The Eighth National

Pay for Performance Summit

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Money on the Table, Lives on the Line: The Best Clinical Result at the Lowest Necessary Cost

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Disclosures

Neither I, Brent C. James, nor any family members, have any relevant financial relationships to be discussed, directly or indirectly, referred to or illustrated with or without recognition within the presentation.

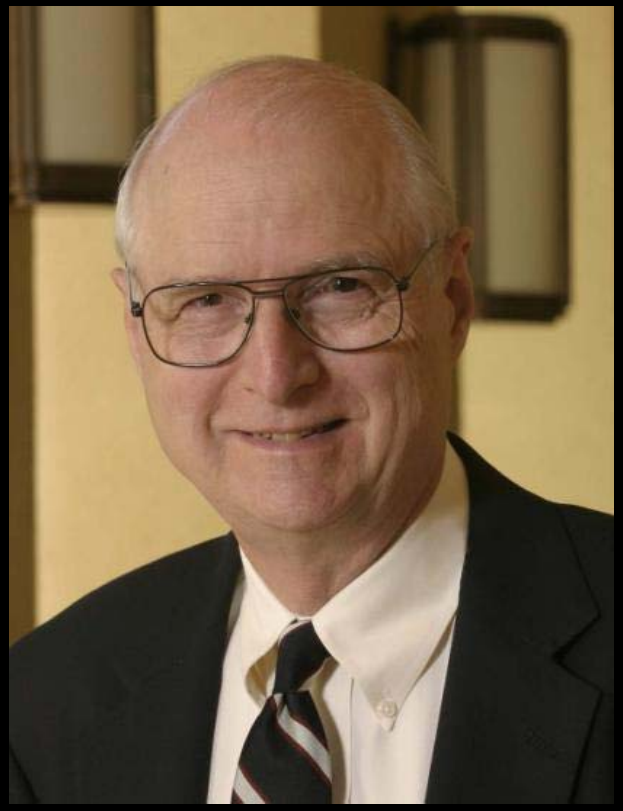
I have no financial relationships beyond my employment at Intermountain Healthcare.

The roots of reform

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

Reform, Part Deux

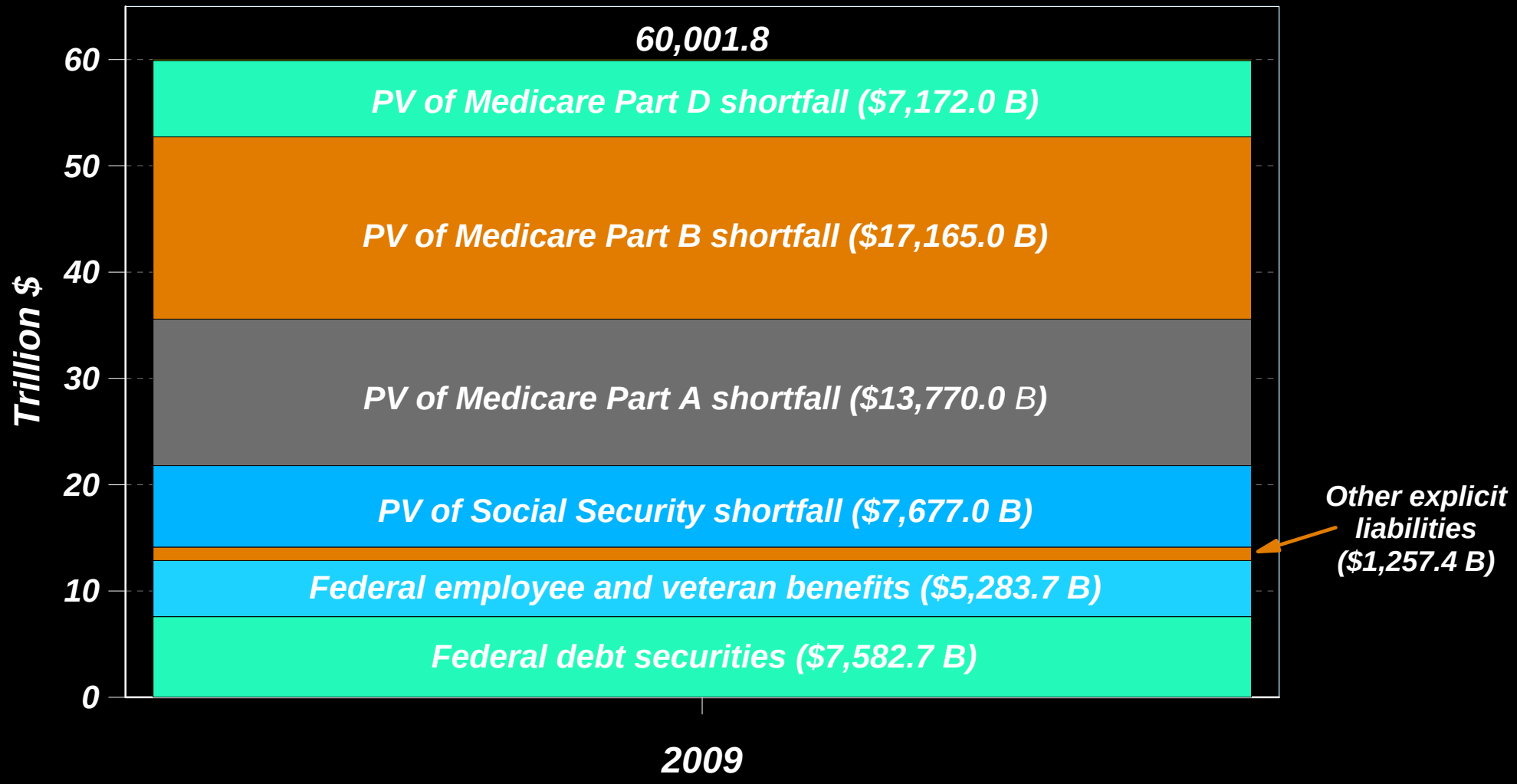
"The United States does not have decades to wait for health system reform; in 2009 about $1.15 trillion of the federal budget was spent on health care. And health care expenditures are growing 2.7% per year faster than non-health care gross domestic product. [The current] reform bill does practically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



Alain Enthoven, PhD
Stanford University

Total U.S. fiscal exposures

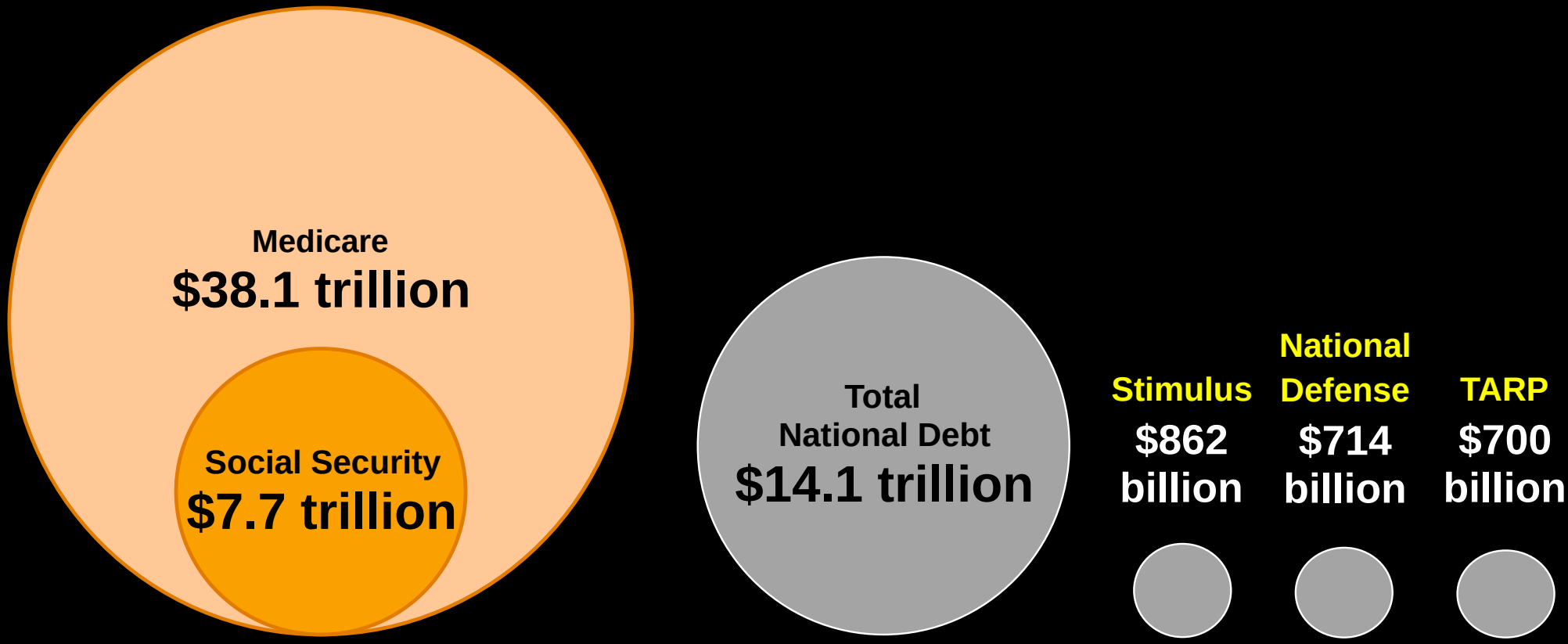
By layering on future obligations, the total net prevent value (PV) of debt rises to over $60 trillion -- about $195,000 for every man, woman and child in the U.S. More than two-thirds of the shortfall arises from health care delivery.)



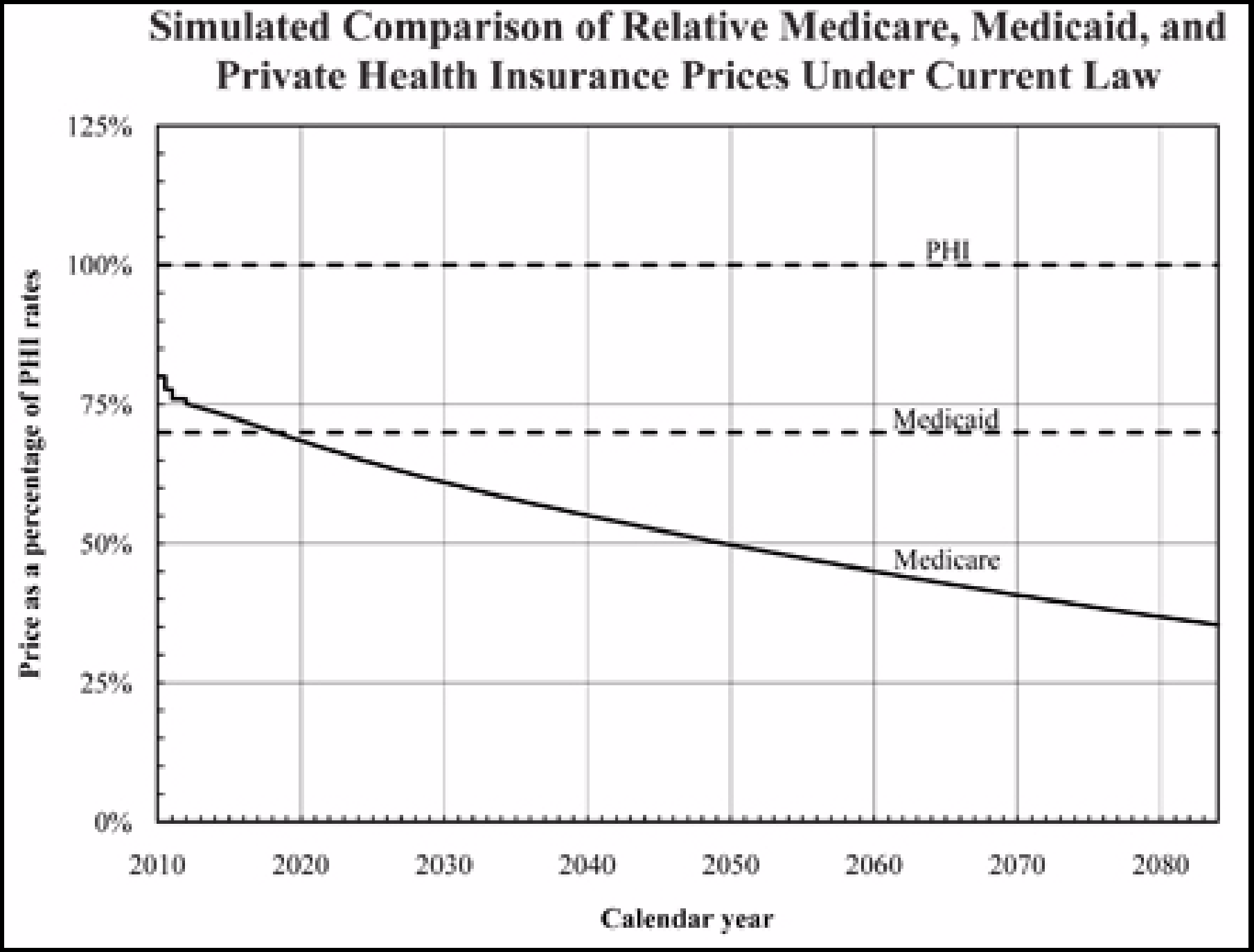
Source: GAO. Financial Reports of the United States Government for the Years Ended September 30, 2009 and 2008.

The Fiscal Gap *(unfunded federal obligations - 2009)*

Unfunded obligations



Health care payments *will* be cut



Massachusetts - a national bellweather

1. ***"Early adopter" of insurance expansion*** *-- model used for the PPACA federal insurance reform act*

2. ***Unintended consequences***
   - *much higher utilization rates in the newly insured*
   - *insufficient primary care = scheduling delays, ED saturarion*

3. ***Grossly overbuilt for this new environment***
   - *too many: beds, high-end technologies, specialists (rescue care)*
   - *10 academic medical centers; population can support ~2-3*
   - *high unit prices (including very high salaries)*

4. ***Health care costs explode***
   - *hits commercial insurance, State budgets*
   - *will be exacerbated by reductions in Federal payments (cost shifting)*

Coming soon to your neighborhood?

5. ***State support for insurer initiatives***

- *~70% "provider at risk" payment*
- *primary care income linked to referral specialists' costs*
- *tiered hospital pricing = shift costs to consumers*
- *small community hospitals "cherry pick"*

(at least, that's how some of the AMCs see it)

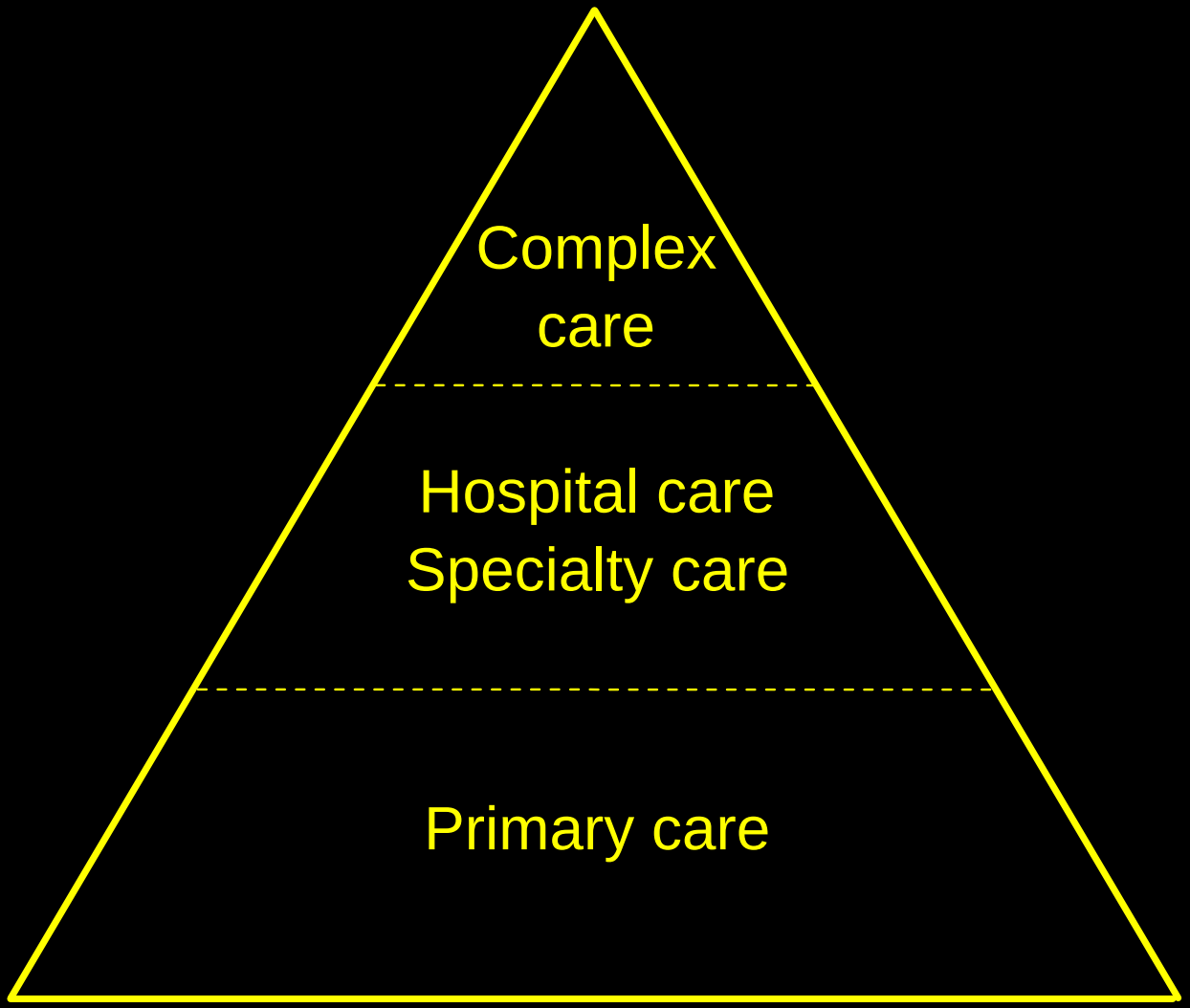
2 main coping strategies

1. ***Focus on the top line***
   - *"Ride this horse 'til it drops"*
   - *build market power - consolidate to negotiate with purchasers*
   - *compete vigorously for fee-for-service cases (medical tourism)*
   - *enhance revenues; increase top-end fee-for-service products*

2. ***Focus on the bottom line:*** *eliminate waste, control costs*

Top-line strategy: Mayo Clinic *($6BB expansion)*

"Ten years from now, there will emerge just a few medical centers with the reputation for health care excellence and patient-focused outcomes that will attract patients from all over the world to their flagship medical center ... [we will], significantly expand our highly-effective practice model and medical assets to be clearly recognized as a global ***destination medical center*** *for decades to come."* *Mayo CEO John Noseworthy*



Fee for Service
(high margin)

Bundled payment
(limited margin)

Capitated payment
(limited margin)

Bottom line strategy: care systems

Shared services organizations:

- *Dartmouth* *(practices across Maine, Vermont, New Hampshire)*
- *Ascension Health* *(120+ hospitals)*
- *Sutter Health* *(largest MediCal in northern California)*

- *Intermountain Healthcare*
  - *an integrated health plan (SelectHealth)*
  - *care management tools (Clinical Programs)*
  - *Shared Accountability Organization (SAO)*

50+% of all resource expenditures in hospitals is

quality-associated waste:

- *recovering from preventable foul-ups*
- *building unusable products*
- *providing unnecessary treatments*
- *simple inefficiency*

Andersen, C. 1991
James BC *et al*., 2006

Shared Baseline "Lean" protocols *(bundles)*

1. ***Identify a high-priority clinical process*** *(key process analysis)*

2. ***Build an evidence-based best practice protocol*** *(always imperfect: poor evidence, unreliable consensus)*

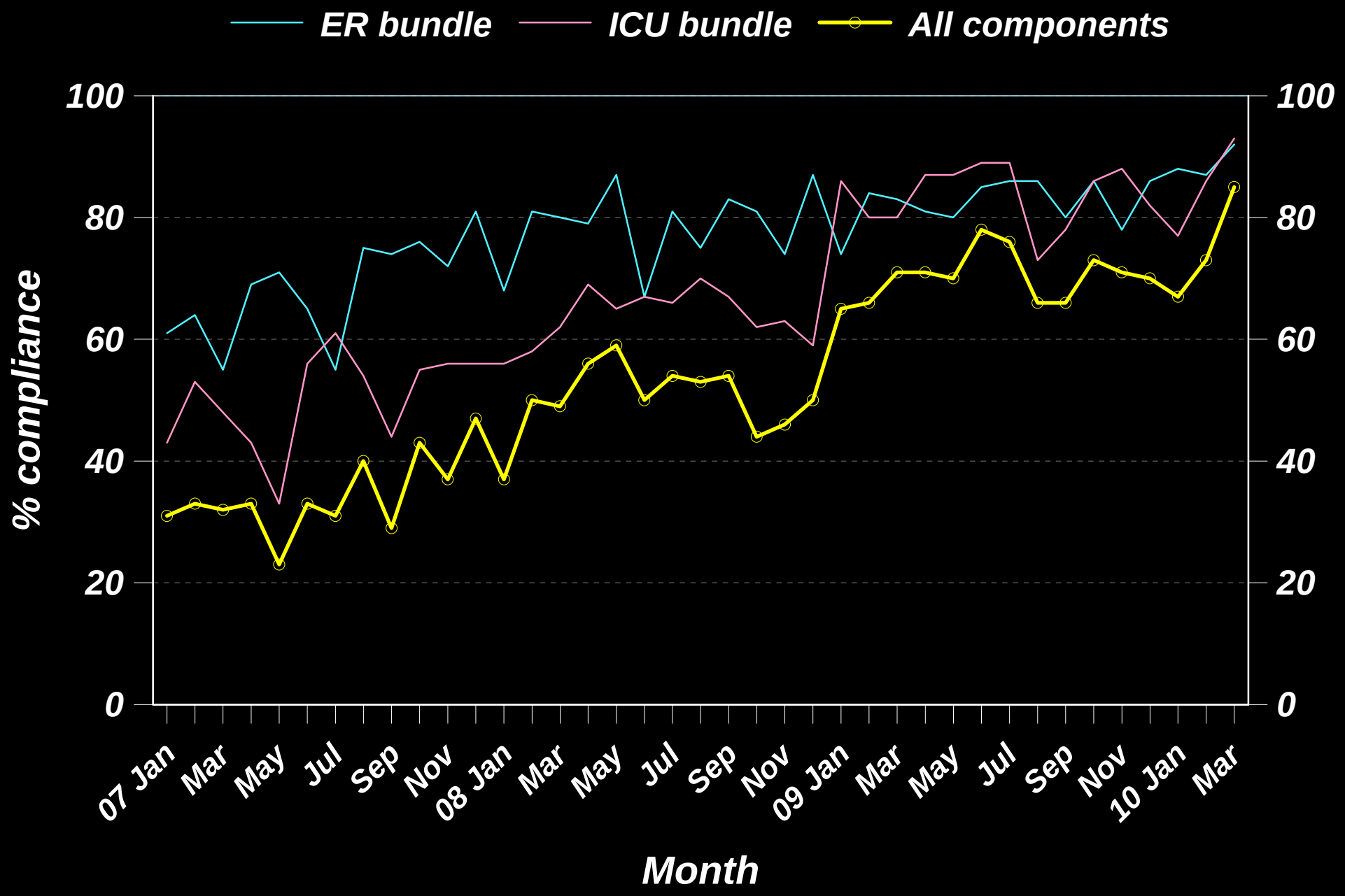
3. ***Blend it into clinical workflow*** *(don't rely on human memory; make it the lowest energy state, default choice that happens automatically unless someone intervenes)*

4. ***Embed data systems to track*** *(1)* ***protocol variations*** ***and*** *(2)* ***short and long term patient results*** *(intermediate and final clinical, cost, and satisfaction outcomes)*

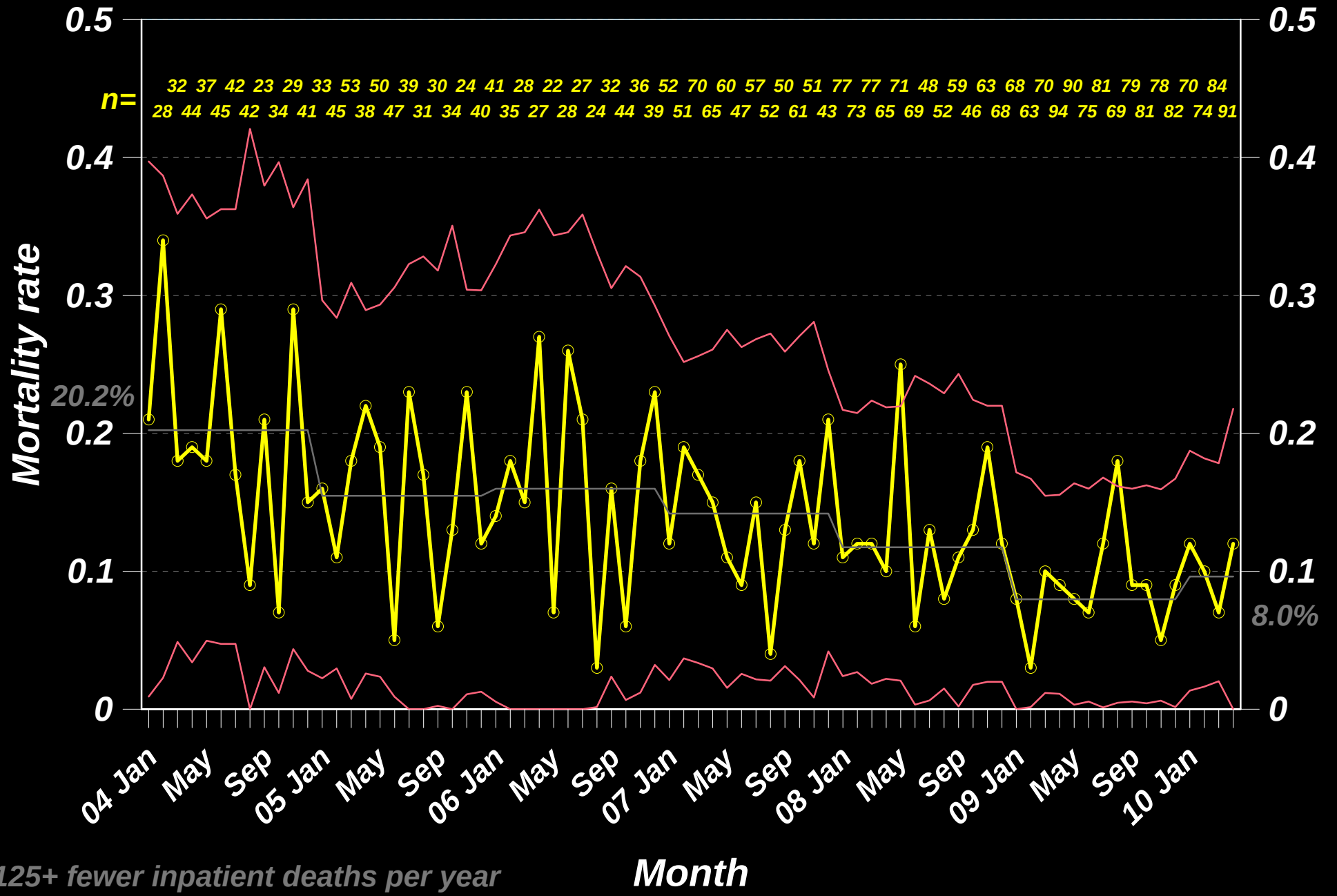
5. ***Demand that clinicians vary based on patient need***

6. ***Feed data back*** *(variations, outcomes)* ***in a learning loop*** *- continuously update and improve the protocol (including gauge theory)*

Sepsis bundle compliance



Sepsis mortality - ER-ICU transfers



125+ fewer inpatient deaths per year

Lesson 1

We count our successes in lives ...

Lesson 2

Very often,

better care is cheaper care ...

Aligning financial incentives

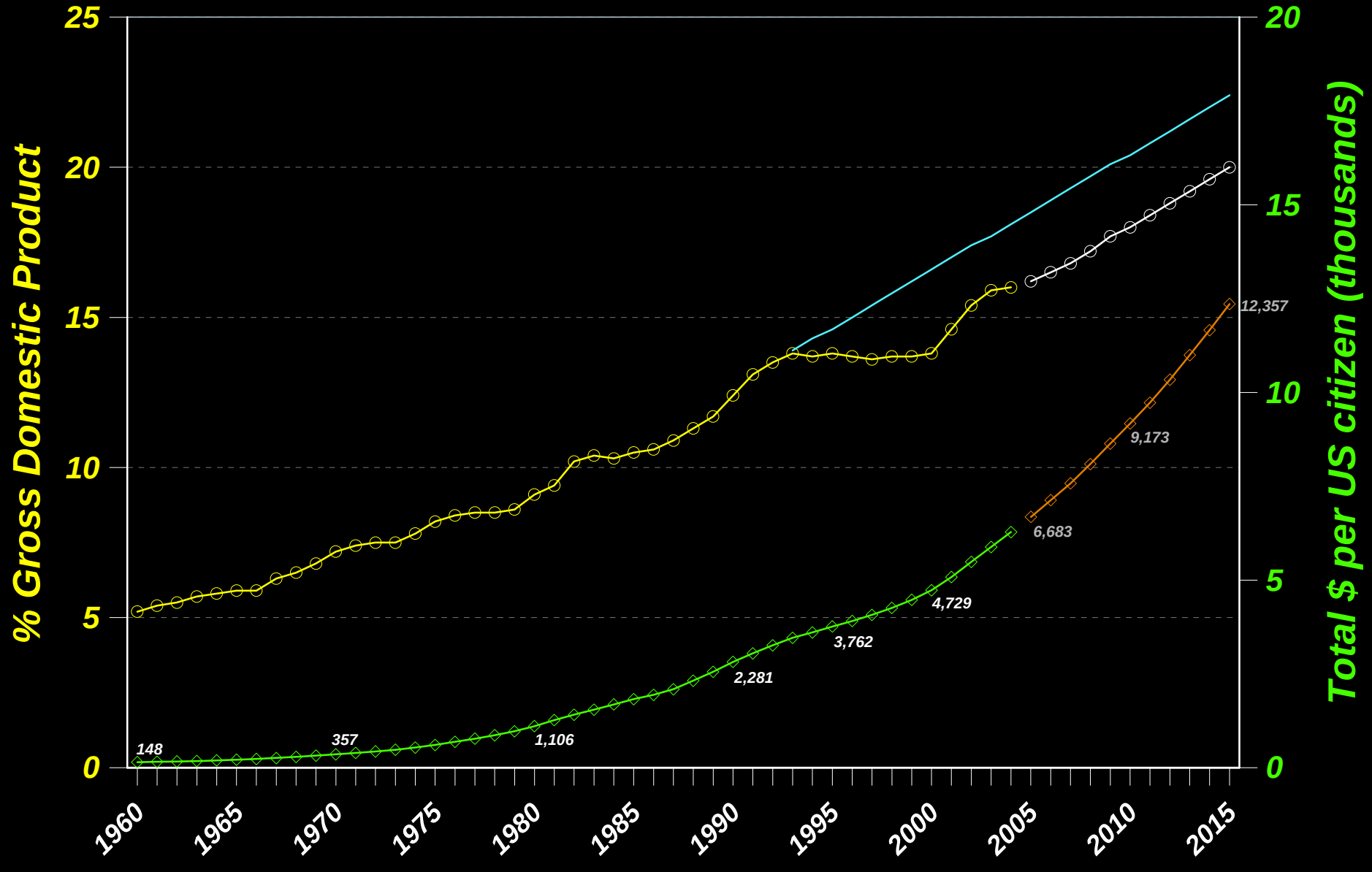
- *Neonates > 33 weeks gestational age who develop respiratory distress syndrome*
- *Treat at birth hospital with nasal CPAP (prevents alveolar collapse), oxygen, +/- surfactant*
- *Transport to NICU declines from 78% to 18%.*
- *Financial impact (NOI; ~110 patients per year; raw $):*

	Before	After	Net
Birth hospital	84,244	553,479	469,235
Transport (staff only)	22,199	- 27,222	- 49,421
Tertiary (NICU) hospital	958,467	209,829	-748,638
Delivery system total	1,064,910	736,086	-328,824
Integrated health plan	900,599	512,120	388,479
Medicaid	652,103	373,735	278,368
Other commerical payers	429,101	223,215	205,886
Payer total	1,981,803	1,109,070	872,733

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***

Bending the cost curve



A new market definition of P4P?

1. ***ACOs, AMHs: sophisticated forms of capitation***
   - *provider at (financial) risk: bundled payment, chronic disease capitation, etc. … but with* ***far better data systems*** *for (1) quality measurement and (2) 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*** *(= waste elimination)* ***live on the clinical side.***

Taken together,

- ***Medicaid's transition into capitated care,***
- ***our expansion into Medicare Advantage,*** *and*
- ***an ongoing commercial insurance shift***

represent at least 70% of Intermountain's inpatient and outpatient business shifting into ***capitated*** *(pmpm)* ***payment***

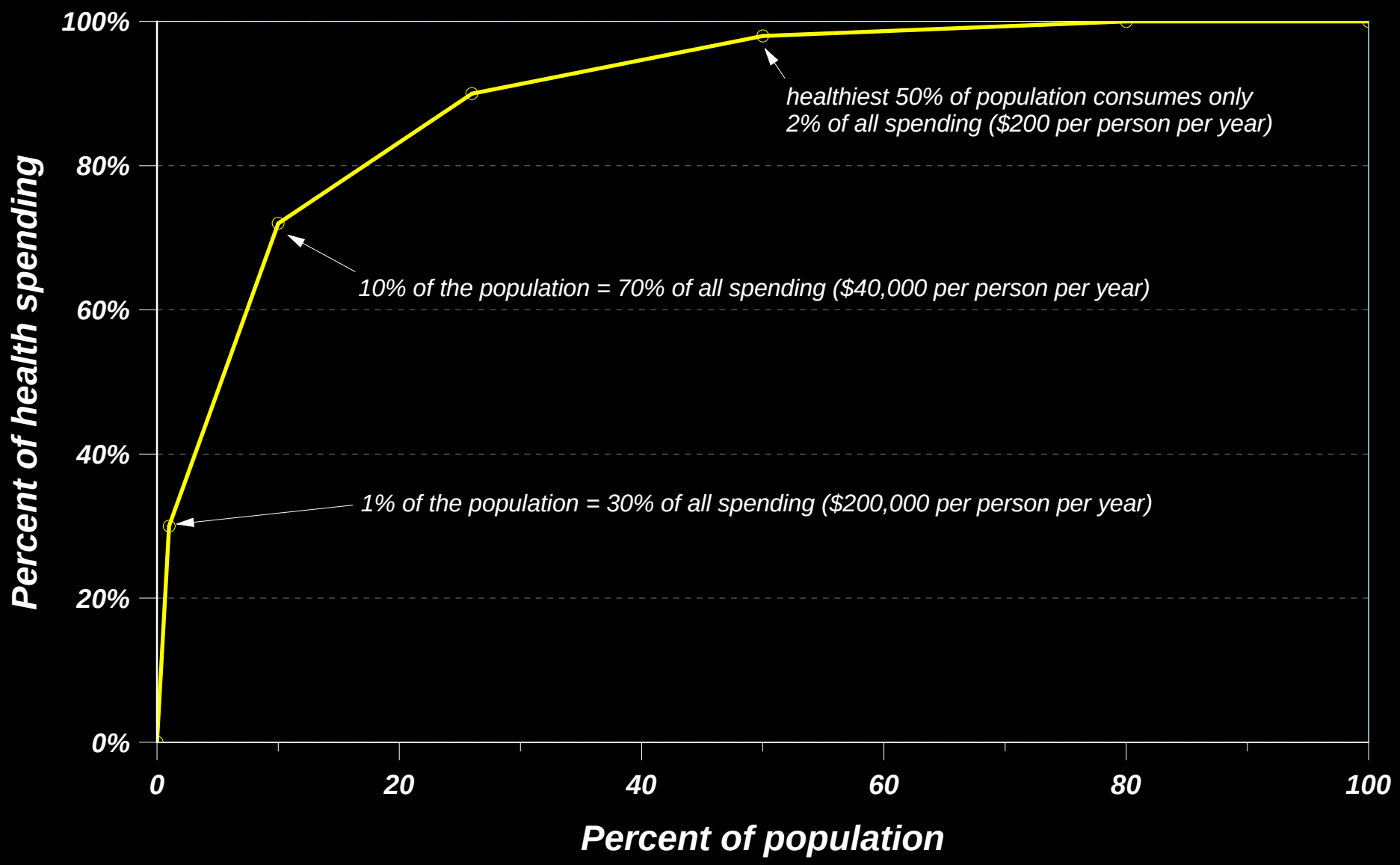
(we believe that other health care delivery groups will face similar shifts)

1. ***Quality improvement*** *(higher quality drives lower cost)* ***is the science of process management***

2. ***A focus on process management forces patient-centered care*** *- care built along the full continuum of care; not buildings, technologies, or physicians*

3. ***Combining patient- centered care with various levels of provider-at-financial-risk forces population-level care and the triple aim***
   - collaborating with other community organizations (churches, schools, local governments, etc.) to promote best health and high function

A few of the people = most of the money



Source: National Medical Expenditure Survey (1997)

Hot spotting

Tools to identify patients likely to have significant health care needs (and costs) now or in the future;

coupled with interventions known to prevent future needs (reducing costs through better care)

Core idea: Prevention defined and applied broadly; "Move upstream" in a classic quality improvement waste elimination approach

First popularized in an article written by Dr. Atul Gawande published in New Yorker Magazine on January 24, 2011; focused on the work of Dr. Jeffrey Brenner in New Jersey

Hot spotting examined broadly

1. ***High utilizers*** *(hospitalization; ED; urgent care; office visits)*
   - *will be exacerbated by reductions in Federal payments (cost shifting)*
2. ***End of life care*** *(Sutter, MGH case studies)*
3. ***Extended palliative care*** *(Dr. Diane Meier)*
   - *home visits to the elderly to prevent ED visits*
   - *mostly pain control, bowel habits*
4. ***Archimedes system*** *(identifies risk of CVD, diabetes, etc.)*
5. ***Pediatric "special needs" clinic*** *(Dr. Ed Clark)*
6. ***Chronic disease management*** *(Clinical Programs CPMs)*
7. ***Shared decision making*** *(preference-sensitive surgery)*
8. ***Patient engagement*** *(telehealth; patient as "first caregiver")*
9. ***Healthy behaviors*** *(partner w other community organizations [schools, churchs, etc.] around tobacco, EtOH, diet/exercise, etc.)*

Hot spotting infrastructure

- ***Requires a coordinating center***
  - *run analysis: identify now or future high utilizer patients*
  - *identify and assign "orphan" patients*

- ***Requires further coordination across settings***
  - *primary care, hospital, home health, hospice, etc.*

A new health care delivery world ...

- ***All the right care*** *(no underuse)**, but***
- ***only the right care*** *(no overuse)**;***
- ***Delivered free from injury*** *(no misuse)**;***
- ***At the lowest necessary cost*** *(efficient)**;***
- ***Coordinated along the full continuum of care*** *(timely; "move upstream")**;***
- ***Under each patient's full knowledge and control*** *(patient-centered; "nothing about me without me")**;***
- ***With grace, elegance, care, and concern.***

Better has no limit ...

an old Yiddish proverb