

The National Pay for Performance Summit
Beverly Hills Room, Hyatt Regency Century Plaza Hotel,
Los Angeles, California
Monday, 6 February 2006, 1:15p - 2:00p

Financial Incentives and Quality Improvement

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W. Edwards Deming

Organize everything around
value-added *(front line)* **work processes**

(Quality improvement is the science of process management)

Three classes of outcomes

- ▶ **Physical outcomes** (*traditional medical "quality"*)
 - medical outcomes: complications and therapeutic goals
 - includes functional status measures (patient perceptions of medical outcomes)
- ▶ **Service outcomes**
 - satisfaction: patients and families, communities, professionals, purchasers, and employees
 - includes access issues (e.g., waiting times)
- ▶ **Cost outcomes**
 - just another outcome of a clinical process
 - includes the cost of the burden of disease

Quality controls cost

More accurately,

*Quality and cost are two sides of
the same coin ...*

*anything you do to one affects
the other*

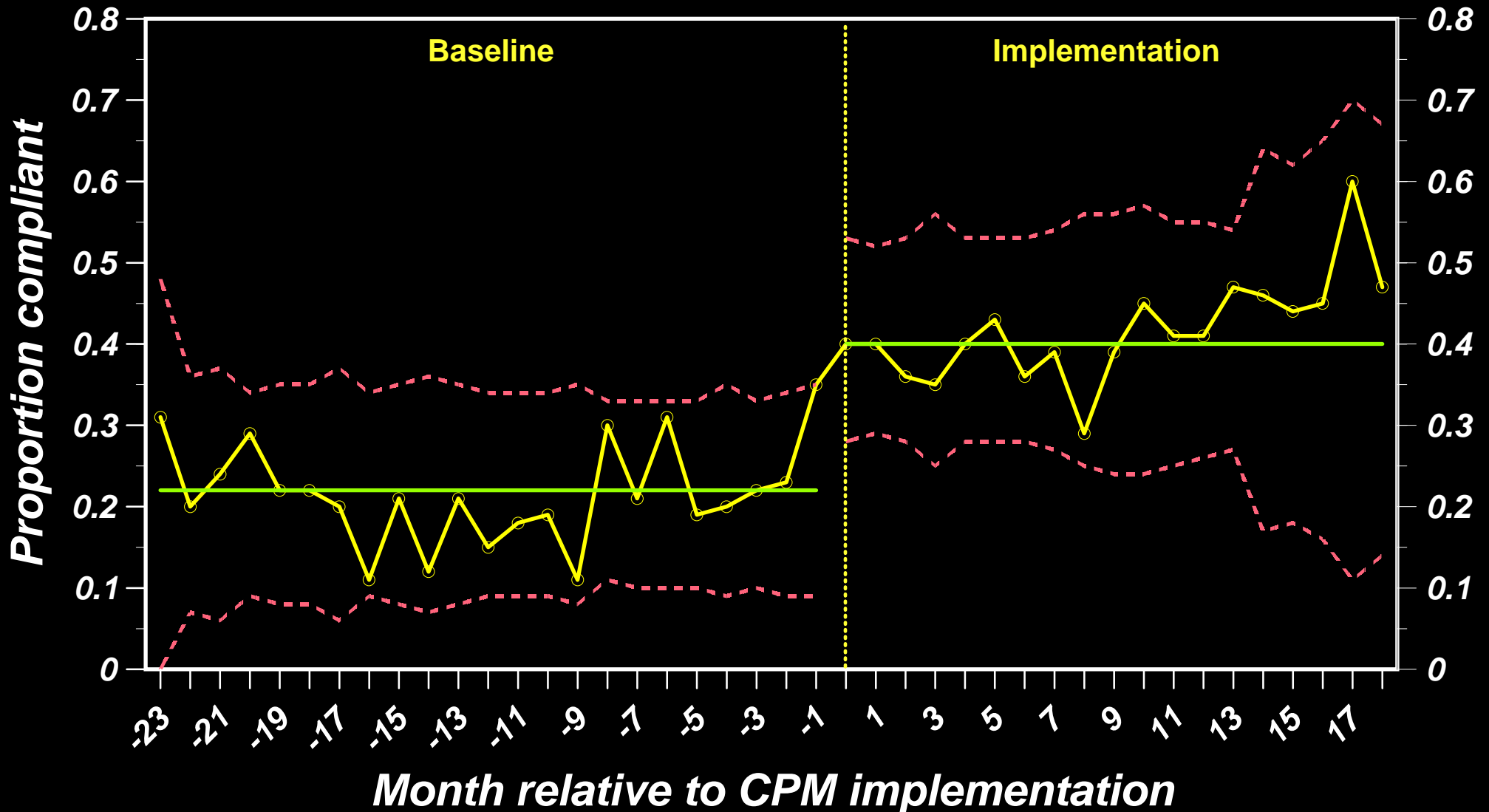
(similarly, cost controls access)

Quality controls cost

	<u>Quality</u>	<u>Cost</u>	<u>Forum</u>	<u>Potential Savings</u>
Waste:				
<i>Quality waste</i>	↑	↓	<i>internal</i>	<i>25-40%</i>
<i>Inefficiency waste</i>	-	↓	<i>internal</i>	<i>> 50%</i>
Cost-benefit	↑	↑	<i>society</i>	<i>(none)</i>

CAP protocol compliance

Implementation Group -- Loose Abx Compliance



Community acquired pneumonia

	<u>without protocol</u>	<u>with protocol</u>	
"Outlier" (complication) DRG at discharge	15.3%	11.6%	↓ 24.7% p<0.001
In-hospital mortality	7.2%	5.3%	↓ 26.3% p=0.015
Relative resource units (RRUs) per case	55.9	49.0	↓ 12.3% p<0.001
Cost per case	\$5211	\$4729	↓ 9.3% p=0.002

CAP - cost versus reimbursement



Impact on net income

Improvement to cost structure	Payment mechanism			
	Discounted FFS	Per case	Per diem	Shared risk
Decrease cost per unit	↑	↑	↑	↑
Decrease # units per case				
Decrease other units per case	↓	↑	↑	↑
Decrease LOS (# nursing hours)	↓	↑	↓	↑
Decrease # of cases	↓	↓	↓	↑
	(45%)	(40%)	(0%)	(15%)

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Strategies to harvest quality savings

1. *Target specific improvement projects*

- ◆ *project likely medical and cost improvements*
- ◆ *track to final budgets*
- ◆ *select projects with internal savings*

2. *Use in contract negotiations*

- ◆ *e.g., demonstrate that clinical improvement has produced a superior total cost compared to competitors, even with a lower fee-for-service discount*
- ◆ *always looks worse within current budget cycle, but savings appear in subsequent cycles*

3. *Partner with purchasers: "shared risk" contracts*

All of these strategies require sophisticated cost and clinical outcome information

Operationalizing QI savings

- ◆ **Put a finance person on every improvement team**
 - *predict work process changes;*
 - *play through payer mix*
 - *into existing expense and income budgets.*
- ◆ **Market clinical quality (medical outcomes)**
 - *service quality drives market share;*
 - *think branding strategies;*
 - *create patient-level demand for access, then*
- ◆ **Use quality results in commercial contracting**
(*shared savings*)
- ◆ **Medicare / Medicaid ???**

Pay for performance methods

Quality premiums:

- ◆ **Condition specific**
- ◆ **extra payments** (usually a percentage)
- ◆ **quality targets** (intermediate [process] and final medical or service outcomes, often in comparison to competing groups)

Shared savings:

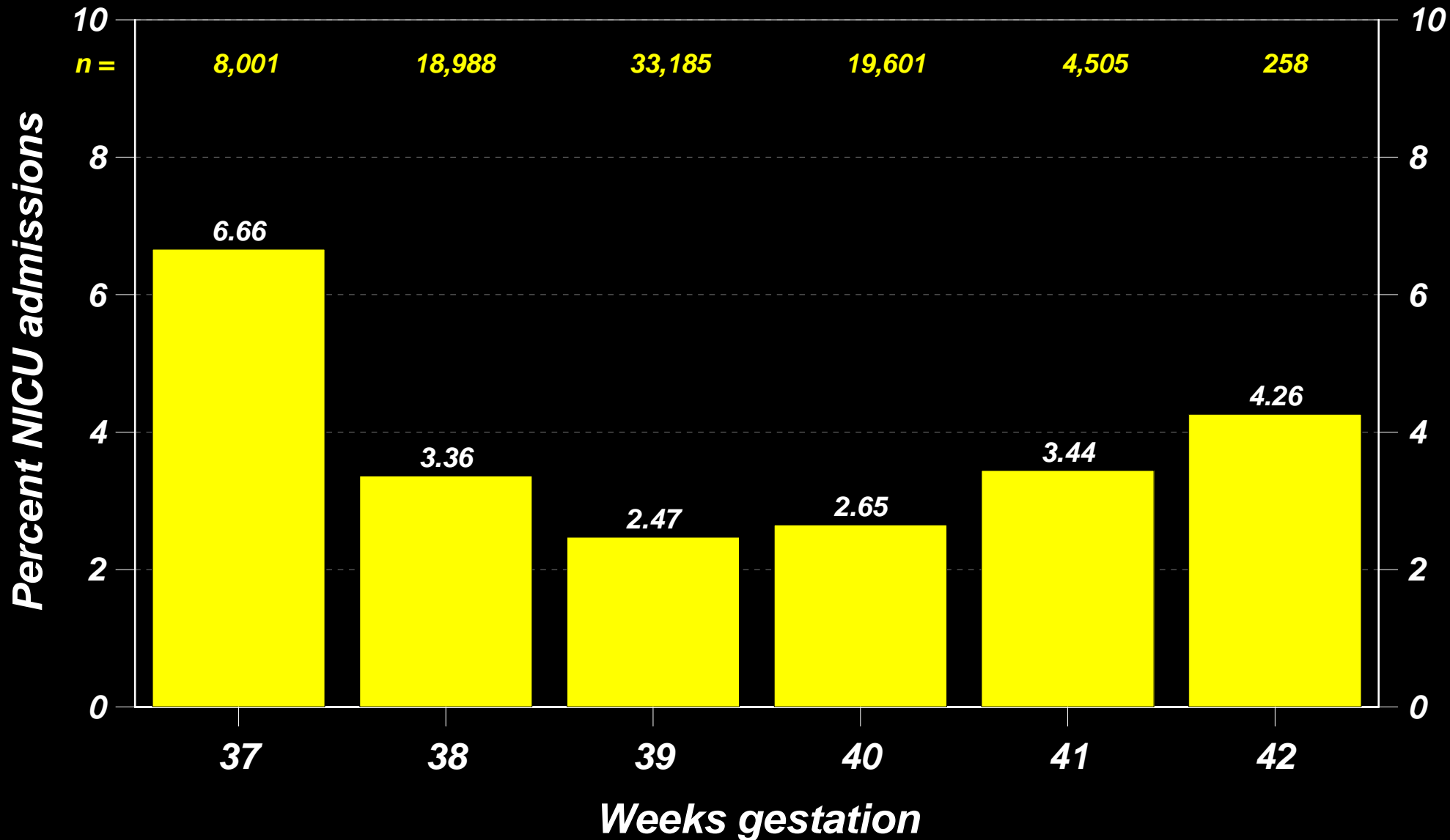
- ◆ **Condition specific**
- ◆ **separate quality performance thresholds**
- ◆ **cost comparison group** (national? local? your own history?)

Issues:

- ◆ **cost and quality data systems** (often presently don't exist)
- ◆ **full versus partial process view** (suboptimization)
- ◆ **lead times for savings** (who makes up-front investment?
who reaps final savings?)

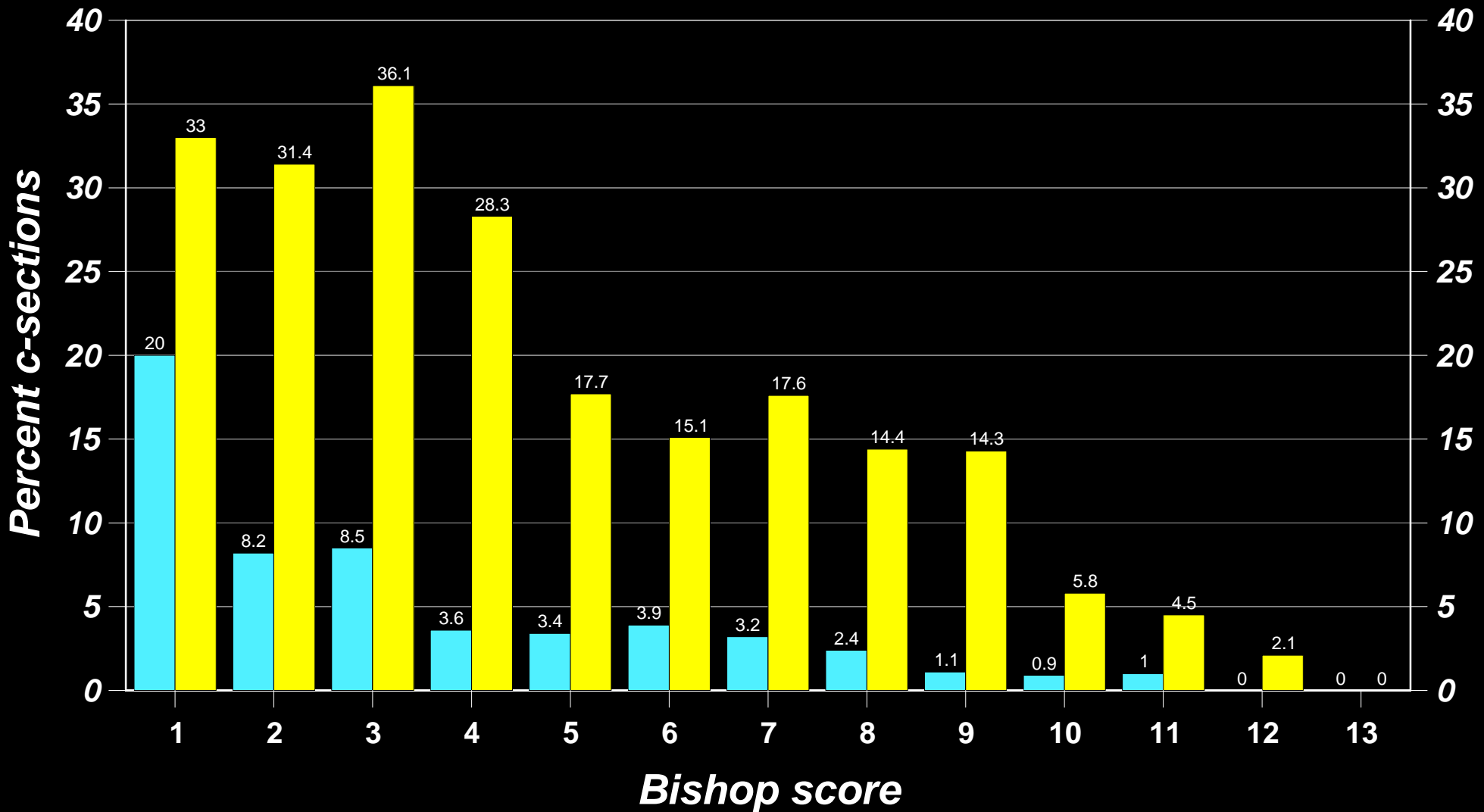
NICU admits by weeks gestation

Deliveries w/o Complications, 2002 - 2003



Unplanned c-section rates

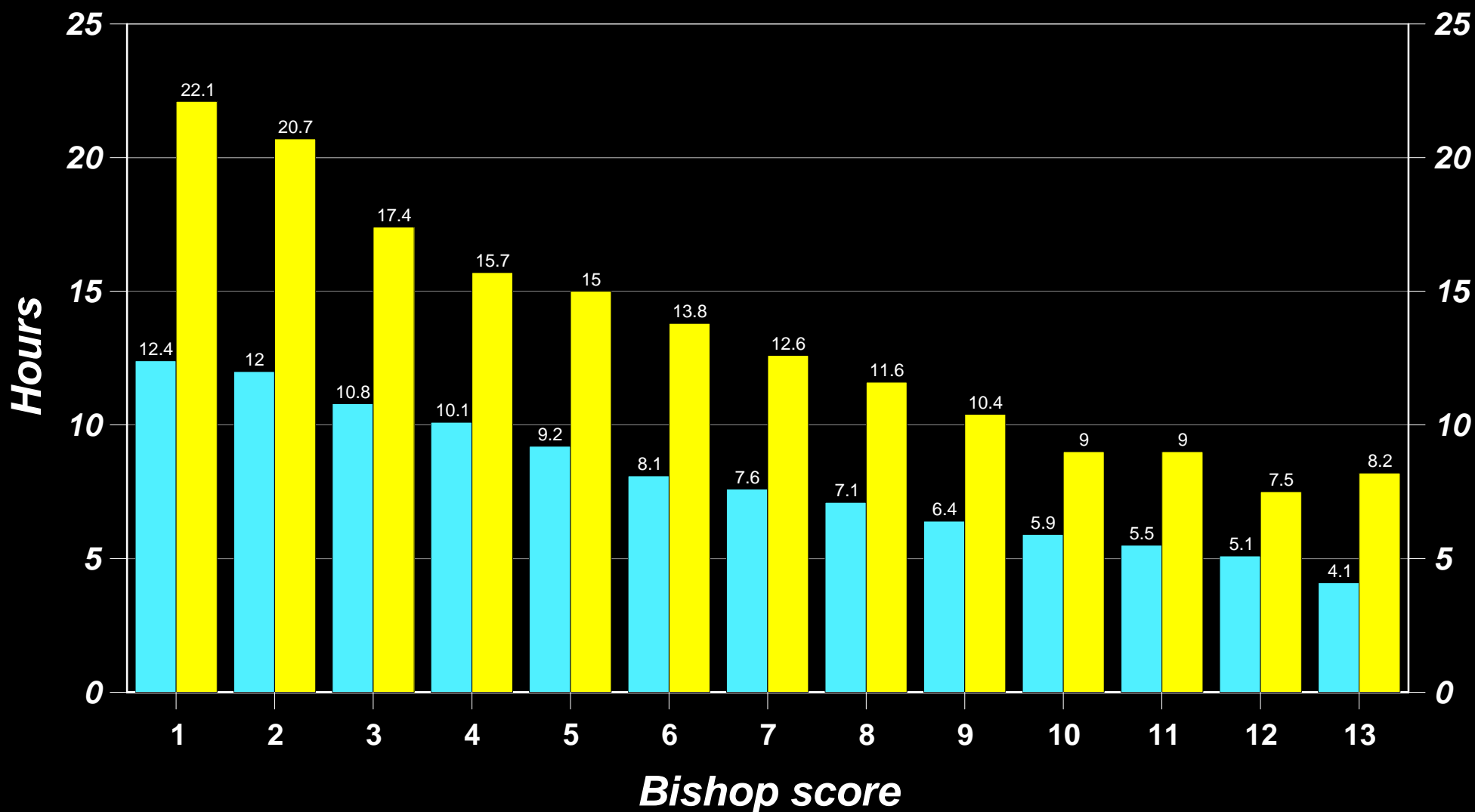
Electively induced patients by Bishop score, Jan 2002 - Aug 2003



<u>n</u>													
<i>Multips</i>	10	49	130	274	567	856	1114	1266	1062	737	415	86	19
<i>Primips</i>	18	35	61	99	164	278	375	487	453	346	179	47	7

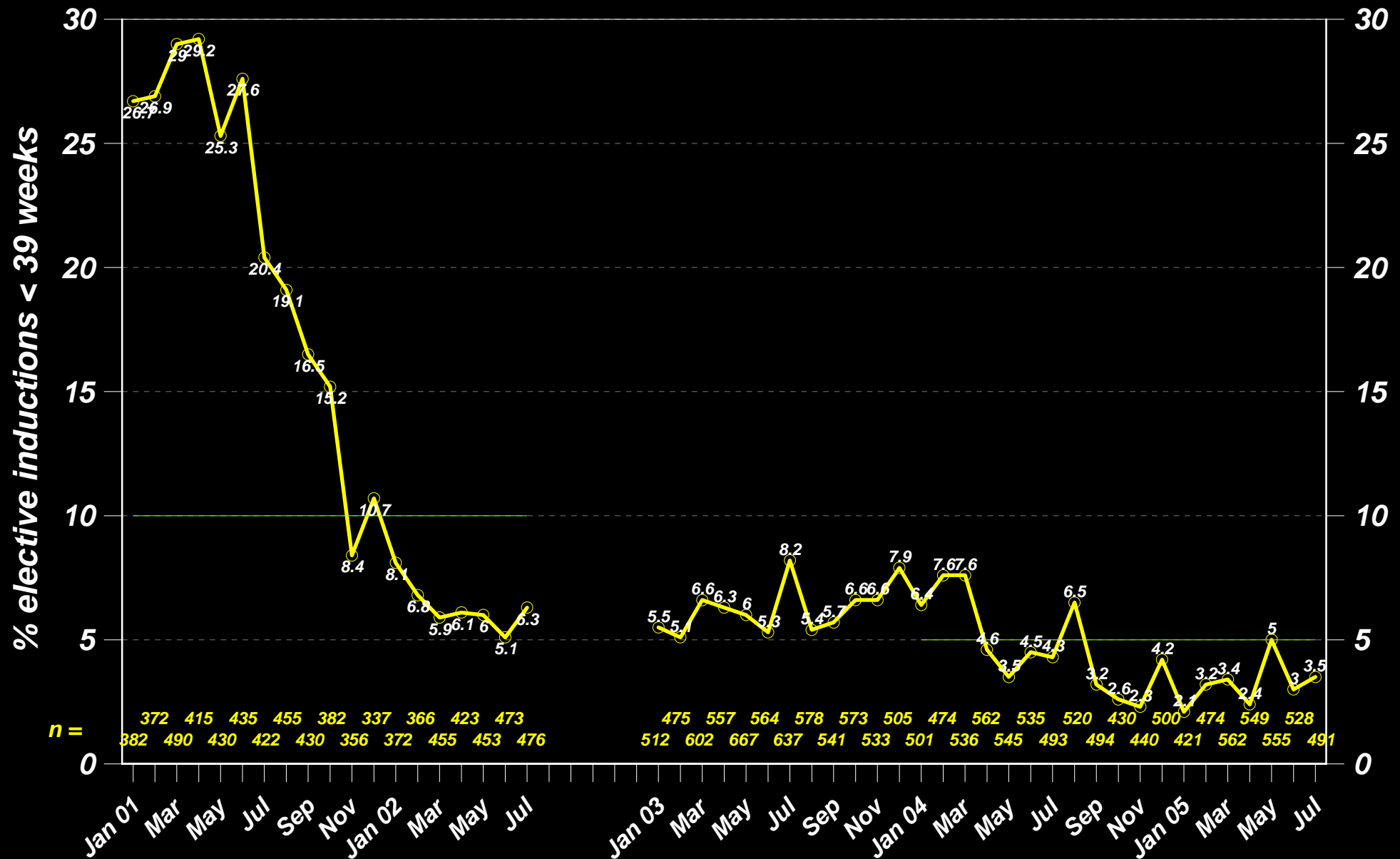
Average hours in labor & delivery

Electively induced patients by Bishop score, Jan 2002 - Aug 2003

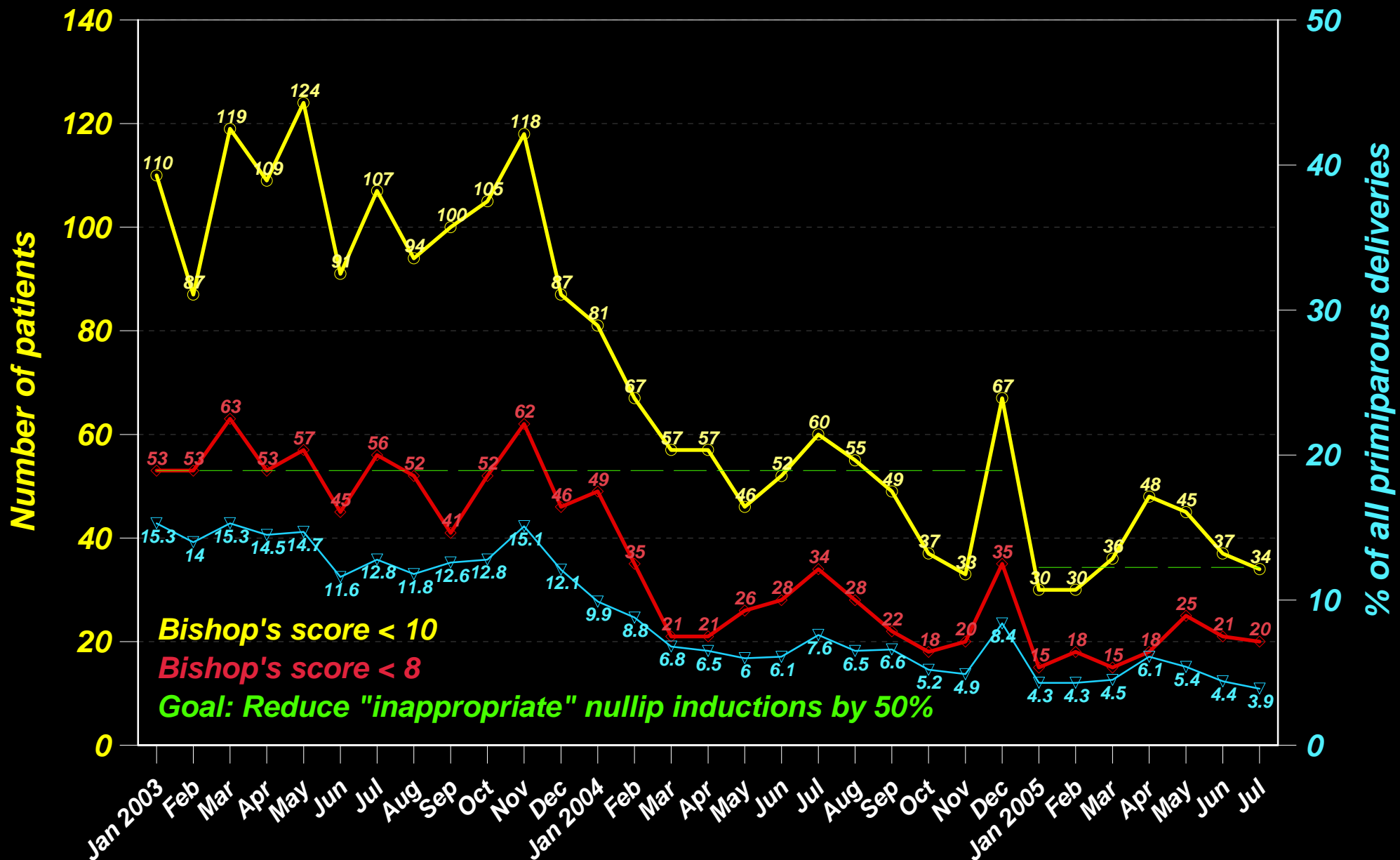


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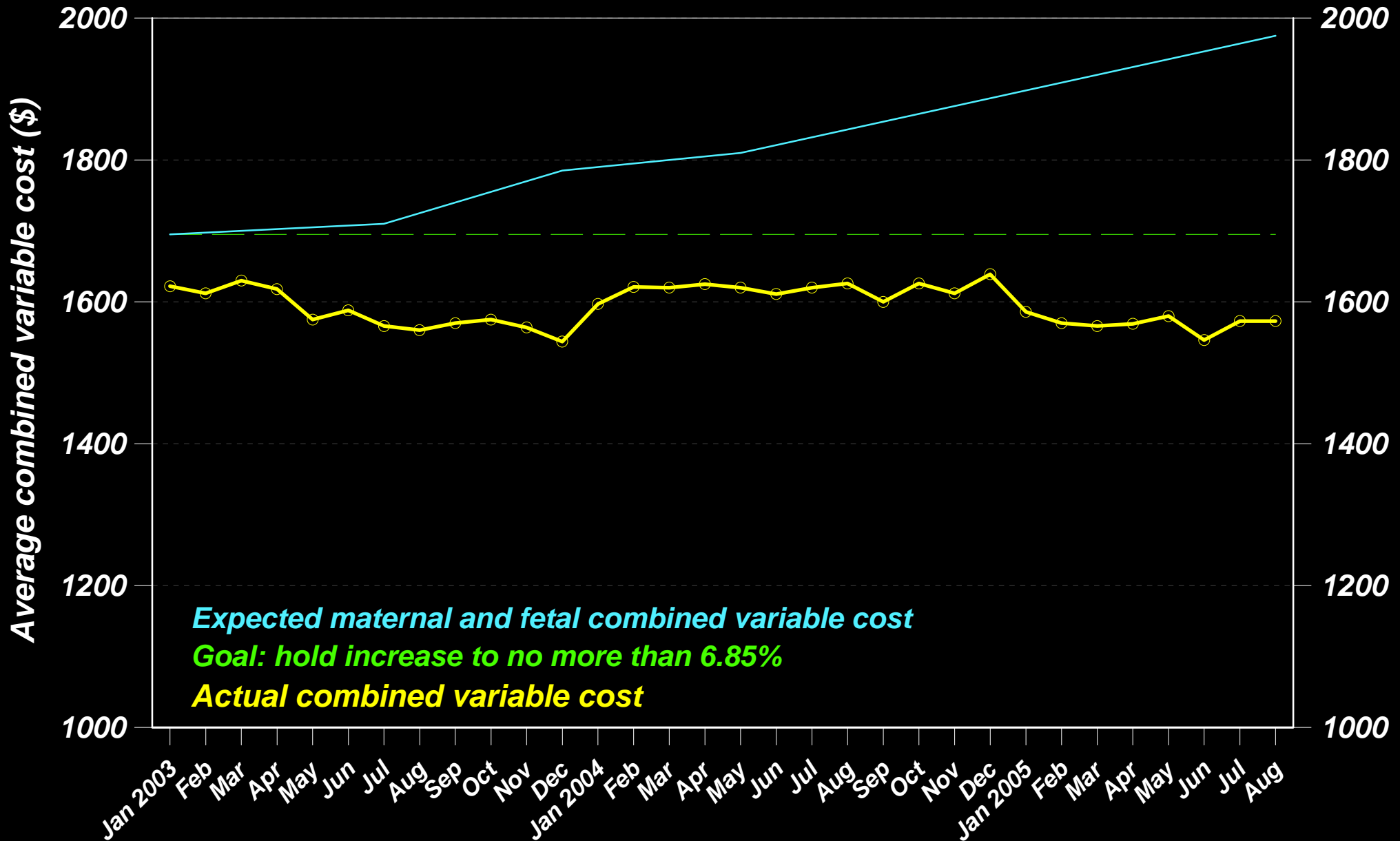
Elective inductions < 39 weeks



Primiparous elective inductions



Labor & delivery variable cost



Quality-based cost improvement

Combined maternal and neonatal variable cost

Deliveries without complications resulting in normal newborns
Actual - expected cost, based on year-end 2000 with PPI inflation

