Steering Committee Observations and Recommendations

Steering Committee Meeting October 15, 2009

These observations and recommendations are the result of a final, five hour steering committee meeting focused on review of measurement recommendations and operational and administrative challenges report. This is an effort to capture the variety of thought from the steering committee members, we did not drive to consensus on these observations, however they do reflect a majority of thought . The steering committee felt compelled to capture and convey lessons learned for the benefit of future health care reform.

Measurement:

- Suggest that a common, validated patient experience tool be used. It will be important that this tool is designed with health literacy consideration as well as administrative burden.
- Measuring chronic condition outcomes (ie: asthma, diabetes etc) within a one year timeframe presents a complex issue as the condition is so long term.
- Measuring impact and clinical outcomes from preventive services is also difficult within a short timeframe, the measure may not reflect true impact of the preventive care.
- Coordination of measures between all health reform initiatives (provider peer grouping, health care home and baskets of care) is imperative so learning's can be maximized and administrative burden minimized.
- It would also be more efficient if one measure can serve as multiple basket evaluations versus designing individual basket measures (ie; one patient experience measure for all baskets).
- There must be a mechanism to audit the delivery of all appropriate components in the basket to avoid legal risk such as perceived fraud by not delivering all basket services.
- To evaluate value, a comparison of fee-for-service VS basket payment would need to be done. Evaluation should include comparison of clinical outcomes, patient preferences and needs, population health outcomes and cost.
- Measurement must be able to assess appropriateness of care.

Operations and Administrative Challenges:

- Variation in purchasing power and contracts may impact providers basket pricing thus impacting providers ability to remain competitive. This could impact the appeal of the basket model in rural settings. Purchasing of both durable medical devices and pharmaceuticals are examples of this challenge.
- If implementation of baskets of care model does not have economic and/or quality of care benefit the steering committee has serious reservations about the uptake of this concept.
- The Steering Committee recognizes that the basket of care model is not tested for cost effectiveness. They suspect that the model could support improved outcomes.

- It will be important for patients and providers to understand clearly what is expected to be delivered within the basket and how shared decision making can support patient engagement.
- Variation in purchasing power for durable goods and pharmaceuticals is significant across different care delivery systems. This may impact the ability and interest in competing in the basket market.
- The legal and regulatory requirements must be considered and resolved.
- The Steering Committee supports the inclusion of medications in their basket, expecting that this may improve patient outcomes. Pharmacy benefit design creates administrative and operational barriers to including medications in baskets currently. The committee supports creation of solutions to resolve these barriers in the future. Medications should be included if possible.

Lessons Learned:

- The effort of exploring the basket model has been extremely valuable, even if uptake is minimal, this activity may propel Minnesota to a total cost of care model sooner. Additionally this process has engaged all stakeholders in dialogue about care delivery innovation. This will serve MN well as we reform health care to be more patient centered and value driven.
- Time parameters were short because this was a legislated, ime limited initiative. The time restrictions did not allow for extensive design work however the time limitations may have forced innovation that would not have occurred so quickly otherwise. There was conscious recognition that the Minnesota baskets were designed without the benefit of episodic care expertise.
- The basket model begins to raise the question about how care is organized (integrated systems vs individual providers, non-integrated systems) One key question is, how do accountable care organizations fit into the care delivery structures. It raises the question about the value of moving toward a total cost of care model.
- The Steering Committee recommends a learning collaborative approach to support implementation, networking and sharing of learnings. It is expected that this will encourage and improve uptake of this model.
- When designing baskets it would be more effective to have greater design parameters such as cost containment, scope, VS lack of restrictions to allow for innovation.
- Uptake or use of each basket will be a strong indication of the value of this care delivery model to the consumer, provider, employer and health plans.
- The basket of care model requires a reformed set of payment rules and processes before widespread adoption.
- By legislation excluding Medicare, Medicaid population, it may severely reduce the number of patients eligible to participate in basket care. This may limit the uptake.
- Communication must be clear to all stakeholder groups – “What’s in it for me?” “Who is in a position to assume risk?” “How is this different than our current model?”
- Stakeholders participating in the initiative progressed from skepticism to embracing the concept of innovation and creativity (open to possibilities).