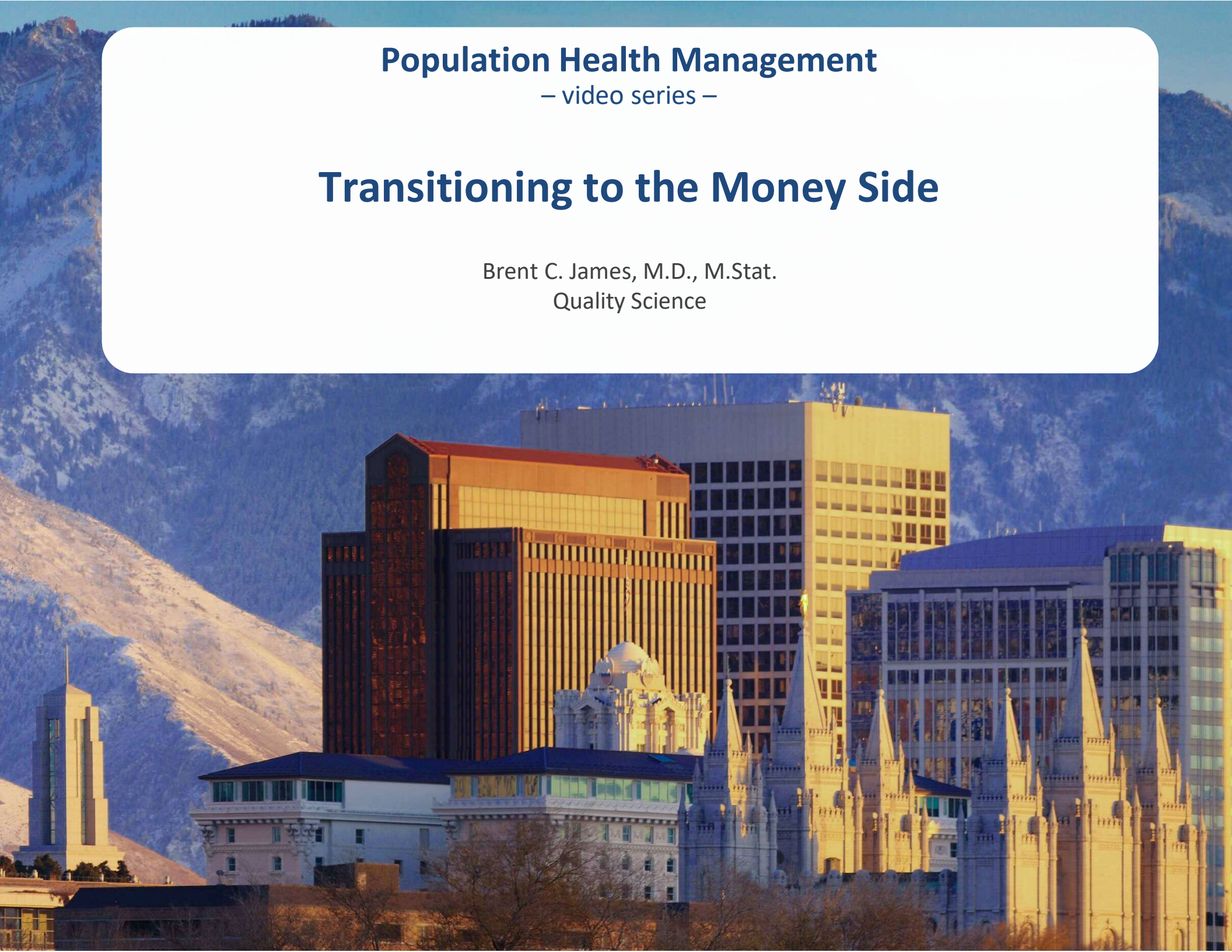


Population Health Management

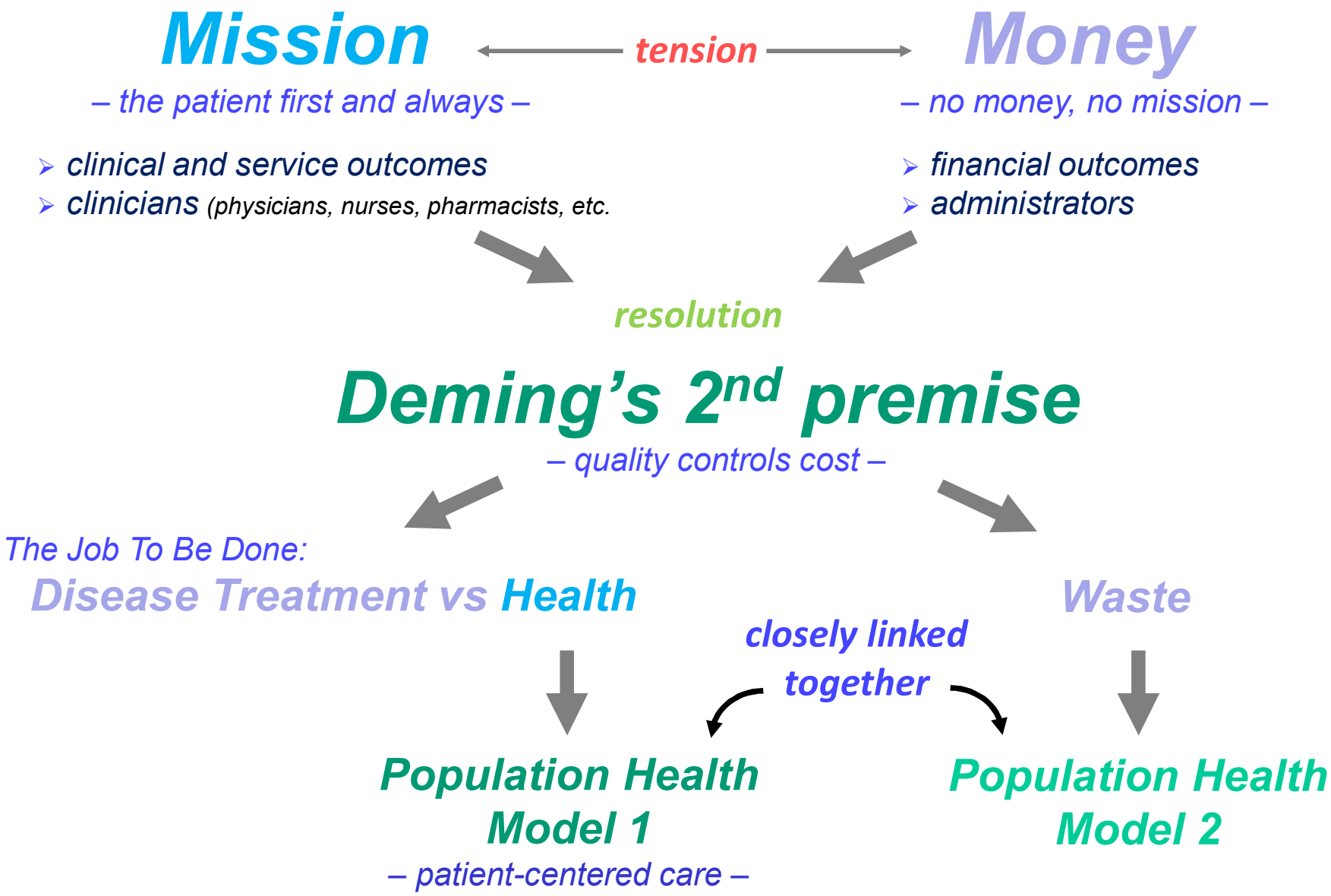
– video series –

Transitioning to the Money Side

Brent C. James, M.D., M.Stat.
Quality Science

Video and slides

Where we've been so far



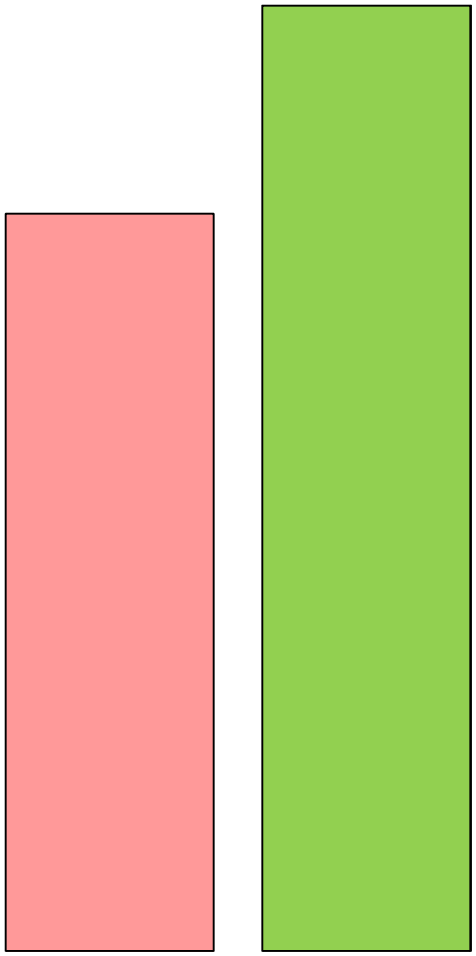
Key concept

From the "money" viewpoint,
the primary goal is

maintain and improving a robust operating margin

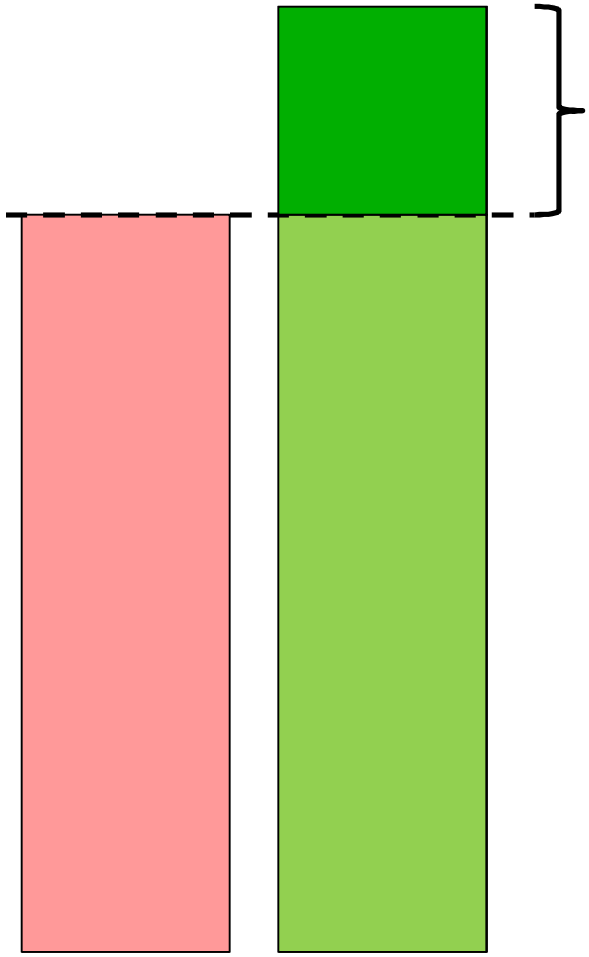
Operating margins *(a.k.a. NOI – net operating income)*

Operating expenses
*(**Costs**)*



Revenues
*(**Income**)*

Operating margins *(a.k.a. NOI – net operating income)*



Operating margin

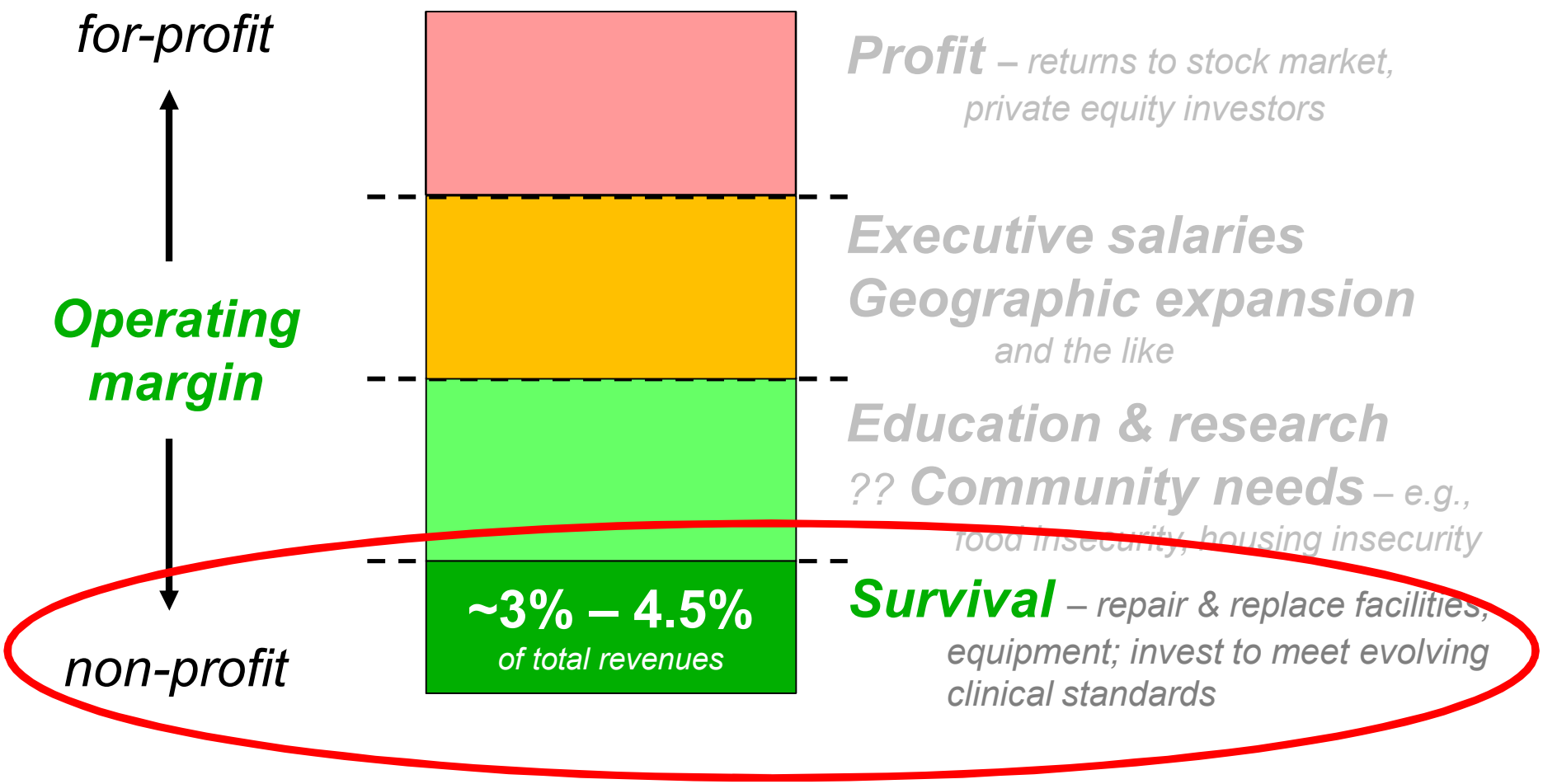
Operating expenses

Costs

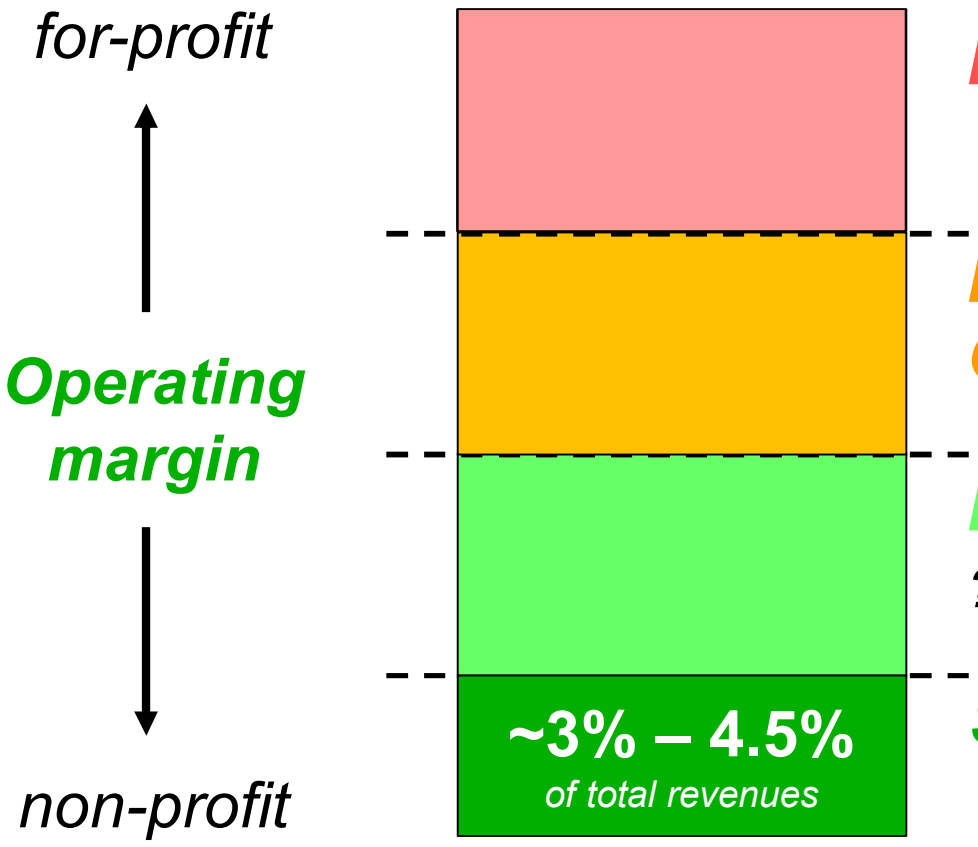
Revenues

Income

Using *(allocating)* an operating margin



Using *(allocating)* an operating margin



Profit *– returns to stock market, private equity investors*

Executive salaries
Geographic expansion
and the like

Education & research

?? ***Community needs*** *– e.g., food insecurity, housing insecurity*

Survival *– repair & replace facilities, equipment; invest to meet evolving clinical standards*

The concept of "operating margin" is fractal

- ***It applies at the level of a whole care delivery organization,*** *as we have just illustrated.*
- ***It also applies at the level of individual case types,*** *that make up the business of a care delivery organization;*
- ***and at the level of individual elements of care,*** *that make up the details of care delivery for a particular case type*

There are 2 ways to maintain and improve operating margins:

1) ***Increase revenues***

2) ***Decrease operating expenses***

In the past

Health care delivery leaders *(administrators and physicians)*
have focused primarily on revenues:

provide more services;
log more "billable events";
increase revenue generated by an event
(negotiate higher prices).

Key argument: At present,

the cost side offers

dramatically larger opportunities for improved financial performance than does *traditional* ***revenue enhancement.***

Past studies estimating *health care delivery* waste; a brief *and incomplete* overview

- 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.
  ~$1.1 trillion to $1.8 trillion (30% to 50+%)

- Berwick DM, Hackbarth AD. Eliminating waste in U.S. health care. *JAMA* 2012; 307(14):1513-16 (Mar 14).
  ~$1.2 trillion (34%)

- Sahni, N, Chigurupati A, Kocher B, Cutler DM. How the U.S. can reduce waste in health care spending by $1 trillion. *Harv Bus Rev* 2015; 93(11): (Oct). https://hbr.org/2015/10/how-the-u-s-can-reduce-waste-in-health-care-spending-by-1-trillion
  - $1 trillion, with specific targets

- Shrank WH, Rogstad TL, Parekh N. Waste in the U.S. health care system: Estimated costs and potential savings. *JAMA* 2019; 322(15):1501-9 (Oct 15).
  ~850 billion (25%); ~25% of that estimated to be "recoverable" *(~6% of total spending)*

- Bueno B, Leo JD, Macfie H. IHI Leadership Alliance. *"Trillion Dollar Checkbook": Reduce Waste and Cost in the U.S. Health Care System.* Boston, MA: Institute for Healthcare Improvement, 2019. http://www.ihi.org/Engage/collaboratives/LeadershipAlliance/Documents/IHILeadershipAlliance_TrillionDollarCheckbook_ReduceWaste.pdf

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*

Quality is ***not*** free *(Phil Crosby was waxing poetic)*

It always requires investment

- *change leadership (time and thought),*
- *study and investigation,*
- *data systems,*
- *physical plant, equipment …*

That investment always happens at the level of

health care delivery operations

it's just that it has a

massive return on investment *(ROI)*

MUCH higher ROI from waste elimination than from revenue growth

Revenue growth:

5 to 9% contribution

for each case added

Net Operating Margin

(and return on investment)

Waste elimination:

50 to >100% contribution

for each case avoided

In summary

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

The best thing of all:

On the cost side, the financial opportunity arises from quality-associated waste.

A focus on quality-associated waste

aligns the money to the mission:

Better quality
reduces cost of operations

One major opportunity for savings

falls outside
health care delivery operations …

we will address that one separately in the final section

– it has to do with the value added by health insurance companies.

A good foundation for a quality-associated waste model is

Activity-Based Costing *(ABC)*

because it defines something called

“units of care”

Next steps in the course

7. ***Discuss health costs, as a foundation for waste elimination***

8/9. ***Add waste to our Population Health model***

10. ***Explore financial alignment*** *– link waste elimination to payment models*

11. ***What does the future hold*** *– forward-looking indicators and a little "crystal ball gazing"*