NPSF Professional Learning Series presents:

The Quality, Safety, and Value Revolutions:
Why Change is No Longer Elective

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Participant Notification

This educational activity offers 1.0 contact hours for physicians, nurses, healthcare executives, and quality and risk professionals.

Physicians

The Doctors Company designates this educational activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™

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This program has been submitted for approval for a total of 1.0 contact hours of continuing education credit toward fulfillment of the requirements of ASHRM designations of Fellow (FASHRM) and Distinguished Fellow (DFASHRM) and towards Certified Professional in Healthcare Risk Management (CPHRM) renewal.

Disclosure

Faculty Disclosure

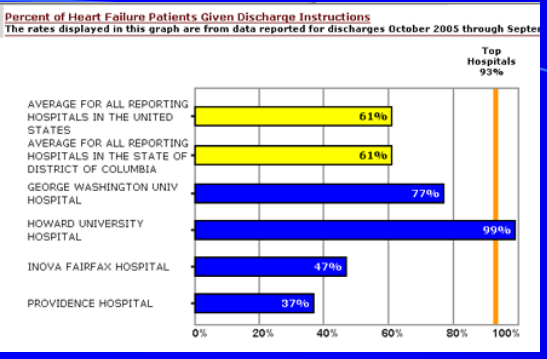
Robert M. Wachter, MD has disclosed no relevant, real or apparent personal or professional financial relationships.

Acknowledgement of Commercial Support

There was no commercial support received for this CME activity.

Learning Objectives

- Describe at least 3 of major policy developments that have driven healthcare delivery organizations to improving value.
- Recall the mixture between clinical processes and outcomes versus patient experience score in the "value-based purchasing" initiative.
- Describe at least one feature of physicians' traditional training that makes hospital-physician alignment challenging.



The Quality, Safety, and Value Revolutions

Why Change is No Longer Elective

Robert M. Wachter, MD

Professor and Associate Chairman, Department of Medicine

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Board Member, Lucian Leape Institute of the NPSF


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Residential site only
Nid wyf yn y swyddfa
ar hyn o bryd. Anfonwch
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I am not in the office at the moment.
Please send any work to be translated.

My Agenda

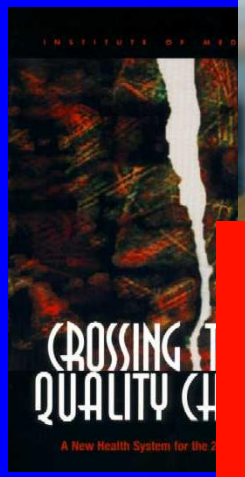
- Quality, patient safety, and value: a decade-long historical perspective
- Some unanticipated consequences and major challenges around transparency and value-promotion policies
- The need for alignment (and why is this so hard for physicians)
- Final thoughts

The Healthcare World of 1999-2001

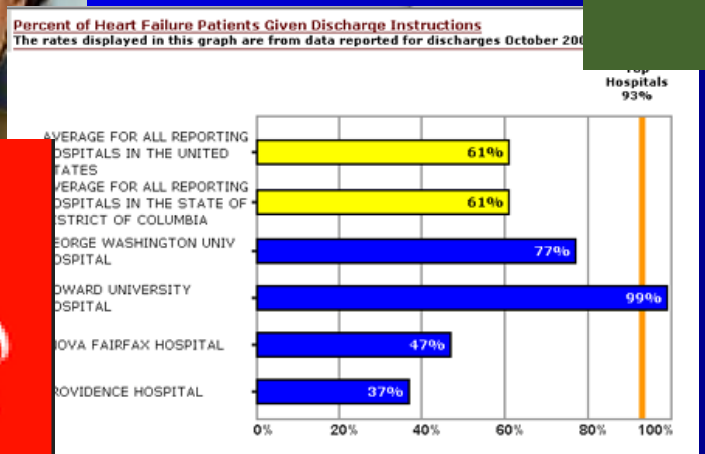
- Quality/safety assumed to be excellent
- Mental model for improvement largely wrong
- No business case to improve safety/quality
- No local expertise, research or best practices
- All of above led to predictable results

The Joint Commission

2000 2002 2004 2006 2008 2010 2012



ACGME



CMS CENTERS for MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program

Trend Line Simplified

- Growing business case for safety/quality
- Steady progression from relatively weak pressures (social pressure, accreditation w/ low chance to fail, transparency), eventually settling on "all of the above" plus payment changes
- While ACA promotes these changes, nearly all are independent of "ObamaCare"
- Recognition of need to remake delivery system to survive/succeed in new healthcare world

Value-based Purchasing and Healthcare Exceptionalism

Value = Quality/Cost

The Two Pauls

The Two Pauls

What Paul Ryan Believes

What Paul Krugman Believes

The Two Pauls

What Paul Ryan Believes

What Paul Krugman Believes

The Need to Get a Handle on Healthcare Costs

Calculation of the VBP Penalty

How Does VBP Work?

- 2% of baseline DRG payment withheld
- Hospitals earn back the withhold based on their VBP score
- For example, a hospital with a VBP score of 60 points earns back ~60% of its 2% withhold

Your VBP Score **59.67**

Clinical: 65

Satisfaction: 48

Estimated Financial Impact

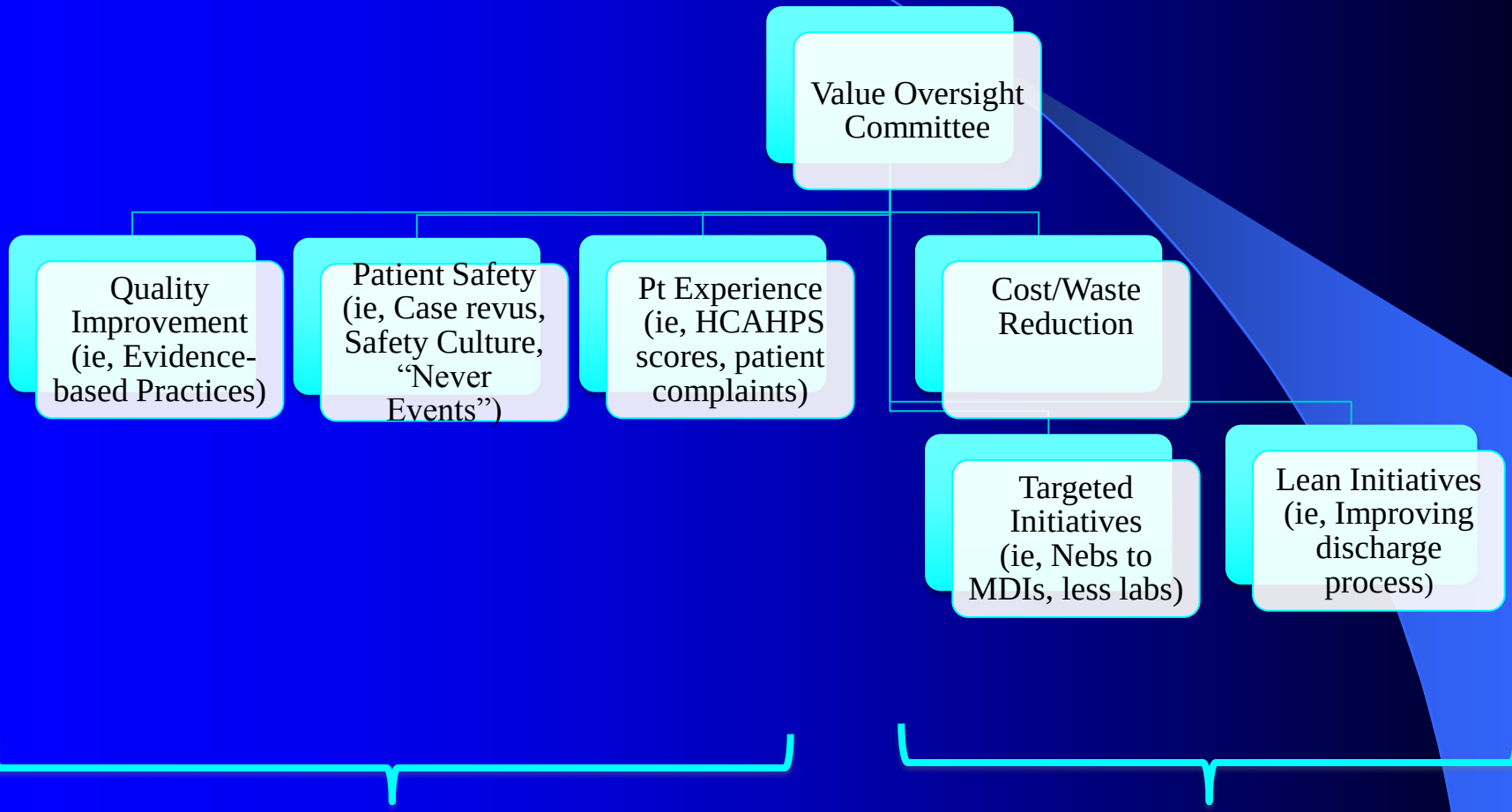
HOLDBACK	**$1,897,139**
EARN BACK	**$1,177,807**
NET TO YOU	**-$719,331**

The New World Order: Transparency *plus* Payment Changes

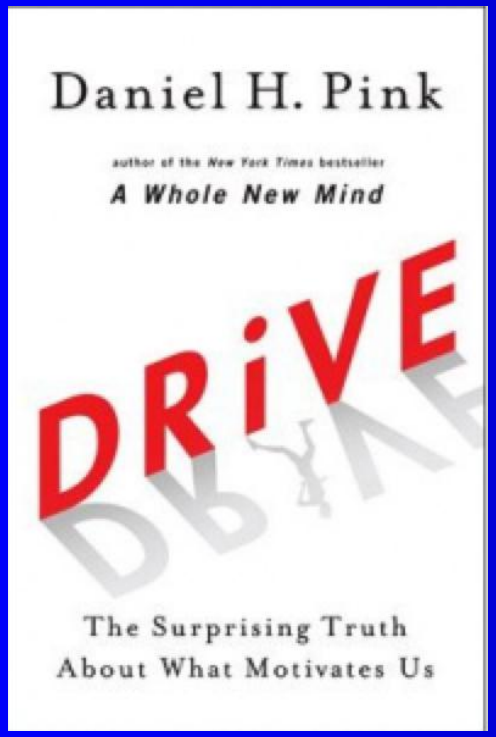
- Value-based Purchasing (VBP) (1%➔2%)
- Hospital-acquired Conditions (HACs) (no pay)
- Readmission penalties (1%➔3%)
- Meaningful use for IT implementation (bonus for MU➔1% cut➔3% cut)
- Plus new payment models such as bundling, ACOs, and possibly SGR fix (who knows?)

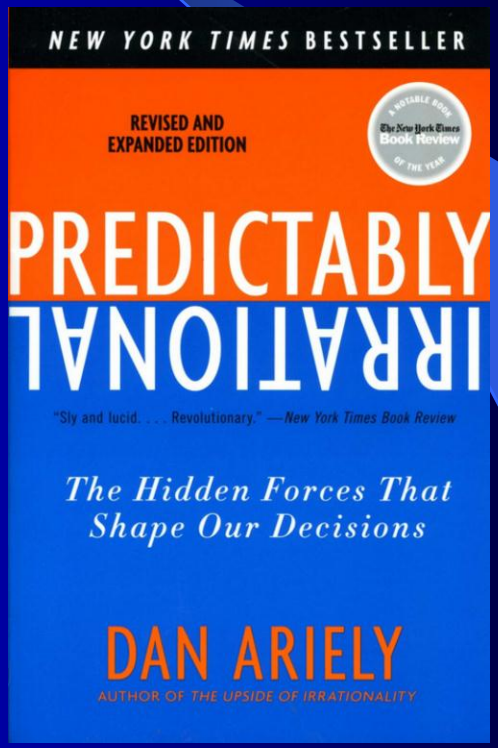
$s at stake by 2017: ~10% of Medicare paymts

UCSF's Model Organizational Chart for a "Value Improvement" Program

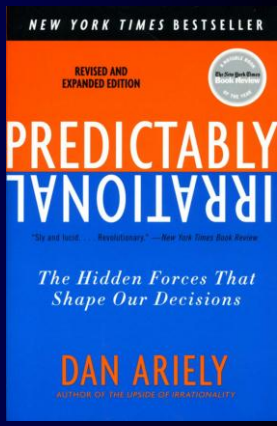


As We Lurch into P4P World: How Good Are $s as Motivator?



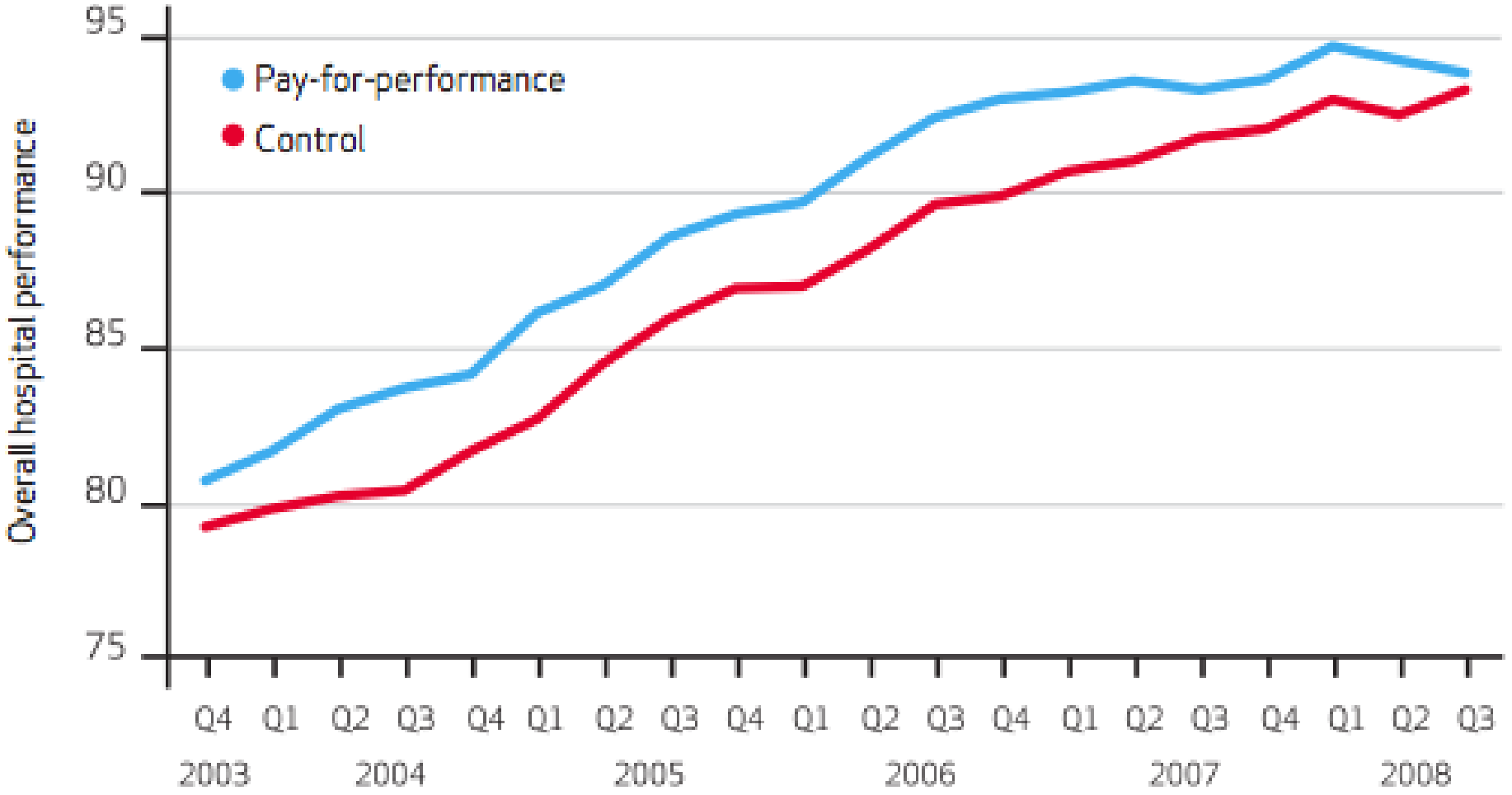


Social vs. Market Transactions: The Israeli Daycare Center



"When a social norm collides with a market norm, the social norm goes away for a long time… Money, as it turns out, is very often the most expensive way to motivate people. Social norms are not only cheaper, but often more effective as well."

Does P4P Work Better Than Simple Transparency? The Jury is Out



Werner R. et al. *Health Affairs* 2011;30:690-8.

The CEO's (Old) Job

- The doctors brought in the patients, so the hospital's customer was the doctors
  - You don't call your best customer onto the carpet for problematic behavior, whether it is:
    - Disruptive
    - Too expensive
    - Poor quality
- The 99-1 vote
- But this is not a viable strategy in today's world

Hospital Leaders Recognize Importance of MD Alignment

Extremely/Very Important to Our Business Model in Next 3-5 Years

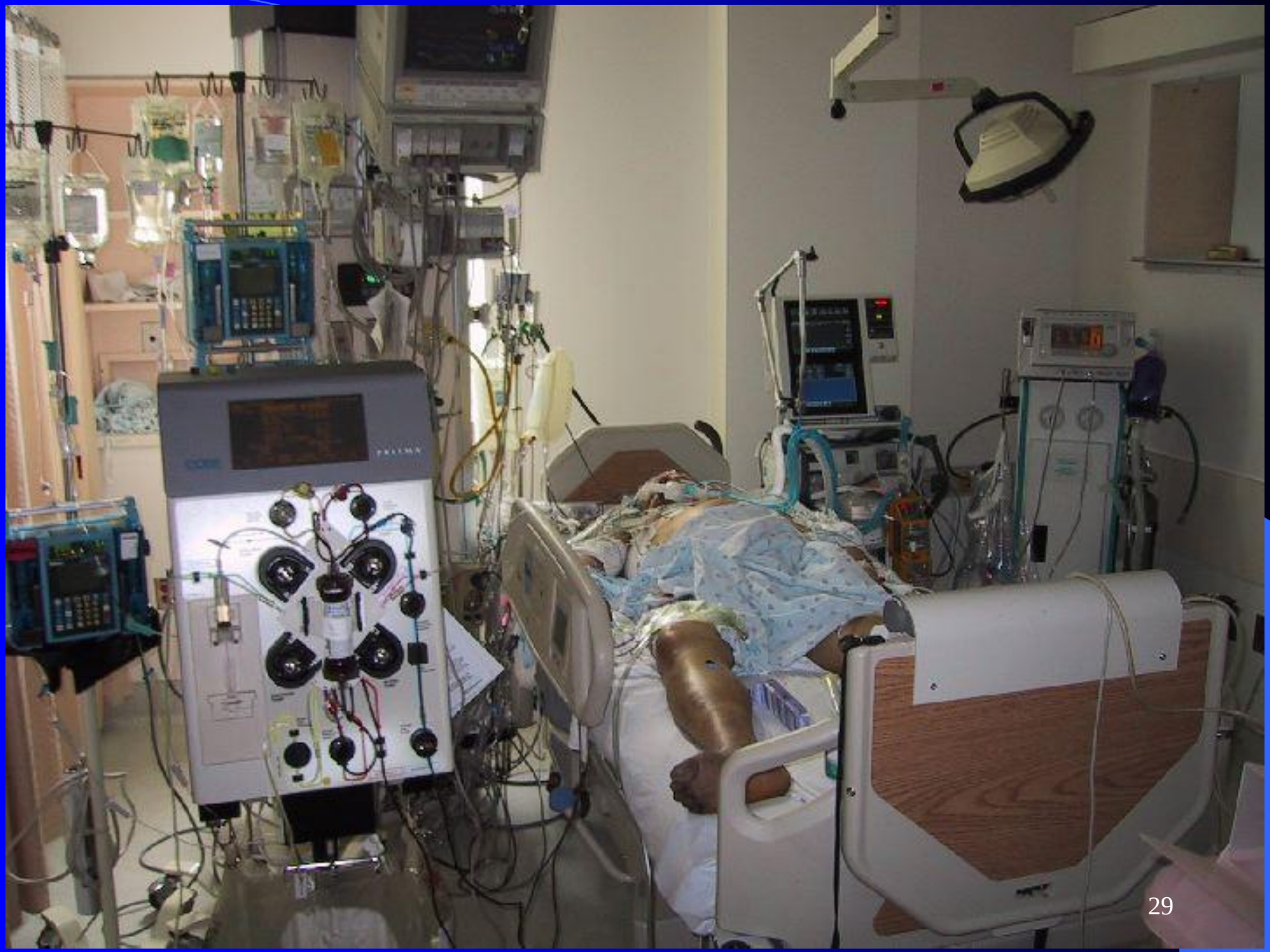
Strategy	% Agree
Aligning with physicians to integrate them fully in clinical redesign efforts	98%
Aligning with physicians to preserve and expand market share	94%
Improving quality to take full advantage of P4P incentives such as CMS value purchasing	92%
Innovative deployment of health information technology across the continuum of care	92%
Redesigning clinical care processes using Lean, Six Sigma or other workflow redesign methods	88%

KPMG/Harris Study

"The core structure of medicine – how health care is organized and practiced – emerged in an era when doctors could hold all the key information patients needed in their heads and manage everything required themselves….We were craftsmen. We could set the fracture, spin the blood, plate the cultures, administer the antiserum. The nature of the knowledge lent itself to prizing autonomy, independence, and self-sufficiency… and to designing medicine accordingly….

But you can't hold all the information in your head any longer, and you can't master all the skills. No one person can work up a patient's back pain, run the immunoassay, do the physical therapy, protocol the MRI, and direct the treatment of the unexpected cancer found growing in the spine. I don't even know what it means to 'protocol' the MRI."

Atul Gawande, *The New Yorker* 2011



How Will Practice Deviations be Handled?

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How to Get it Done: The Necessary-But-Not-Sufficient Stuff

- Create appropriate governance and incentive structure for QI, safety, and value
  - Bottom up & top down; data & stories
- Respect physicians' time and expertise
  - But a 99-1 vote is *not* a tie
- Promote physician leadership
  - Will require new kinds of education and lenses
- In new world, both "sides" need to see shared interests

Final Words

- With change comes opportunity
- Leadership is critical to getting the job done
  - Good news: you're not alone – lots of other forces promoting the quality/safety/value agenda
- In the end, patients are likely to benefit from all of this
- Keep our eyes on the ball

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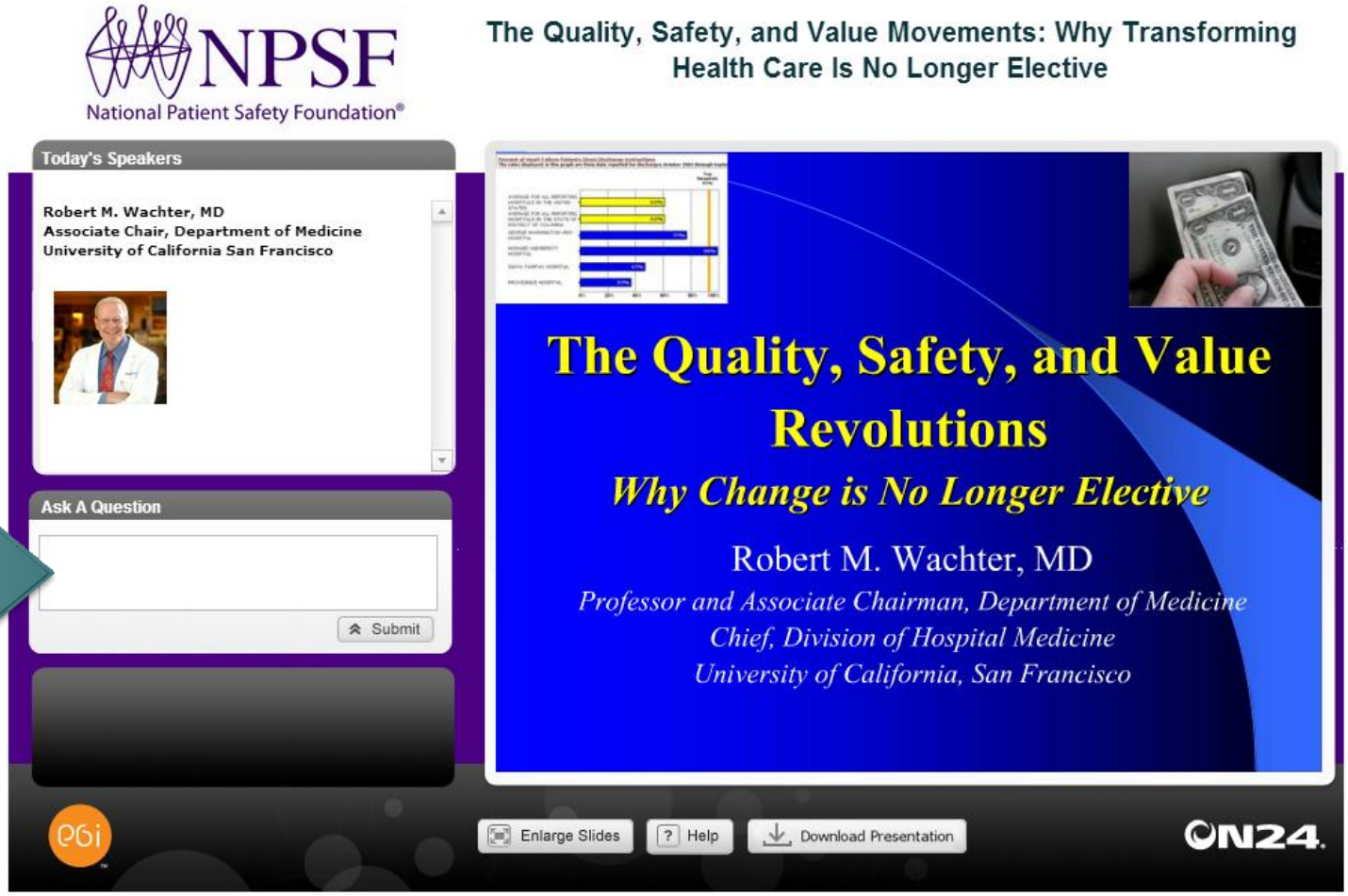
Choluteca Bridge, Honduras

Choluteca Bridge, Honduras

Hurricaine
Mitch, 1998

Submit a Question



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Please enter **NPSFWebcast** (uppercase NPSFW). Click the Submit button.

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If you believe you have an Inquisit account click *find account*
If you forgot your password, please click the forgot password hyperlink.
In subsequent visits, you will only need to add your email address and password.

Please enter the exact way you would like your name displayed on the certificate.
Please check the CE accreditation you wish to earn and then click the **Submit** button

Your Webinar title is listed. Click the title.

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