



Innovations in Conservative Care: Getting to the Right Provider First

Population Health & Care Coordination Colloquium

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Dave Elton, D.C. | SVP Clinical Programs, OptumHealth | david.elton@optum.com

Agenda



Context

- What category of condition is the **largest driver of expenditures in a commercial health plan population?**
 - *Cancer*
 - *Heart disease*
 - *Musculoskeletal (MSK) conditions*
- **Spinal conditions** account for **what % of total expenditures for MSK conditions?**
 - 25%
 - 45%
 - 75%



Spine Care Pathway And DC Value Proposition

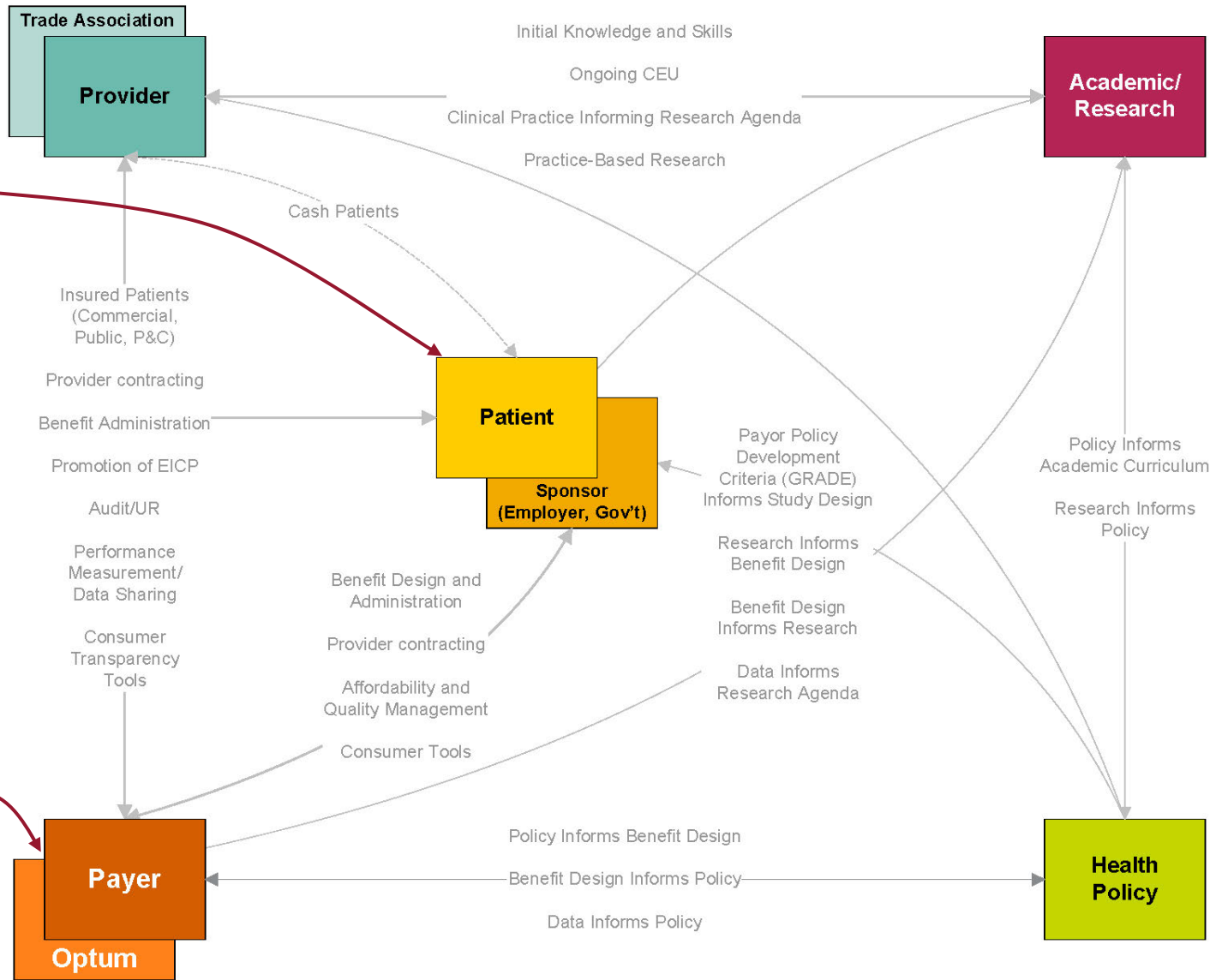


Spine Care Framework

Context - Disclosure

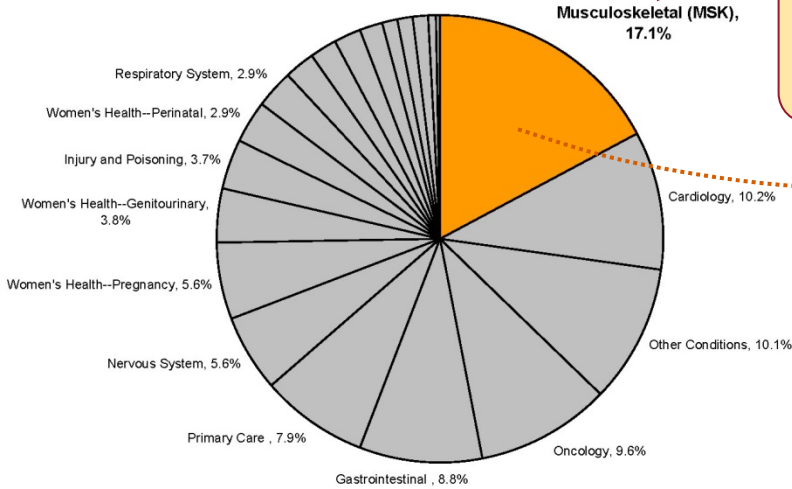
2 When all stakeholders **collaborate** and put the interests of the **patient and sponsor at the center** we generally end up with the **right outcome**.

1 The delivery system is complex with many **stakeholders and points of view**. While I've attempted to offer a **balanced perspective**, I spend most of my time viewing the system through the **lens of the payer**.



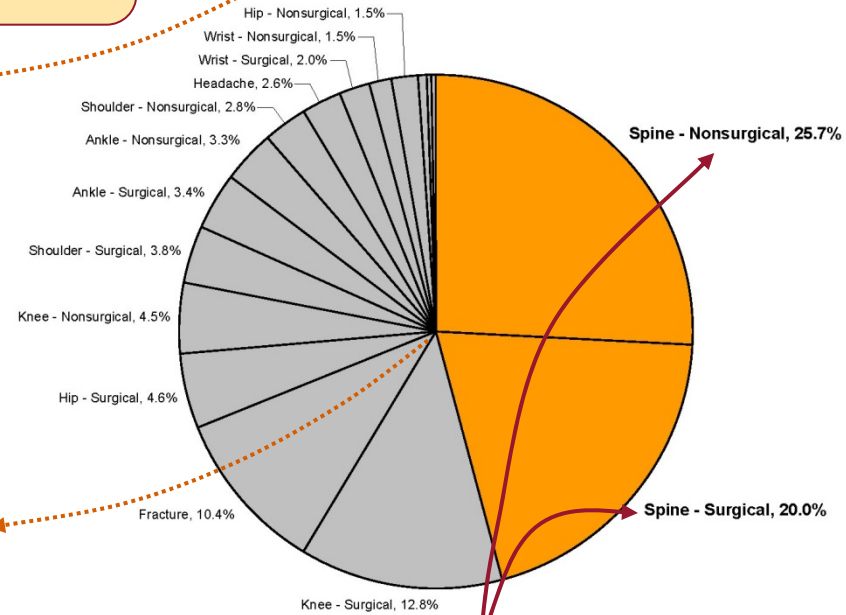
Context - Importance of Musculoskeletal Conditions

Distribution of Medical Expense
R12 Through Q1 of 2012 - 4.8M Commercial Members



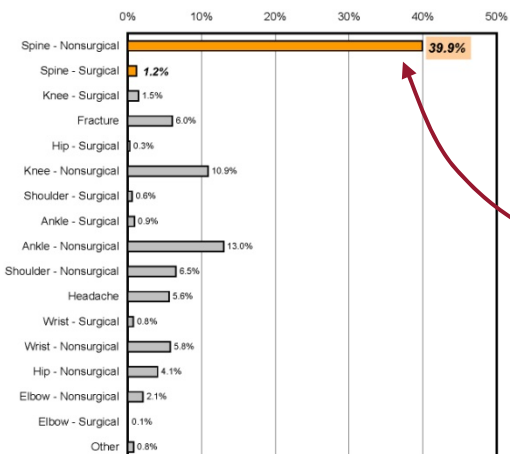
1 MSK expense is top of mind for employers, insurers, ACOs, etc

Distribution of Orthopedic Expense
14.7M Complete Episodes Ending in 2009-2011 - >\$25B

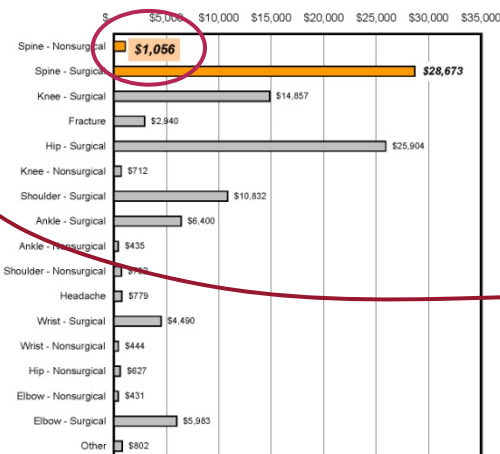


2 Spine expense, particularly non-surgical episodes, is the top driver of MSK

Prevalence of Orthopedic Conditions
14.7M Complete Episodes Ending in 2009-2011



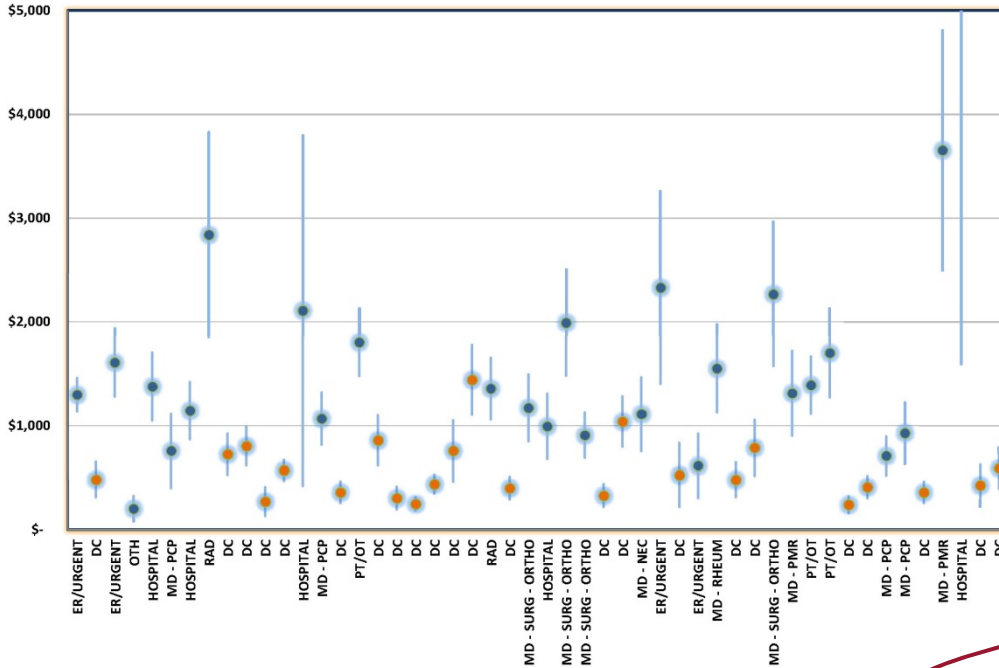
Total Episode Cost of Orthopedic Conditions
14.7M Complete Episodes Ending in 2009-2011



3 Non-surgical spine episodes are filling up provider offices

Context – Variability in Decision-Making

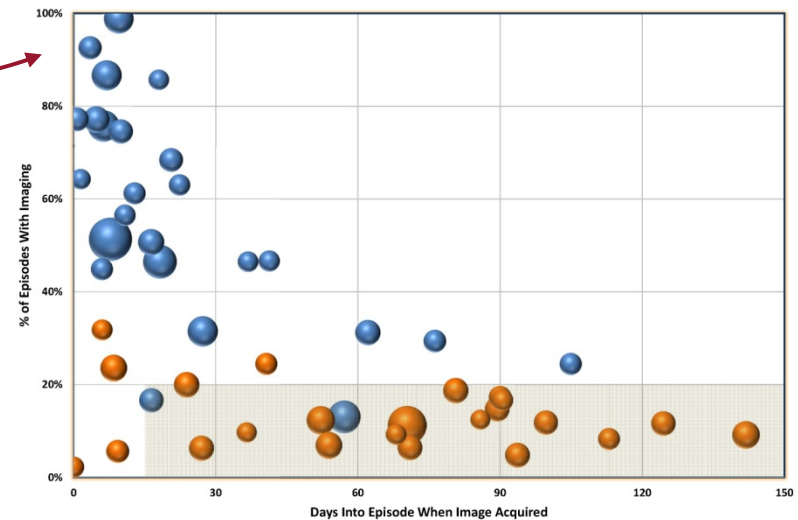
90% Confidence Interval Non-Surgical Spine Total Episode Cost - Philadelphia
Top 50 Providers Functioning as Portal of Entry



1 In **Philadelphia**, like every city in the country, a patient's **spine care pathway is highly dependent on the first provider seen.**

2 Variability in **rate and timing of imaging use** among providers in Philadelphia is an example. The best test for back pain may be the **test of time.**

Rate and Timing of Imaging For Non-Surgical Spine Episodes - Philadelphia
Top 50 Providers Functioning as Portal of Entry



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- Cancer
- Heart disease
- **Musculoskeletal (MSK) conditions**

• Spinal conditions account for **what % of total expenditures for MSK conditions?**

- 25%
- **45%**
- 75%



Spine Care Pathway And DC Value Proposition

• What % of patients with a spinal condition **select a DC as the first provider to see?**

- 6%
- 28%
- 37%

• For the sample data, the **savings to the system**, if all non-surgical spine episodes **started with a DC**, would be?

- \$50,000,000
- \$123,000,000
- \$1,300,000,000



Spine Care Framework

Description of Data

- **Commercial** health plan members – all 50 states
- **All** services, settings and providers
- **14.7 million** complete episodes of MSK complaints ending in **2009-2011**
- **>\$25B** in medical expenditures

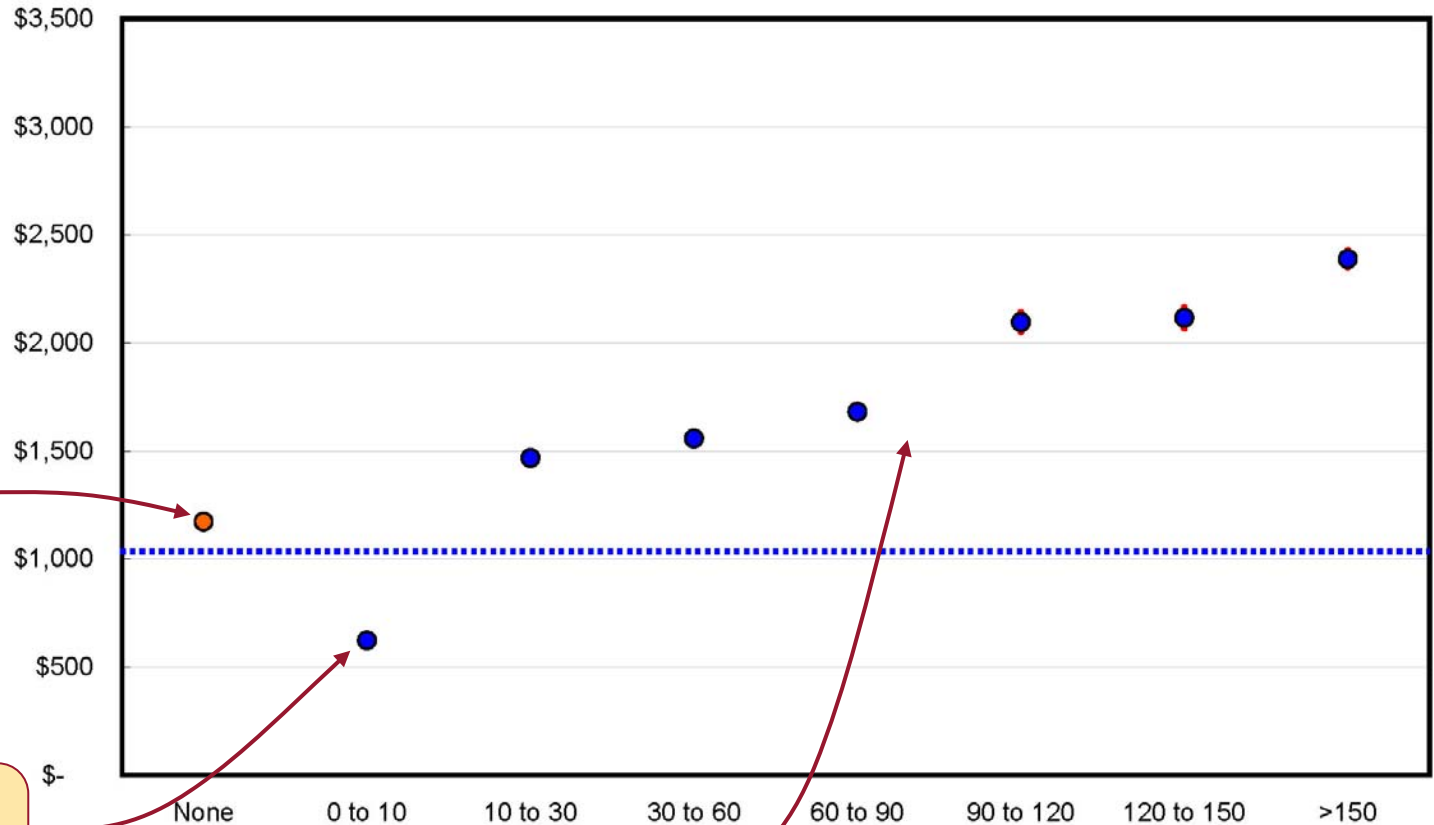
- To keep within available time we will focus on **non-surgical spine** episodes
 - Top cost driver
 - Filling up providers offices
 - Highly variable treatment

- Use **Episode Treatment Groupers (ETG)** to organize data



Service Timing and Episode Cost

90% C.I. Total Episode Cost By Timing of Service Introduction - Manipulation
4.6M Complete Non-Surgical Spine Episodes



1 Manipulation is **the only service**, which if **not provided** at any time in the episode, **leads to total episode costs above baseline**

2 If introduced in the **first 10 days** manipulation **reduces total episode cost**

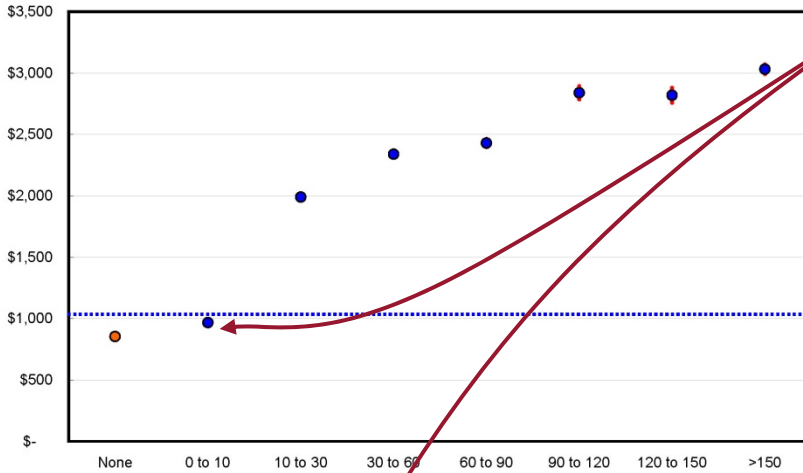
3 **Benefits** of manipulation are **lost** the longer timing of introduction is **delayed**

Service Timing and Episode Cost

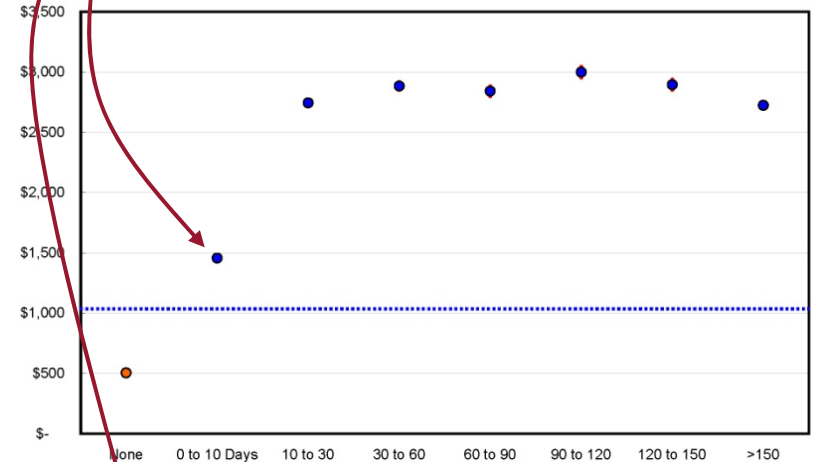
All other services, except 97xxx, increase episode cost if provided at **any time during the episode**

Manipulation is preferable to 97xxx at **all time intervals**

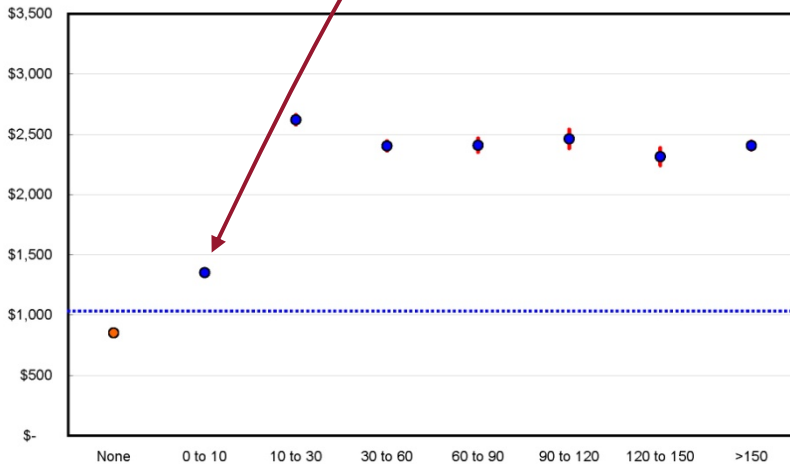
90% C.I. Total Episode Cost By Timing of Service Introduction - 97xxx
4.6M Complete Non-Surgical Spine Episodes



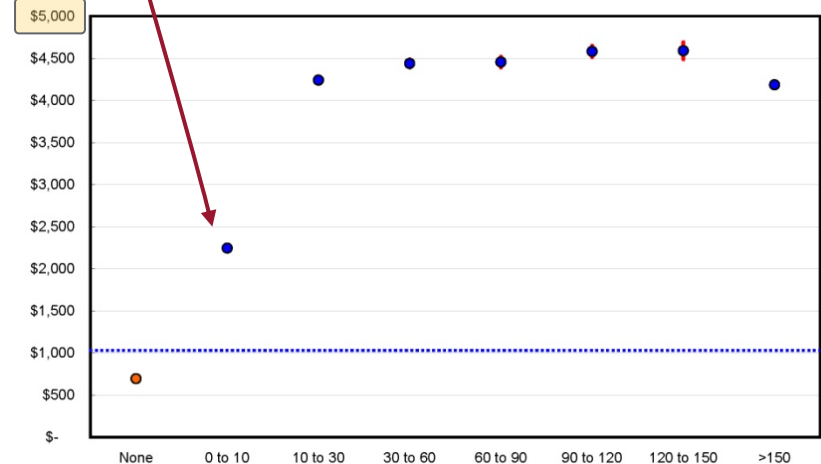
90% C.I. Total Episode Cost By Timing of Service Introduction - Imaging
4.6M Complete Non-Surgical Spine Episodes



90% C.I. Total Episode Cost By Timing of Service Introduction - Rx
4.6M Complete Non-Surgical Spine Episodes

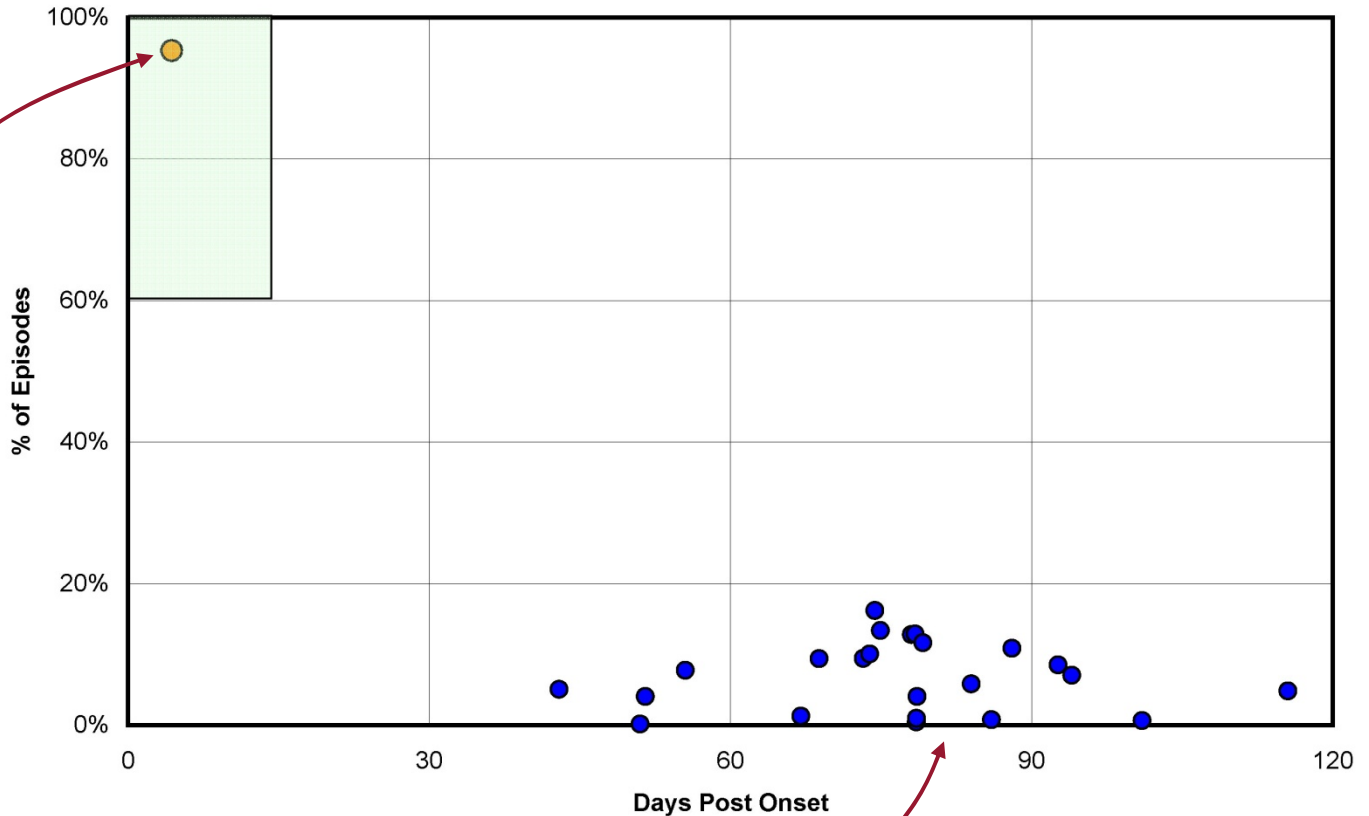


90% C.I. Total Episode Cost By Timing of Service Introduction - Injection
4.6M Complete Non-Surgical Spine Episodes



Rate and Timing of Services by Specialty of 1st Provider Seen

Manip - % of Episodes and Days Post Onset By Entry Point



1

Spine episodes starting with a DC have manipulation introduced in the first 10 days in almost 100% of cases.

As we've seen, this is a good thing.

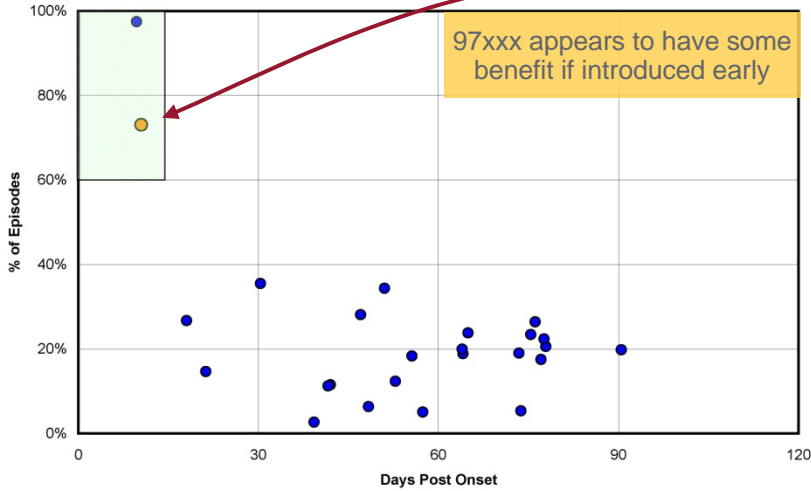
2

Episodes starting with any other specialty have manipulation introduced late, if at all

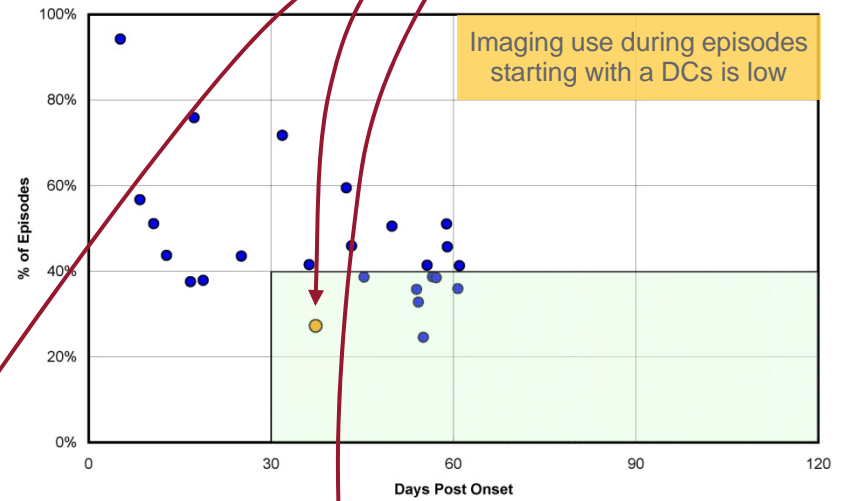
Rate and Timing by Specialty of 1st Provider

Episodes **starting with a DC** appear to have **best alignment with clinical evidence**

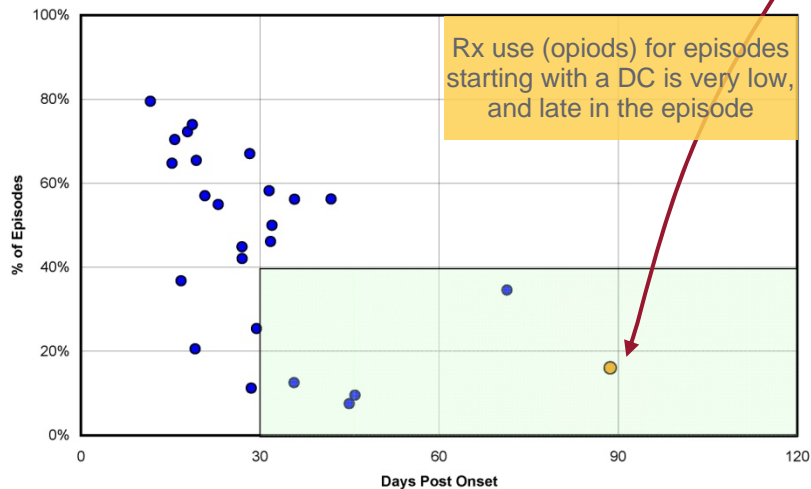
97xxx - % of Episodes and Days Post Onset By Entry Point



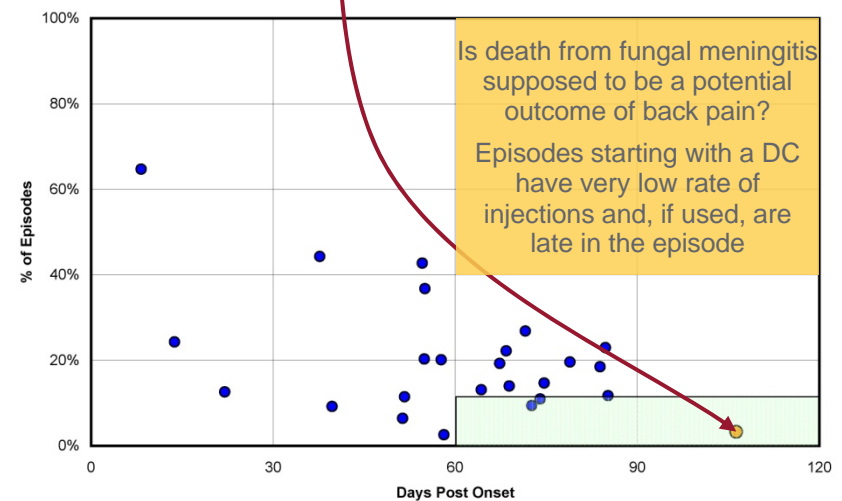
Imaging - % of Episodes and Days Post Onset By Entry Point



Rx - % of Episodes and Days Post Onset By Entry Point

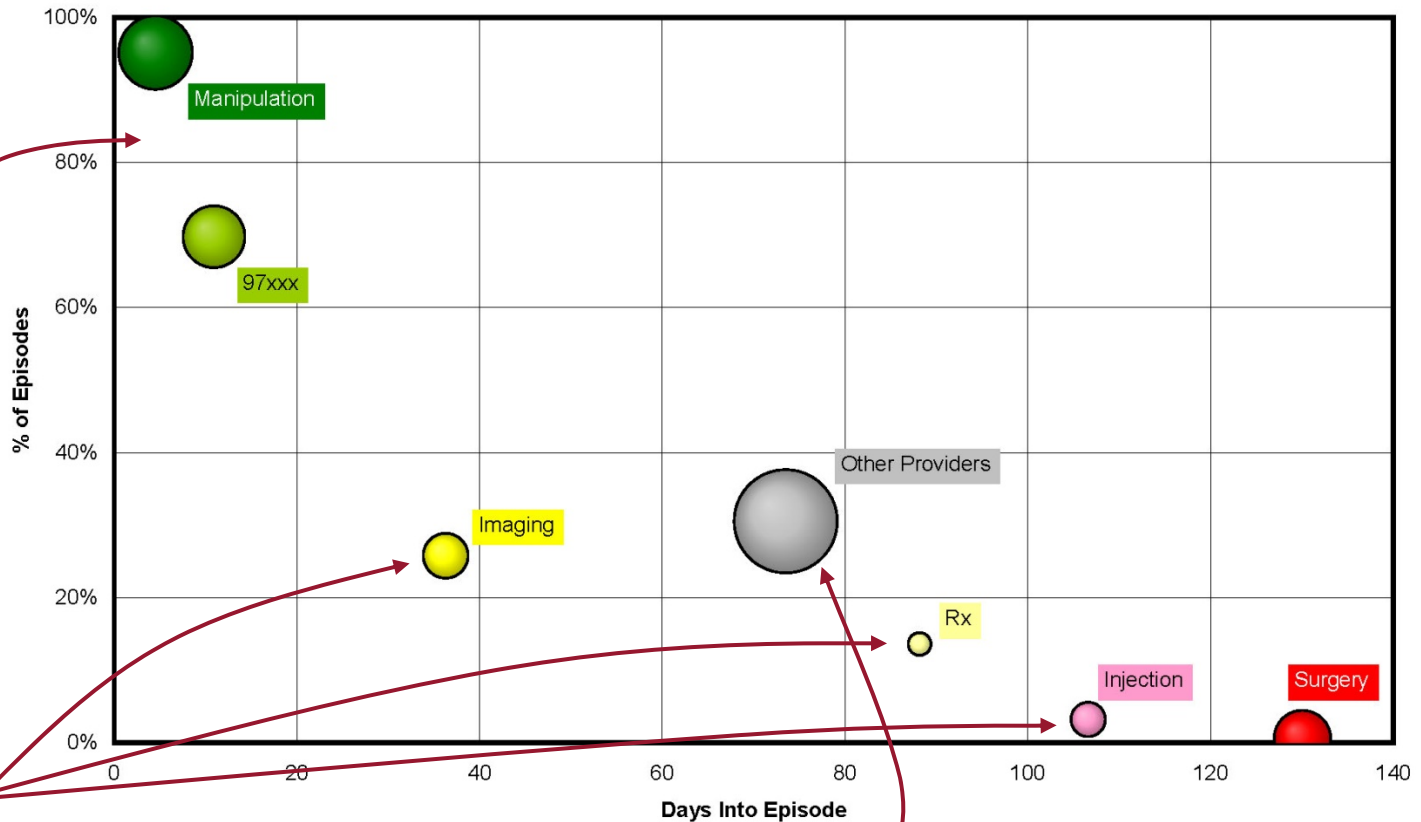


Injection - % of Episodes and Days Post Onset By Entry Point



Care Pathway by Specialty of 1st Provider Seen

Care Pathway - DC
723,000 Complete Spine Episodes
Size = \$ Spent Per Episode

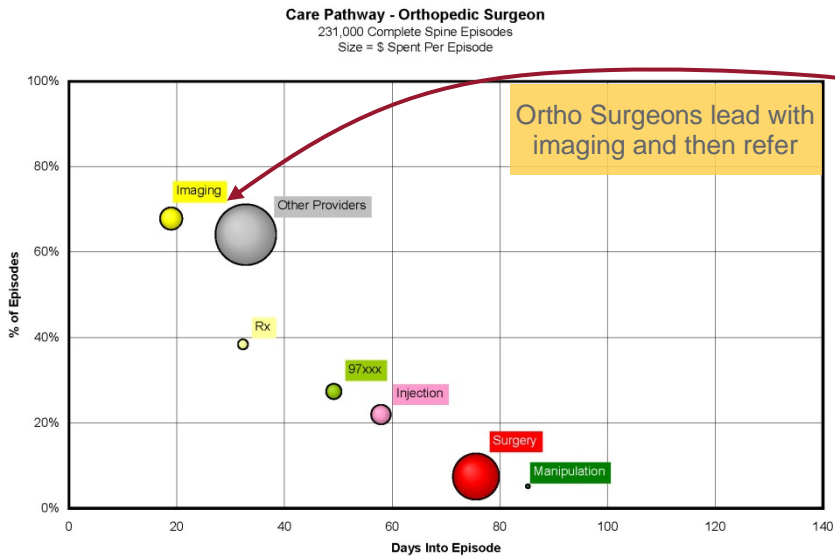
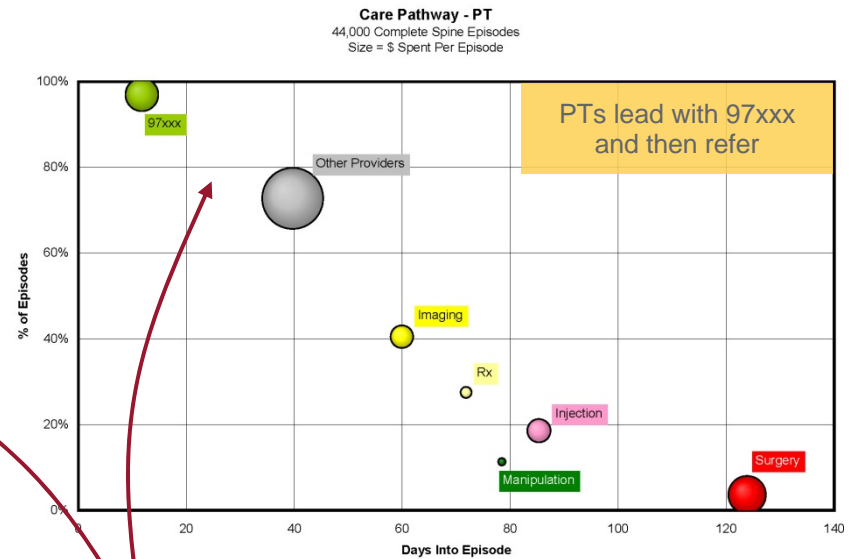
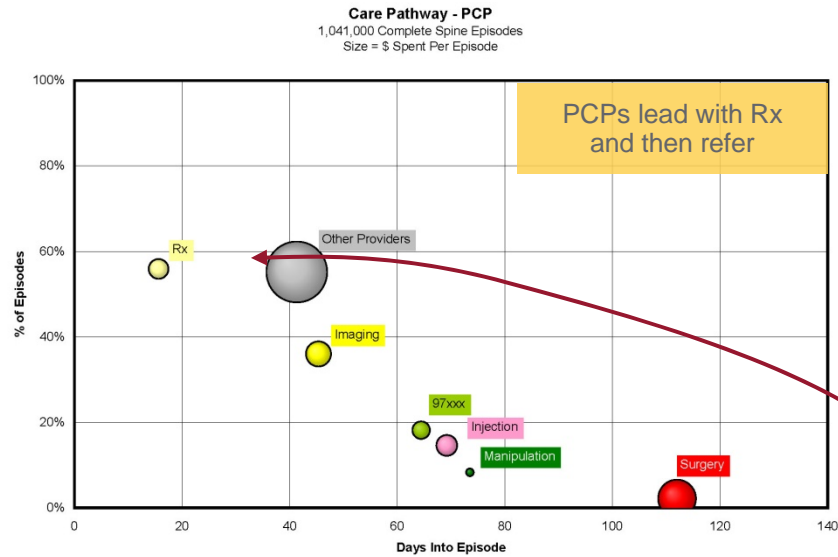


1 Manipulation and 97xxx introduced **early and often**

2 Imaging, Rx, injections and surgery are **infrequent, late and appropriately sequenced**

3 Other providers, resulting in a **fragmented episode**, are introduced **infrequent and late**

Care Pathway by Specialty of 1st Provider Seen



For episodes starting with specialties **other than a DC**, the **suboptimal first service** is associated with **early and frequent referral** to other providers resulting in **fragmentation**.

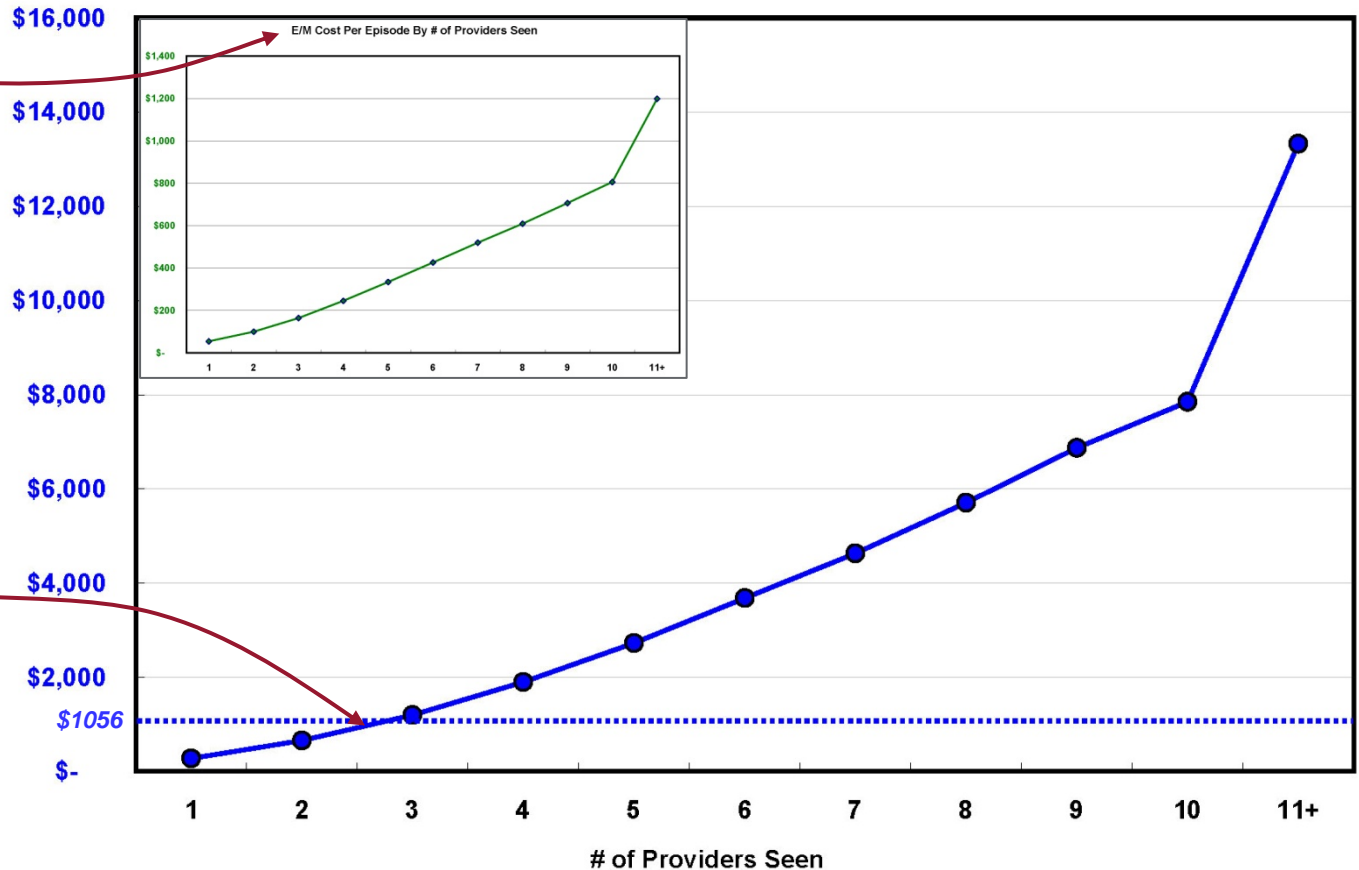
Impact of Care Pathway Fragmentation

2 As an example of the **redundant services** associated with fragmentation is the **growth in E/M payments** for the **same patient, condition and episode**.

1 Total episode cost increases by **\$500 to \$1000** for each **additional provider seen** for a non-surgical spine episode.

>2 providers seen is a marker for inefficient entry point and/or triage.

Non-surgical Spine Total Episode Cost by # of Providers Seen During Episode



"I started out with my **primary care physician**. He had back pain and turned me on to his **back specialist**. I went to an **orthopedic surgeon**. He sent me to a **neurologist**. Then they sent me to a **pain center**. During that time I always went to a **chiropractor**. I went to an **acupuncturist**. I went to a **physical therapist**. As a matter of fact, I went to three different **physical therapists**." –T, Atlanta

Entry Point for Spine Episodes

Spine Episodes By Entry Point

4.7M Surgical and Non-surgical Complete Episodes Ending in 2009-2011

0% 10% 20% 30% 40%

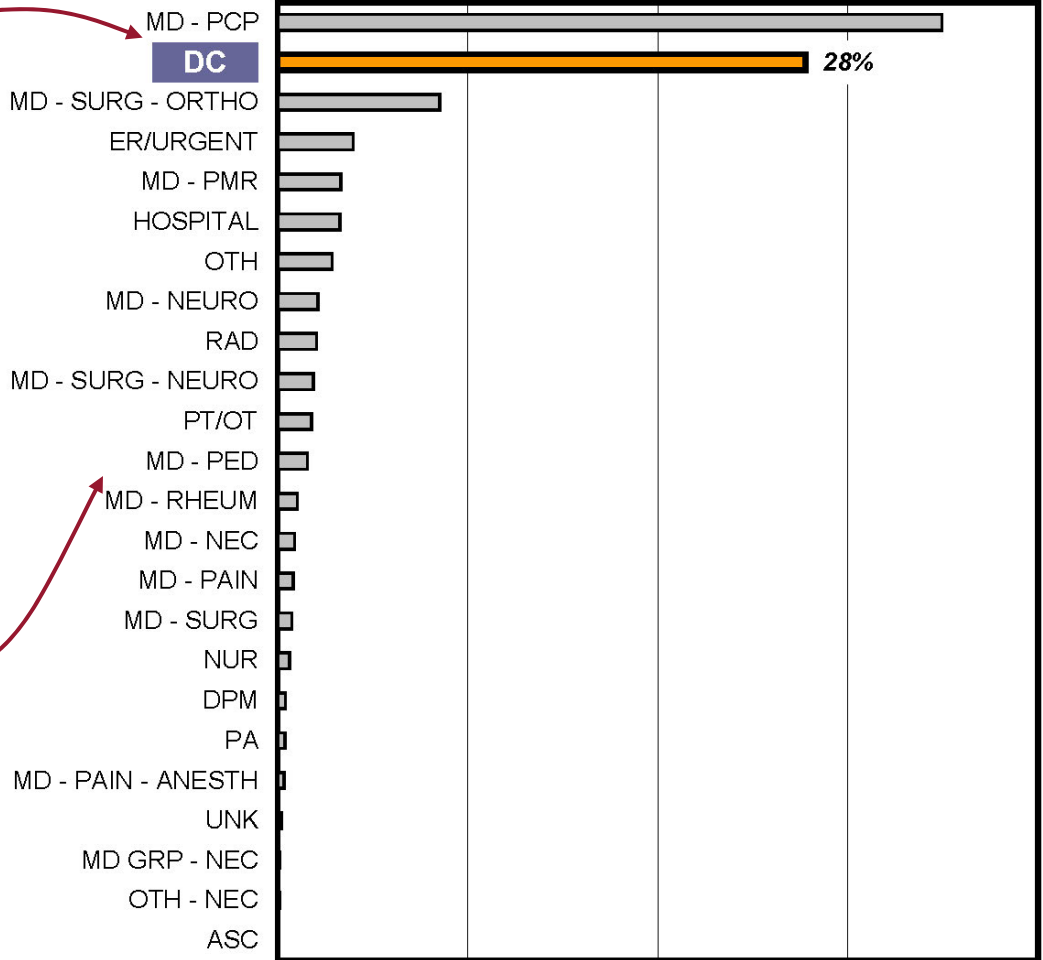
1 28% of spine episodes **start with a DC**, second to PCP.

Do **PCPs** have the time, and are they prepared, to manage spinal conditions?

Is this **limited and valuable resource** (PCPs) needed for other conditions?

2 Are the **other specialties** functioning as the portal of entry for spinal episodes **prepared to manage spine patients**?

If not what are the **cost and fragmentation implications**?



Non-Surgical Spine Episode Cost By Entry Point

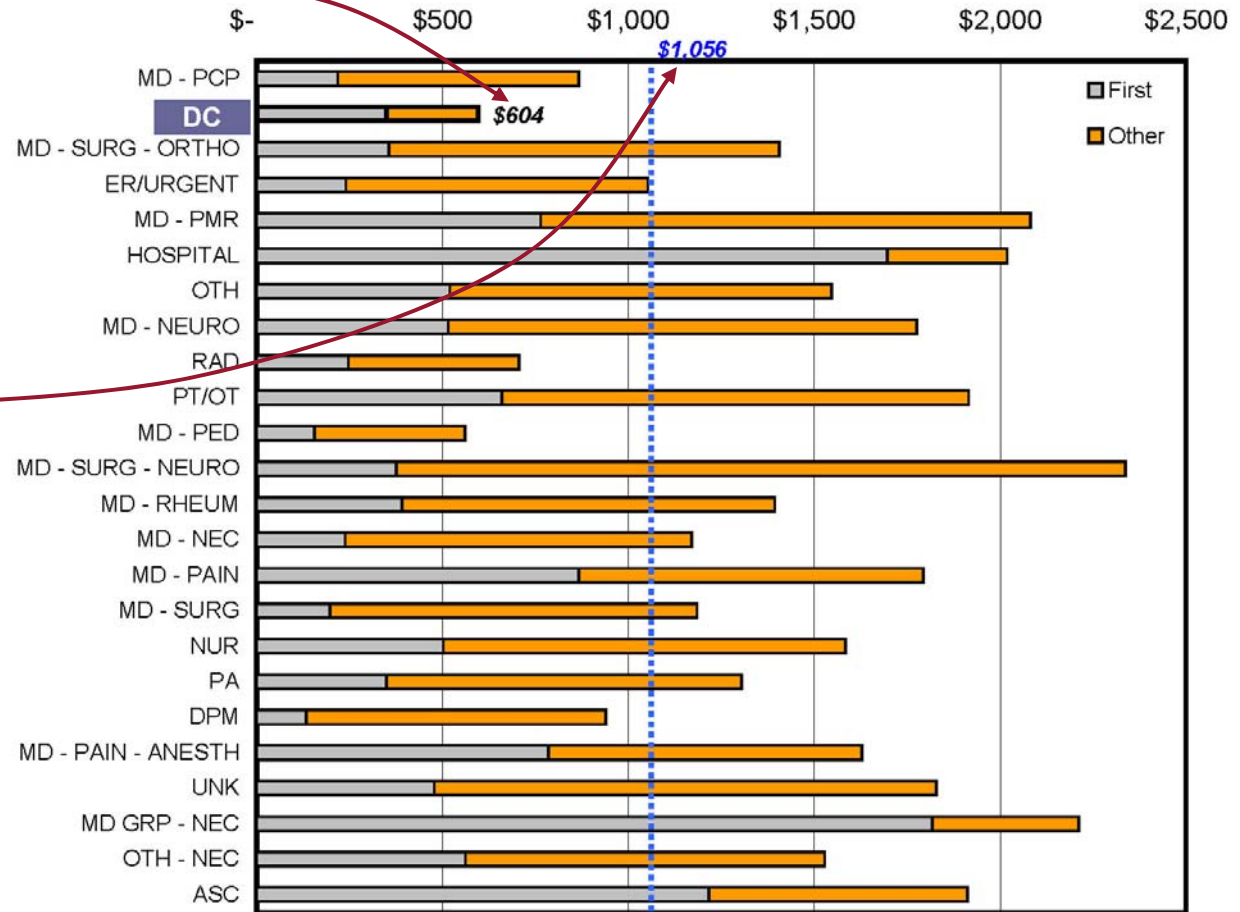
1 Non-surgical spine episodes starting with a DC have the **lowest total episode cost.**

2 For those attempting to do the math if **all non-surgical episodes NOT starting with a DC** started with a DC savings to the system would be **\$1.3B for this sample.**

Including surgical episodes **increases this figure.**

3 DC remains **most affordable** on a **cumulative 3 year look**

Spine Total Episode Cost By Entry Point
 Non-surgical Complete Episodes Ending in 2009-2011



Referrals to DC if Patient Starts With Different Entry Point

Spine Episodes With DC At Any Time By Entry Point
4.7M Surgical and Non-surgical Complete Episodes Ending in 2009-2011

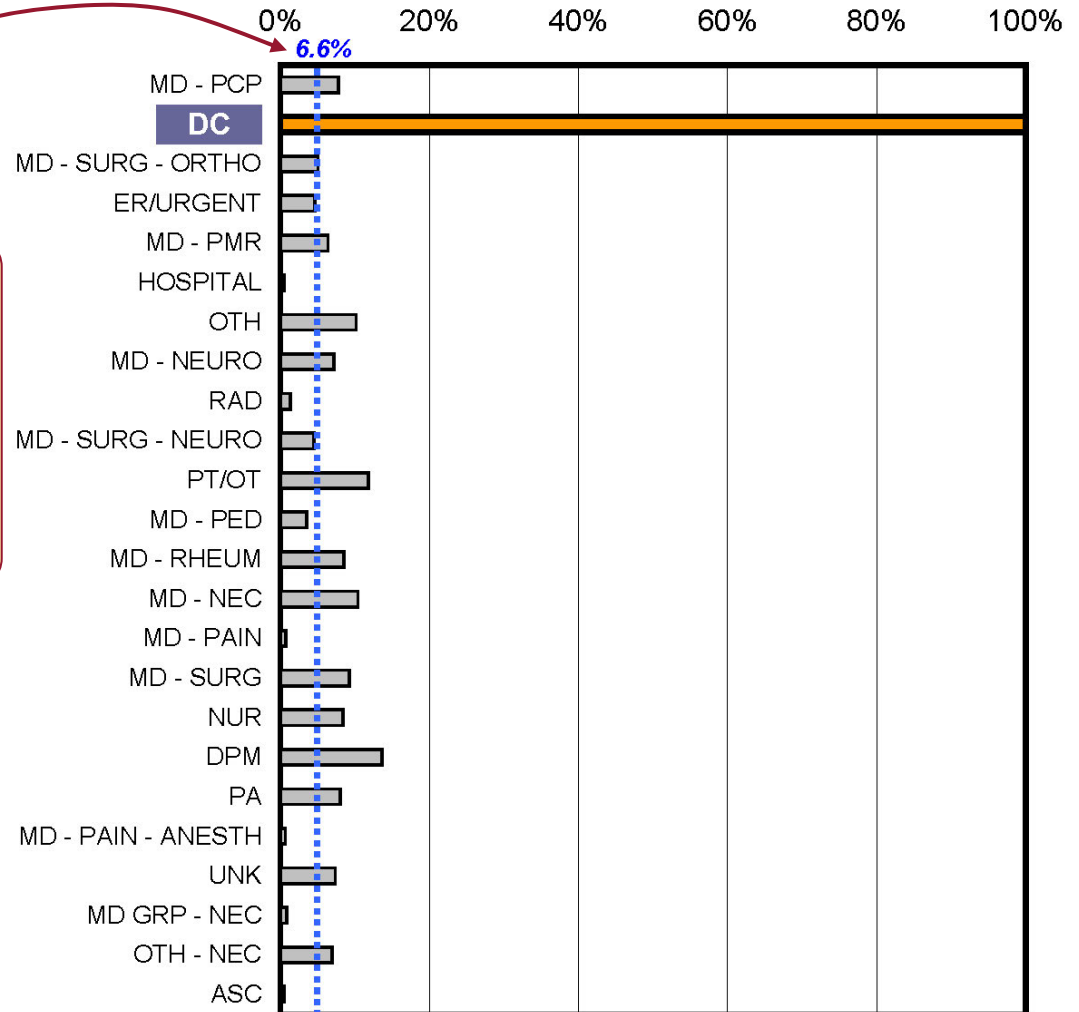
1 For spine episodes **not starting with a DC**, only **6.6%** involve a DC at **any point during the episode**.

2 If **20%** of the episodes not involving a DC **were referred to a DC** within **10 days** of the start of the episode:

- a. **High likelihood** of improved patient care
- b. **>\$300,000,000** savings to the system
- c. **>\$220,000,000** in revenue to DCs

3 Realizing this opportunity requires **over-coming barriers**:

- Communication**
- Control of patient**
- Selling products**
- Physical setting**
- Variability in DC practice**



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Spine Care Pathway And DC Value Proposition

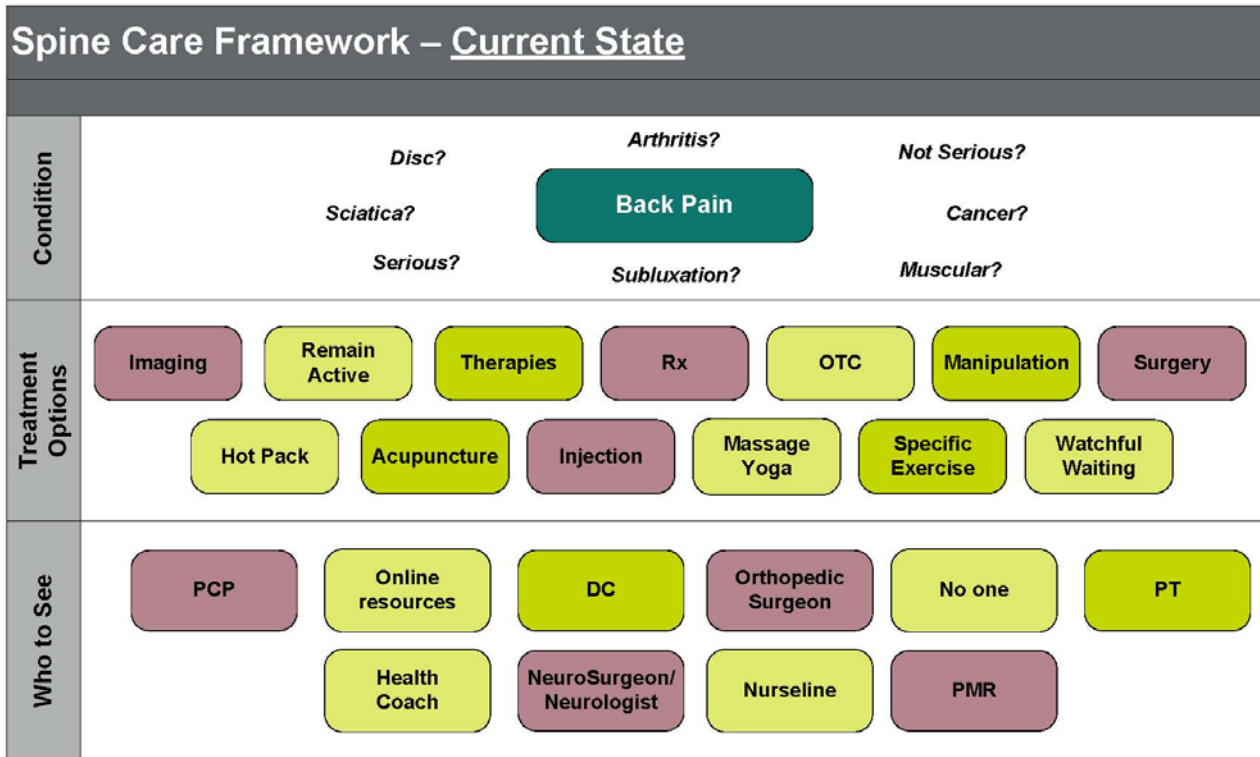
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Spine Care Framework

- What **simple questionnaire** has been demonstrated to improve affordability of spine care?
 - Oswestry
 - PHQ-9
 - **STarTBack Screening Tool**

Current State of Spine Care







It is **2013** and for the top driver of medical expense we **don't know** what to call it, what to do for it or who to see for it

Haldeman S, Dagenais S. A supermarket approach to the evidence-informed management of chronic low back pain. *The Spine Journal* 2008; 8:1-7

Key Learning Points

- Focus on assigning a **diagnostic label** that is often invalid or not useful
- Care is **fragmented**
 - >200 treatment options
 - ~30 different provider types
 - Poor coordination
- **First provider** seen exerts significant influence on the care pathway and the costs of treating LBP
- **Front-loaded** expenditures
 - Many patients incur significant expense soon after initial consultation (imaging, RX, etc)
- **<65% adherence to Clinical Practice Guidelines (CPG)**
 - Practice driven by personal opinion/bias and preconceived notions regarding patients
- **Provider-centric** system
 - Does little to foster health and economic benefits for patients
- **Patients** are challenged to navigate this on their own

Future State

Spine Care Framework					
Classification	<p>Red Flags Complex comorbidities, pregnant, recent spine surgery, neuro</p> 	<p>Low Risk of unfavorable outcome</p> 	<p>Medium Risk of unfavorable outcome</p> 	<p>High Risk of unfavorable outcome</p> 	
Evidence Informed Treatment	<p>Disorder Targeted Medical Management</p> <ul style="list-style-type: none"> Imaging Rx Injection Surgery 	<p>Self-Care/Education/Reassurance</p> <ul style="list-style-type: none"> Remain Active Hot Pack OTC Watchful Waiting 	<p>Conservative</p> <ul style="list-style-type: none"> Manipulation Specific Exercise Therapies Acupuncture 	<p>Modified Cognitive Behavioral Therapy</p> <ul style="list-style-type: none"> Biopsychosocial Assessment Close gaps in patient knowledge Emphasize active self-management Focus on psychological prognostic factors 	
Primary Care Giver	<ul style="list-style-type: none"> PCP Specialist (Ortho/Neuro/PMR) 	<ul style="list-style-type: none"> None Health Coach, nurseline, online resources 	<ul style="list-style-type: none"> DC PT 	<p>GAP? Providers most effective with Medium Risk patients that are also trained to address cognitive issues</p>	
Patient Preferences	<p>Low – need to get to appropriate resource</p>	<p>High – many options</p>	<p>High – many options</p>	<p>Moderate – may not seek/comply with plan</p>	

Who can classify

- PCP
- DC
- PT
- Specialist
- Web resource
- Nurseline
- Health advocate

Evidence informed treatment aligned with classification

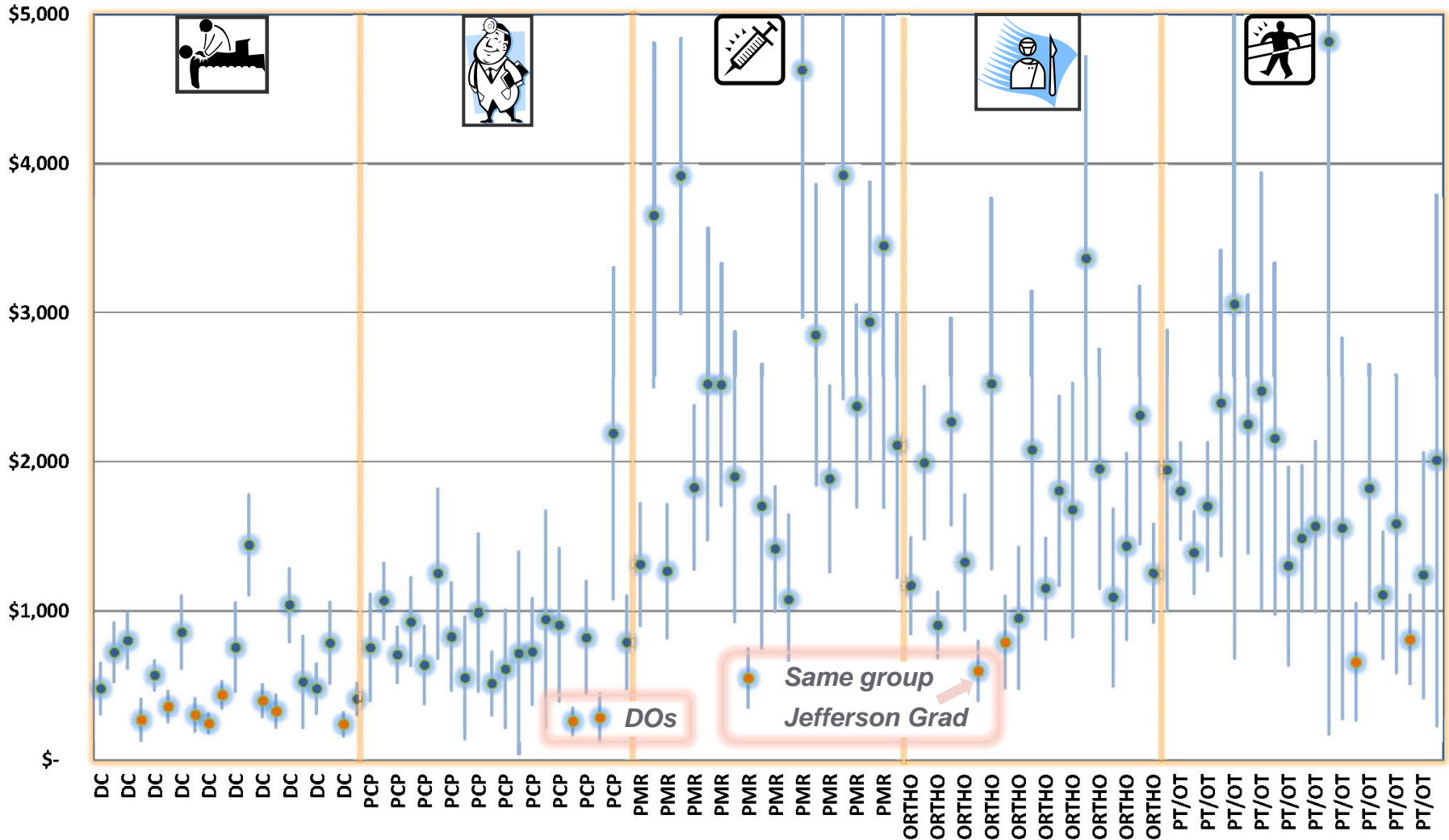
Further opportunity for conservative sub-classification

Pathway optimized if primary care giver is also first provider seen

Key role for resource to help consumers navigate the framework

Systems of Excellence

90% C.I. Non-Surgical Spine Total Episode Cost - Philadelphia
Top 20 Providers By Specialty and Entry Point Volume



Systems of Excellence



- Employer, payer, provider collaboration
- Identify providers who are:
 - High performing and/or
 - Committed to EBM
- Make introductions
- Implement:
 - Common framework
 - Triage/classification
 - Referral process
 - Measurement
- Provide transparency to, and establish cadence, of sharing performance data