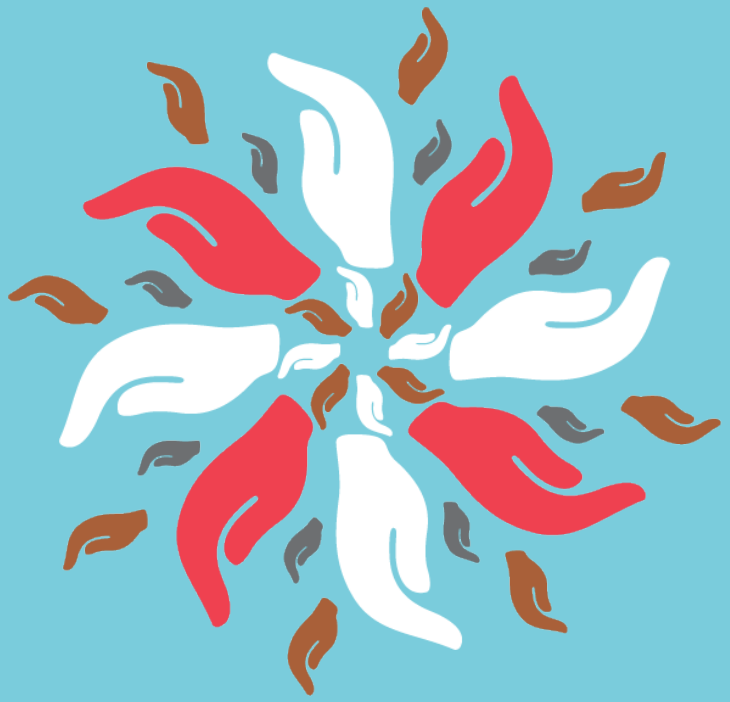


HASA 2013 CONFERENCE

Advancing Healthcare Together.

Hospital Association South Africa
Advancing Healthcare

The Business Case for Quality
David M Munch M.D.

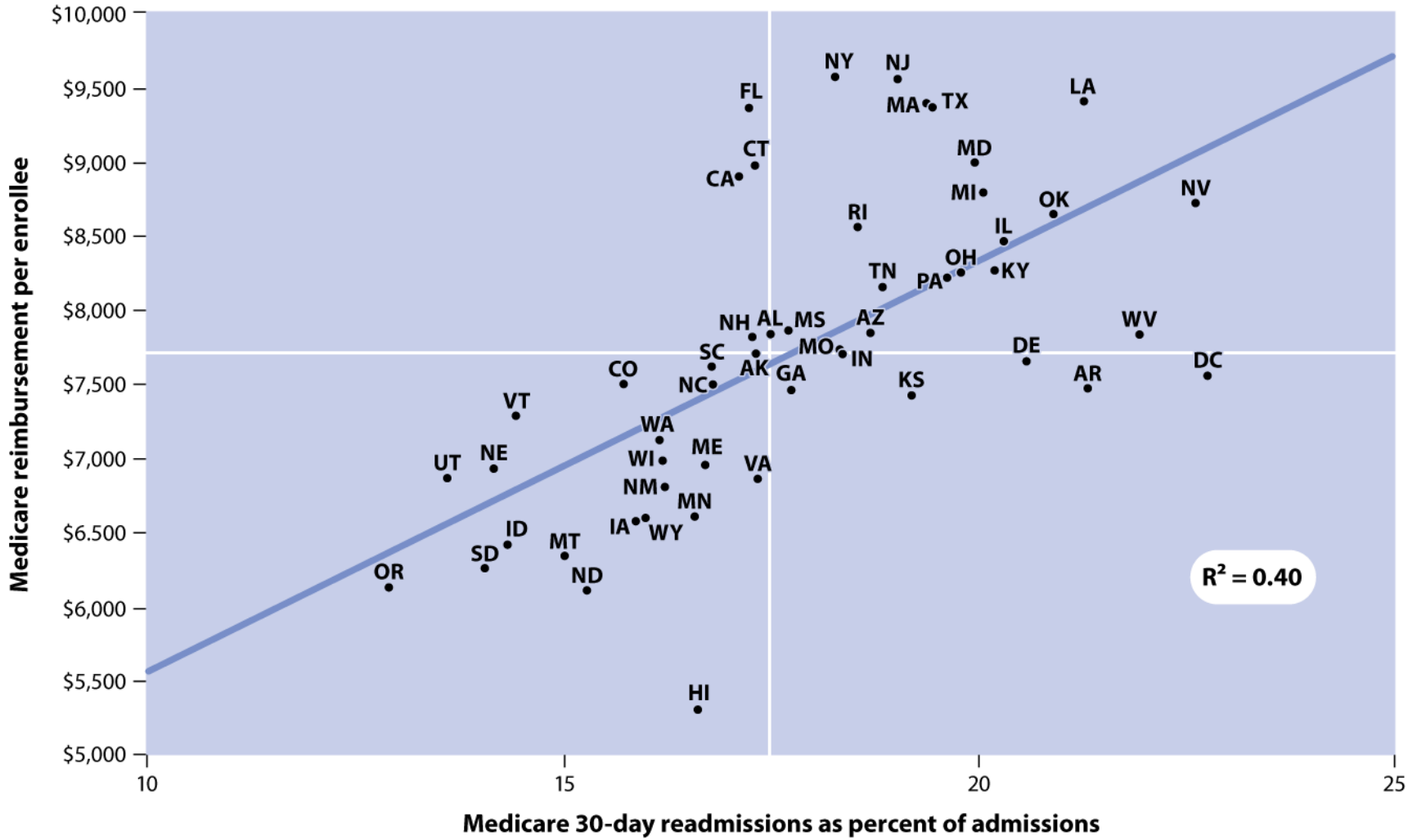
Chief Clinical Officer
Healthcare Performance Partners
Faculty: The Institute for Healthcare Improvement

In the next 40 minutes we will:

Explore the link between quality and the business case from a population level to a State level to an institutional level (case examples) to a patient level (story)

Explore what it takes for quality to advance the business case

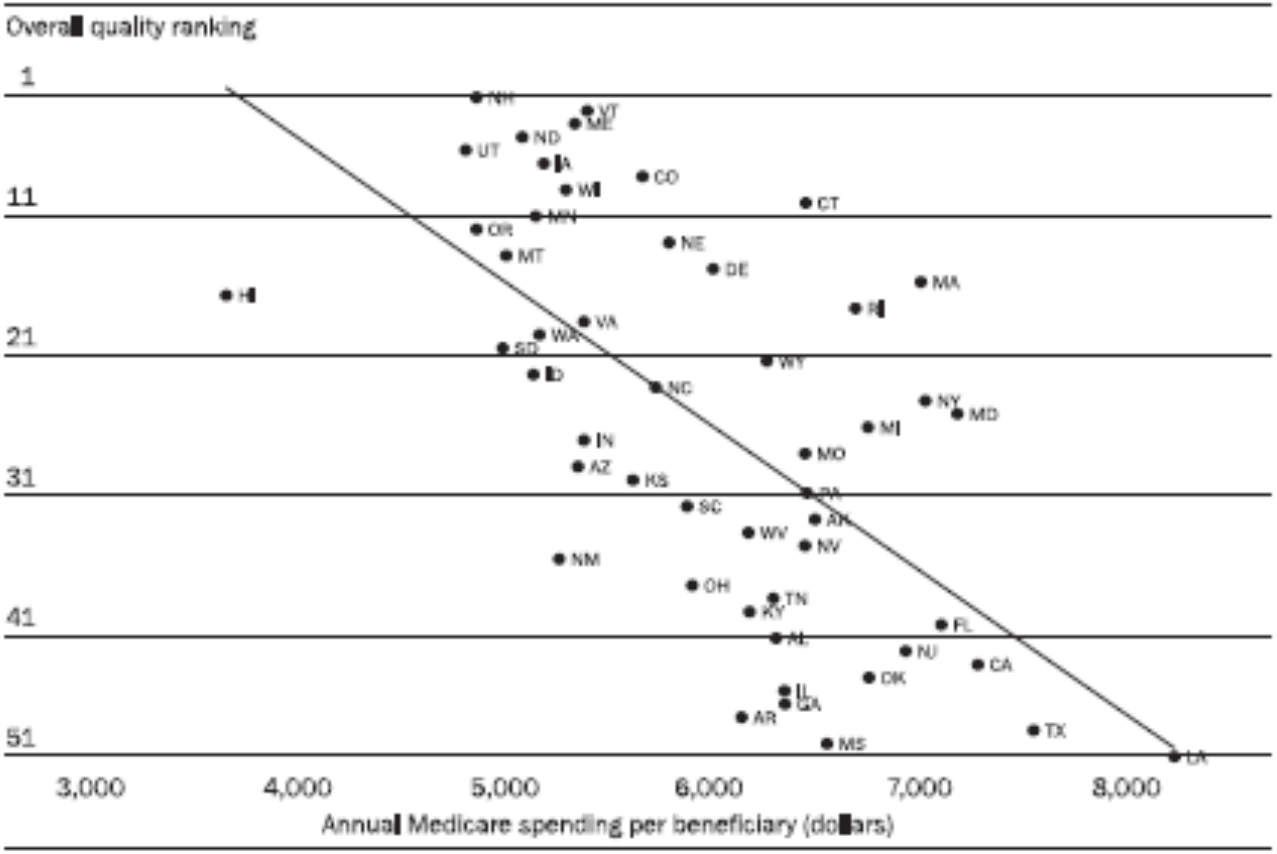
Medicare Cost Per Beneficiary and 30-Day Readmissions by State



DATA: Medicare readmissions—2006–07 Medicare 5% SAF Data; Medicare reimbursement—2006 Dartmouth Atlas of Health Care
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

EXHIBIT 1

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

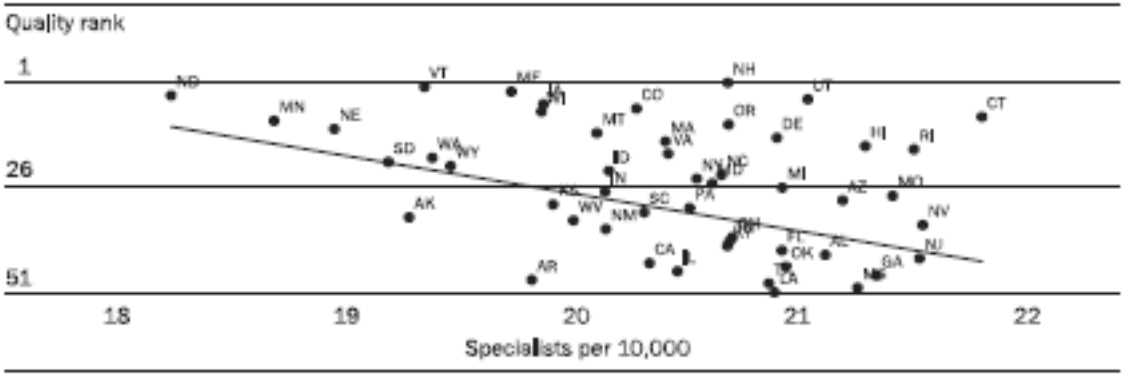


SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Katherine Baicker and Amitabh Chandra: Medicare Spending, The Physician Workforce, And Beneficiaries' Quality of Care. Health Affairs, W4-184, 7 April 2004

EXHIBIT 6

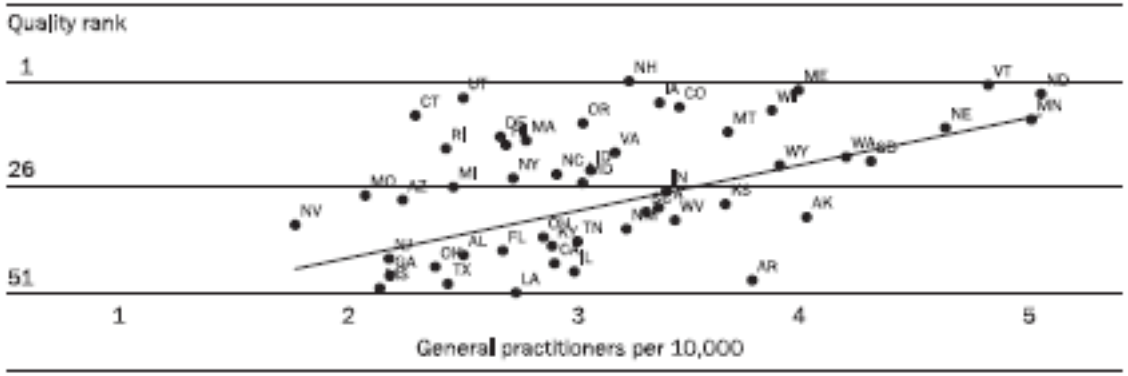
Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values indicate higher quality. Total physicians held constant.

EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values indicate higher quality. Total physicians held constant.

Katherine Baicker and Amitabh Chandra: Medicare Spending, The Physician Workforce, And Beneficiaries' Quality of Care. Health Affairs, W4-184, 7 April 2004

Statewide costs of health care –associated infections: Estimates for acute care hospitals in North Carolina

Direct hospital costs for SSI, C. Diff., & 3 device related HAI's

RESULTS:

In total, 67 (53%) hospitals responded to the survey. The median bed size of respondent hospitals was 140 (interquartile range, 66-350). A "standard" NC hospital diagnosed approximately 100 HAI each year with estimated costs of $985,000 to $2.7 million. The most common HAI was SSI (73%). Costs related to SSI accounted for 87% to 91% of overall costs. In total, the overall direct annual cost of these 5 selected HAIs was estimated to be between $124.1 and $347.8 million in 2009 for the state of NC.

Am J Infect Control. 2013 Sep;41(9):764-8.
doi: 10.1016/j.ajic.2012.11.022. Epub 2013 Feb 27.

U. Of Pennsylvania Medical Center

Business Case for eliminating Hospital Acquired Infections

From Dr. Richard Shannon
Frank Wister Thomas Professor of Medicine
Chairman, Department of Medicine,
University of Pennsylvania School of Medicine

What is the Problem?
The Losses Attributable to CA-BSI are Staggering

Average Payments: $64,894

Average Expense: $91,733

Average Loss from Operations: -$26,839

Total Loss from Operations:-$1,449,306

In only 4 cases did the hospital make money!

The cost of the additional care averaged 43% of the total costs of care

Average LOS: 28 days (7-137)

Only three patients were discharged to home.

The Losses Attributable to Ventilator associated Pneumonia are Equally Staggering

Average Payments: $62,883

Average Expense: $87,318

Average Loss from Operations: -$24,435

Total Loss from Operations:-$2,419,065

The average payments were twice that for a similar care without VAP ($33,569)

Average LOS: 34 days versus 17 days

32% of patients died and 43% underwent tracheotomy.

Making the Defects Personal

37 year old video game programmer, father of 4, admitted with acute pancreatitis secondary to hypertriglyceridemia.

Day 3: developed hypotension, and respiratory failure

Day 6 : fever and blood cultures positive for MRSA secondary to a femoral vein catheter in place for 4 days.

Multiple infectious complications requiring exploratory laparotomy and eventually tracheostomy

Day 86: Discharged to nursing home

10,000 deaths is a statistic, one death is a tragedy.
Joseph Stalin

Penn Medicine/ DOM
Approach to Patient Safety

Trained 220 nurses in the Lean methodology

Exposed all senior leadership to observation exercises at the point of care

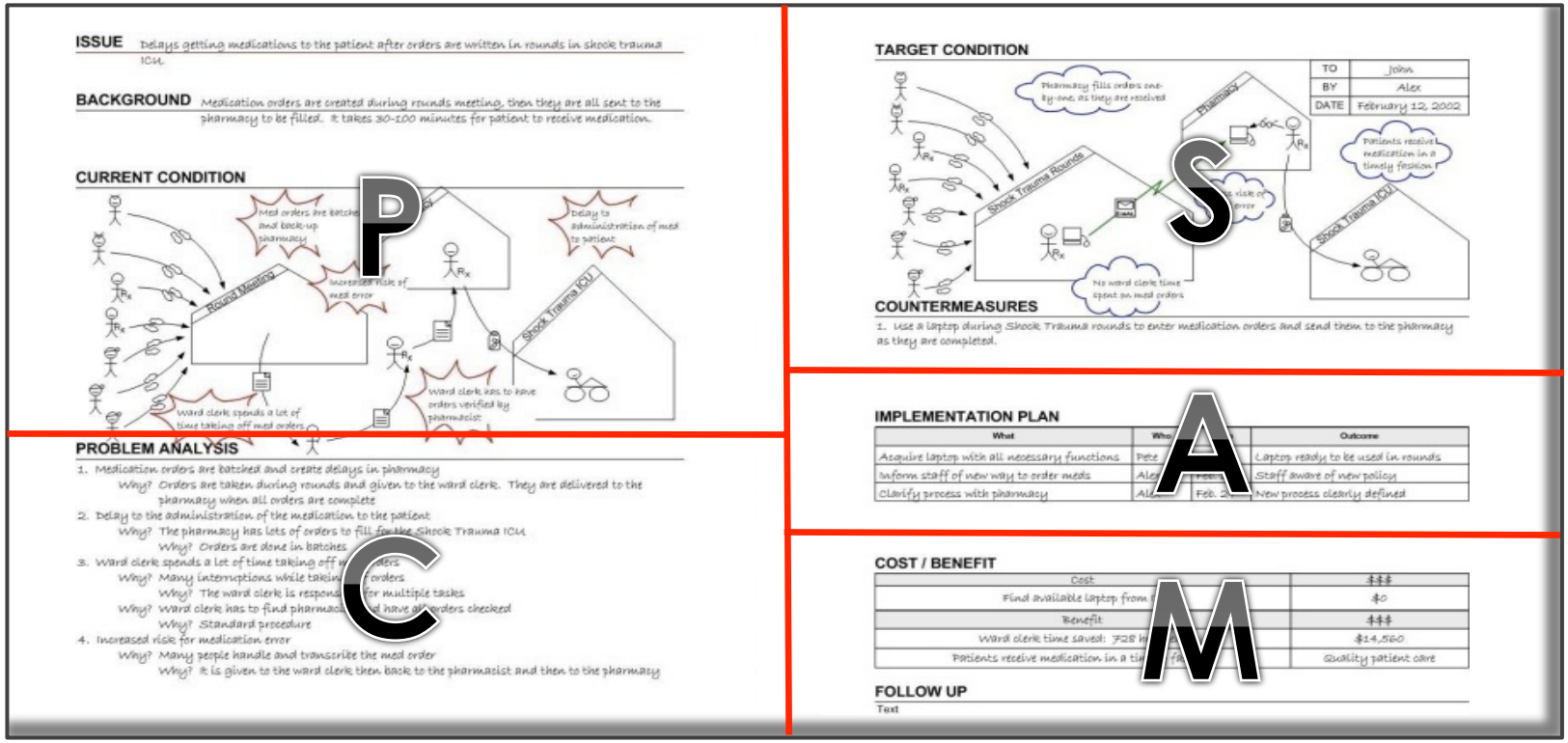
Completely redesigned standard methods for placing and maintaining all catheters.

Incorporated training modules for house staff and fellows.

Create UBCL teams with Problem Solving Skills

- immediate response to defect: process & outcome

Disciplined Problem Solving



A3 Process Follows Scientific Method

Problem
Cause
Solution
Action
Measurement

Similar To Healthcare Familiar PDCA

Rounding on Sick Systems

Rounding on Sick patients

Chief complaint

Present illness

Physical exam/diagnostic test

Therapeutic intervention

Clinical course

Natural history

Assessment of outcome

Rounding on Sick Systems

What's the problem ?

How is work currently done?

What defects are encountered in the work?

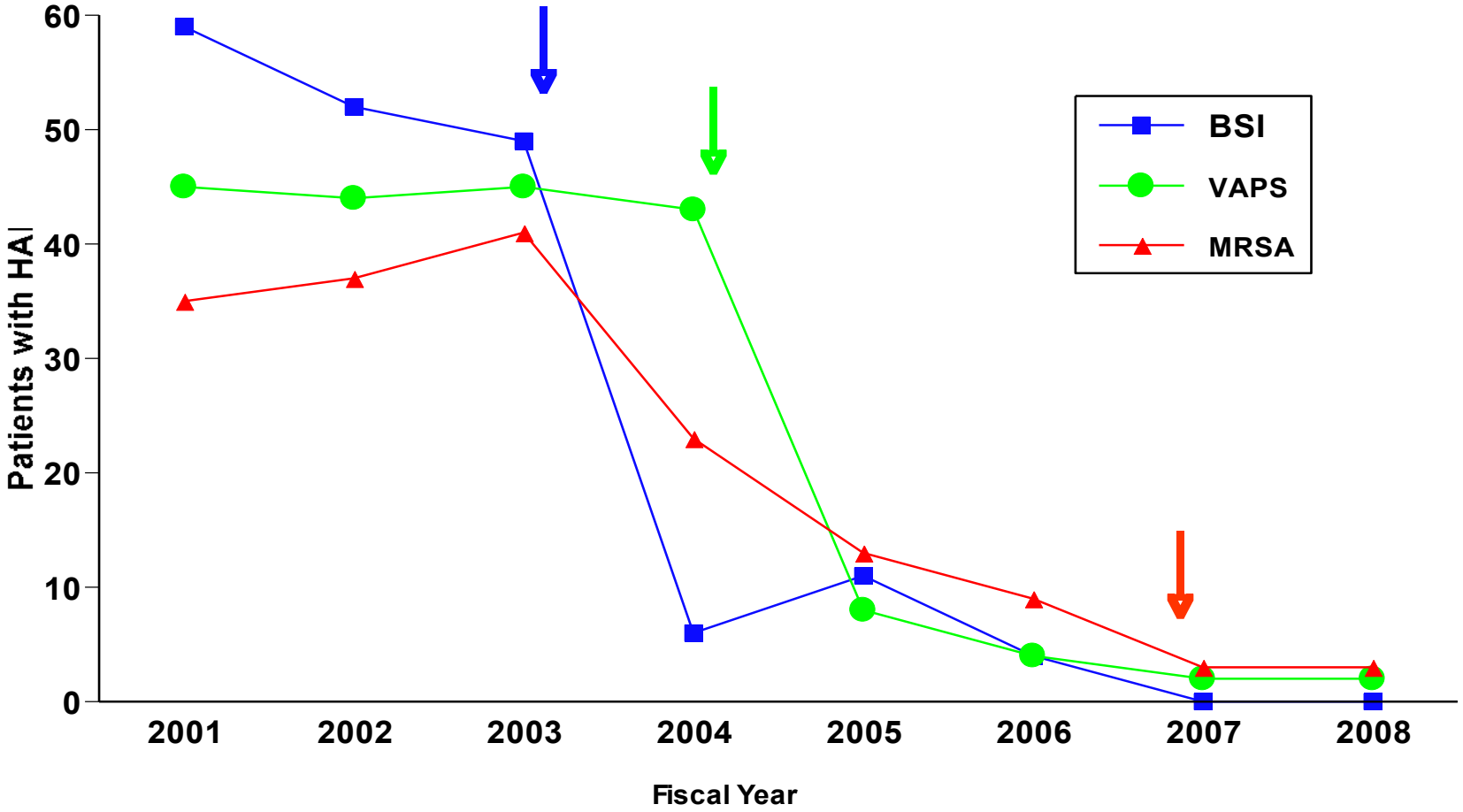
Intervene to eliminate defects

Create a target condition

Measure what actually happens

Gap analysis

Reductions in HAIs



CCU/MICU and HAI
A Big Return on Investment

Total Operating Improvements

CLAB= $1,235,765 (2 years)

VAP= $1,003,162 (1 year)

MRSA= $ 295,342 (1 year)

Highmark PFP = $3,100,000 (2 years)

HAI elimination Initiatives = +$5,634,269

Investment = $85,607

388 additional ICU admissions

57 lives saved

Is Poor Quality Profitable?

Yes, in certain segments if:

- You have a monopolistic situation and mindset
  - Little or no consequence to providing poor quality
- Absence of transparency and comparability
  - Of performance
  - Of cost
- A payment system that allows (and even rewards) it
  - Payment for what you do: The grey zone of professional judgement
  - The absence or restriction of consumer choice

No, if you are talking about the system as a whole

Is Good Quality Profitable?

Yes, for the segments and the system if:

- It is Leaderships Highest Priority
- The Design is Right
  - The Care Processes are efficient and reliable
    - What the patient needs, when they need it, in the right setting, defect free, without waste of people or resources
  - The Care Processes are systematic
    - Management systems
    - Measurement systems
    - Coordinated: hand-offs, transitions
- Payment Systems are aligned

Is Good Quality Profitable?

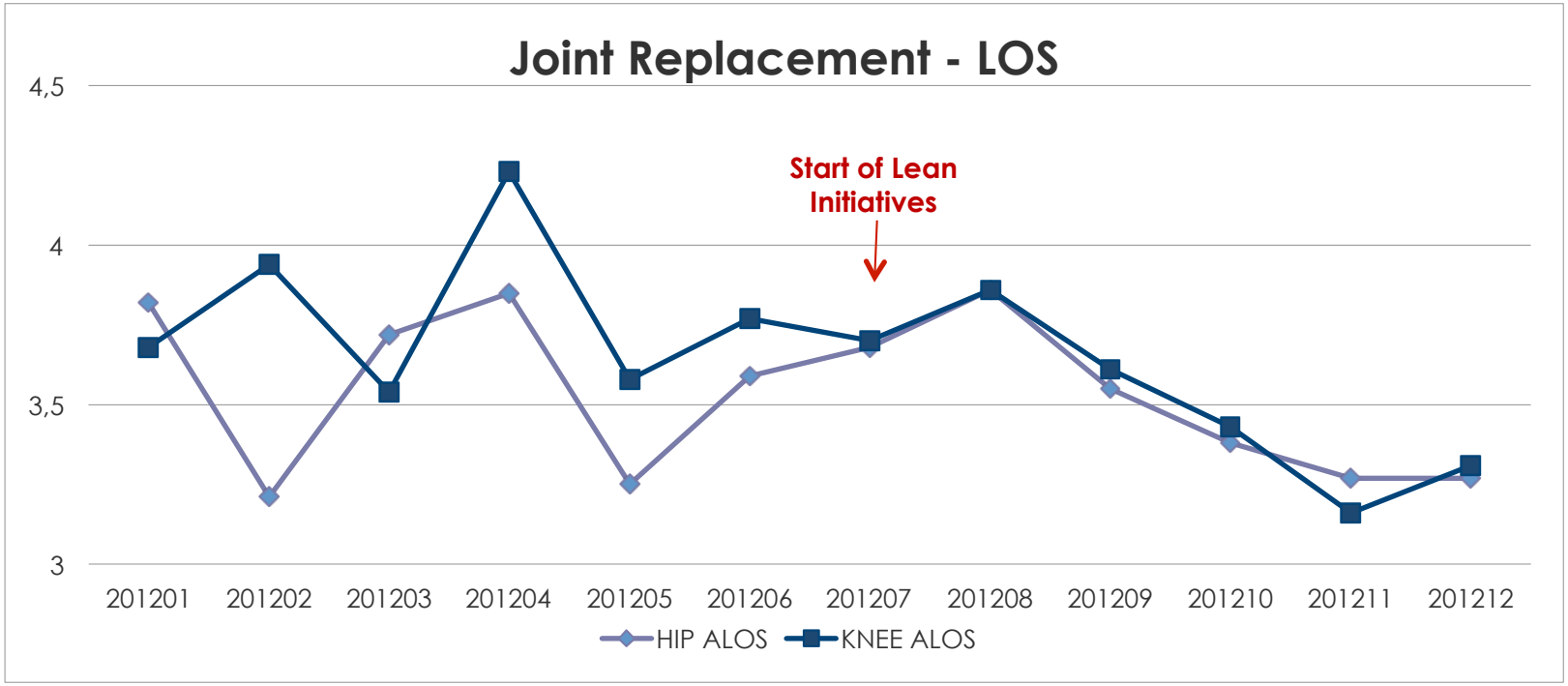
Not if:

- Payment systems are not aligned
- The Design is Wrong
  - The Care Processes are inefficient
    - High levels of variation
  - The Care Processes lack system design
    - Improvement and quality are not core responsibilities of management
    - The Right Measurements are absent
    - Hand-offs and transitions are not intentional
    - The Care process relies on inspection and re-work

What do Mayo Clinic, Cleveland Clinic, Geisinger Health System, Virginia Mason Medical Center, Scott and White Healthcare and Mercy Hospital of Springfield Missouri all have in common?

Preparing for a Bundled Payment Opportunity

Large Academic Medical Center in Philadelphia



Oh, one more thing

July 1995: The Chicago Heat Wave

- Greater than 500 deaths in one week as a result of the head wave
- Significant difference in ethnic related death rates
- Latino's representing 25% of the population accounted for only 2% of the deaths
- Blacks deaths/100,000 population out numbered Whites 1.5 to 1

Why the differences?

What conclusions can you draw?

Eric Klinenberg
Heat Wave: A Social Autopsy of Disaster in Chicago

Thank you

Steven Jobs on Quality and the Monopolistic Culture

“So you make a better copier or a better computer, so what? When you have a monopoly market share, the company is not any more successful. So the people who make the company more successful are the sales and marketing people and they end up running the companies and the product people get driven out of decision making forums and the companies forget what it means to make great products. The product sensibility and genius that brought them to that monopolistic position gets rotted out by people running these companies who have no conception of a good product versus a bad product. They have no conception of the craftsmanship that is required to take a good idea and turn it into a good product… and they collapse in their complacency.”

THIS IS A TEST

Testing Subtitles

Line One

- Bullet One
- Bullet Two

1. Higher quality is likely to require more resources
2. Driving patients to specialty care will result in better outcomes
3. Payment systems are a major determinant of value creation in healthcare