

Supporting Evidence-Based Decisions at the Point of Care

**Center on Health Care Effectiveness
Mathematica Policy Research
Washington, DC**

April 12, 2016

Andrea Ducas • Sanne Magnan • Tara Montgomery
Ann O'Malley • Eugene Rich • Nyna Williams • Daniel Wolfson

Moderator

Eugene Rich
Director, Center on Health Care Effectiveness
Mathematica Policy Research



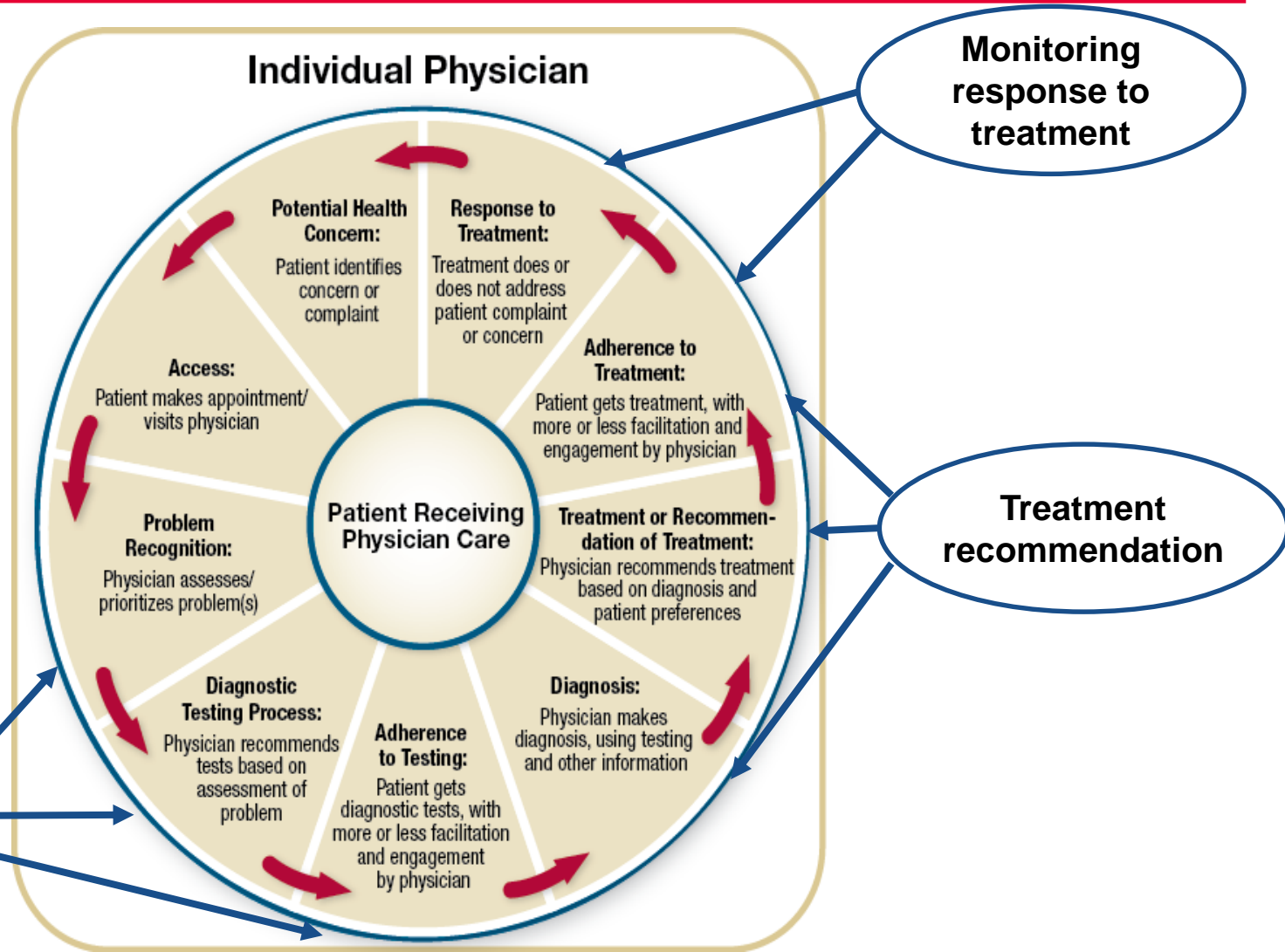
About the Center on Health Care Effectiveness

The Center on Health Care Effectiveness (CHCE) strives to support more evidence-based decision making by patients and clinicians at the point of care.

We conduct and disseminate objective research and policy analyses on how modifications to the policy, delivery system, and practice environment can help clinicians and patients make more informed decisions.

For more information about CHCE, visit
<http://chce.mathematica-mpr.com/>

Conceptual Framework: Physician Decision Making at the Point of Care



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Issue BRIEF

Kara Contreary, Eugene Rich, Anna Collins, Ann S. O'Malley, and Jim Reschovsky

Supporting Better Physician Decisions at the Point of Care: **What Payers and Purchasers Can Do**

INTRODUCTION

For decades, researchers have noted considerable variation among physicians treating otherwise similar patients, with frequent failures to deliver evidence-based care (Schwartz et al. 2014; McGlynn et al. 2003). Studies have highlighted an array of factors that contribute to these deviations from evidence-based practice (Reschovsky et al. 2015; Contreary and Rich forthcoming). In this brief, we use four illustrative clinical cases to explore barriers to and facilitators of physicians recommending evidence-based treatments at the point of care. Because payers determine the financial incentives intended to shape the environment in which physicians make these decisions, we focus on how payment reforms might address these incentives to promote more evidence-based recommendations, and thus higher-value care.

Drawing from prior research, interviews with physicians, and discussions with stakeholders, we note opportunities for health insurers and other purchasers to promote a practice environment that supports following evidence-based recommendations (Mathematica Policy Research 2016). Our analysis suggests that the feasibility and likely effectiveness of these strategies can vary considerably across practice settings, communities, and clinical problems. We conclude that the most promising strategies are those in which local payers and community organizations provide resources or preferential payments so physicians and practices can adapt attributes of their point-of-care setting to facilitate more evidence-based care.

INFLUENCES ON PHYSICIANS' DECISIONS AT THE POINT OF CARE

To ground our investigation in real-world practice, we framed our investigation of factors contributing to or hindering evidence-based practice around four common cases, representing the different types of decisions physicians

make on a daily basis. We chose topics from the *Choosing Wisely*[®] initiative—a program sponsored by the ABIM Foundation. Each topic involves a decision for which there is currently significant variation in practice, but for which the relevant specialty society has endorsed a specific choice as a best practice based on strong available evidence. Our first example concerns

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Issue BRIEF

Anna Collins, Cara Stepanczuk, Nyna Williams, and Eugene Rich

Supporting Better Patient Decisions at the Point of Care: **What Payers and Delivery Systems Can Do**

INTRODUCTION

Prior research has documented a variety of influences on patients' receptiveness to evidence-based recommendations during a medical encounter (Tariman et al. 2012; Ernst et al. 2013; Gibson and Watkins 2013). In this brief, we use four typical clinical cases to explore the barriers to and facilitators of patients' decisions at the point of care. Because payers determine the benefit designs and provider financial incentives that shape the context in which these point-of-care discussions occur, we consider what roles payers can play. We also consider some of the ways delivery systems can better support patients' decisions at the point of care.

In the following discussion, we draw upon a review of the existing research literature and information we collected through focus groups with typical health care consumers and discussions with stakeholders (Mathematica Policy Research 2016). Our analysis highlights opportunities for payers and health care delivery organizations to support patients in typical point-of-care situations, including value-based insurance design, informed decision-making tools, revised provider incentives, and improved physician communication. Our work also notes the importance of the specific clinical problem, patients' circumstances, and community contexts in designing effective supports for patients' decision making at the point of care.

INFLUENCES ON PATIENTS' DECISIONS AT THE POINT OF CARE

In this brief, we use four clinical cases drawn from the *Choosing Wisely*[®] program—an initiative sponsored by the ABIM Foundation—to guide our discussion of barriers to and facilitators of patients' acceptance of evidence-based recommendations at the point of care. Each case represents a decision-making opportunity

for which the relevant medical specialty society has recommended a particular choice, based on evidence, but for which there remains substantial variation in practice.

The first case centers on a child presenting with suspected appendicitis, and which diagnostic test (if any) to order in response. Due to concerns about radiation exposure and the attendant increase in cancer risk, evidence-based guidelines

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Today's Speakers



**Nyna Williams,
Mathematica**



**Daniel Wolfson,
ABIM Foundation**



**Ann O'Malley,
Mathematica**



**Sanne Magnan,
Past President, Institute
for Clinical Systems
Improvement**



**Andrea Ducas,
Robert Wood Johnson
Foundation**



**Tara Montgomery,
*Consumer Reports***

About the Project

Andrea Ducas
Robert Wood Johnson Foundation (RWJF)



Roadmap

1. Context
2. Approach
3. Findings from semi-structured physician interviews

Ann S. O'Malley
Mathematica



Context for the RWJF Project

- **Some U.S. health care spending is for services that may not improve (and in some cases may harm) patient health**
 - Many services backed by strong evidence are underused
- **Variations exist even in cases where evidence is strong and accepted by physicians and professional societies**
- **What are the barriers to and facilitators of evidence-based care?**
- **How can payment reform and other policy strategies:**
 - Help physicians deliver more evidence-based care?
 - Help patients seek out and accept more evidence-based recommendations?

Approach

- **Pick four representative clinical decisions**
 - Relevant to a wide range of physician roles, clinical settings, and patient circumstances
 - With a patient perspective component
- **Identify potential barriers to and facilitators of evidence-based decisions at the point of care**
 - Literature reviews and conceptual framework
 - Physicians and patients
- **Conduct in-depth interviews with practicing physicians from four specialties**
- **Hold focus groups with representative consumers**
- **Conduct stakeholder meeting**

Identifying Representative Clinical Decisions (1)

- **Consensus among professional leaders on the evidence-based recommendation to patients**
 - **But persistent variation in actual practice**
- **Focus on Choosing Wisely® topics**
 - **“In 2012, the ABIM Foundation launched Choosing Wisely® with a goal of advancing a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures.”**
 - **“More than 70 specialty society partners have released recommendations with the intention of facilitating wise decisions about the most appropriate care based on a patient’s individual situation.”**

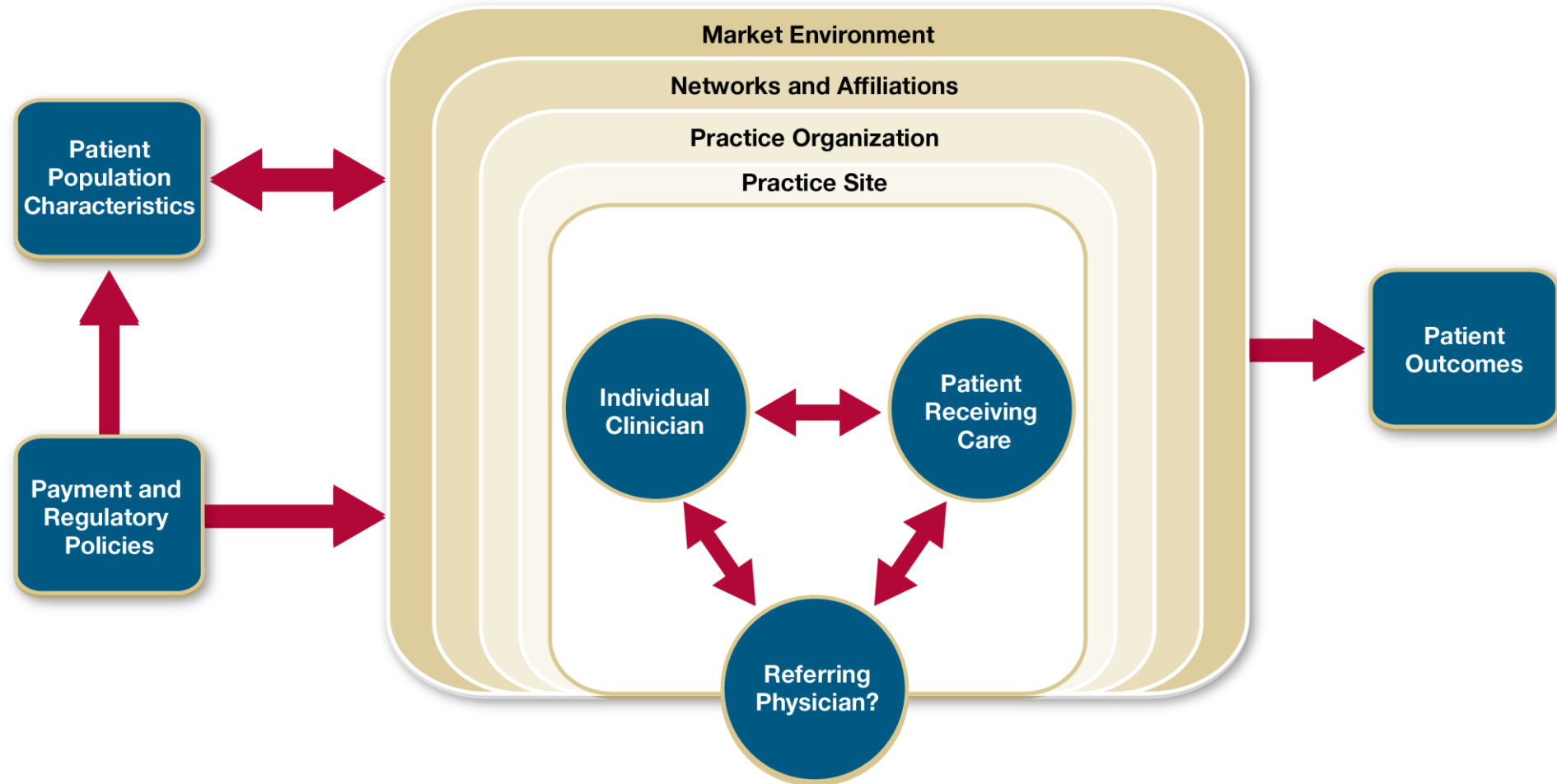
<http://www.choosingwisely.org/>

Identifying Representative Clinical Decisions (2)

Case and domain of care	Evidence-based recommendation
General surgery <i>Suspected appendicitis</i> Diagnostic testing for new patient problem	Consider an ultrasound before recommending a computed tomography (CT) scan to evaluate suspected appendicitis in children.
Cardiology <i>Asymptomatic patient with coronary artery disease (CAD)</i> Diagnostic testing for ongoing health concern	Avoid annual stress cardiac imaging or advanced noninvasive imaging as part of routine follow-up in asymptomatic patients.
Vascular surgery <i>Leg pain from claudication</i> Treatment/intervention	Avoid interventions such as surgical bypass, angiogram, angioplasty, or stent as a first line of treatment.
Gastroenterology <i>Adjusting gastroesophageal reflux disease (GERD) medication</i> Monitoring response to treatment	Titrate long-term acid suppression therapy to the lowest effective dose needed to achieve therapeutic goals for patients with GERD.

Note: Topics drawn from lists developed by the American College of Cardiology, the American College of Surgeons, the American Gastroenterological Association, and the Society for Vascular Surgery

Conceptual Framework: Barriers to and Facilitators of Evidence-Based Physician Recommendations



Source: Adapted from Reschovsky et al. "Factors Contributing to Variations in Physicians' Use of Evidence at the Point of Care." *Journal of General Internal Medicine*, August 2015.

In-Depth Interviews with Physicians from Four Specialties

Objectives of Physician Interviews

- To identify barriers and facilitators that interfere with or promote evidence-based clinical decisions by physicians and patients
 - Used four Choosing Wisely topics/cases
 - Interviewed 36 specialists, 9 each in general surgery, cardiology, vascular surgery, gastroenterology
 - Interviewed with semistructured protocol, verbatim notes, coded and analyzed based on conceptual framework
- To identify **potential implications for payers** and policymakers to promote more evidence-based care

Barriers to, Facilitators of Evidence-Based Decisions: Perceived Patient-Level Themes

- Patient factors have a greater role in claudication, GERD, and CAD (vs. appendicitis)
 - Emergency department (ED) doctors/care protocols took the CT decision out of the patient’s and general surgeon’s hands
 - “Emergency” situation, less time for patients to question
- Patient-level themes
 - Openness to treatment recommendations
 - Insurance coverage/ability to pay
 - Socioeconomic status
 - Patient expectations
 - Patient satisfaction

Patient

Physician

**Practice
site**

**Practice
organization**

**Networks &
affiliations**

Market

Barriers to, Facilitators of Evidence-Based Decisions: Patient Level

For some physicians, patient satisfaction metrics were a barrier to evidence-based decisions for patients who wanted more aggressive testing.

“I certainly have some people who are insistent, and there are rare cases where I think it’s easier to get them on a treadmill and satisfy them....”

—Cardiologist

Physician Level (1)

- Physician-level factors play a strong role
 - Appendicitis less so because site factors rule
- Physician-level themes fall into seven areas:
 - Clinical reasoning (primary reason for decisions)
 - **Skills and competencies (communication facilitator for all cases)**
 - Physician attitudes and professionalism
 - Knowledge about evidence- guidelines
 - Training and prior clinical experience
 - **Perceived personal incentives**
 - Malpractice concerns



Physician Level (2)

- **Perceived personal incentives**
 - “Productivity” measures and payment for advanced imaging or stent placement (even when evidence does not support these interventions) increases use of services
 - Mentioned by vascular surgeons and cardiologists
- **Lack of fee-for-service (FFS) payments may lead to less evidence-based care**
 - Gastroenterologist said being compensated for phone calls would “help [his personal] satisfaction level” in managing PPI titration by phone
 - {Stakeholders noted that “Medicare...doesn’t cover supervised exercise” which is relevant for the cardiology and vascular surgery cases}

Patient

Physician

Practice
site

Practice
organization

Networks &
affiliations

Market

Practice Site Level (1)

- **Electronic health records**
- **Internal practice's guidelines**
- **Peers' standard of care**
- **Care processes and workflow**
- **Workload and perceived time**
- **Resources at the practice site**

Patient

Physician

**Practice
site**

**Practice
organization**

**Networks &
affiliations**

Market

Practice Site Level (2)

- **Care processes and workflow**
 - *“In the real world, [that patient gets] a CAT scan as soon as he gets through the [ER] door.”* —General surgeon
 - Some GI doctors said refills come in via fax and are first handled by a nurse, so the doctor is not thinking about titration for a drug like Nexium
 - A GI doctor said (PPI) titration would be more “feasible” if his delivery system facilitated patient communication by email
- **Resources at the practice site**
 - CT scanners and radiologists are available 24/7 in most places, but ultrasounds and qualified ultrasonographers are not
 - *“To do a good ultrasound, you need a good ultrasonographer. To do a great CAT scan, you don’t need a great anything.”* —General surgeon

Patient

Physician

Practice
site

Practice
organization

Networks &
affiliations

Market

Practice Organization Level (1)

- **Financial incentives**
- Feedback on quality of care
- Feedback on resource use
- Contractual arrangements
- Culture/leadership



Practice Organization Level (2)

- **Financial incentives**

- **Some hospital-employed cardiologists feel pressure to do more tests and procedures**

“The hospital is making tons of money on nuclear imaging or expensive tests. ... The medical director or the COO comes and asks me how I’m doing.... What he’s trying to find out is how many tests I have ordered.”

—System-employed cardiologist



Barriers to, Facilitators of Evidence-Based Decisions: Practice Organization Level

- Feedback
- Specialists interviewed were not measured on quality metric related to the four Choosing Wisely topics
- A few surgeons and cardiologists noted the unintended consequences of quality measures
 - *“I certainly have some people who are insistent, and there are rare cases where I think it’s easier to get them on a treadmill and satisfy them, especially these days when we’re being scored by patient satisfaction. It’s in some of the compensation models, making the patients happier.”* —Cardiologist
 - *“Measures of hospital ED wait times are influencing the ED docs to do knee-jerk CAT scans before they’ve even examined [the patients].”* —*General surgeon
- When specialists reported getting feedback, it was not about providing evidence-based care but about being more “productive”



Networks and Affiliations

- Expectations of referring providers
- Influence of affiliated hospitals
- Arrangements with diagnostic testing facility or surgery center
- Availability of consultative support
- Guidelines at the network/hospital affiliation level

Patient

Physician

Practice
site

Practice
organization

Networks &
Affiliations

Market

Networks and Affiliations

- **Expectations of referring provider**
 - A vascular surgeon said of the local market that when “the referring physician doesn’t get the result he wants from a vascular surgeon,” he or she can “send [the patient] to an interventional cardiologist”
- **Influence of affiliated hospitals**
 - A vascular surgeon said hospital administrators will occasionally come around “and talk about how we need to do more procedures”
 - Another described the “incredible” pressure from his affiliated hospital to treat these cases more aggressively

Patient

Physician

Practice
site

Practice
organization

Networks &
Affiliations

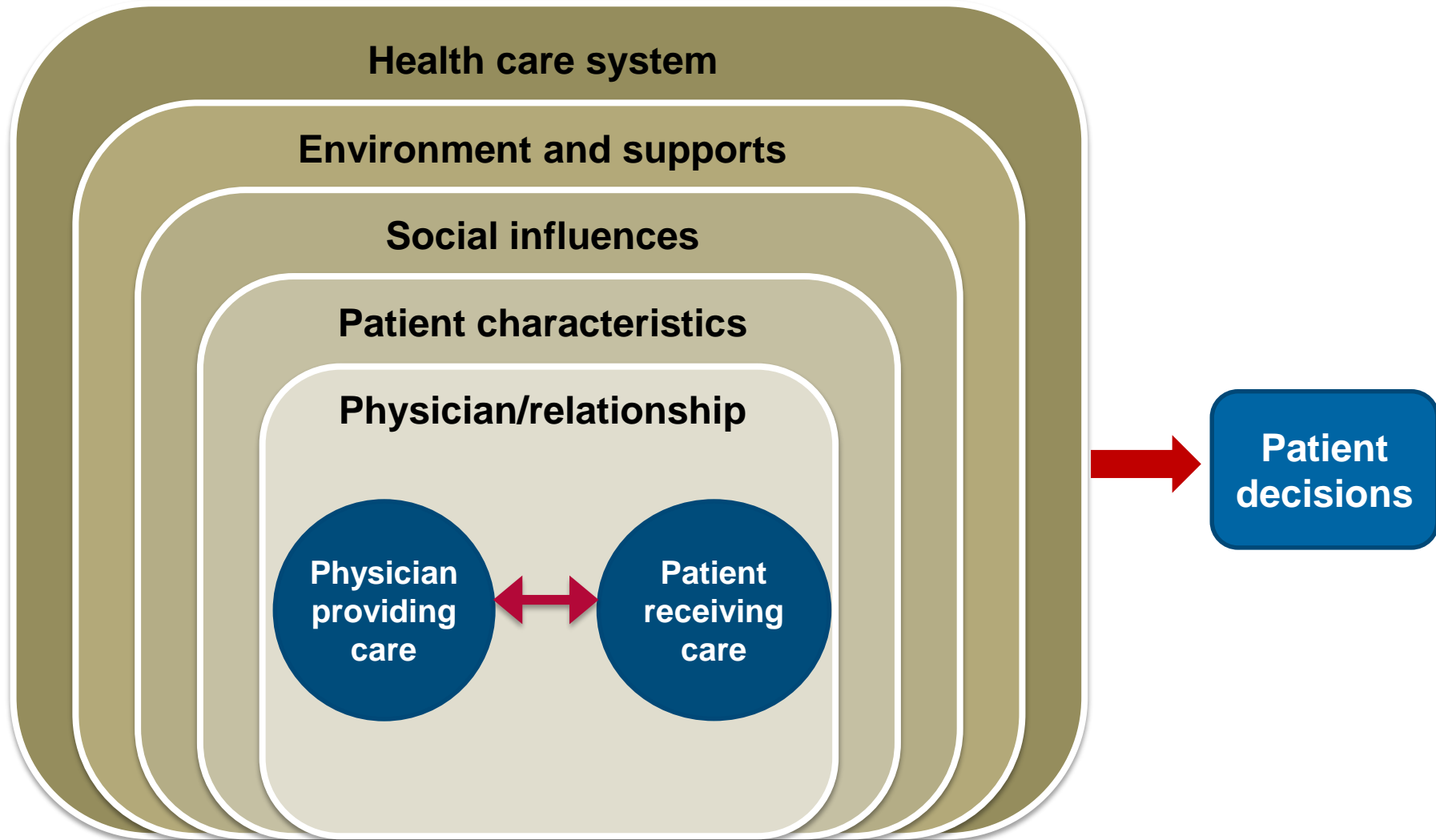
Market

Influences on Patients' Decisions at the Point of Care

Nyna Williams
Mathematica Policy Research

April 12, 2016

Conceptual Framework: Influences on Patient Decisions at the Point of Care



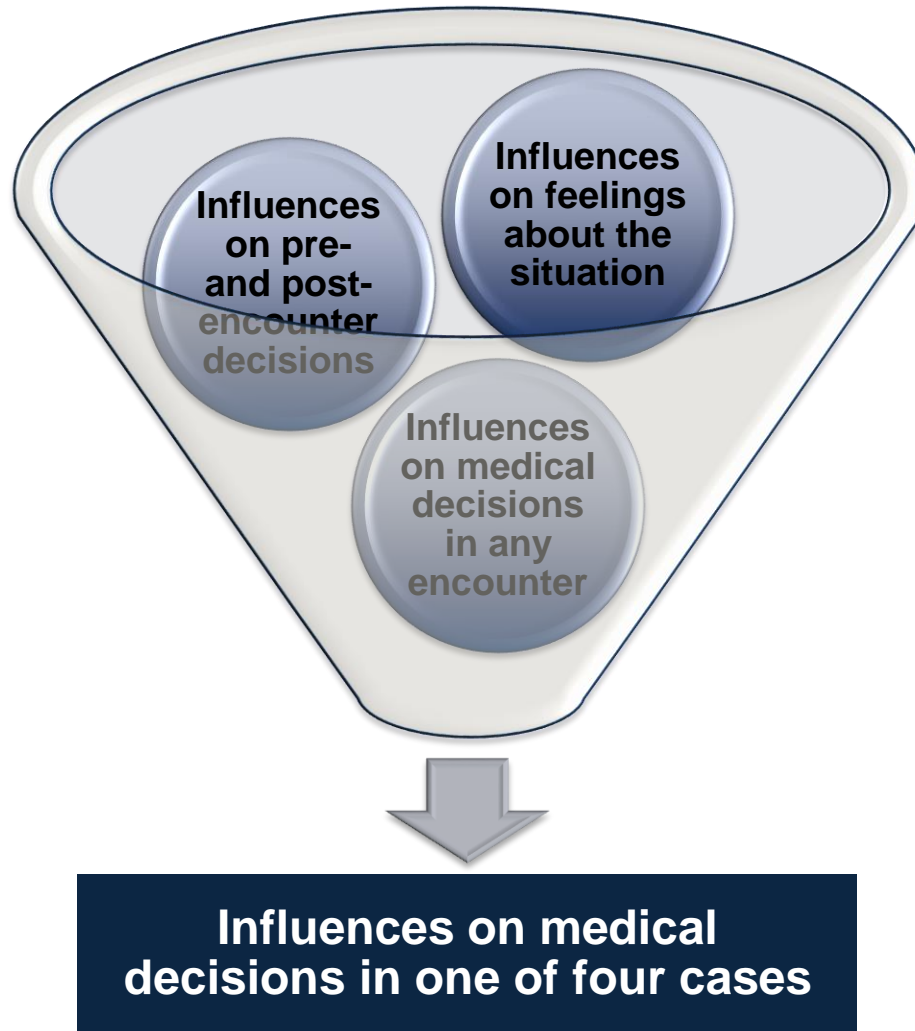
Focus Group Process

- **Purpose: to better understand the factors patients consider as they decide between treatment recommendations in four specific cases**
- **For each case, we presented two recommendations**
 - Not evidence based (“do everything possible”)
 - Evidence based (avoid overuse/overprescribing)
 - Counterbalanced order of recommendations
- **We asked about:**
 - Reactions to the recommendations, preferences regarding how to proceed, and perceived influences on those preferences
 - How reactions and preferences differ between the two recommendations
 - Reactions to revealed evidence-based recommendation

Target Population for Focus Groups

- 1. Parent of a child with suspected appendicitis**
 - Custodial parent of at least one child age 6 to 17
- 2. Adult with CAD**
 - Adult age 40 to 69
 - Self-reported health is “excellent” or “good” (exclude “fair” and “poor”)
- 3. Adult with leg pain from claudication**
 - Adult age 40 to 69
 - Self-reported health is “excellent” or “good” (exclude “fair” and “poor”)
- 4. Adult with GERD**
 - Adult age 40 to 69
 - Self-reported health is “excellent” or “good” (exclude “fair” and “poor”)
 - No more than one visit to a health care provider (other than vision and dental) in the past year

Sifting Through the Influences



Influences on Decisions: Physician/Patient Relationship

- Trust in physician emerged as a major influence on whether to accept a recommendation
- Trust in physician influenced by:
 - Length of time with physician
(preferred longer relationships and appointments)

“The doctor [who] delivered my babies knows my kids well. I would follow her lead. But if a new doctor comes in...[such as] a doctor in an ER...you are usually on guard.”

- Communication style
(preferred clear, patient, and collaborative communication)

“[If they] put everything in layman’s terms...explain how they come up with the diagnosis and the tests they need to run, [I trust them more].”

- Philosophy of care
(preferred minimalistic, holistic, and/or individualized care)

**Physician/
relationship**

**Patient
characteristics**

**Social
influences**

**Environment
and supports**

**Health care
system**

Influences on Decisions: Patient Characteristics

- **Severity of health condition**
 - More pain/more severe = want more medical care and likely to agree with physician recommendation
 - Less pain/less severe = able to challenge recommendation and ask questions
- **Expectations for a physician to “do something”**
 - Desire for a test to confirm medical issue or a treatment to resolve medical issue
- **Personal values regarding treatment and risk**
 - Minimize medication/procedures, highly averse to side effects

“I tend to be a nonintervention-type person. I want to know when I can stop cholesterol medications.”

Physician/
relationship

**Patient
characteristics**

Social
influences

Environment
and supports

Health care
system

Influences on Decisions: Social Influences

- Few perceived that their social network influenced their decisions during an encounter
 - More likely to influence pre-encounter decisions (which physician or practice to select)
- Minor influences:
 - Immediate family such as spouse or parents
 - Friends/family with a medical background
 - Medical history of family members

“There are things you can control and things you can’t control. Family medical history definitely drives my decisions.”

Physician/
relationship

Patient
characteristics

Social
influences

Environment
and supports

Health care
system

Influences on Decisions: Environment and Supports

- **Cost was a concern for a few CAD / leg pain / GERD respondents**
 - Most relied on insurance to cover tests and procedures
 - Most thought of cost for pre- and post-encounter decisions (co-pay for visits, prescriptions)

“I think you care less if the insurance is covering it, but you can still know the price if you want.”

- **Cost was not a concern for those with appendicitis**

“I want them to find out what is the problem [with my child], so they can do all the testing they can do...that’s the bottom line.”

- **Support at home affected decisions for a handful of respondents**

“You need to talk to other family members...especially if they have to take care of you [after the surgery].”

Physician/
relationship

Patient
characteristics

Social
influences

Environment
and supports

Health care
system

Influences on Decisions: Health Care System

- **Access to care and technology more likely to influence pre- and post-encounter decisions**
 - Appointment availability more likely to affect choice of physician or practice (pre-encounter) and follow-up (post-encounter)
- **A few focus group participants believed that information on costs of care could assist with decision-making, but others preferred not to discuss costs**

“Most patients don't want to get into a business relationship with their doctors.”

Physician/
relationship

Patient
characteristics

Social
influences

Environment
and supports

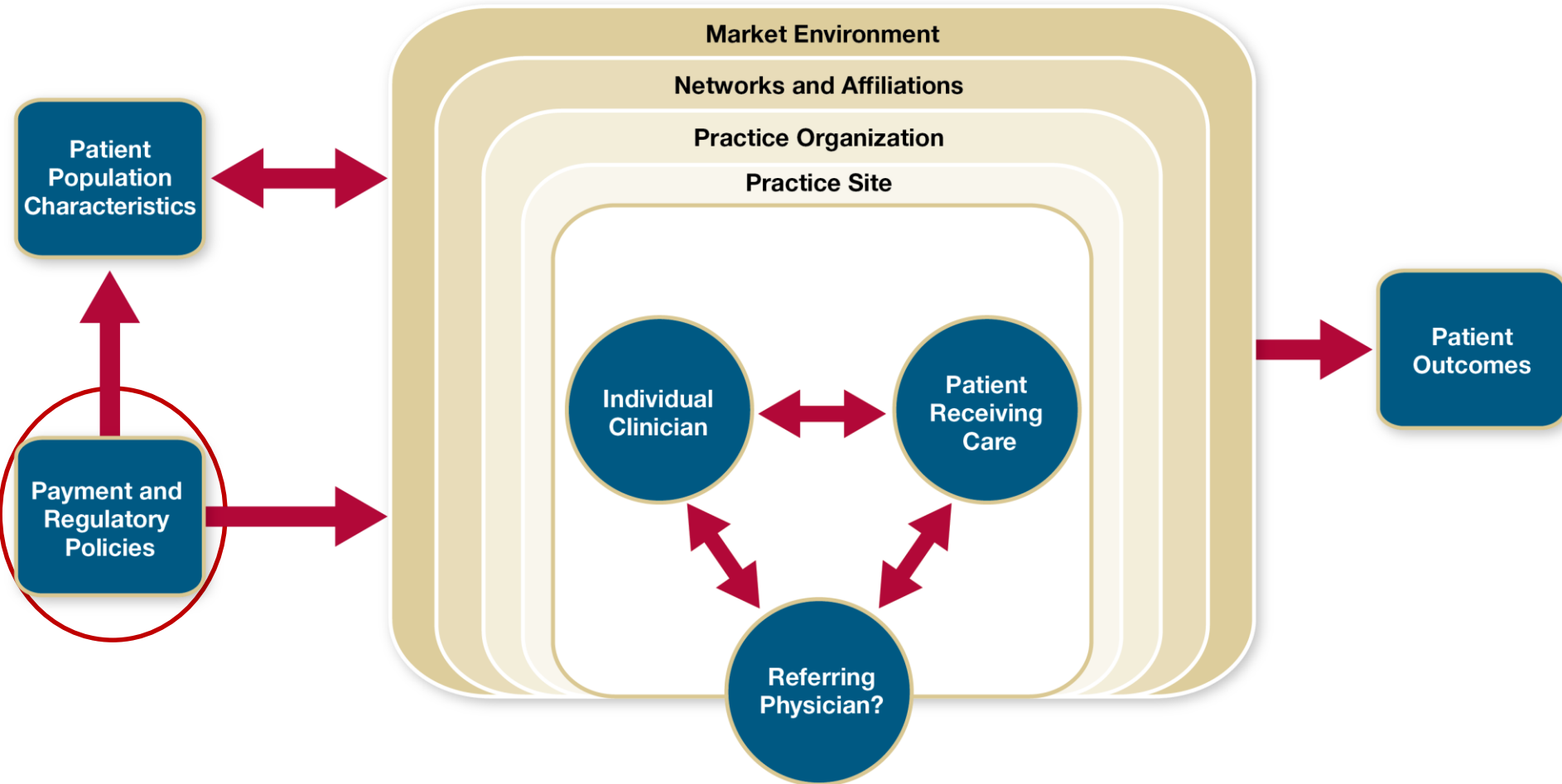
Health care
system

Supporting Evidence-Based Decisions at the Point of Care: What Payers and Delivery Organizations Can Do

Eugene Rich
Mathematica Policy Research

April 12, 2016

Conceptual Framework: Barriers to, Facilitators of Evidence-Based Physician Recommendations



Approach to Analysis of Payer Options

- Literature review with application to conceptual framework
- Policy analysis grounded in four examples of clinical cases
- Will highlight findings from:
 - Interviews (*)
 - Stakeholder meeting discussions (**)

Options for Payers, Purchasers to Promote Evidence-Based Recommendations by Clinicians

- **Contracting with providers involves two main considerations**
 - **How to pay**
 - What services are to be purchased (what to pay for)
 - What the reimbursement will be for each service (how much to pay)
 - **Whom to pay**
 - Practice site requirements
 - Provider network requirements
 - Preferential payments for new practice features
 - Initiatives to enhance contracting practice organizations

FFS Payment to the Physician Decision Maker

- **Appendicitis case (0)**
 - The general surgeon is not paid for ER imaging for appendicitis
- **CAD case (-)**
 - FFS payments reward cardiologist for ↑ cardiac imaging*
- **Claudication case (-)**
 - FFS payments reward vascular surgeon for ↑ vascular interventions*
 - No FFS payment for “supervised exercise”**
- **GERD case (-)**
 - No FFS payment for outreach/counseling for adjusting GERD prescription*

How Much to Pay (FFS revision)

- **CAD, claudication (+?)**
 - **Revising fees to rebalance the level of reimbursement for alternative services could reward more evidence-based care***
 - **But payment reductions can result in:**
 - Physicians performing other services to recoup lost income*
 - Changes to physician practice organizations and affiliated hospitals that lead to higher costs or utilization**

FFS Payment Requirements: Utilization Management

- **Appendicitis (0)**
 - n.a.—prior authorization difficult to apply to urgent problems like appendicitis
- **CAD, claudication (+)**
 - Prior authorizations for imaging and interventions for patients in the Choosing Wisely cases could reduce use*
- **GERD (0)**
 - GERD medications are often over-the-counter*

A stakeholder discussing the cardiology case noted, **“The issue is whether the patient is defined as asymptomatic. If you want to do the test, just define the patient as symptomatic.”**

P4P in FFS

- **Appendicitis (+/-)**
 - Surgeon—quality (complication rate, negative appendectomy rate, etc.) may favor the most accurate diagnostic test (CT);
 - ER doctor—assessment of timely ER evaluation promotes CT*
 - Hospital—depends on P4P measures**
- **CAD, claudication (+/-)**
 - Quality—difficult to verify appropriateness against objective criteria for individual patients**
- **GERD (+/-)**
 - Difficult to verify appropriate management, attribute responsibility for patients; better to focus this effort on primary care**

“Coming up with payment systems by using a micro level of condition is never going to make a system more evidence based.”

“A lot of the issues were hospital incentives, not physician incentives.”

Alternative Payment Models: Episode-Based Payment

Bundled episode-based payments don't usually go first to the physician

- **Appendicitis (+/-)**
 - Opposing forces (with CT, fewer appendectomies but higher testing costs)
- **CAD, claudication (+/-)**
 - Physicians may not necessarily see reduced incentives for testing in patients described in the Choosing Wisely cases
- **GERD (+/-)**
 - GI practice's cost of outreach and GERD management may offset any savings from reduced prescriptions

Some stakeholders noted the potential value of bundled payments oriented around specific conditions (like appendicitis).

Others voiced concerns about the operational feasibility of bundled payments.

Alternative Payment Models: Population-Based Payment (shared savings and capitation)

Population-based payments directed to larger risk-bearing organizations, not to specialty clinicians or practices

- Appendicitis, GERD (+/-)
 - Depends on relative input costs of different services *and*
 - Whether evidence-based care averts costly complications in the relative near term
- CAD, claudication (+)
 - Incentive for the capitated organization to reduce costly interventions
 - Effectiveness affected by how incentives are shared among providers

Stakeholders noted that building an integrated network of providers skilled at delivering high quality care can be a long and complex process.

One stakeholder noted, “From a payer perspective, the risk of pure capitation is underuse.”

Others also noted the issue of patient trust as important to point-of-care decision making.

Changing “Who Is Paid”

Practice Site/Provider Network Requirements

- Appendicitis (+)
 - Require appropriate imaging options as a prerequisite for contracting for emergency care of children
- CAD, claudication (+)
 - “Centers of Excellence” initiatives**
 - Rewarding high quality/low-cost providers with more patients**
- Difficult to enforce in areas with limited provider options**
 - For example, untimely access to surgical treatment of appendicitis is more harmful, on balance, than excess use of CT scans

“Variety of approaches suggested by local conditions...state, regulatory, culture of practice organizations.... A one-size-fits-all policy situation is not very helpful.”

Changing “Who Is Paid”

Preferential Payments for New Practice Features

- **Appendicitis (+)**
 - Payment enhancement for ERs that support 24/7 access to timely and reliable abdominal ultrasound
- **CAD, claudication (+)**
 - Payment enhancement for practices using EHR-based clinical decision tools,^{*}** informed patient decision making**
- **GERD (+)**
 - Payment enhancement for primary care/chronic illness care management**

One stakeholder said, “We should have tech-enabled second-opinion strategies.”

Various stakeholders said the GERD case might have been best managed in the primary care setting. “It’s not a good use of gastroenterologists’ time to be titrating PPI doses.”

Changing “Who Is Paid” Initiatives to Enhance Practice Organizations

- **CAD, claudication, appendicitis (+)**
 - Such as learning collaboratives (for example, with data sharing) to promote evidence-based care
- **GERD (+)**
 - Such as care coordinators for chronic disease management
 - In specialty or in primary care

One stakeholder noted, “Washington [State has a] collaborative of ...medical groups...all sharing what they’re doing in Choosing Wisely.”

Another stakeholder said, “We found multipayer initiatives at the state level can be very effective.”

“The challenge is that these local communities have multiple payers who are competing with each other.”

Options for Payers to Promote Evidence-Based Recommendations by Clinicians

- **FFS revisions: +CAD, claudication, GERD**
- ~~Restrictions on FFS payments (UM): + CAD, claudication~~
- ~~Adjustments to FFS payments (FFS P4P): +/- all~~
- **Episode-based/bundled payment: +/- all**
- **Population payment/capitation: +CAD, claudication**
- **Practice site/provider network requirements: +/- all**
- **Preferential payments for new practice features: +all**
- **Initiatives to enhance contracting practice organizations: +all**

Payer Options to Support Patient Decision Making

- **Variety of opportunities to help patients seek and accept more evidence-based recommendations in typical point-of-care situations**
 - **Benefit changes such as value-based insurance design**
 - **Service-specific requirements for patients and clinicians to engage in shared decision making**
 - **Incentives for provider organizations to facilitate informed decision making by patients**
 - **Payers directly providing patients with information about evidence-based services or provider's use of evidence-based services**
- **Patients will differ in their responses to these strategies depending on:**
 - **Specific clinical problem and practice setting**
 - **Patients' circumstances and community context**

Delivery Organization Options to Support Patient Decision Making

- **Clinician training to support more informed decision making by patients**
- **Provision of formal resources such as decision aids**
- **Patients' trust in clinicians is key**
 - **Practice-based initiatives to improve this aspect of physician-patient communication could be beneficial in each of our cases**

Discussant

**Sanne Magnan,
Past President, Institute for
Clinical Systems Improvement**







HCP LAN

Health Care Payment Learning & Action Network

April 12, 2016

PURPOSE

The Health Care Payment Learning & Action Network (LAN) was launched because of the need for:



Better Care

The LAN seeks to shift our health care system from the current fee-for-service payment model to a model that pays providers and hospitals for quality care and improved health.



Smarter Spending

In order to achieve this, we need to shift our payment structure to incentivize quality and value over volume.



Healthier People

Such alignment requires the participation of the entire health care community. The LAN is a collaborative network of public and private stakeholders.

OUR GOAL

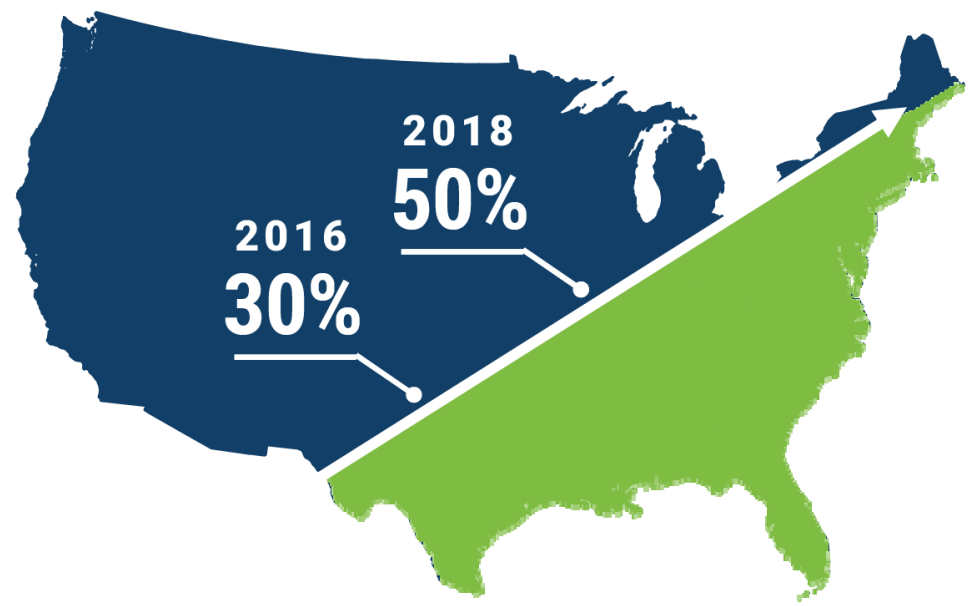
Goals for U.S. Health Care

2016
30%
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

2018
50%
In 2018, at least 50% of U.S. health care payments are so linked.

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

Adoption of Alternative Payment Models (APMs)



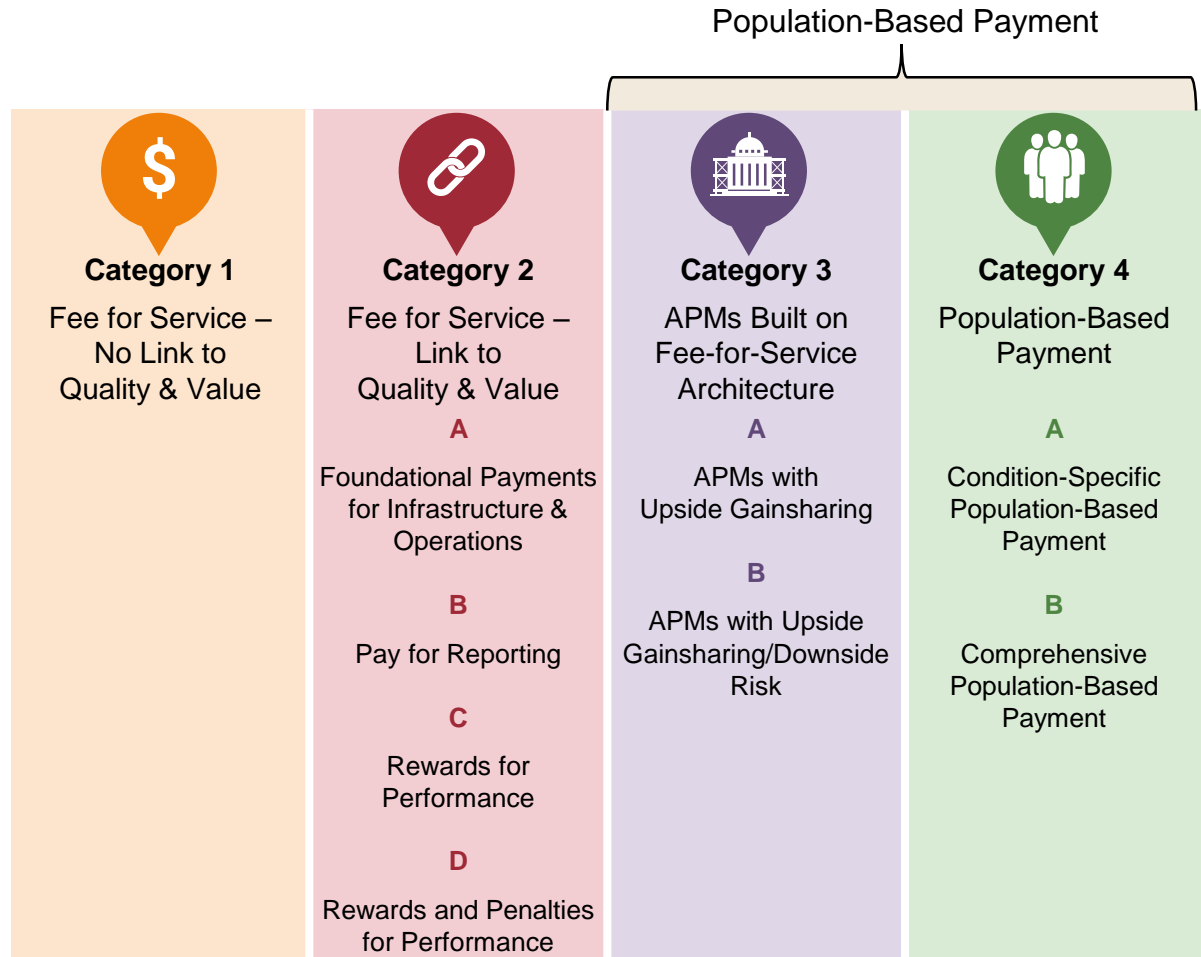
Better Care, Smarter Spending, Healthier People

APM FRAMEWORK

At-a-Glance

The *Framework* is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities



The framework situates existing and potential APMs into a series of categories.

PBP Work Group

Population-Based Payment (PBP)



16 Members

Chairs



Dana G. Safran
Senior Vice President, Performance Measurement and Improvements, Blue Cross Blue Shield of Massachusetts

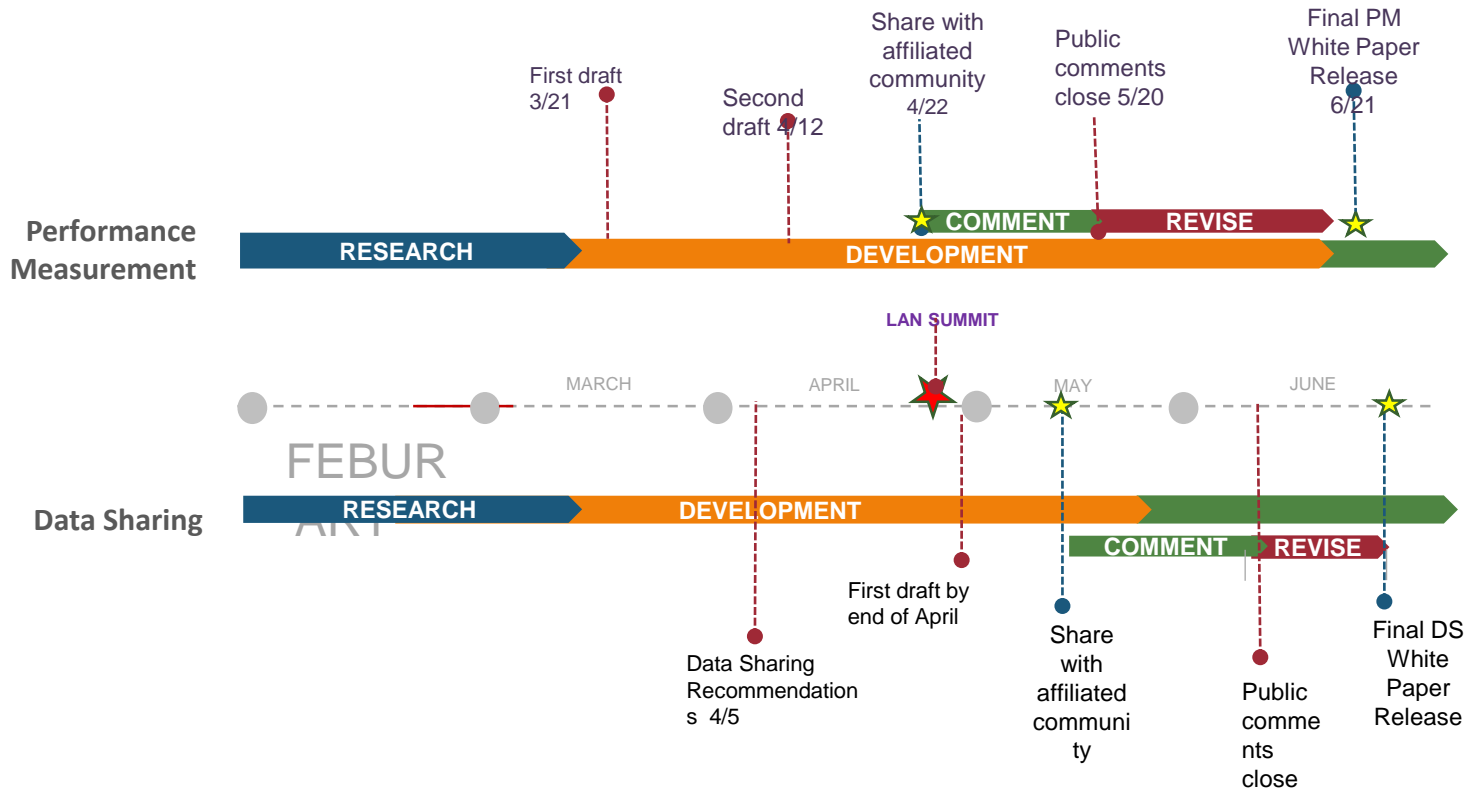


Glenn Steele, Jr.
Chairman, xG Health System

This group is identifying the most important elements of population-based payment models for which alignment across public and private payers could accelerate their adoption nationally, with a focus on data sharing, financial benchmarking, quality measurements, and patient attribution.

- ✓ Establishing patient attribution and financial benchmarking standards
- ✓ Developing performance measurement guidelines
- ✓ Identifying data sharing requirements

PBP Timeline: Performance Measurement and Data Sharing



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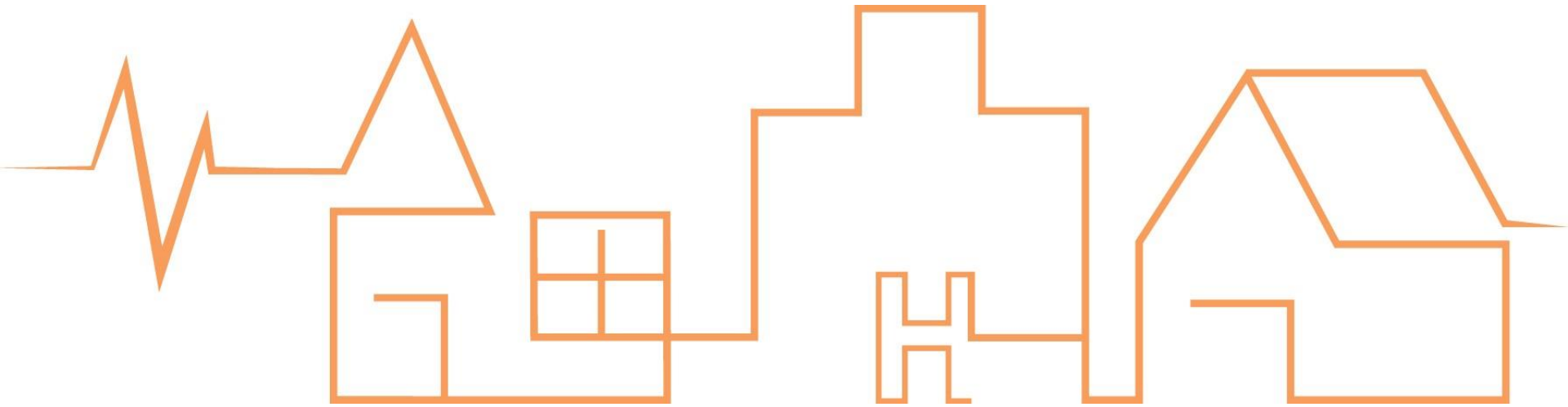
<https://www.hcp-lan.org>



Ask a question

PaymentNetwork@MITRE.org

Going Beyond Clinical Walls



Purpose: to communicate to health care audiences the value of connecting with community resources, including public health

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https://www.icsi.org/health_care_transformation/population_health/going_beyond_clinical_walls/

Discussant

**Daniel Wolfson,
ABIM Foundation**



Discussant

Tara Montgomery,
Consumer Reports



Questions?



**Nyna Williams,
Mathematica**



**Daniel Wolfson,
ABIM Foundation**



**Ann O'Malley,
Mathematica**



**Sanne Magnan,
Past President, Institute
for Clinical Systems
Improvement**



**Andrea Ducas,
Robert Wood Johnson
Foundation**



**Tara Montgomery,
*Consumer Reports***

For More Information

- **Please contact:**
 - Eugene Rich
 - ERich@mathematica-mpr.com



Mark Your Calendars!

The next CHCE event will be held May 12, 2016
12:00–1:30 p.m. (ET)

**Accelerating the Use of Evidence in Health Care
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