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 <u>everything</u> 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 ...

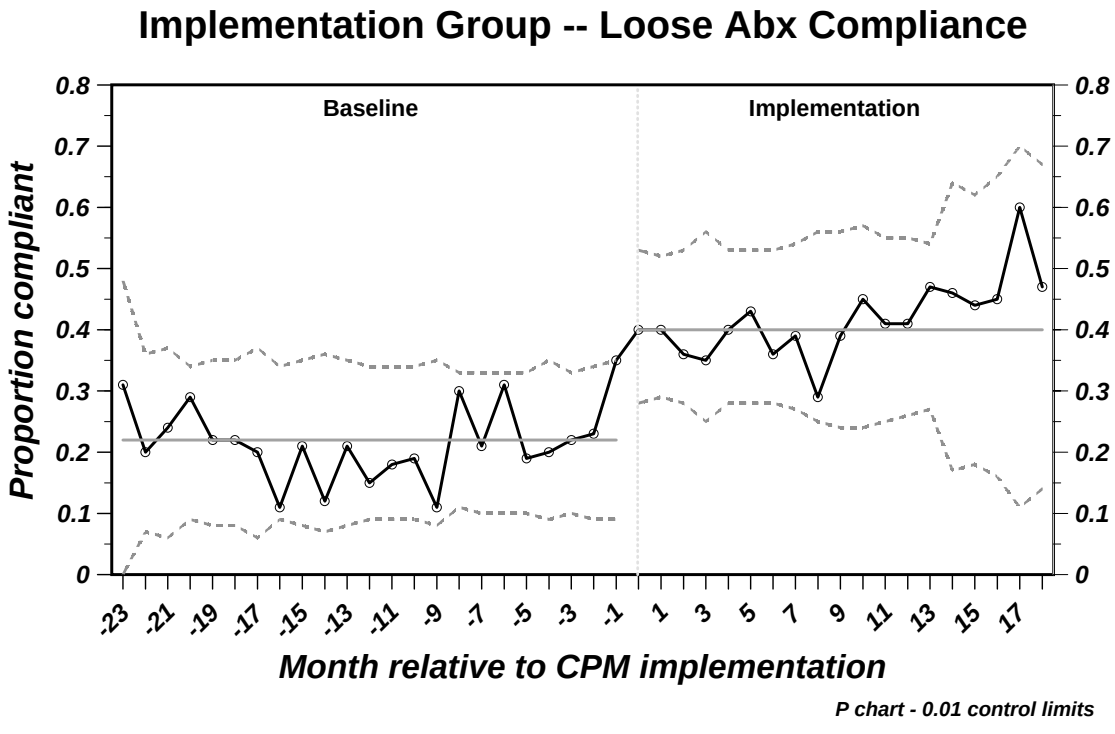
anything you do to one affects the other

(similarly, cost controls access)

Quality controls cost

	Quality	Cost	Forum	Potential Savings
Waste:				
Quality waste	↑	↓	***internal***	***25-40%***
Inefficiency waste	–	↓	***internal***	***> 50%***
Cost-benefit	↑	↑	***society***	***(none)***

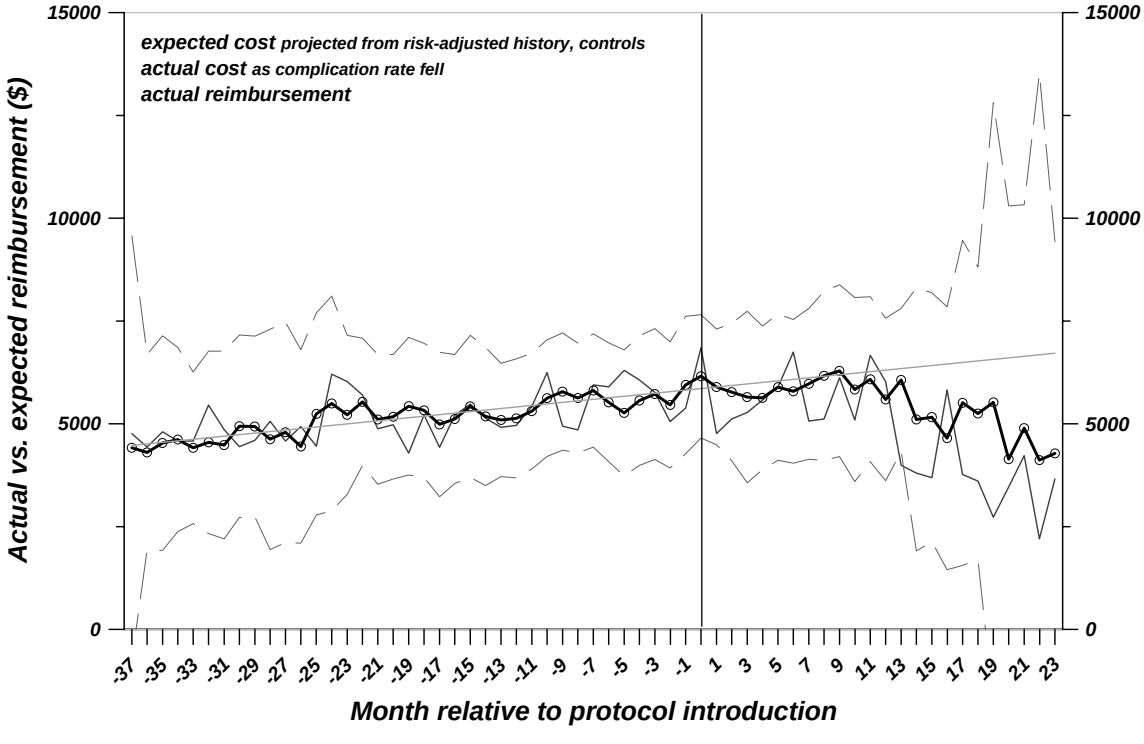
CAP protocol compliance



Community acquired pneumonia

	without protocol	with protocol	
"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 commerical 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)***

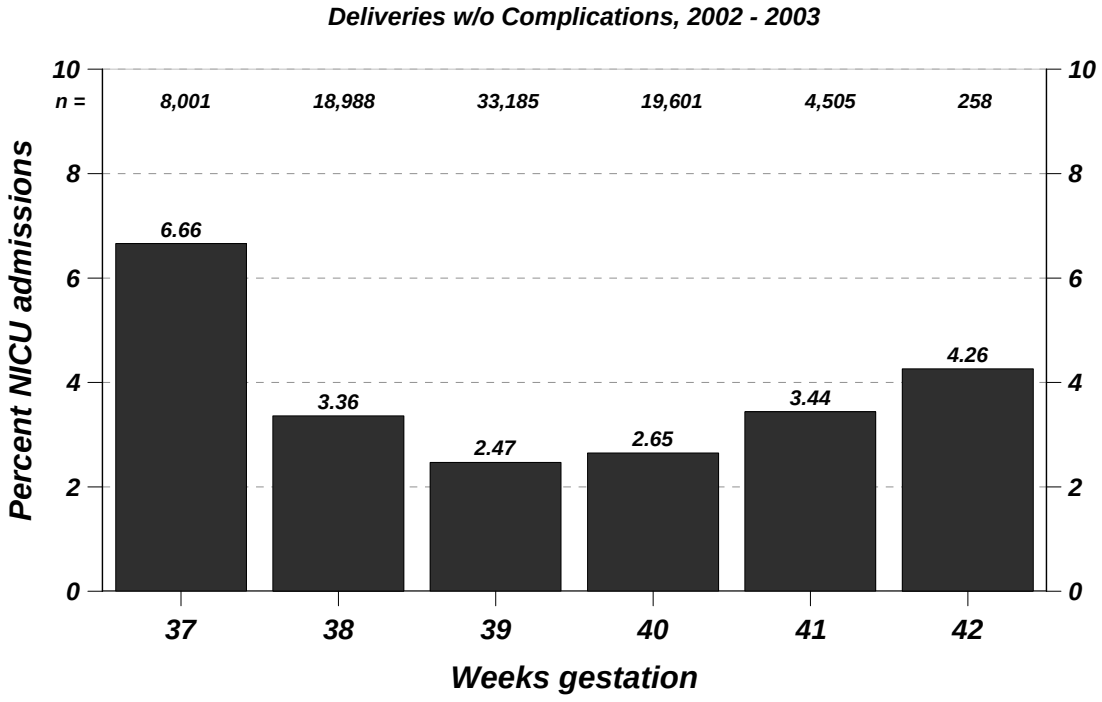
Shared savings:

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

Issues:

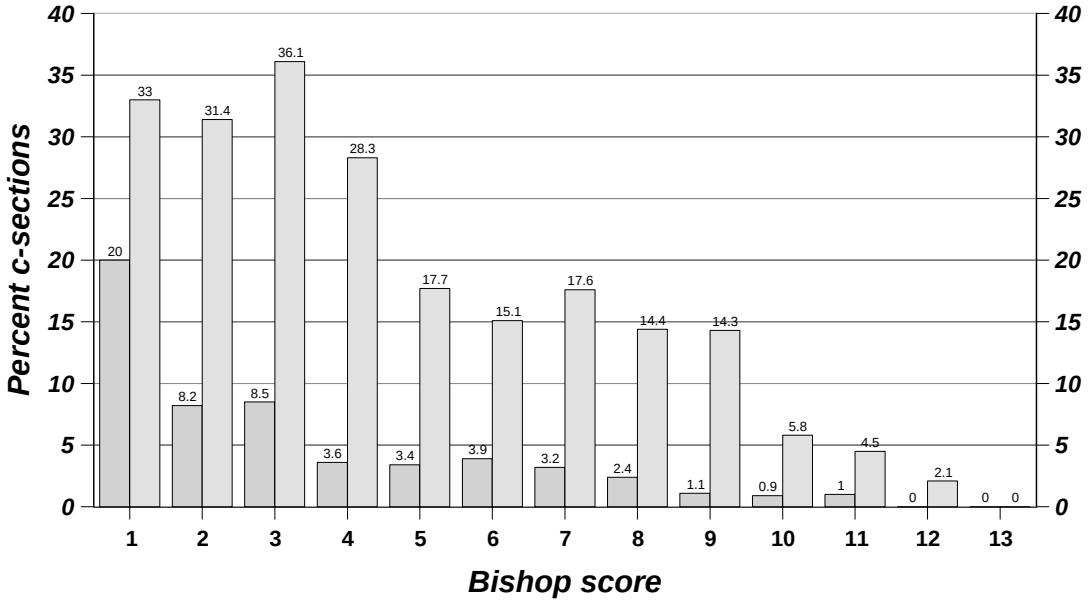
- ***cost and quality data systems*** ***(often presently don't exist)***
- ***full versus partial process view*** ***(suboptimization)***
- ***lead times for savings*** ***(who makes up-front investment? who reaps final savings?)***

NICU admits by weeks gestation



Unplanned c-section rates

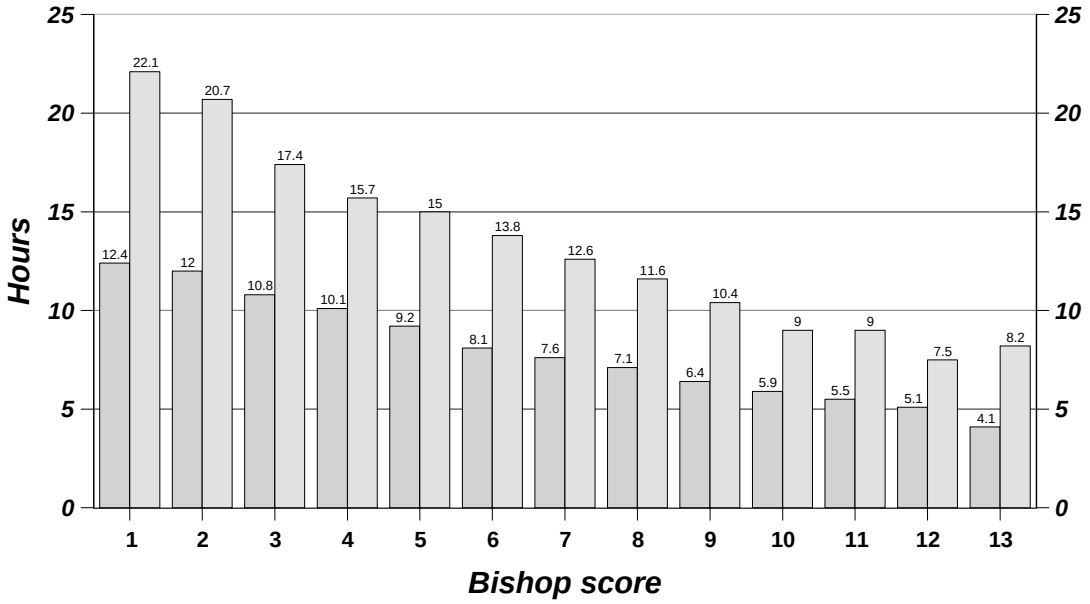
Electively induced patients by Bishop score, Jan 2002 - Aug 2003



n												
Multips	10	49	130	274	567	856	1114	1266	1062	737	415	86	19
Primips	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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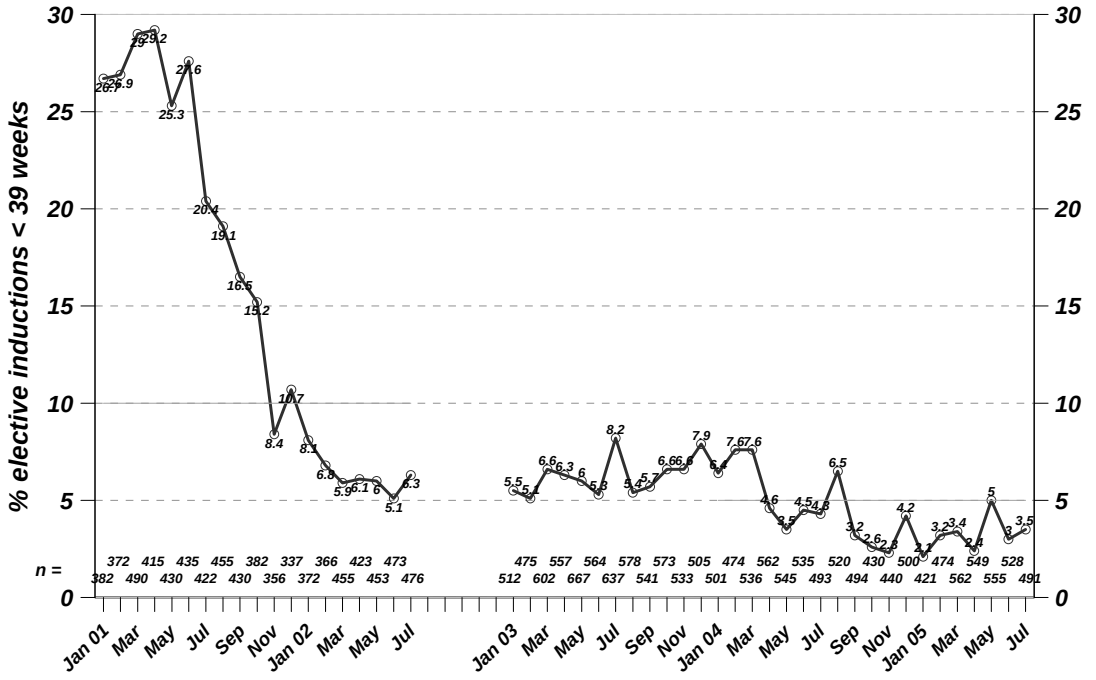
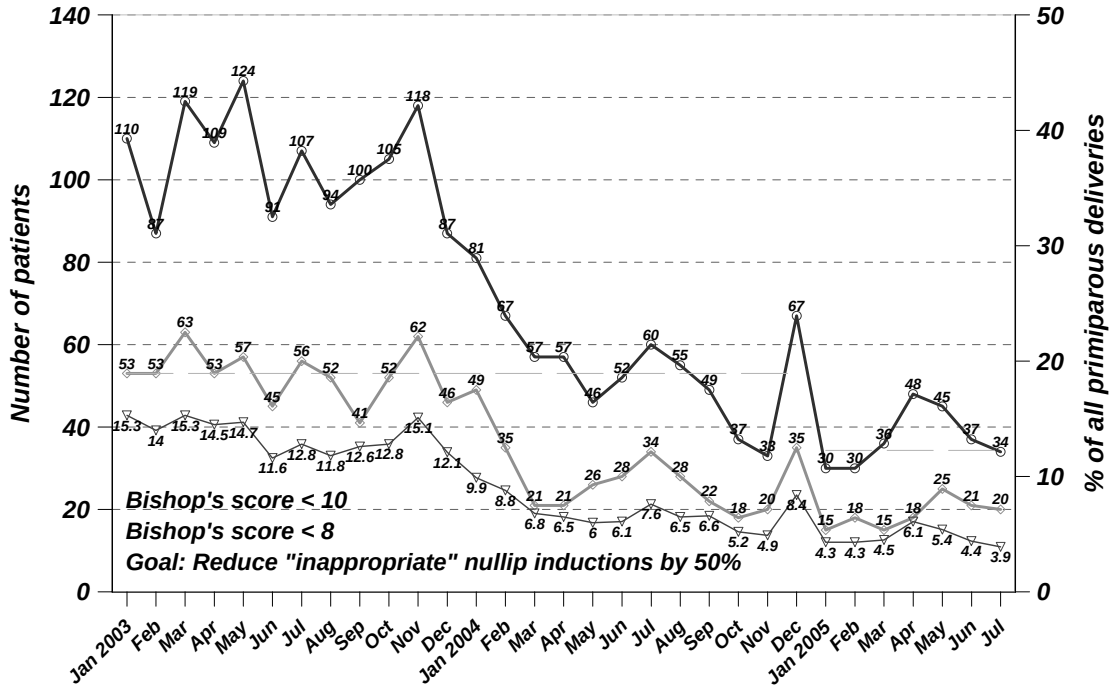
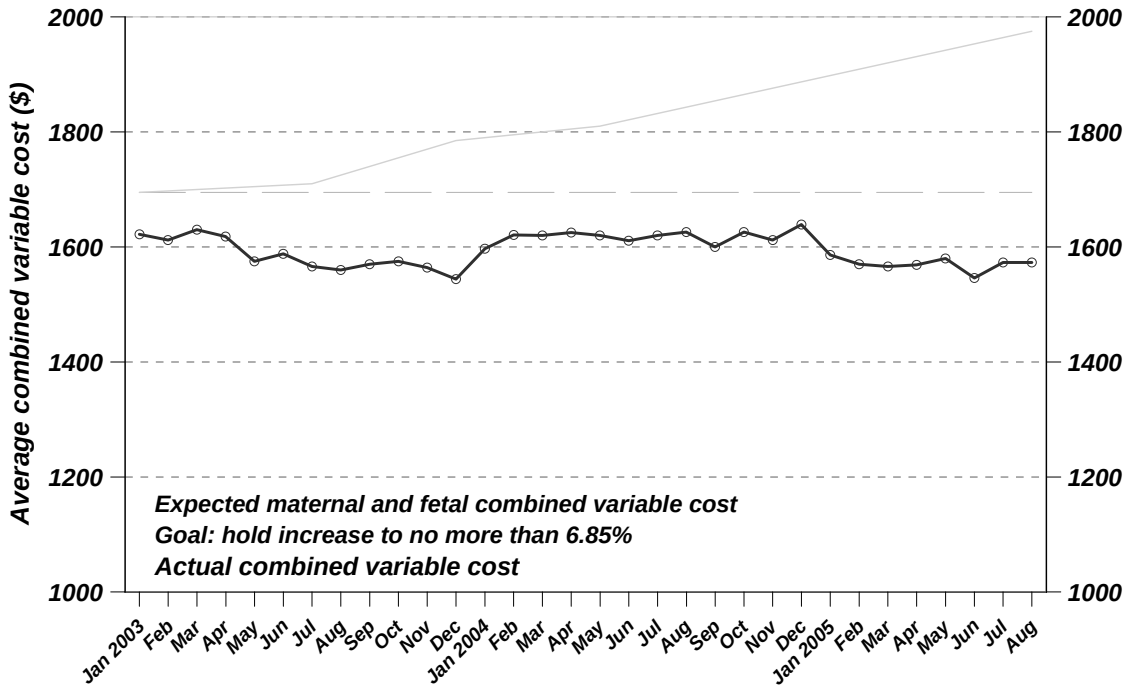
Elective inductions < 39 weeks



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