Issues Forum:
Surviving Health Care Reform

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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.
1. The roots of reform

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

The uninsured - who are they?

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncitizens</td>
<td>9.5 million</td>
<td>(~20.7%)</td>
</tr>
<tr>
<td>Eligible but not enrolled</td>
<td>12 million</td>
<td>(~26.1%)</td>
</tr>
<tr>
<td>Temporarily uninsured (job change)</td>
<td>9 million</td>
<td>(~19.6%)</td>
</tr>
<tr>
<td>Free riders (income &gt; $84,000)</td>
<td>7 million</td>
<td>(~15.2%)</td>
</tr>
<tr>
<td>Long-term uninsured</td>
<td>8 million</td>
<td>(~17.4%)</td>
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“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.”

Total U.S. fiscal exposures

By layering on future obligations, the total net present 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.


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

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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.

1. Massively raise taxes (mandatory health insurance; increased Medicare copays and deductibles; fees on pharma, device makers, care providers, insurers, etc., passed along to patients)
2. Decrease benefits (e.g., cut Medicare Advantage, means test Medicare; tighten coverage criteria for specific interventions)
3. Shift money from other areas in the federal budget
4. Shift responsibility to States
5. Decrease payments to care providers
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), **spiralizing prices, and limited access** (46.6 million uninsured Americans, increasing rates of under-insured, employers exiting the insurance market, medical tourism)
50+\% of all resource expenditures in hospitals and clinics 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

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:
• Enthusiasm 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*. 
Sepsis bundle compliance

Sepsis mortality - ER-ICU transfers

~116 fewer inpatient deaths per year
1. Diabetes, HbA1c Testing
   The percent of patients with diabetes who had a HbA1c test within the last 12 months:
   Your Achievement: 70%
   System Goal: 60%
   Managed Care Incentive Goal: 55%
   Your Score in this area is: 80%

2. Diabetes, LDL Testing
   The percent of patients with diabetes who had an LDL test within the last 12 months:
   Your Achievement: 94%
   System Goal: 60%
   Managed Care Incentive Goal: 65%
   Your Score in this area is: 100%

3. Urine Microalbuminuria Screen
   Number of patients with a diagnosis of diabetes who had an appropriate urine screen in last 12 months:
   Your Achievement: 75%
   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: 91%
   Your Score in this area is: 100%

5. Clinical Learning Day
   Attendance of Clinical Learning Day Program in 2000 or 2001:
   Your Score in this area is: 100%

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
- 10% from Item 4 Asthma Care
- 25% from Item 5 Attend Clinical Learning Day

Your Total Managed Care Incentive Score is: 75%

Poor HbA1c control
Excellent lipid control

![Graph showing the percentage of diabetic patients with LDL < 100](image)

CPM with clinic care managers

**Complex diabetes patients - hospitalization rates**

<table>
<thead>
<tr>
<th></th>
<th>1 year</th>
<th>2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>26%</td>
<td>39%</td>
</tr>
<tr>
<td>Care management</td>
<td>21%</td>
<td>31%</td>
</tr>
</tbody>
</table>

(All patients)
Physicians with embedded care management support were significantly (8%) more productive than controls.
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 $):

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

5. The healing professions are changing

From craft-based practice
- individual physicians, working alone (housestaff ::= apprentices)
- handcraft a customized solution for each patient
- based on a core ethical commitment to the patient and
- vast personal knowledge gained from training and experience

To profession-based practice
- groups of peers, treating similar patients in a shared setting
- plan coordinated care delivery processes (e.g., standing order sets)
- which individual clinicians adapt to specific patient needs
- early experience shows
  - less expensive (facility can staff, train, supply an organize to a single core process)
  - less complex (which means fewer mistakes and dropped handoffs, less conflict)
  - better patient outcomes
Why "profession-based" practice?

1. It produces better outcomes for our patients
2. It eliminates waste, reduces costs, and increases available resources for patient care
3. It puts the caring professions back in control of care delivery
4. It is the foundation for useful shared electronic data -- an important next step in care delivery improvement

An era of very rapid change

- The professions passed the tipping point roughly 9 years ago; accelerating very rapidly
- Similar major change in care delivery operations
- Tightly linked to better internal data (true transparency)
- Often called "Organized Care:" Health care as an organized system focused around patient need (not built around physicians or technology)
- Key policy need: Financial incentives (payment) aligned to appropriate patient-centered professional goals
- Key operational idea: Don't wait for Washington
Mortality amenable to health care

Deaths per 100,000 population


The Wall Street Journal

Perverse Incentives in Health Care
April 5, 2007
John C. Goodman, President, National Center for Policy Analysis

Research at Dartmouth Medical School suggests that if everyone in America went to the Mayo Clinic, our annual health-care bill would be 25% lower (more than $500 billion!), and the average quality of care would improve. If everyone got care at Intermountain Healthcare in Salt Lake City, our healthcare costs would be lowered by one-third.

Of course, not everyone can get treatment at Mayo or Intermountain. But why are these examples of efficient, high-quality care not being replicated all across the country? The answer is that high-quality, low-cost care is not financially rewarding. Indeed, the opposite is true. Hospitals and doctors can make more money providing inefficient, mediocre care.
December 2006

**Wells Fargo inflation summary, 1988-2006**

### COST OF LIVING INDEX

<table>
<thead>
<tr>
<th>Wasatch Front</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index</strong></td>
<td><strong>% Change</strong></td>
</tr>
<tr>
<td>All Categories</td>
<td>154.6</td>
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<tr>
<td>Housing</td>
<td>182.8</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Health Care</td>
<td>157.2</td>
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<tr>
<td>Food at Home</td>
<td>201.2</td>
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<tr>
<td>Clothing</td>
<td>113.2</td>
</tr>
<tr>
<td>Food Away</td>
<td>162.2</td>
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<tr>
<td>Utilities</td>
<td>128.7</td>
</tr>
<tr>
<td>Recreation</td>
<td>139.1**</td>
</tr>
<tr>
<td>Education &amp; Comm.</td>
<td>124.6**</td>
</tr>
<tr>
<td>Other Goods &amp; Svs.</td>
<td>104.3**</td>
</tr>
</tbody>
</table>

*Last six-month percentage change compared with same period one year ago.

**National Data Source: U.S. Bureau of Labor Statistics**

### Looking ahead - the next 5 years

- **Massive pressure on health care costs**
  - PPACA will accelerate cost increases

- **Increased emphasis on payment reform**
  - ACOs, bundled payment, disease capitation
  - Medicare Part C (provider-at-risk Medicare Advantage "Lite")

- **Ballooning "transparency"**
  - continuing expansion of external quality measurement systems

- **Steady progress on shared health IT**

- **Continued shift to "organized care"**
"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