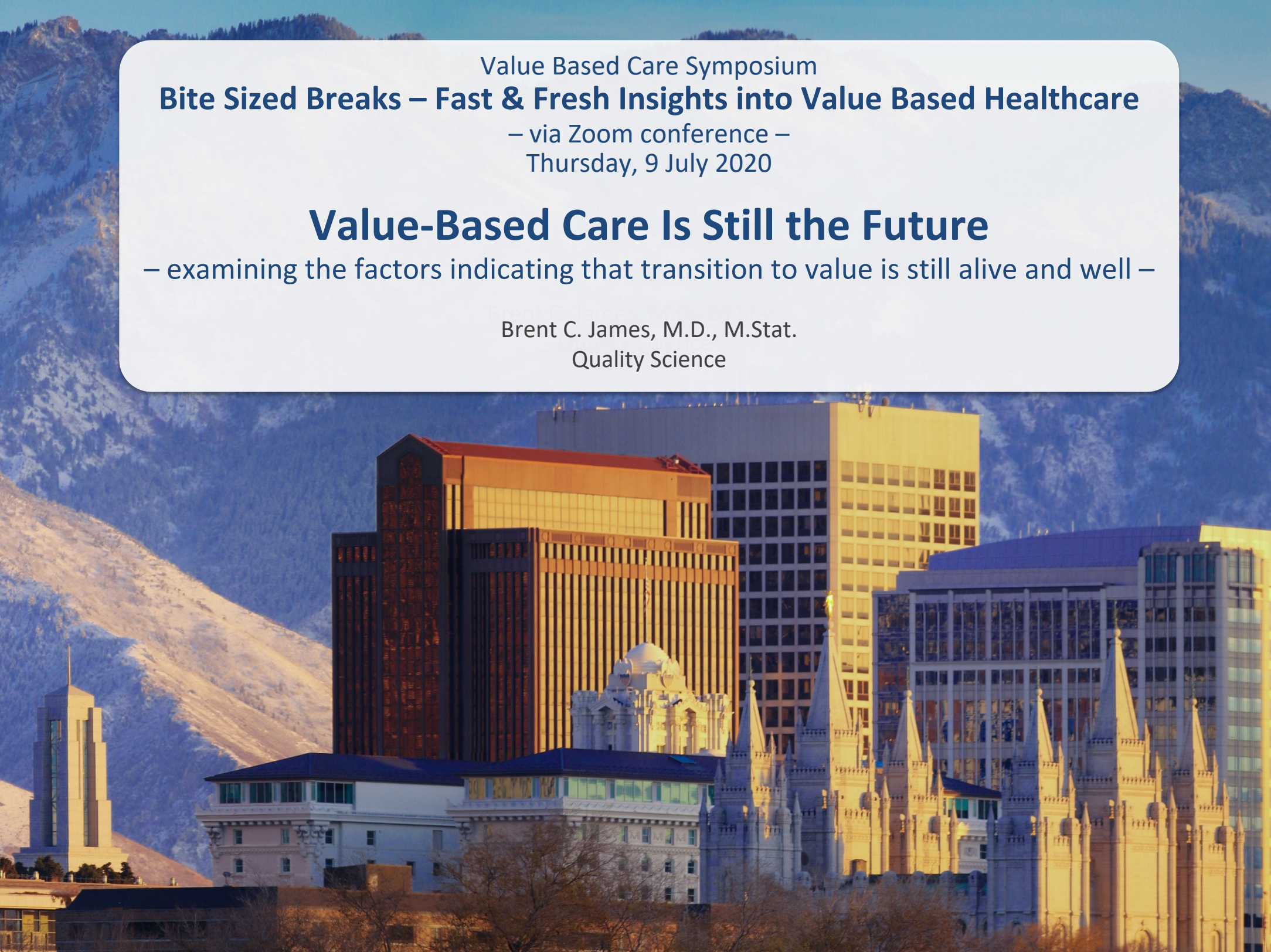


Value Based Care Symposium

Bite Sized Breaks – Fast & Fresh Insights into Value Based Healthcare

– via Zoom conference –

Thursday, 9 July 2020

Value-Based Care Is Still the Future

– examining the factors indicating that transition to value is still alive and well –

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.

The core problem / opportunity:

Clinical variation

Quality Science

Four main subtypes *of clinical variation*

1. ***Massive variation in clinical practices*** *(impossible that all, or even most, patients receive good care)*
2. ***High rates of inappropriate care*** *(risk of harm inherent in the treatment outweighs any potential benefit)*
3. ***Preventable care-associated injury and death*** *(patient safety)*
4. ***Striking inability to "consistently do what we know works"*** *(high reliability care)*

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

Variation translates into 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.

Quality Science

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*

Follow the money!!

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

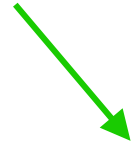
massive return on investment *(ROI)*

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

Quality waste has a nested structure

	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).

Financial alignment

Who makes the investment?

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

versus

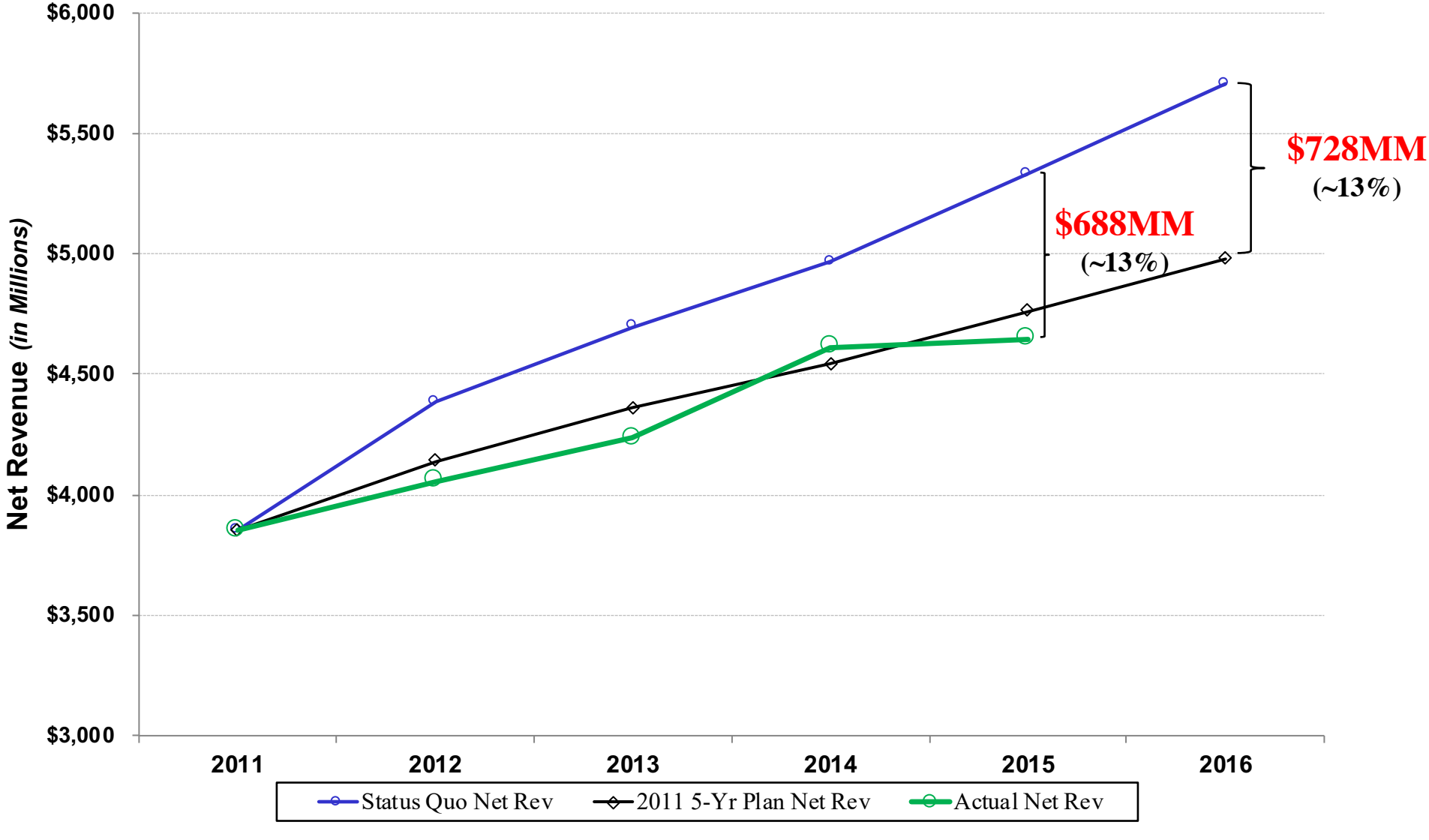
Who gets the waste savings?

(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 improving quality and reducing waste at one system



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Given that framework,

What does the future hold?

Walter Gretzky (Wayne Gretzky's father):

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

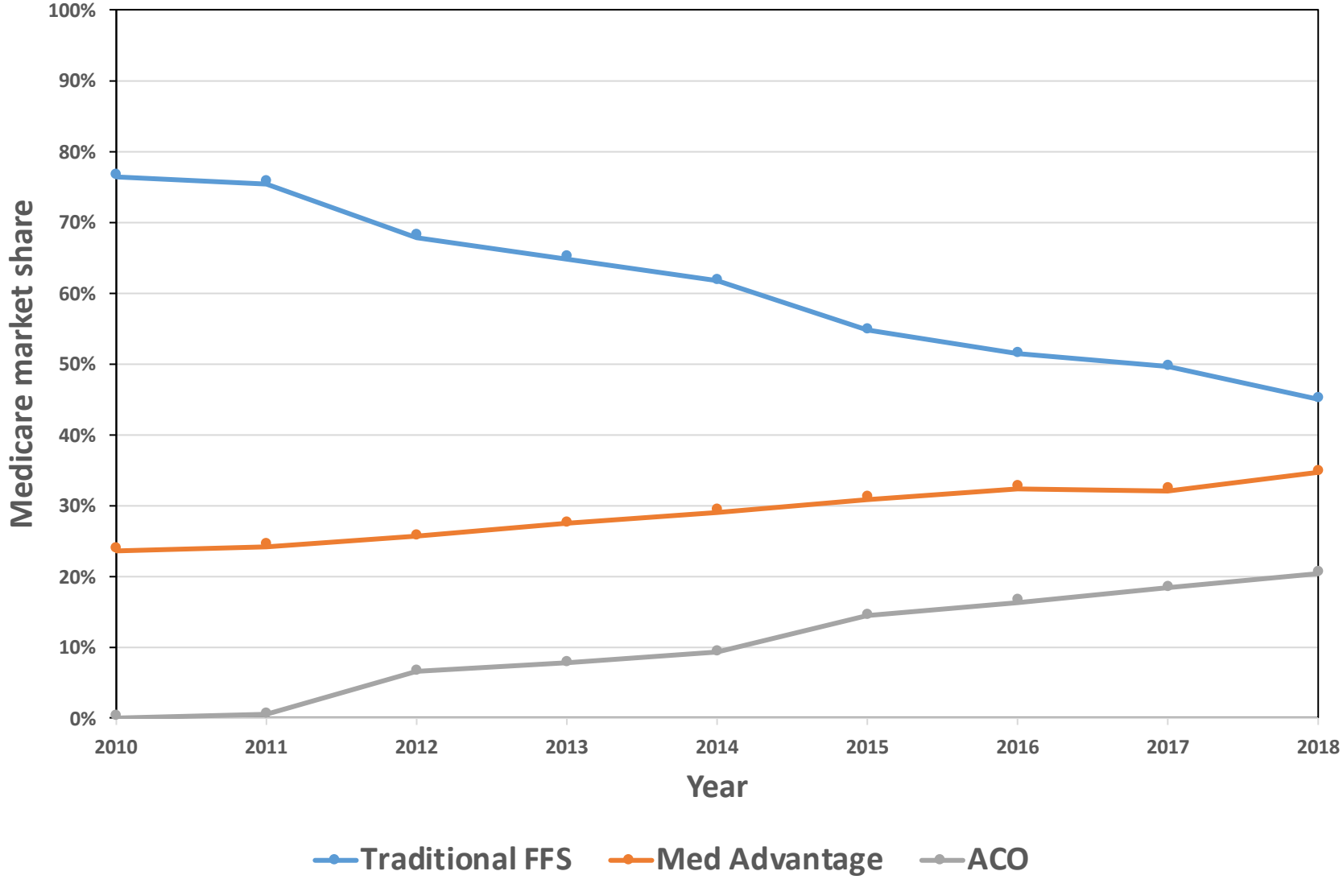
“Pay for value” continues to grow

Forward looking indicators:

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

  ACOs *(Leavitt Partners; mostly commercial)*

Medicare trends over time



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  (11% of large employers, according to Modern Healthcare)

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- ***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*

Better has no limit ...

an old Yiddish proverb