



Principles for Effective Health Care Reform

Our guiding principles:

Collaboration · Innovation · Impact

**We believe that today's
healthcare and social services
need to change in
fundamental ways.**

**This requires new strategies and
high-impact innovations.**

**We seek to design, develop, manage
and pilot new programs that will
serve as replicable models of care.**

**Together with community-based
organizations and public
and private funders
we work to create these
fundamental changes.**

Partners in Care Foundation
W. June Simmons, CEO

July 1, 2008

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Seth Ellis, Board Chair
Fran Hanckel, Think Tank
Chair, White Raven Consulting
Molly Coye, MD, MPH, CEO,
Health Technologies, Inc.
James Mangia, CEO, St. John's
Well Child & Family Center
Gerald Sullivan, Chairman,
The Sullivan Group
Richard Swanson, VP,
California Association
of Physician Groups
Robert Tranquada, MD,
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On June 16, 2008 Partners in Care convened a group of prominent California healthcare leaders to devise ways to ensure that all Californians eligible for publicly funded care will have access to effective care and that expenditures will be directed where they do the most good.

Think Tank Participants and Endorsers of the Guiding Principles:

Molly Coye, MD, MPH	CEO	Health Technologies, Inc.,
Seth Ellis	COO	Motion Picture & Television Fund
Frances Hanckel, ScD	Senior Partner	White Raven Consulting
James Mangia	President & CEO	St. John's Well Child and Family Center
Gerald Sullivan	Chairman	The Sullivan Group
Richard Swanson	Vice President	California Association of Physician Groups
Paul Torrens, MD, MPH	Professor of Health Services	UCLA School of Public Health
Robert Tranquada, MD		LA Care Health Plan
Peter Winston	Executive Administrator	SynerMed

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Design Principles for Allocating Scarce Healthcare Resources

- I. *Healthcare is a public good. California's public programs should be redesigned to produce benefits in proportion to current public spending.*
- II. *An effective health program provides patients access to appropriate, high quality care and empowers them to take responsibility for their own health.*
- III. *California must adopt tactics and programs that have been proven to benefit patients and providers, from exemplars both within and outside our state.*

Implementing the Allocation Principles

- I. *Healthcare is a public good. California's public programs should be redesigned to produce benefits in proportion to current public spending. (Benefits here include relieving pain and suffering; improving health; prevention and promoting patient responsibility; and enhancing patient safety.)*
 - A) California policy must be designed to cost effectively realize optimal benefits to individuals, with focus on high risk and high cost groups.
 - B) We need to shift the emphasis in spending from costly, often ineffective treatments for short-term illness towards proven, effective services that improve long-term health and quality of life.
 - i) Policy should support evidence-based acute care, chronic care management, and primary prevention.
 - C) Publicly funded healthcare needs effective programs targeting vulnerable populations, including ethnic minorities and people with various disabilities, who currently have unequal access to quality care and generate disproportionately high costs.
 - D) Integrated and coordinated care, the process and goal of *managed care*, is an **absolute** requirement to achieve optimal health and support for older adults and persons with chronic illnesses and disabilities. Economies of scale are necessary to be able to provide case management, disease management and implement innovative technologies to monitor and treat patients at home.
 - E) Care should be provided in the least institutional, least expensive environment possible. We need to relieve pressure on safety net providers, such as community clinics and emergency rooms, by funding appropriate care at the appropriate location. This should include creating incentives for health plans, communities, and large physician groups to make urgent care available evenings and weekends outside of the emergency room. In-home technologies, physician extenders, care coordination and policies to support information exchange between organizations are all ways to achieve this cost-effectively.



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II *vAn effective state health program provides patients access to appropriate, high quality care and empowers them to take responsibility for their own health.* The most efficient way to ensure this is to provide each patient with a “medical home” that integrates and coordinates services enabling them to retain their independence and function outside of institutional settings.

A) *Commercially insured Californians have had access to a medical home for 30 years by choosing managed care; over the last decade, many low-income Californians have had similar services through the Medi-Cal managed care programs. Now it is time to provide coordinated care to those publicly insured who do not have a medical home – the largest group of which includes the Medi-Cal aged, blind, and disabled populations and other low-income individuals. (The uninsured will hopefully be covered in future). Other states' experience has shown that mandating managed care for this population could save 15% or more over the current fee-for-service system and the California LAO estimates savings of about \$100 million. Quality and coordination of care, disease management, patient education and preventive care strategies helped bring about these savings.*

i) *The State should create programs and incentives for the integration of Medicare and Medi-Cal managed care for those who are dually eligible, so that savings from innovative preventive care and enhanced supportive services can be realized within a single health plan.*

ii) *Primary prevention is essential for people with and at risk of developing chronic illnesses. Strong, innovative prevention strategies will result in both cost savings and improved quality of life.*

B) *Policies and programs should be reviewed and revised to ensure they create incentives for positive change and avoid unintended negative consequences. One possible and highly desirable such incentive would support managed care providers' ability to establish urgent care services that attract patients who need rapid attention but do not require intensive emergency room care.*

C) *California should lead integration in mental health, dental and physical health, because they interrelate so thoroughly. (For example, depression is a major driver of health care expenditures). Current regulations, which prevent providers from billing for primary care and mental health services on the same day, not only prevent integration of primary care and behavioral health but also discourage preventive and less expensive mental health interventions. Barriers and disincentives to integration of all health-related care should be removed through regulatory change. Coordination of discretionary and entitlement funds and services must be achieved through managed care coordination.*

D) *Information infrastructure is needed to facilitate coordination of care and access at the patient level across the various components of the system. The state should facilitate exchange of information and integrated health records for patients and providers through enabling regulation and active participation in statewide information sharing efforts like Cal-RHIO.*

i) *State dollars should be allocated to support tracking health outcomes and evaluating patient experience to identify cost-effective and high quality/impact services and systems.*

III *California must adopt tactics and programs that have been proven to benefit both patients and providers – from exemplars within and outside our state.*

A) *Publicly funded healthcare systems for populations with long-term debilitating conditions should be based on the chronic and palliative care models, which focus on team-based care, prevention, symptom control, in-home supports, involvement of the family and community, and direct patient engagement and responsibility for decision-making.*



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- B) Because of the deeply engrained history of program fragmentation and politicization of healthcare policy, California needs to appoint and empower a **Health Czar** to drive an *integrated*, cost-effective system for all state-funded beneficiaries, by directing resources toward coordinated community and team-based care.
- i) The position's purpose would be the improvement of publicly funded healthcare in California, with a mandate to extract an annual plan from the Departments of Insurance, Managed Care, Health Care Services, and other relevant departments involved in providing clinical and other services such as In-Home Supportive Services (IHSS) and the Multipurpose Senior Services Program (MSSP). Each department would be charged with setting targets for specific changes and priorities for integration and submitting progress reports.
 - ii) The 'Czar' should assure that all such plans include incentives to reward efficiency and promote innovations such as telehealth/telemedicine, home-based care, programs that build self-care skills, and provision of in-home monitoring equipment and assistive devices as well as other spending that directly benefits patients, including disease management and patient education, and health IT.
 - iii) The 'Czar' should be supported by an independent commission of broadly respected healthcare experts, with a six-month mandate to produce a framework for change within state-level agencies that will spur collaboration, integration, coordination, and innovation across all aspects of state-funded health care and supportive services.

Summary Recommendations for California's FY 2008-09 Budget – and beyond:

1. Maintain Medi-Cal coverage for existing populations to avoid further expansion of the uninsured. Continue the current *annual* Medi-Cal recertification process. Quarterly recertification would create an unwarranted burden on providers as well as the Medi-Cal system.
2. Maintain both medical services and community supports that enable vulnerable beneficiaries to stay at home and out of institutions.
3. Expand Managed Care to all Medi-Cal populations, particularly aged, blind and disabled recipients. Actively promote Medicare/Medi-Cal integration for dually eligible recipients to enhance coordination and capture savings from both systems.
4. Enact cuts only in counties that do not broadly comply with all of the above. Cuts outside of the above recommendations should be made proportionally to meet targets set for the healthcare budget.
5. Allow providers and health plans to share in long-term savings through incentives for excellent care, innovation, and improved patient outcomes and shared allocation of actual savings among providers, health plans and the state.
6. Appoint a 'Health Czar,' supported by an independent panel of healthcare experts, to bring coherence and innovation to current public programs.
7. Maximize federal match as consistent with these principles and other recommendations.

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