National Conference of State Legislatures
2010 Legislative Summit
Room 109-112, Kentucky Intl Convention Center, Louisville,Kentucky
Wednesday, 28 July 2010 -- 8:00a - 9:30a

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*

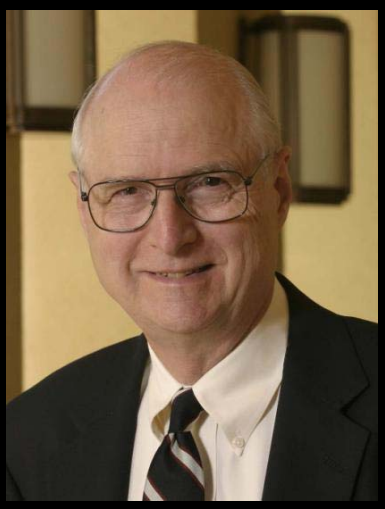
The uninsured - who are they?

Noncitizens		*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		*8 million*	*(~17.4%)*

Source: Rep. Lamar Smith, Christian Science Monitor, 16Aug09

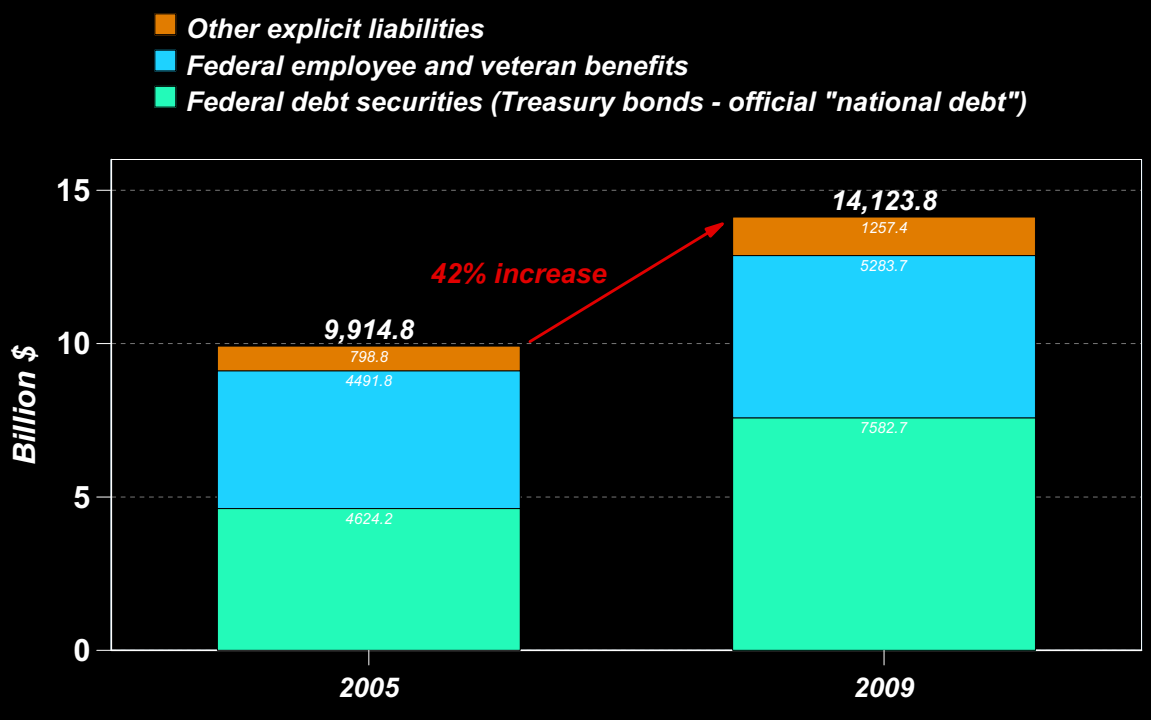
Reform, Part Deux

"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

U.S. national debt

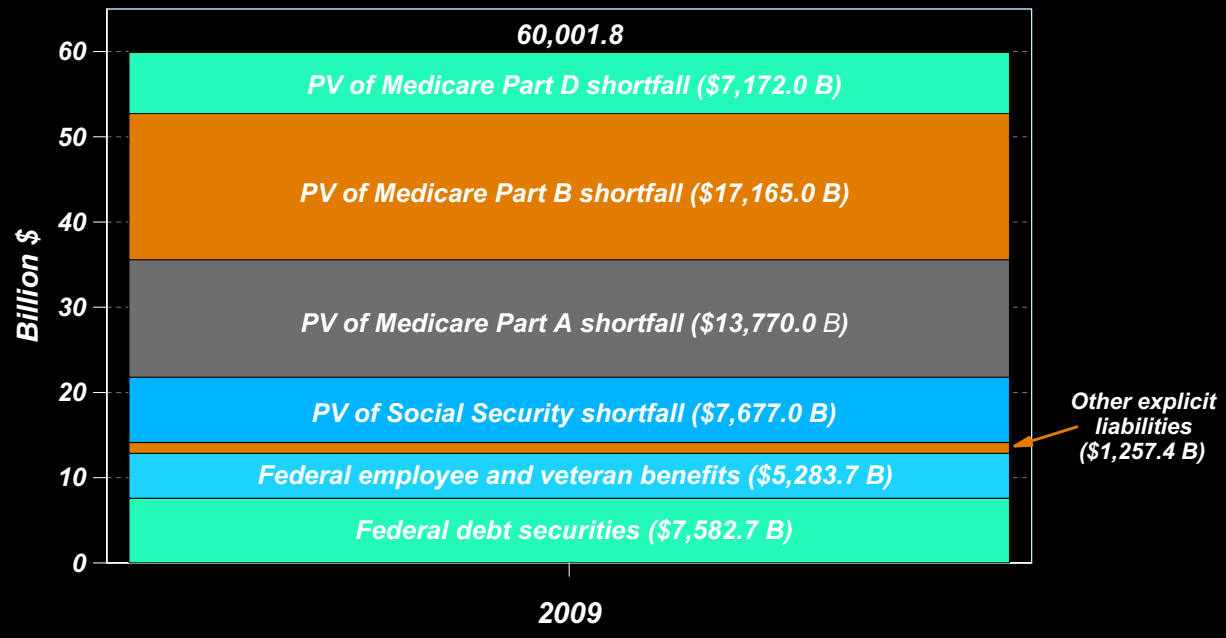


Over $45,000 for every man, woman and child in the U.S.

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 imbala
addressed in several diff
changes would r *ent*
increase

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.

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

Funding federal health care

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)*, ***spiraling 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:

- *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

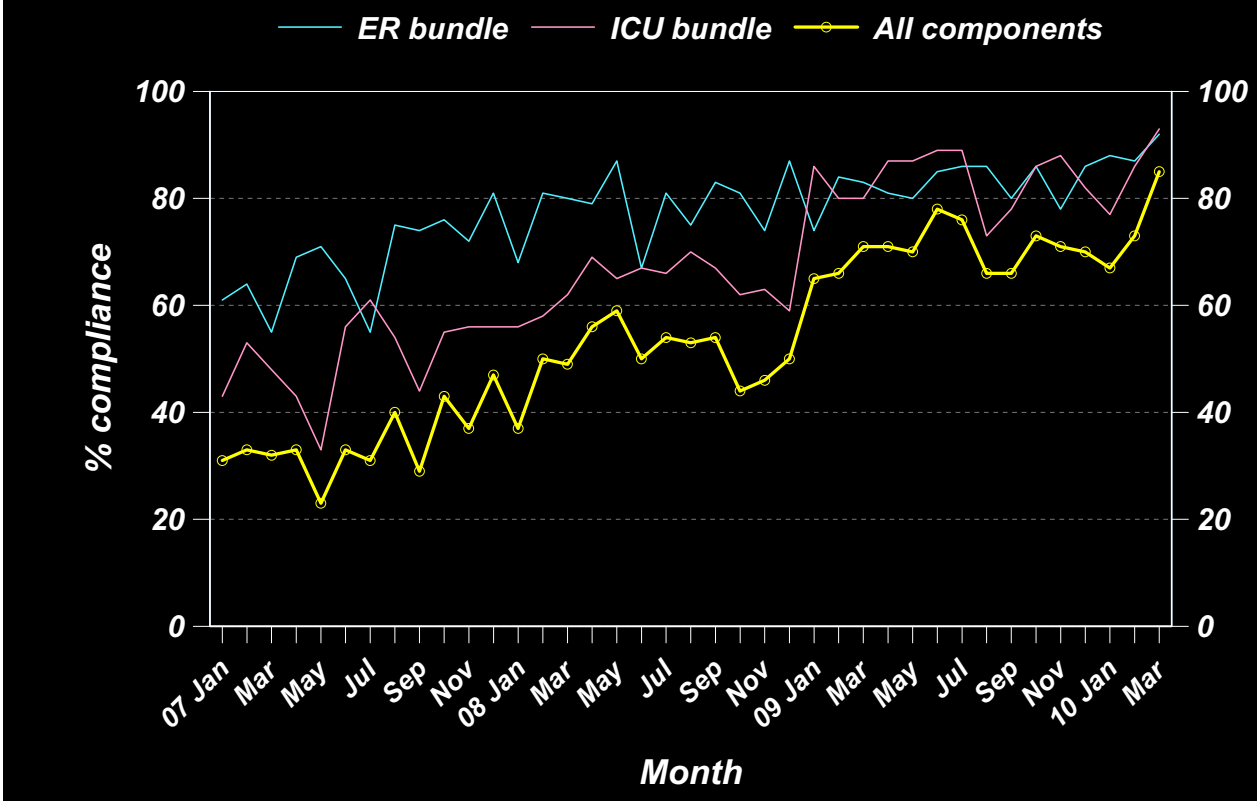
When abstract guidelines hit real patient care, experience clearly shows that *(with very rare exception)*

No protocol fits <u>every</u> patient;

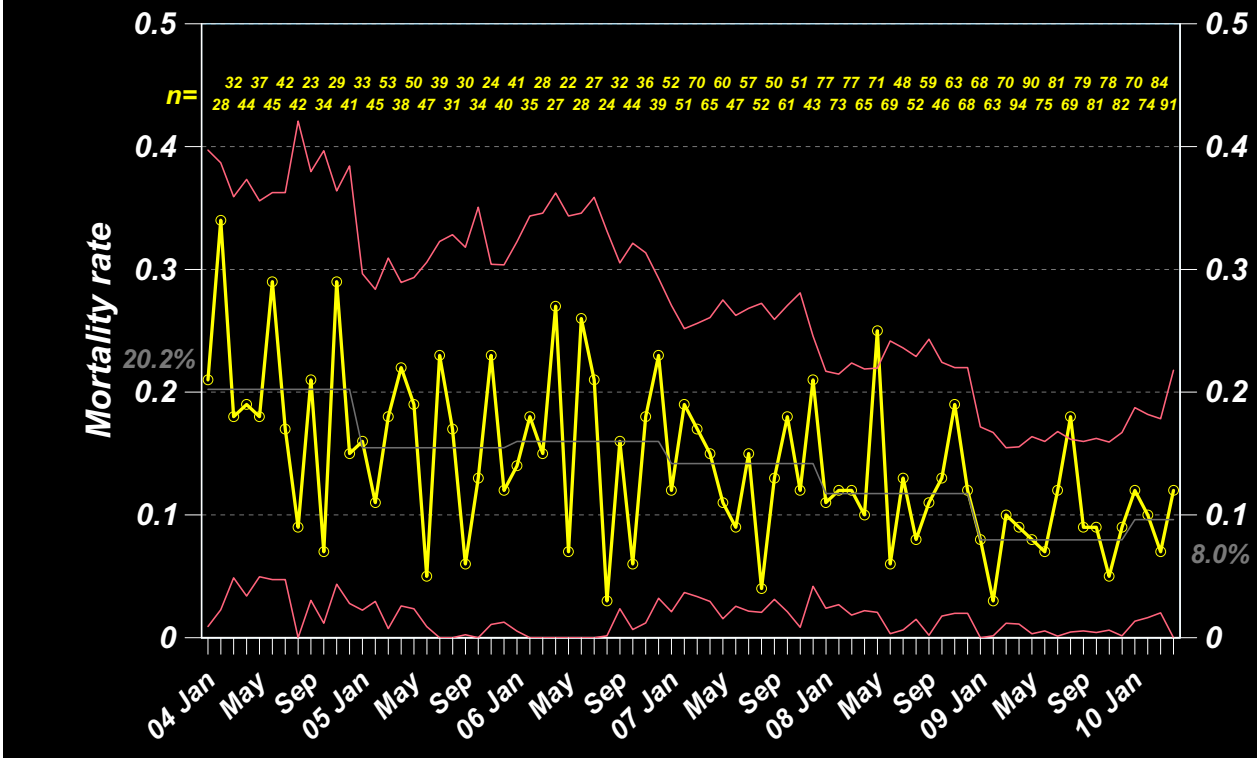
more important,

No protocol *(perfectly)* ***fits <u>any</u> patient.***

Sepsis bundle compliance



Sepsis mortality - ER-ICU transfers



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	LDL Value**	Last A1c: Date	A1c 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	LDL Value**	Last A1c: Date	A1c 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													

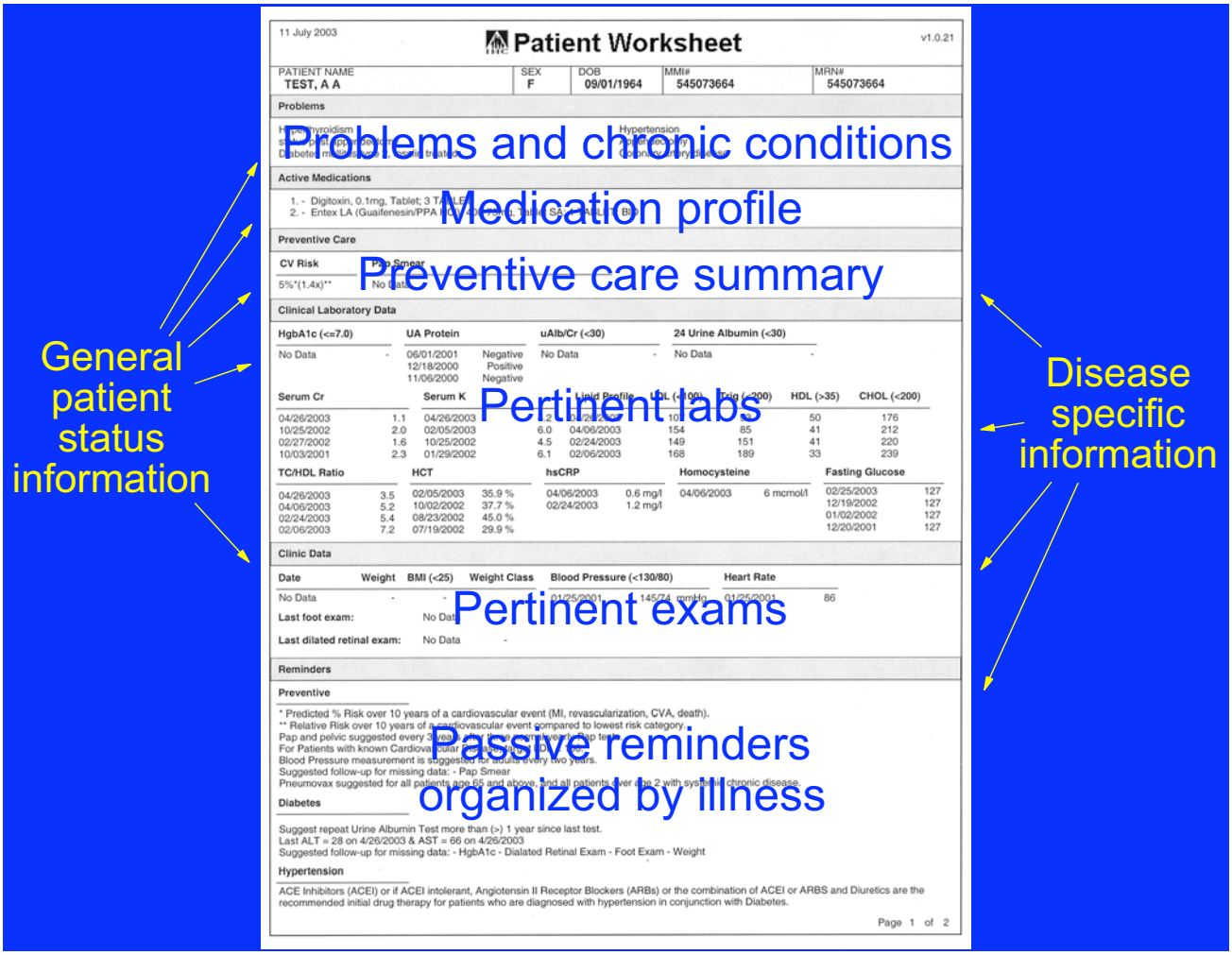
Note: Higher Risk Patients are those whose last A1c value was >8.0, last LDL>100, Triglycerides>400, or not tested during the reporting period

* 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.



Diabetes Summary Report

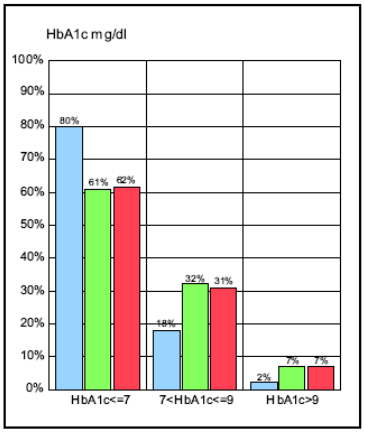
Provider: Towner, Steven (168)

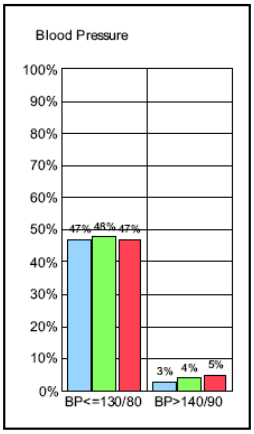
Period: Jan 2005 - Dec 2005

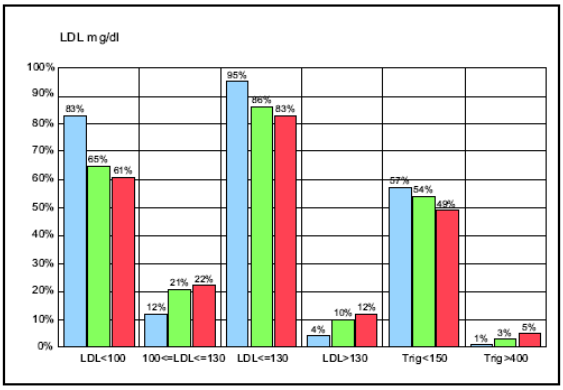
Patients Tested (Prop of Tot Pts%) - All Patients

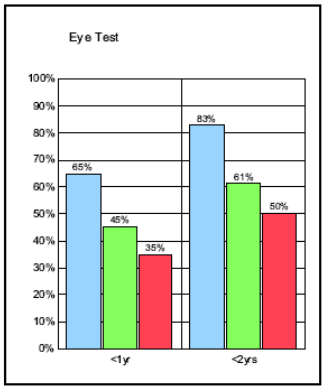
	Provider	Region	System
HbA1c	188(97%)	1,582(90%)	25,429(83%)
LDL	190(98%)	1,658(94%)	26,040(85%)
Eye Exam	159(82%)	399(23%)	6,509(21%)
Microalbuminuria	159(82%)	1,236(70%)	14,969(49%)
Blood Pressure	188(97%)	1,248(71%)	15,344(65%)
Total Patients	**194**	**1,757**	**30,470**

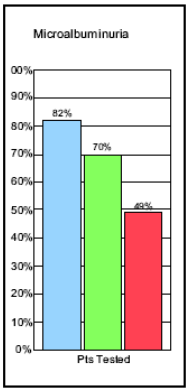
1. LDL measures represent two years ending in the chose period. 2. Eye exam % calculated using Health Plans patients only. 3.Includes spot microalbumin, 24 hour urine for protein and microalbumin/creatine ratio within the reporting period, or any history of treatment for nephropathy. 4. Blood pressure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

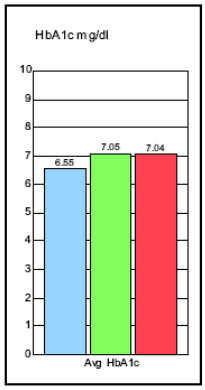












IHC Primary Care Clinical Programs: Adult Diabetes Medical Director Summary Report

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

Medical Director: Towner

Family Practice

	Diabetes Patient Count	Hemoglobin A1c Summary: Tested	Tested, result NA	Percentages based on only those with available A1c results: A1c<=7.0	7.0<A1c<=8.0	A1c>8.0	LDL Summary: Tested	Tested, result NA	Percentages based on only those with available LDL results: LDL<=100	100<LDL<=130	LDL>130
IHC Health Plans	50	44(88%)	0(0%)	17(39%)	13(30%)	14(32%)	47(94%)	0(0%)	25(53%)	13(28%)	8(17%)
All Other Payers	128	113(88%)	0(0%)	60(53%)	30(27%)	23(20%)	116(91%)	0(0%)	54(47%)	36(31%)	17(15%)
Combined	178	157(88%)	0(0%)	77(49%)	43(27%)	37(24%)	163(92%)	0(0%)	79(48%)	49(30%)	25(15%)
Family Practice Summary:											
IHC Health Plans	50	44(88%)	0(0%)	17(39%)	13(30%)	14(32%)	47(232%)	0(0%)	25(53%)	13(28%)	8(17%)
All Other Payers	128	113(88%)	0(0%)	60(53%)	30(27%)	23(20%)	116(91%)	0(0%)	54(47%)	36(31%)	17(15%)
Combined	178	157(88%)	0(0%)	77(49%)	43(27%)	37(24%)	163(92%)	0(0%)	79(48%)	49(30%)	25(15%)

Internal Medicine

	Diabetes Patient Count	Hemoglobin A1c Summary: Tested	Tested, result NA	Percentages based on only those with available A1c results: A1c<=7.0	7.0<A1c<=8.0	A1c>8.0	LDL Summary: Tested	Tested, result NA	Percentages based on only those with available LDL results: LDL<=100	100<LDL<=130	LDL>130
IHC Health Plans	49	41(84%)	2(4%)	18(46%)	10(26%)	11(28%)	47(96%)	1(2%)	25(54%)	16(35%)	5(11%)
All Other Payers	230	196(85%)	0(0%)	109(56%)	49(25%)	38(19%)	219(95%)	0(0%)	127(58%)	54(25%)	30(14%)
Combined	279	237(85%)	2(1%)	127(54%)	59(25%)	49(21%)	266(95%)	1(0%)	152(57%)	70(26%)	35(13%)
IHC Health Plans	33	31(94%)	0(0%)	16(52%)	6(19%)	9(29%)	28(85%)	1(3%)	11(41%)	12(44%)	1(4%)
All Other Payers	101	79(78%)	0(0%)	44(56%)	14(18%)	21(27%)	86(85%)	0(0%)	47(55%)	23(27%)	15(17%)
Combined	134	110(82%)	0(0%)	60(55%)	20(18%)	30(27%)	114(85%)	1(1%)	58(51%)	35(31%)	16(14%)
IHC Health Plans	18	14(78%)	0(0%)	9(64%)	4(29%)	1(7%)	17(94%)	0(0%)	11(65%)	3(18%)	2(12%)
All Other Payers	98	92(94%)	0(0%)	54(59%)	26(28%)	12(13%)	91(93%)	0(0%)	54(59%)	25(27%)	9(10%)
Combined	116	106(91%)	0(0%)	63(59%)	30(28%)	13(12%)	108(93%)	0(0%)	65(60%)	28(26%)	11(10%)
IHC Health Plans	49	40(82%)	0(0%)	24(60%)	4(10%)	12(30%)	49(100%)	0(0%)	25(51%)	16(33%)	6(12%)
All Other Payers	221	192(87%)	0(0%)	116(60%)	44(23%)	32(17%)	216(98%)	0(0%)	132(61%)	56(26%)	21(10%)
Combined	270	232(86%)	0(0%)	140(60%)	48(21%)	44(19%)	265(98%)	0(0%)	157(59%)	72(27%)	27(10%)

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

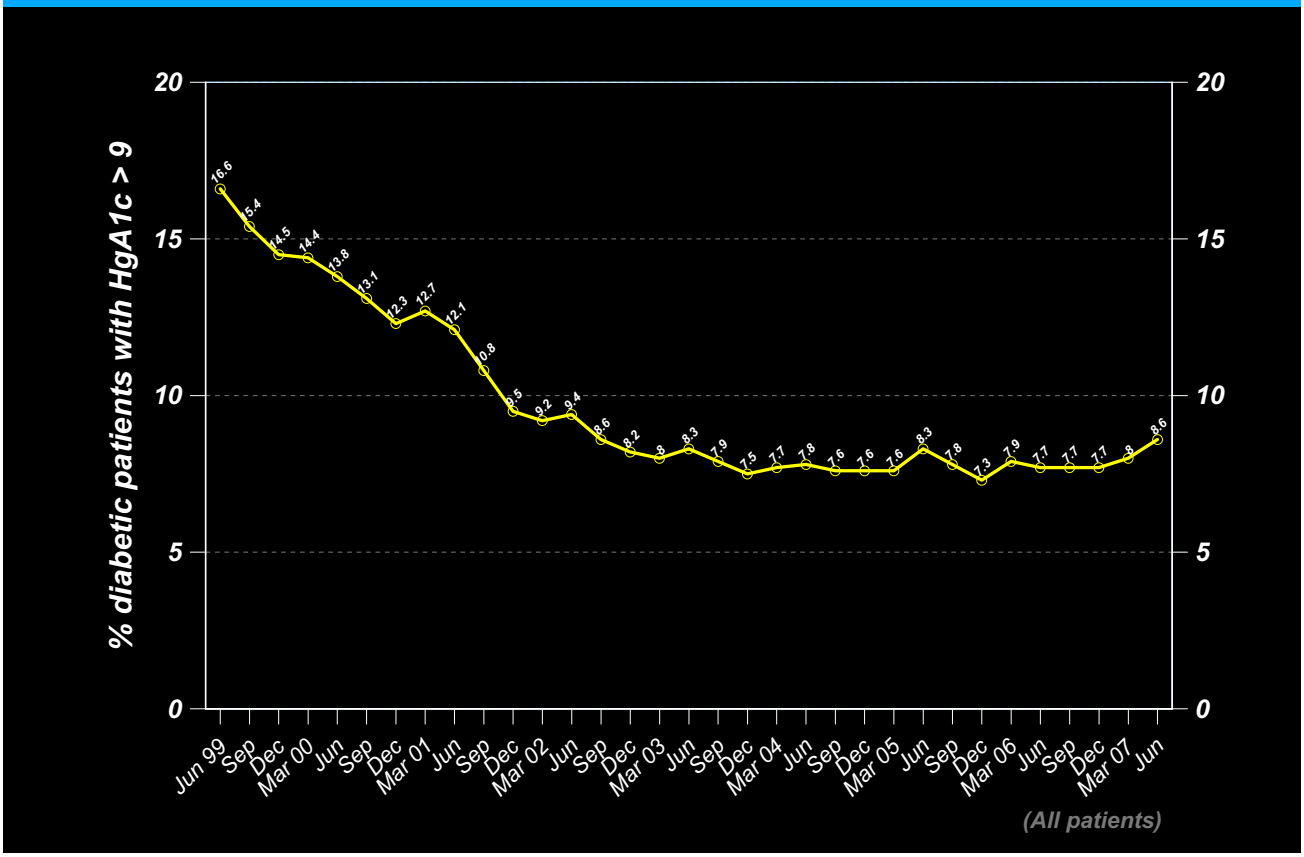
Your total score is computed using the following weighting:

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

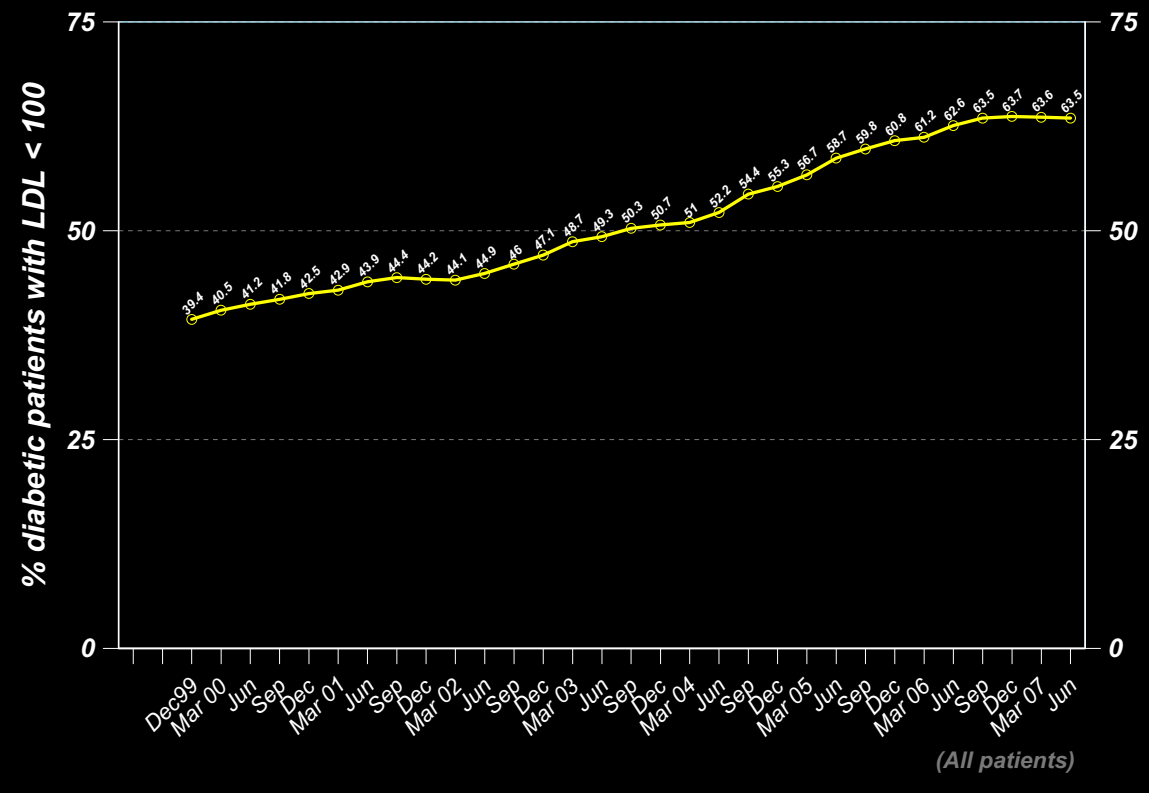
Your Total Managed Care Incentive Score is: 75%

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

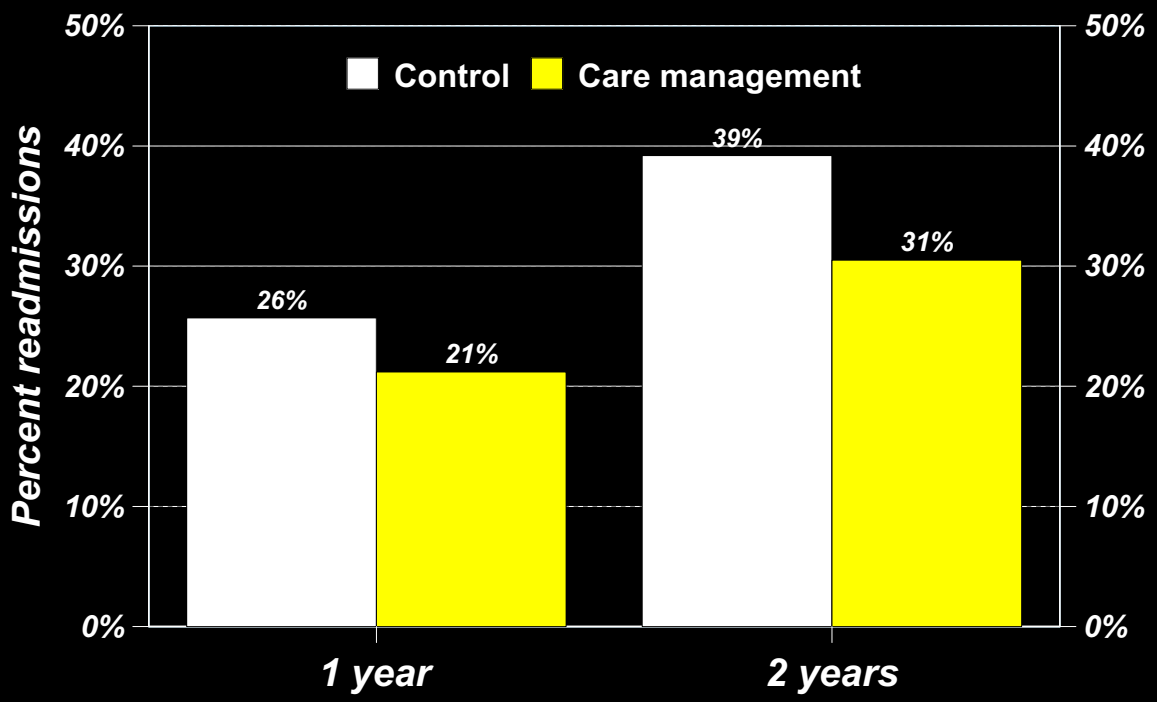
Poor HbA1c control



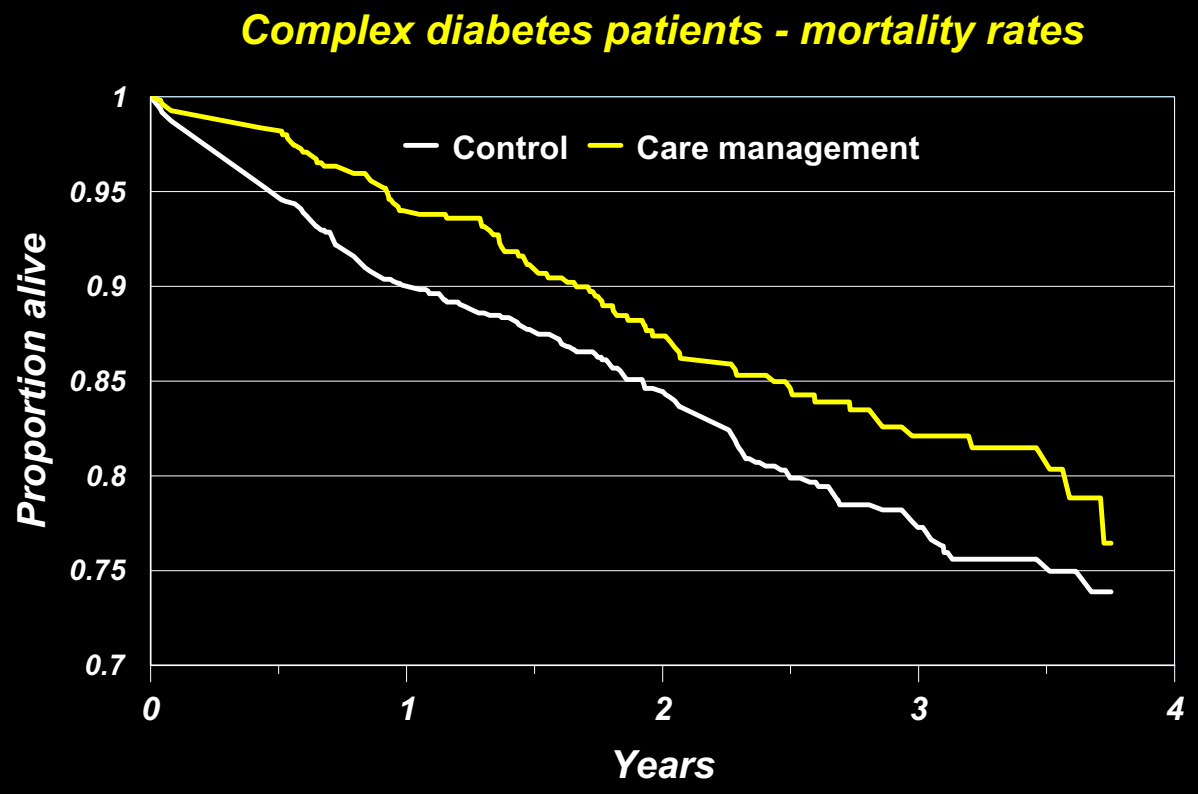
Excellent lipid control



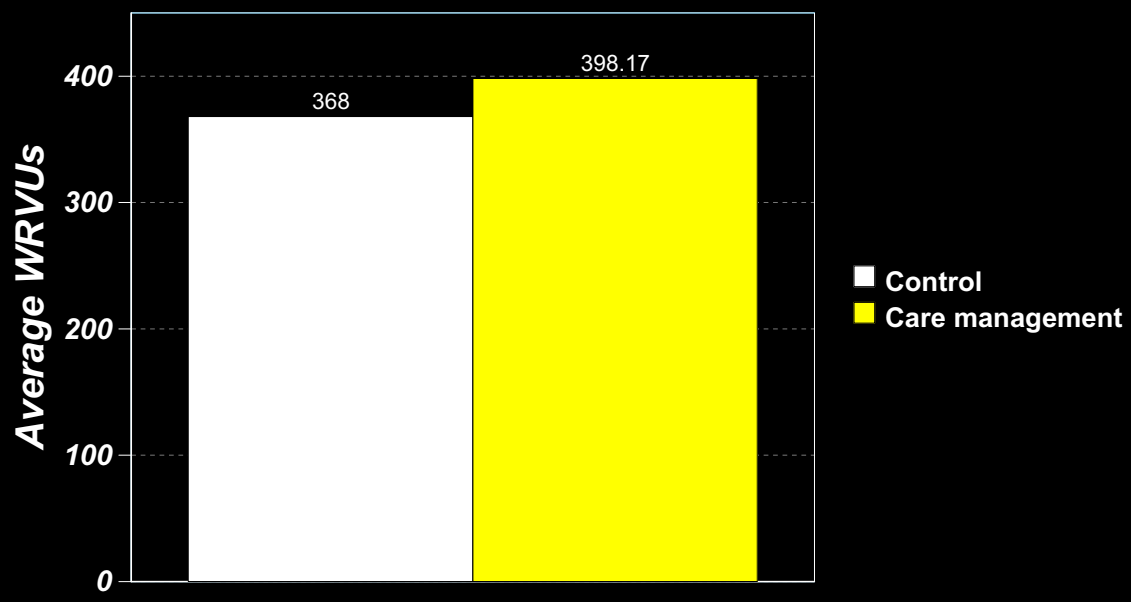
CPM with clinic care managers



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

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

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*

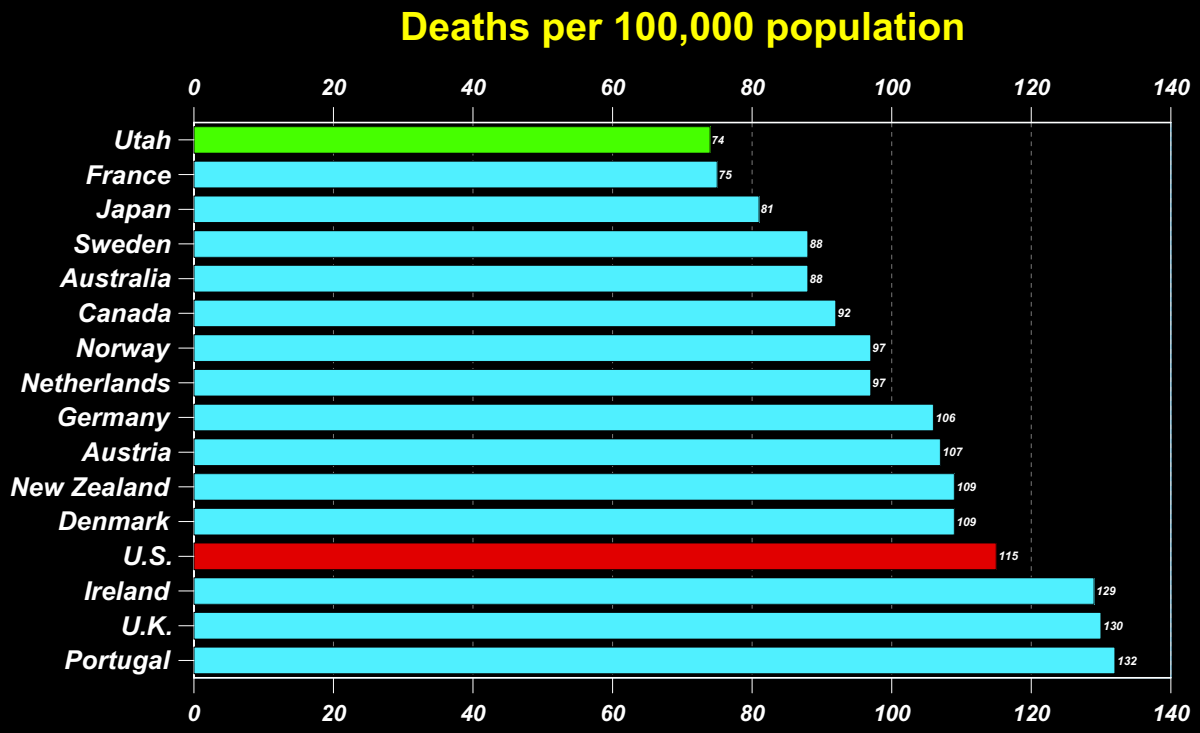
Why "profession-based" practice?

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



Source: World Health Organization, Nolte and McKee, Rutgers Center for State Health Policy Standardized for age (1998)
Utah from 2003, normalized for general US change from 1998

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.

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)

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

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).