Improving Value: Better Care at Lower Cost

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Outline

1. Defining terms
2. IOM (“NAM”) Report and its aftermath
3. Radical Redesign
4. The woeful state of our service industry
5. The greatest untapped resource
But first, a disclaimer...
Value = \frac{Quality}{Cost}
What is “quality” to a patient/customer?

1. Clinical quality (often assumed)

2. “Service Quality”
   - Communication
   - Empathy
   - Convenience
   - Personalization
   - Responsiveness
**Efficiency**

**ef·fi·cient**

əˈfiSHənt/

*adjective*

(especially of a system or machine) **achieving maximum productivity with minimum wasted effort or expense.**
“There is nothing so useless as doing efficiently that which should not be done at all.”

Peter Drucker
BEST CARE AT LOWER COST

The Path to Continuously Learning Health Care in America

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the nation / Improving health
Broad overview
What’s changed since *Quality Chasm*?

- Complexity and excess costs
- New tools and levers
- Continuous learning capacity
The vision
Moving from the linear

Science → Evidence → Care
The vision
From missed opportunities, waste, and harm

Science → Evidence → Care → Patient Experience

Insights poorly managed → Evidence poorly used → Experience poorly captured

Communities → Clinicians → Patients

Missed Opportunities, Waste, and Harm

INSTITUTE OF MEDICINE
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Advising the nation / Improving health
The vision
And best care at lower cost
Quality
Persistent missed opportunities, waste, and harm

- **Patient harm** – One-fifth to one-third of hospital patients harmed during their stay, largely preventable.

- **Recommended care** – Only about half of recommended preventive, acute, and chronic care actually delivered.

- **Outcome shortfalls** – If care quality matched highest statewide performance, there would have been 75,000 fewer deaths nationally.
### Sources of unnecessary health spending

**TABLE S-1 Estimated Sources of Excess Costs in Health Care (2009)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate of Excess Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>$210 billion</td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>$130 billion</td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$190 billion</td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>$105 billion</td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>$55 billion</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 billion</td>
</tr>
</tbody>
</table>
New tools and levers
Capacity changes since 2000

- Computing
  - Better connectivity to information and among participants
  - Stronger processing capacity for new knowledge
- Systems/process improvement strategies spreading with increasing success
- Patient-clinician culture change strategies in play
- Policy levers for incentives, transparency, accountability, engagement
The Paradox of Innovation in Health Care

The past half-century has seen unprecedented knowledge generation and technical innovation in biomedical science; there is much more to come

but

our systems for choosing, training, deploying, and paying the health care workforce and organizing their work have not kept up with the biomedical science.
SOAP Notes, anyone?

“Any system of care that depends on the personal knowledge and analytic capabilities of physicians cannot be trusted.”

- Lawrence L. Weed, MD & Lincoln Weed
The leading edge(s)...

- Center for Medicare and Medicaid Innovation Center (CMMI)
Our Innovation Models

The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

Learn More >
The leading edge(s)... 

• Center for Medicare and Medicaid Innovation Center (CMMI)

• Patient-Centered Outcomes Research Institute (PCORI)
The leading edge(s)...

- Center for Medicare and Medicaid Innovation Center (CMMI)
- Patient-Centered Outcomes Research Institute (PCORI)
- Health Care Payment Learning and Action Network (LAN)
APM Framework Draft White Paper
The leading edge(s)...

• Center for Medicare and Medicaid Services Innovation Center (CMMI)
• Patient-Centered Outcomes Research Institute (PCORI)
• Health Care Payment Learning and Action Network (LAN)
• Private Sector innovation
New Rules for Radical Redesign in Health Care

- Change the balance of power
- Standardize what makes sense
- Customize to the individual
- Promote wellbeing
- Create joy in work

- Make it easy
- Move knowledge, not people
- Collaborate and cooperate
- Assume abundance
- Return the money

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IHI Leadership Alliance

http://bit.ly/1ReprXC
Summary

National Health Service (NHS) culture is sustained by a set of core values including respect and dignity, compassion, and inclusion – the latter refers to a commitment to treat everyone with equal respect and significance. Given the diversity of the NHS workforce, these values have particular significance.

Recent research demonstrates that very little progress has been made in the past 20 years to address the issue of discrimination against black, minority and ethnic (BME) staff in the NHS. There is evidence too of discrimination experienced by many other groups including women, lesbian, gay, bisexual and transgender (LGBT) staff, people with disabilities and religious groups.

In this report we use data from the NHS Staff Survey to assess the scale of the problem before drawing on wider work on climates of inclusion to suggest comprehensive strategies to bring about lasting and pervasive change. The data is interrogated to answer the following questions.

- What are the differences in experienced discrimination between NHS staff from different demographic and work backgrounds (e.g., ethnic group, gender, occupational group etc.)?
Eliminating Low-value care...
Value Stream Mapping
The Patient’s Perspective for Migraine

Redesign creates:
1. Evidence-based care
2. High patient satisfaction
3. Same-day access
4. Rapid return to function
5. Lower cost for buyers and sellers
Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians

**ABSTRACT** The adult primary care “physician shortage” is more accurately portrayed as a gap between the adult population’s demand for primary care services and the capacity of primary care, as currently delivered, to meet that demand. Given current trends, producing more adult primary care clinicians will not close the demand-capacity gap. However, primary care capacity can be greatly increased without many more clinicians: by empowering licensed personnel, including registered nurses and pharmacists, to provide more care; by creating standing orders for nonlicensed health personnel, such as medical assistants, to function as panel managers and health coaches to address many preventive and chronic care needs; by increasing the potential for more patient self-care; and by harnessing technology to add capacity.
“Physician shortage”
“Wedge” approach to Primary Care service capacity

Service Needs

- Technology
- Patients
- Non-licensed healthcare personnel
- Non-physician licensed practitioners
- Physicians

Time
How bad are we?
Travel arrangements ...
Medical Consultation
The greatest untapped resource for high-value care:

Patients
(with enabling technology)
Strep throat
Self-monitoring of oral anticoagulation: a systematic review and meta-analysis

Dr C Heneghan, MRCGP, P Alonso-Coello, MD, JM Garcia-Alamino, RN, R Perera, PhD, E Meats, BSc, Prof P Glasziou, FRACGP
Original Investigation

Effect of Self-monitoring and Medication Self-titration on Systolic Blood Pressure in Hypertensive Patients at High Risk of Cardiovascular Disease
The TASMIN-SR Randomized Clinical Trial

Richard J. McManus, FRCPG; Jonathan Mant, MD; M. Sayeed Haqae, PhD; Emma P. Bray, PhD; Stirling Bryan, PhD; Sheila M. Greenfield, PhD; Miren I. Jones, PhD; Sue Jowett, PhD; Paul Little, MD; Cristina Penalvo, MA; Claire Schwartz, PhD; Helen Shackleford, RGN; Claire Shovelton, PhD; Jeni Varghese, RGN; Bryan Williams, MD; F.D. Richard Hobbs, FMedSci

**IMPORTANCE** Self-monitoring of blood pressure with self-titration of antihypertensives (self-management) results in lower blood pressure in patients with hypertension, but there are no data about patients in high-risk groups.

**OBJECTIVE** To determine the effect of self-monitoring with self-titration of antihypertensive medication compared with usual care on systolic blood pressure among patients with cardiovascular disease, diabetes, or chronic kidney disease.

**DESIGN, SETTING, AND PATIENTS** A primary care, unblinded, randomized clinical trial involving 552 patients who were aged at least 35 years with a history of stroke, coronary heart disease, diabetes, or chronic kidney disease and with baseline blood pressure of at least 130/80 mm Hg being treated at 59 UK primary care practices was conducted between March 2011 and January 2013.

**INTERVENTIONS** Self-monitoring of blood pressure combined with an individualized self-titration algorithm. During the study period, the office visit blood pressure measurement target was 130/80 mm Hg and the home measurement target was 120/75 mm Hg. Control patients received usual care consisting of seeing their health care clinician for routine blood pressure measurement and adjustment of medication if necessary.

**MAIN OUTCOMES AND MEASURES** The primary outcome was the difference in systolic blood pressure between intervention and control groups at the 12-month office visit.
Dialysis

At the regional hospital Ryhov in Jönköping, there has been a unit for self-dialysis for several years.
"In theory there is no difference between theory and practice. In practice there is."

- Yogi Berra (maybe)
Transition turbulence:

“One foot in the canoe –
and one on the dock…”
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Thank you!