The Cost of Quality

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Improving People's Lives Through Innovations in Personalized Health Care
Volume-driven to Value-driven Payment Transition

Source: Center for Healthcare Quality and Payment Reform
Value = \frac{\text{Patient outcomes achieved}}{\text{Dollar expended}}
Value =

- Cost of Personnel
- Cost of Equipment
- Cost of Space
- Cost of Drugs
- Cost of Supplies

- Mortality
- Patient Safety Indicators
- Patient Satisfaction
- Readmissions
- Length of Stay
Clear goals and timeline for shifting volume to value

“Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people.”

—Sylvia M. Burwell, Health and Human Services Secretary
Let’s revisit what we know…

- The rules in health care are changing:
  - Consumer-driven market (consumerism)
  - Performance-based model (quality and value)
  - Reimbursement will decrease (revenues)
- The U.S. has the highest healthcare costs in the world and lower quality outcomes than many countries.
Changes in Value-Based Healthcare Delivery Systems

Porter, 2013

1. Organizational change-integrated practice units

2. Measurement of outcomes and costs for every patient

3. Move to bundled payments for care provided

4. Integrated care delivery systems

5. Expand geographic reach

6. Build enabling informatics/technology platforms
Medical Group Report Card:

<table>
<thead>
<tr>
<th>Medical Group</th>
<th>Recommended Care</th>
<th>Patients Rate Their Medical Group</th>
<th>Average Payment by Patient &amp; Health Plan for Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Group A</td>
<td>GOOD</td>
<td>EXCELLENT</td>
<td>LOWER PAYMENT</td>
</tr>
<tr>
<td>Medical Group B</td>
<td>FAIR</td>
<td>GOOD</td>
<td>HIGHER PAYMENT</td>
</tr>
<tr>
<td>Medical Group C</td>
<td>POOR</td>
<td>GOOD</td>
<td>LOWER PAYMENT</td>
</tr>
<tr>
<td>Medical Group D</td>
<td>EXCELLENT</td>
<td>GOOD</td>
<td>LOWEST PAYMENT</td>
</tr>
<tr>
<td>Medical Group E</td>
<td>GOOD</td>
<td>EXCELLENT</td>
<td>HIGHER PAYMENT</td>
</tr>
<tr>
<td>Medical Group F</td>
<td>Too few patients in sample to report</td>
<td>GOOD</td>
<td>HIGHER PAYMENT</td>
</tr>
</tbody>
</table>
Ohio’s episode timeline

- **Episode design**
- **Implementation readiness**
- **Reporting period**
- **Performance period**
- **Reporting launch**
- **Performance period launch**


Wave 1:
- Reporting only
- Performance Y1
- Performance Y2
- Performance Y3

Wave 2:
- Reporting only
- Performance Y1
- Performance Y2

Wave 3¹:
- Reporting only
- Performance Y1

¹ Expected timing for Wave 3
This is an example of the reports that have been delivered since March 2015 for the first wave of episodes.

Anthem, Aetna, United Healthcare, CareSource, Molina Healthcare, Buckeye Community Health Plan, Paramount Advantage, Ohio Governor’s Office of Health Transformation.

EPISODE of CARE PAYMENT REPORT

PERINATAL

July 1, 2013 to June 30, 2014

Reporting period covering episodes that ended between July 1, 2013 and June 30, 2014.

PAYER NAME: Ohio Medicaid FFS

PROVIDER CODE: 1234567

PROVIDER NAME: XYZ Women’s Health Center

You would be eligible for gain or risk sharing of N/A.

Episodes inclusion and exclusion:
- Total episodes: 154
- 48% Excluded 74 Episodes
- 52% Included 80 Episodes

Risk adjusted average spend per episode:
- Distribution of provider average episode spend (risk adj.)
- You are here: $4,160

Episodes risk adjustment:
- 95% of your episodes have been risk adjusted

Quality metrics:
- Your performance on quality metrics that will be ultimately linked to gain sharing:
  - HIV screening: 53%
  - CVI screening: 71%
  - C-section: 31%
  - Follow-up visit: 30%

Potential gain/risk share:
- N/A

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Box plots of direct surgical supply cost by surgeon
Complication rate by median direct case supply cost

Complication Rate, %

Median direct case supply cost, USD

Size of circle is proportional to the number of observations

Complication rate by median direct case supply cost
## Prototype Scorecard

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>LOS Index</th>
<th>Direct Cost Index</th>
<th>7 Day Readmit</th>
<th>14 Day Readmit</th>
<th>30 Day Readmit</th>
<th>Mortality Index</th>
<th>PSI 09</th>
<th>PSI 10</th>
<th>PSI 11</th>
<th>PSI 12</th>
<th>PSI 13</th>
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<td>4</td>
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</tbody>
</table>
Demonstration Data
Operations Councils: Enabling the Front Line

Quality and Safety

Patient Experience

Operational Logistics/Efficiency

Faculty/Staff Satisfaction

Finance

Moffatt-Bruce, Funai 2015
Working together to create the care delivery models of the future

- Executive oversight group
- Determines strategic direction of work, reviews progress and affirms implementation plans

- Key leads for Data Analytics, Care Model, Post-Acute, IHIS/Clinical IT, Communications and Change Management
- Reviews progress of transformation coaches, ensures alignment across clinical areas and provides implementation support

- Transformation Coaches and Operations Council
- Defines scope, maps current state, designs preferred future state and makes recommendations for implementing change
Balanced Scorecard

Quality
- Readmissions
- Hospital Acquired Condition
- Post-Op Appointment

Patient Experience
- HCAHPS
- CG-CAHPS

Operational Efficiency
- Length of Stay
- Discharge Time
- Discharge Disposition
- Clinical Pathway Development

Cost
- Volume
- Gain (Loss)/Encounter
- Direct Variable Costs/Encounter
Patient Journey

Scheduling/Pre Cath
- Wait
- Scheduling
- Wait
- Arrival/Parking

Registration
- Sign In
- Wait
- Register
- Wait

Pre Procedure
- Escort to IPR
- Wait
- Cath Prep
- Wait
- Wait

Family Support
- Anxious
- Wondering what's wrong
- Confused
- Overwhelmed
- Confused
- Anxious
- Lost
- Nervous
- Alone
- Lack of distractions
- Anxious
- Lots of activity
- Uncertainty
- Frustrated
- with alarms
- Wondering
- why they were asked
- to arrive so early

Schedule procedure
Provide education and procedure details
Answer questions
Provide day of procedure details and contact information

Register patient
in IHIS

Walk with patient
and family to IPR
Escort to waiting room
or patient room

Vitals, PMH, prep area
MD/RN explanation of procedure and consent
Clear, concise comm.
Answering questions
Use of whiteboard

Procedures
Transport to Cath Lab
- Procedure Time Out
- Procedure
initiative, diagnostic testing, intervention

Wait
- Transport to IPR
- Post-
Procedure Care
- Recovery
Necessary Wait
- Discharge Prep
- Wait
- Prepare to go home
- Wait
- Transport Out

Recovery: Same Day/Overnight
- Wait
- Lightly sedated
- Hungry
- Thirsty
- Anxious
- Ready to go home
- Info overload
- Fear of complications

Family Support
- Calming
comm. w/patient
- Involve
patient in questions
- Provide sedation
- Explaining activities during procedure
- Encouraging questions from patient
- Assessing pain level
- Stabilize
patient
- Vitals
- Assess
pain
- Continued
monitoring
- Answering
questions
- Provide food/drink
- Follow up appointments
- & tests scheduled
- Patient education & check
for understanding
- Review AVS
- Cardiac Rehab consult
- Pharmacy consult (if stented)
- Remove IV
and leads
- Transport via
wheelchair
to vehicle

Legend
- Patient Actions
- Patient Emotions
- Staff Actions
The number refers to the number of staff having direct interaction with patient
- Family Support
Family is able to be present, if available
Deliverables

- Reliable data that is physician and service specific
- Engagement of stakeholders
- Development of standardized work for procedures and care
- Set reasonable improvement metrics for both quality and cost
- Align quality and outcomes with the value proposition
- Continuously measure and improve based on results
- Publish and share results with AAMC, UHC and other stakeholders (OHA)
TRANSFORMING SICK CARE TO HEALTH CARE
Clinical Transformation: Enabling the Learning Health System
Thank you !!!!

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Santino Cua, MS
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Bob Campbell, MBA
Erica Porter, RN