ALTARUM
HEALTHCARE VALUE HUB

Healthcare Value Hub:

SHOWCASE OF NEW RESOURCES & ROAD MAP TO ACTION

Lynn Quincy, Director, Healthcare Value Hub

Aug 28, 2018

A Patient-Centered, High-Value Health System….

- …is integrated with public health and social services sectors and focuses on the people it is meant to serve by addressing inequities, high costs, poor coordination and other problems.

- This system allocates resources wisely and delivers care that is equitable, effective, affordable and patient-centered.

THE UNITED STATES HAS A HEALTHCARE VALUE PROBLEM

High and rising, plus unwarranted variation in prices

HEALTHCARE PRICES

Unacceptable variation in healthcare quality

QUALITY UNEVEN

Too little cost and quality transparency

NO TRANSPARENCY

Creating A Patient-Centered, High-Value Health System….

- ….requires an evidence-based understanding of the drivers of high costs, uneven quality and health inequities…

- …as well as evidence about the strategies that counteract those drivers, incorporate patient preferences and needs, and systematically deliver high value.

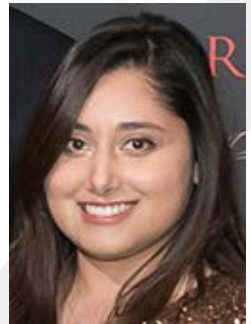
What is the Healthcare Value Hub?

With support from the Robert Wood Johnson Foundation:

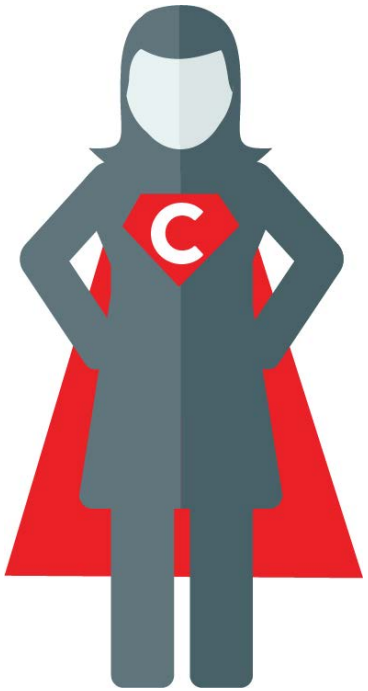
- Altarum's Healthcare Value Hub has free resources to help YOU work on healthcare value issues.
- The Healthcare Value Hub reviews evidence to identify the policies and practices that work best.
- We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and connect them to researchers and other resources.







What is a consumer advocate?



A person whose job is to
protect and promote the welfare and rights of consumers,
for example, by
giving advice, testing products
or trying to improve laws relating to
the sale of goods and services.

Free Hub Resources

COST & QUALITY PROBLEMS

IMPROVING VALUE

ADVOCATE RESOURCES

STATE NEWS

A layered approach to Hub products

Button

Infographic

Glossary

Easy Explainer

Research Brief

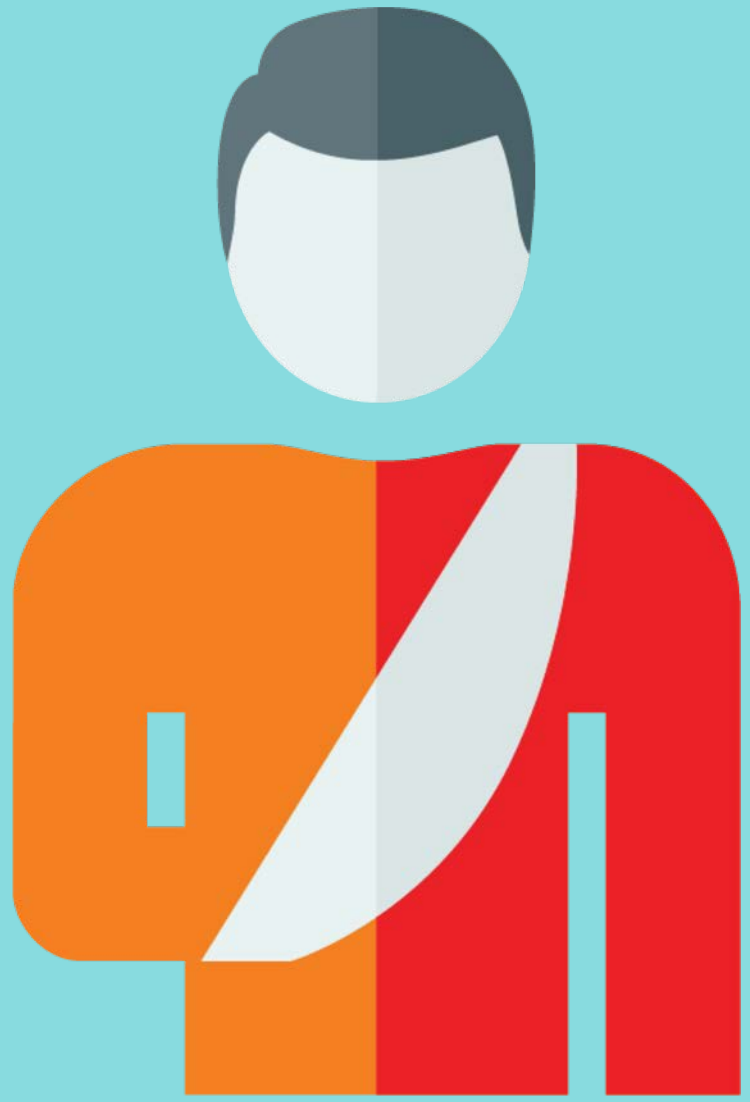
Extensive Evidence Review

Road Map to a High-Value System:

- Consumer Harm
- Drivers of High Costs & Uneven Quality
- Solutions

Road Map:

The Story of Consumer Harm



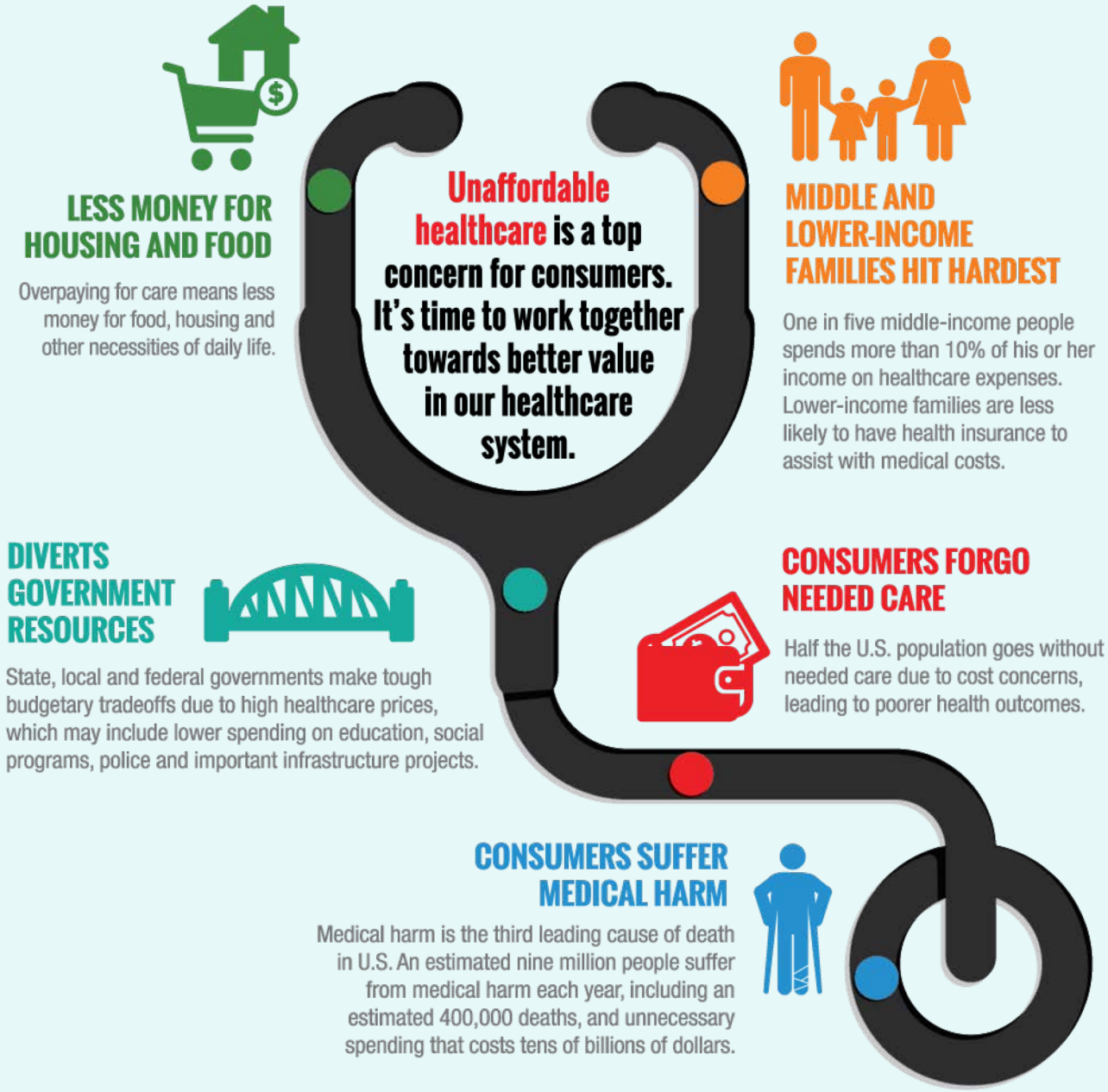
Focus groups and polling show…

Consumers are Outraged about Healthcare Costs & Complexity

- 71% of Americans say the system is "in a state of crisis" or "has major problems.“ *Gallup, Dec 2017*
- Americans are more worried about health care costs than the costs of college, housing or child care, *Ipsos, 2018*
- On a bipartisan basis, Americans see a critical role for government in fixing the system. *KFF, Dec 2016*

THE IMPACT OF HIGH PRICES AND UNEVEN QUALITY:

CONSUMER HARM



HOW CONSUMERS EXPERIENCE AFFORDABILITY PROBLEMS

Going without coverage due to

HIGH PREMIUMS

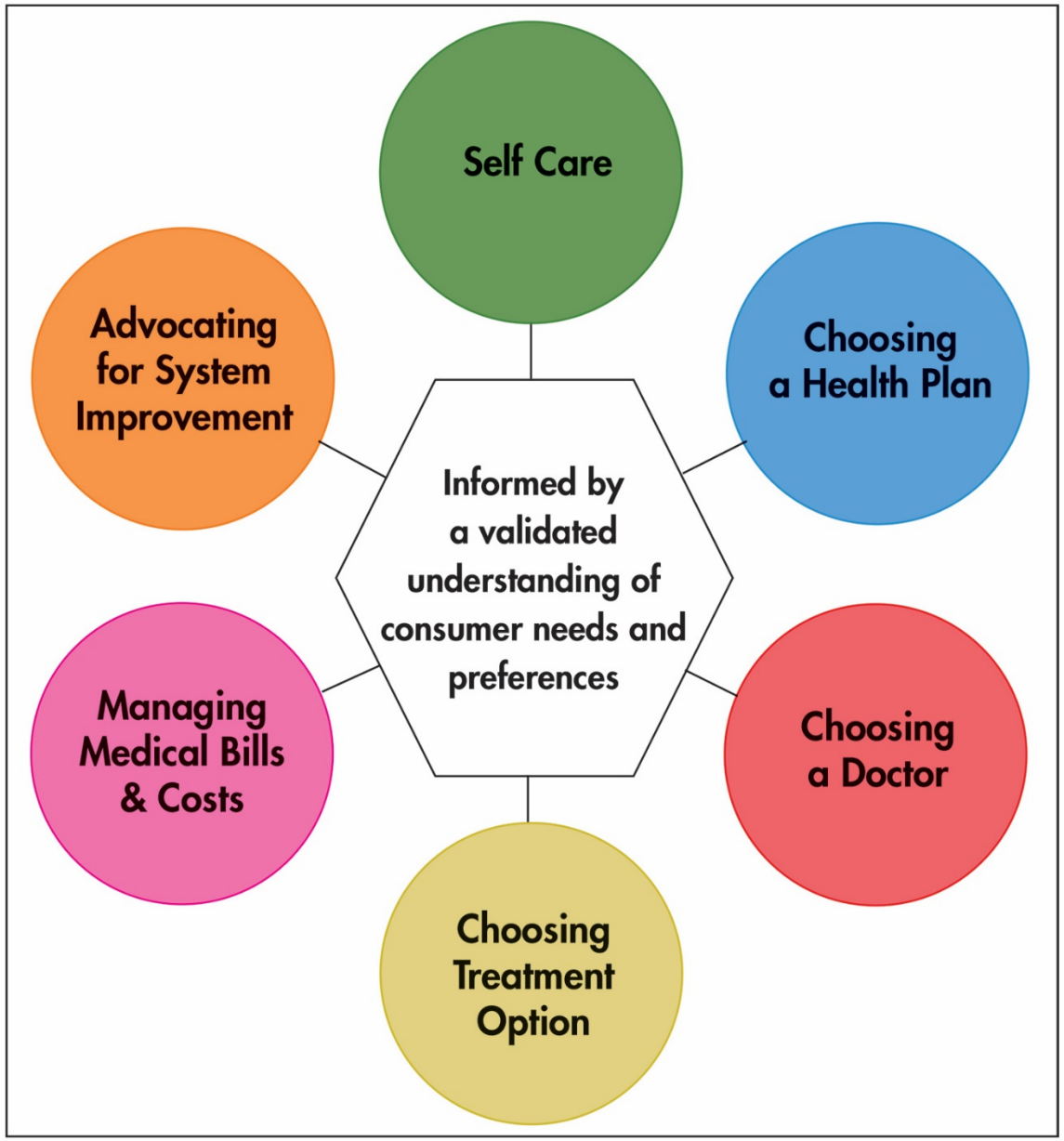
Delaying or foregoing care due to concerns about

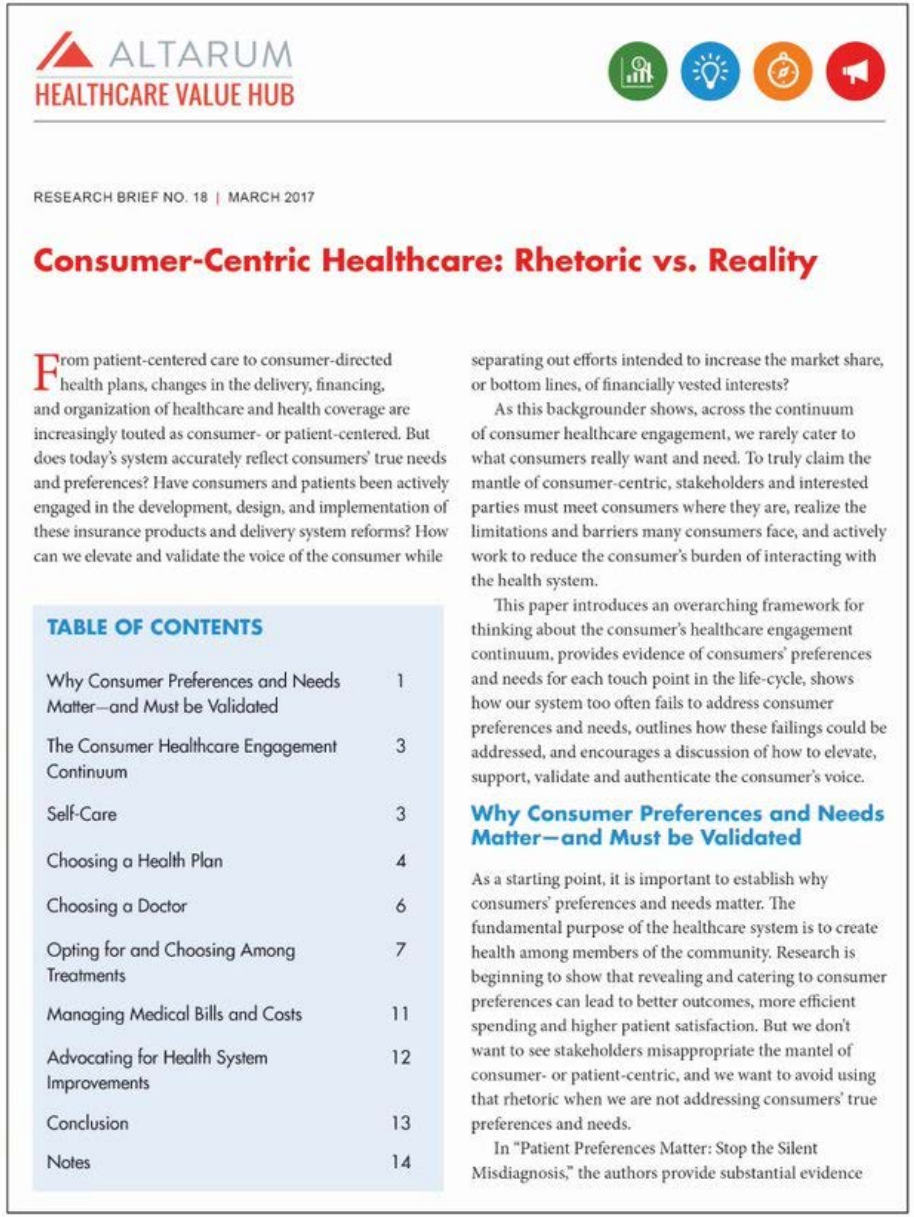
HEALTH COSTS

Getting care but struggling to pay resulting

MEDICAL BILLS

Consumer Healthcare Engagement Points





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RESEARCH BRIEF NO. 18 | MARCH 2017

Consumer-Centric Healthcare: Rhetoric vs. Reality

From patient-centered care to consumer-directed health plans, changes in the delivery, financing, and organization of healthcare and health coverage are increasingly touted as consumer- or patient-centered. But does today's system accurately reflect consumers' true needs and preferences? Have consumers and patients been actively engaged in the development, design, and implementation of these insurance products and delivery system reforms? How can we elevate and validate the voice of the consumer while separating out efforts intended to increase the market share, or bottom lines, of financially vested interests?

As this backgrounder shows, across the continuum of consumer healthcare engagement, we rarely cater to what consumers really want and need. To truly claim the mantle of consumer-centric, stakeholders and interested parties must meet consumers where they are, realize the limitations and barriers many consumers face, and actively work to reduce the consumer's burden of interacting with the health system.

This paper introduces an overarching framework for thinking about the consumer's healthcare engagement continuum, provides evidence of consumers' preferences and needs for each touch point in the life-cycle, shows how our system too often fails to address consumer preferences and needs, outlines how these failings could be addressed, and encourages a discussion of how to elevate, support, validate and authenticate the consumer's voice.

TABLE OF CONTENTS

Why Consumer Preferences and Needs Matter—and Must be Validated

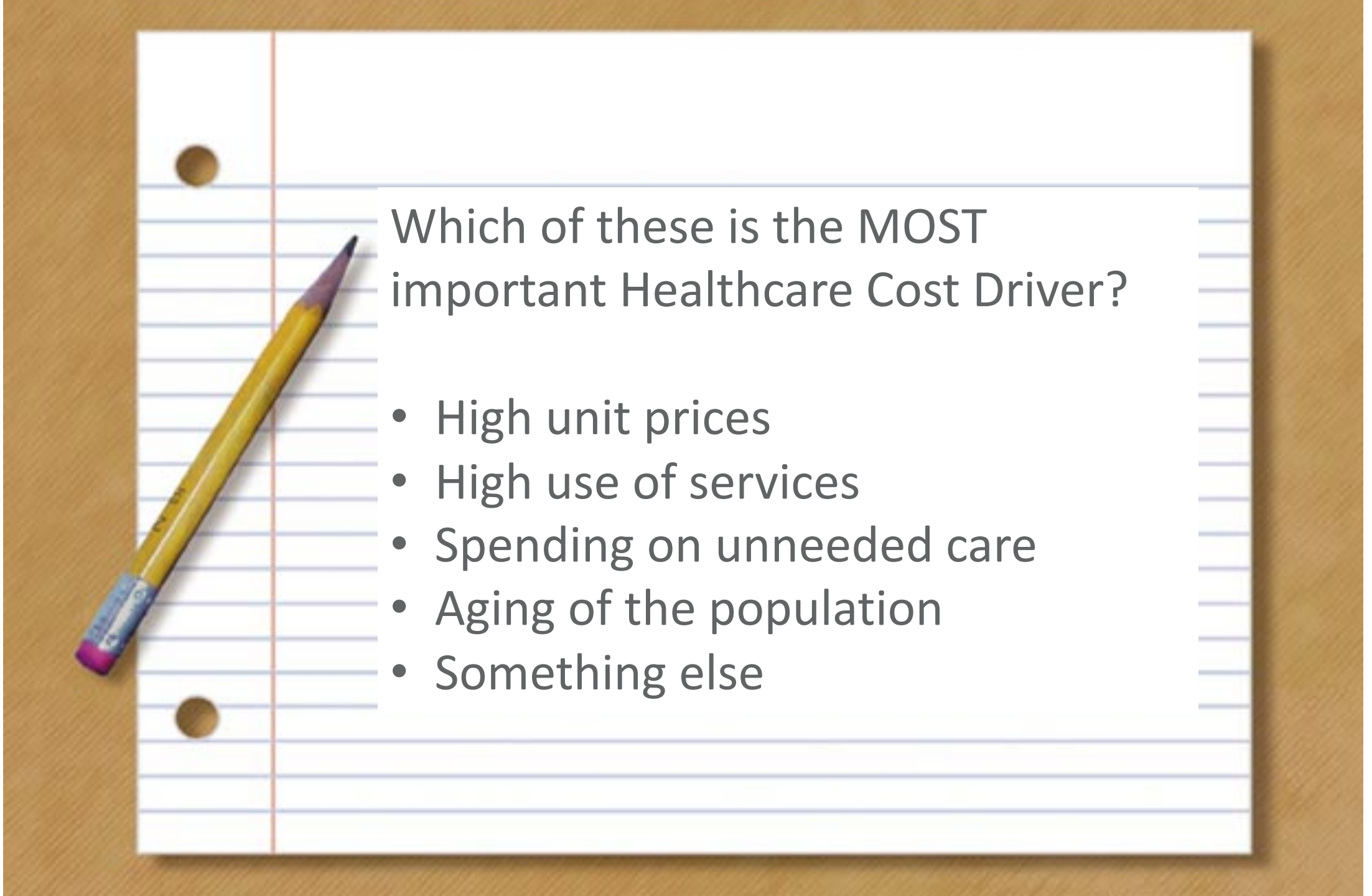
As a starting point, it is important to establish why consumers' preferences and needs matter. The fundamental purpose of the healthcare system is to create health among members of the community. Research is beginning to show that revealing and catering to consumer preferences can lead to better outcomes, more efficient spending and higher patient satisfaction. But we don't want to see stakeholders misappropriate the mantel of consumer- or patient-centric, and we want to avoid using that rhetoric when we are not addressing consumers' true preferences and needs.

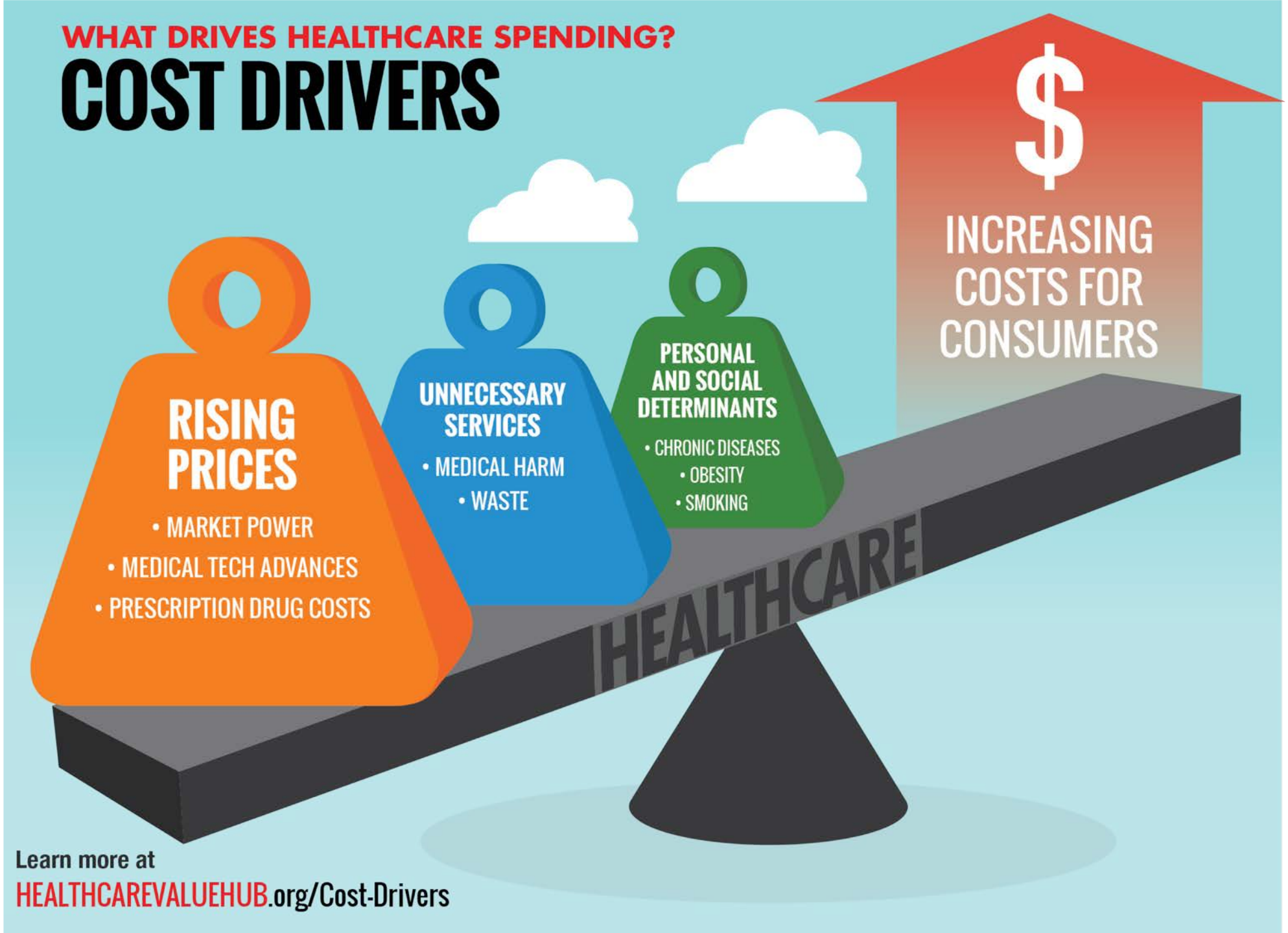
In "Patient Preferences Matter: Stop the Silent Misdiagnosis," the authors provide substantial evidence

Consumer-Centric Healthcare: Rhetoric vs. Reality, Research Brief No. 18, Healthcare Value Hub (March 2017).

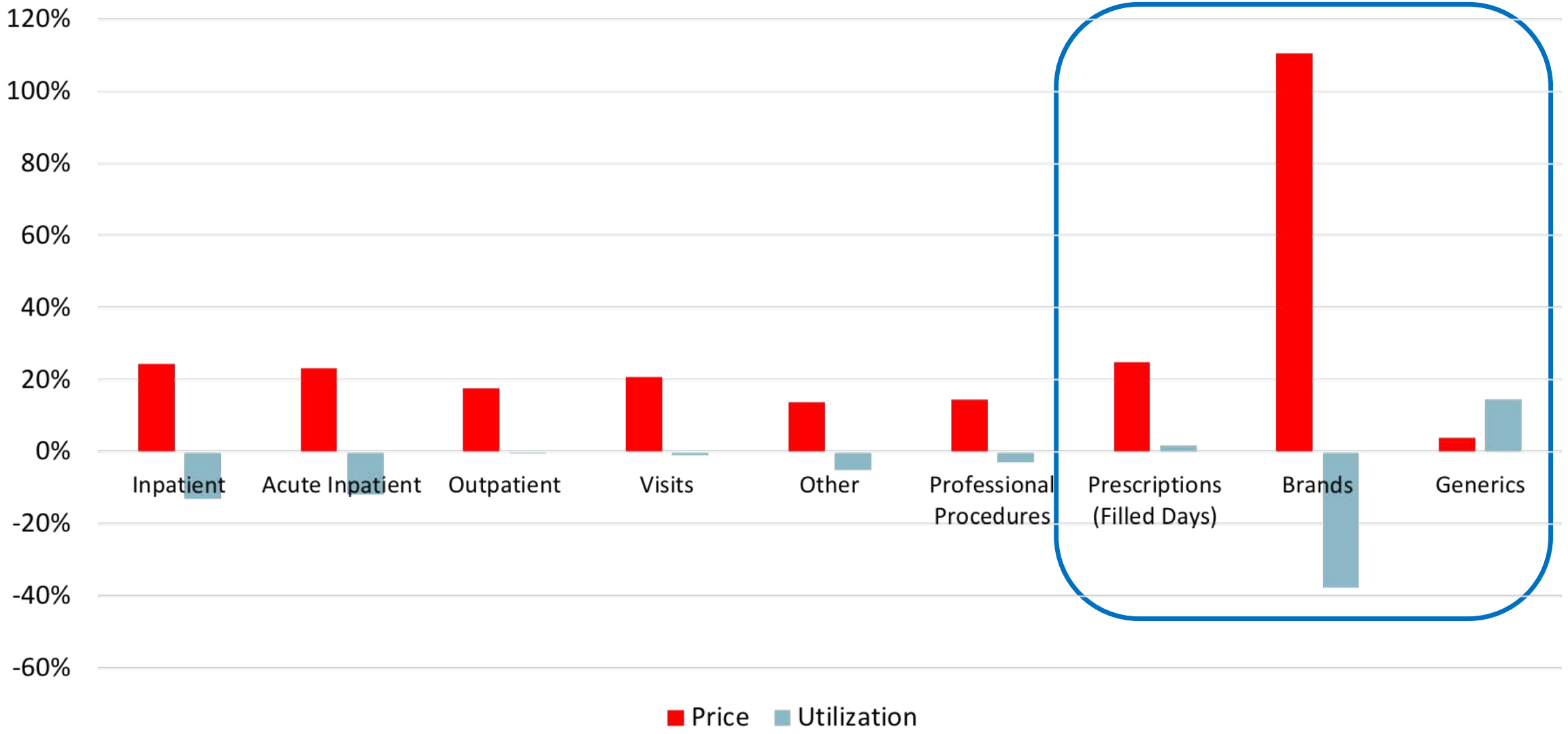
Road Map:

Drivers of high costs, uneven quality and health inequities


Which of these is the MOST important Healthcare Cost Driver?
• High unit prices
• High use of services
• Spending on unneeded care
• Aging of the population
• Something else


WHAT DRIVES HEALTHCARE SPENDING?
COST DRIVERS
$
INCREASING COSTS FOR CONSUMERS
RISING PRICES
• MARKET POWER
• MEDICAL TECH ADVANCES
• PRESCRIPTION DRUG COSTS
UNNECESSARY SERVICES
• MEDICAL HARM
• WASTE
PERSONAL AND SOCIAL DETERMINANTS
• CHRONIC DISEASES
• OBESITY
• SMOKING
HEALTHCARE
Learn more at
HEALTHCAREVALUEHUB.org/Cost-Drivers

Prices Drive Spending: 2015-2016 Spending Increases Decomposed



Source: Health Care Cost Institute, Health Care Cost and Utilization Report, 2016

THE ROAD TO DRUG COMPETITION

HAMPERED BY POLICIES, BARRIERS AND DELAY TACTICS

For information on how our current system thwarts drug competition see:

HEALTHCAREVALUEHUB.org/Drug-Spending

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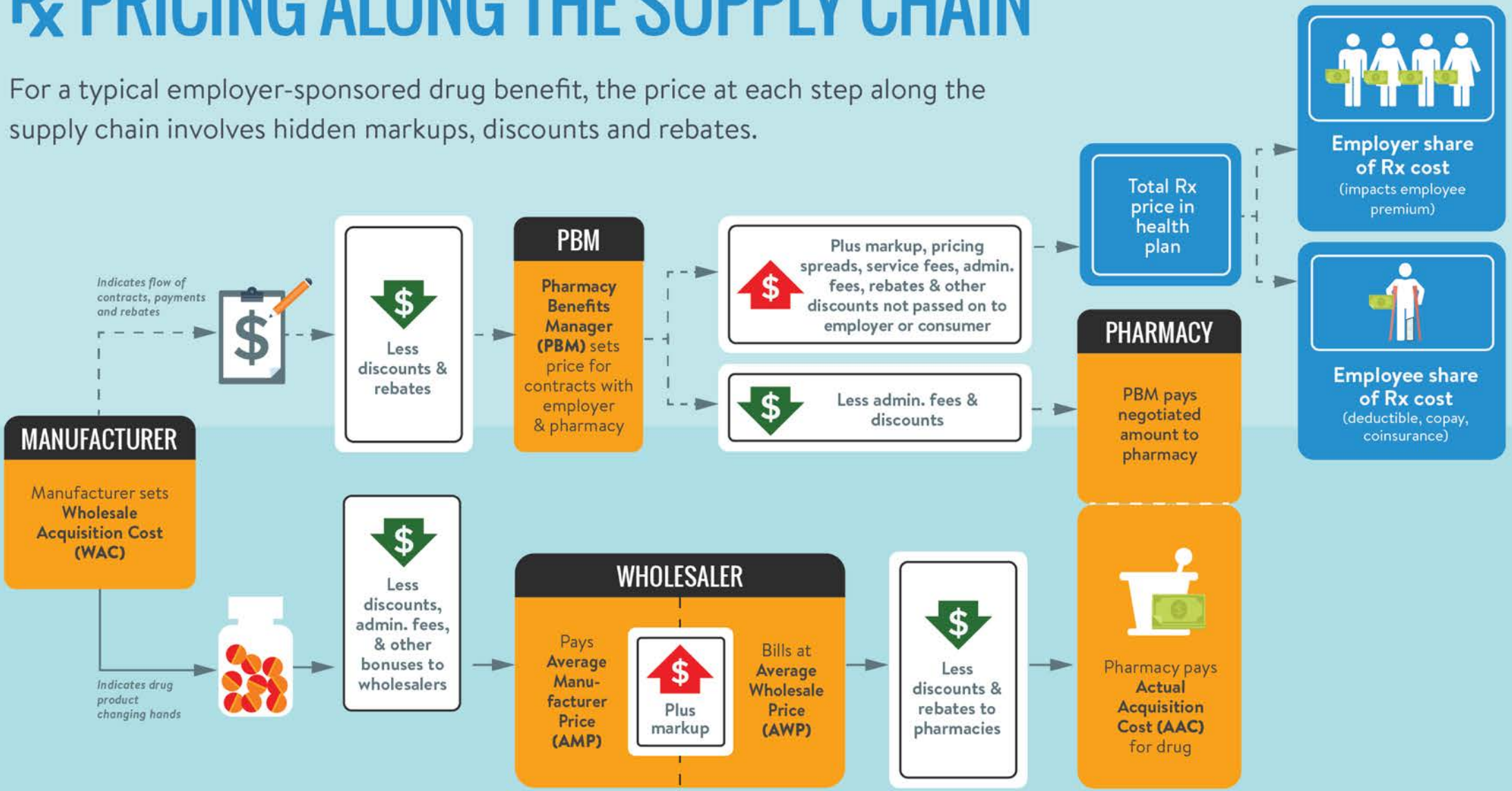
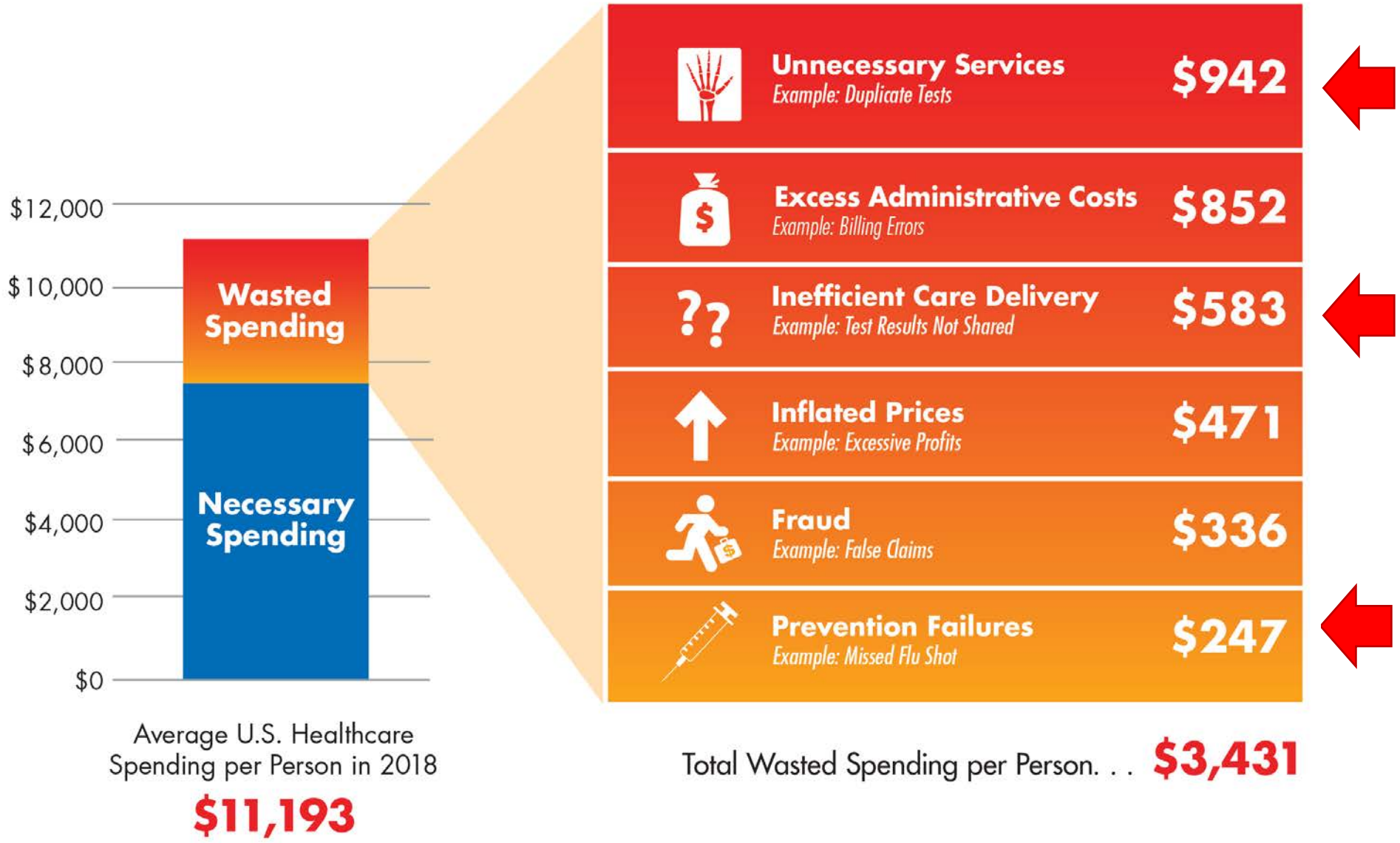
Rx PRICING ALONG THE SUPPLY CHAIN

For a typical employer-sponsored drug benefit, the price at each step along the supply chain involves hidden markups, discounts and rebates.



Learn more at www.HealthcareValueHub.org/Drug-Spending/

Approximately 1 in 3 Healthcare Dollars is Waste



LOW-VALUE CARE .vs HIGH-VALUE CARE

LOW-VALUE CARE

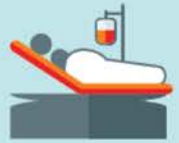
EXAMPLES

Unneeded diagnostic testing

Unneeded imaging

Bloodwork for low-risk surgery

Use of branded drugs when generics are available



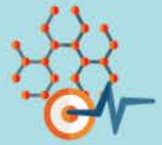
Elective/unwarrented C-sections

Spending wasted on low-value care is estimated to be more than $340 billion each year.

HIGH-VALUE CARE

EXAMPLES

Getting a flu shot



Cancer screening when appropriate

Coordinating care for complex patients

Prenatal care

Eye screening for diabetics

Providing more high-value care could avoid costly care later, saving more than $55 billion each year.

For details on the strategies, go to:

HEALTHCAREVALUEHUB.org/low-vs-high-value-care

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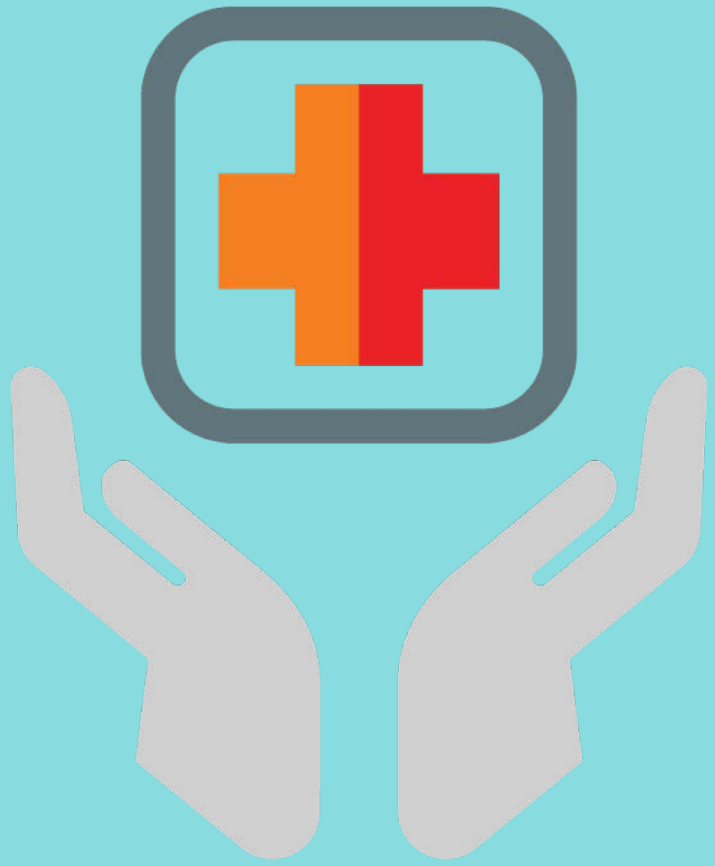
Road Map:

Final Word on Drivers



- Advocates, policymakers and others need a LOCAL playbook

THE NEW YORKER

ANNALS OF MEDICINE

THE COST CONUNDRUM

What a Texas town can teach us about health care.

by Atul Gawande

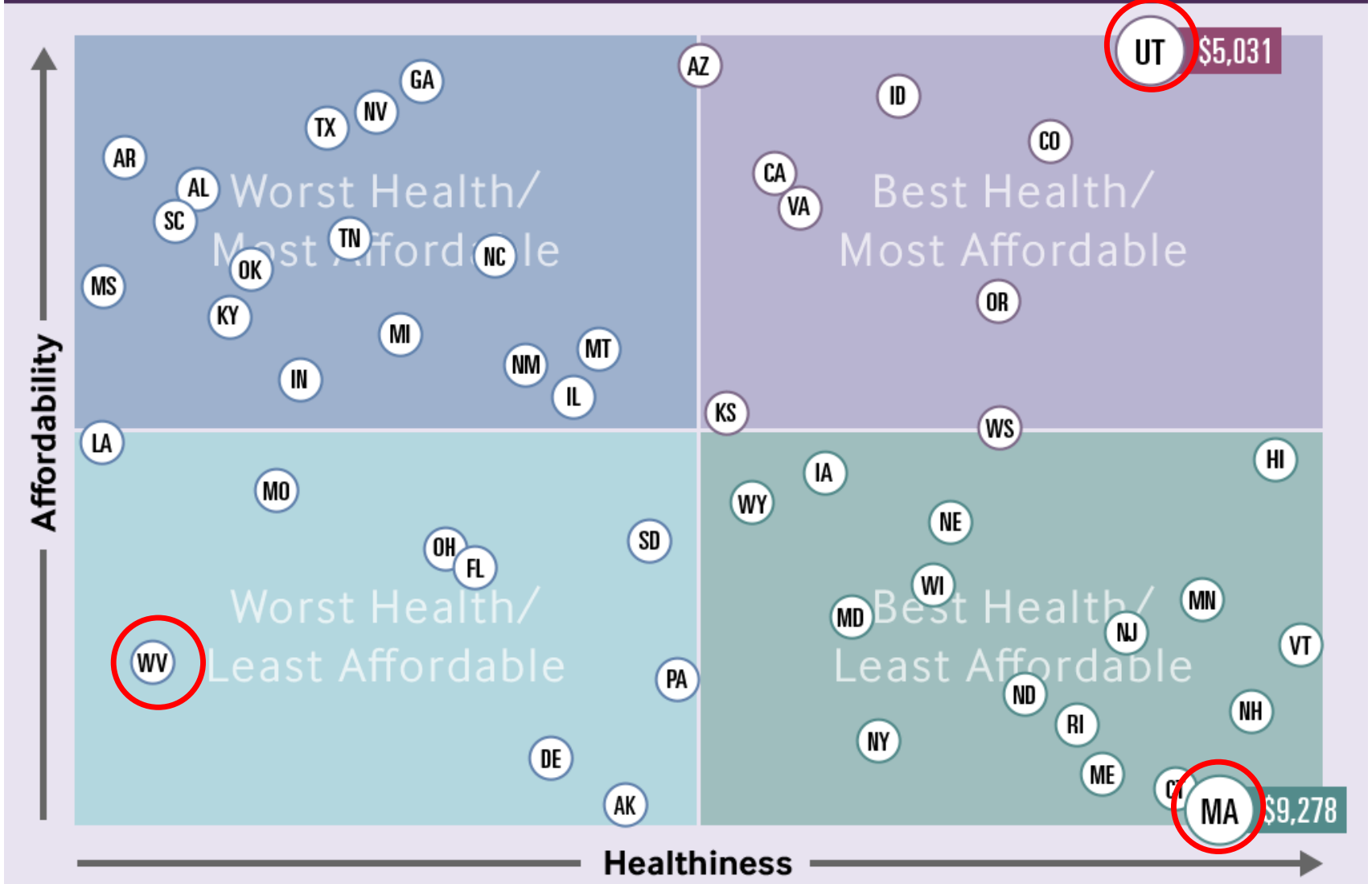
JUNE 1, 2009

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.

Costlier care is often worse care. Photograph by Philip Toledano.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much higher labor and living costs—spends more per person on health care. In 2006, Medicare spent fifteen thousand dollars per enrollee here, almost twice the national average. The income per capita is twelve thousand dollars. In other words, Medicare spends three thousand dollars more per person here than the average person earns.

The explosive trend in American medical costs seems to have occurred here in an especially intense form. Our country's health care is by far the most expensive in the world. In



X Axis: Health Ranking by State *Source: United Health Foundation, 2013*

Y Axis: Health Care Expenditures per Capita by State of Residence *Source: Kaiser Family Foundation, 2009*

From University of Utah Health Care, adapted with permission.

Filter News by State

Pennsylvania

Filter News by Topic

All Topics

State News

Pennsylvania

Pennsylvania has many providers that participate in cost saving and quality improvement initiatives. One prime example is Geisinger Health System's pay-for-performance initiative, which ties a significant portion of the health system's physician salaries to quality and financial performance. Furthermore, more than 225 hospitals and health systems formed the Pennsylvania Healthcare Quality Alliance (PHCQA) whose goal is to develop a statewide hospital quality measurement.

The Pennsylvania Cost Containment Council is an independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of healthcare and increasing access for all citizens regardless of ability to pay.

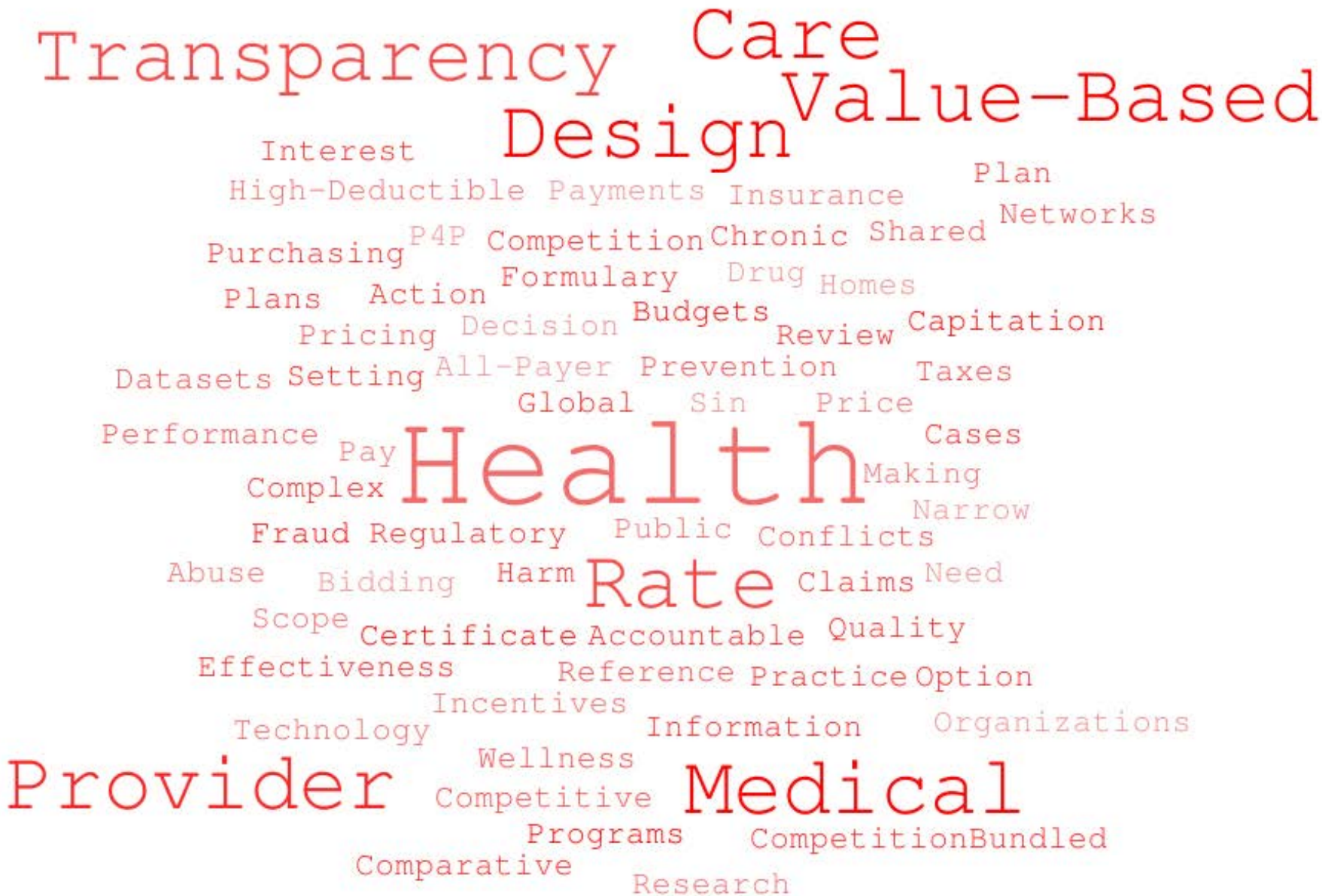
In 2013, Pennsylvania was awarded $1.5 million dollars in a State Innovation Model (SIM) Design grant from CMS to develop payment models that would improve quality of care and reduce costs of patients. In 2014, Pennsylvania was awarded another $3 million dollars to build on the overarching goals it proposed the previous year.

Pennsylvania | May 8, 2018 | News Story

Area Hospitals Get Mixed Reviews in Statewide Study

Road Map:

Solutions


Transparency
Care
Value-Based
Design
Interest
High-Deductible
Payments
Insurance
Plan
Networks
Purchasing
P4P
Competition
Chronic
Shared
Formulary
Drug
Homes
Plans
Action
Budgets
Pricing
Decision
Review
Capitation
Datasets
Setting
All-Payer
Prevention
Taxes
Global
Sin
Price
Performance
Pay
Health
Cases
Complex
Making
Narrow
Fraud
Regulatory
Public
Conflicts
Abuse
Bidding
Harm
Rate
Claims
Need
Scope
Certificate
Accountable
Quality
Effectiveness
Reference
Practice
Option
Incentives
Technology
Information
Organizations
Wellness
Provider
Medical
Competitive
Programs
CompetitionBundled
Comparative
Research

More than 50 solutions have been proposed

To assess interventions, ask:

1. Are you addressing the right system problem?
2. Have you targeted the right system actor?
3. Does the evidence show that it works?

Road Map:

Solutions

- Accountability for States

KEY STATE STRATEGIES TO BETTER HEALTHCARE VALUE

States have responsibility for fair, efficient health systems. For details:

HEALTHCAREVALUEHUB.org/state-accountablility

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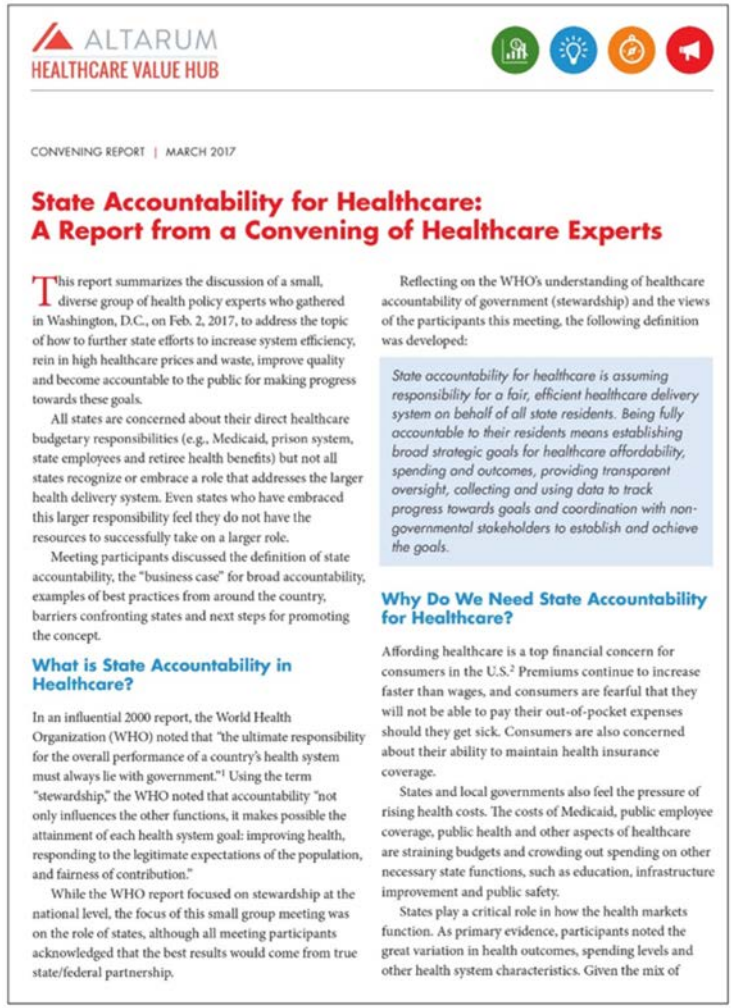
Why Make States Accountable?

- States are close to the unique, local market conditions that give rise to high prices, waste and “entrepreneurial spirit.”
- Inter-connectedness of the health system means a comprehensive view needed.
- The only stakeholder with the incentive to broadly consider the entire health system, from social determinants to provider workforce.
- When health system works well, helps all payers – relief for state budgets.
- Consumers, employers and even providers want states to play this role

State Accountability for Healthcare



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CONVENING REPORT | MARCH 2017

State Accountability for Healthcare: A Report from a Convening of Healthcare Experts

This report summarizes the discussion of a small, diverse group of health policy experts who gathered in Washington, D.C., on Feb. 2, 2017, to address the topic of how to further state efforts to increase system efficiency, rein in high healthcare prices and waste, improve quality and become accountable to the public for making progress towards these goals.

All states are concerned about their direct healthcare budgetary responsibilities (e.g., Medicaid, prison system, state employees and retiree health benefits) but not all states recognize or embrace a role that addresses the larger health delivery system. Even states who have embraced this larger responsibility feel they do not have the resources to successfully take on a larger role.

Meeting participants discussed the definition of state accountability, the "business case" for broad accountability, examples of best practices from around the country, barriers confronting states and next steps for promoting the concept.

What is State Accountability in Healthcare?

In an influential 2000 report, the World Health Organization (WHO) noted that "the ultimate responsibility for the overall performance of a country's health system must always lie with government."[1] Using the term "stewardship," the WHO noted that accountability "not only influences the other functions, it makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution."

While the WHO report focused on stewardship at the national level, the focus of this small group meeting was on the role of states, although all meeting participants acknowledged that the best results would come from true state/federal partnership.

Reflecting on the WHO's understanding of healthcare accountability of government (stewardship) and the views of the participants this meeting, the following definition was developed:

State accountability for healthcare is assuming responsibility for a fair, efficient healthcare delivery system on behalf of all state residents. Being fully accountable to their residents means establishing broad strategic goals for healthcare affordability, spending and outcomes, providing transparent oversight, collecting and using data to track progress towards goals and coordination with non-governmental stakeholders to establish and achieve the goals.

Why Do We Need State Accountability for Healthcare?

Affording healthcare is a top financial concern for consumers in the U.S.[2] Premiums continue to increase faster than wages, and consumers are fearful that they will not be able to pay their out-of-pocket expenses should they get sick. Consumers are also concerned about their ability to maintain health insurance coverage.

States and local governments also feel the pressure of rising health costs. The costs of Medicaid, public employee coverage, public health and other aspects of healthcare are straining budgets and crowding out spending on other necessary state functions, such as education, infrastructure improvement and public safety.

States play a critical role in how the health markets function. As primary evidence, participants noted the great variation in health outcomes, spending levels and other health system characteristics. Given the mix of

Assuming responsibility for a fair, efficient healthcare delivery system on behalf of ***all*** state residents.

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RESEARCH BRIEF NO. 14 | October 2016

Measuring Healthcare Value at the State Level: Advocates' Guide

Many Americans find it alarmingly difficult to get good value for their healthcare dollar. According to numerous reports, we overpay for much of our healthcare and get uneven quality in return. Excess healthcare spending crowds out other important purchases and burdens individuals, employers and governmental budgets.

Because the specific conditions that give rise to high prices, unnecessary services and uneven quality vary tremendously between and within geographic areas states are the key system actors likely to be at the forefront of meaningful progress on healthcare cost and value issues.

States are underpowered to address poor healthcare value. The absence of timely and reliable data limits the ability to identify healthcare cost drivers, poor-quality hot spots and whether or not interventions designed to improve healthcare value are working. Aggregate data on quality and spending can ensure that we aren't fixing one area while breaking another and show us whether the state's overall healthcare bill is in line with the overall economic growth and quality improvements. Detailed data allows policymakers to understand what drives disparities and to design and implement appropriate interventions. In short, we cannot improve the cost and quality of healthcare without the support of robust data.

For the most part, healthcare value is not now measured at the state level. To address this shortcoming, this guide describes the major domains of healthcare value measurement and points to readily available state-level data resources that can begin to show states are performing on healthcare value. It also identifies the key data that are lacking.

SUMMARY

This guide describes the major domains of healthcare value measurement and identifies readily available data resources that begin to fill in the healthcare value picture at the state level.

While currently available data provides a pretty robust starting point for healthcare value measurement, this nationally collected data is insufficient if states are to take a data-driven approach to addressing healthcare value for their residents.

The Hub's companion report, *Measuring Healthcare Value at the State Level: A Call to Action*, details the additional data needed and provides case study examples of states that already collect this critical data.

What are the Domains of Healthcare Value?

Healthcare value is getting good quality care for a fair price. We must stop overpaying at the household, employer or governmental level because, at the end of the day, the consumer pays the bill.

It is also about enabling consumers to navigate the healthcare system safely and confidently. This means that data on price and quality is trusted, actionable and readily available so that the risk of encountering poor performers, or an outrageously inflated price, is minimized.

Finally, a properly working healthcare system is sensitive to consumers' varying ability to pay for the care they need. Healthcare, after all, is not a luxury, but a vital service necessary for life and quality of life.

With this description of healthcare value in mind, we believe states should use the following broad categories to measure healthcare value for their residents:

- Spending and Cost
- Affordability
- Health Outcomes
- Medical Harm
- Patient Experience

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RESEARCH BRIEF NO. 15 | December 2016

Measuring Healthcare Value at the State Level: A Call to Action

Consumers in the U.S. are worried about high healthcare prices—and for good reason. The evidence is very strong that we overpay for healthcare, receive too many low-value services and outcomes are not uniformly high. Getting to better healthcare value is critical to reaching our nation's goal of broad access to quality healthcare for all, whereas overspending burdens for household, employer, and state and federal budgets.

States are key system actors likely to be at the forefront of meaningful progress on healthcare cost and value issues because the specific conditions that give rise to high prices, unnecessary services and uneven quality vary tremendously between and within geographic areas. Yet most states are not equipped to address poor healthcare value on behalf of their residents.[1] Specifically, the absence of timely and reliable public data limits their ability to identify healthcare cost drivers, poor-quality hot spots and whether or not interventions designed to improve healthcare value are working.

This report is a *Call to Action* that details the types of data that should be collected at the state level and provides best-practice examples—proof-of-concept that systematic measurement of healthcare value is already taking place in selected states around the country.

SUMMARY

States play a critical role in the provision of healthcare to their residents, yet few states are armed with the data that would allow them to comprehensively assess or address the poor healthcare value faced by many families.

This report is a *Call to Action* that details the minimum five domains states should track as part of broad commitment to better healthcare value for their residents (spending, affordability, outcomes, medical harm and patient experience). It describes the key analyses that should be performed at the state level and provides "proof-of-concept" case study examples of states that already collect this critical data.

As described in the Hub's companion report, *Measuring Healthcare Value at the State Level: Advocates' Guide*, some state-level data is already widely available. But the picture is incomplete and states must do their own data collection to fill the void.

What is Healthcare Value?

Healthcare value is receiving quality care for a fair price. We must stop overpaying at the household, employer and governmental levels because, at the end of the day, the consumer is paying the bill.

Getting to healthcare value means we use our system's resources wisely, including investing appropriately at the community level, to achieve high-quality, equitable health outcomes; preferences and needs of consumers/patients are revealed and taken into account, and our healthcare system is transparent with respect to best practices, prices, quality and outcomes.

Ideally, states would have policies in place that would enable consumers to navigate the healthcare system safely and confidently. This means that data on price and quality is trusted, actionable and readily available, and the risk of encountering poor performers, or an outrageously inflated price, is minimized.

Finally, a properly working healthcare system is sensitive to consumers' varying ability to pay for the care they need. Healthcare, after all, is not a luxury, but a vital service necessary for life and quality of life.

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RESEARCH BRIEF NO. 20 | NOVEMBER 2017

Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.[1] Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.[2] While all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

SUMMARY

It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising health-care costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.[3]

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.[4] States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in "upstream" approaches that lead to healthier communities. Research shows that just 10-20 percent

Coverage and Healthcare Value are Intertwined

- Coverage is the top factor in improving access to care, coordination of care and quality outcomes.
- Better healthcare value is essential to sustaining coverage gains.
- Reforms designed to produce better healthcare value (provider payment reform, etc.) rely on a population with coverage.

Road Map:

Solutions

- Addressing Social Determinants of Health

SOCIAL DETERMINANTS OF HEALTH

The conditions where you live, work and play impact your health outcomes.

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Addressing Personal and Social Determinants of Health

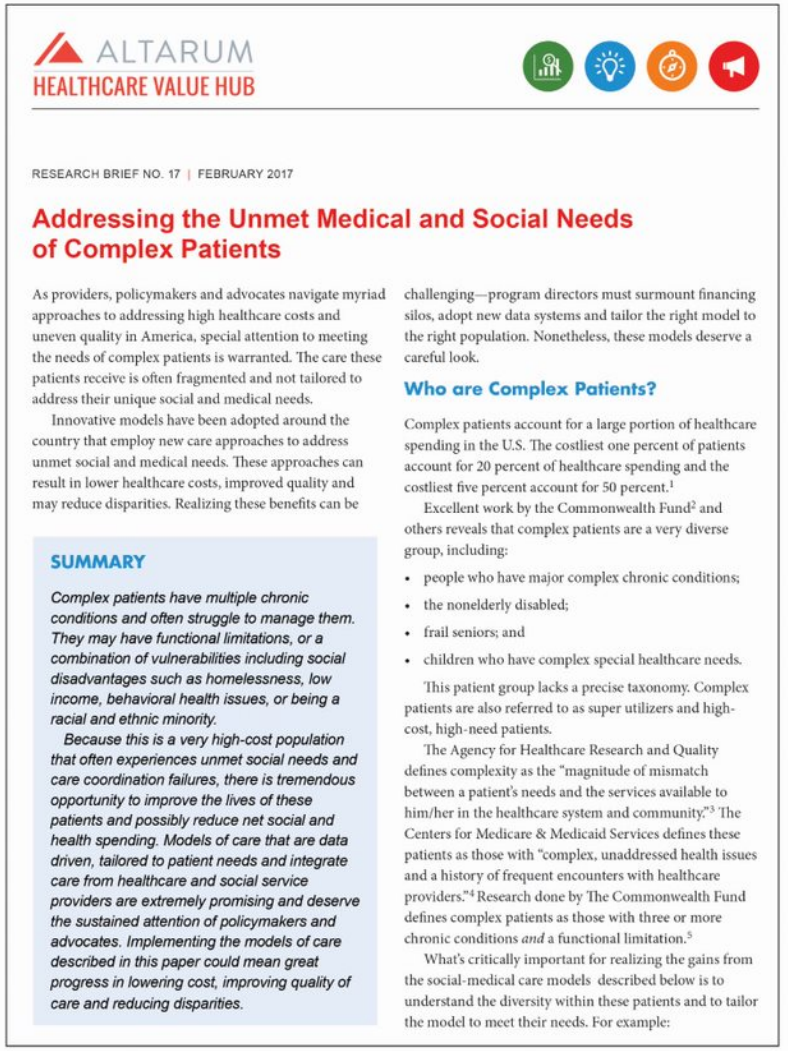
- Assess community needs and capacity to address needs
- Collect data to better track disparities and support targeted interventions
- Place-based, Accountable Health Structures, plus variations
  - Environmental nudges
  - Social-medical models of care
- Address financing silos

What are “Place-based, Accountable Health Structures”?

- “Place-based” approaches seek to integrate care, improve population health, and occasionally control costs.
- Place-based approaches use a backbone organization to coordinate healthcare (including behavioral health), public health, social services, and community-based supports to meet medical and social needs of all individuals living in a specific place.

Social-Medical Care Teams

- Strong evidence with respect to outcomes and possible savings when addressing complex patients



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RESEARCH BRIEF NO. 17 | FEBRUARY 2017

Addressing the Unmet Medical and Social Needs of Complex Patients

As providers, policymakers and advocates navigate myriad approaches to addressing high healthcare costs and uneven quality in America, special attention to meeting the needs of complex patients is warranted. The care these patients receive is often fragmented and not tailored to address their unique social and medical needs.

Innovative models have been adopted around the country that employ new care approaches to address unmet social and medical needs. These approaches can result in lower healthcare costs, improved quality and may reduce disparities. Realizing these benefits can be challenging—program directors must surmount financing silos, adopt new data systems and tailor the right model to the right population. Nonetheless, these models deserve a careful look.

SUMMARY

Complex patients have multiple chronic conditions and often struggle to manage them. They may have functional limitations, or a combination of vulnerabilities including social disadvantages such as homelessness, low income, behavioral health issues, or being a racial and ethnic minority.

Because this is a very high-cost population that often experiences unmet social needs and care coordination failures, there is tremendous opportunity to improve the lives of these patients and possibly reduce net social and health spending. Models of care that are data driven, tailored to patient needs and integrate care from healthcare and social service providers are extremely promising and deserve the sustained attention of policymakers and advocates. Implementing the models of care described in this paper could mean great progress in lowering cost, improving quality of care and reducing disparities.

Who are Complex Patients?

Complex patients account for a large portion of healthcare spending in the U.S. The costliest one percent of patients account for 20 percent of healthcare spending and the costliest five percent account for 50 percent.[1]

Excellent work by the Commonwealth Fund[2] and others reveals that complex patients are a very diverse group, including:

- people who have major complex chronic conditions;
- the nonelderly disabled;
- frail seniors; and
- children who have complex special healthcare needs.

This patient group lacks a precise taxonomy. Complex patients are also referred to as super utilizers and high-cost, high-need patients.

The Agency for Healthcare Research and Quality defines complexity as the "magnitude of mismatch between a patient's needs and the services available to him/her in the healthcare system and community."[3] The Centers for Medicare & Medicaid Services defines these patients as those with "complex, unaddressed health issues and a history of frequent encounters with healthcare providers."[4] Research done by The Commonwealth Fund defines complex patients as those with three or more chronic conditions *and* a functional limitation.[5]

What's critically important for realizing the gains from the social-medical care models described below is to understand the diversity within these patients and to tailor the model to meet their needs. For example:

Does your state have these social-medical models? Find out using our Inventory by State!

101 Programs in 34 states profiled

Is your local program missing? Let us know!

Sample Website Profile

Hennepin Health	Minnesota

Hennepin Health is county-level non-profit HMO that integrates social services with patient care. The program brings together the county hospital, the county social services provider, a federally qualified health center, and the county-owned and operated health plan. This partnership facilitates better care coordination and data sharing. It also enables financial flexibility in how services are delivered and integrated. Services include supportive housing, job placement, and targeted case-management. Hennepin Health analyzes medical histories and utilization data to target high-cost and high-need patients among the roughly 12,000 Medicaid beneficiaries it serves. These patients do not fit a specific profile but many have multiple chronic conditions, socioeconomic barriers to care, and/or behavioral health challenges. The program is one of the most well-known in the country and has received significant national attention.

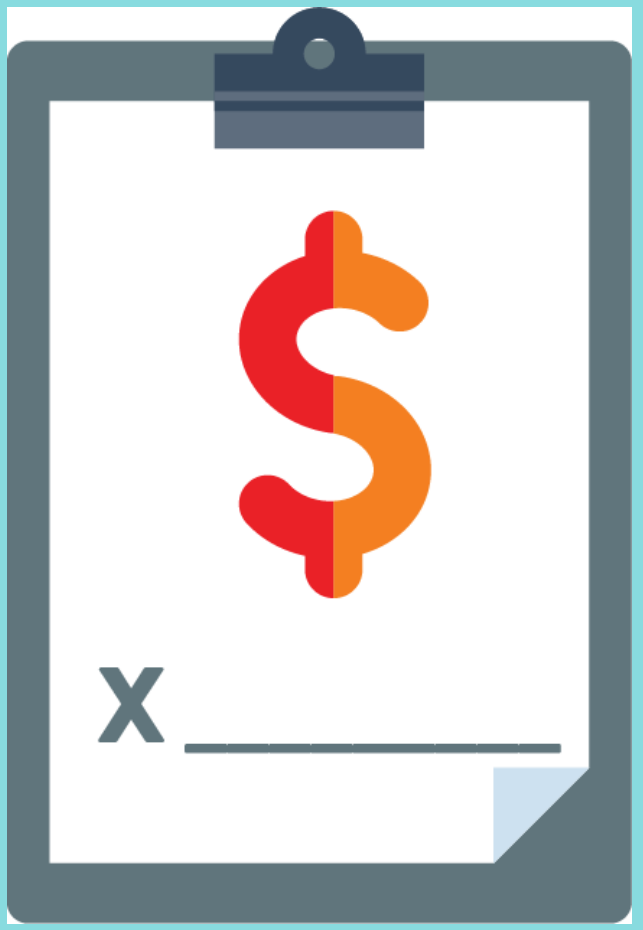
Partner Organizations	• Metropolitan Health Plan *(health plan/insurer)* • Hennepin County Medical Center *(hospital)* • Hennepin County Human Services and Public Health *(social services)* • NorthPoint Health and Wellness Center *(health center)*
Target Population	Medicaid, with: complex needs and high-cost such as multiple chronic conditions, socioeconomic barriers to care such as housing, and serious mental illness
Care Team	Care manager, nurses, physician, behavioral health professional
Timeframe	2012 - ongoing
Results/ Studies	Peer-reviewed research showed that 2012-2013 ER use dropped 55% among the intervention group
Funding	Accountable Care Model: Medicaid per-member per-month fees fund medical care and social services funded by county health department
Resources	Program website 2016 - case study by the Commonwealth Fund 2014 - review in *Health Affairs*

http://www.healthcarevaluehub.org/advocate-resources/state-programs-address-complex-patients/

Road Map:

Solutions

- Addressing High Unit Prices



UNREASONABLE PRICES: STRATEGIES

Price Transparency

HIGH PRICES

Anti-trust, CON/DON, foster competition to address

MONOPOLY POWER

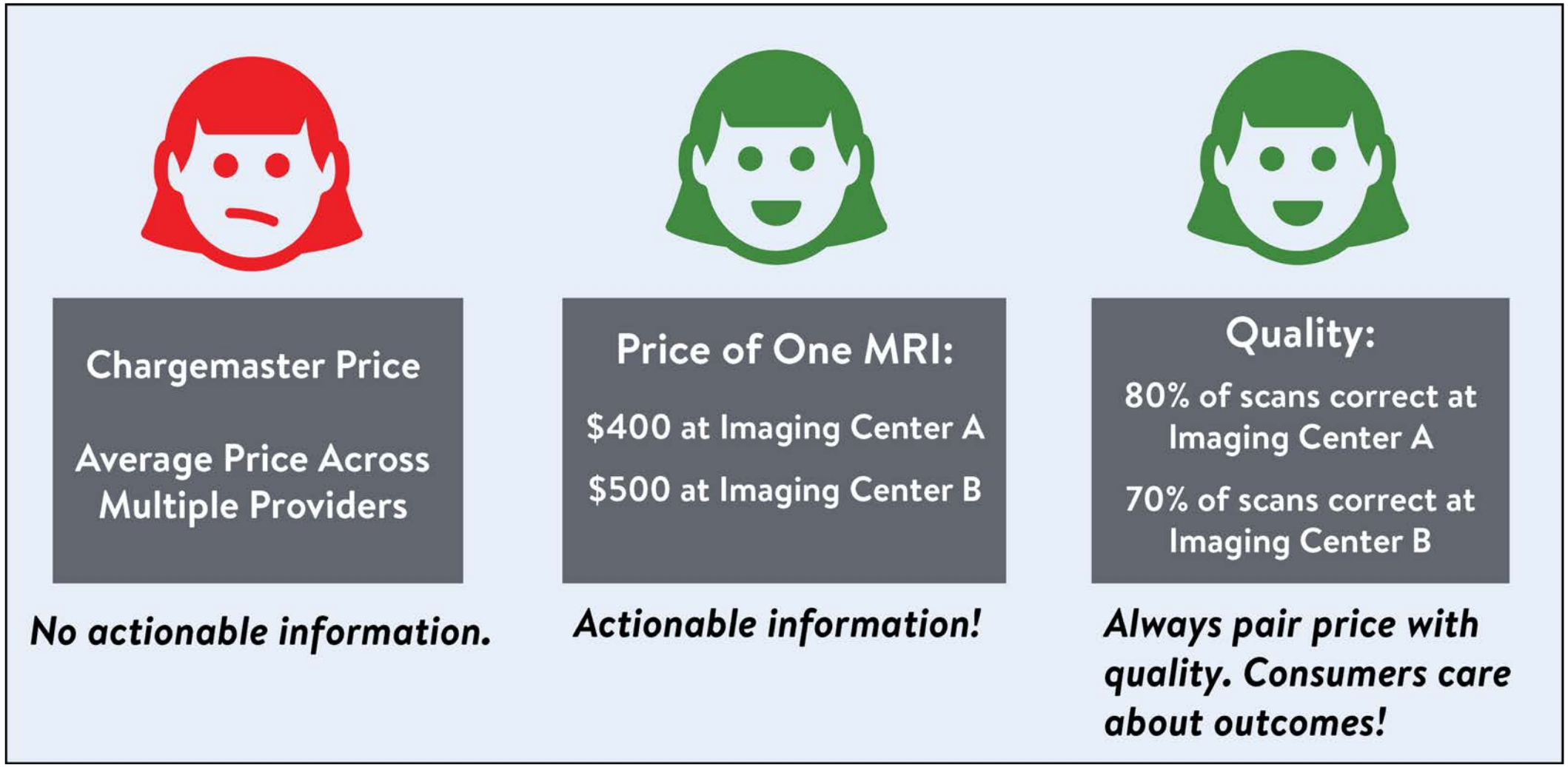
Reference pricing, rate setting, price regulation to address

PRICING OUTLIERS

Global Budgets to cap

OVERALL SPENDING

Healthcare Price Transparency…

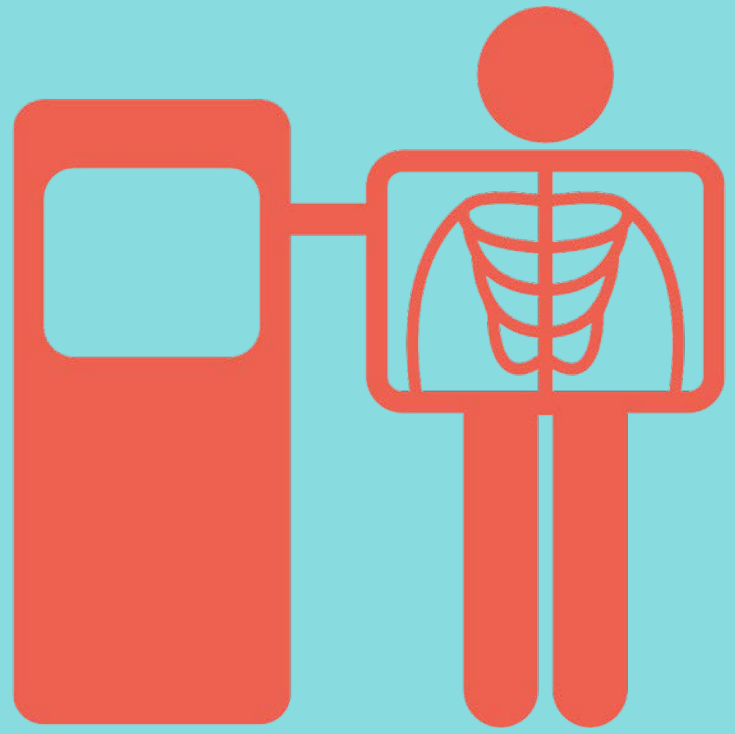


…helps protect consumers from Surprise Medical Bills, but may not drive value in the marketplace-especially when markets lack competition.

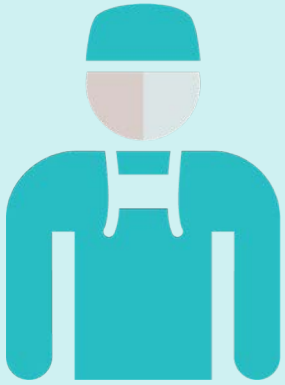
Road Map:

Solutions

- Getting Utilization Right



GETTING UTILIZATION RIGHT: STRATEGIES



Provider Payment Reform

GET INCENTIVES RIGHT

Non-Financial Provider Incentives

ALSO POWERFUL

Patient Shared Decision-Making should be the

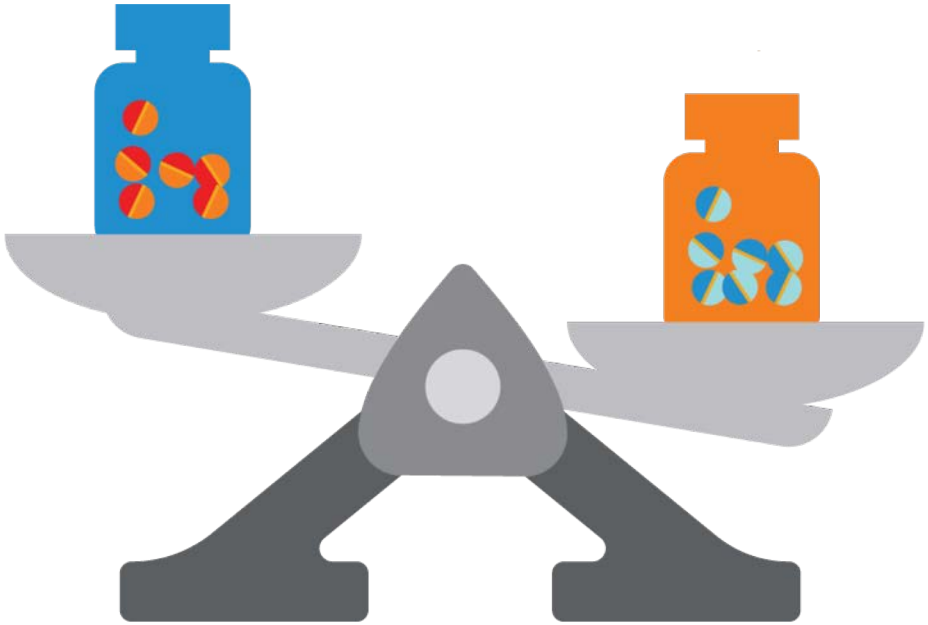
STANDARD OF CARE

Insurance Benefit Design but

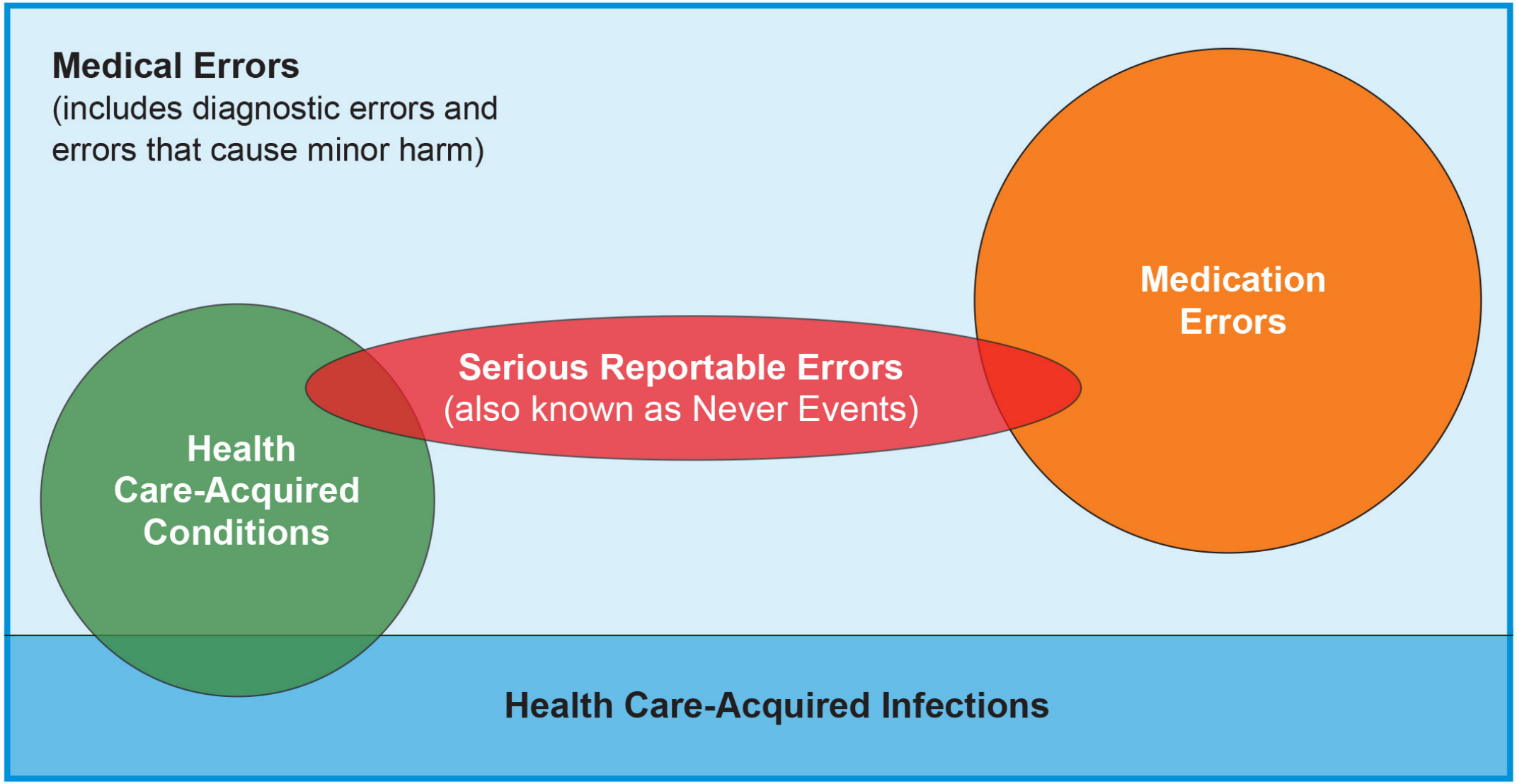
KEEP IT SIMPLE

Sufficient Comparative Effectiveness Research Underlies Many Value Efforts:

Up to 50% of our care may be provided without evidence of effectiveness



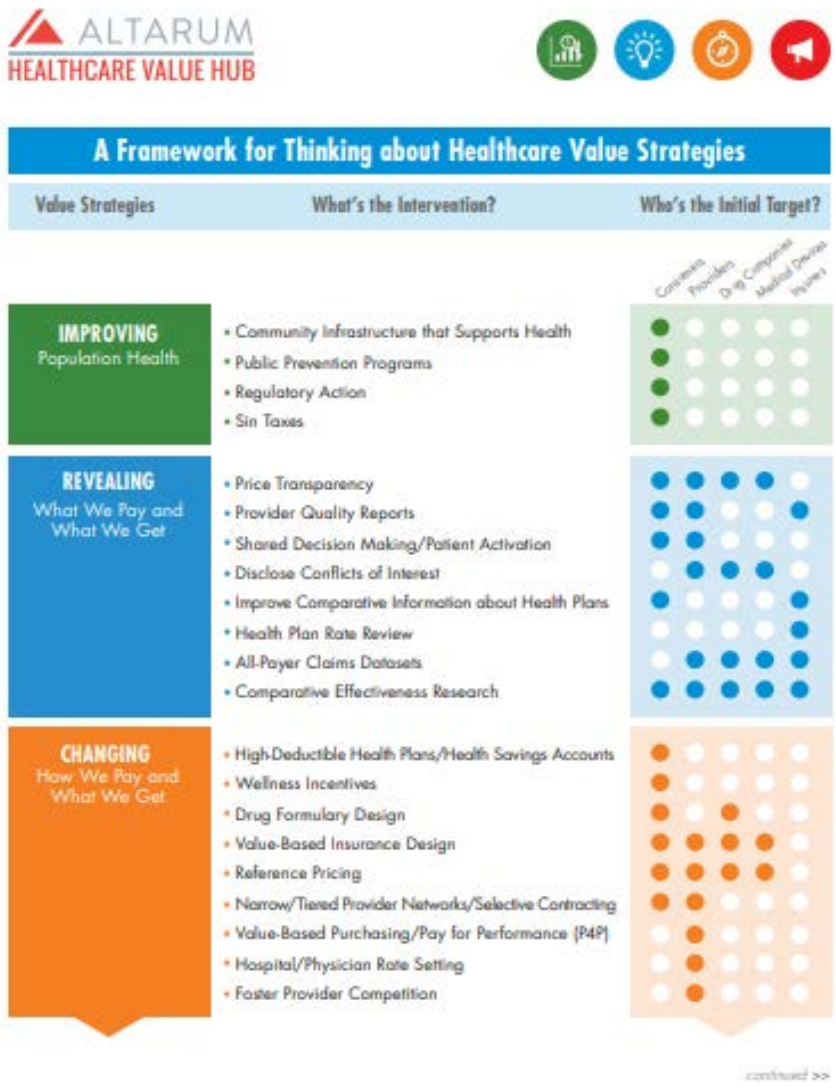
Types of Medical Harm and How They Overlap

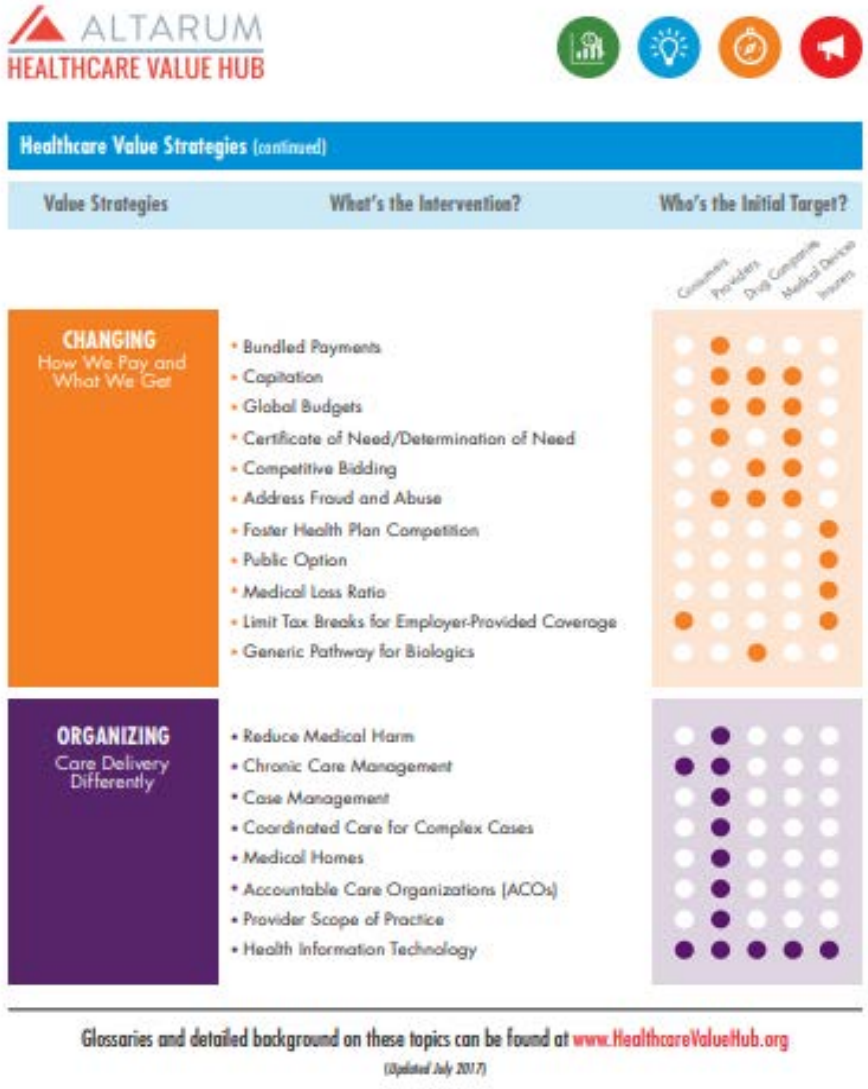


Notes: Graphic excludes benign errors and near misses that don't cause harm. Poor reporting of harm makes it difficult to gauge the relative frequency of each type of harm.

Source: Health Care Value Hub, *Medical Harm: A Taxonomy*, Research Brief No. 9 (November 2015).

More strategies from the Healthcare Value Hub



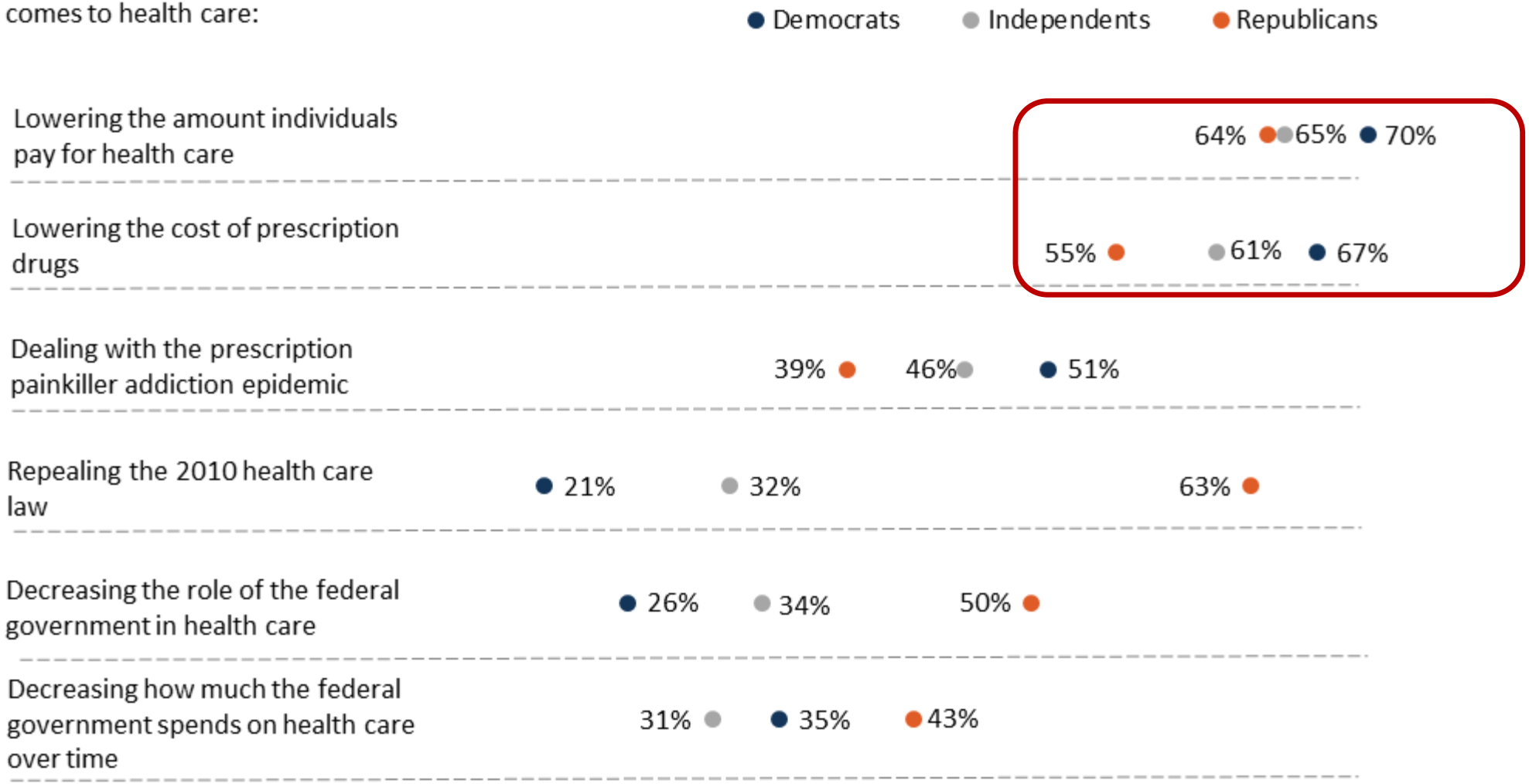


Lift Up Consumer Voices

Figure 3

Lowering Out-of-Pocket Costs Tops Health Care Priorities Among Partisans, Other Priorities Vary by Party

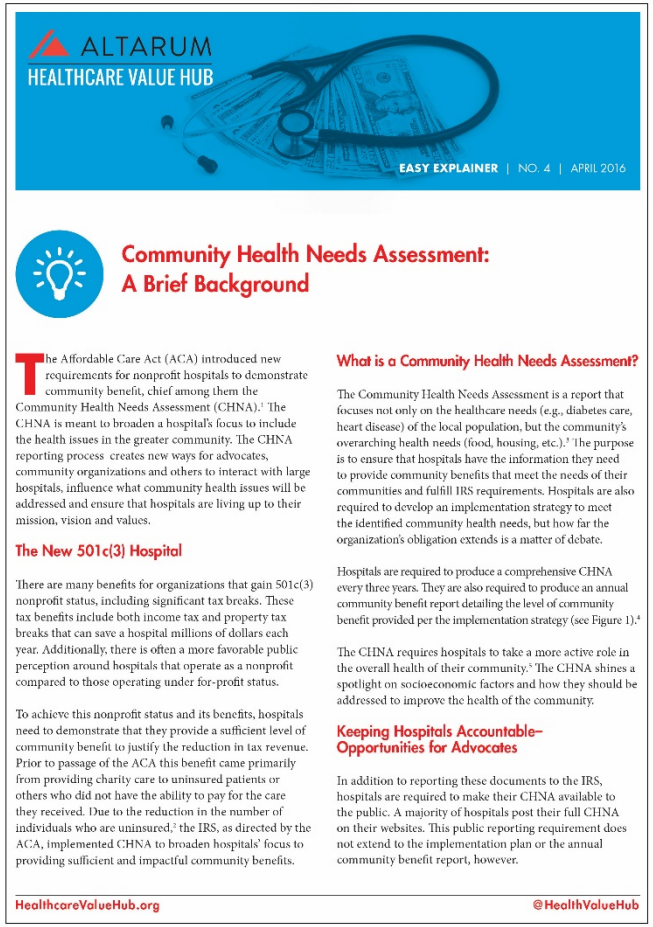
Percent who say each of the following things should be a "top priority" for Donald Trump and the next Congress when it comes to health care:



NOTE: Question wording abbreviated. See topline for full question wording. Items asked of half samples.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)

THE HENRY J. KAISER FAMILY FOUNDATION

Hub Resources:



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EASY EXPLAINER | NO. 4 | APRIL 2016

Community Health Needs Assessment: A Brief Background

The Affordable Care Act (ACA) introduced new requirements for nonprofit hospitals to demonstrate community benefit, chief among them the Community Health Needs Assessment (CHNA).[1] The CHNA is meant to broaden a hospital's focus to include the health issues in the greater community. The CHNA reporting process creates new ways for advocates, community organizations and others to interact with large hospitals, influence what community health issues will be addressed and ensure that hospitals are living up to their mission, vision and values.

The New 501c(3) Hospital

There are many benefits for organizations that gain 501c(3) nonprofit status, including significant tax breaks. These tax benefits include both income tax and property tax breaks that can save a hospital millions of dollars each year. Additionally, there is often a more favorable public perception around hospitals that operate as a nonprofit compared to those operating under for-profit status.

To achieve this nonprofit status and its benefits, hospitals need to demonstrate that they provide a sufficient level of community benefit to justify the reduction in tax revenue. Prior to passage of the ACA this benefit came primarily from providing charity care to uninsured patients or others who did not have the ability to pay for the care they received. Due to the reduction in the number of individuals who are uninsured,[2] the IRS, as directed by the ACA, implemented CHNA to broaden hospitals' focus to providing sufficient and impactful community benefits.

What is a Community Health Needs Assessment?

The Community Health Needs Assessment is a report that focuses not only on the healthcare needs (e.g., diabetes care, heart disease) of the local population, but the community's overarching health needs (food, housing, etc.).[3] The purpose is to ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities and fulfill IRS requirements. Hospitals are also required to develop an implementation strategy to meet the identified community health needs, but how far the organization's obligation extends is a matter of debate.

Hospitals are required to produce a comprehensive CHNA every three years. They are also required to produce an annual community benefit report detailing the level of community benefit provided per the implementation strategy (see Figure 1).[4]

The CHNA requires hospitals to take a more active role in the overall health of their community.[5] The CHNA shines a spotlight on socioeconomic factors and how they should be addressed to improve the health of the community.

Keeping Hospitals Accountable– Opportunities for Advocates

In addition to reporting these documents to the IRS, hospitals are required to make their CHNA available to the public. A majority of hospitals post their full CHNA on their websites. This public reporting requirement does not extend to the implementation plan or the annual community benefit report, however.

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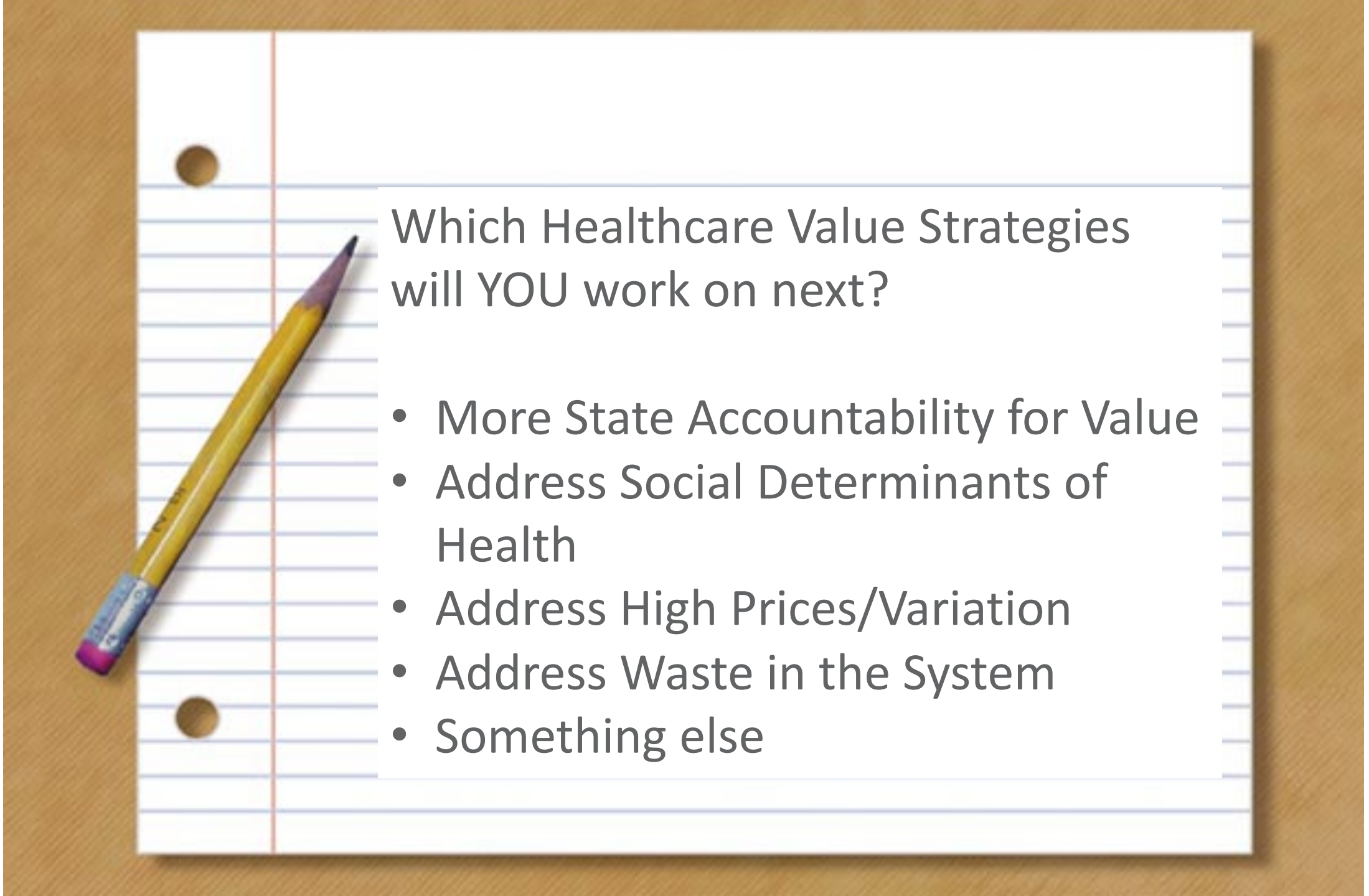
Which Healthcare Value Strategies will YOU work on next?
• More State Accountability for Value
• Address Social Determinants of Health
• Address High Prices/Variation
• Address Waste in the System
• Something else

Questions?

Contact Lynn at Lynn.Quincy@Altarum.org or any member of the Hub team with follow-up questions.

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