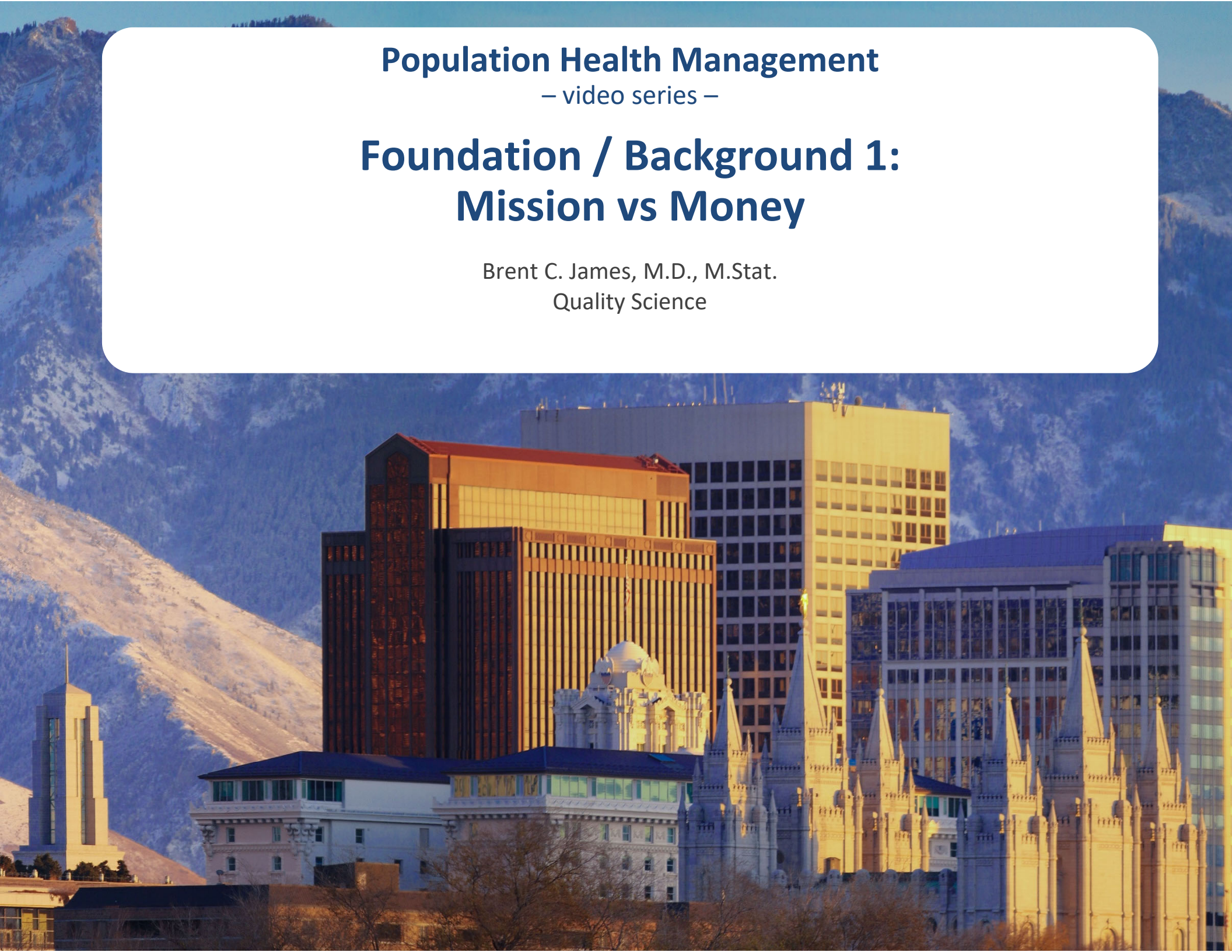

Population Health Management

– video series –

Foundation / Background 1: Mission vs Money

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Quality Science

Video and slides

I. Background & framing

A. Two polarities / tensions

1. Polarity #1

Mission vs money

1889 – the founding of Johns Hopkins University Hospital

- ***Separated medical practice from administration***
- ***Purpose: Simplify increasingly complex care delivery operations***
- ***Not a new idea*** *– for example, Benjamin Franklin used a similar approach almost 150 years earlier, when founding a hospital in Boston*
- ***AHA promoted it broadly in Canada & the U.S.***
- ***Moved from there to the rest of the world*** *– today, it's the standard in all modern societies*

Under this new structure

- ***Medical staff "owned" clinical outcomes***
- ***Professional administrators "owned" financial performance*** *(operations – supply chain, staffing, billing, facility & equipment maintenance, etc.)*

The healing professions

- ***We put our patients first*** *-- as clinicians, we place our patients' health needs before any other end or goal; we act as our patients' advocates. We accept, promote, and honor a* ***fiduciary trust*** *on behalf of our patients.*

- ***We maintain a special body of knowledge*** *-- as clinicians, (1) we practice - we apply knowledge not generally available outside of the professions (**information disparity**). (2) We teach - we transmit that knowledge to the next generation. And (3) we learn - we improve the knowledge we ourselves received.*

- ***We police our own ranks*** *-- acting on behalf of patients, we assure that all members of the healing profession respect our fiduciary trust and are competent (**a social contract; the official definition of "professional autonomy"**)*

- ***Limited training / experience with / understanding of operations and finance***

Administration

- ***Trained in / deep experience with operations and financial performance*** *– managing budgets*
- ***Ability to manage finances defines "success"*** *– recognition and promotion*
- ***Limited training / experience with / understanding of "clinical"***

Under this new structure

- ***Medical staff "owned" care delivery*** *(clinical outcomes)*
- ***Professional administrators oversaw*** *("owned")* ***operations*** *(supply, staffing, billing, etc. – financial outcomes)*
- ***In theory, strong coordination bridged the operational separation***
- ***In practice, it often did not*** *– powerful "tribes" developed, with different aims, different metrics, and different organizational structures*

Principle-based leadership *(Horton)*

1. ***Mission*** *– the care of the patient*

2. ***Money*** *– "no money, no mission" –*

   if a care delivery group can't make payroll, buy supplies, keep the power turned on, and the like, then its mission is meaningless: it will fail as a business and won't be able to deliver any mission-based care

3. ***Politics*** *– relationships and reputation –*

   e.g., tolerate and accommodate demands from a high-volume physician; score well on external rankings

Functional *(if unintentional)* sociopathy:

Generating income** (making money) **by letting patients come to avoidable harm.

Claiming that you didn't know,
when you could have known;

or saying that it's someone else's responsibility;

are not valid excuses.

William Edwards DEMING

Resolving the polarity:

Quality improvement's 2nd Premise

1. *all productive human activity can be described as* ***processes***

2. *every process produces*

3 parallel sets of outcomes

3. ***Fundamental knowledge*** –

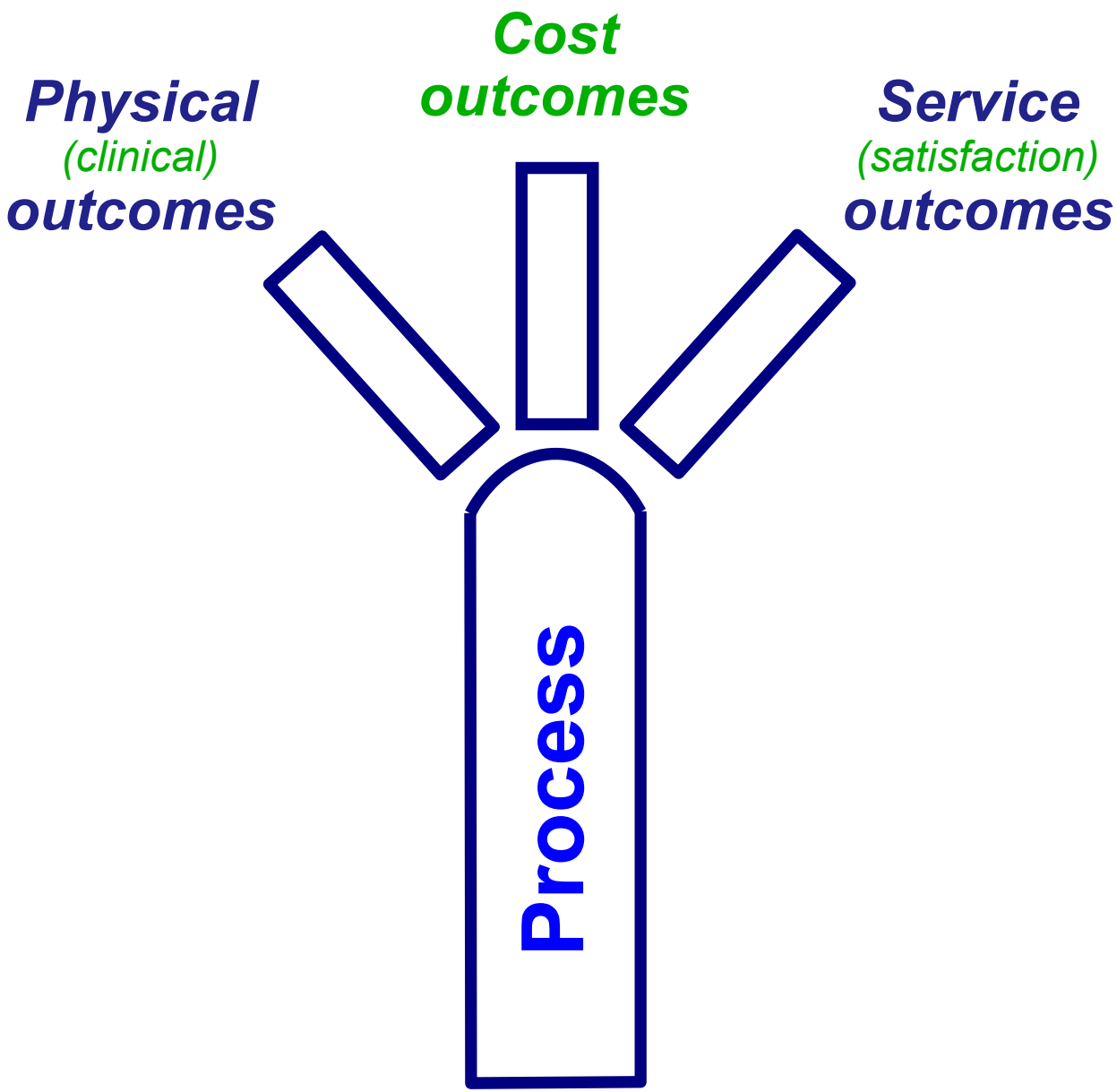
there is a difference between theory and reality

Premise 2:

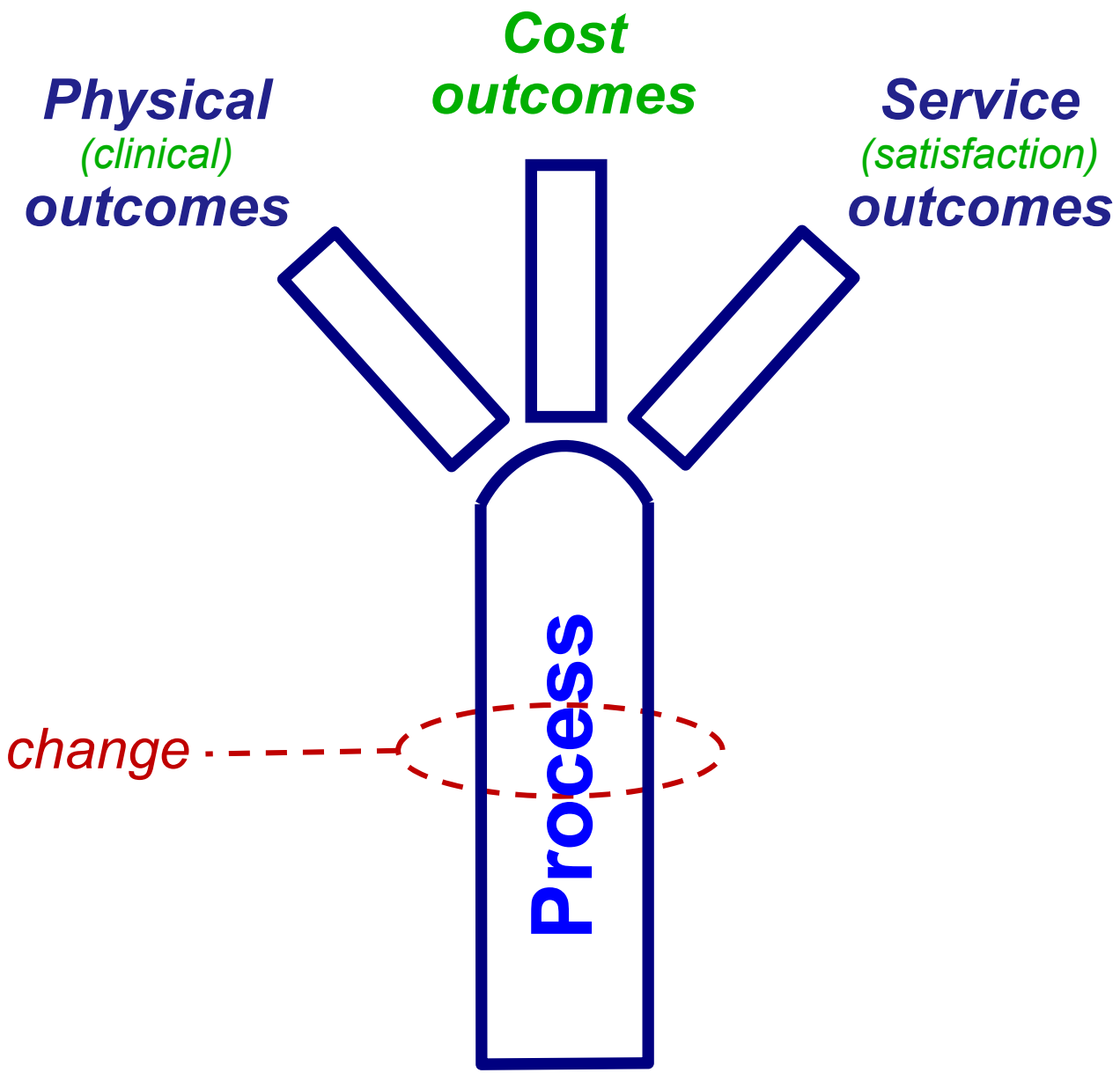
All processes always produce

3 parallel classes of outcomes

Deming: Processes produce outcomes



Deming: Processes produce outcomes



Key insight #1:

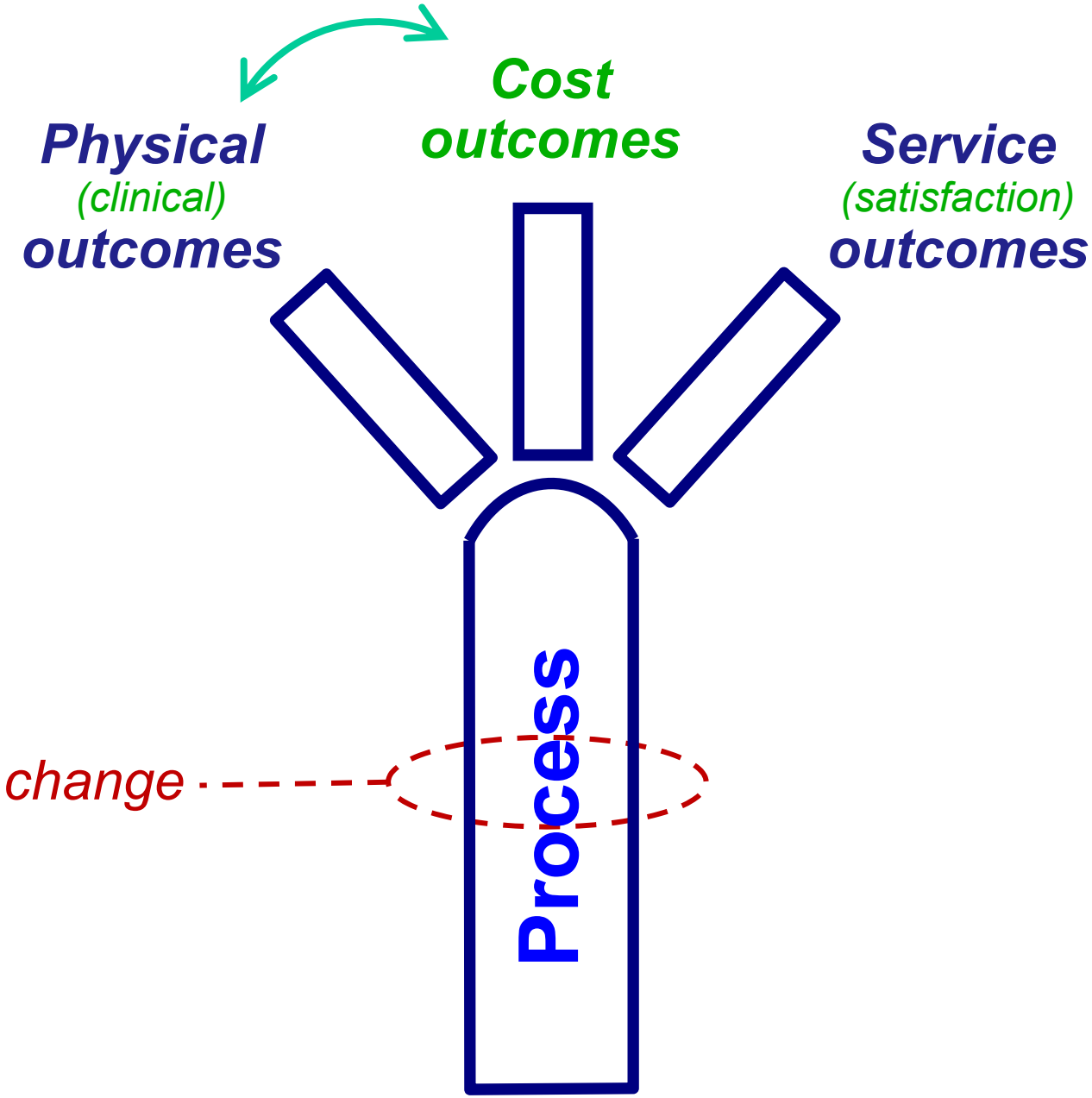
When you modify a process with an aim to improve any one of the 3 sets of parallel outcomes, by definition

you always unavoidably change the other 2 sets of outcomes.

The impact on secondary (non-targeted) outcomes could be ***large; it could be small*** *(or intermediate in size)*;
it could be positive, rather than negative;

but it will always happen!

Deming: Processes produce outcomes



The term “quality” describes the

(positive?) ***attributes of an outcome***

“Quality” can thus apply to

- *physical (clinical) outcomes*
- *service outcomes (customer satisfaction)*
- *cost outcomes*

(but when used in an unqualified way, nearly always means the attributes of physical (= clinical) outcomes)

***Deming studied how physical outcomes** (quality)*
and cost outcomes interact –

he discovered 3 causal linkages.

Key insight #2:

Quality controls cost

more accurately, they are 2 sides of the same coin; changing one *(quality)* ***can positively change the other*** *(cost)*.

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Quality controls cost

1. ***Quality waste***
   - *a step in a process fails*
   - *sometimes that process failure causes an outcome failure*
   - *forcing either repair (rework) or discard ("throw it away" – scrap)*

   (manage the process so it doesn't fail in the first place: higher quality, lower cost)

2. ***Inefficiency waste***
   - *2 parallel processes*
   - *have identical outputs (same quality)*
   - *one consumes fewer resources (lower cost)*

3. ***Cost effectiveness***
   - *better physical outcomes (higher quality)*
   - *but legitimately consumes more resources (higher cost)*

Recommended resource –

Watch "Quality Controls Cost" *(36 minutes)* ***on the Intermountain Healthcare Institute for Healthcare Delivery Research YouTube channel:***

https://www.youtube.com/watch?v=DKt27qP6WKA

Key insight #3:

The clinical side** (quality) **and the money side** (cost of operations) **work closely together. They're intertwined.

Optimal performance requires that they be managed together.

Keep priorities straight: Mission always comes before money.
Manage quality to drive financial success.

Definition of waste *within Deming's quality theory*

1. ***Quality*** *(attributes of physical outcomes)* ***improves***

   which ***causes***

2. ***costs of operation to fall***

The value equation

$$\text{Value} = \frac{\text{Physical}_{\text{outcomes}} + \text{Service}_{\text{outcomes}}}{\text{Cost}_{\text{outcomes}}}$$

The value equation

$$\text{Value} = \frac{\text{Physical outcomes} + \text{Service outcomes}}{\text{Cost outcomes}}$$

How much "waste" opportunity?

30-50+% *of all health care resource expenditures are*

quality-associated waste:

- *recovering from preventable foul-ups*
- *building unusable products*
- *providing unnecessary treatments*
- *simple inefficiency*

Institute of Medicine Roundtable on Value and Science-Driven Healthcare. T*he Healthcare Imperative: Lowering Costs and Improving Outcomes*. Yong, Pierre L., Saunders, Robert S., and Olsen, LeighAnne, editors. Washington, DC: National Academy Press, 2010.

Some viable estimates suggest

*as much as **65%** of all care delivery spending is quality-associated waste.*

In 2021, that's as much as $2 trillion in financial opportunity;

***10 to 100 times** greater than opportunities associated with traditional revenue models*