing data sets, or creation of standards for new data collection.
Dissemination and Translation of CER

- includes activities or investments that disseminate CER findings and put them into practice. Activities and investments range from dissemination and distribution of CER information to improving processes and outcomes in health care and public health delivery systems through CER translation and adoption.
Examples of Activities in Each Major Category Activity

- **Research**  Comparing outcomes of treatments or care delivery for a specific condition

- **Human & Scientific Capital**  Training new researchers to conduct CER or developing CER methodology and standards

- **CER Data Infrastructure**  Developing a distributed practice-based data network, linked administrative or EHR databases, or patient registries

- **Dissemination and Translation of CER**  Building tools and methods to disseminate findings and translate CER into practice to improve health outcomes for patients
Strategic Framework

Cross-Cutting Priority Themes

- CE Research
- Human & Scientific Capital for CER
- CER Data Infrastructure
- Translation and Adoption of CER

Priority Populations

Priority Conditions

Types of Interventions

Specific investments can be within a single category or be cross-cutting in one of the priority themes.
Cross-Cutting Investment Opportunities
Under-researched populations (e.g., priority/underserved populations, multiple chronic conditions)
Under-researched interventions (e.g., procedures, behavior change, end-of-life care)
Unlikely to be addressed given roles and capacities in CER
Opportunities to catalyze cross-cutting data, research and collaboration

CER Investment Decisions

Human & Scientific Capital for CER
CE Research Priorities
CER Data & Research Infrastructure (Research data repositories & clinical research networks)
Translation & Adoption of CER

Training
CER methods development
Methods for patient/consumer engagement

Expressed public and federal needs for CER
Explicit Prioritization with Public Input
High-priority, feasible, non-duplicative CER topics

Inventories of existing CER infrastructure
Evidence generation
- Clinical research networks
- Registries, surveillance databases, research quality observational databases

Evidence linkages
- Claims, other admin databases
- EHRs and distributed data networks

Inventory of existing CER translational & dissemination activities
Potential Capacity for Translation through Federal delivery systems & public-private partnerships

Funding based on identified high-priority gaps
Funding based on high-value CER portfolio to fill gaps
Funding based on identified high-priority gaps

Legend:
CER Investment Opportunities
Enhanced Human & Scientific Capital for CER
New Comparative Effectiveness Research
Enhanced CER Infrastructure
CER Findings into Practice and Public Health
CER Is Not Unique to U.S.

- UK
- Canada
- France
- Germany
- Australia
Is CER NICE? (Apologies to C.S. Lewis)

- Ask a Perelandrian!

- National Institute for Health and Clinical Excellence (NICE)
- Established 1999, National Health Service, UK
- Analyzes both the clinical effectiveness and cost-effectiveness of new and existing medicines, procedures, and other technologies and provides guidance on appropriate treatments for specific diseases or types of patients.
- If NICE approves a drug, device, or procedure, it must be covered by the NHS, (but local health authorities make coverage decisions about treatments that NICE has not yet evaluated).
A sinister technocratic organization, National Institute of Coordinated Experiments (NICE), is gaining power throughout England with a plan to "recondition" society, and it is up to the protagonist, Dr. Ransom, and his friends (including the re-animated Merlin the Magician) to squelch this threat by applying age-old wisdom to a new universe dominated by science.
First Quartile

• Compare the effectiveness of treatment strategies for atrial fibrillation including surgery, catheter ablation, and pharmacologic treatment.

• Compare the effectiveness of the different treatments (e.g., assistive listening devices, cochlear implants, electric-acoustic devices, habilitation and rehabilitation methods [auditory/oral, sign language, and total communication]) for hearing loss in children and adults, especially individuals with diverse cultural, language, medical, and developmental backgrounds.

• Compare the effectiveness of primary prevention methods, such as exercise and balance training, versus clinical treatments in preventing falls in older adults at varying degrees of risk.

• Compare the effectiveness of upper endoscopy utilization and frequency for patients with gastroesophageal reflux disease on morbidity, quality of life, and diagnosis of esophageal adenocarcinoma.

• Compare the effectiveness of dissemination and translation techniques to facilitate the use of CER by patients, clinicians, payers, and others.

• Compare the effectiveness of comprehensive care coordination programs, such as the medical home, and usual care in managing children and adults with severe chronic disease, especially in populations with known health disparities.

• Compare the effectiveness of different strategies of introducing biologics into the treatment algorithm for inflammatory diseases, including Crohn’s disease, ulcerative colitis, rheumatoid arthritis, and psoriatic arthritis.
A Brief Word on Personalized Medicine and CER

• Definition - the application of genomic and molecular data to better target the delivery of health care, facilitate the discovery and clinical testing of new products, and help determine a person's predisposition to a particular disease or condition.
  
i.e. Prescribing the right drug at the right dose for the right person, based on unique variations in their DNA.

• **Dichotomy** between studying populations and the promise of personalized medicine: How can CER at a broad population level be balanced with the goals and rapid scientific advancements in the area of personalized and stratified medicine in order to encourage the development of targeted therapies for sub-groups?

• CER studies include the evaluation of approaches to health care delivery and care management that foster the effective application of personalized medicine.
AMA Embraces Direct-to-Consumer Advertising

"Coronary bypass! Upstairs! Third floor! Twelve hundred, firm! Check it out!"

Just Kidding!
“The AMA opposes conferring a federal CER entity with the authority to make or recommend coverage or payment decisions for payers.”
“While the AMA supports the use of cost-effectiveness considerations by physicians, we emphasize that cost-effectiveness is subordinate to the consideration of safety and clinical effectiveness. Cost-effectiveness must not be used by payers to preclude or limit the availability of a safe and effective technology that is medically indicated.”
“Physicians should have access to the best available evidence at the point of care to ensure that the chosen intervention is the most effective for a given patient and condition, in reducing morbidity and mortality.”

Implicit Support for POC Clinical Decision Support?
The shape of things to come
Who Is Quad/Graphics?

- Founded in 1971
- The world’s **largest** privately held printer of magazines and catalogs
- **10 printing** plants in 6 states
- International partnerships with printers in Poland, Argentina and Brazil
- **9,500 employees**, approximately 6,000 in Wisconsin
- > **$2 billion** in annual sales
A Sample of Quad/Graphics Clients

Advertising Age
Cargo
Entertainment Weekly
Elegant Bride
Golf Digest
Health
JC Penney
Life
National Geographic
Newsweek
People
Self
Time Inc.
U.S. News & World Report
Victoria’s Secret
Williams-Sonoma
Why Is Quad/Graphics in the Healthcare Business?

- **Control costs** by providing a full range of healthcare services
- **Focus** on wellness, preventive medicine
- **Offer benefits** that attract, retain staff
- **Maintain flexibility** in benefits design
- **Improve patient access** with onsite facilities

**Essentially...**

**Because the Healthcare System is Broken!**
“We’ll keep you well; and by the way, if you get sick, we’ll take care of that, too.”

Harry V. Quadracci, Founder, Quad/Graphics
Who Is QuadMed?

We provide innovative, high-value health care solutions to companies, improving the overall health and productivity of their people.
QuadMed Model: the “Three-Legged Stool”

• Wellness at Work
  – On-Site Primary Care Clinics
  – Patient-Centered Medical Home
  – Worker’s Comp

• Innovative Information Management
  – Claims Management / TPA Function
  – Data Warehouse (Ingenix)
  – Electronic Medical Records (GE)
  – Internet Portal

• Benefit Design
  – Value-based Insurance Design (VBID)
  – Balance Patient Choice Against Steerage
  – Emphasize Personal Responsibility for Health-Related Lifestyle Choices
Integration of Services

"Your oil's fine, but your blood-sugar level's a little low."
QuadMed Philosophy

Practice better medicine – not less medicine.

This will ultimately save more money than treating healthcare as a short-term, bottom-line expenditure.
QuadMed “Prospective Medicine” Strategy

- **Provide** on-site primary care & selected specialty care
- **Focus** on prevention and wellness
- **Restructure** the delivery of primary care
  - Salaried providers, not “Production” based reimbursement
  - Incentives based on quality – Customer Satisfaction, adherence to guidelines, preventive services, collegiality, committee participation
  - Provide ample “face time” with patients
- **Provide** specialty care & hospital care through direct contracting - “Narrow Networks”
- **Remove** waste and improve Quality - LEAN
- **Integrate** workers compensation into primary care services
QuadMed Clinic Locations

MillerCoors Brewing
- Primary Care
- Fitness Center
- Occupational Med
- Rehab

Briggs & Stratton
- Primary Care
- Fitness Center
- Occupational Med
- Rehab

Northwestern Mutual
- Primary Care
- Occupational Med

Briggs & Stratton
- Primary Care
- Rehab

QG Lomira, WI
- Primary Care
- EAP, AODA
- Rehab
- Fitness Center
- Dental
- Vision

QG Sussex, WI
- Primary Care
- Surgery
- EAP, AODA
- Rehab
- Fitness Center

QG West Allis, WI
- Primary Care
- ENT
- Orthopedics
- Cardiology
- Occupational Medicine
- EAP, AODA
- Rehab
- Fitness Center
- Dental
- Vision Care

QG Saratoga Springs, NY
- Primary Care
- EAP, AODA
- Rehab
- Fitness Center

QG Martinsburg, WV
- Occupational Med
- Primary Care
- EAP / AODA
- Fitness
- Rehab
Financial Results
QuadMed Track Record

Average healthcare cost per employee

$ Thousands


Midwest
Quad/Graphics
Average Healthcare Cost Trend

2000-2007 per employee per year

4.9%
Value-Based Benefit Design is the explicit use of plan incentives to encourage enrollee adoption of one or more of the following:

- appropriate use of **high value services**, including certain prescription drugs and preventive services;
- adoption of **healthy lifestyles**, such as smoking cessation or increased physical activity, and
- use of **high performance providers** who adhere to evidence-based treatment guidelines.

Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans, such as a Health Savings Accounts.

Source: NBCH VBBD Purchaser Guide
Value-based Insurance Benefit Design (VBID)

- “Fiscally responsible, clinically sensitive" benefits design

- Benefit design that encourages the delivery of high impact, relatively low-cost interventions that have been shown to prevent costly disease progression.

- "The reason we provide health benefits is not to have zero net costs. If you want to save money, don’t cover people."
  - A. Mark Fendrick – co-director of the University of Michigan School of Public Health’s Center for Value-Based Insurance Design
QuadGraphics’ Benefit Design: 2008 and beyond

Weekly premium of $21 per single, $33 per couple, $45 per family*

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Quad/Clinics</th>
<th>Services</th>
<th>Deductible</th>
<th>Coverage</th>
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<tr>
<td></td>
<td>400 Specialists</td>
<td>$6</td>
<td>$30</td>
<td>100%</td>
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<tr>
<td></td>
<td>9 Hospitals</td>
<td>$25-200</td>
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</tr>
<tr>
<td>Network</td>
<td>98 Hospitals</td>
<td>$300/500</td>
<td>$2,300 max</td>
<td>80%</td>
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<tr>
<td></td>
<td>6,650 Doctors</td>
<td>$400/800</td>
<td>$400/800</td>
<td></td>
</tr>
<tr>
<td>Non-network</td>
<td></td>
<td></td>
<td></td>
<td>70%</td>
</tr>
</tbody>
</table>

* Does not include $10 ($8 + $2) LeanYou! Premium Reduction
QuadMed as Patient-Centered Medical Home

- Team-based Primary care
- Foster close interpersonal relationships
- “What does a holistic philosophy entail? Balance is essential in both personal and professional life to nurture and fulfill human needs—physically, mentally and spiritually. Moreover, decisions are made for **long-term benefit**, rather than short-term reward. Relationships between employees and QuadMed and its clients are based on trust, common goals and providing mutual benefits for those who are involved.”
Patient-Centered Medical Home (PC-MH)

**Description**: practice-based care model for providing comprehensive primary care for children, youth and adults in a health care setting. The PC-MH facilitates partnerships between individual patients and their personal physicians and – when appropriate – the patient’s family. The Joint Principles (AAP, AAFP, ACP, AOA) define the following key characteristics of the PC-MH:

**Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

**Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the PC-MH. The statement features eight sub-points highlighting specific responsibilities, education, decision making, technology, participation and other necessary elements to improve quality and safety.

Enhanced Access to care is available through systems such as Open Access scheduling, extended hours and new options for communication (such as secure messaging via the Internet) between patients, their personal physician and practice staff.
The Chronic Care Model

Adapted from Glasgow, et al
LeanYou! 2008: Marrying Wellness and Benefits

- **LeanYou! Premium Reduction** (Employee only)
  - $2 / week:
    - Sign up for LeanYou! program
    - Biennial on-line HRA (“How’s Your Health?”)
    - Commit to having a LeanYou! health evaluation during the year
  - $8 / week additional:
    - Sign tobacco-free attestation

- **LeanYou! Achievement Award** (Employee and Spouse)
  - Increased cash rewards: $400, $175, $50
Lean You!

Well You Diabetes

Well You Asthma

Well You Hyperlipidemia

Well You Hypertension
Well You! for Diabetes – Chronic Condition Management

- Innovative **Value-Based** Benefit Design
- New in 2007
- Modeled after the Asheville Project
- Extension of **Lean You!**
- **$0 co-pay** for most diabetic meds if:
  - Regular visits with Diabetic Nurse Educator
  - Qualify for Lean You! Program
  - Compliant with provider visit, medications and disease-management guideline requirements
- Estimated value ~ $400 annually
Two Recent Examples – Welcome to My World…
Coronary artery scanning showed abnormal coronary circulation, with a single coronary ostium directly off the anterior surface of the aorta, giving rise to all 3 coronary arteries.
Robotic Hysterectomy
“If you cannot measure it, you cannot improve it.”

- William Thomson Lord Kelvin
  1895
In God We Trust
(Everyone Else Bring Data)
# Evidence-Based Medicine Compliance

## Ingenix Database

<table>
<thead>
<tr>
<th>Condition</th>
<th>WI Compliance Rate</th>
<th>National Compliance Rate</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Low Back Pain</td>
<td>93.9%</td>
<td>93.9%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>62.7%</td>
<td>44.1%</td>
<td>58.4%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>71.6%</td>
<td>49.4%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>40.1%</td>
<td>21.0%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>79.8%</td>
<td>66.3%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Depression</td>
<td>84.4%</td>
<td>84.3%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>74.1%</td>
<td>55.6%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>82.4%</td>
<td>53.9%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>93.6%</td>
<td>71.3%</td>
<td>74.9%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>89.2%</td>
<td>73.0%</td>
<td>75.8%</td>
</tr>
<tr>
<td>Obesity</td>
<td>75.5%</td>
<td>46.1%</td>
<td>46.1%</td>
</tr>
<tr>
<td>Pediatric Asthma</td>
<td>64.0%</td>
<td>69.4%</td>
<td>61.6%</td>
</tr>
</tbody>
</table>
What can we, as employers, do to fix the Health Care crisis?
Recognize and Foster the Maturation of HC as an Industry

• **Invest in Primary Care**
  – Whether On-site or Community-based Medical Homes
  – Soften / Standardize “Corporate Practice of Medicine” laws

• **Promote Patient Incentives for Healthy Behaviors**
  – Encourage Fed to Soften ADA / HIPAA / ERISA to Promote Achievement Incentives for Clinical Metrics; e.g. BP / Glucose / AIC / Cholesterol etc.

• **Remove Piecemeal Provider Incentives for Chronic Care Management**
  – Blend Fee-for-service and Care Coordination; Carefully ‘Sprinkle’ P4P

• **Promote Population Health Management of Covered Lives**
  – Along the Wellness Continuum, *One Patient at a Time*…
Place a New Focus on Population Health Management

one patient at a time…

- Value-based Benefit Design
- Alignment of Incentives
- Member Health Risk Assessment
- Biometric Screening
- Predictive Modeling
- Risk Stratification
- Member Outreach / Coaching
- Chronic Condition Management
- Patient Adherence
Place a New Focus on Care Coordination

- **Don Berwick, Thomas Nolan, and John Whittington**, of the IHI “The Triple Aim: Care, Health and Cost” (from Health Affairs, May/June 2008) Calls for creation of “Integrator” in support of the Triple Aim (improved experience of care, improved population health and reduced per capita cost), via **Medical Home**
  - “… assume the responsibility for building the capability and infrastructure to enable primary care practices to function in this expanded role.” page 764

- **George Halvorson** – coined new phrase, “Care Linkage Deficiency” (from Health Care Reform Now! A Prescription for Change) – calls for creation of “Infrastructure Vendors”
  - “In short, the optimal marketplace should be data-rich, strategically incented, ergonomically elegant, electronically interconnected, economically efficient, and set in a context of constant systems enhancement and process improvement. That’s the environment the IVs should be hired to create.” page 176
Perhaps Healthcare is too big a problem to tackle…

Unless we break it out as
Healthcare Financing Reform
&
Healthcare Delivery Transformation
“My third felony was a smart move. Folks on the outside are still waiting for health care.”
Accountable Care Organizations and Provider Compensation

Payer
- Risk-Adjusted PMPM
- Fee-For-Service
- Pay for Performance

ACO
- RVUs
- Coding Accuracy
- Chart Completion
- Schedule Efficiency
- EBM
- Patient Satisfaction

ACO Providers

Salary +

Providers
Potential Primary Care Bonus Metrics

- **Productivity**
  - RVUs (work units)
  - Scheduling Efficiency
  - Chart Completion
- **Quality**
  - EBM Compliance
  - Whole Person Measure
  - Patient Satisfaction
- **Citizenship**
  - Medical Directorship
  - Committee Participation
  - Coding Accuracy
Paying for the Patient-Centered Medical Home (PC-MH)

**Payment** would reflect the value of physician care management work that falls outside of a face-to-face visit. It would pay for services associated with coordination of care, support adoption and use of health information technology for quality improvement and support provision of enhanced communication access. It would also recognize the value of physician work associated with remote monitoring of clinical data using technology, allow for separate fee-for-service payments for face-to-face visits, and recognize case mix differences in the patient population being treated within the practice.

**Payment** to Primary Care Providers in the QuadMed PC-MH Model – a mix of:

- Salary / Quality Incentives / Fee for Service

**Alignment of Incentives is essential for PC-MH success!**
Future Directions – Healthcare Financing Reform

- Increased Value-based Benefit Design
  - Selected **Chronic Care** Conditions:
    - Diabetes, Hypertension, Hyperlipidemia, Asthma, Depression
  - Stratify Patient Co-Pays – Along the “Friction” Continuum
    - Comparative Effectiveness
- Expand Wellness Program Incentives for Participants
  - Participation Incentives
  - Achievement Incentives
- Adjust Primary Care Physician / Provider Incentives; Salary Plus:
  - Risk-Adjusted Care **Coordination** Fees, PMPM
  - De-emphasized **Piecework** Fees
  - Judicious Use of **P4P** for Selected Measures
- Encourage Accountable Care Organizations / Integrators / PCMH / Infrastructure Vendors
Future Directions – Healthcare Delivery Transformation

• Accelerate Lean Transformation of Healthcare - *IHI “Triple Aim”*
  – **Patient Experience** – Concierge-like Services
  – **Population Health** - Evidence-based Medicine
  – **Per Capita Cost** – Narrow Networks / Centers of Excellence

• Increased Clinical IT Infrastructure
  – Improve EMR **User Interaction Design**
  – Incorporate **Disease Registry** into EMR
  – Continue to Develop **Clinical Decision Support**
  – HRA / PHR / **Patient Portal** (“cockpit”)
  – Expand use of **Virtual Encounters**

• Personalized Medicine
  – Incorporate **Genomics** into Daily Practice
  – **Population Health** – One Person at a Time…
QUADMED PRESIDENT
Raymond J. Zastrow
Raymond J. Zastrow, M.D. is the president of QuadMed, which helps companies develop on-site health care for its employees.

Archive: Raymond J. Zastrow
Back To School
I truly wish I could get behind the House of Representatives on...
(Near) Future State (?)

• Purchasers Paying for Outcomes
  – Accountable Care Organizations
  – Performance Guarantees / Shared Savings

• Prospective Health
  – Population Health “one person at a time”

• Meaningful Use of EMR
  – Clinical Decision Support – Best Practice Alerts
    • At Point of Care
    • Asynchronously
  – Collect Data for Ongoing CER (future state)
  – Consumer Informatics – Patient Portal
    • Care Navigator
...is better decision making by patients and providers. To achieve this, the nation will need effective strategies for disseminating CER findings and promoting their adoption into clinical practice.
“In the future, the place of medicine's art in the care of the sick may to a large degree depend on the manner in which computers are used. With their help, primary-care physicians may find time to give the personalized kind of care each individual so rightly deserves”

Truman G. Schnabel, MD, NEJM 1983
Raymond J. Zastrow, M.D.

President / QuadMed

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