The Sixth National
Pay for Performance Summit
Hyatt Regency Hotel, 5 Embarcadero Center, San Francisco, California
Wednesday, 23 March 2011 -- 5:45p - 6:30p

Quality: An Imperative for (Financial) Survival

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Disclosures

The content of this presentation does not relate to any product of a commercial entity; therefore, I have no ethical conflicts or relationships to report. I have no financial relationships beyond my employment at Intermountain Healthcare.

Outline

1. ***A rapidly developing financial crisis***
2. ***Opportunity: health care delivery falls short of its theoretic potential***
3. ***We know why: the collision of 2 factors***
4. ***We have found proven solutions*** *(with examples)*
5. ***Improve value, fail financially*** *(perverse payment)*
6. ***Bending the cost curve*** *- aligning financial incentives*

1. The roots of reform

- *46 million people without health insurance*
- *cost increases that are bankrupting the country*

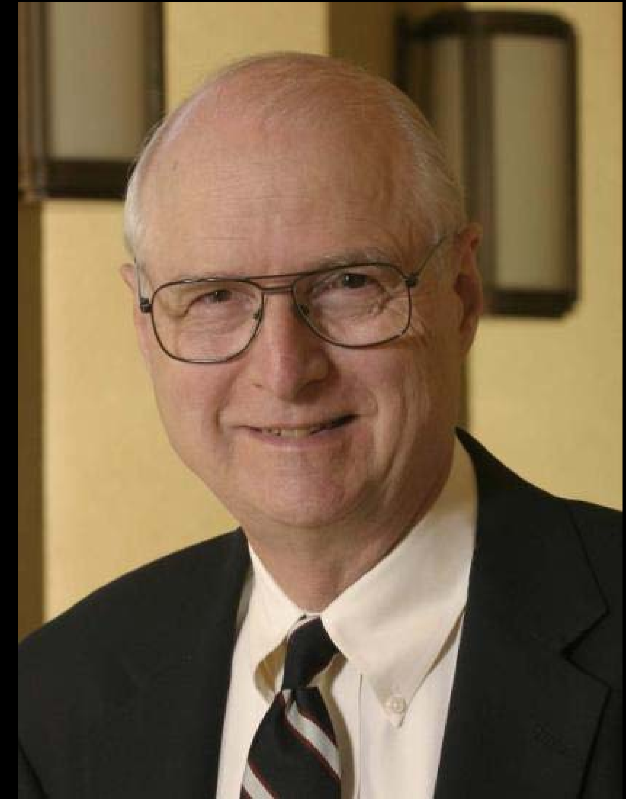
The uninsured - who are they?

◆ ***Noncitizens*** *(explicity excluded)*	***9.5 million***	*(~20.7%)*
◆ ***Eligible but not enrolled***	***12 million***	*(~26.1%)*
◆ ***Temporarily uninsured*** *(job change)*	***9 million***	*(~19.6%)*
◆ ***Free riders*** *(income > $84,000)*	***7 million***	*(~15.2%)*
◆ ***Long-term uninsured*** *(real benefit)*	***8 million***	*(~17.4%)*

Source: Rep. Lamar Smith, "If Uncle Sam Becomes Your Doctor," Christian Science Monitor, 12Aug09, p9

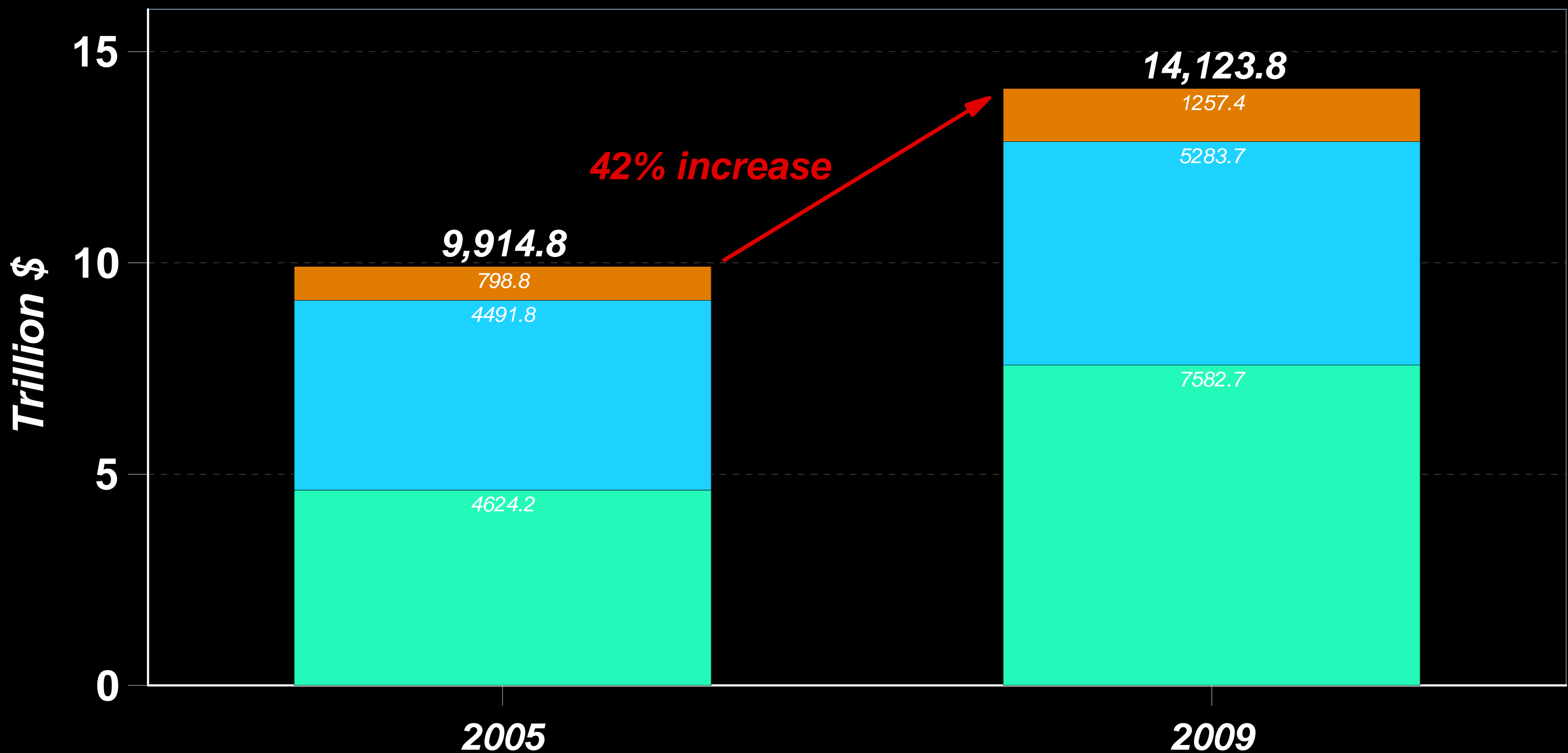
Reform, Part Deux

"The United States does not have decades to wait for health system reform; in 2009 about $1.15 trillion of the federal budget was spent on health care. And health care expenditures are growing 2.7% per year faster than non-health care gross domestic product. [The current] reform bill does practically nothing to slow health expenditures."



Alain Enthoven, PhD
Stanford University

The "official" U.S. national debt

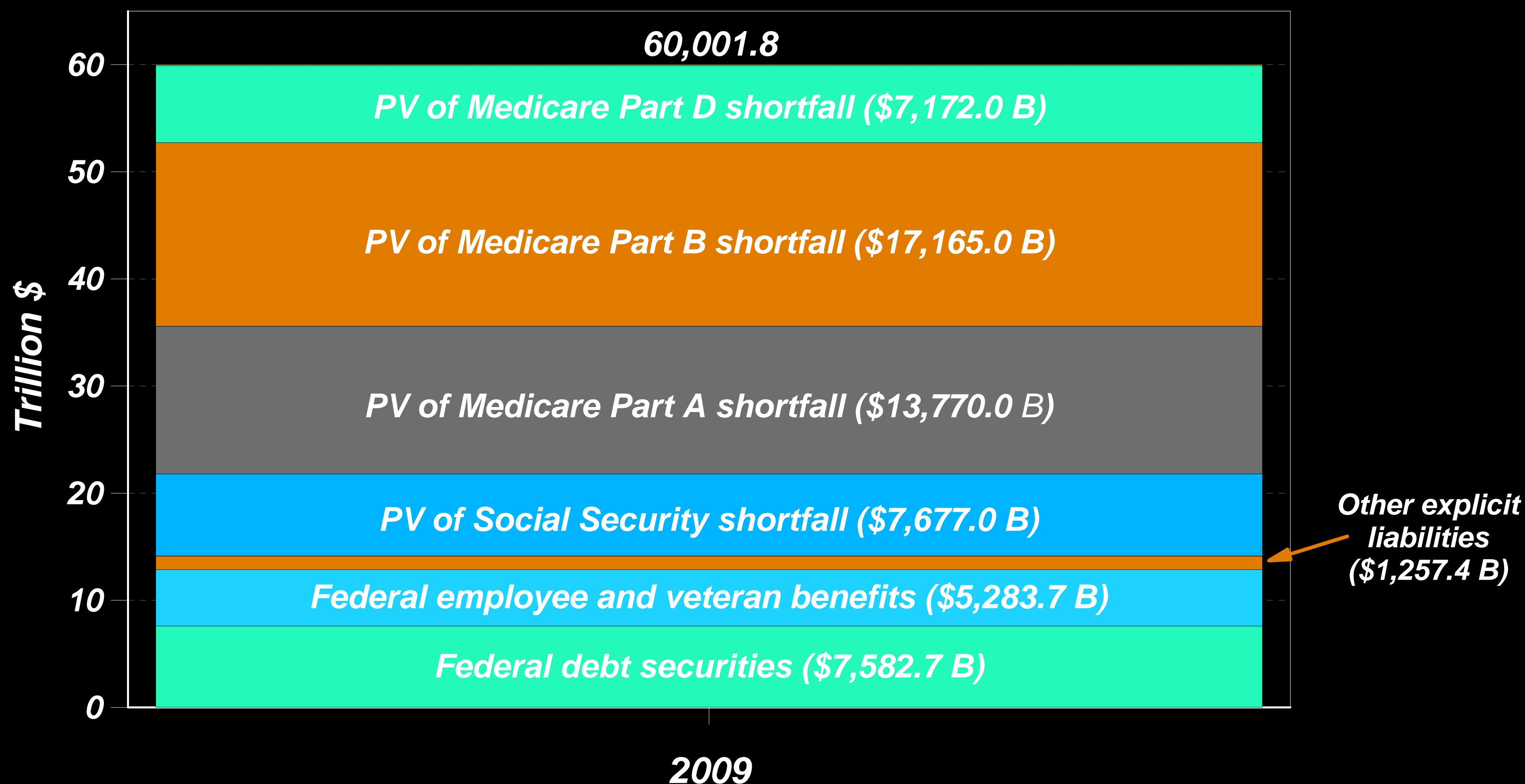


Over $45,000 for every man, woman and child in the U.S.

Source: GAO. Financial Reports of the United States Government for the Years Ended September 30, 2009 and 2008.

Total U.S. fiscal exposures

By layering on future obligations, the total net prevent value (PV) of debt rises to over $60 trillion -- about $195,000 for every man, woman and child in the U.S. More than two-thirds of the shortfall arises from health care delivery.)



Source: GAO. Financial Reports of the United States Government for the Years Ended September 30, 2009 and 2008.

Balancing the Medicare books

"The long-range financial imbalance could be addressed in several different ways... these changes would require an immediate 134 percent increase in the tax rate or an immediate 53 percent reduction in expenditures."

Medicare Board of Trustees; *The 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 12, 2009

Balancing the Medicare books

“The long-range financial im...
addressed in sever...
changes w... nt
in...

The reform bill – with its combination of additional taxes
and reduced payments – is preliminarily estimated
to accomplish about 1/4th of this change, assuming that
the payment reductions embedded in the bill go into effect.
The Medicare Board will report in more detail later this year.

...edicare Board of Trustees; *The 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 12, 2009

ACA will impact State budgets

1. ***Massive increases in Medicaid rolls*** *(main mechanism by which ACA covers the presently uninsured; Feds cover all costs for the first 2 years, then shifts back to present division with Utah paying ~30%)*

2. ***Funds currently going to safety net and charitable care free up, but ...***

3. ***Care utilization rates for the "newly insured" typically run about twice normal rates***

4. ***State citizens will bear additional federal burdens*** *(insurance mandates, higher federal taxes = less available States taxes)*

5. ***Cost shifting from federal health care increases*** *(CMS currently pays 82% of the true cost of inpatient Medicare in Utah; shortfall likely to increase signficantly in face of federal financial pressures)*

The next step:

Health care reform,

as opposed to the

health insurance reform

that just passed (PPACA).

2. The opportunity *(care falls short of its theoretic potential)*

1. ***Well-documented, massive, variation in practices*** *(beyond the level where it is even remotely possible that all patients are receiving good care)*

2. ***High rates of inappropriate care*** *(2 - 32% of all care delivered, depending on specific condition examined)*

3. ***Unacceptable rates of preventable care-associated patient injury and death***

4. ***A striking inability to "do what we know works"***

5. ***Huge amounts of waste*** *(>50%, by best recent measures)*, ***spiraling prices, and limited access*** *(46.6 million uninsured Americans, increasing rates of under-insured, employers exiting the insurance market, medical tourism)*

3. Why? The collision of 2 forces:

(1) ***Continued reliance on the "craft of medicine"***

(clinicians as stand-alone experts)

runs up against

(2) ***Clinical uncertainty***

in the context of

(3) ***Payment that encourages utilization***

The craft of medicine *(each physician an expert)*

An individual physician

- ***placing her patient's health care needs before any other end or goal,***
- ***drawing on extensive clinical knowledge gained through formal education and experience***

Can craft

- ***a unique diagnostic and treatment regimen customized for that particular patient.***

Medicine's promise:

This approach will produce the best result possible for each patient.

Clinical uncertainty *(a hundred years of science)*

1. ***Lack of valid clinical knowledge*** ***regarding best treatment***
   (poor evidence)
2. ***Exponentially increasing new medical knowledge***
   (doubling time has decreased to ~8 years; at current rates, a clinician will need to learn, unlearn, then relearn half of their medical knowledge base 5 times during a typical career)
3. ***Continued reliance on subjective judgment*** *(subjective recall is dominated by anecdotes, and notoriously poor when estimating results across groups or over time)*
4. ***Limitations of the expert mind when making complex decisions***
   Miller, 1956: The magic number 7, plus or minus 2: some limits on our capacity for processing information
   Eddy: "The complexity of modern medicine exceeds the capacity of the unaided human mind"

Which, combined with the craft of medicine, leads to:

- *Enthusiam for unproven methods …* *Mark Chassin, MD*
- *The maxim, "If it might work, try it" …* *David Eddy, MD, PhD*
- *Quality means "spare no expense" …* *Brent James, MD, MStat*

4. We have found proven solutions

Shared baselines *(a form of Lean Production)* **-**
A multidisciplinary team of health professionals:

1. ***Select a high priority care process***
2. ***Generate an evidence-based "best practice" guideline***
3. ***Blend the guideline into the flow of clinical work***
   - *staffing*
   - *training*
   - *supplies*
   - *physical layout*
   - *educational materials*
   - *measurement / information flow*
4. ***Use the guideline as a shared baseline, with clinicians free to vary based on individual patient needs***
5. ***Measure, learn from, and (over time) eliminate variation arising from professionals; retain variation arising from patients*** *("mass customization")*

Practical limitations on protocol use

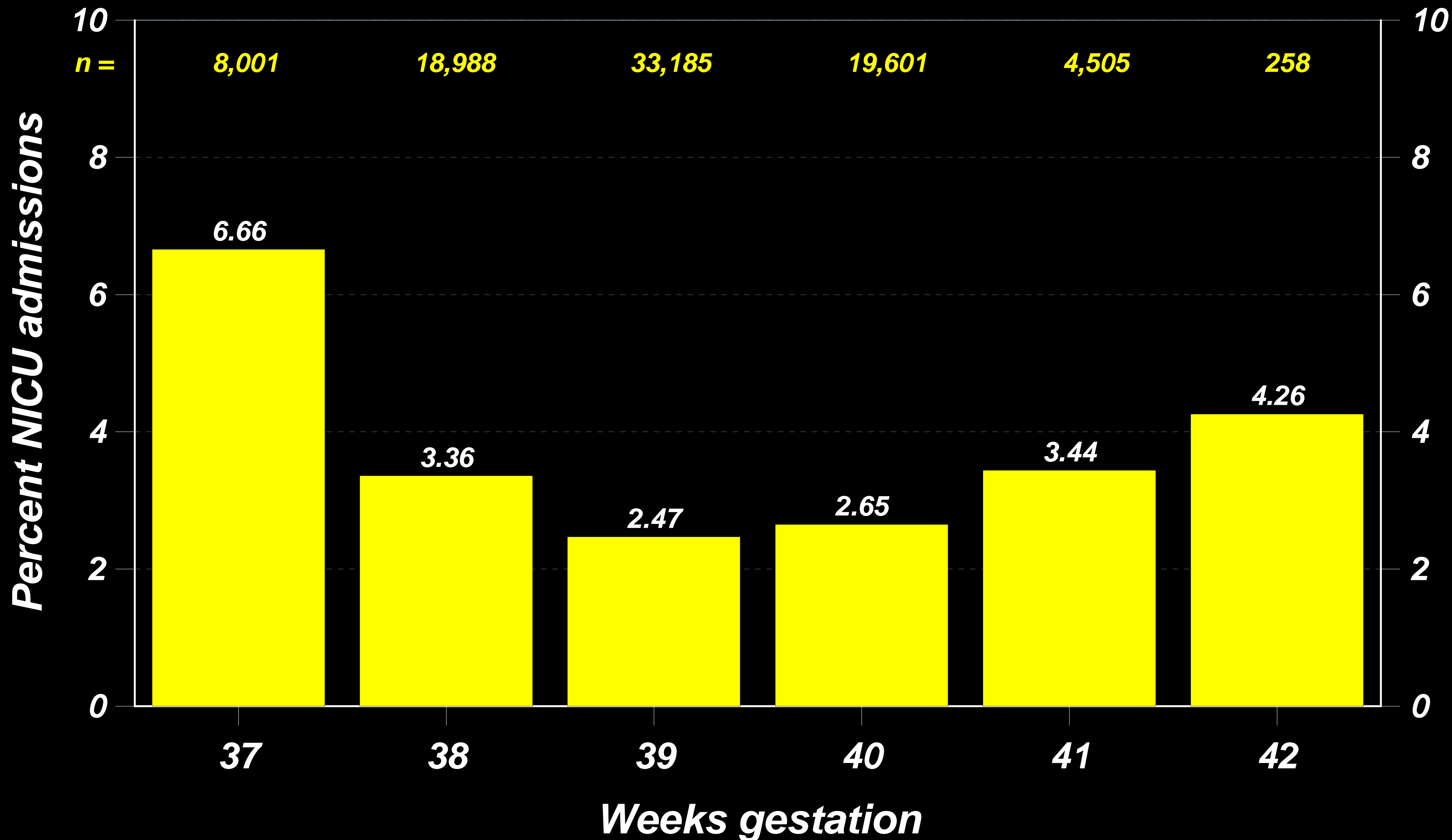
When abstract guidelines hit real patient care, experience clearly shows that (with very rare exception)

No protocol fits every patient;

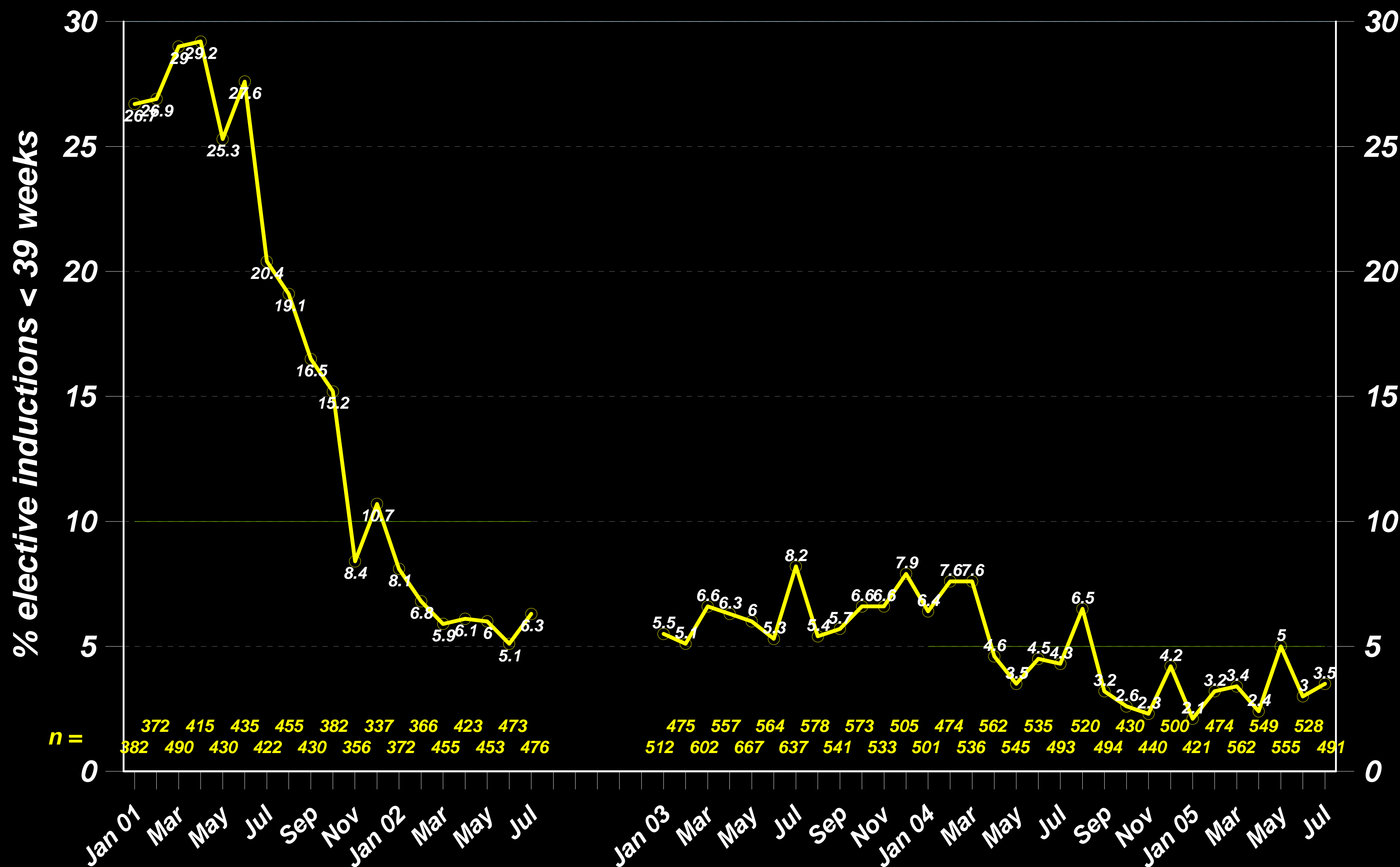
more important,

No protocol (perfectly) fits any patient.

NICU admits by weeks gestation

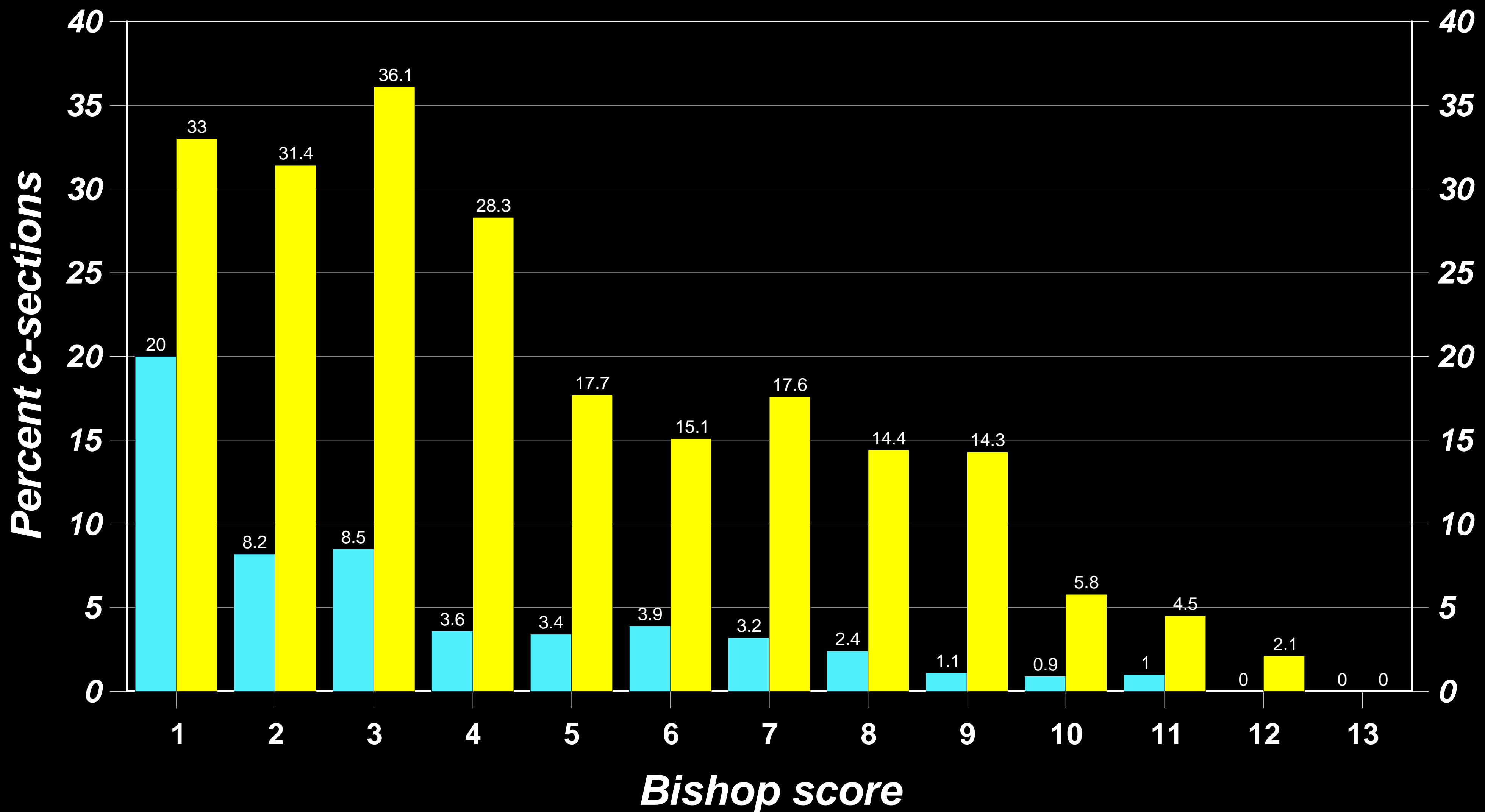


Elective inductions < 39 weeks



Unplanned c-section rates

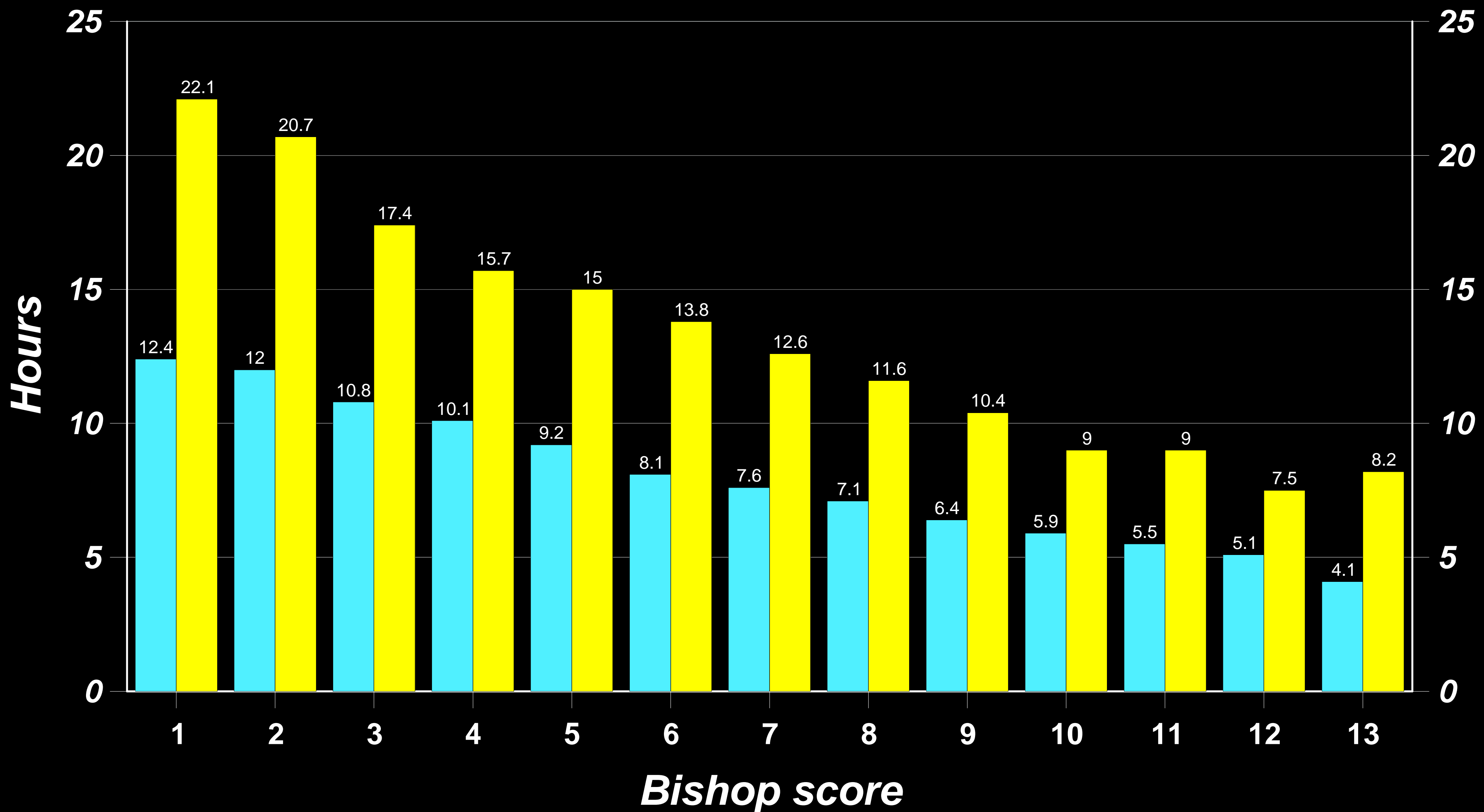
Electively induced patients by Bishop score, Jan 2002 - Aug 2003



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*

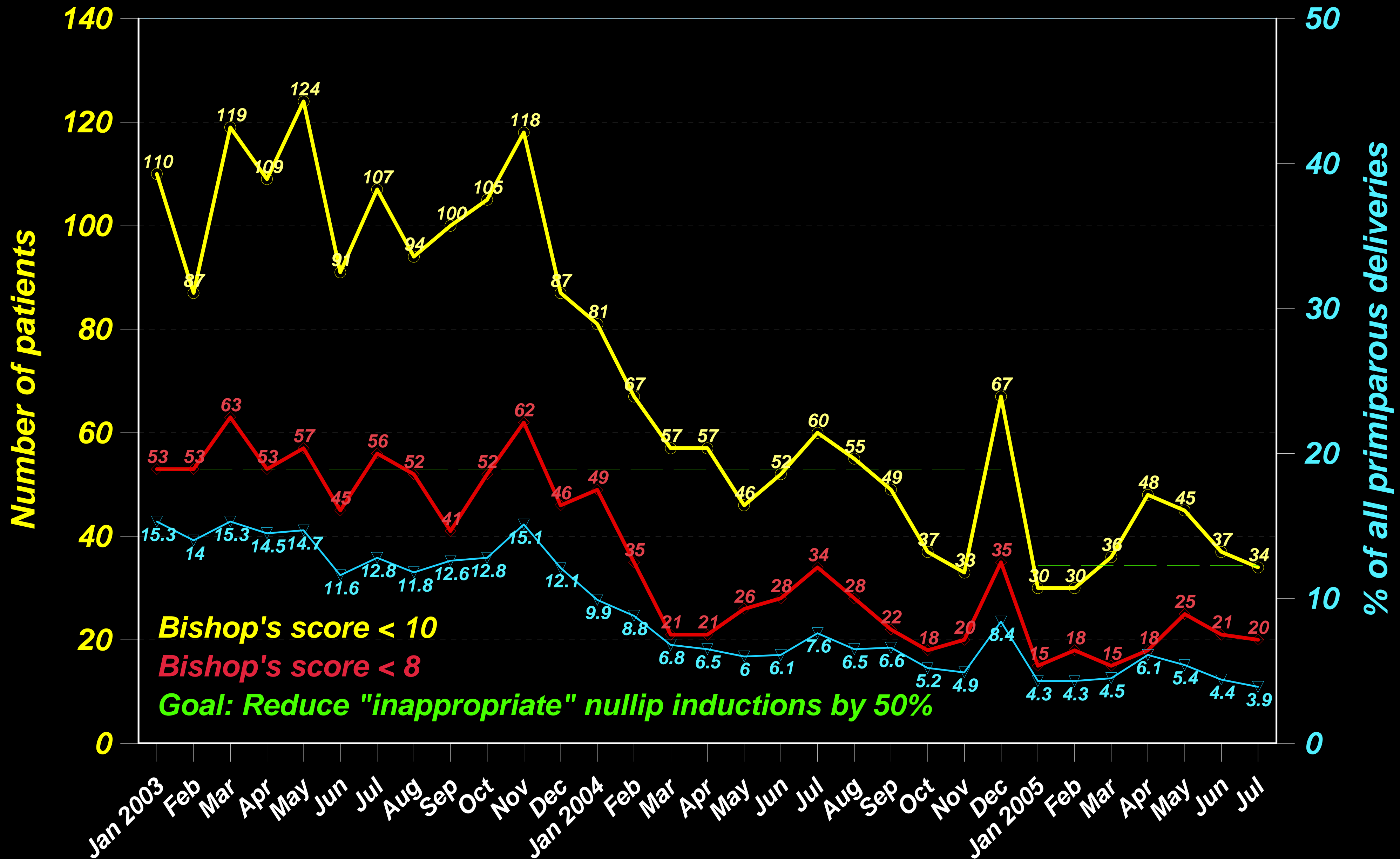
Average hours in labor & delivery

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

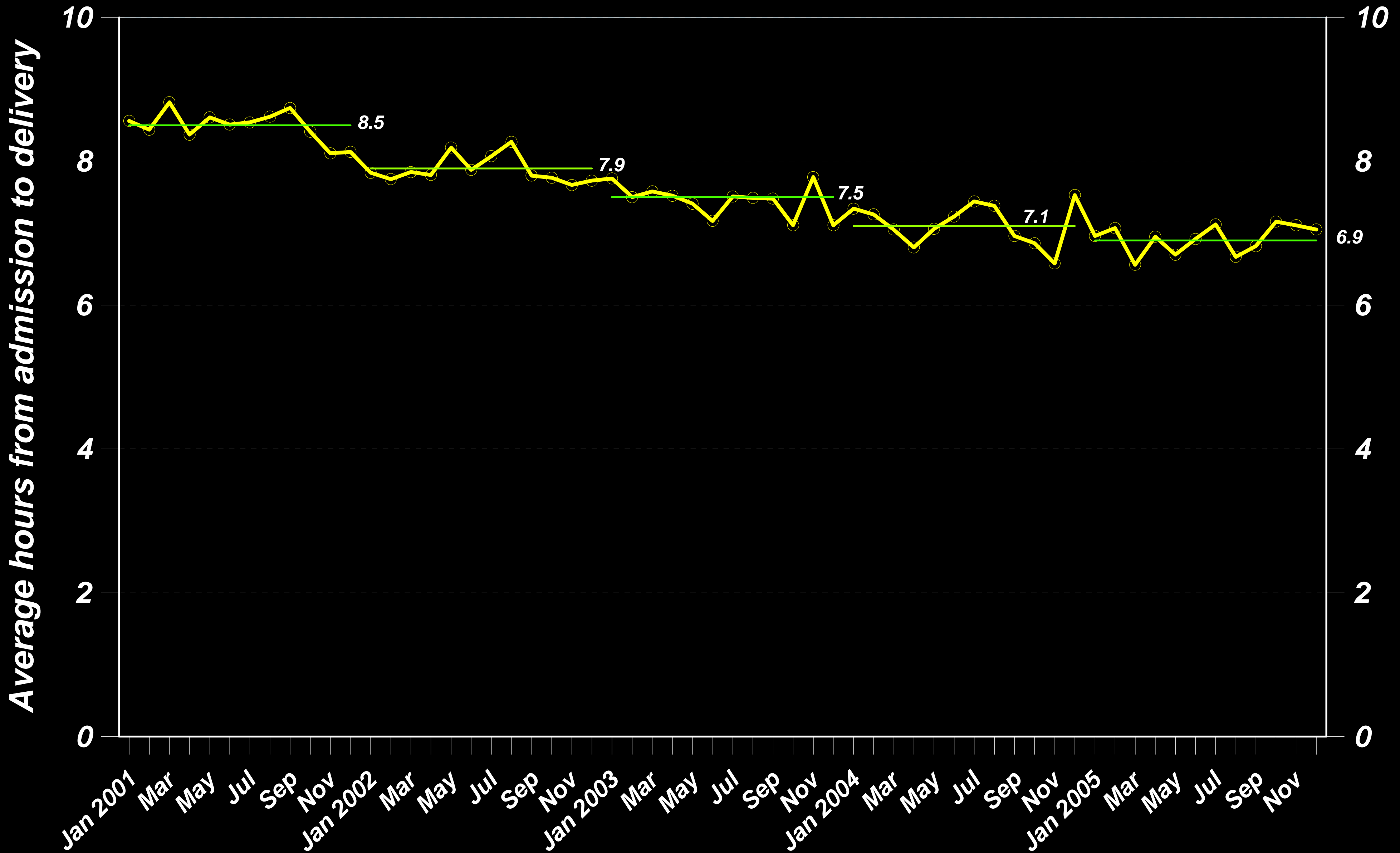


n													
Multips	*10*	*49*	*130*	*274*	*567*	*856*	*1114*	*1266*	*1062*	*737*	*415*	*86*	*19*
Primips	*18*	*35*	*61*	*99*	*164*	*278*	*375*	*487*	*453*	*346*	*179*	*47*	*7*

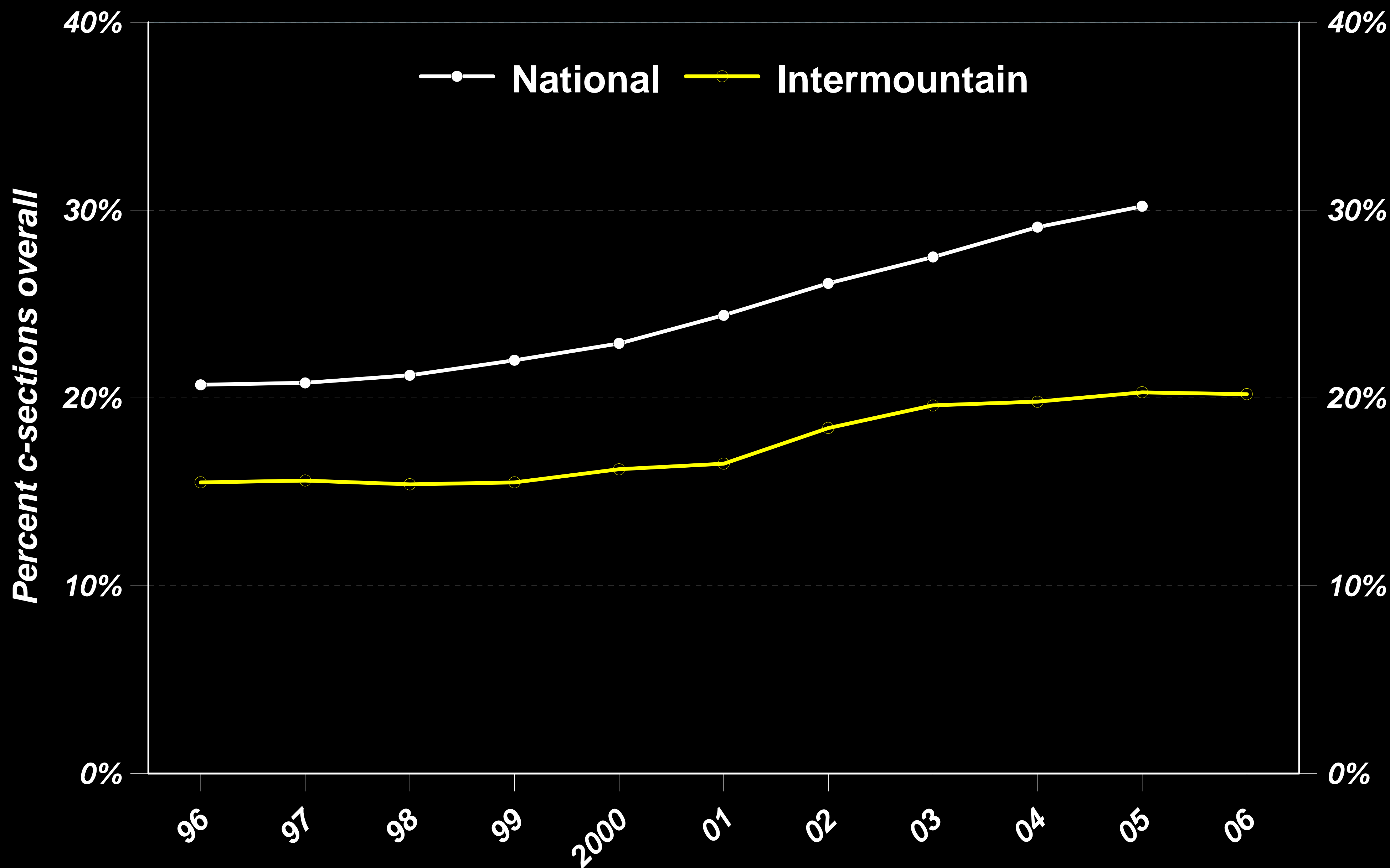
Primiparous elective inductions



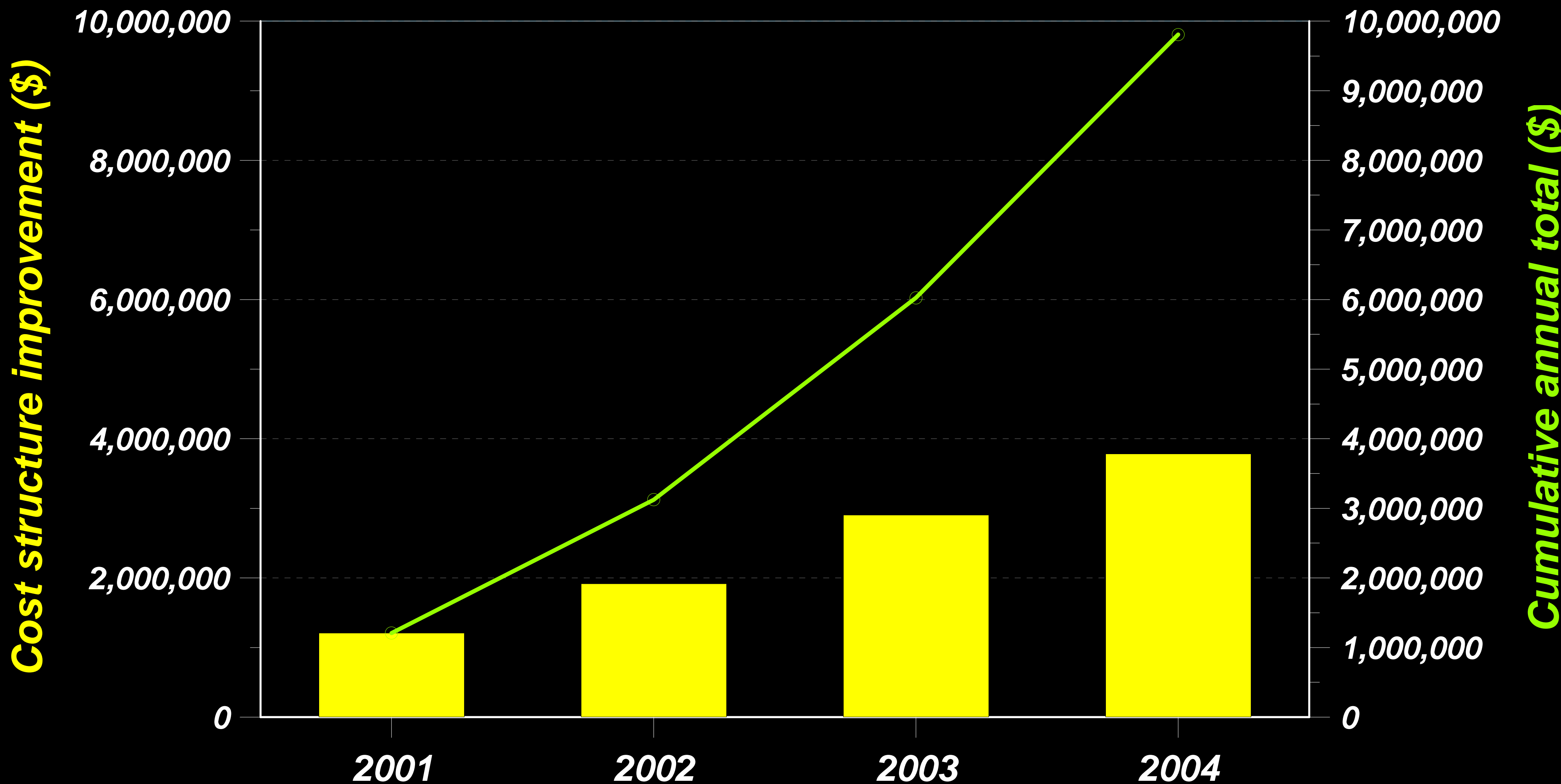
Elective induction: length of labor



Overall c-section rate



Quality-based cost improvement



A "medical home"

1. ***A care management nurse*** *(all major chronic diseases)*
2. ***Embedded in a primary care practice*** *(requires 4-5 primary care physicians to support 1 care management nurse)*
3. ***Integrated decision support*** *(Shared Baseline care process model = integrated patient registry, protocol-driven decision support)*
4. ***Closely coordinated specialists*** *(referral network)*
5. ***Strong patient-to-clinician and clinician-to-clinician communications***

IHC Primary Care Clinical Programs: Adult Diabetes Patients in your Practice

Reporting Period: 01-Jan-04 To 31-Dec-04

Steven Towner (168) -- Internal Medicine **Salt Lake Clinic, Main** 205 Total Patient(s) **Medical Director: Towner**

IHC Health Plans -- Higher Risk **9 Patient(s)**

Lab Summary: ** NA-Result Not Available

Patient ID	Patient Name	IDX MRN	Telephone	DOB	Last PCP Visit	Endocrinologist	Last LDL: (24 mths) Date	Value**	Last A1c: Date	Value**	Microalbumuria: Date	Result**	Eye Exam Date
*54320		1765154			12/20/2004		12/20/2004	136 †	12/20/2004	8.6	12/20/2004	NEG	9/13/2004
Corrections													
40471		1389217			6/7/2004	Samuel Abbate	9/22/2004	133	9/22/2004	6.1	3/25/2004	NEG	12/2/2004
Corrections													
21056		1398065			6/10/2004		7/14/2003	118	6/10/2004	7.9	6/10/2004	NEG	Not Tested
Corrections													
47705		1767453			11/4/2004		10/4/2004	118	10/4/2004	5.8	Not Tested		Not Tested
Corrections													
307		1092701			5/17/2004		5/10/2004	115	5/10/2004	11	3/8/2004	NEG	Not Tested
Corrections													
3432		1888085			12/1/2004		4/23/2004	113	10/8/2004	7.4	4/23/2004	NEG	5/10/2004
Corrections													
35912		1865525			4/7/2004		12/9/2004	105 †	12/9/2004	6.9	3/22/2004	NEG	Not Tested
Corrections													
*39339		1847553			4/13/2004	James Grua	11/7/2003	88	Not Tested		Not Tested		Not Tested
Corrections													
*54287		1120578			12/30/2004		11/20/2004	74	11/15/2004	10.8	11/20/2004	NEG	Not Tested
Corrections													

IHC Health Plans -- Lower Risk **28 Patient(s)**

Lab Summary: ** NA-Result Not Available

Patient ID	Patient Name	IDX MRN	Telephone	DOB	Last PCP Visit	Endocrinologist	Last LDL: (24 mths) Date	Value**	Last A1c: Date	Value**	Microalbumuria: Date	Result**	Eye Exam Date
9947		1254184			7/31/2004		7/31/2004	99	7/31/2004	6.2	7/31/2004	NEG	2/20/2004
Corrections													
32984		1767645			10/4/2004		11/3/2003	99	9/27/2004	5.9	9/27/2004	NEG	9/18/2004
Corrections													
23420		1767681			7/7/2004		7/7/2004	98	7/7/2004	7.4	7/7/2004	NEG	1/1/2004
Corrections													
*35956		3019278			10/21/2004		12/1/2003	95	7/12/2004	5.8	10/21/2004	NEG	8/27/2004
Corrections													

Note: Higher Risk Patients are those whose last A1c value was >8.0, last LDL>100, Triglycerides>400, or not tested during the reporting period

* Indicates a new patient on the list from last reporting period.

† Indicates an IHC Health Plans patient who has a pharmacy benefit, is over 40 years old with an LDL test above 100, and is not on a lipid lowering drug.

‡ Indicates an IHC Health Plans patient who has a pharmacy benefit, a positive microalbuminuria test and is not on ACEI or ARB medication.

Please make corrections in the shaded area and fax this report form to Jennifer Davis at 442-3026.

CONFIDENTIAL: This material is prepared pursuant to Utah Code Ann. 26-25-1 et. Seq., Idaho Code Ann. 39-1392 et seq., for improvement of the quality of hospital and medical care rendered by hospitals or physicians.

11 July 2003

Patient Worksheet

v1.0.21

PATIENT NAME	SEX	DOB	MMI#	MRN#
TEST, A A	F	09/01/1964	545073664	545073664

Problems

Hypothyroidism
status post appendectomy
Diabetes mellitus type 2, insulin treated

Hypertension
Appendectomy
Coronary artery disease

Problems and chronic conditions

Active Medications

1. - Digitoxin, 0.1mg, Tablet; 3 TABLE
2. - Entex LA (Guaifenesin/PPA HCl) 400-75mg, Tablet SA; 1 TABLET; BID

Medication profile

Preventive Care

CV Risk	Pap Smear
5%*(1.4x)**	No Data -

Preventive care summary

Clinical Laboratory Data

HgbA1c (<=7.0)		UA Protein		uAlb/Cr (<30)		24 Urine Albumin (<30)	
No Data	-	06/01/2001	Negative	No Data	-	No Data	-
		12/18/2000	Positive				
		11/06/2000	Negative				

Serum Cr		Serum K		Lipid Profile	LDL (<100)	Trig (<200)	HDL (>35)	CHOL (<200)
04/26/2003	1.1	04/26/2003	4.2	04/26/2003	[illegible]	[illegible]	50	176
10/25/2002	2.0	02/05/2003	6.0	04/06/2003	154	85	41	212
02/27/2002	1.6	10/25/2002	4.5	02/24/2003	149	151	41	220
10/03/2001	2.3	01/29/2002	6.1	02/06/2003	168	189	33	239

Pertinent labs

TC/HDL Ratio		HCT		hsCRP		Homocysteine		Fasting Glucose	
04/26/2003	3.5	02/05/2003	35.9 %	04/06/2003	0.6 mg/l	04/06/2003	6 mcmol/l	02/25/2003	127
04/06/2003	5.2	10/02/2002	37.7 %	02/24/2003	1.2 mg/l			12/19/2002	127
02/24/2003	5.4	08/23/2002	45.0 %					01/02/2002	127
02/06/2003	7.2	07/19/2002	29.9 %					12/20/2001	127

Clinic Data

Date	Weight	BMI (<25)	Weight Class	Blood Pressure (<130/80)		Heart Rate	
No Data	-	-		01/25/2001	145/74 mmHg	01/25/2001	86

Last foot exam: No Data

Last dilated retinal exam: No Data -

Pertinent exams

Reminders

Preventive

* Predicted % Risk over 10 years of a cardiovascular event (MI, revascularization, CVA, death).
** Relative Risk over 10 years of a cardiovascular event compared to lowest risk category.
Pap and pelvic suggested every 3 years after three normal yearly Pap tests.
For Patients with known Cardiovascular Disease, target LDL < 100.
Blood Pressure measurement is suggested for adults every two years.
Suggested follow-up for missing data: - Pap Smear
Pneumovax suggested for all patients age 65 and above, and all patients over age 2 with systemic chronic disease.

Diabetes

Suggest repeat Urine Albumin Test more than (>) 1 year since last test.
Last ALT = 28 on 4/26/2003 & AST = 66 on 4/26/2003
Suggested follow-up for missing data: - HgbA1c - Dialated Retinal Exam - Foot Exam - Weight

Hypertension

ACE Inhibitors (ACEI) or if ACEI intolerant, Angiotensin II Receptor Blockers (ARBs) or the combination of ACEI or ARBS and Diuretics are the recommended initial drug therapy for patients who are diagnosed with hypertension in conjunction with Diabetes.

Passive reminders organized by illness

General patient status information

Disease specific information

Diabetes Summary Report

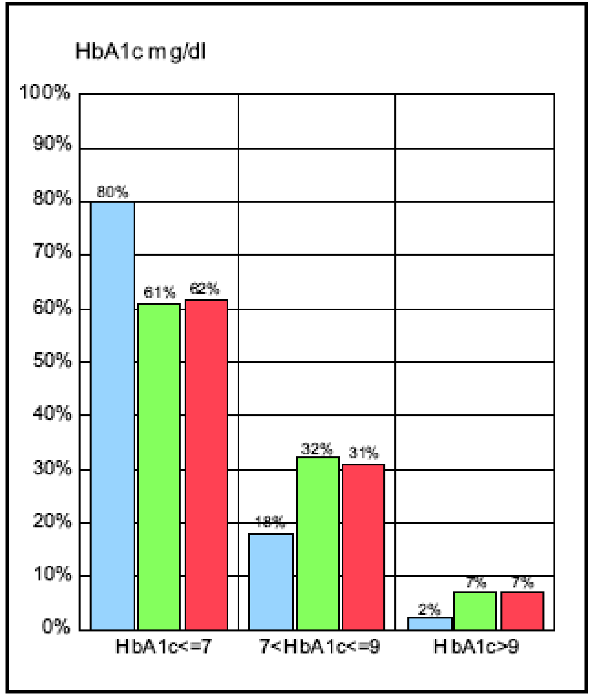
Provider: Towner, Steven (168)

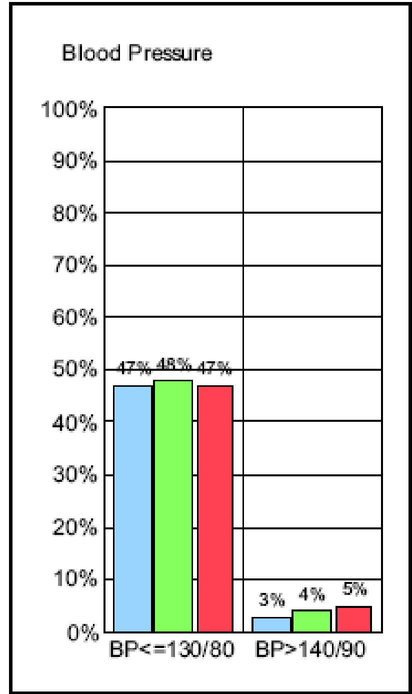
Period: Jan 2005 - Dec 2005

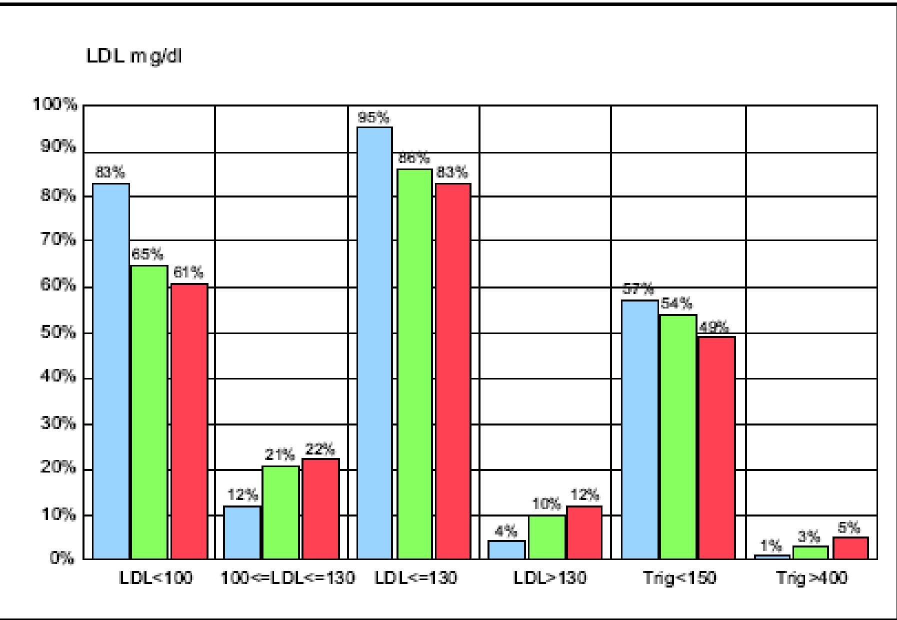
Patients Tested (Prop of Tot Pts%) - All Patients

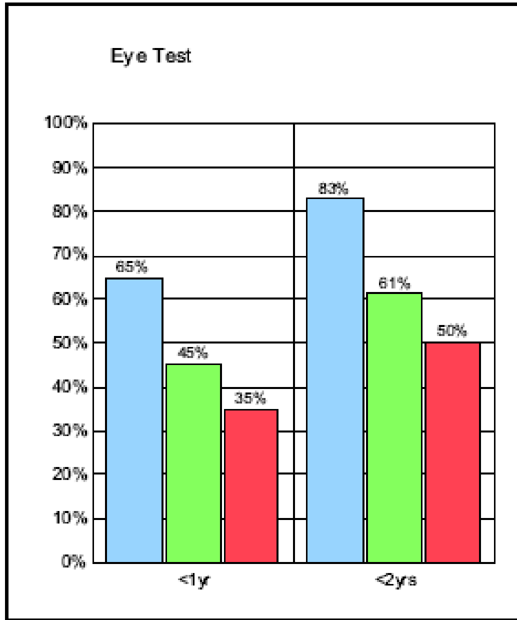
	Provider	Region	System
HbA1c	188(97%)	1,582(90%)	25,429(83%)
LDL	190(98%)	1,658(94%)	26,040(85%)
Eye Exam	159(82%)	399(23%)	6,509(21%)
Microalbuminuria	159(82%)	1,236(70%)	14,969(49%)
Blood Pressure	188(97%)	1,248(71%)	15,344(65%)
Total Patients	**194**	**1,757**	**30,470**

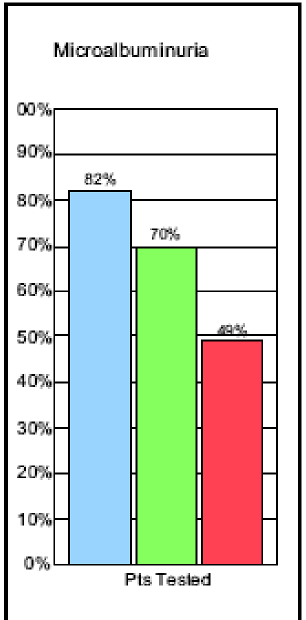
1. LDL measures represent two years ending in the chose period. 2. Eye exam % calculated using Health Plans patients only. 3.Includes spot microalbumin, 24 hour urine for protein and microalbumin/creatine ratio within the reporting period, or any history of treatment for nephropathy. 4. Blood pressure data only available for physicians with access to Clinical Workstation and/or Results Review.

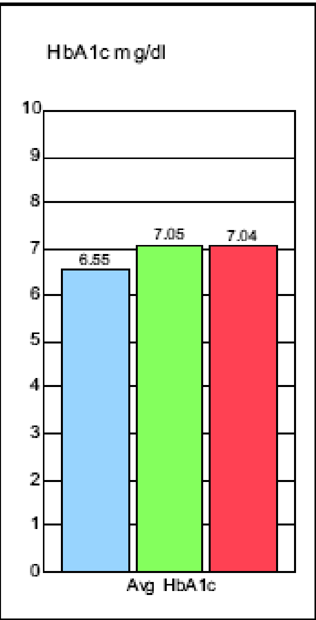












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IHC Primary Care System Goals and Managed Care Incentive Achievement Summary: Internal Medicine

Reporting Period: 01-Jan-04 To 31-Dec-04

Medical Director: Towner

1.) Diabetes, HbA1c Testing

The percent of patients with diabetes who had a HbA1c test within the last 12 months.

Your Achievement:	78%
System Goal:	80%
Managed Care Incentive Goal:	85%
Your Score in this area is:	**0%**

2.) Diabetes, LDL Testing

The percent of patients with diabetes who had a LDL test within the last 24 months.

Your Achievement:	94%
System Goal:	80%
Managed Care Incentive Goal:	85%
Your Score in this area is:	**100%**

3.) Urine Microalbuminuria Screen

Number of patients with diagnosis of diabetes who had appropriate urine screen in last 12 months.

Your Achievement:	72%
Goal:	45%
Managed Care Incentive Goal:	55%

Your Score in this area is: 100%

4.) Asthma Care

Percent of patients in your Internal Medicine Group with "higher risk asthma" who filled at least one prescription for a controller in the last year.

Your Group Achievement	94%
Goal:	82%
Managed Care Incentive Goal:	87%

Your Score in this area is: 100%

5.) Clinical Learning Day

Your Score in this area is 100%

Attended a Clinical Learning Day Program in 2003 or 2004

Your Score for each of the above measures is computed as follows:
-100% if you exceed the Managed Care Incentive (MCI) goal
-0% if you are below the System Goal
-50%-100% sliding scale if you are between the System and MCI goals

Managed Care Incentive Summary

Your total score is computed using the following weighting:

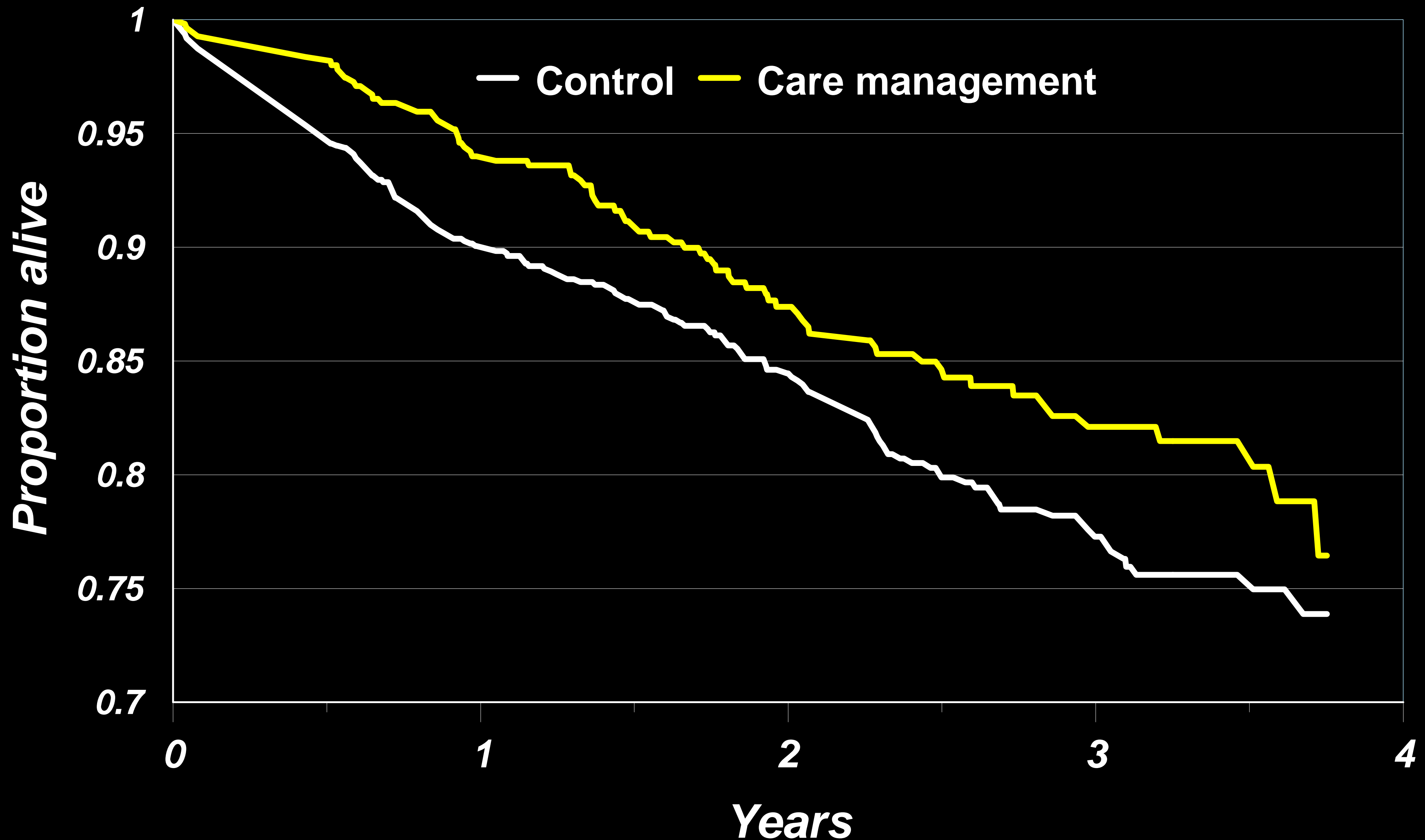
25% from Item 1 Diabetes (HbA1c Testing)
25% from Item 2 Diabetes (LDL Testing)
10% from Item 3 Urine Microalbuminuria Screen
15% from Item 4 Asthma Care
25% from Item 5 Attend Clinical Learning Day

Your Total Managed Care Incentive Score is: 75%

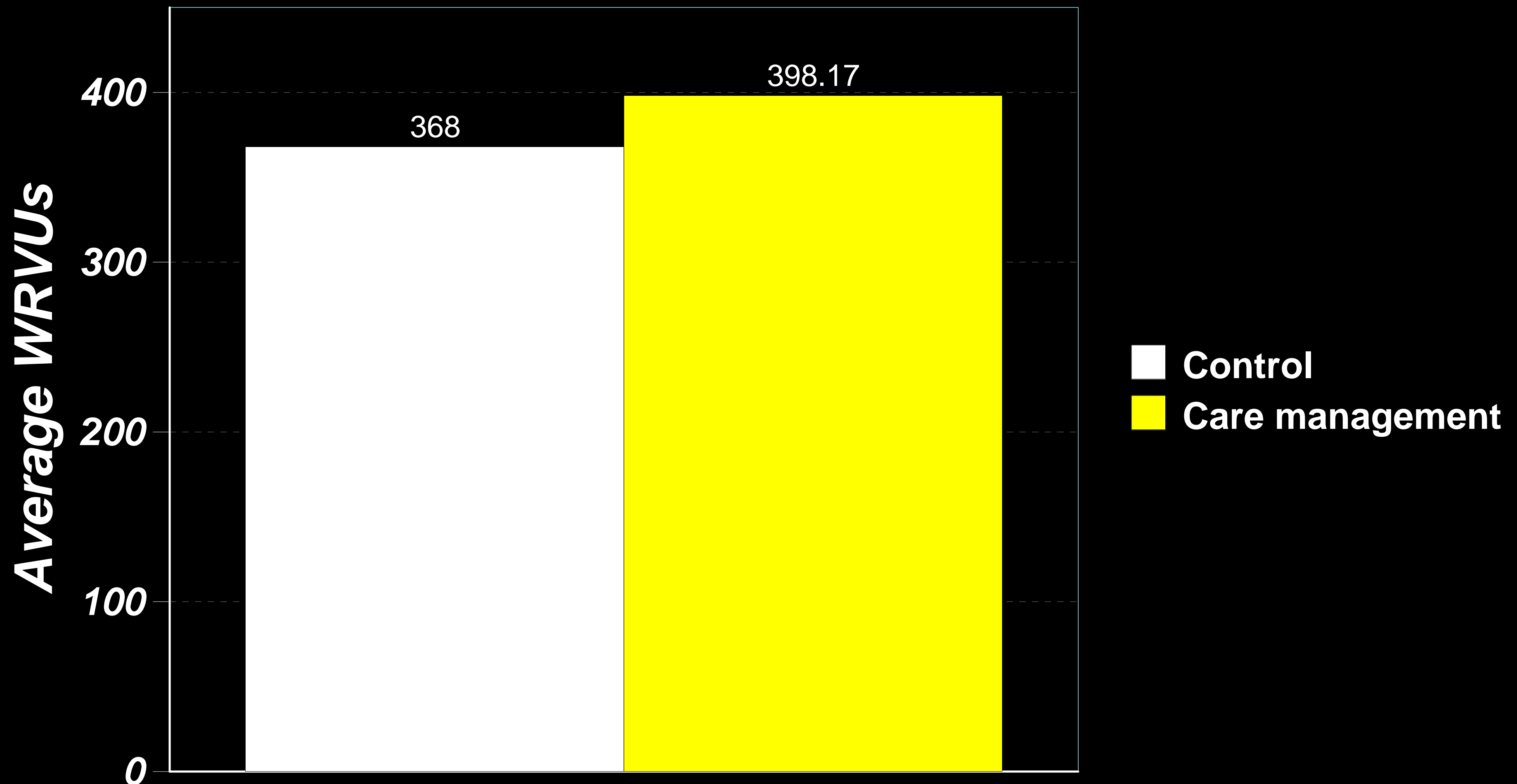
Please fax corrections to this report to: Steven Towner 355-3746

Employed

CPM with clinic care managers

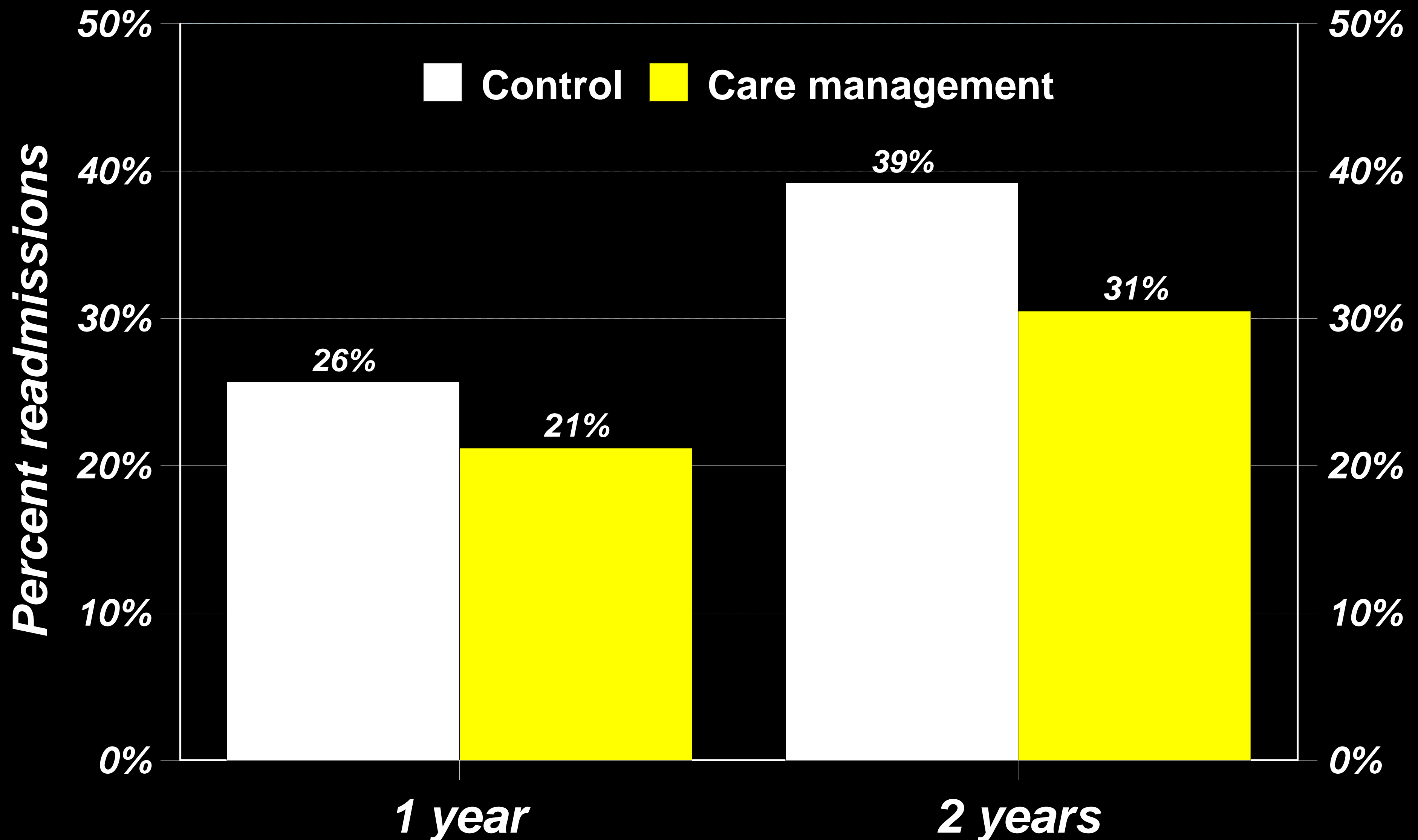


Physician productivity *(WRVUs - work relative value units)*



Physicians with embedded care management support were significantly (8%) more productive than controls

QI is innately a preventive strategy



Deming: Quality controls costs

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

5. Improve value, fail financially *(perverse incentives)*

	Per Case	
	Cost	NOI
Normal delivery:	**<1.00>**	**303**
Unplanned c-section:	**<2.05>**	**648**

Aim: *reduce unplanned c-sections by 2 percentage points*
(6.25% to 4.25%; more than 600 fewer c-sections per year)

Reduced cost:	**1,991,860**
Reduced revenue** (insurance payments)**:	**2,216,800**
Reduced NOI:	**224,940**

(2008 data)

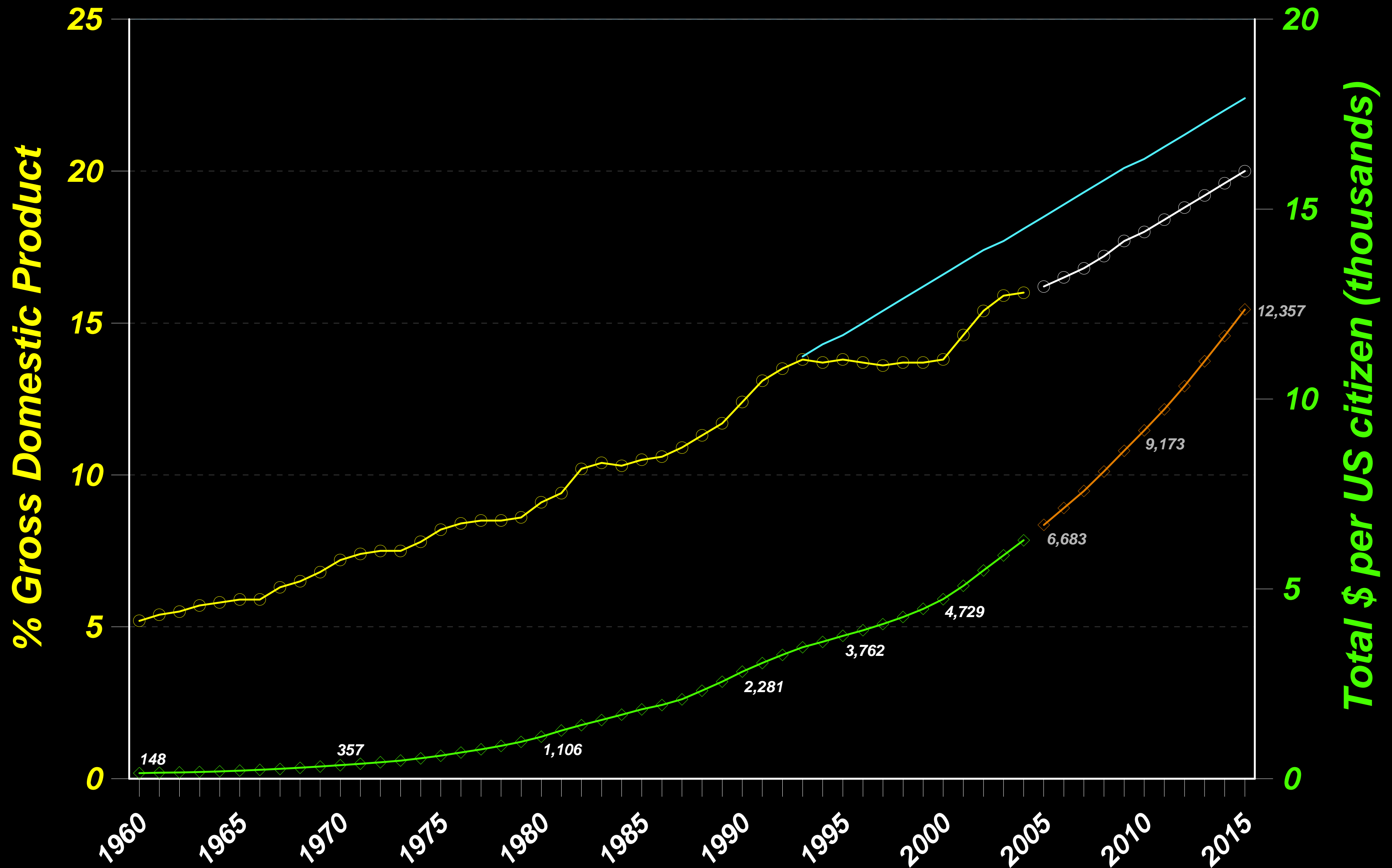
Impact on net income

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%)

Most current payment mechanisms

- ***Actively incent overutilization:*** *do more, get paid more - even when there is no health benefit*
- ***I am paid to harm my patients*** *(paid more for complications)*
- ***Actively disincents innovation that reduces costs through better quality*** *(a key success factor for the rest of the U.S. economy)*
- ***Very strong, deep, wide evidence showing exactly this effect throughout U.S. healthcare***

6. Bending the cost curve



Provider at financial risk

1. ***ACOs, AMHs: sophisticated forms of capitation***
   - *provider at (financial) risk: bundled payment, chronic disease capitation, etc. ... but with*
   - *better data systems (quality measaurement) and better risk adjustment*

2. ***Represent "managed care at the bedside"***
   - *managed care the only method that has "bent the cost curve"*
   - *shifts control / accountability from insurers to care delivery groups*

3. ***More than 80% of cost saving opportunities live on the clinical side***

Wells Fargo inflation summary, 1988-2006

December 2006

WELLS FARGO

COST OF LIVING INDEX

	Wasatch Front			National			
	Index Mar. 1988=100	% Change 6 Mos.*	(Non-Seas. Adj.) 1 Mo. Prior	Index Mar. 1988=100	% Change 6 Mos.*	(Non-Seas. Adj.) 1 Mo. Prior	(Seas. Adj.) 1 Mo. Prior
All Categories	**154.6**	**-0.1%**	**0.2%**	**173.4**	**2.7%**	**0.1%**	**0.5%**
Housing	182.8	2.7	0.1	175.6	3.8	0.1	0.4
Transportation	120.2	-11.4	-1.4	163.9	0.8	0.9	1.8
Health Care	157.4	0.1	-0.1	249.5	3.9	0.0	0.1
Food at Home	201.2	3.3	3.1	170.6	1.8	0.0	-0.3
Clothing	113.2	-1.6	0.6	102.9	0.2	-2.5	0.6
Food Away	162.2	0.0	0.0	168.7	3.2	0.3	0.3
Utilities	128.7	-1.0	0.0	175.4	3.1	1.1	1.2
Recreation	139.1**	5.8	0.0	109.8†	1.3	-0.4	-0.3
Education & Comm.	124.6**	5.6	0.0	116.2†	2.5	-0.1	0.2
Other Goods & Svcs.	104.3**	0.0	0.0	243.3	2.6	0.7	0.8

*Last six-month percentage change compared with same period one year ago.
**(Feb. 1998=100 base)

National Data Source: U.S. Bureau of Labor Statistics
†(Dec. 1997=100 base)

Summary

- ***Care delivery is changing ...***
  from craft-based practice *(clinicians as individual experts)*
  to profession-based practice *(true clinical teams)*

- ***Better care can produce much lower operating costs ...***
  most efforts currently produce windfalls for purchasers, due to perverse payment mechanisms *(this is what is driving pay for performance and shared savings initiatives)*

- ***PPACA targets new payment mechanisms that align financial incentives***
  - a series of "rapid cycle" demonstration projects
  - "provider at financial risk" = shared savings payment models
  - parallel clinical and quality service measures to insure that provider groups do not withhold beneficial, necessary care

- ***Look not to Washington - the real solutions are coming off the health care delivery front line***

- ***Get started <u>now</u>***
  - unsustainable government outlays will drive intense pressure

Better has no limit

*"I am sorry for you, young men (*and women*) of this generation. You will do great things. You will have great victories, and standing on our shoulders, you will see far, but you can never have our sensations. To have lived through a revolution, to have seen a new birth of science, a new dispensation of health, reorganized medical schools, remodeled hospitals, a new outlook for humanity, is not given to every generation."*

-- Sir William Osler

At the opening of the Phipps Clinic in England, near the end of his career. Cited in

Reid, Edith Gittings. *The Great Physician: A Life of Sir William Osler.* New York, NY: Oxford University Press, 1931 (p. 241).