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TABLE *of* EXPERTS

IMPROVING LIVES WITH A HEALTHIER HEALTHCARE SYSTEM

A Discussion on How to Heal Healthcare

BY CYNTHIA FLASH
Contributing writer

The Puget Sound Business Journal held a roundtable Aug. 25 featuring a panel of four healthcare experts to discuss challenges within the healthcare system and how to improve the system to better serve consumers and patients. The topic is not only important to the people who receive healthcare, but to the businesses that partner with healthcare providers and insurance companies to get healthcare services to their employees.

Jaja Okigwe, senior vice president strategic development, with Premera Blue Cross, moderated the discussion. Panelists included Dr. John Espinola, executive vice president healthcare services, with Premera Blue Cross; Dr. Daniel Lessler, chief medical officer with Washington Health Care Authority, the state's top healthcare purchaser, covering more than 2 million Washington residents; Dr. Carlos A. Pellegrini, chief medical officer with UW Medicine; and Dr. Al Fisk, chief medical officer with The Everett Clinic.

Their discussion has been edited for length and clarity.

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Okigwe: What is the problem with healthcare? Consumers are really confused. Why doesn't the system work as one would expect it and how would you explain it to your family members?

Espinola: Healthcare doesn't always work the way it should. In general patients pay a lot for what they get because too often then don't get what they need, too often they get what they don't need and that causes harm and too often their experience is not as good as they deserve. One reason is that it's not the most transparent process, and that makes it hard for anyone to make decisions and be informed. Another reason is that healthcare in general has gone through a major shift in the past 50 to 60 years, where we clinicians have moved from being healers to being technicians. We've started to de-emphasize relationships because we are less available to serve the role of healer. That leaves patients seeking help from others.

Fisk: Every system is perfectly designed to get the results it gets. We don't have much of a system. We have a fair amount of chaos. There's a lack of transparency and the relationship has not been emphasized as much as it should be. The system isn't designed for a clear pathway for results.

Pellegrini: In the way the system was designed, there is an incentive to do more, to do something because you get paid for something. That has led to the development of a culture that utilizes a lot of diagnostic tests, a lot of procedures, some using complex devices, some of which bring very little value to the patient but gets payment to a physician, and/or the system.

Lessler: And it's a very fragmented system. When you dig deeper into the system problems, even my personal experience helping my parents navigate fee-for-service Medicare, there's a total lack of communication. The right hand doesn't know what the left hand is doing, often.

Espinola: One more important attribute found in many successful markets is competition. In healthcare, competition doesn't function that well, therefore the natural market forces that seek to solve the problems of the customer don't come into play. Why? Lack of geographic competition, lack of transparency into true cost and value. The consumer is protected from real cost so they might not be shopping as much as they could. Here's an analogy: Let's say I need a rake and go to a big box store to get one. Once I walk in, I end up going to a far corner of the store to get the rake. Along the way back to the register, a bunch of store clerks have decided that they have better ideas for me and they start to put other items in my cart. By the time I get to the register I've got a lawn mower, a leaf blower, a lawn chair, and some other things. And, I don't know the price of any of them. Interestingly, I don't even have to pay for them. I just know that I have them and they were recommended to me by lawn care experts. It's a similar experience in healthcare. Many people walk in the door and something happens and they don't know what's happening until afterwards.

Okigwe:We spend a lot in this country on healthcare, $3 trillion, per capita that comes to about $9,000 per head. That's about 50 percent more than the next country. Why isn't it 50 percent better?

Fisk: The system we have rewards volume. It doesn't reward value to the customer. In general, we spend way more than any other country and our quality is inferior. In the marketplace, 80 to 90 percent of the time volume services are recognized, but they're not always needed and are not always the right ones.

Pellegrini: The system is fragmented and, for the most part, the costs are hidden from the patient and the physician. A doctor places an order for a test and usually does not know how

HEALTHCARE EXPENDITURES PER CAPITA

much it will cost. The patient is billed for only a portion of the expense to the system. Add to that a health record that's not coordinated with other providers in the region or in the nation, you add to the fragmentation and the next healthcare provider may be ordering the same tests.

Lessler: Price differs. For any service we pay much more in this country. We've got to ask why. If you look at other countries, many have fee-for-service systems, but they have lower costs. Prices are lower. Why? To what extent can markets fix that problem? That's an open problem.

Fisk: Look at the cost of medication - it's dramatically higher in this country for the same medicine. It's a result of how the political system has decided to handle medication costs. It's unbelievable how much medicine costs here compared to Canada and other countries.

Espinola: We have a fascination with tech. We think the more advanced the technology is the more valuable it is. Look at heart disease therapies, for example. We see the law of diminishing returns in play. The first therapies to manage heart disease are aspirin, blood pressure medicine and cholesterol medicine. The costs for this are a few hundred dollars a year. If we move to the next level, you start to see interventions like an angioplasty, stents, fancy stents with drugs and radiation in them and then finally a major bypass surgery. These procedures can cost thousands or tens of thousands of dollars. For heart disease, most of the benefit of the various therapies comes with the medicines. Each next level of therapy offers less and less benefit but at a much much higher cost. For that last mile of therapy we tend to spend way more, but get very little benefit. And it happens in many other examples. Technology is promoted relentlessly because there's an economic interest for those who make the technology. We don't address the diminishing returns and we don't price things appropriately to the value.

Okigwe: Are there unique problems or challenges faced by Washingtonians that are different here than elsewhere?

Pellegrini: Many of the problems and challenges are similar to other states, but we differ in our geography and on the way the population is distributed with large areas of sparse population and a paucity of medical services. Another difference is that Washingtonians live here because they like the outdoors, there's a lot of potential accidents and trauma. And you can move from one county to another and life expectancy in years varies tremendously from one to the other.

Okigwe: So, the same macro is going on between North Seattle and South Seattle or Everett and Tacoma, based on the economy and education levels?

Lessler: I would underscore the differences in health within King County, which are truly remarkable in terms of disparities. That brings up a whole set of bigger issues on what drives population health, how much does medical care drive population health? Other western industrialized countries have better health indicators (longevity, neonatal mortality, maternal health/mortality) than this country, also spend less of their GDP on healthcare delivery, but more of their GDP on social supports, whether it's childcare or housing. The goal is to achieve population health but the path is not solely through medical care. In terms of healthcare delivery, this state looks like the rest of the country. We have incredible practice variations. Why are you far more likely to have a hysterectomy in one community than another?

Fisk: We need to remember that 90 percent of the determinants of health have nothing to do with providing medical care. We have a limited ability to make substantial improvements in the health of the population without having a more effective way for our society to deal with the social determinants of health.

Okigwe: How do we make it work better?

Fisk: Three things:

1. The shift toward payment for value. At The Everett Clinic we're interested in pay for value, but we're still 90 percent fee for service.

2. Transparency. The Everett Clinic has posted all our prices online, hoping our competitors would post their prices. But they haven't.

3. You need society to do a better job of investing in the social determinants of health.

At The Everett Clinic, we're transparent in quality, and patient experience and physicians know their quality scores are compared to everybody else. But that's just one system among many and we've worked at that for a long time and have an opportunity to do better.

Espinola: In our community we have equated broad access with value. I can take my insurance card to any provider. When we flip the equation, that those who deliver value are where the access occurs, we can enable change. Then the purchaser is funneling money toward value. In Washington we have a history of thinking we need access to every provider, rather than selecting providers based on value.

Fisk: When patients know cost, they choose the most expensive thing, thinking it's the best. But it's not the case.

Pellegrini: This value we put on the freedom of choice also leads to less than efficient and effective healthcare because of fragmentation and the inability to coordinate care. Since we don't have electronic health records that talk to each other, if a patient chooses one clinic and next time they go to another clinic or to another system of care all together because of access issues or perceived geographic location that's more convenient, the care becomes fragmented. If you're being treated in three primary care settings that don't talk to each other, you're likely to get three different tests, three different medications, significant difference in price, etc. If we could educate the public to make them

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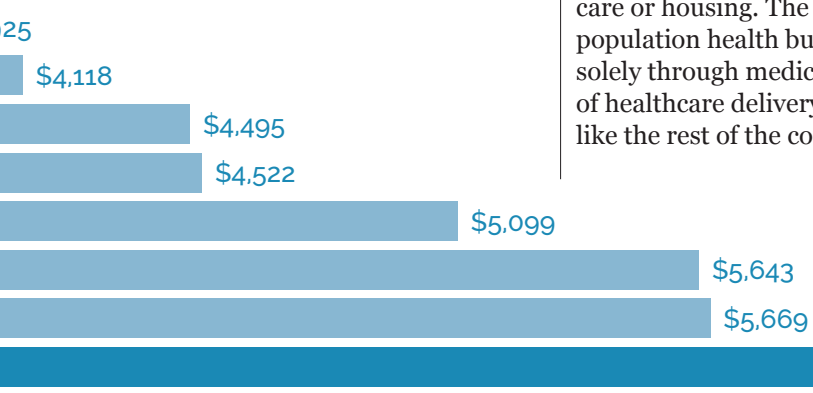
OVERALL HEALTHCARE RANKINGS AROUND THE WORLD

The Commonwealth Fund ranked countries' healthcare systems based on quality, efficiency, access to care, equity and healthy lives.

This is how they ranked:



SOURCE: Both graphics were created using the Commonwealth Fund's 2014 ranking.

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understand that for quality of care they should make the best choice and stick to that choice we would gain a lot.

Okigwe: Are there any bring lights that we could look to that are solving these problems?

Pellegrini: At UW Med we are focusing on six areas we believe address many of these issues.

1. Standardization of procedures and processes.

2. Development of a medical home.

3. Management of population health (among our 37 clinics).

4. Management of data (used to coordinate care better).

5. Focusing on health (preventing someone from becoming a patient).

6. Introduce innovation in a smart way.

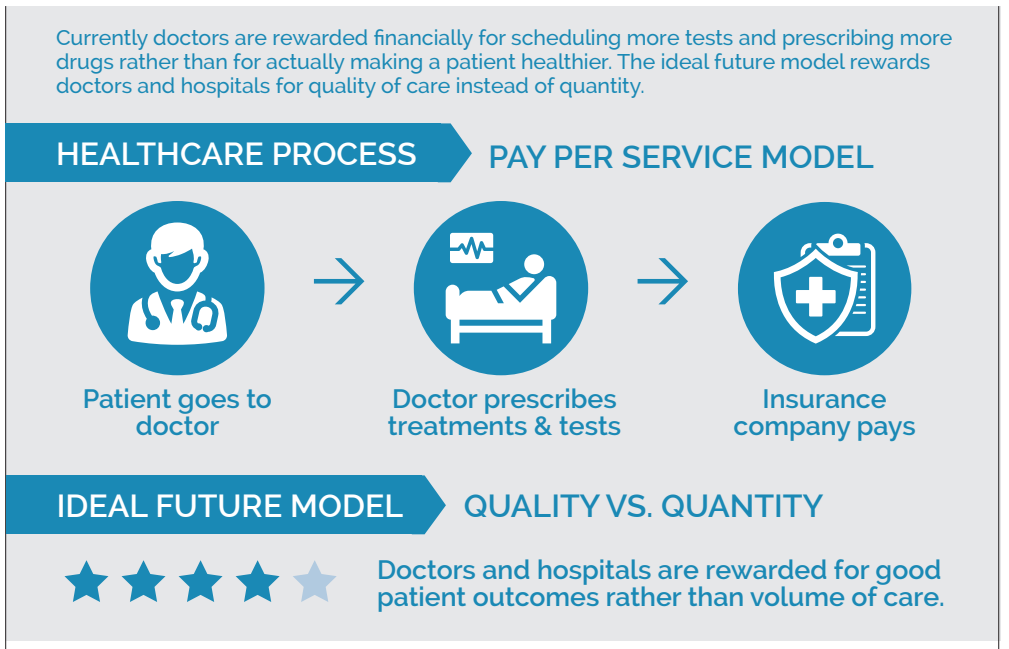
Fisk: There are some organizations that deliver better care than average. Group Health - their quality of care is very good. Around the country there are other organizations that perform quite well, but it's a very small minority.

Lessler: We're very optimistic. Everybody realizes there's a long way to go. There's terrific clinical leadership in this state and these three folks (on the panel) are an example of that, and there's others. We see our role as a (healthcare) purchaser to drive that change, to motivate it as we pay for care and to partner and collaborate with the delivery community and to help them in the transition.

Okigwe: How can we all work together to encourage health-system change?

Fisk: The Washington Health Alliance brings together health plans, purchasers and providers to help develop systems. It's fairly unique that they're all represented around the table.

Pellegrini: This idea of working collaboratively with the thought that the success of the (Washington) Health Care Authority is tied to our success as well. We have continuous conferences where we're discussing how to provide better care with the use of the resources that we have. If we could have access to all the claims of every single patient that Premera has, it allows us to provide better care to the patient.



Espinola: There's huge opportunity if we shift away from fee for service. It encourages conflict between those who pay for care and those who provide care. Those two parties wrestle each other to try to control costs by controlling the cost of each individual service. As we shift to wanting to move in the direction of value, we can see that we can sit on the same side of the table - providers and payers - and look at the problem of who we're trying to serve, and work together to win by serving them better. If we stay in fee for service, it's butting heads, like a game of whack a mole. You're never addressing the problem, while the cost continues to escalate.

Okigwe: What can small and large businesses do to help facilitate the change of a healthcare delivery system that is currently based on the fee-for-service model and transition to a value-based model? How will the change affect their bottom line?

Pellegrini: Get involved and work with third parties and with healthcare delivery systems to accelerate the change to a value-based model. Facilitating the creation of centers of excellence, offering the opportunity to do bundles to better align objectives, working with their workforce to educate them in terms of getting into a primary care medical home model and approaching the issue of employee health as a population management health.

Fisk: He who pays the piper calls the tune. Employers, if self-insured, should put in place significant incentives to reward value, and specifically, quality, lower total cost of care, and patient experience. If fully insured, they should ask their insurance company to do the same.

Lessler: Businesses in Washington should:

1. Familiarize themselves with the Washington Health Alliance website. They should especially review reports on practice variation and the community check up. They should ask the third party administrator/plans with which they contract what they are doing to assure that their employees (the employees of businesses/purchasers) are receiving the highest quality care. For example, what are they doing to assure that there is not unnecessary variation among the providers they contract with? How are they utilizing the clinical performance data available on the community check up to improve care?

2. Familiarize themselves with the recommendations of the state's Bree Collaborative, and insist that the third party administrator/plans they contract with develop a plan to implement these recommendations.

3. Review the decisions of the Washington State Health Technology Program and ask their third party administrator/plans the extent to which their clinical policies conform to the coverage decisions of the Washington State Health Technology Assessment. And where they do not, ask them to explain why.

Espinola: First, learn more about the problem and how it impacts you and your employees:

1. You pay too much for what you're getting for your employees.

2. Your employees often don't receive the care they need.

3. Your employees sometimes get care they don't need.

4. Your employees often don't have the experience they deserve.

Then make changes in how you purchase healthcare in order for the system to change. An easy first step is to offer your employees choices that encourage the preferential use of high-value providers. Doing so helps create an environment where providers compete on cost and quality to attract your business. Moving in that direction will allow for innovation in provider payment/partnership models and drive to a better bottom line with lower cost with greater predictability around quality and experience.

Pursuing those tactics has the potential to improve the bottom line in as much as less variation, more evidence-based care = better quality = lower cost.

MEET THE EXPERTS

Dr. Al Fisk

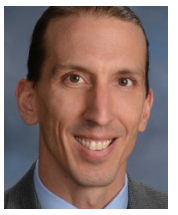
Dr. Al Fisk is chief medical officer at The Everett Clinic, which serves more than 318,000 patients in Snohomish County. He joined the clinic in 1986 as a primary care internist. In January 2000 Dr. Fisk became The Everett Clinic's medical director until he was promoted to the newly created role of chief medical officer in 2009. Dr. Fisk has helped position the clinic as national leader for high quality care and best workplace practices. During his tenure, the American Medical Group Association awarded the clinic with the Preeminence Award for outstanding physician and staff satisfaction, and the Acclaim Award for safe integrated care. Dr. Fisk has been called upon by Congress to testify on needed improvements in Medicare and healthcare reform.

Dr. Carlos Pellegrini

Dr. Carlos Pellegrini was appointed UW Medicine's first chief medical officer in December 2015, providing executive leadership and strategic guidance for the clinical practice standards of UW Medicine clinical programs at all UW Medicine practice sites. He also leads the initiatives for the transformation of clinical practice to achieve the national goals for healthcare reform known as the Triple Aim: better patient experience, better health outcomes, and better value of care. Dr. Pellegrini was born in Argentina and received his M.D. from the University of Rosario Medical School, where he trained in general surgery. He completed a second surgical residency at the University of Chicago and joined the faculty at the University of California, San Francisco. Dr. Pellegrini in 1993 became chair of the UW Department of Surgery, a position he held until his appointment as chief medical officer.

Dr. Daniel Lessler

Dr. Daniel Lessler is chief medical officer for the Washington State Health Care Authority (HCA), which administers the state's Medicaid program and Public Employees Benefits. Prior to joining the HCA, Dr. Lessler was professor of medicine at the University of Washington School of Medicine and senior associate medical director at Harborview Medical Center. Dr. Lessler has participated in local and statewide efforts to improve the quality and cost effectiveness of healthcare. His research and administrative interests have focused on the design and operation of programs that promote high quality, cost effective medical care. He is particularly interested in improving preventive and chronic illness care for underserved and vulnerable populations, and applying Health Information Technology to achieve such improvement. Dr. Lessler holds a Bachelor's degree in Human Biology from Stanford University. He earned his medical degree at the Stanford University School of Medicine and a Master's in Health Administration from the University of Washington.



Dr. John Espinola

Dr. John Espinola is the executive vice president of healthcare services at Premera Blue Cross, leading Premera's strategy to ensure customers receive healthcare services they need with the experience they want and deserve. Healthcare Services is comprised of two departments. Healthcare Delivery Systems is primarily responsible for provider contracting and provider services. Integrated Health Management offers programs that improve quality and safety of care and the member's experience with healthcare services. Prior to joining Premera in 2010, Dr. Espinola served in different roles in other health plans and practiced geriatric medicine. He is board certified in Geriatrics and Internal Medicine. He trained in Internal Medicine at Scripps Clinic and in Geriatrics at Harborview Medical Center. He has a Doctor of Medicine and Masters of Public Health from Tufts University School of Medicine, a Masters in Business Administration from the University of Washington, and a Bachelor of Arts from the College of the Holy Cross.