California Health Care Foundation

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Issue Brief

Managing Cost of Care:
Lessons from Successful Organizations

The influx of newly insured Californians through the public exchange and Medicaid expansion has renewed efforts by health care organizations to manage the cost and quality of patient care. In 2015, the California Quality Collaborative (CQC) decided to identify best practices for managing total cost of care, so as to encourage adoption more broadly across California's delivery system. The goal of the project was to identify replicable patient management strategies that effectively eliminate or modify unnecessary services while improving the quality of patient care. The project did not focus on strategies to address cost of care by reducing unit prices or altering contract arrangements.

To reveal the most effective strategies, CQC interviewed top-performing health care organizations around the country with demonstrated results in reducing the total cost of care. Organizations were identified through publicly reported data from Medicare and privately reported by the Integrated Healthcare Association (IHA), which collects and aggregates health plan data on commercial populations. Of the 20 organizations invited, 15 agreed to participate in separate 90-minute structured interviews.

Each interview included questions on the organization's:

- Experience with managing total cost of care
- Drivers for improving the cost of care
  - Cost categories addressed, in order of importance
  - Time to implementation
  - Key program elements
  - Results achieved
- Use of external performance benchmarks
- Challenges

Defining Total Cost of Care

Total cost of care refers to the cost of all medical services consumed by a population of patients in a year, and includes all covered professional, hospital, pharmacy, and ancillary care.

Overview of the Organizations Interviewed

The organizations varied in size, structure, and depth of experience with patient population management.

The majority had contracts that included financial rewards for improving total cost of care. At the time of the interviews, approximately two-thirds of provider groups had financial accountability for both inpatient and outpatient costs for a defined population. This was primarily through a capitated payment for both inpatient and outpatient services. The remaining one-third had either shared savings relationships with payers or were capitated for a smaller portion of the group's health care expenditures (e.g., professional services).

Successful provider groups came in several forms. Physician-owned independent provider associations (IPAs) and medical group models, as well as hospital-sponsored or foundation model provider organizations, were all represented. Both for-profit and nonprofit organizations participated in the interview process.

Years of experience varied widely. For some organizations, accountability for cost of care was a new initiative, whereas others had actively managed cost of care for more than 20 years.

Successful Strategies: Primary Care Based and Organizationally Based

Successful organizations tended to pursue one of two strategies: (1) primary care based, and (2) organizationally based. Approximately one-third of the health care organizations interviewed fell into the primary care based model and one-half deployed tactics in a largely organizationally based model. The remainder were mixed models that used elements of both strategies.

Primary Care Based Model

These organizations deployed all their resources at the primary care sites. Strategies and tactics to manage both quality and cost were executed by bringing data, education, and resources directly to the primary care practices. From analytics and education to newly embedded staff, resources were deployed in the local primary care practice to engage and support patients.

"We are very hands-on with our PCPs. We carefully profile the PCP panel so we can target practices with high service use and get that information quickly back to the PCP so they can impact it."

— CEO of provider organization that is using primary care based model

Organizationally Based Model

These organizations tended to deploy resources centrally or regionally. Programs were not integrated within the primary care practices; instead, they were managed centrally and coordinated with primary care practices. These organizations still valued primary care, but took steps to impact populations across multiple practices from a centralized or regionalized hub.

"We implemented a seven-part program geared to any patient in the hospital and focused on the top 5% to 10% that drive 80% of our cost. We hired lots of people, nurse practitioners, to manage those patients in the home to keep these patients out of the hospital."

— VP of organization using organizationally based approach

Comparison of Models

The research findings indicate that both approaches can be successful. Both types of organizations reported improved outcomes in common utilization metrics, such as readmission rates, acute admission rates, use of the emergency department (ED), and length of stay in the hospital. (Most organizations relied on utilization metrics to manage total cost of care; due to the delay in claims processing, actual cost of care is only available months after the observation time period.)

For example, one primary care based organization reported a reduction in readmission rates from 16% to 9% in less than 12 months. It also quoted 20% improvement in overall hospital admission rates for its targeted population. Another primary care based organization reported managing an aging Medicare population) for over five years without any increase in total cost of care.

One organizationally based group reported reduction in total acute inpatient days from 1,400 days per 1,000 patients to 700 days for a Medicare Advantage population within 12 months. The same organization reported reductions in total acute hospital days per 1,000 patients for their commercial and Medicaid populations of 40% and 30%, respectively. Another IPA reported 40% to 50% reduction in acute admission rates for both Medicare and commercial populations within three years of implementing their programs.

Addressing the Key Driver: Facility Costs

Interview participants were asked to isolate the most important initiative that drove their cost-of-care reductions. Many of the participants were challenged with this exercise because programs were often implemented in tandem and had synergistic effects. One clear theme emerged: For 14 of the 15 organizations interviewed, the primary focus was inpatient or institutional costs. Their main initiatives were almost always focused on reducing acute and post-acute facility stays, including both the frequency of use (hospital admission rates) and the duration of use (length of stay).

The following programs were the most commonly used to address inpatient costs.

Hospitalists

Hospitalists were often described as the most essential element to address total cost of care. Placing a dedicated and specialized physician team at hospitals, often supported by coordinators or nurses, was important both to manage intrastay costs and to reduce readmissions through better discharge planning and coordination.

Hospitalists also participated frequently in triaging patients in the ED to assess whether an acute admission might safely be avoided by using lower cost environments, such as skilled nursing care or enhanced care in the patient's home.

Expanding Post-Acute Care Services

Expanding the capability of post-acute care services, or creating a more robust "middle layer" of care, was another common approach. Dedicated teams of physicians and nurses were deployed in nursing home facilities to reduce length of stay and also reduce the likelihood of readmission from post-acute to acute care. This new "middle layer" was seen as critical in providing a quality and lower-cost alternative to hospitalization.

Multidisciplinary Teams for Patients with Complex Needs

Many organizations described the effectiveness of creating multidisciplinary teams for patients with complex needs. Reducing admission rates for patients with highly complex medical and/or psychosocial needs was the main goal of these programs. Multidisciplinary teams were often implemented in conjunction with defined programs for patients making the transition from a hospital back to their home.

Multidisciplinary Case Review Meetings

Several organizations described the use of consistent and replicable multidisciplinary case review meetings (held daily or weekly) with integrated tracking and accountability. The meetings often included primary care, nursing, hospitalists, and administrative staff and were commonly led by a respected physician with experience in facilitating team meetings. Structured meeting agendas ensured consistency from meeting to meeting; action items were tracked and revisited to assure accountability.

Preferred Provider Networks

Finally, many organizations focused on proactively directing patients within a preferred network of specialist providers that were committed to collaborating with the organization. This step was often seen as critical in ensuring reliability and consistency of patient care.

While the focus on inpatient costs was consistent for organizations with either primary care based or organizationally based strategies, the differences were evident in the implementation, as described in Table 1 on the following page.

Table 1. Process in Action, by Program and Model

	PRIMARY CARE BASED MODELS	ORGANIZATIONALLY BASED MODELS
Inpatient Care Team (hospitalists, care managers, and coordinators)	▸ Hospitalists bring information to the PCP in direct patient-focused communication and in regular case review meetings. ▸ PCPs primarily drive decisions and implement discharge planning in conjunction with the team on site at the hospital.	▸ Hospitalists manage all inpatient care and communication discharge plans to PCPs. ▸ The inpatient care team may even communicate with post-discharge patients directly via phone (or occasionally even via follow-up post discharge visits).
Care for Patients with Complex Needs	▸ PCPs identify patients with complex needs (often supported by analytic reports supplied by the provider organization). ▸ A multidisciplinary team of nurses, coordinators, or patients coaches work on site at the primary care practice to support the complex medical and/or psychosocial needs of these patients.	▸ A multi-disciplinary team of physicians, nurses, coordinators, pharmacists, and social workers or coaches identifies a targeted panel of patients as having complex medical or psychosocial needs. ▸ The team manages the medical care of these patients, either in a specialized clinic setting or in the patient's home, and communicates the plan to the PCP.
Case Review Meetings	▸ A physician champion facilitates a weekly meeting at a primary care practice; the participants include the PCP, an on-site patient coach, the practice administrator, and a hospitalist. ▸ The team reviews a defined agenda, including practice patients currently in the hospital, patients who have been recently discharged, patients with complex needs, and/or patients who have multiple hospital or ED visits. ▸ Plans of care are tracked for each meeting and progress evaluated.	▸ A medical director leads a case review forum on a daily basis at each hospital where the provider organization has admissions. ▸ Team participants include physicians, discharge planners, and patient coaches assigned responsibility for the care in the hospital and the plan of care for the patient upon discharge. ▸ Discharged patients may be offered participation in specific programs under the leadership of the medical director.

Secondary Strategies: Going Beyond Facility Costs

After addressing facility costs, organizations tackled a wide variety of secondary strategies, such as outpatient surgery, pharmacy practices, and several others. Some of the variation might be related to patient population. Although most of the organizations interviewed served Medicare populations, others responded with examples from commercial and Medicaid populations. Across the board, results were mixed; some organizations were able to demonstrate improvement whereas others were not. Examples of successful strategies are described below.

Use of outpatient surgery. One organization focused extensively on the use of outpatient surgery and measured the rate of use of an ambulatory surgery center versus hospital-based outpatient surgery for specific procedures. This organization reported 50% to 100% cost reduction for the same surgical procedure when performed in a freestanding versus hospital-based facility.

Generic prescribing. Another organization focused on generic prescribing and believed it could still make measured improvement in the rate of generic versus brand use. For this organization, each percentage point increase in generic prescribing saved approximately $1 million annually.

Reducing high-cost pharmaceuticals and imaging procedures. Another organization used collaborative forums with specialists to decrease the use of high-cost pharmaceuticals and imaging procedures. Its most successful project was with rheumatologists, who agreed to protocols for the use of specific injectable medications. The organization believed this collaboration was the root of significant annual savings.

Leadership Support

Many interview participants highlighted that successful execution depended on a foundation of organizational support. Two themes emerged as important types of support for improving cost of care: (1) supportive organizational culture, and (2) committed leadership and organizational alignment.

Supportive Culture

To support improvement in total cost of care, organizations most commonly cited the following attributes: (1) prominent physician leadership, (2) transparent reporting of cost as well as quality, (3) experience with team-based care, and (4) emphasis on continuous improvement.

Physicians in top leadership roles led the battle for enhanced quality and cost reduction in tandem. This leadership was often coupled with the concept of stewardship, where organizations openly shared information on both quality and cost performance and defined success using measures from both domains.

Not surprisingly, successful organizations nearly always deployed team-based care in some fashion, demonstrating that many disciplines are critical to provide care efficiently.

Finally, many interviewees described a relentless pursuit for improvement. The organization's current performance on any given measure, even if it reflected improvement, was never seen as the end result. Targets were continually assessed and the bar raised to stimulate further improvement.

Leadership and Organizational Alignment

All those interviewed emphasized that the effort to improve cost of care must be driven by organization leadership, often the chief executive officer. This was especially true for organizations more recently engaged with value-based reimbursement models and still deriving a large (if not majority) proportion of their revenue from fee-for-service. As a greater share of revenue was derived from population-based payments, a tipping point was reached where structures of the organization were redesigned. Specifically, compensation and incentive systems were adjusted and resources from one department were scaled down while new functions were added.

For example, one organization described early failures in managing cost of care until leadership changed physician compensation and invested significantly in new analytic capabilities. The organization hired an analytics vendor to produce reports that provided physician leaders greater insights into where costs, as well as quality, could be improved. The added investment in analytics was offset by reduction in other administrative areas.

Another interviewee described a wholesale change in their discharge management process to focus only on a subset of the population who, according to the data, were at highest risk for readmission.

Finally, most organizations described a strong culture of accountability for results. Senior leadership regularly monitored key outcomes and tied team and individual performance to achievement. Key outcomes were often benchmarked against data purchased from aggregators or data provided by health plans that compared one provider organization to another. The measures most commonly used to evaluate performance included:

1. Admission rates and readmission rates (to acute or post-acute care facilities)
2. Length of stay for inpatient and post-acute facility stays
3. Rates of ED use
4. Total or specialty-specific cost of care per member (per month or per year)

Summary and Implications for Provider Organizations

The health care organizations interviewed offered valuable insights into how they managed the cost of care. In summary, a roadmap emerged for provider organizations interested in sharpening their own focus on the cost side of the value equation.

- **Health care organizations need to assess their cultural and leadership foundation.** It is clear that successful organizations shared common cultural attributes driven by the organization leadership. Nearly all organizations attributed success in execution to these basic core beliefs.
- **Organizations should decide between primary care based versus organizationally based strategies.** Organizations face a major strategic decision about whether to organize programs and resources within primary care practices and assign accountability at the local level (primary

care based) or collaborate with primary care practices and assign accountability centrally or regionally for program execution (organizationally based).

- **The initial target should be inpatient and facility costs.** Successful programs provided many examples aimed at reducing per-member costs or, more often, the surrogate measures of cost, such as hospital days per 1,000 enrollees. Health care organizations seeking to reduce cost of care can use benchmarks from health plans or vendors to evaluate which programs to launch first.
- **Organizational foundation is critical.** Based on the diversity of provider organizations reporting success, any organization appears capable of addressing cost of care, as long as the foundation is strong. Successful organizations included large groups, small organizations, medical groups, IPAs, those new to population management, and those with decades of experience. The common element appears to be the foundation from which an organization begins the work — whether the leadership is committed, and the culture supports, a shift from volume to value.

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The CQC is a multi-stakeholder health care improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California. The CQC generates scalable and measurable improvement in health care delivery in ways important to patients, purchasers, providers, and health plans.

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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