Pay or Play: Pay for Performance and the "Value" of Healthcare

Friday, February 16, 2007

Mr. Steve Rushing

Course Summary to Date:

- Strategy
- Environmental Scan
- Cost #1 thing driving strategy in industry
- Most difficult things to do with strategy – alignment across organization
- IT strategy and relationship to strategic thinking (alignment absolutely necessary)
- Robotics
  - Self service kiosk
  - Home health
    - Technology not sticking like it would be expected because of reimbursement rules
- Zero sum game (macro economic game) – reducing costs reduces someone else's revenue
- Human/CompUSA opening senior brain fitness centers
- Chronic disease management and bank teaming up
- ROI
  - 60% of technology functionality is never used
  - Installing software vs. implementing the system
  - Vendor philosophy – install it quickly and learn it over time (not necessarily good because they never come back to it, workarounds become permanent)
  - There is no such thing as an interim solution.
  - Become IT projects because most hospital line manager are not trained in managing large scale, complex systems/software (manages must change from process oriented to constantly implementing change, good example is Jack Welch and GE)
  - Positive ROI for clinical information systems? Not yet. What are we going to do differently – (some of the architecture structures are old ->data processing systems not knowledge based systems)
  - To go paperless, you must focus on the things that paper does well, not just the bad stuff about paper. It's very portable, easy to work with. Two things paper does that we have not figured out how to automate: nurse's - list of things to do, physician – prints out schedule and takes notes on it
  - Google, mySpace healthcare
  - ROI is spotty (some organization are able to show a positive ROI, some can't)

Pay or Play: Pay for Performance and the "Value" of Healthcare

Pay for Performance: way to line up strategy

Healthcare has been a bright spot in the economy. The 2001-2003 recession would have been worse without healthcare.

Is 16% of GDP for health too much? Where else would the money be spent?

How do you make the decisions about whose costs get cut?

What if we could change the slope of the curve and get more "value" for what we spend? (note: increased access is also obviously a critical issue, but a topic for another day)

The slope is changing a little (% increase in national health expenditures)

2003 8.3%
2004 7.2%
2005 6.9%

Take the 1.9T and not cut it to 1.2T, but redistribute it to those with illnesses so they get 100% of the care they need (average is currently 55%). Results would lead to overall decrease in per capita expenditures.

End Goal: reward providers who are more efficient and provide higher quality of care

- Financial incentives
- Predefined performance targets
    - Efficiency, productivity, quality
- Targeted recipients
    - Individuals, teams, organizations

Why pay a doctor to do what's right?

Practice near-term process goals: reward hospitals and physicians and other key clinicians for adopting key strategic responses believed to lead to the difficult to measure end goal

Views on controlling healthcare costs

- Reduce inappropriate medical care (75%)
- Evidence based medicine (70%)
- Increased and more effective use of IT (66%)
- Increase the use of disease and care management strategies for the chronically ill (65%)
- Reward providers who are more efficient and provide higher quality care (61%)

Zero sum game: revenue loss offset with margin improvement

PMPM = per member per month

10 Lessons Learned:

1. Financial incentives do motivate change
2. Non financial incentives can also make a difference
3. Engaging physicians is a critical activity
4. There is no clear pictures yet of return on investment
5. Public reporting is a strong catalyst for providers to improve care
6. Providers need feedback on their performance
7. Providers need to be better educated on P4P
8. Data integrity is important
9. Experience with managed care matters
10. P4P is not a magic bullet

Practices shaped like a bell-shaped curve. Instead of focusing on the best practice, get rid of the worst practices. Data is critical to doing things with a non-financial incentive.

Majority of quality data comes from claims (which are not always right).

Medicare is experimenting with going away from episodic care to chronic illness care – test pilot program around the country.
Looking at cost and quality -> value