# Innovations in Conservative Care: Getting to the Right Provider First

Population Health & Care Coordination Colloquium

3/14/2013

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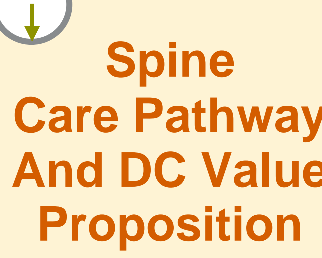
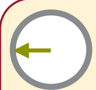
# Agenda

**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**

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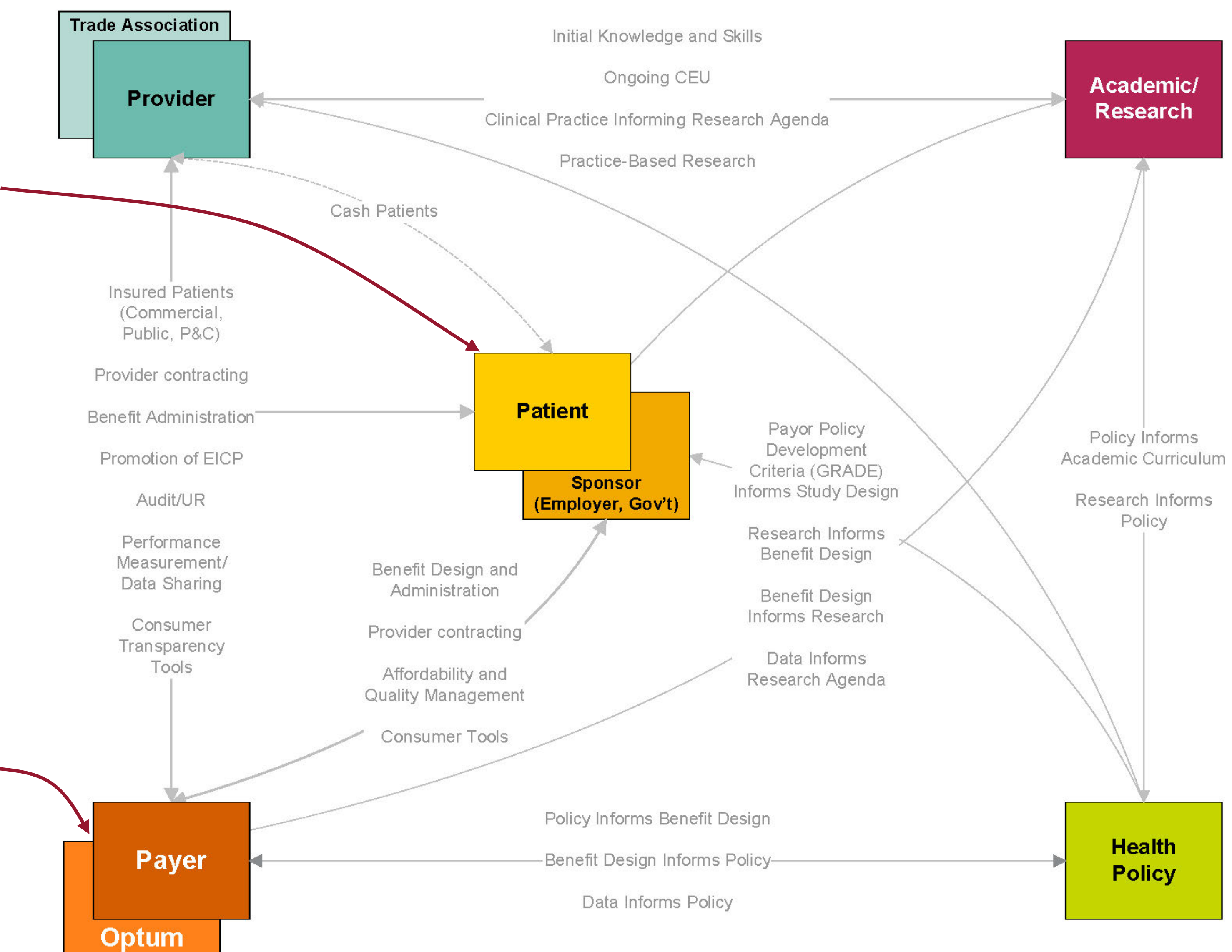
# Context - Disclosure

**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**.

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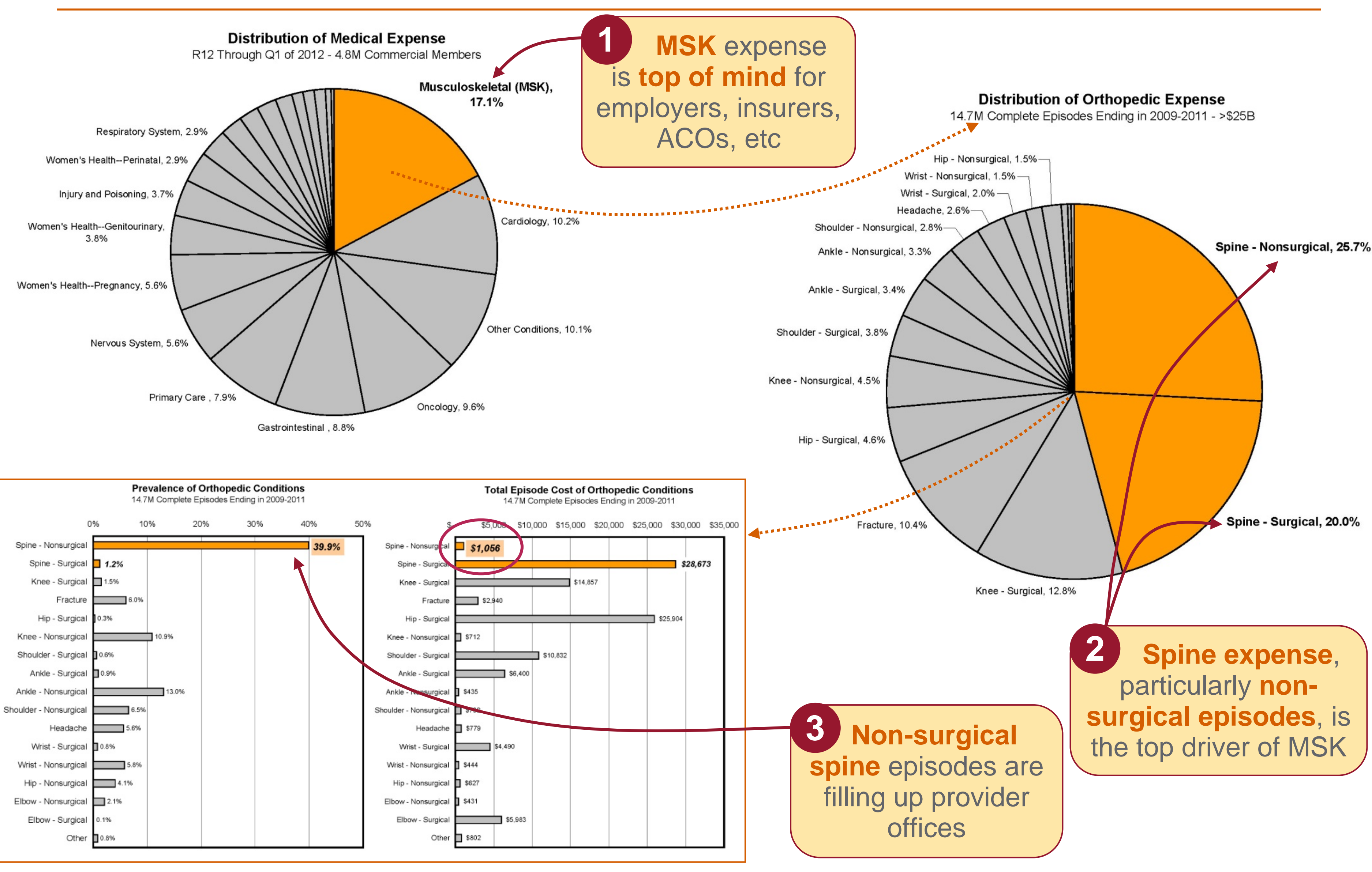
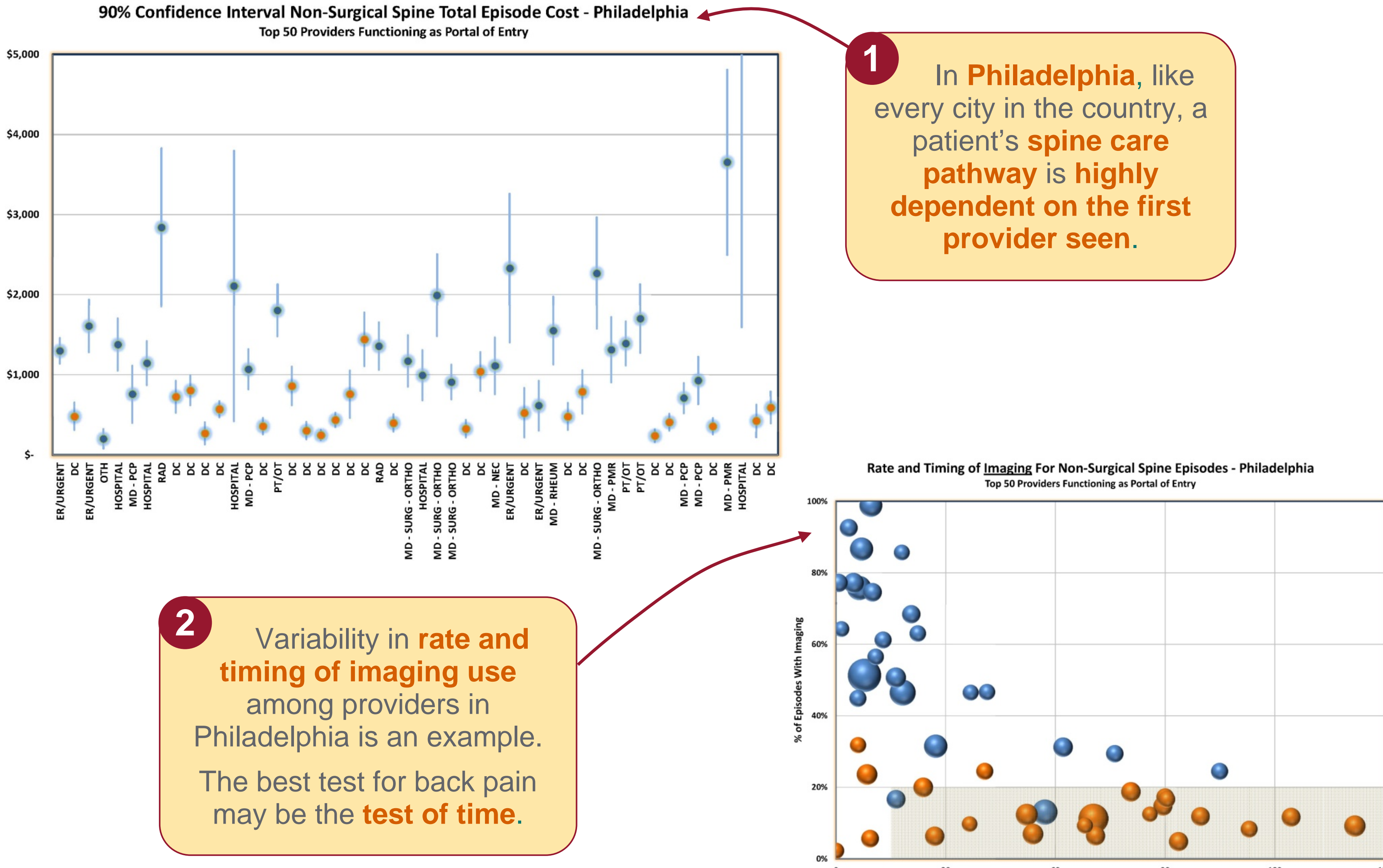
# Context - Importance of Musculoskeletal Conditions



# Context – Variability in Decision-Making

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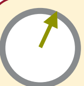


## Context

**health plan population?**

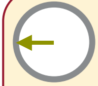
- *Cancer*
- *Heart disease*
- ***Musculoskeletal (MSK) conditions***

- Spinal conditions account for **what % of total expenditures for MSK conditions?**
  - *25%*
  - ***45%***
  - *75%*

## Spine Care Pathway And DC Value Proposition

- 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

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# 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

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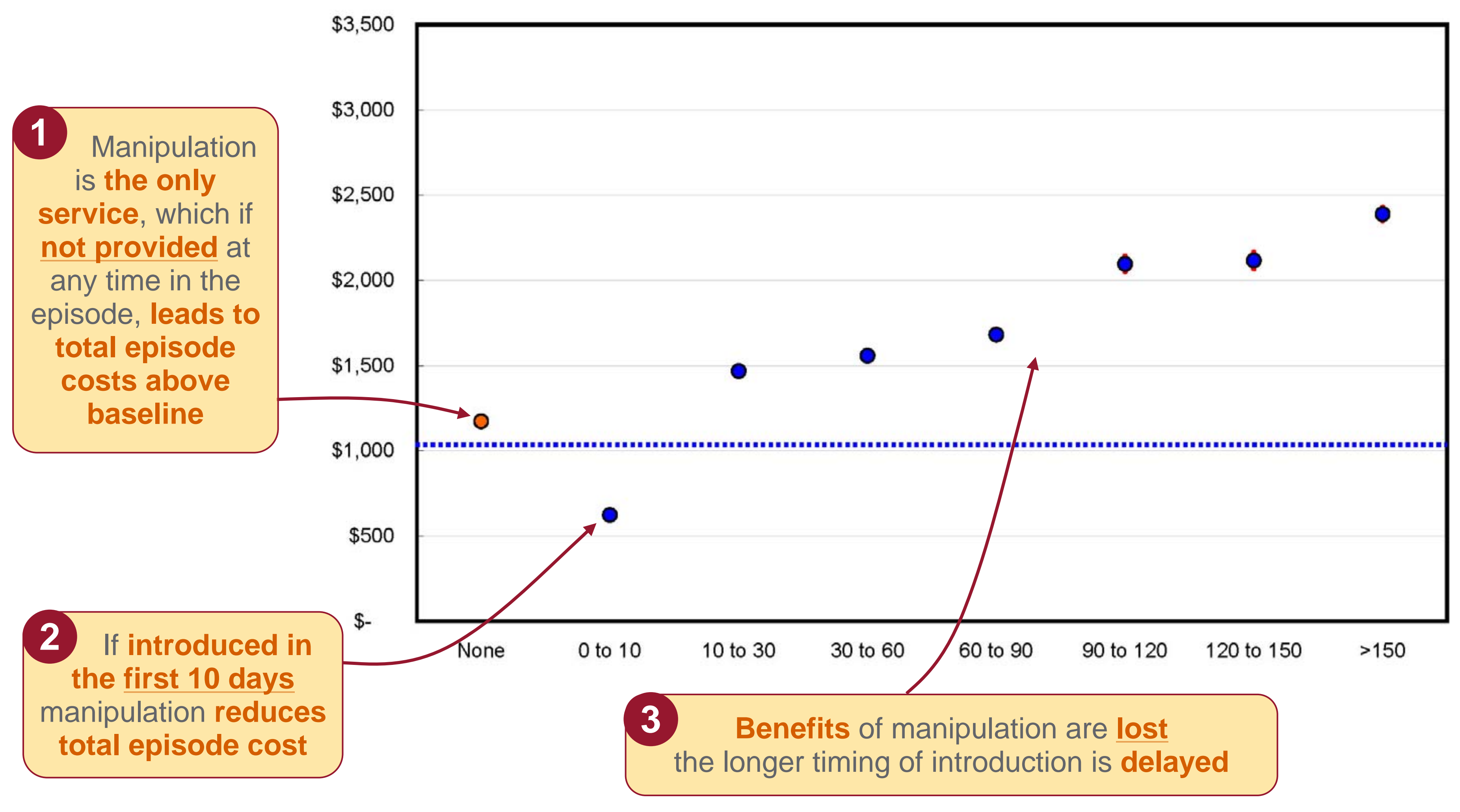
# Service Timing and Episode Cost

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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**

# Service Timing and Episode Cost

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

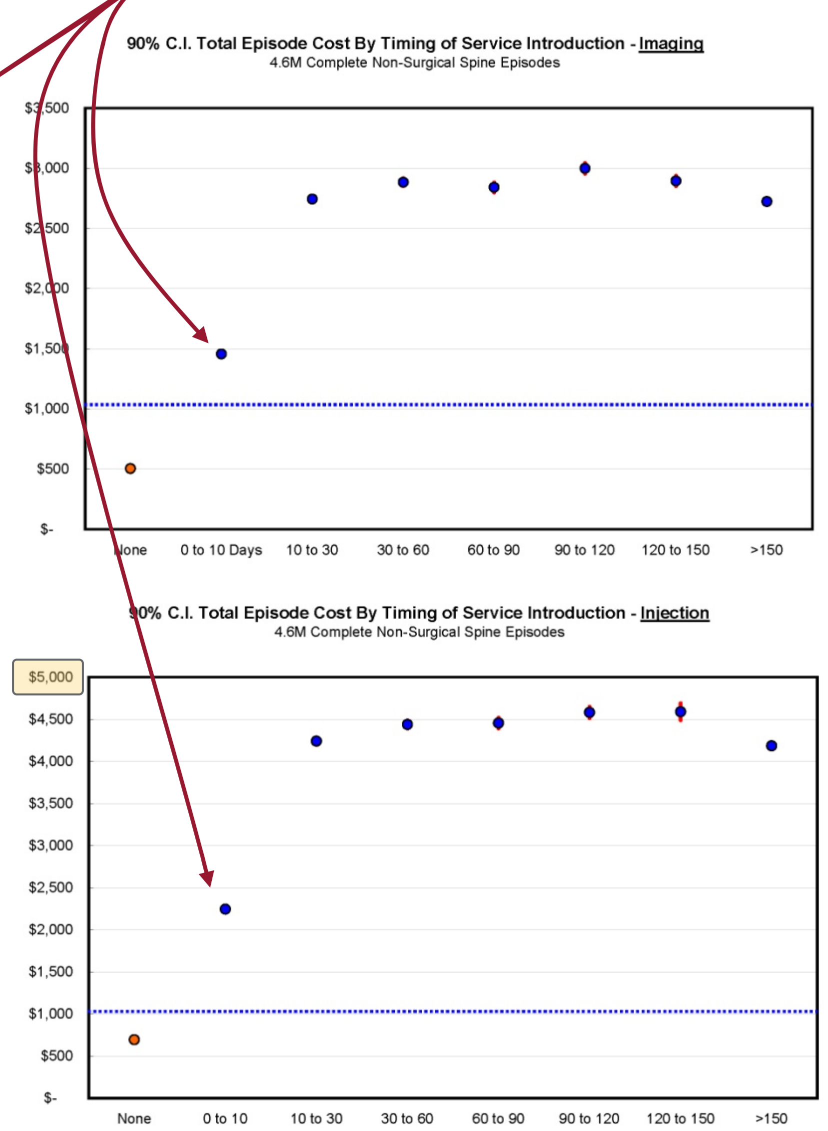
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$-

None | 0 to 10 | 10 to 30 | 30 to 60 | 60 to 90 | 90 to 120 | 120 to 150 | >150

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

$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$-

None | 0 to 10 | 10 to 30 | 30 to 60 | 60 to 90 | 90 to 120 | 120 to 150 | >150

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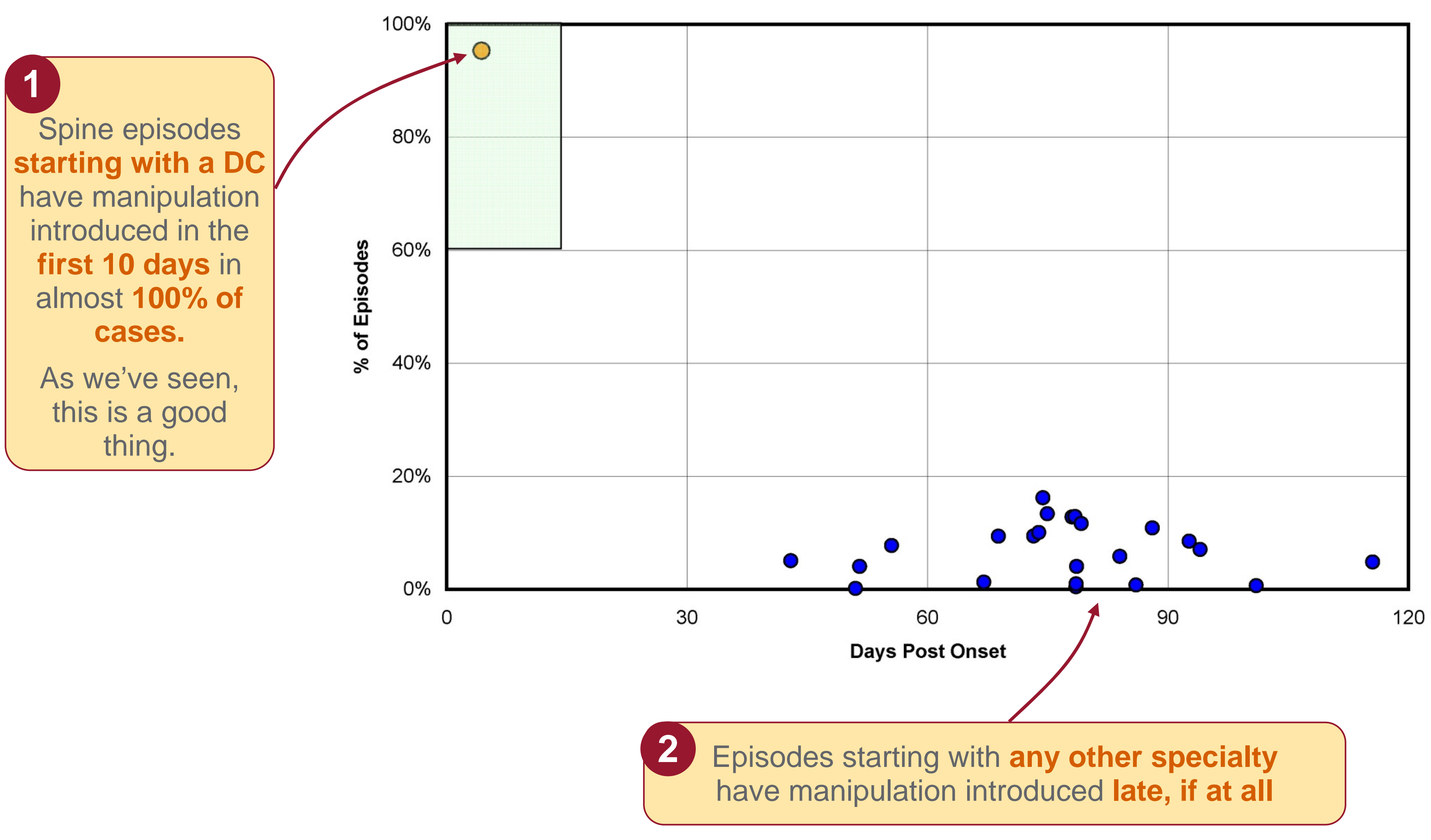
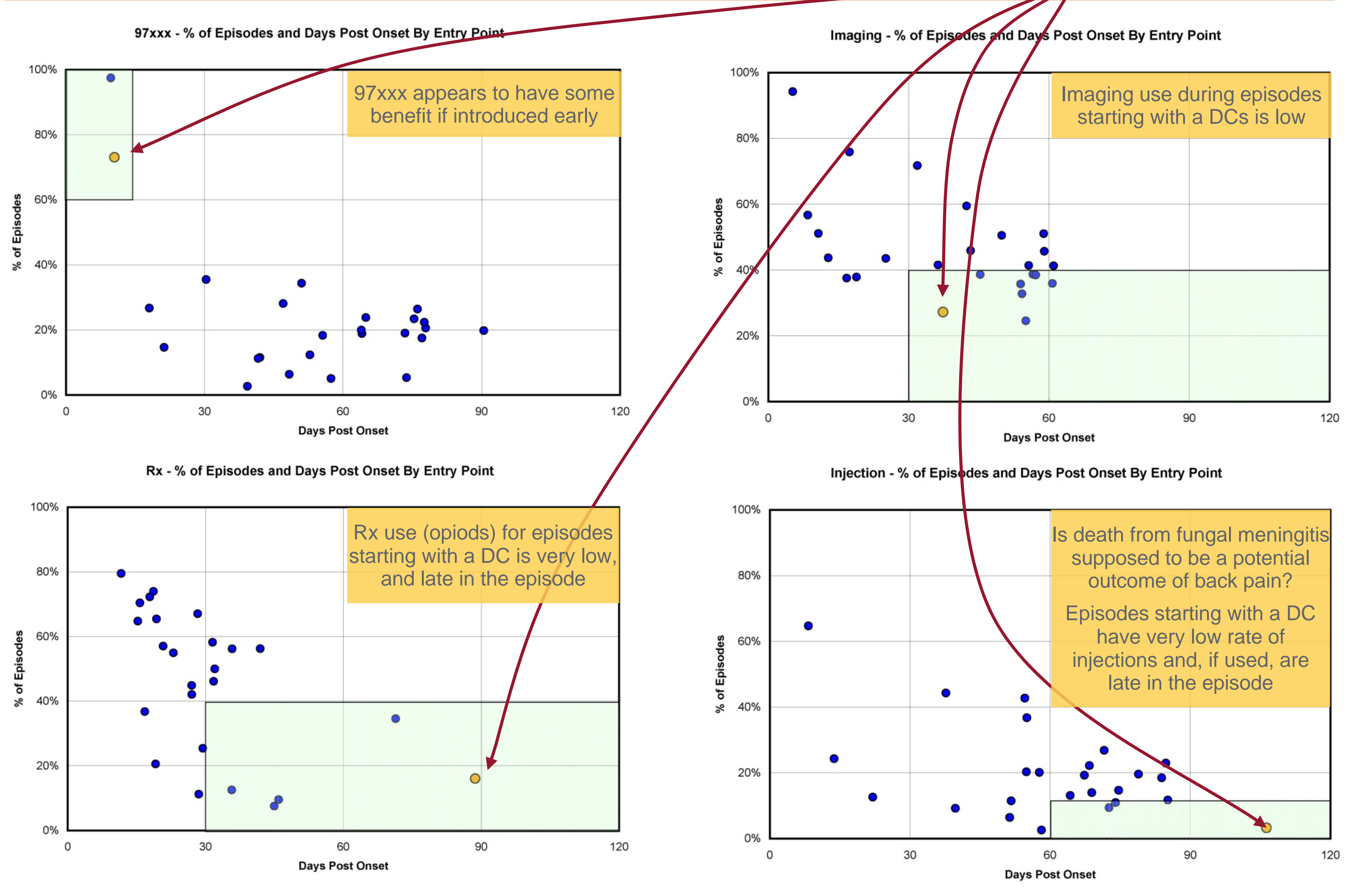
# Rate and Timing of Services by Specialty of 1st Provider Seen



# Rate and Timing by Specialty of 1st Provider

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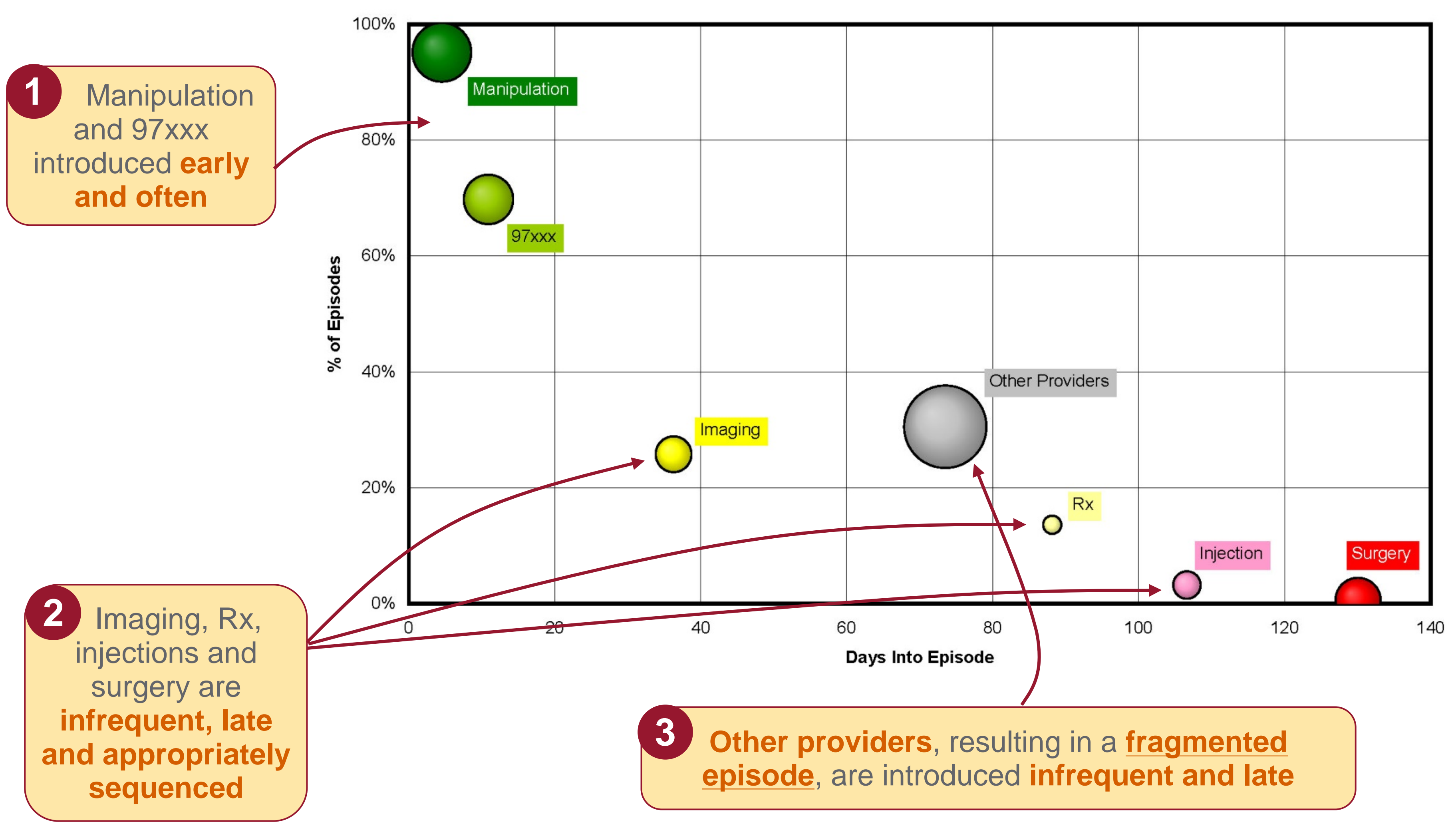
# Care Pathway by Specialty of 1st Provider Seen



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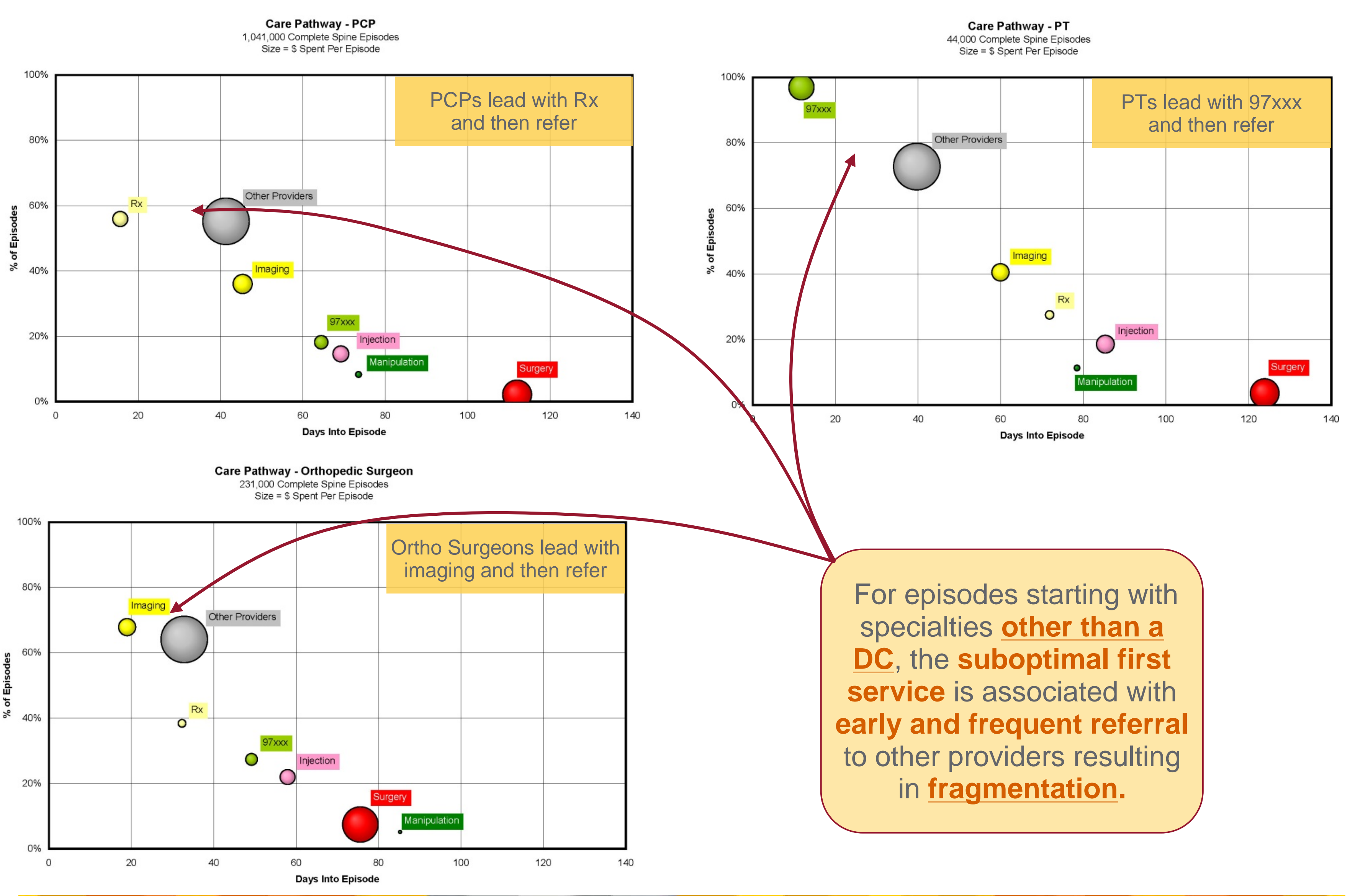
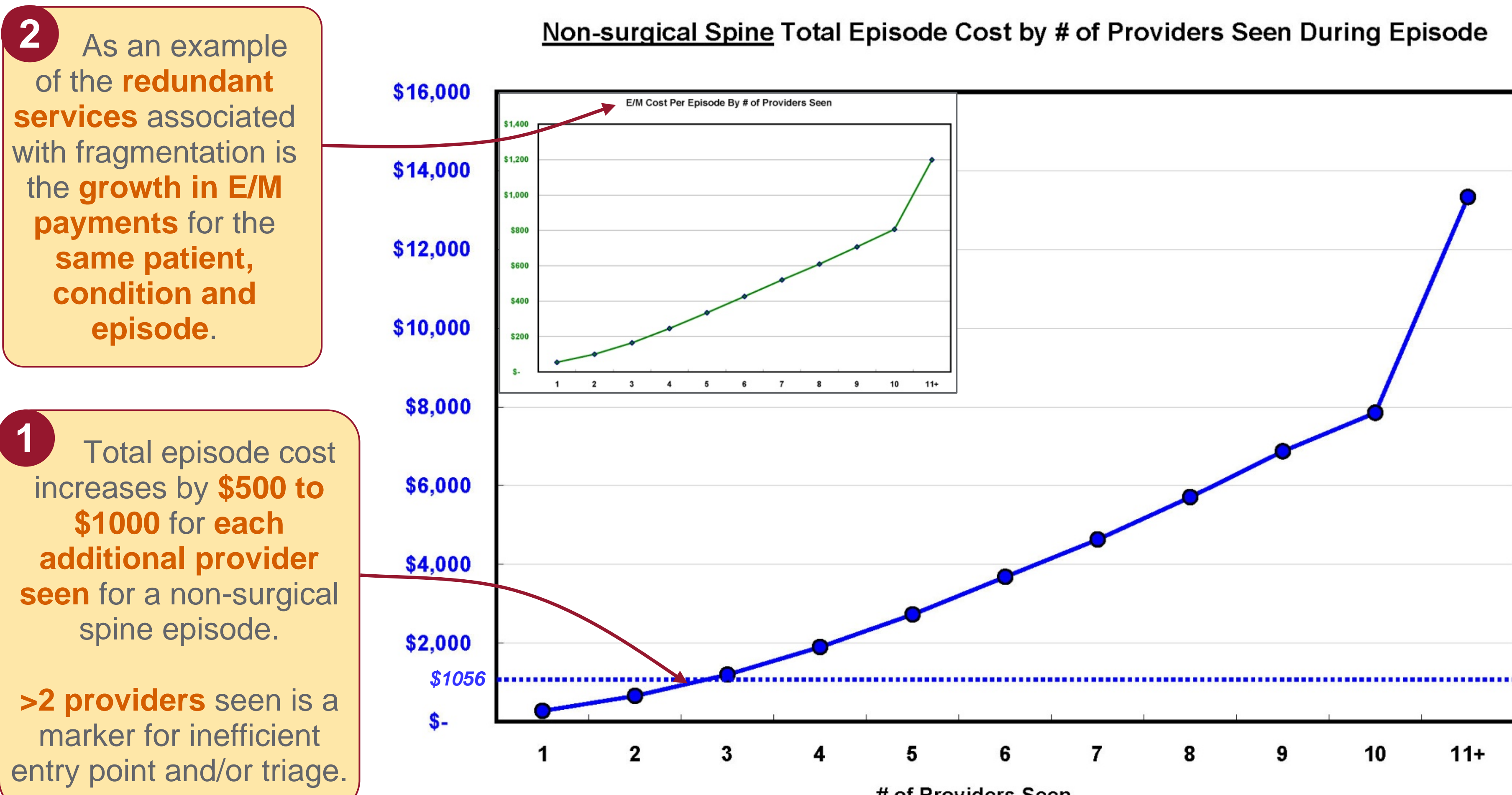


# Impact of Care Pathway Fragmentation




"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

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# Entry Point for Spine Episodes

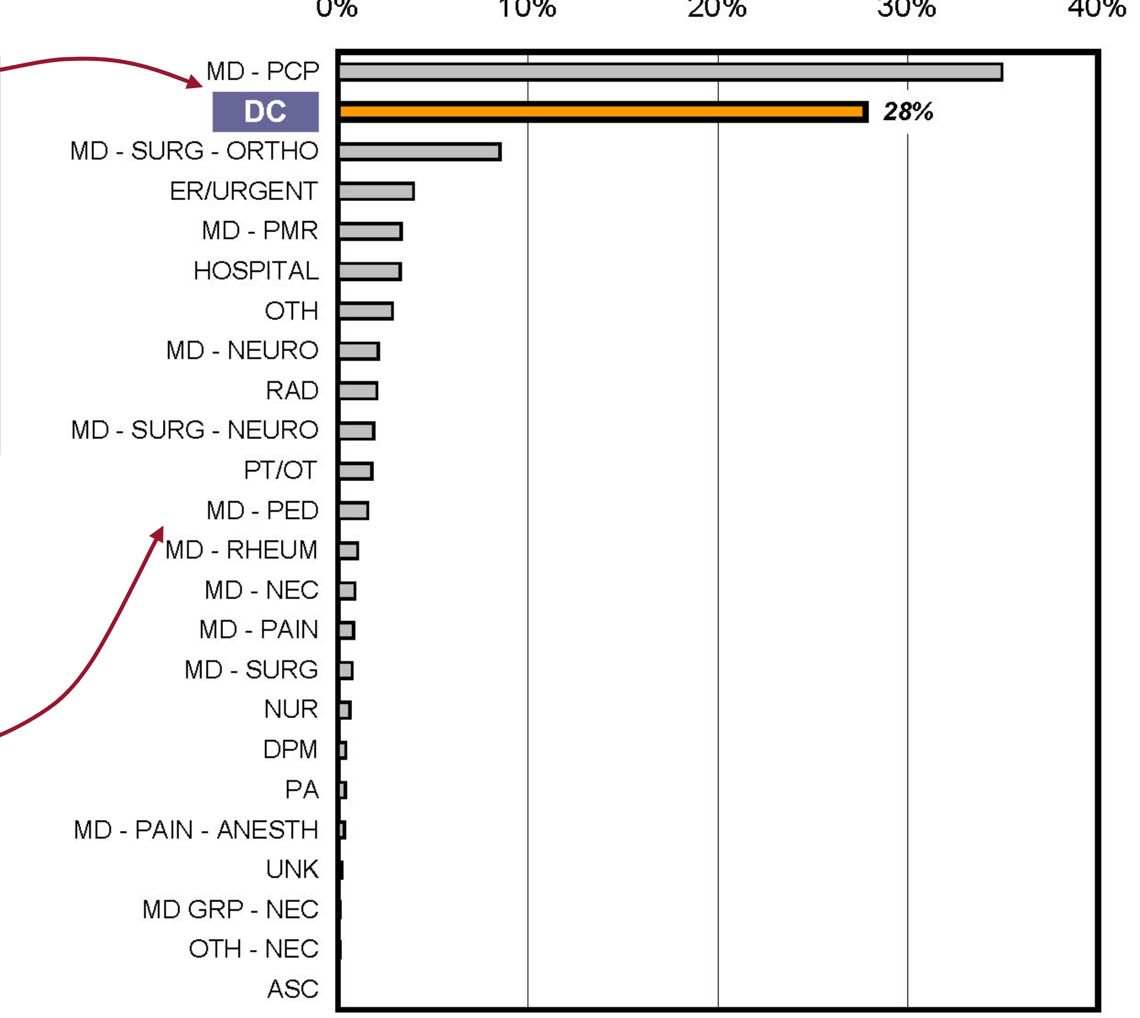
1 **28%** of spine episodes **start with a DC,** second to PCP.

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**?

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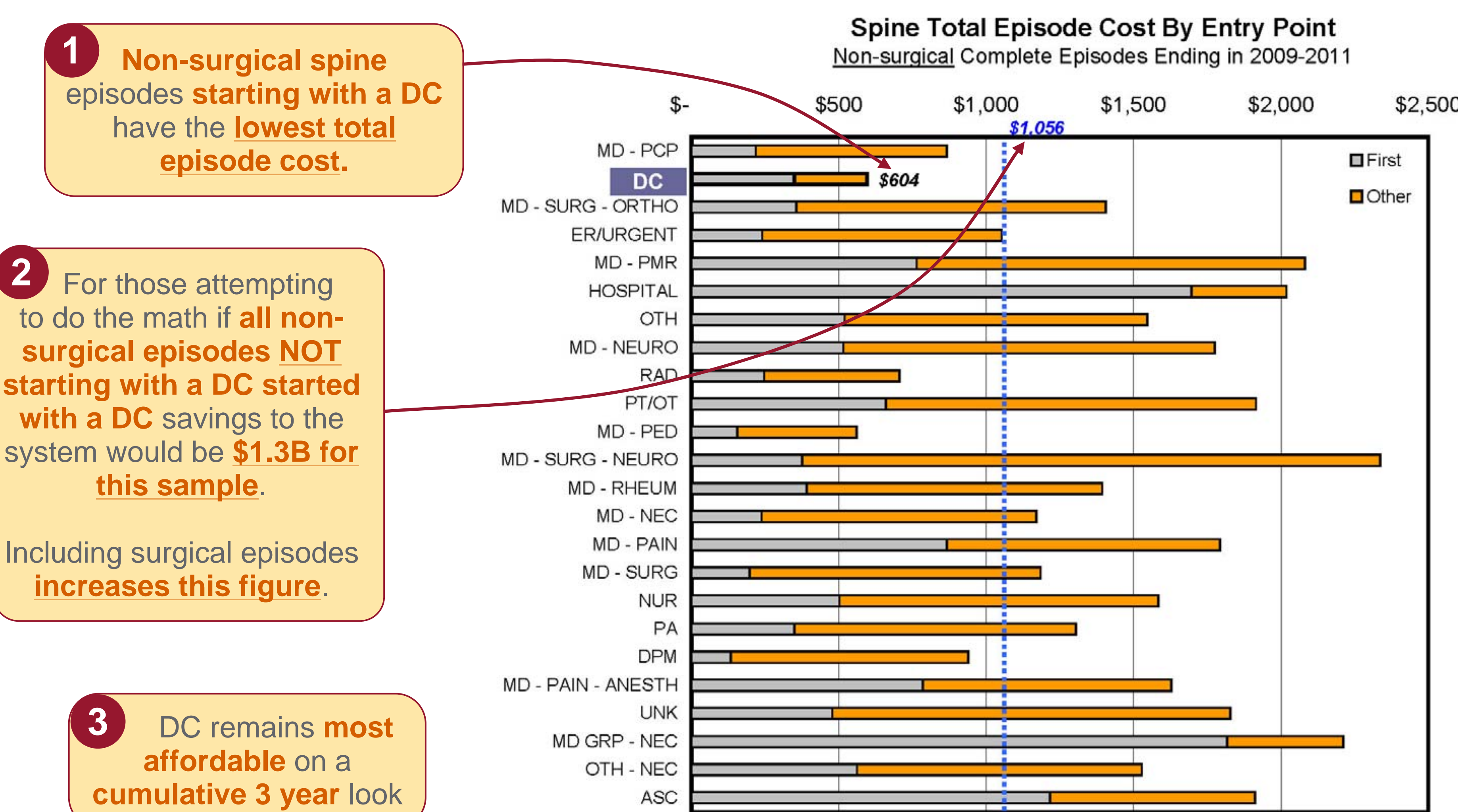
# Non-Surgical Spine Episode Cost By Entry Point

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# Referrals to DC if Patient Starts With Different Entry Point

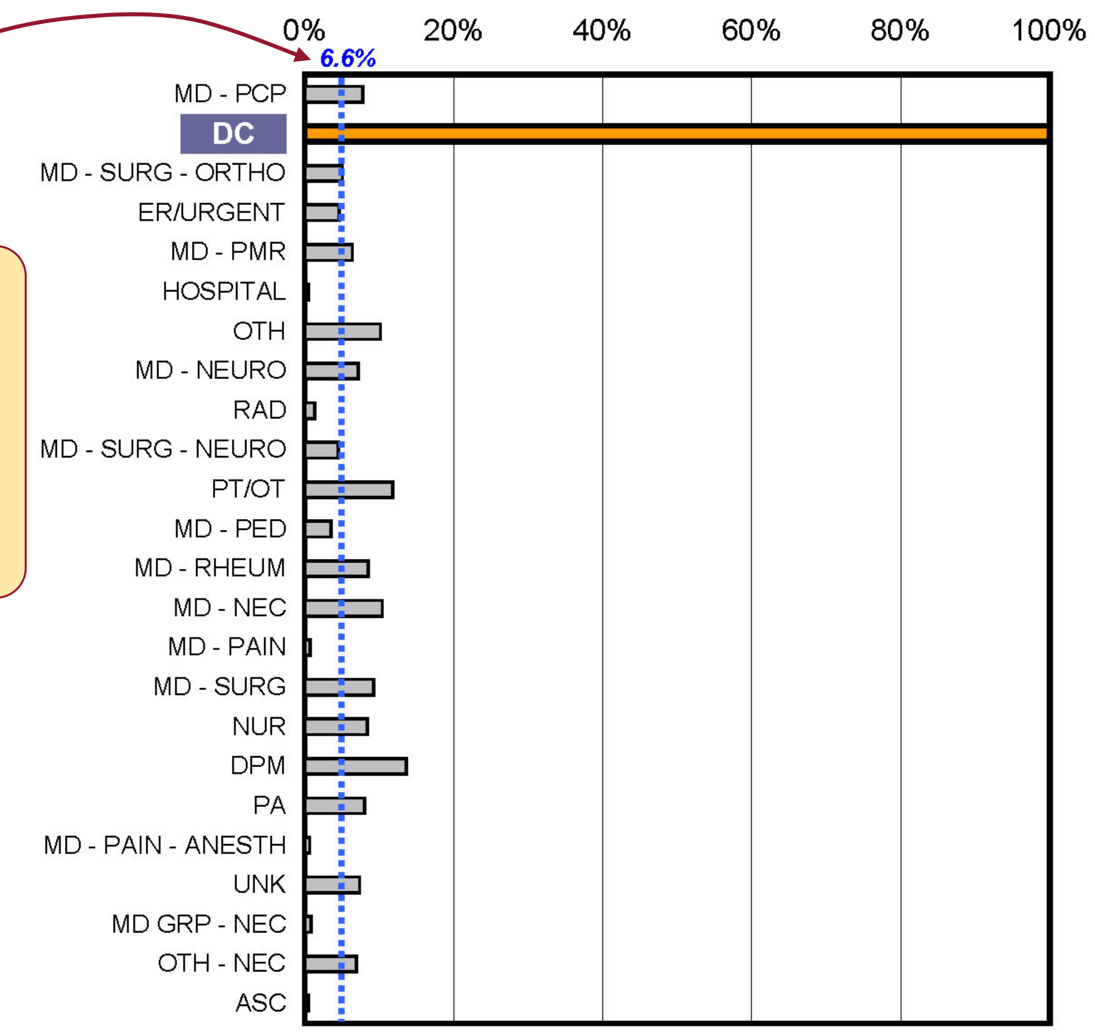
**1** For spine episodes **not starting with a DC**, only **6.6%** involve a DC at **any point during the episode.**

**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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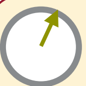

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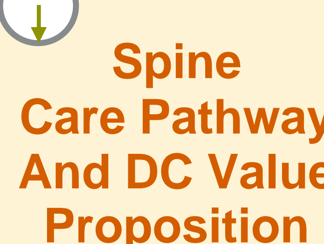

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**Spine Care Framework**

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

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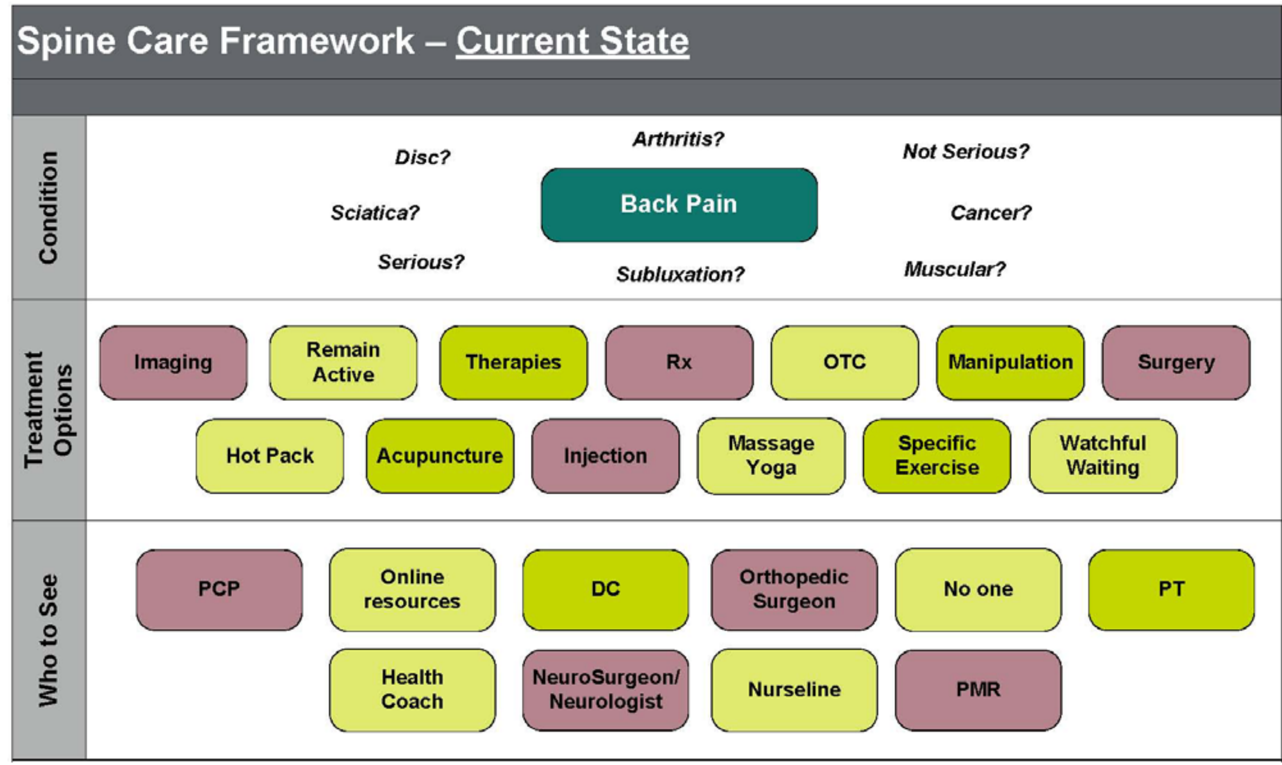
# Current State of Spine Care




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

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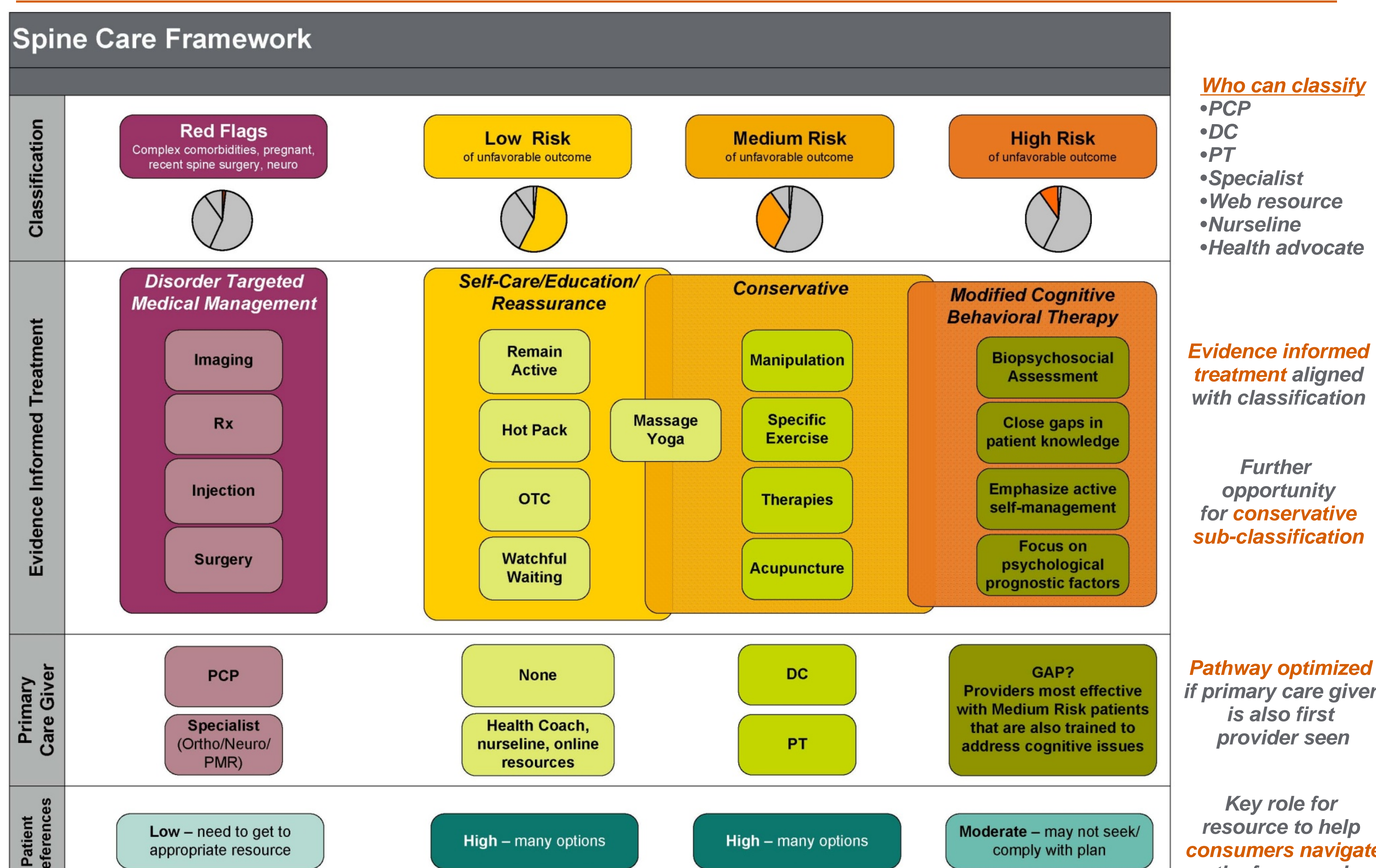
# Future State

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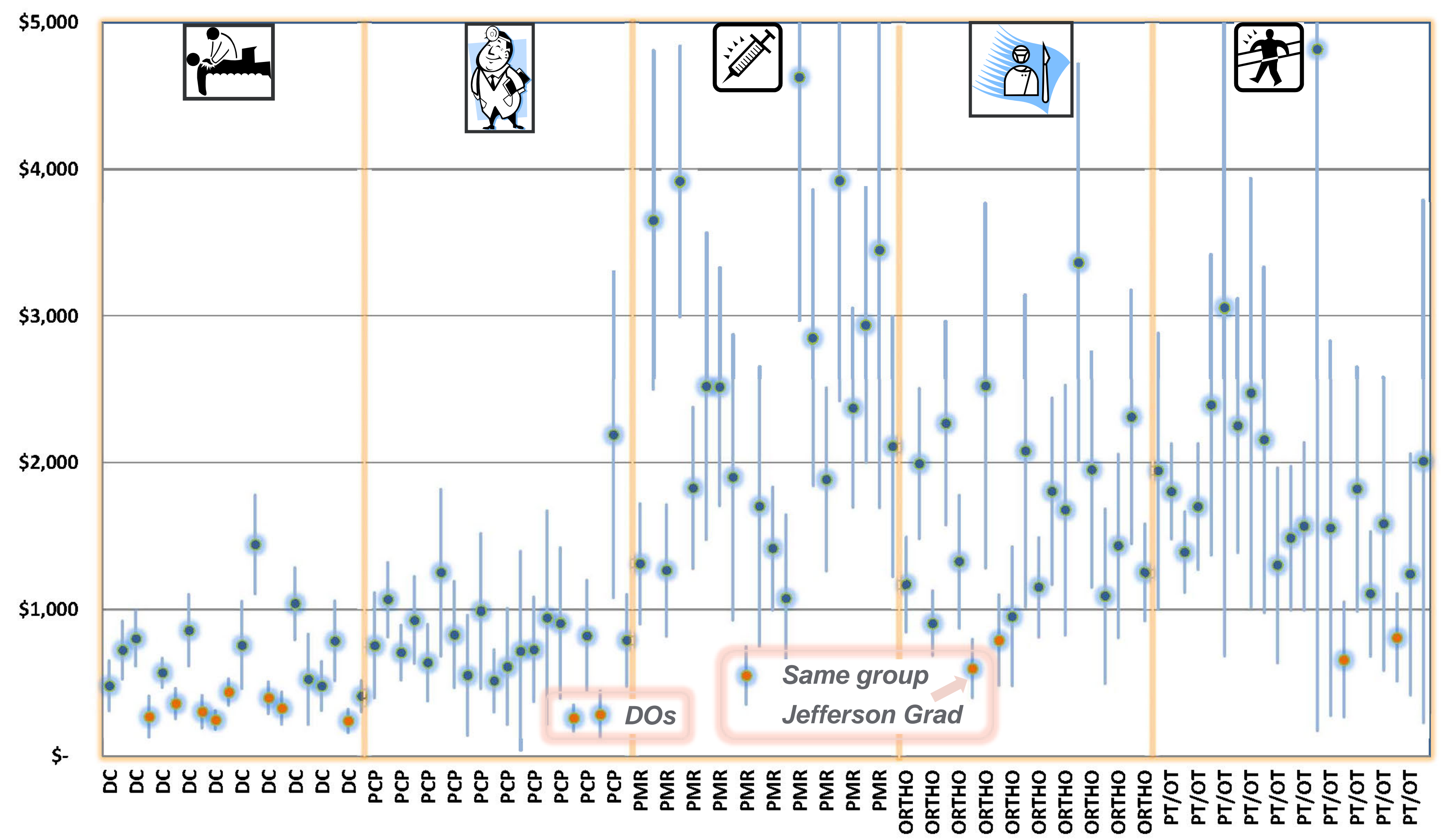
# Systems of Excellence

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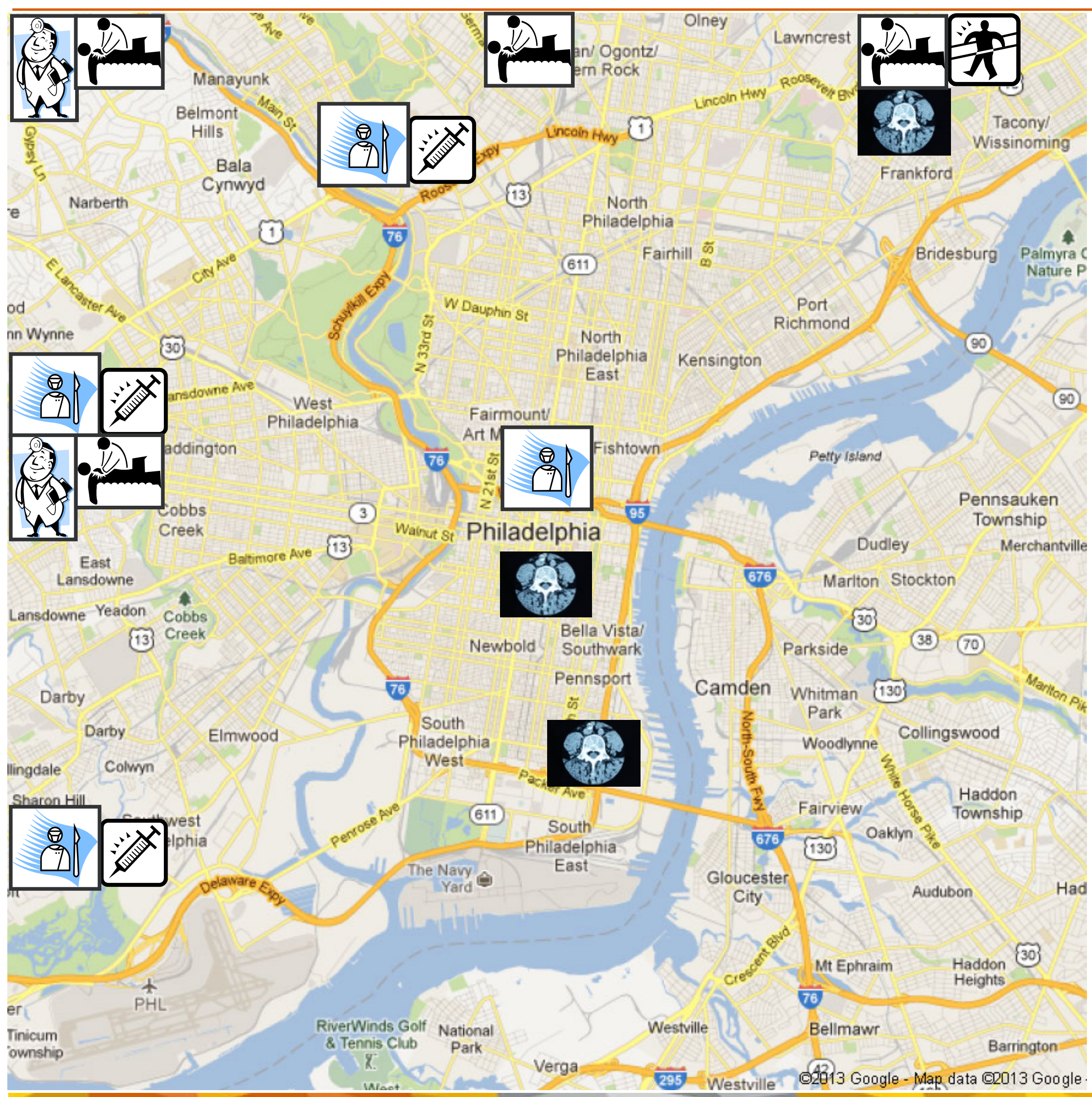


- Employer, payer, provider collaboration
- Identify providers who are:
  - High performing and/or
  - Committed to EBM
- Make introductions
- Implement:
  - Common framework
  - Triage/classification
  - Referral process
  - Measurement
- Provide transparency to, and establish cadence, of sharing performance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

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