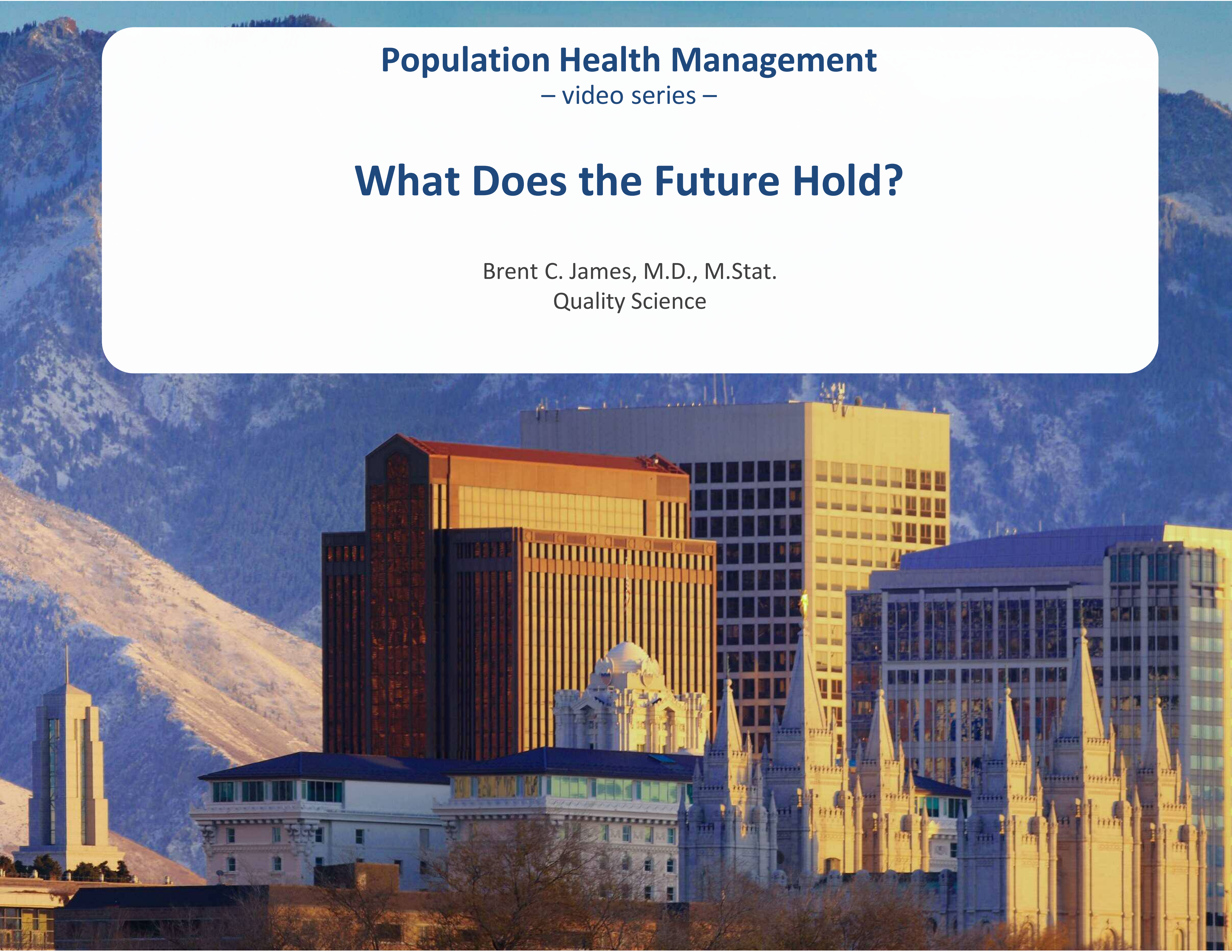

Population Health Management

– video series –

What Does the Future Hold?

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Quality Science

Video and slides
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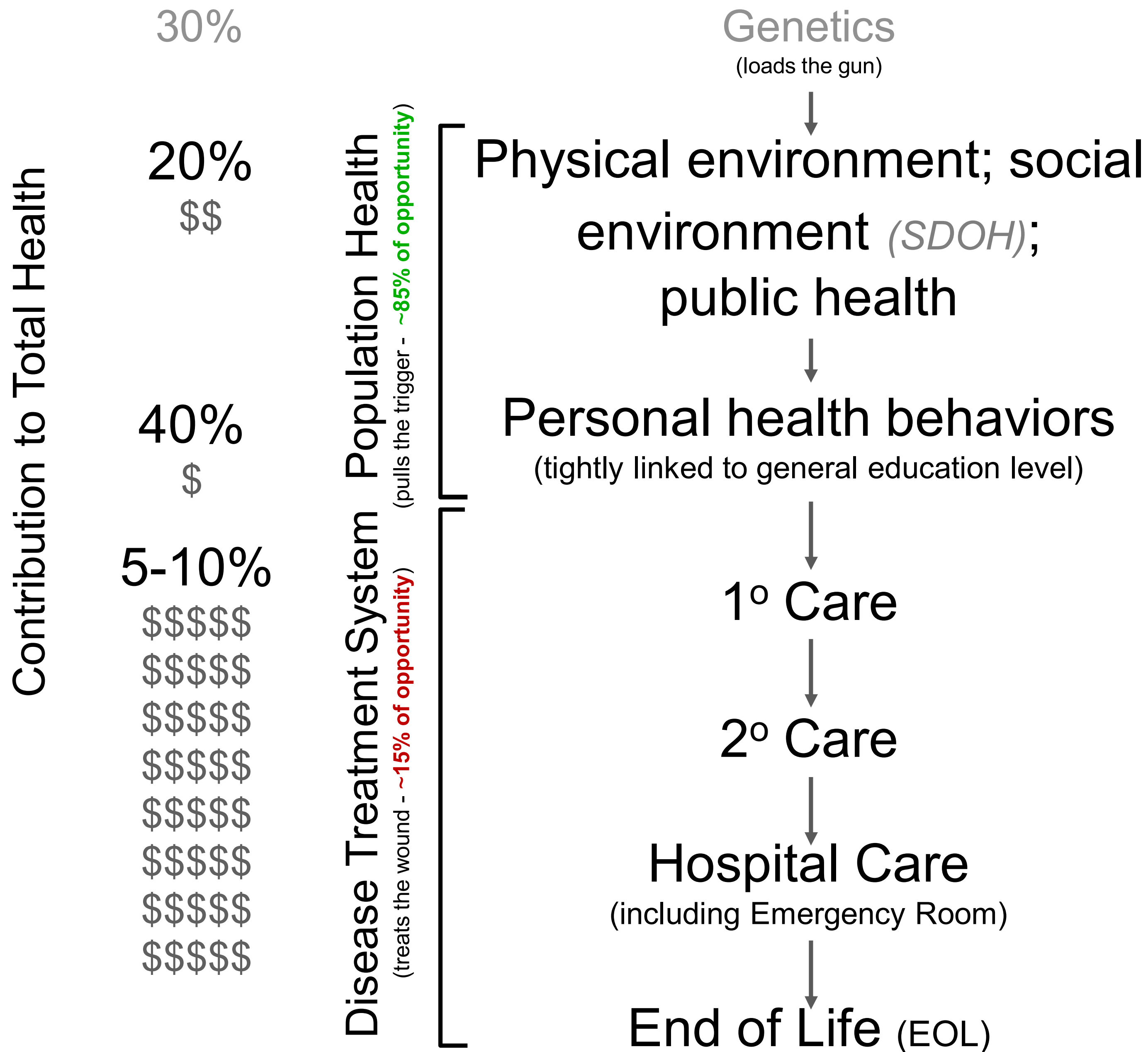
Health-based model *for Population Health*



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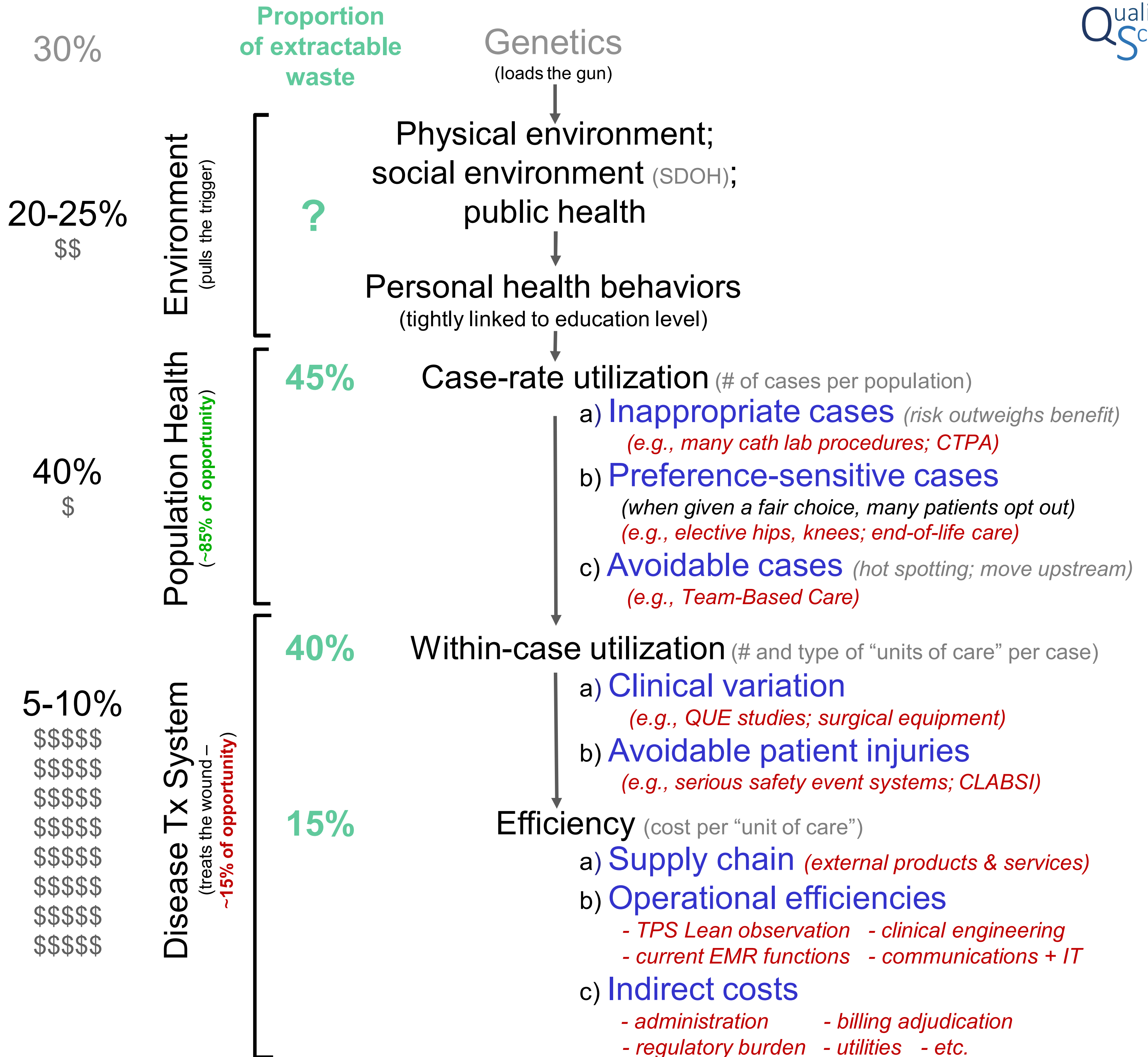
Waste-based model *for Population Health*

Waste class	% of all waste	Waste subclasses
3. Case-rate utilization *(# cases per population)*	45%	a) Inappropriate cases *(risk outweighs benefit)* *(e.g., many cath lab procedures; CTPA)* b) Preference-sensitive cases *(when given a fair choice, many patients opt out)* *(e.g., elective hips, knees; end-of-life care)* c) Avoidable cases *(hot spotting; move upstream)* *(e.g., team-based care)*
2. Within-case utilization *(# and type of units per case)*	40%	a) Clinical variation *(e.g., QUE studies; surgical equipment)* b) Avoidable patient injuries *(e.g., serious safety event systems; CLABSI)*
1. Efficiency *(cost per unit of care)*	15%	a) Supply chain *(external products & services)* b) Operational efficiencies *- TPS Lean observation - clinical engineering - current EMR functions - communications + IT* c) Indirect costs *- administration - billing adjudication - regulatory burden - utilities - etc.*



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30%
Proportion of extractable waste
Genetics
(loads the gun)
Contribution to Total Health
20-25%
$$
Environment
(pulls the trigger)
?
Physical environment; social environment (SDOH); public health
Personal health behaviors
(tightly linked to education level)
40%
$
Population Health
(~85% of opportunity)
45%
Case-rate utilization (# of cases per population)
a) Inappropriate cases (risk outweighs benefit)
(e.g., many cath lab procedures; CTPA)
b) Preference-sensitive cases
(when given a fair choice, many patients opt out)
(e.g., elective hips, knees; end-of-life care)
c) Avoidable cases (hot spotting; move upstream)
(e.g., Team-Based Care)
5-10%
$$$$$
$$$$$
$$$$$
$$$$$
$$$$$
$$$$$
$$$$$
$$$$$
Disease Tx System
(treats the wound –
~15% of opportunity)
40%
Within-case utilization (# and type of “units of care” per case)
a) Clinical variation
(e.g., QUE studies; surgical equipment)
b) Avoidable patient injuries
(e.g., serious safety event systems; CLABSI)
15%
Efficiency (cost per “unit of care”)
a) Supply chain (external products & services)
b) Operational efficiencies
- TPS Lean observation - clinical engineering
- current EMR functions - communications + IT
c) Indirect costs
- administration - billing adjudication
- regulatory burden - utilities - etc.

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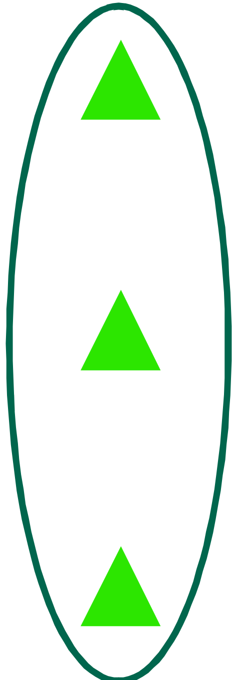
Final *(general)* model for Population Health

- ***Comprehensive***
  - *– "contains" all elements / examples of waste found in other models*
- ***Nested***
  - *– eliminates overlaps between categories (e.g., must eliminate all inappropriate care, before estimating gains to be had from optimizing care execution)*
  - *– that enables accurate estimates of the total amount of waste, and the relative size of different waste categories*
- ***Links to proven action***
  - *– theory becomes "real" only when actual outcomes change*
  - *– includes examples of successful waste elimination in every category*
  - *– that's why it currently ignores Misdiagnosis – no proven solutions yet*
- ***Ties directly to payment mechanisms***
  - *– the key to financial alignment*

Financial alignment under different payment mechanisms

WASTE REMOVAL LEVEL	% of all waste	FFS	Per case	Provider at risk
3. Case-rate utilization *(# cases per population – population health)*	45%	▼	▼	▲
2. Within-case utilization *(# and type of units per case)*	40%	▼	▲	▲
1. Efficiency *(cost per unit of care)*	15%	▲	▲	▲

PAYMENT METHOD: FFS, Per case, Provider at risk



Note: For green arrows, savings from waste elimination accrue to the care delivery organization; for red arrows, savings go to payer organizations.

James Brent C and Poulsen Gregory P. The case for capitation: It's the only way to cut waste while improving quality. *Harv Bus Rev* 2016; 94(7-8):102-11, 134 (Jul-Aug).

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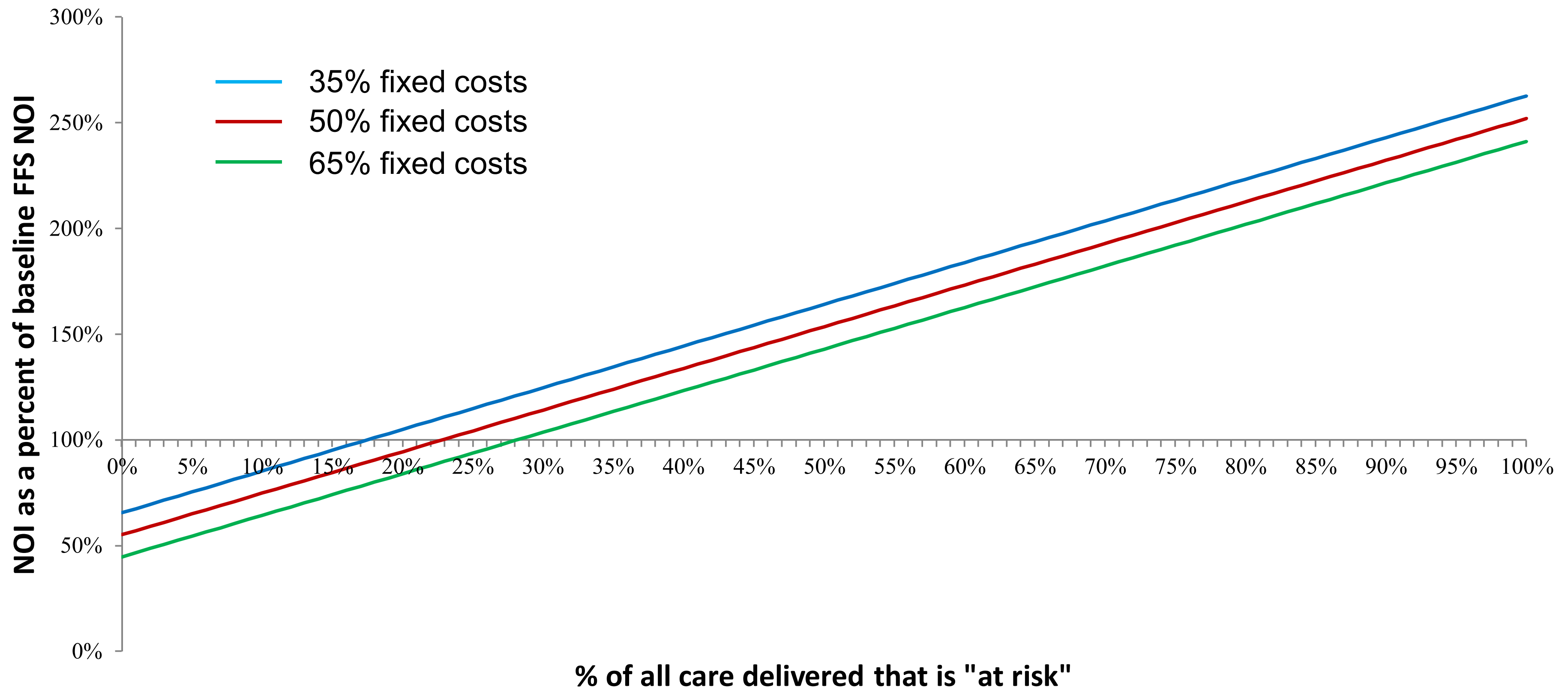
Finding the "at risk" tipping point



Assumptions:

- Hospital only – does not include outpatient care
- **10% drop in total "case rate" utilization** (hospital volume drops by 10%), from waste elimination efforts
- Intermountain's current mix of FFS, Medicare DRG, commercial DRG, and Medicaid "at risk" care
- Intermountain's current operating margins within those classes (e.g., for Medicaid = -23%; Medicare = -19%)
- 3% premium increase for bearing risk
- **100% of cost savings, adjusted for fixed costs, come back to hospital** (dramatically not true if someone else moves upstream, reduces inpatient utilization, and drops hospital volumes from the outside)

Given that framework,

What does the future hold?

Walter Gretzky (Wayne Gretzky's father):

Skate to where the puck is going to be, not where it has been.

"Pay for value" continues to grow

Forward looking indicators:

- ***Kaiser Permanente*** *(continued rapid growth within existing geographic markets)*
- ***Medicare Advantage*** *(continued rapid growth)*
  ACOs *(Leavitt Group – continued growth; mostly commercial)*

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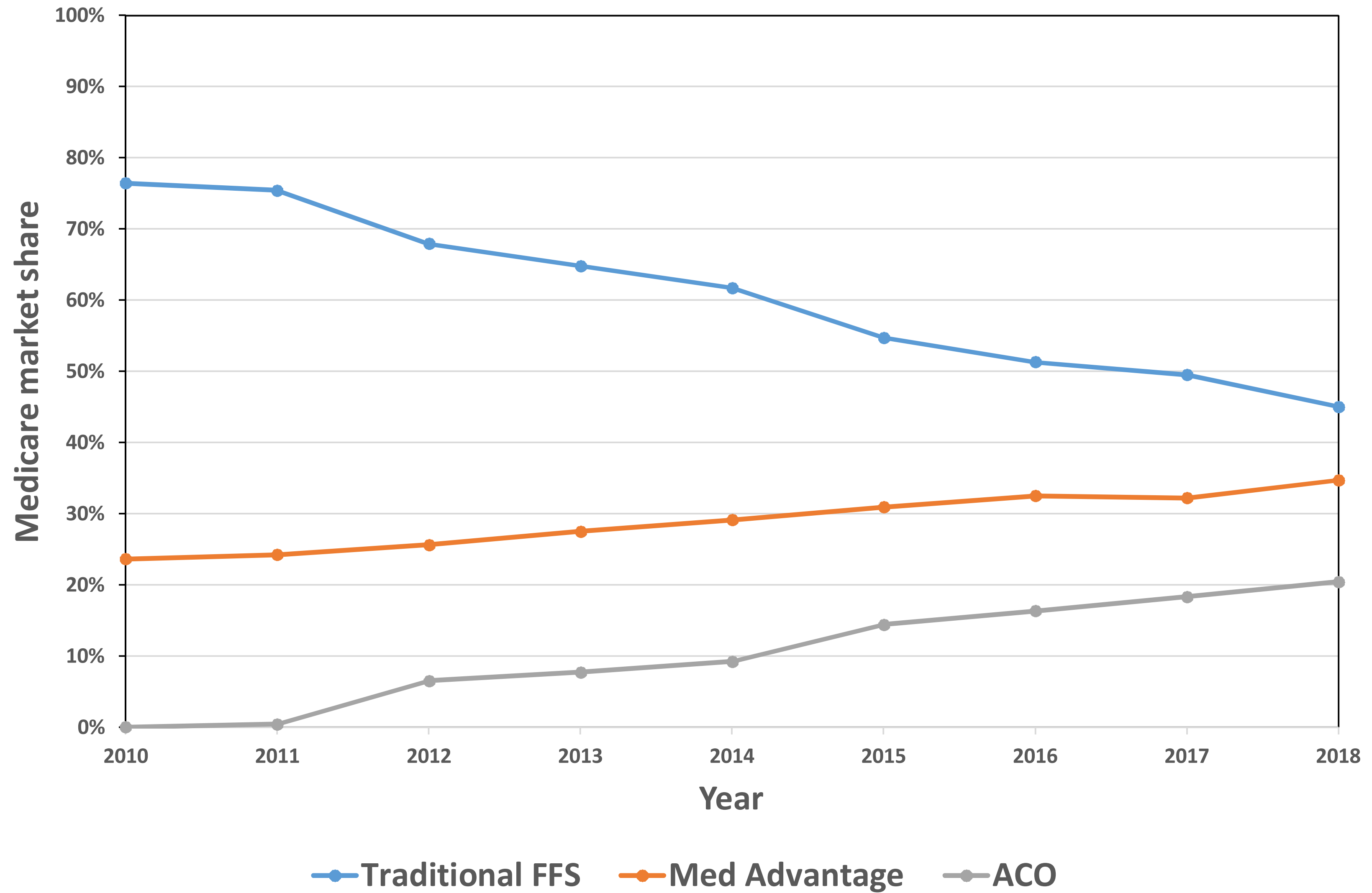
Medicare trends over time



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"Pay for value" continues to grow

Forward looking indicators:

- ***Kaiser Permanente*** *(continued rapid growth within existing geographic markets)*
- ***Medicare Advantage*** *(continued rapid growth)*
  ACOs *(Leavitt Group – continued growth; mostly commercial)*
- ***ERISA direct to provider contracting***
  (11% of large employers, according to Modern Healthcare)

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"Pay for value" continues to grow

Forward looking indicators:

- ***Kaiser Permanente*** *(continued rapid growth within existing geographic markets, mostly)*
- ***Medicare Advantage*** *(continued rapid growth)*
  ACOs *(Leavitt Group; mostly commercial)*
- ***ERISA direct to provider contracting*** *(11% of large employers, according to Modern Healthcare)*
- ***Provider-payer consolidation*** *(vertical alignment)* *by ownership or partnership (e.g., UPMC; United Healthcare; HPH / Queens Health Systems partnerships with HMSA)*

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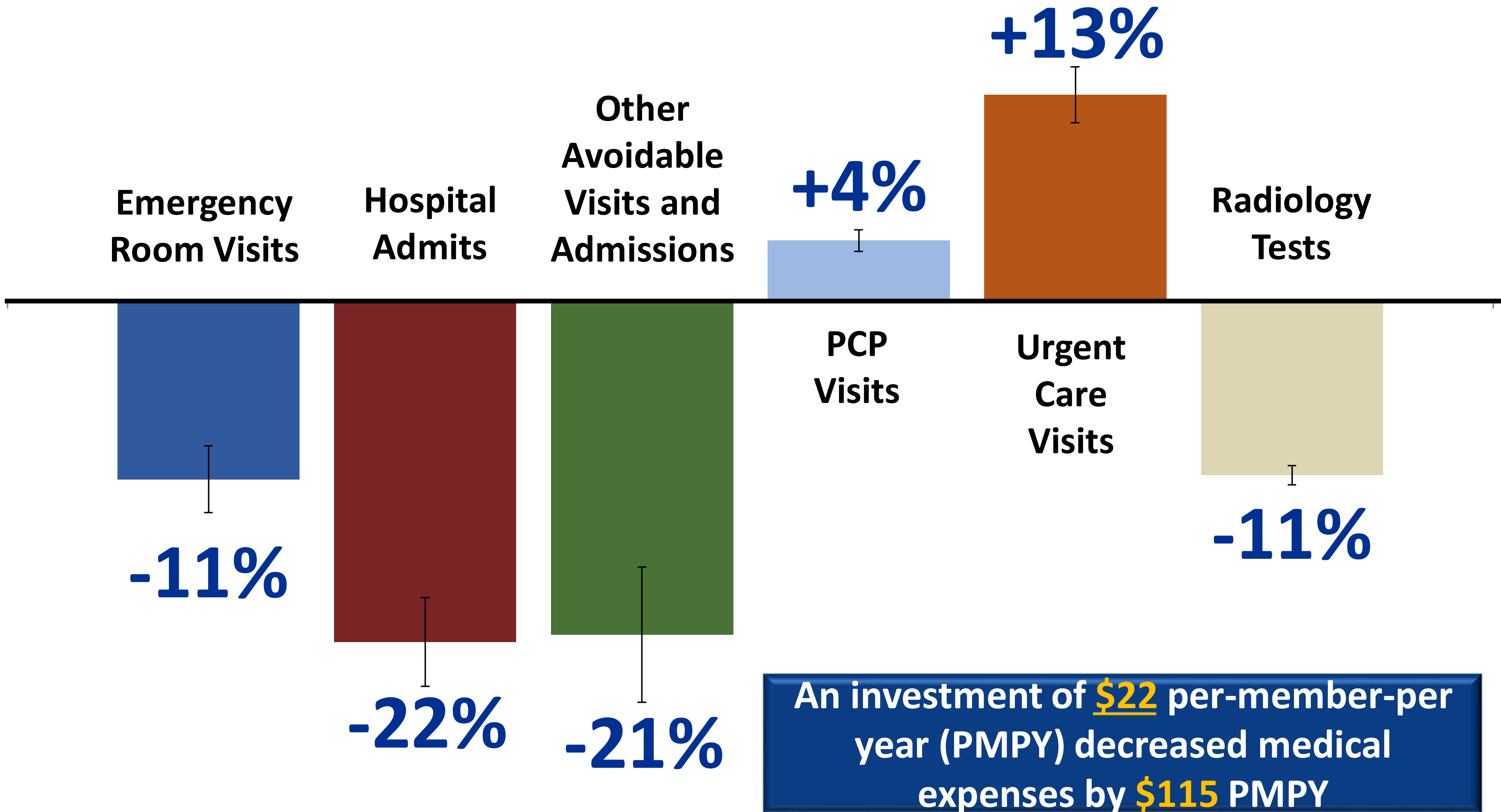
Team-Based Care

(3rd generation coordinated medical home)



Reiss-Brennan B, Brunisholz KD, Dredge C, Briot P, Grazier K, Wilcox A, Savitz L, and James B. Association of integrated team-based care with health care quality, utilization, and cost. *JAMA* 2016; 316(8):826-34 (Aug 23/30).

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ChenMed

- ***Built around "move upstream" primary care***
- ***Focused on Medicare Advantage*** *(at present)*
  – *sought out sickest patients* *(that nobody else wanted)*
  – *classic disruptive innovation*
- ***Concierge practice***
  – *400 patients per physician-led team*
  – *each patient has the physician's* *(team's, actually)* *cell phone number*
- ***Insist on full capitation***
  – *hospitalization rates down by 40 to 50%*
  – *very agile; under COVID, shifted to full telehealth in less than a week*
- ***CAGR: ~40 to 50%***
  x – started in south Florida area
  – *currently in 24 cities, 80+ clinics,* *Miami to Chicago, Philadelphia to Houston – requests to move into 75+ more cities*
- ***Lots of copy-cats***

Why the accelerating shift?

It aligns the money to the mission –
better clinical outcomes eliminate quality-associated waste

Waste elimination opportunities are
10 to 100 times larger
than opportunities from traditional revenue enhancement

ROI from waste elimination is similarly
10 to 100 times larger
than ROI from traditional revenue enhancement

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Implications – we will see:

- ***Increasing focus on waste elimination through "move upstream" strategies:*** *primary care-based population health and clinical variation control using clinical decision support tools (a.k.a. clinical knowledge management = "learning healthcare systems")*

- ***Care delivery organizations will increasingly seek capitated risk*** *through ownership or partnership (role of health insurance organizations changes dramatically)*

- ***Stand-alone specialty care practices and hospitals become "price takers"*** *– intense competition mainly around payment rates*

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If you rely on traditional methods,

you will not be able to compete

with those who can

manage at a clinical process level

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This is your wake-up call …

change or die

Better has no limit ...

an old Yiddish proverb