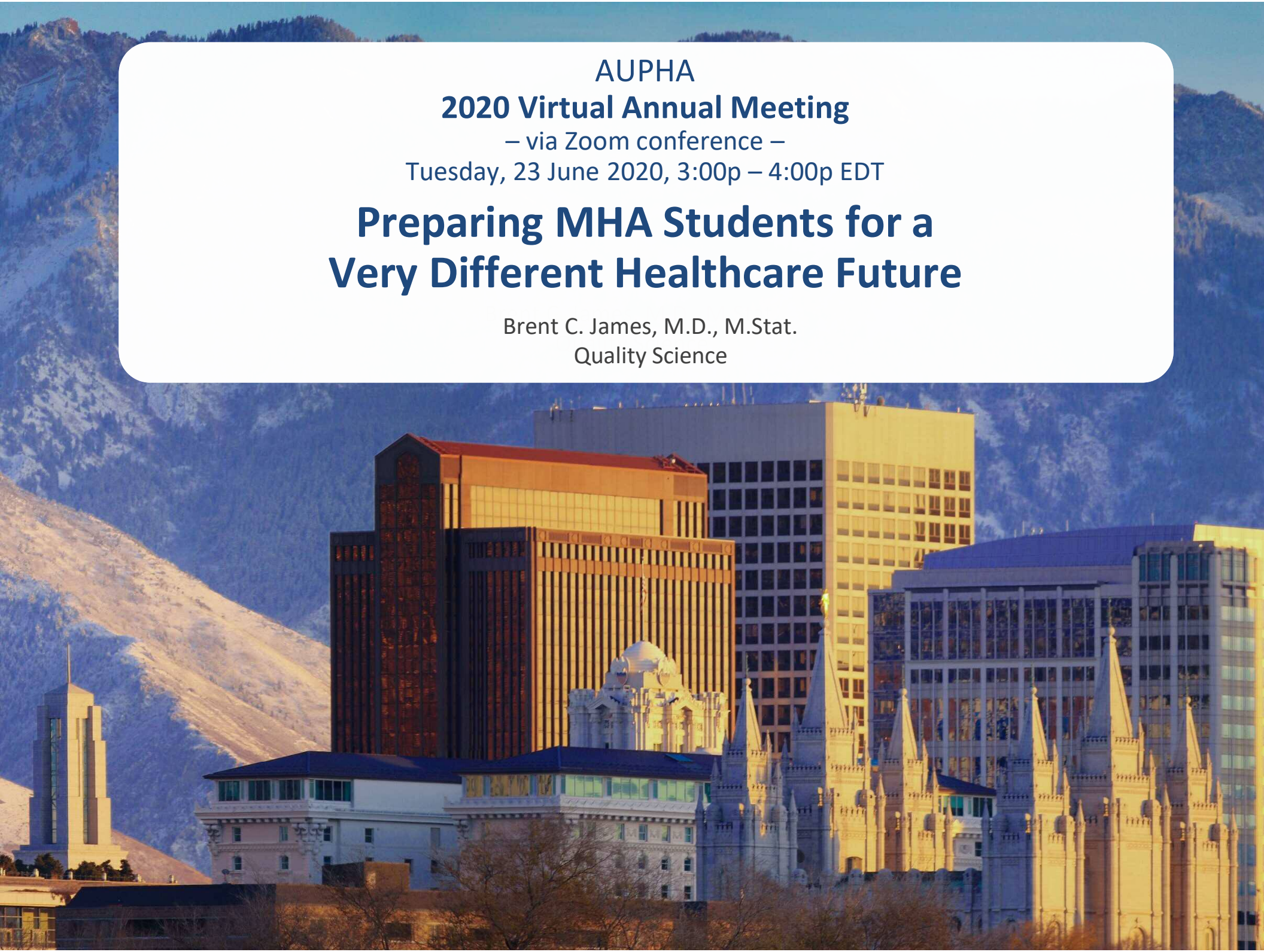


AUPHA

2020 Virtual Annual Meeting

– via Zoom conference –

Tuesday, 23 June 2020, 3:00p – 4:00p EDT

Preparing MHA Students for a Very Different Healthcare Future

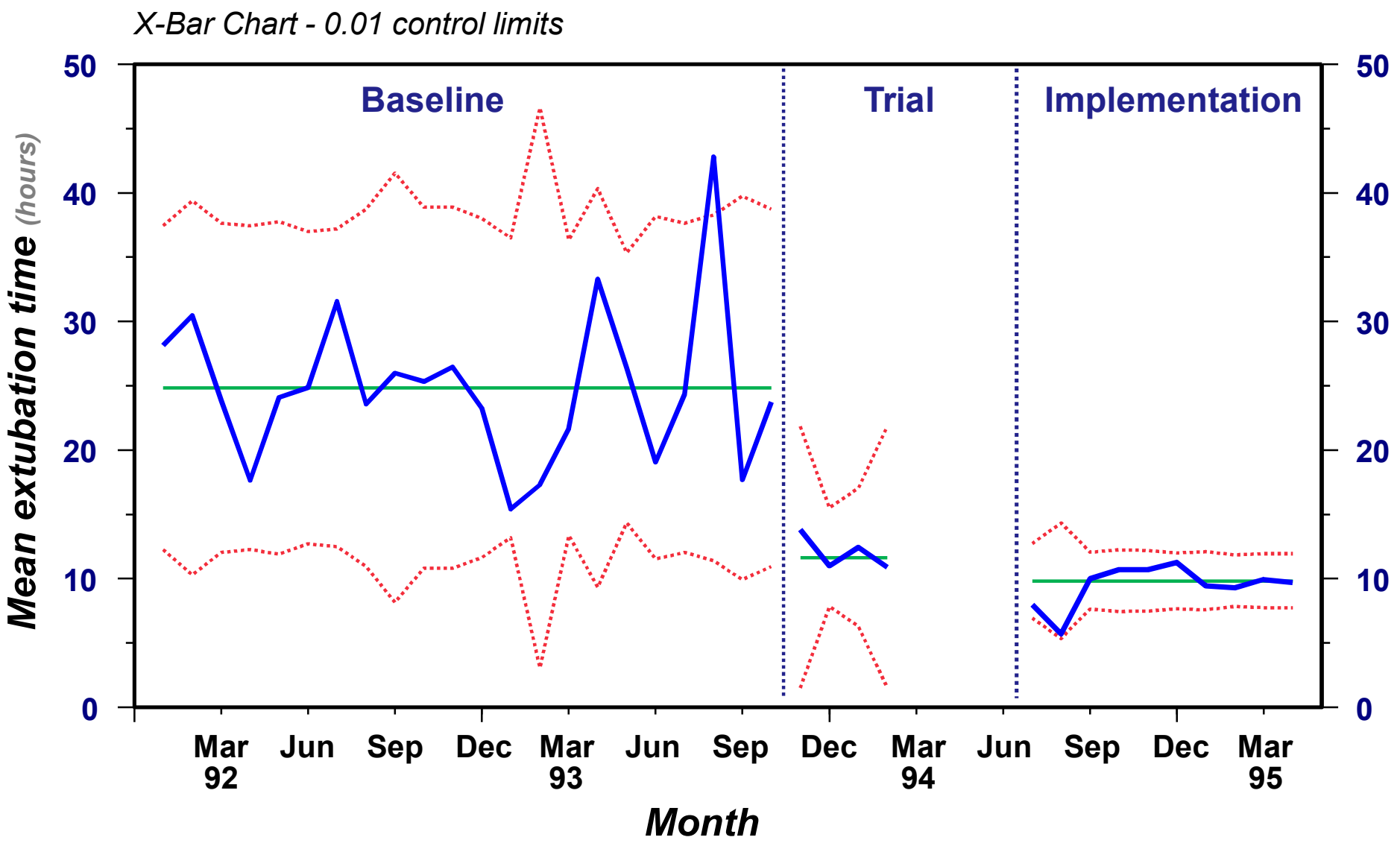
Brent C. James, M.D., M.Stat.
Quality Science

Disclosures

*I receive a monthly retainer as a part time (3 days / month) senior advisor for **Health Catalyst**.*
I also own (a small amount of) Health Catalyst stock.

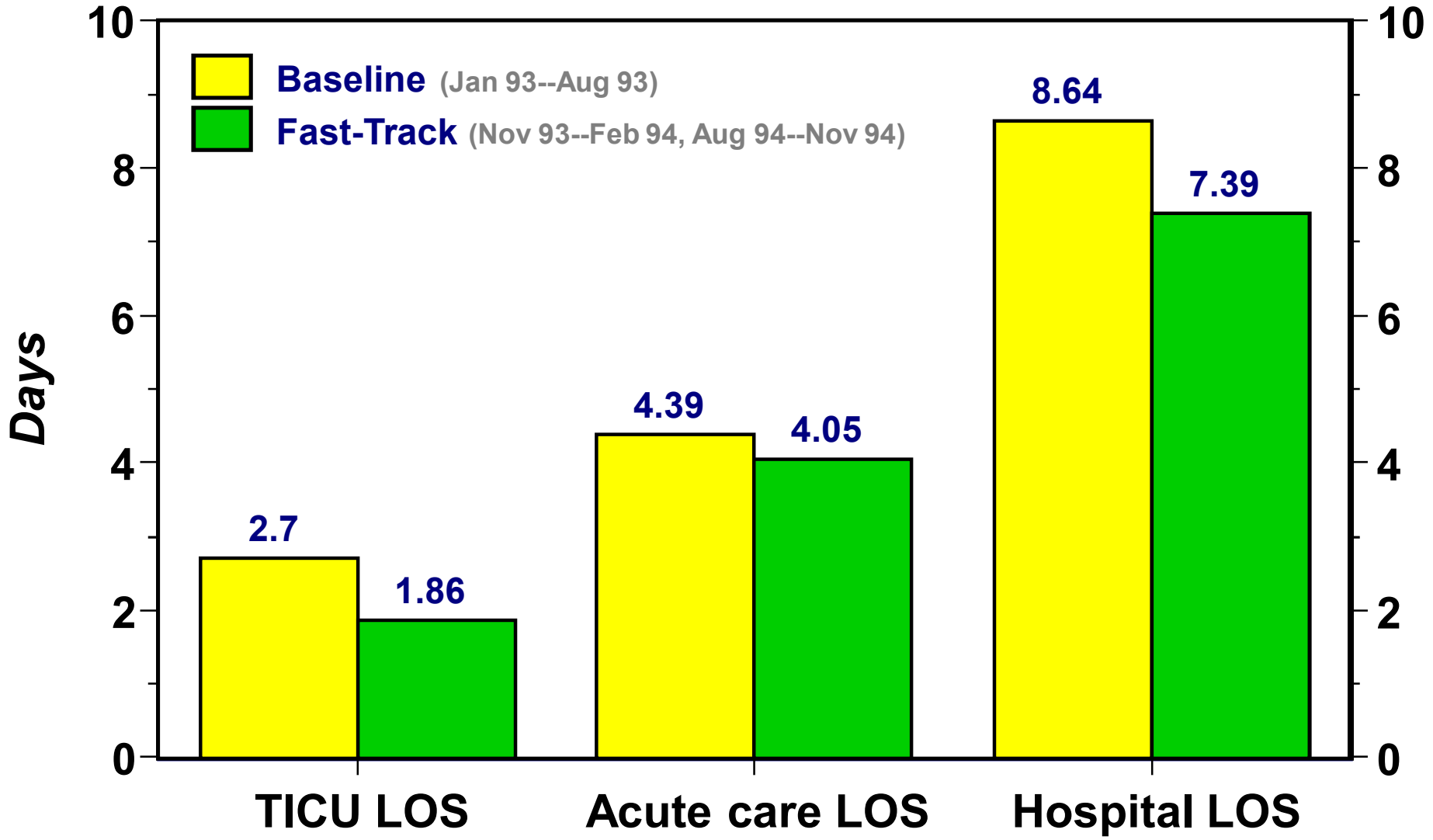
Other than that, neither I nor any family members have any relevant financial relationships to be directly or indirectly discussed, referred to or illustrated within the presentation, with or without recognition.

Fast-track extubation protocol



LDS Hospital Heart Services

Fast-track extubation protocol



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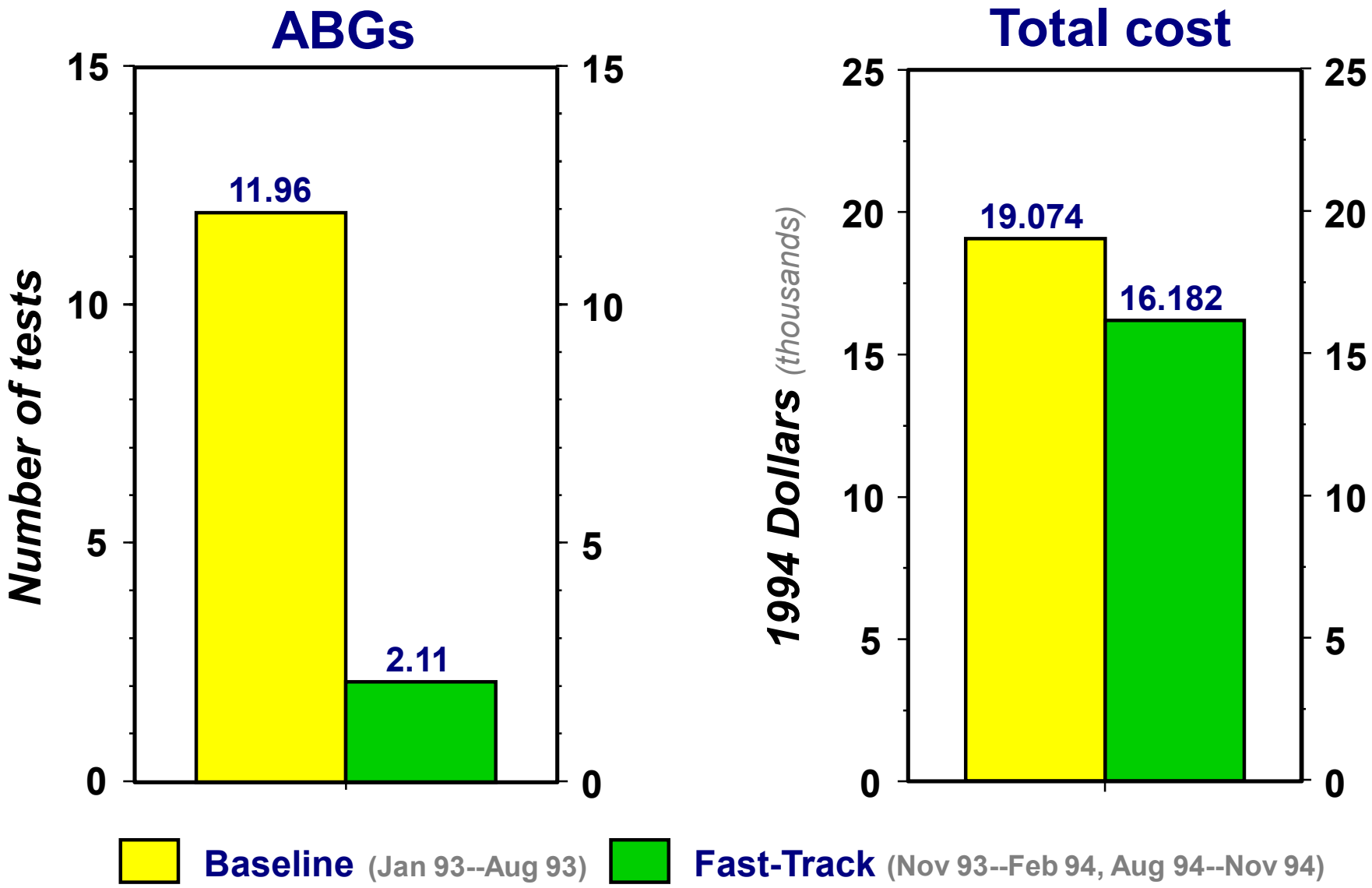


LDS Hospital Heart Services

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

1. ***Massive variation in clinical practices*** *(beyond even the remote possibility that all patients receive good care)*
2. ***High rates of inappropriate care*** *(where the risk of harm inherent in the treatment outweighs any potential benefit)*
3. ***Unacceptable rates of preventable care-associated patient injury and death***
4. ***Striking inability to "do what we know works"***

James, B.C. Testimony to the U.S. Senate Finance Committee, February 2009

Variation leads to waste

30-50+% *of all health care resource expenditures are*

quality-associated waste:

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

Institute of Medicine Roundtable on Value and Science-Driven Healthcare. T*he Healthcare Imperative: Lowering Costs and Improving Outcomes*. Yong, Pierre L., Saunders, Robert S., and Olsen, LeighAnne, editors. Washington, DC: National Academy Press, 2010.

Some viable estimates suggest

*as much as **65%** of all care delivery spending is quality-associated waste.*

In 2020, that's as much as $2 trillion in financial opportunity;

***10 to 100 times** greater than opportunities associated with traditional revenue models*

Quality is ***not*** free *(Phil Crosby was waxing poetic)*

It always requires investment

- *change leadership (time and thought),*
- *study and investigation,*
- *data systems,*
- *physical plant, equipment …*

it's just that it has a

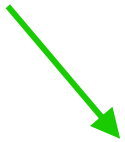
massive return on investment *(ROI)*

MUCH higher ROI from waste elimination than from revenue growth

Revenue growth:

5 to 9% contribution

for each case added



Net Operating Margin

(and return on investment)

Waste elimination:

50 to >100% contribution

for each case avoided

We know why this happens

Causes of clinical variation

1. ***Complexity*** *(clinical uncertainty)* *in the context of*
2. *continued, primary* ***Reliance on human memory***
   – the "craft of medicine" *and*
3. ***Low transparency*** *– poor data linking clinical choices to patient outcomes in routine practice*

Management strategies that fail to address these root causes will perform suboptimaly or fail entirely

We have found proven solutions

(a clinical management method)

Quality Science

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*** *(= clinical decision support; don't rely on human memory; make "best care" the lowest energy state, default choice that happens automatically unless someone must modify)*
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 those data back*** *(variations, outcomes)* ***in a Lean Learning Loop*** *- constantly update and improve the protocol*

James Brent C., Savitz Lucy A. How Intermountain trimmed health care costs through robust quality improvement efforts. *Health Affairs* 2011; 30(6):1185-91 (June).

Lesson 1

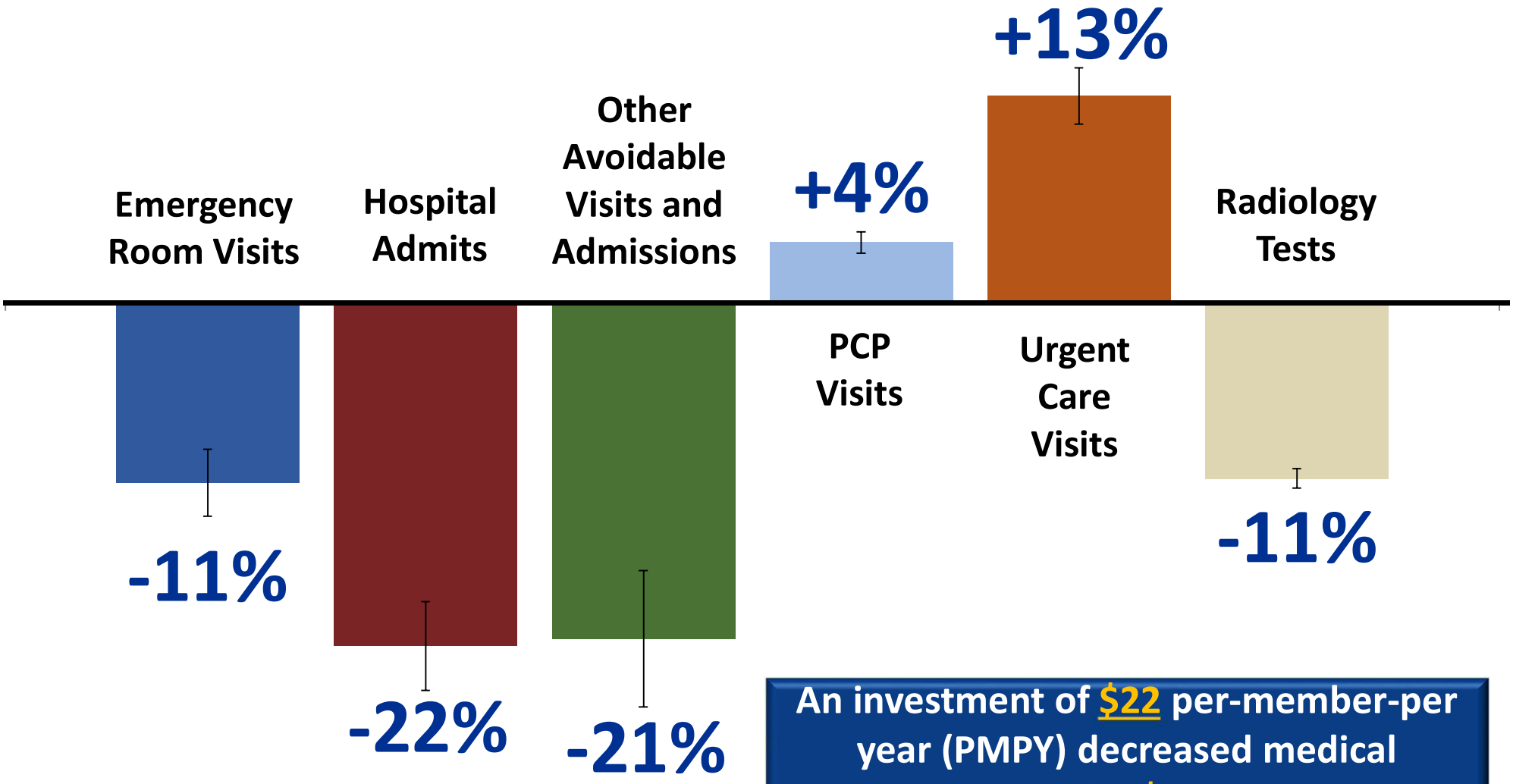
Within the healing professions,

We count our successes in lives

(Mission always comes first)

Team-Based Care

(3rd generation patient-centered medical home)



An investment of $22 per-member-per year (PMPY) decreased medical expenses by $115 PMPY

Reiss-Brennan B, Brunisholz KD, Dredge C, Briot P, Grazier K, Wilcox A, Savitz L, and James B. Association of integrated team-based care with health care quality, utilization, and cost. *JAMA* 2016; 316(8):826-34 (Aug 23/30).

Lesson 2

Nearly always

better care is cheaper care

through waste elimination

Nested levels of waste

	Waste class	% of all waste	Waste subclasses
3.	Case-rate utilization *(# cases per population)*	45%	a) Inappropriate cases *(risk outweighs benefit)* *(e.g., many cath lab procedures; CTPA)* b) Preference-sensitive cases *(when given a fair choice, many patients opt out)* *(e.g., elective hips, knees; end-of-life care)* c) Avoidable cases *(hot spotting; move upstream)* *(e.g., team-based care)*
2.	Within-case utilization *(# and type of units per case)*	40%	a) Clinical variation *(e.g., QUE studies; surgical equipment)* b) Avoidable patient injuries *(e.g., serious safety event systems; CLABSI)*
1.	Efficiency *(cost per unit of care)*	15%	a) Supply chain b) Administrative inefficiencies *- regulatory burden - billing thrash* *- TPS Lean observation - current EMR function*

Financial alignment under different payment mechanisms

WASTE REMOVAL LEVEL	% of all waste	PAYMENT METHOD: FFS	Per case	Provider at risk
3. Case-rate utilization *(# cases per population)*	45%	▼	▼	▲
2. Within-case utilization *(# and type of units per case)*	40%	▼	▲	▲
1. Efficiency *(cost per unit of care)*	15%	▲	▲	▲

Note: For green arrows, savings from waste elimination accrue to the care delivery organization; for red arrows, savings go to payer organizations.

James Brent C and Poulsen Gregory P. The case for capitation: It's the only way to cut waste while improving quality. *Harv Bus Rev* 2016; 94(7-8):102-11, 134 (Jul-Aug).

Lesson 3: Financial alignment

Who makes the investment?

(always a care delivery group – it is clinical change)

versus

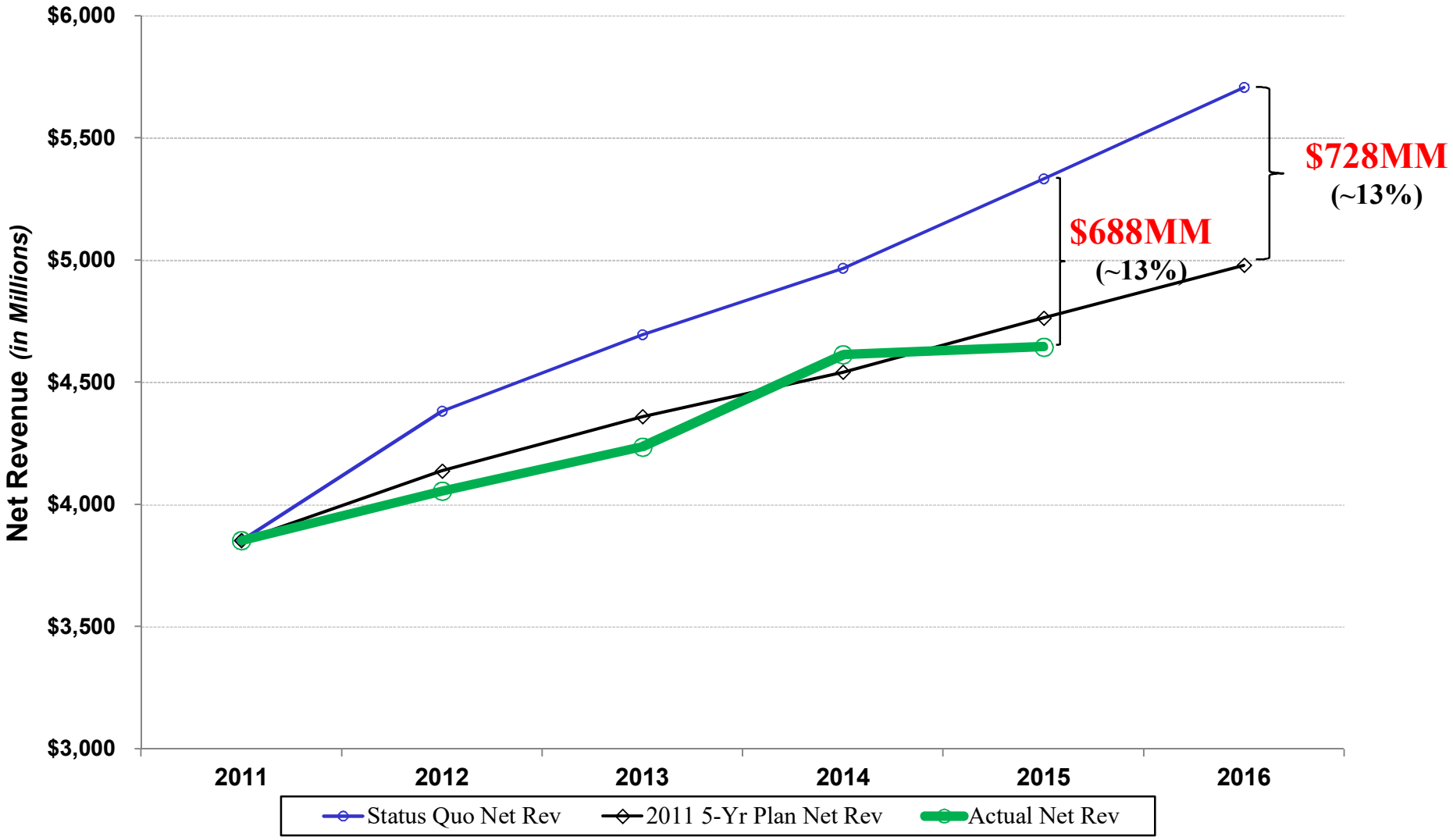
Who gets the waste savings?

(depends on type of waste, versus payment mechanism)

There are proven, viable ways to address this, even under fee-for-service

(coming later in the series)

Financial impact of clinical quality improvement at Intermountain



James Brent C and Poulsen Gregory P. The case for capitation: It's the only way to cut waste while improving quality. *Harv Bus Rev* 2016; 94(7-8):102-11, 134 (Jul-Aug).

Given that framework,

What does the future hold?

What knowledge and skills will MHA students "need to succeed" in the future, compared to today?

Walter Gretzky (Wayne Gretzky's father):

Skate to where the puck is going to be, not where it has been.

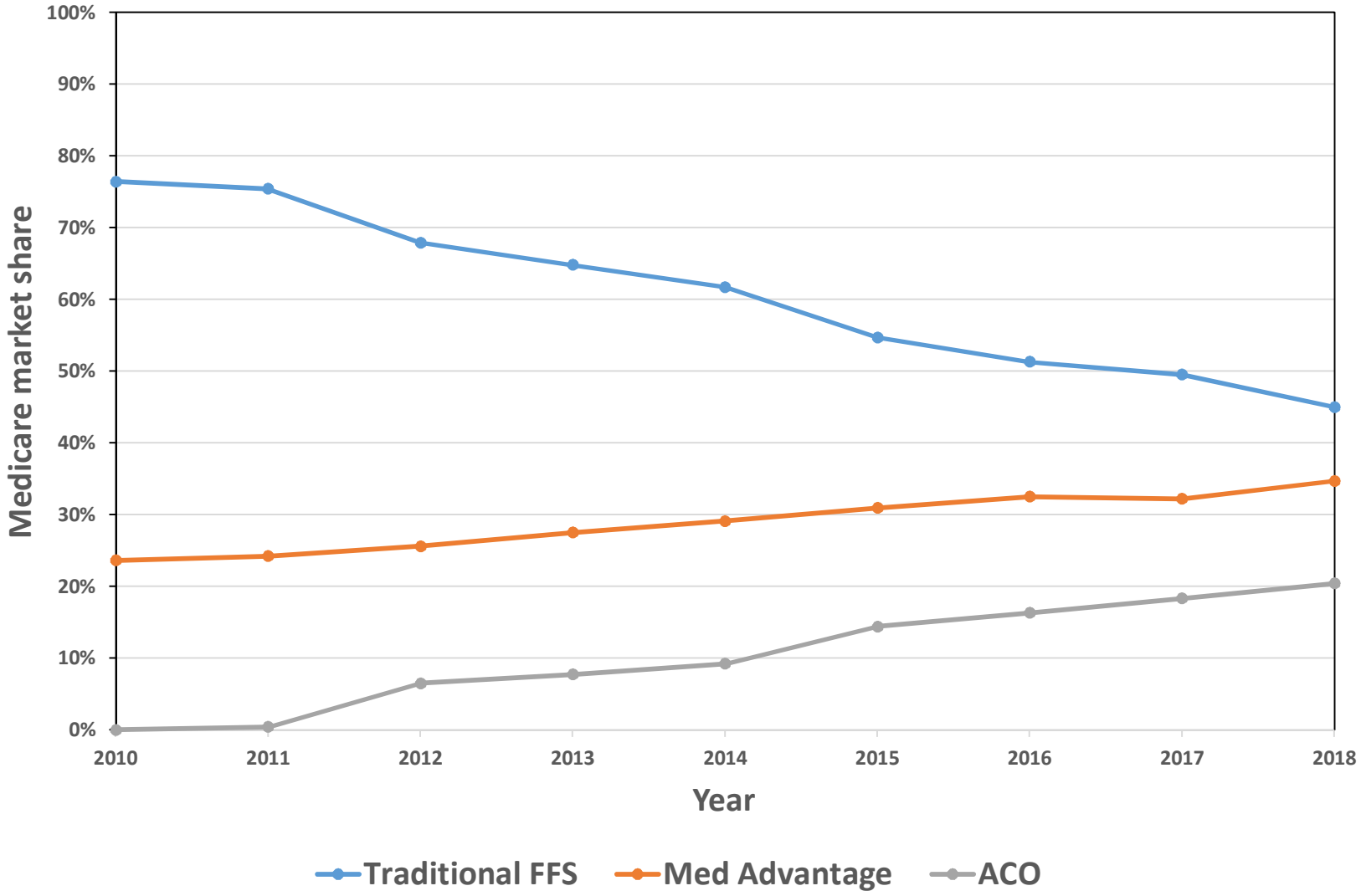
“Pay for value” continues to grow

Forward looking indicators:

- ***Kaiser Permanente*** *(continued rapid growth within existing geographic markets)*
- ***Medicare Advantage*** *(continued rapid growth)*

  ACOs *(Leavitt Group – continued growth; mostly commercial)*

Medicare trends over time



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- ***ERISA direct to provider contracting***
  (11% of large employers, according to Modern Healthcare)

“Pay for value” continues to grow

Forward looking indicators:

- ***Kaiser Permanente*** *(continued rapid growth within existing geographic markets, mostly)*
- ***Medicare Advantage*** *(continued rapid growth)*
  ACOs *(Leavitt Group; mostly commercial)*
- ***ERISA direct to provider contracting***
  (11% of large employers, according to Modern Healthcare)
- ***Provider-payer consolidation*** *(vertical alignment)*
  by ownership or partnership (e.g., UPMC; United Healthcare; HPH / Queens Health Systems partnerships with HMSA)

Implications – we will see:

- ***Increasing focus on waste elimination through "move upstream" strategies:***
  primary care-based population health and clinical variation control using clinical decision support tools *(a.k.a. clinical knowledge management = "learning healthcare systems")*

- ***Care delivery organizations will increasingly seek capitated risk*** *through ownership or partnership* *(role of health insurance organizations changes dramatically)*

- ***Stand-alone specialty care practices and hospitals become "price takers"*** *– intense competition mainly around payment rates*

Are we preparing our students to thrive in this new health care delivery world?

One last critical idea …

A question:

What is the single most important factor that determines

- *clinical quality of care / patient experience of care*
- *perceptions in the community* (*"back door" advertising – dramatically more effective than <u>any</u> other modality in driving patient volume and market share)*
- *productivity*
- *long-term financial performance?*

The answer:

Medical staff and workforce engagement / morale

Prominent thought leader: *Dr. Stephen J. Swensen*

- *recently retired from Mayo Clinic* (*Mayo's Chief Quality Officer, then head of Leadership Development)*
- *now lives in Heber, Utah* (*avid Nordic skier)*
- *his new book on the topic came out on 7 February 2020 –* Mayo Clinic Strategies to Reduce Burnout

Another possible resource: *Jill Green*, *COO, Mission Health, North Carolina*
(*c/o Health Catalyst)*

Better has no limit ...

an old Yiddish proverb