

MORE ACCESS TO HEALTH CARE

Opportunities for Leadership in Value, Quality, and Equity

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California's efforts to increase access to health insurance coverage and health care services reflect political, professional, and consumer leadership and a shared sense of social responsibility and will.

This commitment is mirrored in the reduction in the number of the uninsured living in our state, in spite of efforts by the Administration to weaken the necessary infrastructure, which includes funding for outreach and enrollment workers to enroll hard-to-reach, eligible populations. Medi-Cal and Covered California leadership (which included extending the amount of time in which eligible individuals could sign up for coverage) combined with a number of activist community-based organizations to enable the state to beat the odds, reaching and retaining millions of beneficiaries. Medicaid Coverage expansions in 32 states and Washington, D.C., was not the only Affordable Care Act (ACA) win. Most notably, the commitment to preventive health care services as part of essential benefits helped to ensure that more than 55 million women gained access to contraceptive coverage without co-payments and deductibles. Additional progress included enabling consumers with a preexisting condition to gain vital access to coverage, young adults up to age 26 gaining coverage through their parents' plans, retaining foster care youth as they aged out of the system at age 18 up to age 26, and efforts to reduce health care costs through a variety of cost containment learning efforts through the Center for Medicaid and Medicare Innovation (CMMI).

Yet the almost daily barrage of Congressional and Administrative efforts to further weaken the ACA, beyond the elimination of the individual mandate (in 2019) and premium subsidies, will likely not decrease in intensity. Furthermore, the fiscal health of Medicaid and Medicare is also under siege and, until recently, funding commitment to the Children's Health Insurance Program (CHIP) was also at risk. The danger to the Deferred Action for Childhood Arrivals Program (DACA) and other immigrant populations not only impacts those populations at risk of deportation but unfortunately has caused a substantial chilling effect upon Latino/a populations seeking health care in California and across the nation. In addition, further "rollback" strategies will likely be introduced at the federal level, which will further impinge upon our state's safety net network and other entities. Against this backdrop, a number of state-based experiments, including those states that are seeking greater control over their health care programs, may entail:

- 1) Waivers enabling rollbacks of ACA benefit requirements (Idaho),
- 2) Weakening of consumer protections that will likely result in insurance companies charging higher premiums to people who are sicker and older, and
- 3) The availability of cheaper, less comprehensive plans that do not meet ACA requirements.

These will likely result in a quilt of dramatic coverage variation across the country. In contrast, in an effort to shore up the ACA and keep premiums lower, California represents one of nine states considering a requirement that residents carry health insurance as a means of ensuring access, while also helping to keep premiums lower.

These and other issues will likely impact the health and well-being of Californians, increasing pressures on policymakers to identify alternative ways to expand coverage, while also achieving the triple aim of increasing value, quality, and consumer voice as stepping stones to creating effective learning health care systems, while simultaneously addressing social determinants of health.

Quality, Patient-Centered Care and Value: Building Steps Toward Creating a Learning Health Care Community

While the United States spends more than \$3.4 trillion a year on health care (vastly more per person than any other developed country), our average life expectancy is 79.3 years, or 31st among developed countries. Growing awareness that our costly investments have not resulted in improved health outcomes has contributed to the increasing demand from patients, providers, hospitals, and health insurers for higher-quality care and value. This requires a systemic recognition of the inherent and potentially dangerous waste in health care delivery, the need for greater transparency in achieving better outcomes at a reduced cost, and the need for sustained and replicable innovation as part of building a learning health care system.

As one example of efforts to change the paradigm, the Center for Healthcare Value (CHV), under the auspices of the Philip R. Lee Institute for Health Policy Studies at UCSF, is pursuing two kinds of strategic approaches: Caring Wisely™ and the Measuring Value Initiative (MVI). Caring Wisely, launched in 2012, represents an organized process for engaging and supporting frontline clinicians in efforts to remove unnecessary costs from health care delivery systems and improve the quality of care delivered. The program combines an ideas contest, in which providers and staff identify areas that could be targeted to reduce inefficiencies and health care costs, followed by a selective full proposal stage, in which intervention strategies are vetted. A final implementation component entails the partnership of a small number of innovators with testable ideas and an implementation science team, including health systems leaders in quality, operations, finance, and information technology. Initial results show notable improvements in value related to blood transfusions, inpatient respiratory care, operating room supply costs, postoperative opiate use, length of stay for colorectal surgery and gynecology-oncology surgical patients, and overuse of antibiotics.

The CHV Measuring Value Initiative, in partnership with the UCSF Clinical Innovation Center, began in 2016 and represents a multidisciplinary internal analysis and consultation service aimed at supporting and aiding improvement work throughout UCSF Health. The program's early efforts include:

- 1) Leveraging the health care cost-accounting system to define patterns of clinical care and opportunities for improvement;
- 2) Designing a cost-of-care calculator—a method for measuring and understanding the impacts of clinical initiatives;
- 3) Linking frontline clinical improvement work to the financial processes of the health care system, including forecasting, budgeting, purchasing, and supply chain management; and
- 4) Developing methods to better link clinical and financial data, using novel big data approaches.

CHV has also begun to work with employers, labor unions, and other purchasers, as well as consumers, patients, and other groups, to establish payment policies that support organizations that try to improve price, quality, and other aspects of value (<https://healthvalue.ucsf.edu/>).

These programs, which incorporate a multidisciplinary team of innovators, implementors, health services researchers, health care financing experts, informatics, and implementation scientists, represent efforts to rigorously test and learn valuable local lessons within smaller laboratories—for example, a department or unit, where the experimentation can take into consideration local culture. This testing is crucial as health care delivery is beginning to shift and respond to both public and private payers who are pursuing significant changes in the financial incentives for care delivery. This transformation, from revenue that is based on fee-for-service to one that promotes value within a budget and changes in reimbursement, including shared savings, bundled payments, and capitation (Bindman, Pronovost, Asch, 2018), will require substantial system capacity to be successful.

The types of needed “bold experiments” will likely not occur at a time when leaders of health care organizations continue to be concerned about jeopardizing profit margins. Developing capacity and the confidence to implement evidence-based, locally tested and evaluated change represents such a building block. Additional building blocks will consist of institutional replications that will also draw upon the skills of additional team members from throughout the health care system, clinicians, administrators, information system levers, legal counsel, and intellectual property and privacy officers (Bindman, Pronovost, and Asch, 2018). Furthermore, federal, state, and private foundation support for additional experiments—for example, those aimed at incorporating a variety of quality improvement methods, such as reducing hospital-acquired infections and readmissions for heart failure—could substantially reduce some of that financial risk to health care organizations (Bindman, Pronovost, and Asch, 2018).

Social Determinants of Health (SDHs) and Inequity

The increased consciousness regarding the impacts of social determinants of health (SDH) and growing inequity on health outcomes, as well as a shift to patient management of chronic health conditions, will also require the medical community to play an activist role that goes beyond clinic walls. SDH include early life experiences; socioeconomic conditions (income and poverty); quality and level of education; access to employment,

work/life balance, and work environment; social and physical infrastructure and living conditions; social networks; and public safety (Braveman, Egerter, Williams, 2011). Evidence indicates that many social determinants are associated with chronic stress, resulting in biologic and physiologic influencers on the regulatory systems, including the metabolic, cardiovascular, and peripheral nervous systems. Addressing socioeconomic factors that exacerbate, and in some cases cause, health issues has become an imperative whether you are a payer or provider, a nonprofit or for-profit entity. National, state, and foundation initiatives are increasingly supporting developing wraparound services to foster health and reduce unnecessary medical costs, including stable housing paid for by Medicaid, support for transportation, and access to healthier foods and safer environments. Yet, clearly, more investments will need to be made in the years ahead, as Accountable Care Organizations and Accountable Care Communities, among others, recognize the importance of multi-sectoral, partnership approaches that close this vital chasm. Other relevant testing, in terms of taxes on sugar-sweetened beverages, tobacco, and marijuana, represent not only public health efforts to decrease consumption but also important pools of funding for additional community investments.

As is true of learning health care communities, further testing and innovation, as well as rigorous evaluations that incorporate social determinant variables along with a wide array of relevant data sets (e.g., education, employment, juvenile justice, etc.), will play a significant role in demonstrating the vital “return on investments” both in the short and long run.

Given the diversity and economic strength of our state, California is at an important crossroads. Will California continue to play a leadership role in advancing improvements in our health and well-being? Based upon our history, the answer is likely to be yes, but it will require an extensive and ongoing commitment from all of us.



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References:

1. Bindman AB, Pronovost PJ, Asch DA. Funding innovation in a learning health care system. *JAMA*. 2018 Jan 9; 319(2):119–120.
2. Braveman P, Egerter S, Williams D. The social determinants of health: Coming of age. *Annu Rev Public Health*. 2011(32):381–98.
3. The Center for Health Care Value, UCSF. <https://healthvalue.ucsf.edu/> (downloaded February 2, 2018).