LVBCH 2015 CONFERENCE

"Buying Value in Healthcare"
May 8, 2015

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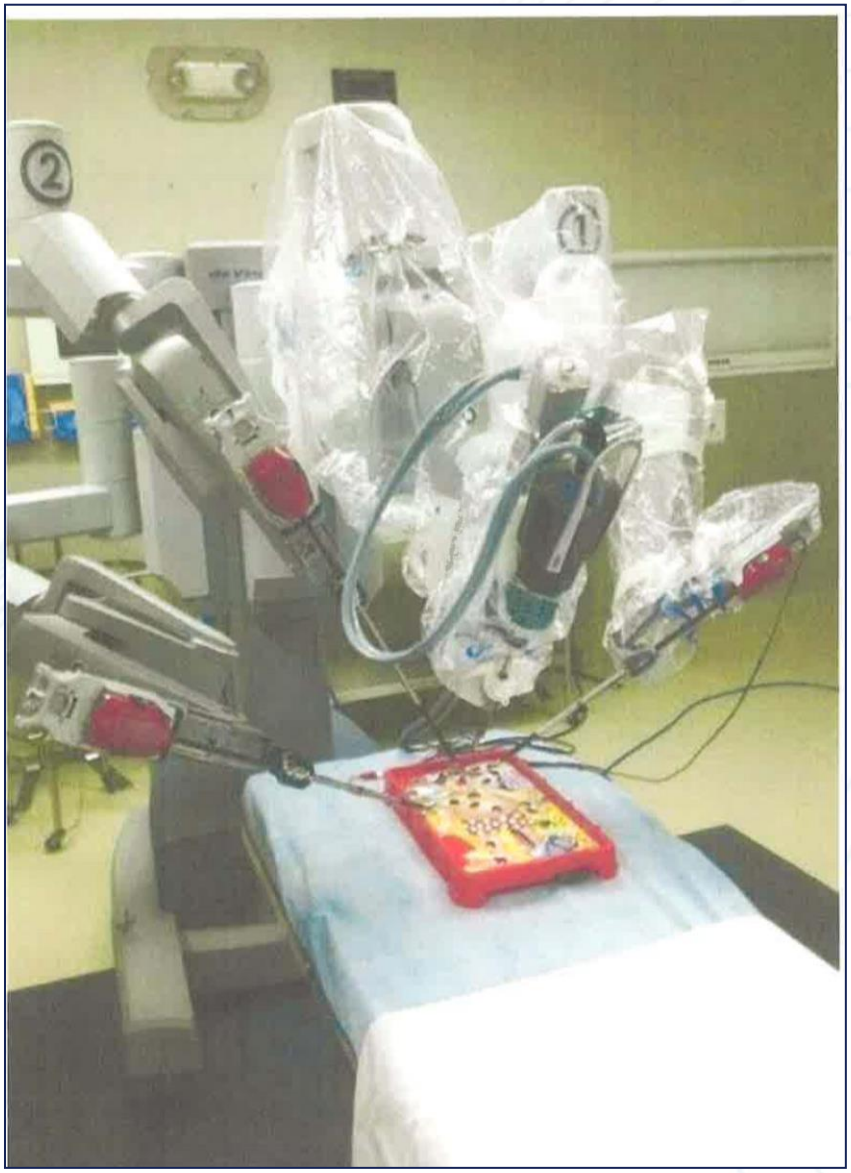

"All the News That's Fit to Print"

The New York Times

VOL. CLXIII . . . No. 56,386 ©2014 The New York Times SUNDAY, JANUARY 19, 2014

Patients' Costs Skyrocket; Specialists' Incomes Soar

When a Doctor Becomes an Entrepreneur, Small Procedures Offer Big Returns

By ELISABETH ROSENTHAL

CONWAY, Ark. — Kim Little had not thought much about the tiny white spot on the side of her cheek until a physician's assistant at her dermatologist's office warned that it might be cancerous. He took a biopsy, returning 15 minutes later to confirm the diagnosis and schedule her for an outpatient procedure at the Arkansas Skin Cancer Center in Little Rock, 30 miles away.

That was the prelude to a day-long medical odyssey several weeks later, through different private offices on the manicured campus at the Baptist Health Medical Center that involved a

by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures — or doing more of lucrative ones.

It does not matter if the procedure is big or small, learned in a decade of training or a week-long course. In fact, minor procedures typically offer the best return on investment: A cardiac

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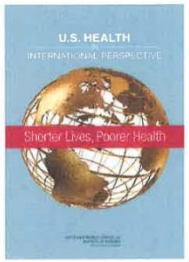
U.S. Health in International Perspective

Shorter Lives, Poorer Health



The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although Americans' life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation. To gain a better understanding of this problem, the National Institutes of Health (NIH) asked the National Research Council and the Institute of Medicine to convene a panel of experts to investigate potential reasons for the U.S. health disadvantage and to assess its larger implications. The panel's findings are detailed in its report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health*.

For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women.

A Pervasive Pattern of Shorter Lives and Poorer Health

The report examines the nature and strength of the research evidence on life expectancy and health in the United States, comparing U.S. data with statistics from 16 "peer" countries—other high-income democracies in western Europe, as well as Canada, Australia, and Japan. (See Table.) The panel relied on the most current data, and it also examined historical trend data beginning in the 1970s; most statistics in the report are from the late 1990s through 2008.

The panel was struck by the gravity of its findings. For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence,

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The Washington Post

To Your Health

Once again, U.S. has most expensive, least effective health care system in survey

By Lenny Bernstein June 16

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	6	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	8	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	6	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes tax. ** Expenditures shown in U.S. PPP (purchasing power parity). Australia $ data as from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund Access Survey and 2012 World Health Organization and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

… all hospitals are accountable to the public for their degree of success…

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg

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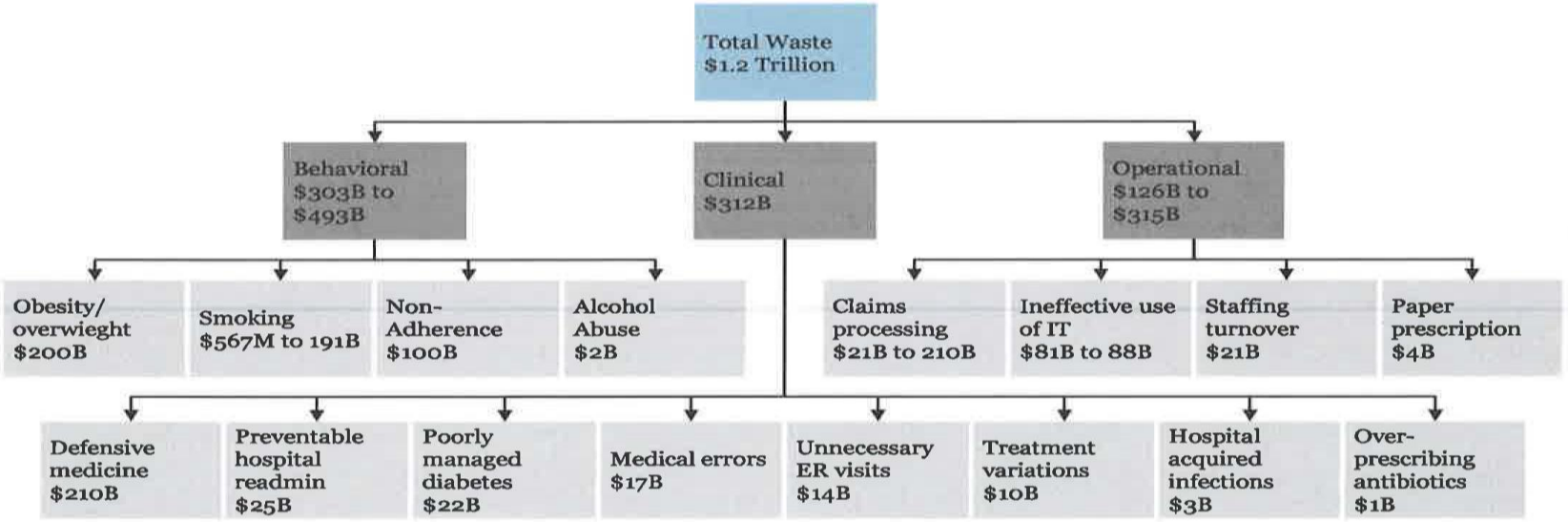
IMMIGRATION (P. 35) | MILLER TIME (P. 64) | P&G's BUZZ MOMS (P. 32)
The McGraw-Hill Companies
BusinessWeek
MAY 29, 2006
www.businessweek.com
Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work
BY JOHN CAREY (P. 72)
DRUGS
PSYCHIATRY
CHIROPRACTIC
ASPIRIN
REST
WATCH & WAIT
YOGA
SURGERY

Waste in US Healthcare

Opportunities to eliminate wasteful spending in healthcare add up to $1.2 trillion of the annual $2.2 trillion spent nationally; these categories overlap

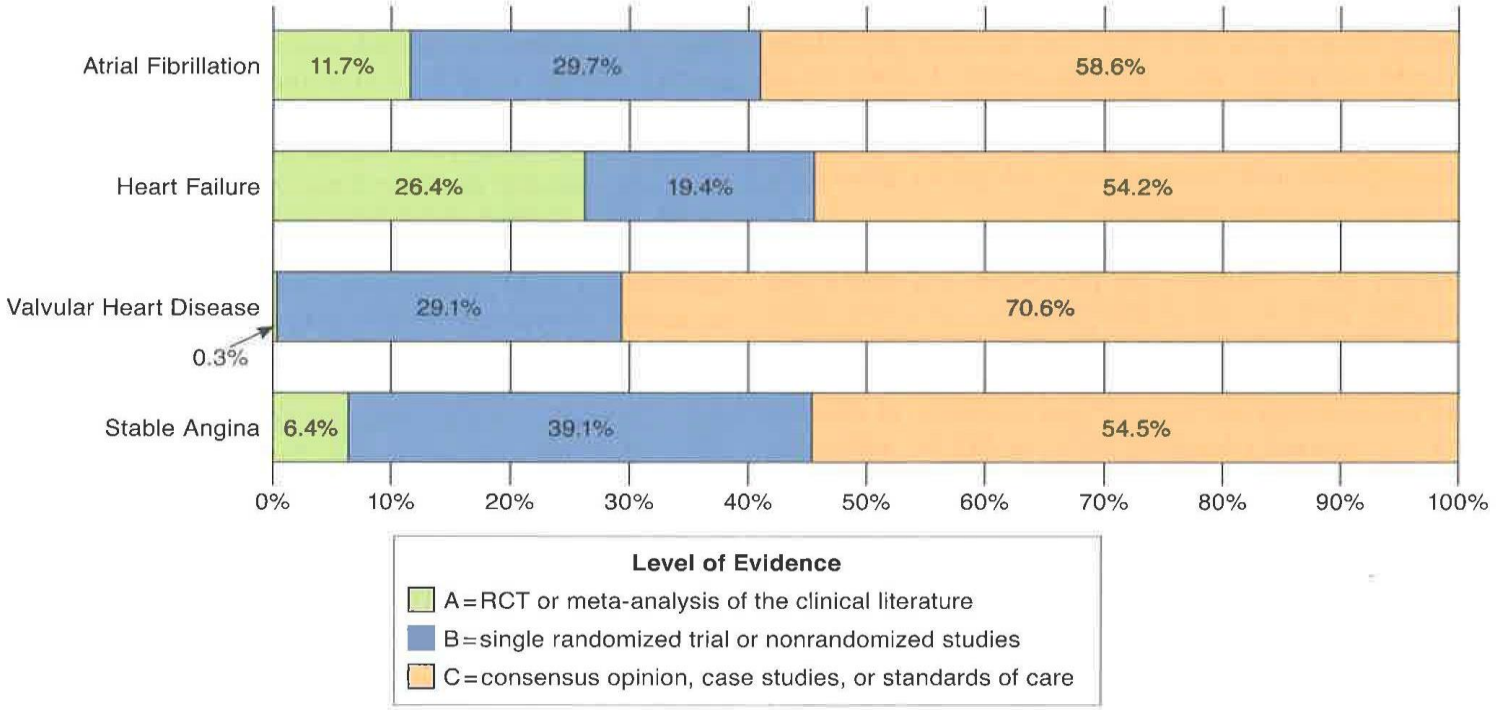


Waste cannot be eliminated immediately. However, by viewing waste in these baskets, the size of opportunities can be prioritized and rewarded. Like health spending itself, these categories overlap. Reducing one basket can affect the size of the others.

Source: Analysis by PwC's Health Research Institute based on published studies on inefficiencies in healthcare.

Medical and Pharmacy Coverage Decision Making at the Population Level

FIGURE 2 Proportion of Select Clinical Practice Guideline Recommendations for Cardiac Disease by Supporting Level of Evidence



Source: Tricoci P, Allen JM, Kramer JM, Califf RM, Smith SC Jr. Scientific evidence underlying the ACC/AHA clinical practice guidelines.[14]
RCT=randomized controlled trial.

It is possible to improve care and dramatically lower costs.

Berwick Annals 2/98

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Getting to 10%

CARE-RELATED COSTS

- Prevent medical errors
- Prevent avoidable hospital admissions
- Prevent avoidable hospital readmissions
- Improve hospital efficiency
- Decrease costs of episodes of care
- Improve targeting of costly services
- Increase shared decision-making

ADMINISTRATIVE COSTS

- Use common billing and claims forms

RELATED REFORMS

- Medical Liability Reform
- Prevent Fraud and Abuse

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jama.com

October 22/29, 2014

Volume 312, Number 16
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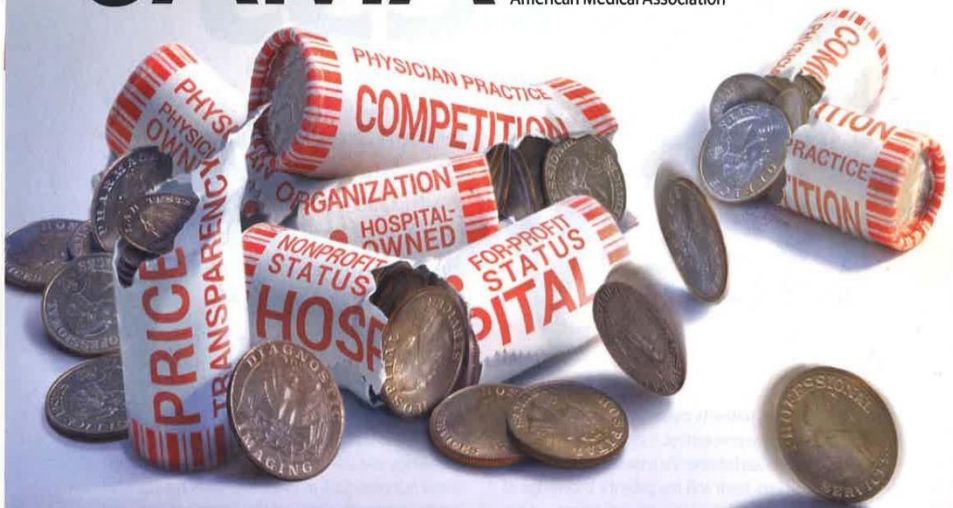
JAMA

Journal of the American Medical Association



Price, Cost, and Competition in Health Care

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LC Baker and Coauthors

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Viewpoint

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L Grigoryan, BW Trautner, and K Gupta

Issue Highlights and Complete Contents on page 1611

Definition of Quality
Institute of Medicine

"The degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

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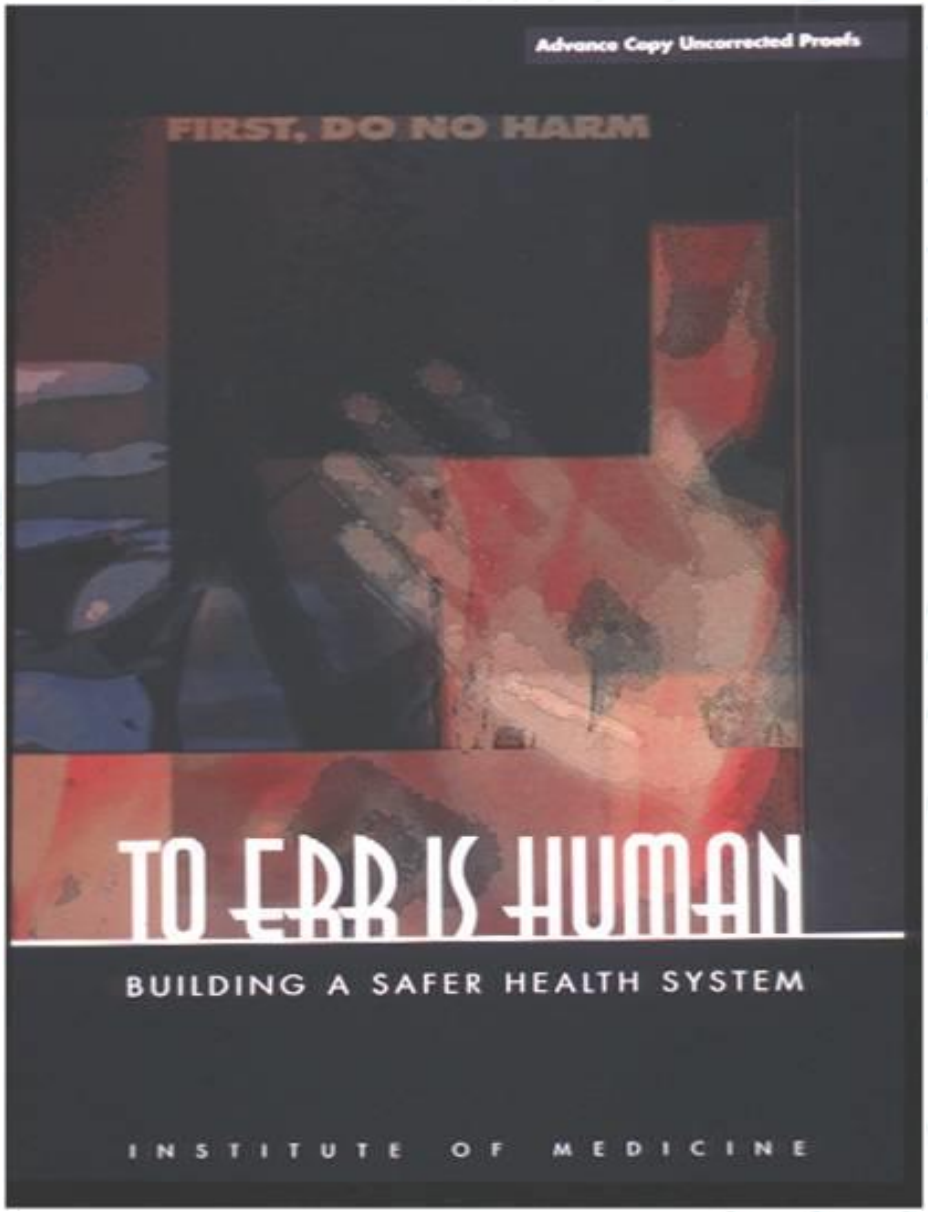

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The Wall Street Journal
September 21, 2012

How to Stop Hospitals From Killing Us

Medical errors kill enough people to fill four jumbo jets a week. A surgeon with five simple ways to make health care safer.

BY MARTY MAKARY

WHEN THERE IS a plane crash in the U.S., even a minor one, it makes headlines. There is a thorough federal investigation, and the tragedy often yields important lessons for the aviation industry. Pilots and airlines thus learn how to do their jobs more safely.

The world of American medicine is far deadlier: Medical mistakes kill enough people each week to fill four jumbo jets. But these mistakes go largely unnoticed by the world at large, and the medical community rarely learns from them. The same preventable mistakes are made over and over again, and patients are left in the dark about which hospitals have significantly better (or worse) safety records than their peers.

As doctors, we swear to do no harm. But on the job we soon absorb another unspoken rule: to overlook the mistakes of our colleagues. The problem is vast. U.S. surgeons operate on the wrong body part as often as 40 times a week. Roughly a quarter of all hospitalized patients will be harmed by a medical error of some kind. If medical errors were a disease, they would be the sixth leading cause of death in America—just behind accidents and ahead of Alzheimer's. The human toll aside, medical errors cost the U.S. health-care system tens of billions a year. Some 20% to 30% of all medications, tests and procedures are unnecessary, according to research done by medical specialists, surveying their own fields. What other industry misses the mark this often?

25%
Hospitalized patients who are harmed by medical errors
Source: New England Journal of Medicine

It does not have to be this way. A new generation of doctors and patients is trying to achieve greater transparency in the health-care system, and new technology makes it more achievable than ever before.

I encountered the disturbing closed-door culture of American medicine on my very first day as a student at one of Harvard Medical School's prestigious affiliated teaching hospitals. Wearing a new white medical coat that was still creased from its packaging, I walked the halls marveling at the portraits of doctors past and present. On rounds that day, members of my resident team repeatedly referred to one well-known surgeon as "Dr. Hodad." I hadn't heard of a surgeon by that name. Finally, I inquired. "Hodad," it turned out, was a nickname. A fellow student whispered: "It stands for Hands of Death and Destruction."

Stunned, I soon saw just how scary the works of his hands were. His operating skills were hasty and slipshod, and his patients frequently suffered complications. This was a man who simply should not have been allowed to touch patients. But his bedside manner was impeccable (in fact, I try to emulate it to this day). He was charming. Celebrities requested him for operations. His patients worshiped him. When faced with excessive surgery time and extended hospitalizations, they just chalked up their misfortunes to fate.

Dr. Hodad's popularity was no aberration. As I rotated through other hospitals during my training, I learned that many hospitals have a "Dr. Hodad" somewhere on staff (sometimes more than one). In a business where reputation is everything, doctors who call out other doctors can be targeted. I've seen whistleblowing doctors suddenly assigned to more emergency calls, given fewer resources or simply badmouthed and discredited in retaliation. For me, I knew the ramifications if I sounded the alarm over Dr. Hodad: I'd be called into the hospital chairman's office, a dread scenario if I ever wanted a job. So, as a rookie, I kept my mouth shut. Like the other trainees, I just told myself that my 120-hour weeks were about surviving to become a surgeon one day, not about fixing medicine's culture.

98,000
Annual deaths from medical errors in the U.S.
Source: Institute of Medicine

Hospitals as a whole also tend to escape accountability, with excessive complication rates even at institutions that the public trusts as top-notch. Very few hospitals publish statistics on their performance, so how do patients pick one? As an informal exercise throughout my career, I've asked patients how they decided to come to the hospital where I was working (Georgetown, Johns Hopkins, D.C. General Hospital, Harvard and others). Among their answers: "Because you're close to home";

Please turn to the next page

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Researchers suggest 2 paths to get patients back on statins [PAGE 18]

Professional Issues

HEALTH CARE LITIGATION ■ MEDICAL EDUCATION ■ ETHICS ■ PROFESSIONAL REGULATION

4/22/13

TOP 10 ways to improve patient safety NOW!

A newly released evidence review narrows the field of targets to prevent harm. These are things hospitals should be doing to protect patients. { By Kevin B. O'Reilly }

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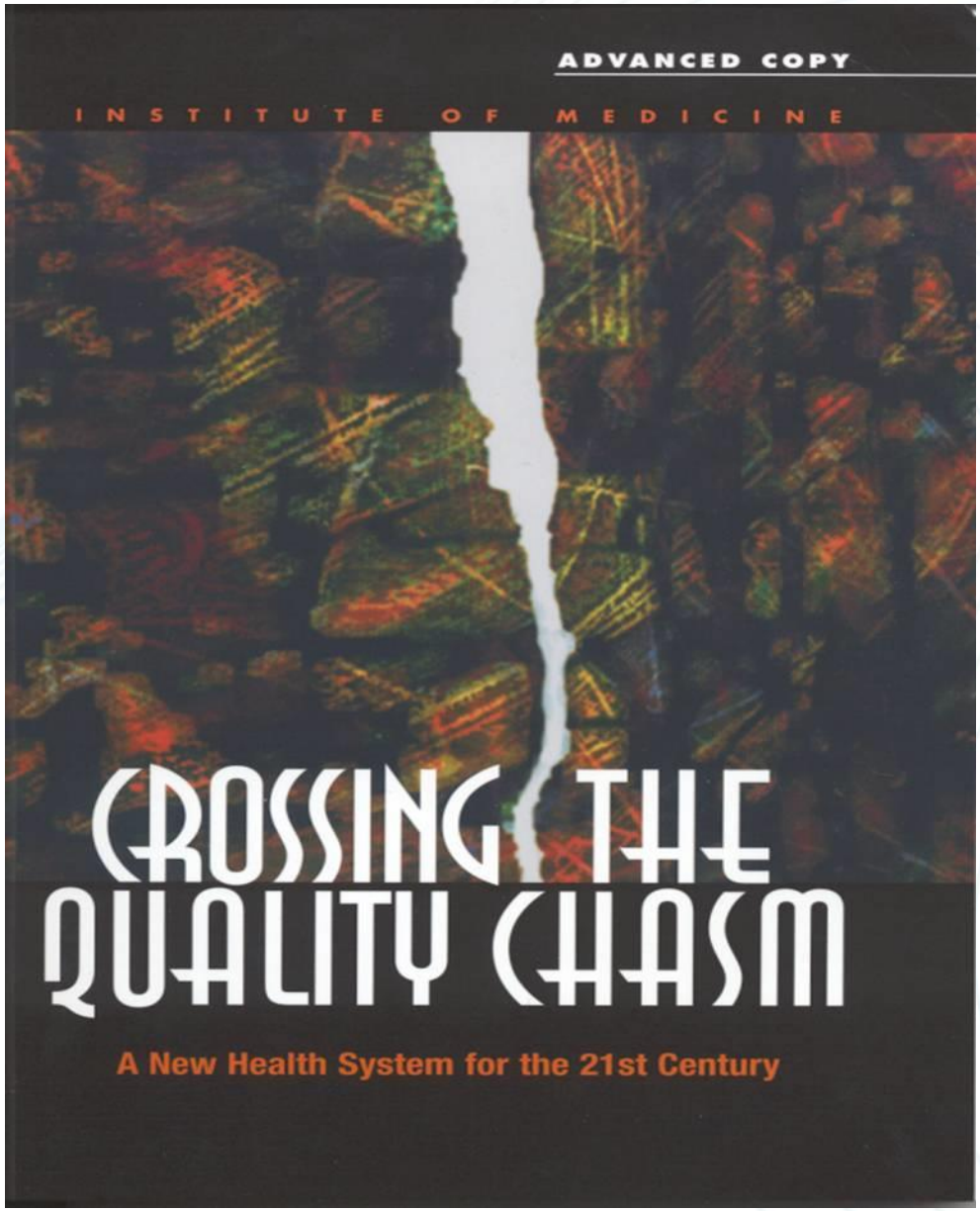
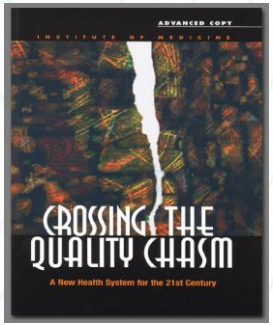


Institute of Medicine Report 2001

Outlines Key Dimensions of the Healthcare Delivery System



- ***Safe***: avoiding injuries to patients from the care that is intended to help them.
- *Effective*: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding **underuse** and **overuse**, respectively).
- *Patient-centered*: providing care that is **respectful** of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*: **reducing waits** and sometimes harmful **delays** for both those who receive and those who give care.
- *Equitable*: providing care that does **not vary** in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- *Efficient*: **avoiding waste, including waste of equipment, supplies, ideas, and energy**.

Source: Institute of Medicine 2001; 5-6

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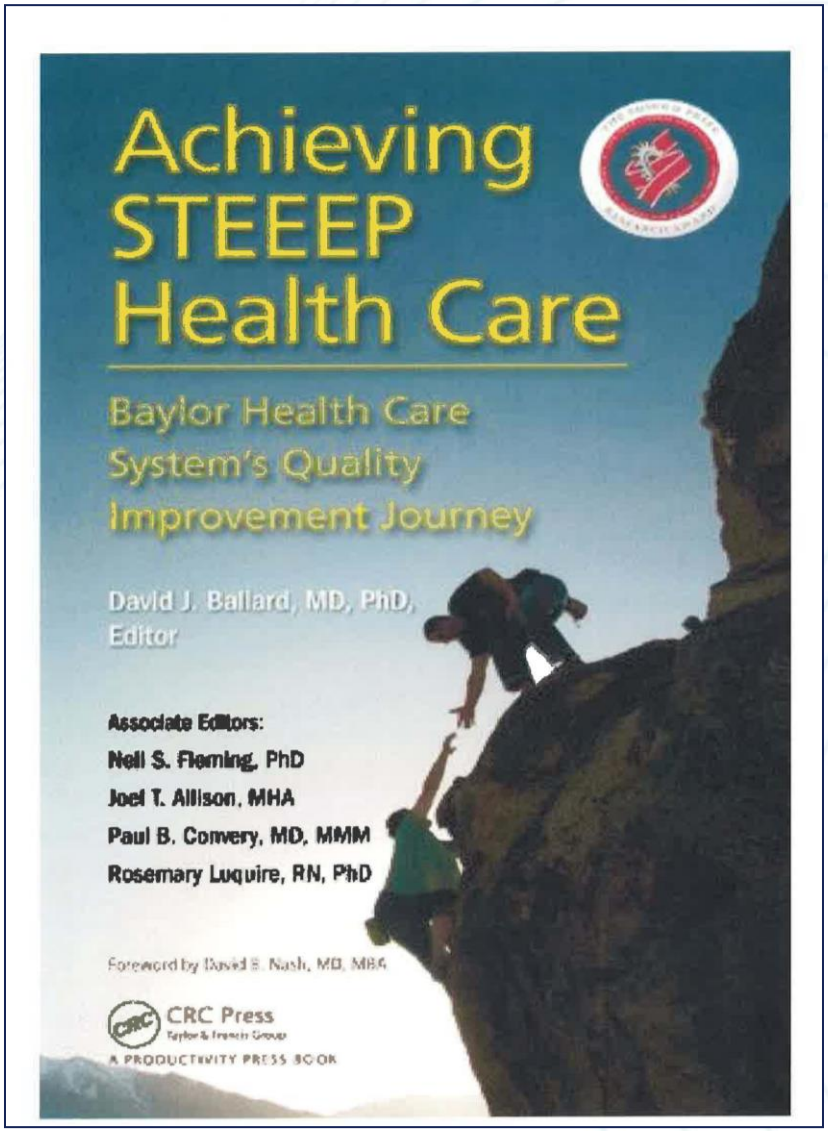


Is Population Health the Answer?

1. What's the question?
2. Where are we now?
3. Where are we going in the future?

Population Health: Conceptual Framework

Health outcomes and their distribution within a population

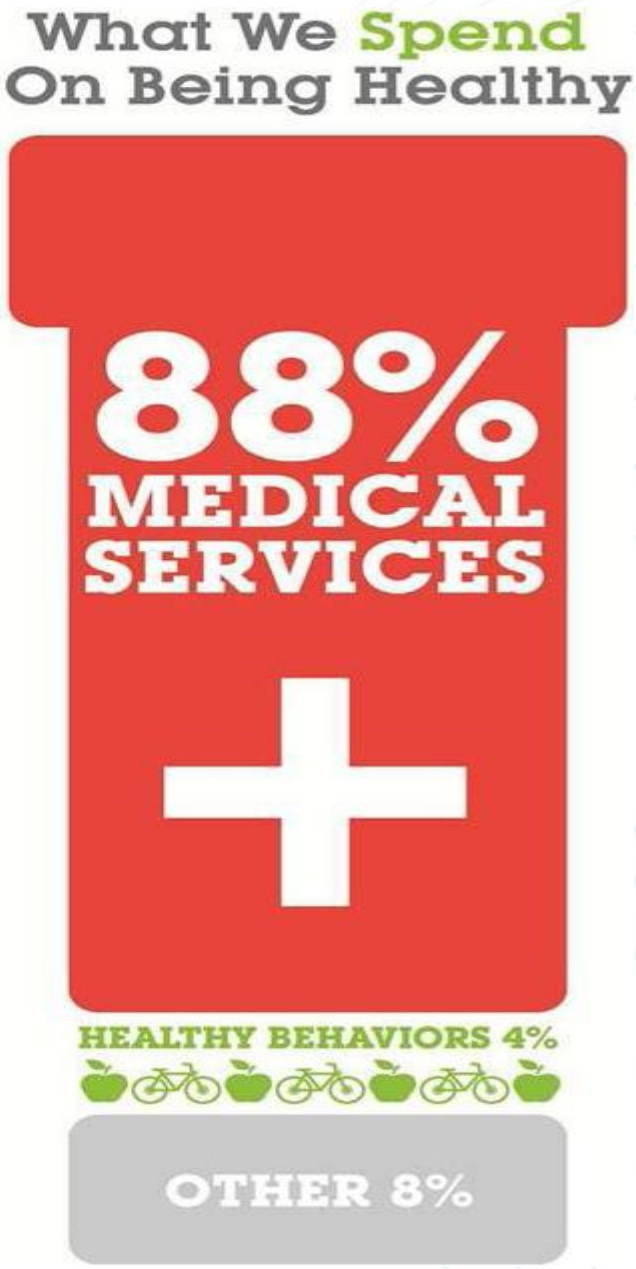
Morbidity
Mortality
Quality of Life

Health determinants that influence distribution

Medical care
Socioeconomic status
Genetics

Policies and interventions that impact these determinants

Social
Environmental
Individual



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Source: Bipartisan Policy Center, "F" as in Fat: How Obesity Threatens America's Future (TFAH/RWJF, Aug. 2013)

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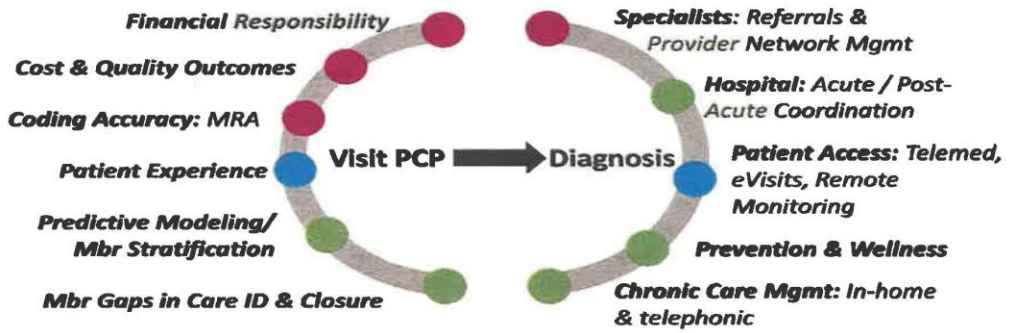
Episodic vs. Population Health Models – transitioning from ***volume to value***

Episodic Model

Population Health Model



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FIRST EDITION

POPULATION HEALTH

EXECUTIVE EDITORS

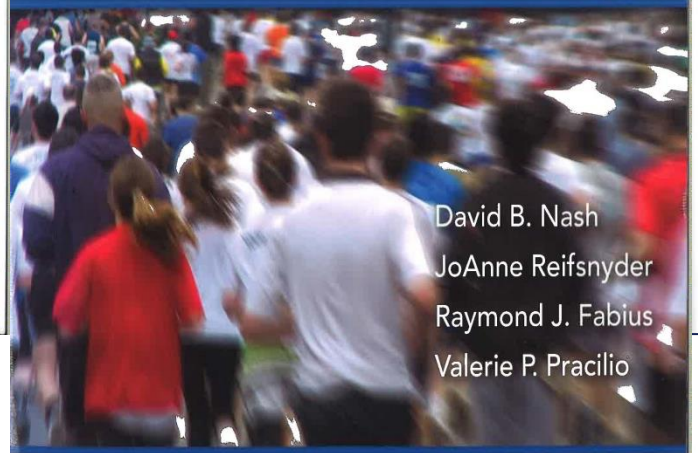
ROBERT J. ESTERHAY | LAQUANDRA S. NESBITT | JAMES H. TAYLOR | H.J. BOHN, JR.

FOREWORD BY

DAVID B. NASH

POPULATION HEALTH

CREATING A CULTURE OF WELLNESS



David B. Nash
JoAnne Reifsnyder
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Valerie P. Pracilio

KEY STRATEGIES FOR HEALTHCARE IN THE NEXT TRANSFORMATION

PROVIDER-LED POPULATION HEALTH MANAGEMENT

RICHARD HODACH, MD, MPH, PhD

FOREWORD BY: DAVID B. NASH, MD, MBA, FOUNDING DEAN, JEFFERSON SCHOOL OF POPULATION HEALTH

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VOLUME 17, NUMBER 5, OCTOBER 2014 ISSN: 1942-7891

Population Health Management

CONTENTS

- Emergency Room Decision-Support
- Worksite Weight Management
- Burden of Diabetes
- Managing Electronic Medical Records
- Genomic Testing for Obstructive CAD
- Evaluating Health Care Costs and Health Risks
- Worksite Primary Care Clinics

The Official Journal of
Population Health ALLIANCE

School of Population Health
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Better Health

…He’s back!

What Percentage of Adult Americans do the Following?

1. Exercise 20 minutes 3 x week
2. Don't smoke
3. Eat fruits and vegetables regularly
4. Wear seatbelts regularly
5. Are at appropriate BMI

Annals Int Med
April 2006

Determinants of Health

1. Smoking
2. Unhealthy diet
3. Physical inactivity
4. Alcohol use

Together, these account for 40% of all deaths.

Reforming Health Care or Reforming Health?

1. US spends under 2% of its health dollars on population health

2. Chronic Diseases, which comprise 80% of total disease burden, have no dedicated federal funding stream

War on Cancer?

President Richard M. Nixon

- 38 yrs. and billions of dollars later:
  - Almost entirely due to declines in smoking

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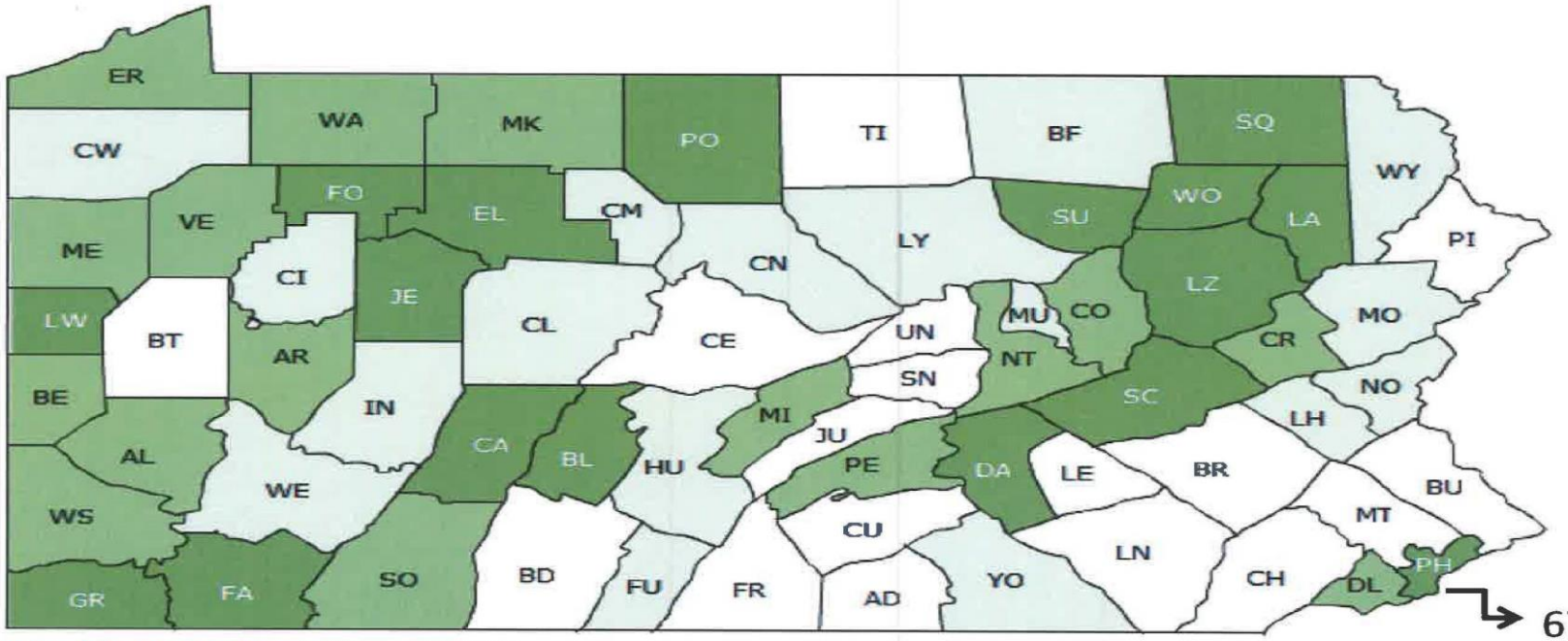
Pennsylvania Health Outcomes Ranks by County



www.countyhealthrankings.org – RWJF and UWPHI

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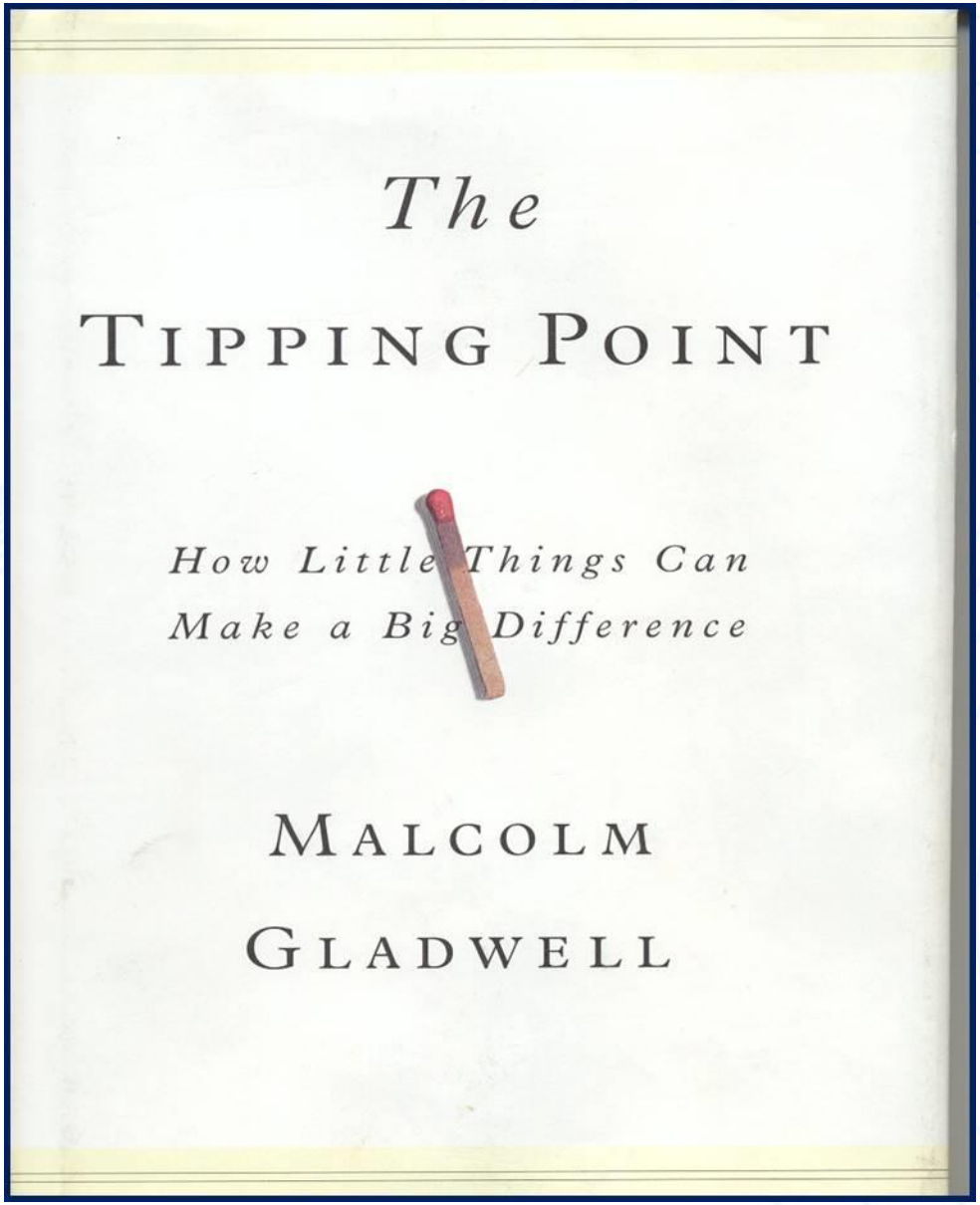

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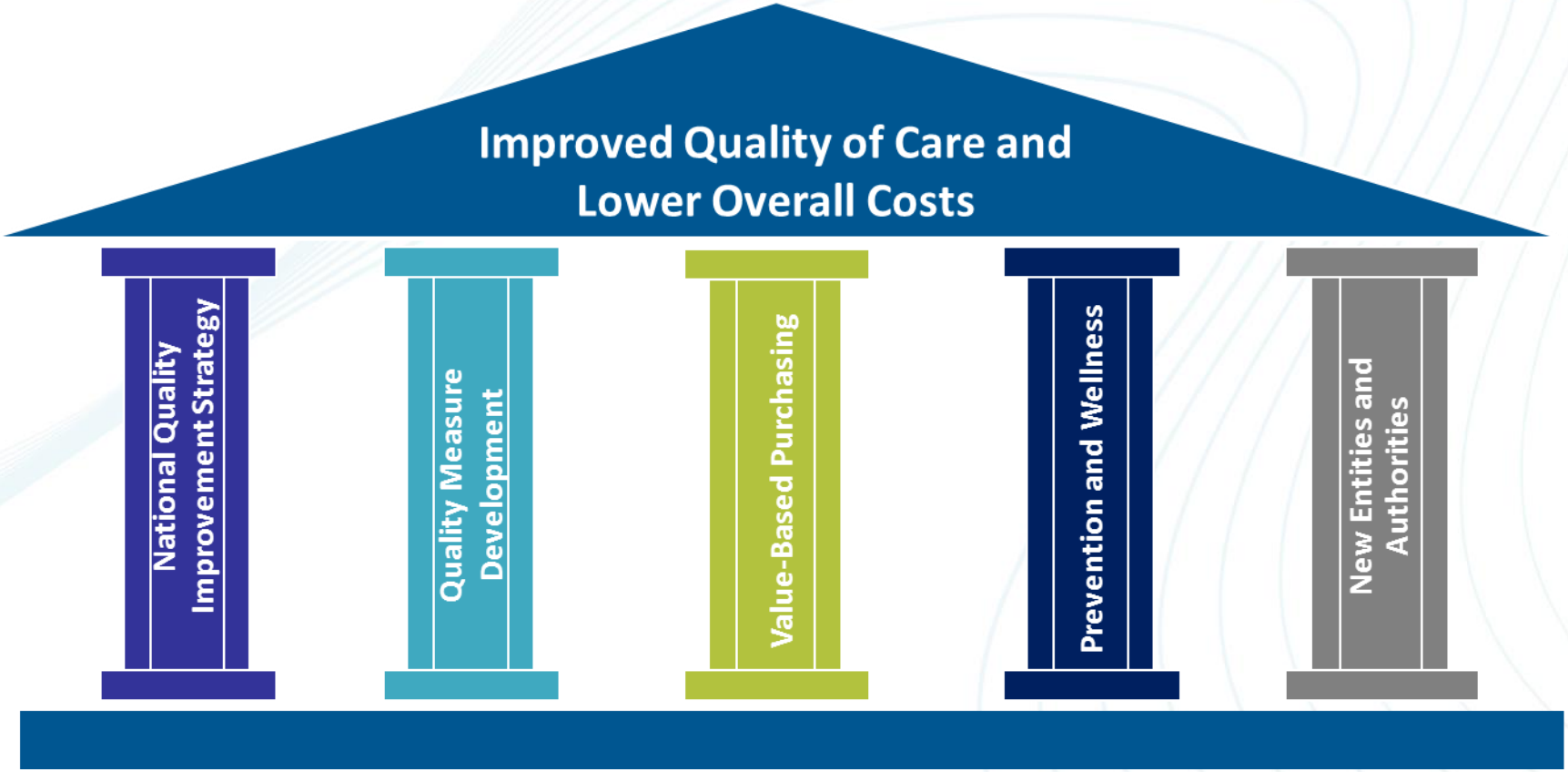
Health Reform Builds on the Current Quality Infrastructure



The Four Underlying Concepts of Cost Containment Through Payment Reform…

Tying payment to **evidence and outcomes** rather than per unit of service	**"Bundling" payments** for physician and hospital services by episode or condition
Reimbursement for the **coordination of care** in a medical home	**Accountability for results** - patient management across care settings

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PHYTEL

Help · Kevin Johnson

Population Management System

Search Patients | Go

Patients | Appointments | Outreach | Population Insight | Care Management | PQRS | Hospital Readmission | Reports

Condition Dashboard | Population Benchmarks | Comparison | Population Summary | Data Summary | Patient List | Configuration

Date Range:
Monthly
Quarterly

Recent Reports:
Annual HbA1C
Annual LDL-C testing
Physician Comparison

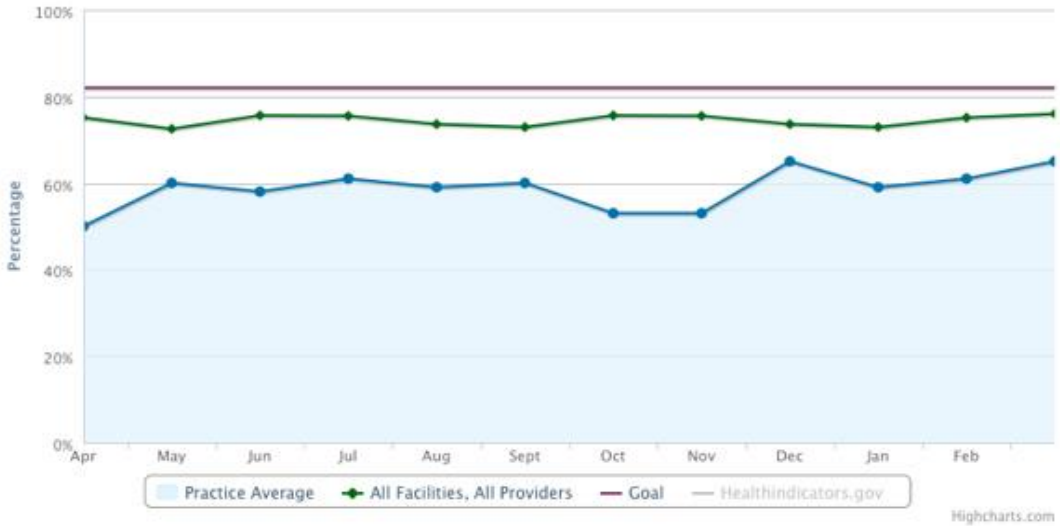
Group: Medical Center, Westside | Provider: 17 Providers

Population Benchmark Report

Export

Report: Quality Initiative | Diabetes | Operational | Annual HbA1C testing

Annual HbA1C testing



Diabetes	Benchmark	QTR 1 (2011)		QTR 4 (2010)		QTR 3 (2010)		QTR 2 (2010)		QTR 1 (2010)		Trend
Identified Population		2,183		2,167		2,180		2,166		2,168		
Measures	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	
Annual HbA1c testing	85.3	**1,773**	**80.1**	1,754	81	1,761	81.6	1,752	81	1,764	81.6	↑
HbA1c > 9.0	12.2	**220**	**13.0**	208	12.7	208	13.7	232	12.2	213	18.0	↔
HbA1c < 7.0	45.3	**862**	**40.8**	832	42.5	928	42.4	926	41.9	910	41.5	↓

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Humana's Accountable Care Organization Pilot

- Unites expertise of Humana and Norton Healthcare of Louisville
- One of only five pilots in the U.S. authorized by Dartmouth and Brookings
- Accountability of measured outcomes, cost, and patient delivery
- Industry-standard performance measures including financial, quality, regulatory
- Core principles:
  - Integrated care delivery among provider teams
  - Defined patient population to measure
  - Pay-for-results based on improved outcomes and cost

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Where Knowledge Informs Change

BROOKINGS

NORTON HEALTHCARE

By Susan DeVore and R. Wesley Champion

Driving Population Health Through Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0935
HEALTH AFFAIRS 30,
NO. 1 (2011): 41-50

ABSTRACT **Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients' satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today's health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.**

Susan DeVore (susan_devore@premierinc.com) is president and chief executive officer of the Premier healthcare alliance, in Charlotte, North Carolina.

R. Wesley Champion is a senior vice president at Premier Consulting Solutions, in Charlotte.

Lucky 7
Population Health TO DO LIST

1. What about your own associates?
   (HRAs, Wellness & Prevention)
2. Keep the well, well
3. PCMH's (who will lead?)
4. Registries
5. Retail clinics (Walgreens, CVS)
6. Managed Care Partners
7. Leadership Training

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What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income

How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care

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NATIONAL QUALITY FORUM

Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities

Environmental Scan and Analysis to Inform the Action Guide

DECEMBER 20, 2013

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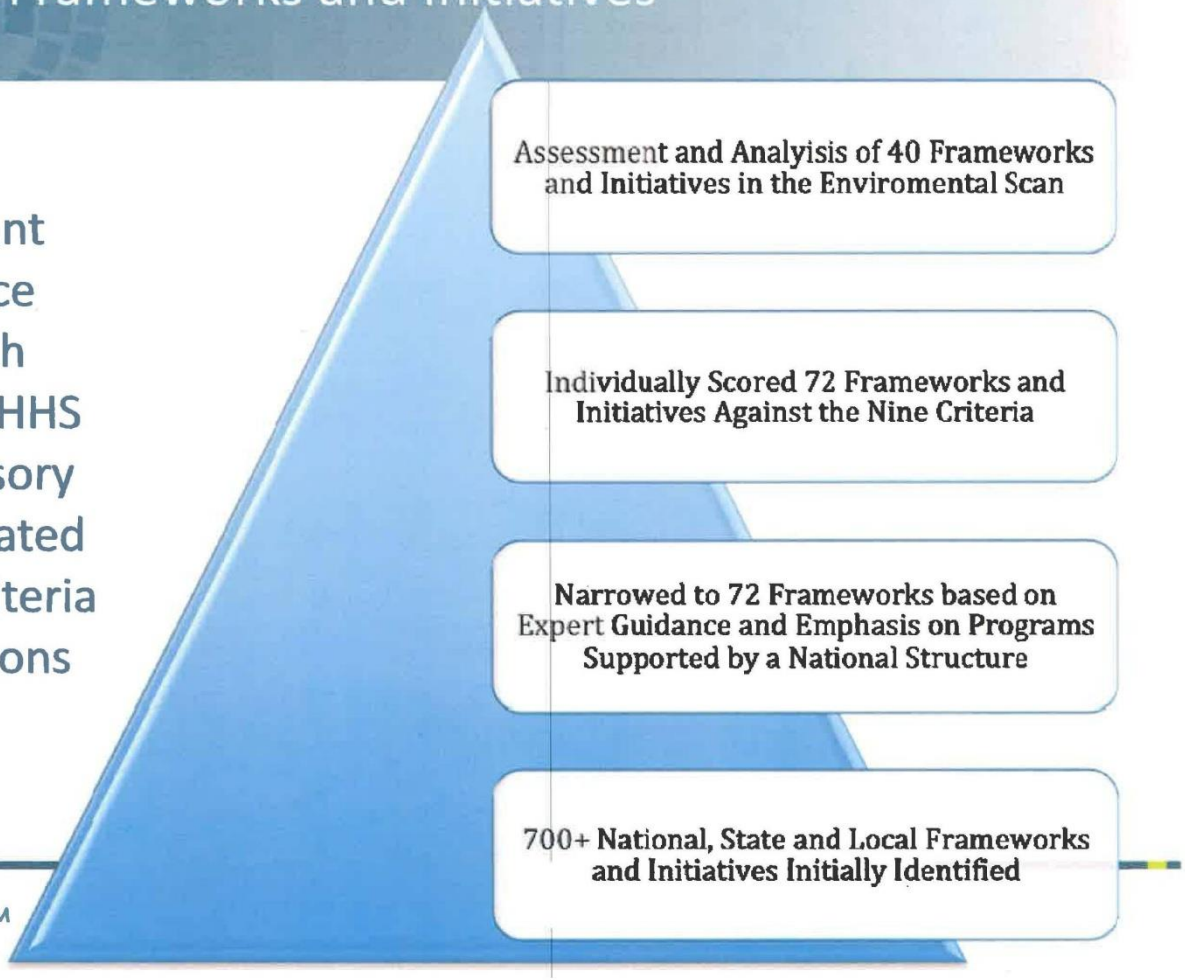
Environmental Scan: Identifying Frameworks and Initiatives

Key informant strategy, face validity with experts from HHS and the Advisory Group, then rated using initial criteria and descriptions



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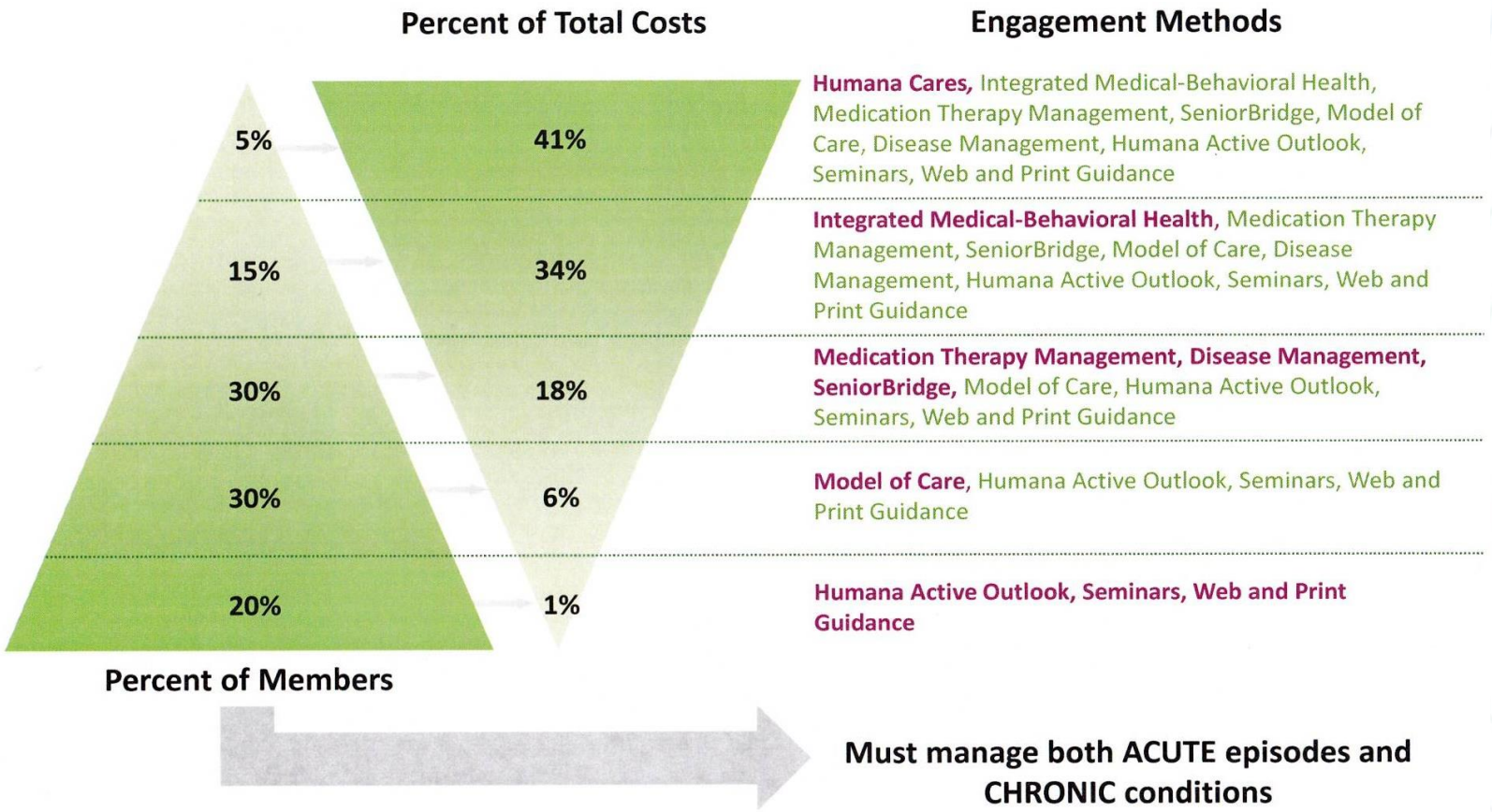
Retail Senior Segment
Medical Management of Members Across a Continuum on Needs

We are focused in managing high cost / high acuity patients both Acute and Chronic



Humana

Note: Senior Bridge deal is pending

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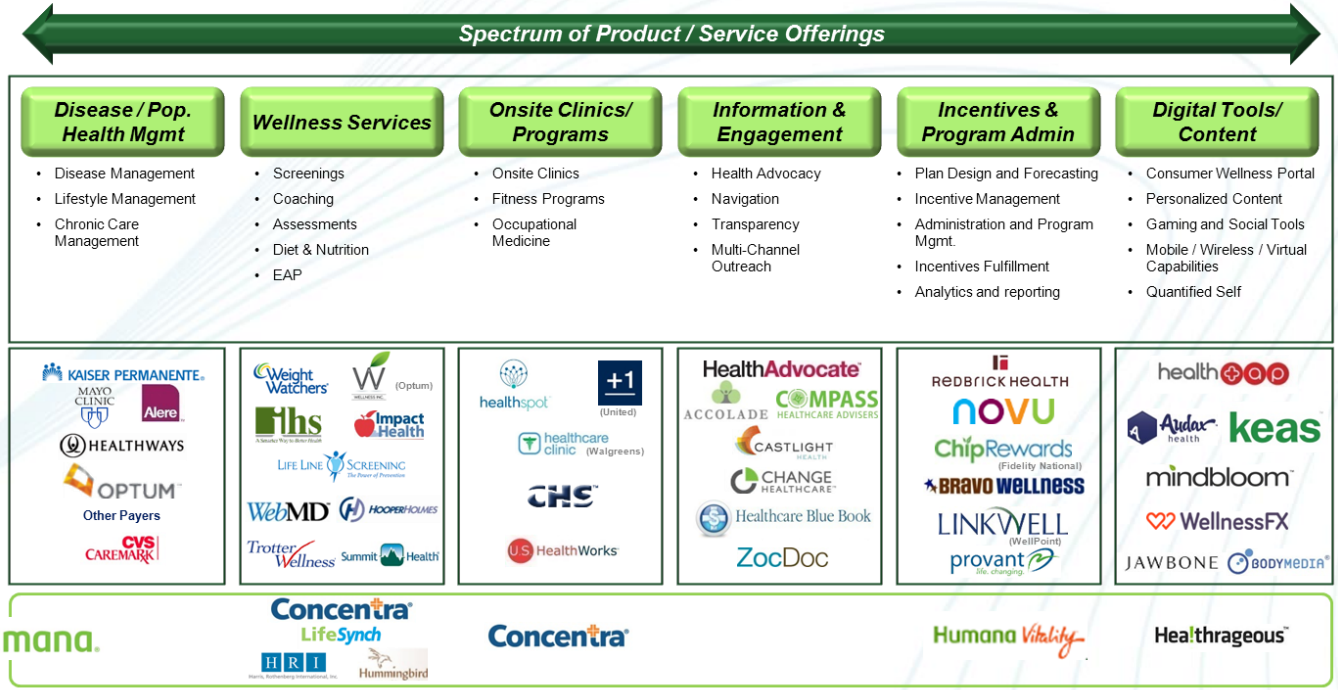
Market Landscape of Health & Wellness

The H&W landscape is fragmented, with a major opportunity for a player to assemble "sticky" value-add offerings to create a comprehensive platform



How could Humana begin to think about building a health & wellness enterprise of significant relevancy and size?

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JOURNAL REPORT

HEALTH CARE

THE WALL STREET JOURNAL. Monday, February 24, 2014 | R

Follow The Experts
An Online Conversation
DETAILS, R2

How to Bring the Price Of Health Care Into the Open

There's a major effort under way to make sure patients know what they'll have to pay—*before* they make any decisions about treatment. Some people think it will make all the difference.

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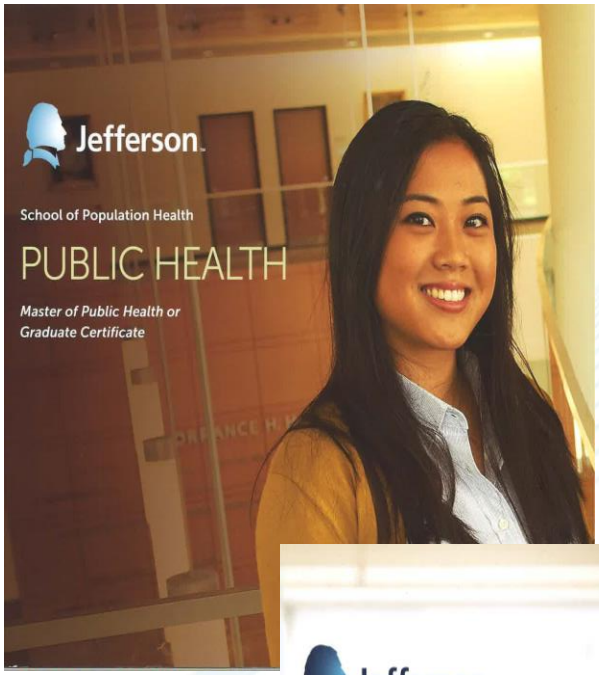

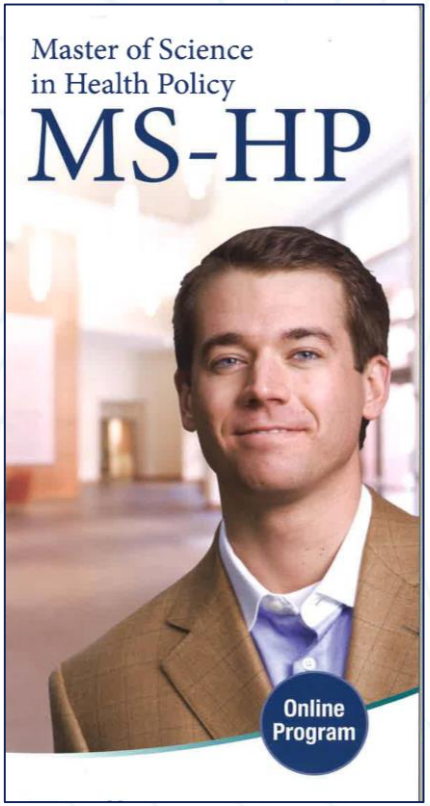

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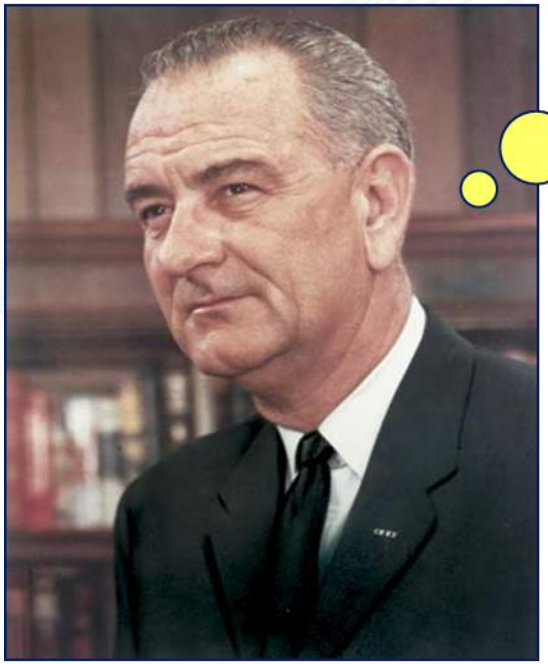
"It's always better to have them in the tent pissing out, than outside the tent pissing in."



President, L.B. Johnson