



## *Information: The Foundation of UHC*

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# Key Objectives of UHC

- Financially stable, sustainable program
- Maximum population coverage
- Coverage for a public health-informed mix of highest-value services with low cost sharing
- Manage incentives for cost-shifting
  - To other types of service
  - To other types of providers
  - To other sources of payment (insurers, patients, charity, etc.)
- \*\* Demonstrable Value \*\*
  - “Better outcomes at lower price”
  - Value = Cost / Outcome



# Why is Measurement Critical to Success?

*How else do you know that it's "working"?*

Core principles of measurement:

1. You can't manage what you don't measure
2. You can't measure without concrete data
3. Measurement accuracy is directly proportional to data quality / completeness / integrity
4. \*\* You must design measurement as part of the overall program design – at the outset, not afterwards
  - Very hard to “go back” and generate data post facto
  - And doing so questions the credibility of your measurement



# Risks of Poor Measurement

- Poor measurement allows out-of-control spending, poor outcomes, perverse behavior and waste
- Examples:
  - Large Western US insurer capitulating primary care
  - Care coordination in a regional health plan
  - Fraud and abuse in a national US payer
  - “Leaky border” between “pharmacy” and “specialty pharmacy”



# What is Needed?

1. Start with the question you are trying to answer (examples)
2. Design metrics that will demonstrate if program goals are met
3. Identify the data needed to perform that measurement
4. Ensure that you collect the required data, starting Day 1
  - Encoded, normalized data
  - Tolls / people / expertise to analyze them
  - Well designed analytic strategy and procedures

*Use what you have, and make plans based on it:*

- Surveys
- Utilization of primary care services
- Prescription fills
- Encounter logs
- Biometrics / lab values / test results / radiology
- Diagnoses
- Demographics

**What analytic results will inform action?**

# Measurement Must Be “Actionable”

- What comprises “cost”?
  - Unit cost – and how to measure that
  - Utilization rate
  - “Mix” of patients and conditions treated
    - Risk adjustment
- How about “quality”?
  - Little agreement on definitions, metrics
  - HEDIS, URAC, NQF... etc.
- Cost: Lack of transparency, no agreement on “cost”
- Quality: Art vs science of medicine

*Don't be shy about demanding an ROI on your initiatives*

# Pharmacy vs Medical Spending: Mutual Impact

Choose Metric : Cost PMPM 

Trend

	2011		2012		2013	
	Cost PMPM	Change	Cost PMPM	Change	Cost PMPM	Change
<b>Medical</b>	\$343.57	--	\$353.98	3.0%	\$339.86	-4.0%
<b>Hospital Inpatient Facility</b>	\$80.37	--	\$82.30	2.4%	\$78.71	-4.4%
<b>Hospital Outpatient Facility</b>	\$44.39	--	\$45.53	2.6%	\$42.26	-7.2%
<b>Facility Based Physician</b>	\$40.03	--	\$43.11	7.7%	\$42.90	-0.5%
<b>Office Visit Physician</b>	\$66.00	--	\$67.99	3.0%	\$66.13	-2.7%
<b>Ancillary Services</b>	\$112.78	--	\$115.06	2.0%	\$109.85	-4.5%
<b>Behavioral</b>	\$13.30	--	\$13.97	5.0%	\$12.02	-13.9%
<b>PBM Drug</b>	\$67.55	--	\$67.39	-0.2%	\$66.58	-1.2%
<b>Total</b>	<b>\$424.43</b>	<b>--</b>	<b>\$435.35</b>	<b>2.6%</b>	<b>\$418.46</b>	<b>-3.9%</b>

Legend : Change over +4%      Change below - 4%      Change between - 4% & +4% : Blank



The “toothpaste rule”

# Pharmacy and Medical Spending – By Disease

## Chronic Care Episode Analysis (complete episodes only)

Chronic Condition	Medical Cost	Pharmacy Cost	Total Cost	Percent Rx
Diabetes	\$46,964,870	\$45,233,666	\$92,198,536	49.1%
Hypertension	\$57,500,231	\$22,613,111	\$80,113,341	28.2%
Cardiac congenital disorder	\$104,465,100	\$196,699	\$104,661,800	0.2%
Asthma	\$31,044,960	\$31,312,048	\$62,357,009	50.2%
<b>Total</b>	<b>\$153,202,750</b>	<b>\$99,355,524</b>	<b>\$252,558,274</b>	<b>39.3%</b>

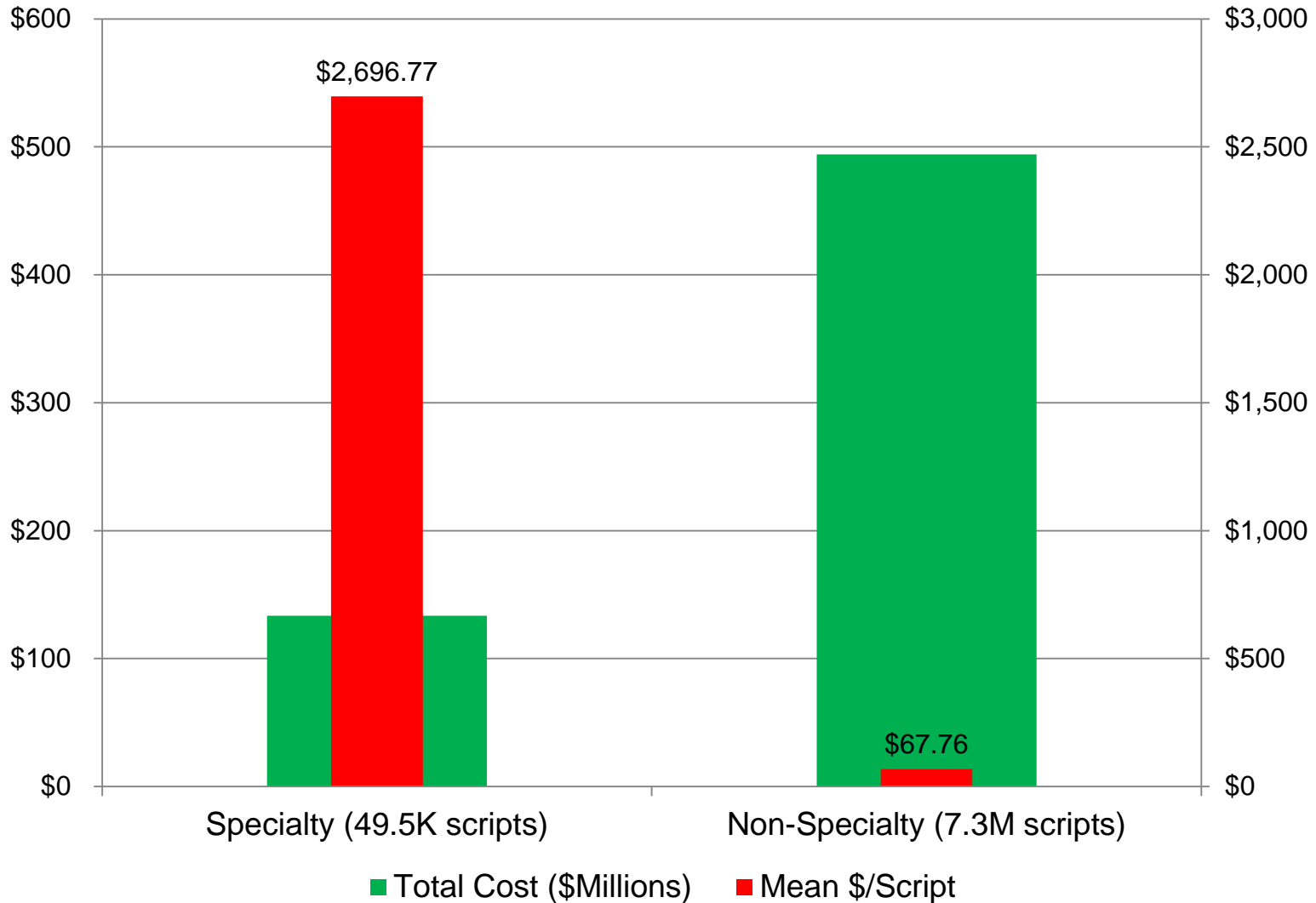
## Acute Care Episode Analysis (complete episodes only)

Acute Episode	Medical Cost	Pharmacy Cost	Total Cost	Percent Rx
Aortic aneurysm	\$4,823,789	\$33,832	\$9,681,409	0.3%
Acute bronchitis	\$6,314,863	\$953,982	\$13,583,709	7.0%
Orthopaedic infection, all sites	\$2,387,347	\$178,767	\$4,953,461	3.6%
Orthopaedic disease, all sites	\$6,799,201	\$42,024	\$13,640,426	0.3%
<b>Total</b>	<b>\$20,325,200</b>	<b>\$1,208,605</b>	<b>\$41,859,005</b>	<b>2.9%</b>

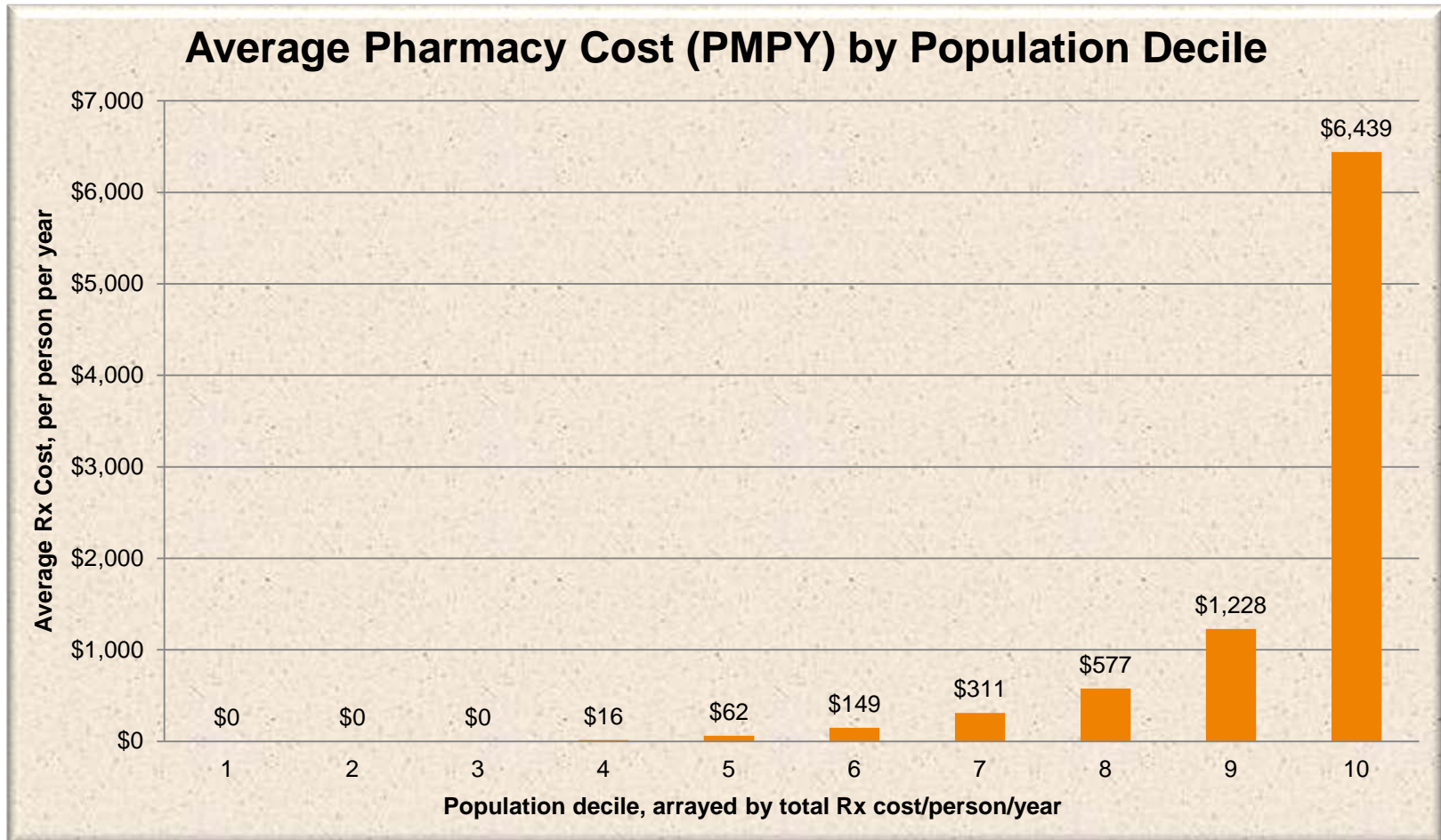
- How much is being spent on medicines for each common diagnosis?
- What medicines are being used for each diagnosis? Are they appropriate?



# Caveat: Routine vs “Specialty” Pharmacy



# Annual Pharmacy Costs per Person, by Decile



- Commercial population, all with drug benefit
- Includes both specialty and non-specialty drugs, but not those billed to medical benefit
- One decile constitutes approximately 85,000 members

# Summary

- UHC Schemes must have information to survive
  - Financially
  - Politically (public policy)
- Information is the key to:
  - Controlling the budget
  - Ensuring that funds pay for effective care
  - Proving that programs produce a measurable benefit
  - Justifying ongoing program costs
- In a dynamic world, people, diseases, medicines, treatments and finances change constantly
  - Routine measurement is therefore critical to understand outcomes, adjust objectives and tactics & prove program value
  - Measurement must occur at a level that provides information for action or else it is simply “interesting” but without value