Baskets of Care Annotated Bibliography

Prometheus Payment Model

1."PROMETHEUS Payment Set to Test New Method of Paying Providers for High-Quality Health Care". Robert Wood Johnson Foundation. http://www.rwjf.org. 2008

An article describing a pilot to test provider payment system, which creates common clinical incentives for all parties; payment based on a case rate that encompasses what science indicates are the resources all providers should consider in treating a patient (based on adherence to clinical guidelines and patient outcomes). Pilot to be operational 1/09 and supported by $6.4 million from Robert Wood Johnson Foundation.
Two initial pilot sites selected as Rockford, IL., and Mpls., MN; two others to follow. Goals of pilot are to expand starter set of Evidence-informed Case Rates (ECR's), total amount that will be paid to providers who treat a patient for a particular condition. ECR payments include: *base*-minimum level of service for uncomplicated care; *severity adjustment*-potential complication factors; *margin*- financial incentive to adhere to guidelines; and *withhold* amount to be paid later based on how provider performs on a scorecard of quality metrics. There are currently 12 ECR's for certain types of cancer, cardiology & orthopedic care as well as ECR's for routine and preventive care.

2. Gosfield, A. "Making Prometheus Payment Rates Real: Ya' Gotta Start Somewhere". Robert Wood Johnson Foundation. June 2008.

A paper describing in laymen's terms the basis of the PROMETHEUS Payment model. First Design Team meeting took place in December 2004; small group of experts and stakeholders from multiple disciplines with diverse set of skills. Identified IRP Claimshop (developers of software to track care provided to patients an allocate dollars to the providers) and Bridges to Excellence (developers of Scorecard which will report to providers their comparative performance) as partners to constitute the first "service bureau". First White Paper released in early 2006. Design Team chose primary chronic care, cancer, joint replacement and cardiac conditions as the initial types of clinical care to focus on. Next step involved selecting specific conditions and good supporting CPG's. They then deconstructed those CPG's by analyzing which specific services would create the continuum of care. There was no real information available about what it costs to treat a patient for a condition as called for by any CPG. Design Team obtained access to two major national claims databases in an effort to translate deconstructed CPG's into ECR's. Five explicit cushions built into the ECR to account for the limitations in the databases. Core services described with payment model detail include diabetes and AMI hospitalization.

3. "Theory, Results and Implementation". National Healthcare Incentives Institute Conference 10/19/2008- 10/21/2008.

Pre-conference slide presentation from speakers including Francois de Brantes, National Coordinator Prometheus Payment; Meredith Rosenthal, PhD, Harvard School of Public Health; Amita Rastogi, MD Prometheus Payment; Chad Brown, Prometheus Payment; Jim Knutson, Aircraft Gear; Greg Everett, IRP- Claimshop; and Carrie Tichey, HealthPartners. Presentation includes overview of model, warranty concept, ECR's, Rockford implementation, and HealthPartners experience (AMI pilot).

4. Camillus JA, de Brantes, F. "Evidence-Informed Case Rates: A New Health Care Payment Model". The Commonwealth Fund. April 2008.

Article highlights the work done to create the Prometheus payment model. New model intends to address failings of traditional fee-for-service and capitation systems. Goals of new model include to limit both underuse and overuse, eliminate unwarranted variation, reduce risk selection problems, promote clinical integration between providers and deliver recommended high-quality care. Initially gathered experts to form 5 working groups. Working groups identified 10 conditions for ECR development. Criteria used in condition selection process:
1. Conditions have high prevalence or high cost per event
2. There is wide variation in the treatment of the condition
3. Treatment of the condition requires coordination among providers
4. Treatment of the condition requires services that are not currently reimbursed
5. Condition has clear boundaries and
6. Clinical practice guidelines exist for the condition.
The working group then attempted to estimate the ECR base by walking a patient step-by-step through the relevant clinical practice guideline. The following questions were used:

1. What are the actual resources used to provide the recommended care?
2. Who is most likely to use these resources?
3. Where might the care happen most of the time?
4. How long will it take?

An essential component of the ECR is the performance withhold. Provider performance is to be tracked using two models:

1. The Prometheus scorecard, and
2. Normal claims activity.

It is acknowledged that choosing performance measures that drive desired behavior can be challenging; may need to focus on outcomes and avoid process measures where clinical guidelines call for flexibility and a physician's best judgment. Four pilot sites to be selected with a plan to develop an additional 50-60 ECR's during the next three years.

5. Gosfield, A. "A New Payment Model for Quality: Why Care Now". American Journal Of Medical Quality. May/June 2007.

Editorial summarizing the Prometheus payment model. Author concludes that this payment model offers a disciplined way to approach the central quality mission of the American health care system.

Geisinger Care Model (4)

1. Paulus, R., Davis, K., Steele, G. "Continuous Innovation In Health Care: Implications of The Geisinger Experience". Health Affairs September/October 2008.

Paper describing the Geisinger Health System's innovation strategy for care model redesign. Geisinger's innovation approach is highly collaborative, uses various criteria to target specific care models for redesign, includes the development of a clinical business case, and uses a variety of improvement methodologies. Article details Geisinger's innovation examples of: Medical home: Geisinger's Personal Health Navigator; chronic disease care optimization; and acute-episode care: Geisinger ProvenCare (CABG program).

The CABG program involved embedding 40 discrete care-process steps into both human and electronic workflows. Ultimately, GHP and its employer customers were most attracted to a single-episode package price that included preoperative evaluation and work-up, all hospital and professional fees, all routine postdischarge care, and management of any related complications occurring within 90 days of elective CABG surgery. The episode payment included a discount of 50% from the average related postoperative readmission cost experienced in a two-year historical comparison group.

The ProvenCare program has been expanded to include hip replacement, cataract surgery, and percutaneous coronary intervention; further expansion to bariatric surgery, lower back surgery, and perinatal care is actively under way.

Central to nearly all Geisinger innovation is the use of the EHR and data infrastructure to automate care, remove geographic barriers, empower consumers, and improve reliability.

Carol.com

1.Yee, C. "Carol.com cuts jobs, changes strategy". http://www.startribune.com/business. November 11, 2008.

Bloomington-based Carol.com, a Twin Cities company attempting to create an online medical marketplace, has struggled to attract users to its year-old website. Article reports that company is now cutting 25 jobs. It is reported that medical providers never got comfortable with posting their services online for comparison-shopping and consumers were confused. The company also has a website in Seattle. The company intends to focus on consulting and software services aimed at hospitals, clinics and physicians.

Medicare Heart Bypass Demonstration

1. "Medicare Participating Heart Bypass Center Demonstration". Extramural Research Report, Health Care Financing Administration. September 1998.

The Medicare Participating Heart Bypass Center Demonstration was done to evaluate the feasibility and cost effectiveness of a negotiated all-inclusive bundled payment for CABG while maintaining quality. Participating hospitals were encouraged to market their services to referring physicians and beneficiaries and to offer incentives to attract patients. It was found that an all-inclusive bundled payment could provide an incentive to physicians and hospital to collaborate.

Demonstration summary:
HCFA selected four initial participants (Saint Joseph's Hospital of Atlanta, St. Joseph Mercy Hospital in Ann Arbor, The Ohio State University Hospitals in Columbus, and University Hospital in Boston). Under the demonstration Medicare paid each hospital a single global rate for each discharge in DRG's 106 and 107. The rate included all inpatient hospital and physician services. First payments were received in May and June of 1991. Three additional participants were added in 1993 (St. Luke's Episcopal Hospital in Houston, St. Vincent's Hospital in Portland, Oregon, and Methodist Hospital in Indianapolis). The evaluation period extended through the second quarter of 1996, allowing for 5 and 3 years, respectively for the original and additional sites.

Brief summary of findings:

- Total Medicare savings estimated to have been $50.3 million in 5 years.
- Three of four of the original hospitals were able to make changes in physician practice patterns and hospital operations that generated significant cost savings.
- Holding many patient risk factors constant, a statistically significant, negative, trend in inpatient mortality rate was found among demonstration hospitals.
- Demonstration patients also received fewer bills for their surgery and found the billing process to be easier than expected.
- No systematic differences in self-reported health outcomes between demonstration and non-demonstration patients.
- Most hospitals reduced ICU stays by one full day and routine stays by another two to three days.
- All hospitals felt they were in a better position to negotiate managed care contracts because of the demonstration.
- Single largest administrative burden for hospitals under the demonstration involved billing and collection.
- Most salient accomplishment of the demonstration was the reduction in hospital costs in three of four hospitals where the micro-cost data were analyzed.

High Performance Delivery System

1. Shih, A., Davis, K., Schoenbaum, SC., Gauthier, A., Nuzum, R., McCarthy, D. "Organizing the US Health Care Delivery System For High Performance". Commonwealth Fund. August 2008.

A Report from The Commonwealth Fund Commission that examines fragmentation in our health care delivery system and offers policy recommendations to stimulate greater organization-established mechanisms for working across providers and care settings. Our fragmented system rewards high-cost, intensive medical intervention over higher-value primary care, including preventive medicine and the management of chronic disease.

This report identifies six attributes for an ideal health care delivery system: information flow to providers and patients through electronic health record systems; care coordination and care transition support; peer accountability and teamwork among providers; easy access to appropriate care; accountability for the total care of the patient; and continuous innovation to improve quality, value, and patient experiences.

The Commission recommends payment reforms: bundled payment systems that reward coordinated, high-value care and expansion of pay-for-performance programs to reward high-quality, patient-centered care; patient incentives to choose to receive care from high-quality, high-value systems; regulatory changes to remove barriers to clinical integration; accreditation programs for organized delivery systems; changes in provider training; government support to help facilitate organization where necessary; and an acceleration in the adoption of health information technology.

Examined 15 diverse health care delivery systems, four important lessons emerged:

- Ideal delivery system is achievable; existing delivery systems have many of the key attributes.
- There is more than one way to organize providers to achieve those key attributes.
- Although there are diverse approaches, some form of organization is required to achieve these attributes.
- Leadership is a critical factor in the success of delivery systems.

Recommended strategies:

- Payment reform offers the opportunity to stimulate greater organization as well as higher performance; recommend movement away from fee-for-service payment system toward bundled payment systems that reward coordinated, high-value care. Additionally, recommend expanding pay-for-performance programs.
- Patients should be given incentive to choose to receive care from high-quality, high-value delivery systems.
- The regulatory environment should be modified to facilitate clinical integration among providers.
- There should be accreditation programs that focus on the six attributes of an ideal delivery system.

- Provider training programs should be required to teach systems-based skills and competencies, including population health, and be encouraged to include clinical training in organized delivery systems.
- In instances where formal organized delivery systems may not develop on their own, government should play a greater role in facilitating or establishing the infrastructure for an organized delivery system, for example through assistance in establishing care coordination networks, care management services, after-hours coverage, health information technology, and performance improvement activities.
- Providers should be required to implement and utilize certified electronic health records that meet functionality, interoperability, and security standards, and to participate in health information exchange across providers and care setting within five years.