COLLEGE OF POPULATION HEALTH

The Florida Alliance for Healthcare Value

"How Covid Crashed the System: A Guide to Fixing American Health Care"

May 6, 2024
David B. Nash, MD MBA
Founding Dean Emeritus
Dr. Raymond C. and Doris N. Grandon Professor of Health Policy
Jefferson College of Population Health

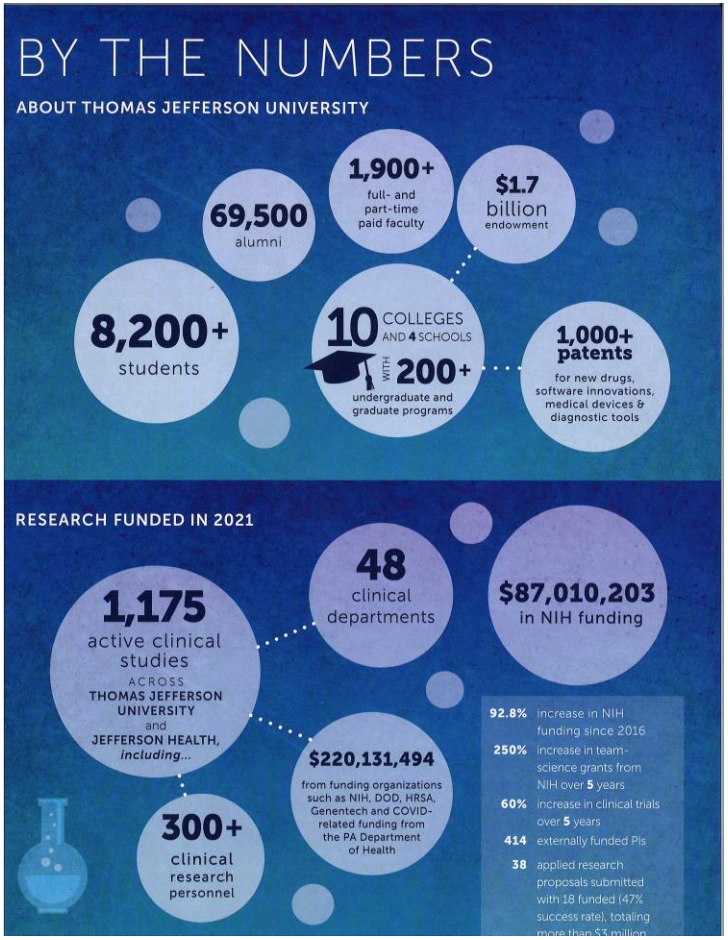
Jefferson
Thomas Jefferson University


Jefferson
Jefferson

Jefferson Approaching Scale of Top 10 Integrated Delivery & Financing Systems

Total Operating Revenue ($bn)

*Jefferson Health operating revenue based on unaudited consolidated balance sheet of the University as of November 30,2021 and includes the accounts of Einstein Health network (acquired on October 4, 2021) and HPP (acquired on November 1, 2021)


BY THE NUMBERS
ABOUT THOMAS JEFFERSON UNIVERSITY
69,500 alumni
1,900+ full- and part-time paid faculty
$1.7 billion endowment
8,200+ students
10 COLLEGES AND 4 SCHOOLS WITH 200+ undergraduate and graduate programs
1,000+ patents for new drugs, software innovations, medical devices & diagnostic tools
RESEARCH FUNDED IN 2021
1,175 active clinical studies ACROSS THOMAS JEFFERSON UNIVERSITY and JEFFERSON HEALTH, including...
48 clinical departments
$87,010,203 in NIH funding
$220,131,494 from funding organizations such as NIH, DOD, HRSA, Genentech and COVID-related funding from the PA Department of Health
300+ clinical research personnel
92.8% increase in NIH funding since 2016
250% increase in team-science grants from NIH over 5 years
60% increase in clinical trials over 5 years
414 externally funded PIs
38 applied research proposals submitted with 18 funded (47% success rate), totaling

"All the News That's Fit to Print"

The New York Times

EARLY EDITION

Today, humid, morning fog, showers in areas, high 76. **Tonight,** partly cloudy, humid, low 64. **Tomorrow,** strong afternoon thunderstorms, high 78. Weather map, Page 26.

VOL. CLXXI .... No. 59,424 © 2022 The New York Times Company NEW YORK, SUNDAY, MAY 15, 2022 $6.00

ONE MILLION

A NATION'S IMMEASURABLE GRIEF

Each dot represents one person who has died of Covid-19 in the United States.

THE WALL STREET JOURNAL.

ESSAY

America Forgot the 1918 Flu. Will We Also Forget Covid?

The Spanish flu pandemic killed 50 million people worldwide, but acts of God are less memorable than wars and other disasters caused by humans

HEALTH | HEALTHCARE

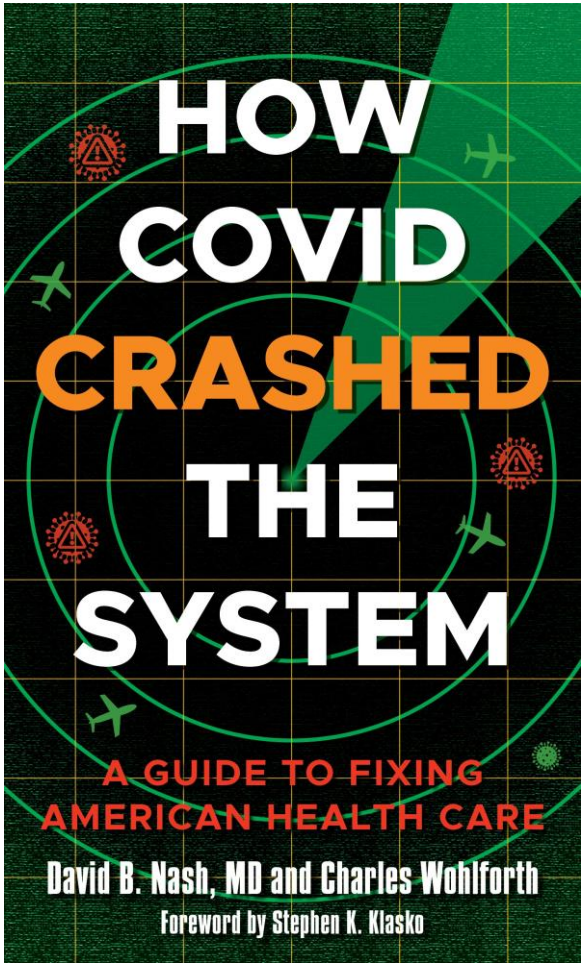
The U.S. Invested Millions to Produce Masks at Home. Now Nobody's Buying.

Domestic production of masks, other medical gear falters as hospitals return to lower-cost foreign suppliers

By Bob Tita Follow

Feb. 4, 2024 10:00 am ET

Hospitals haven't wanted to accommodate the higher costs of U.S.-made medical protective items, domestic manufacturers say. PHOTO: SHANNON STAPLETON/REUTERS

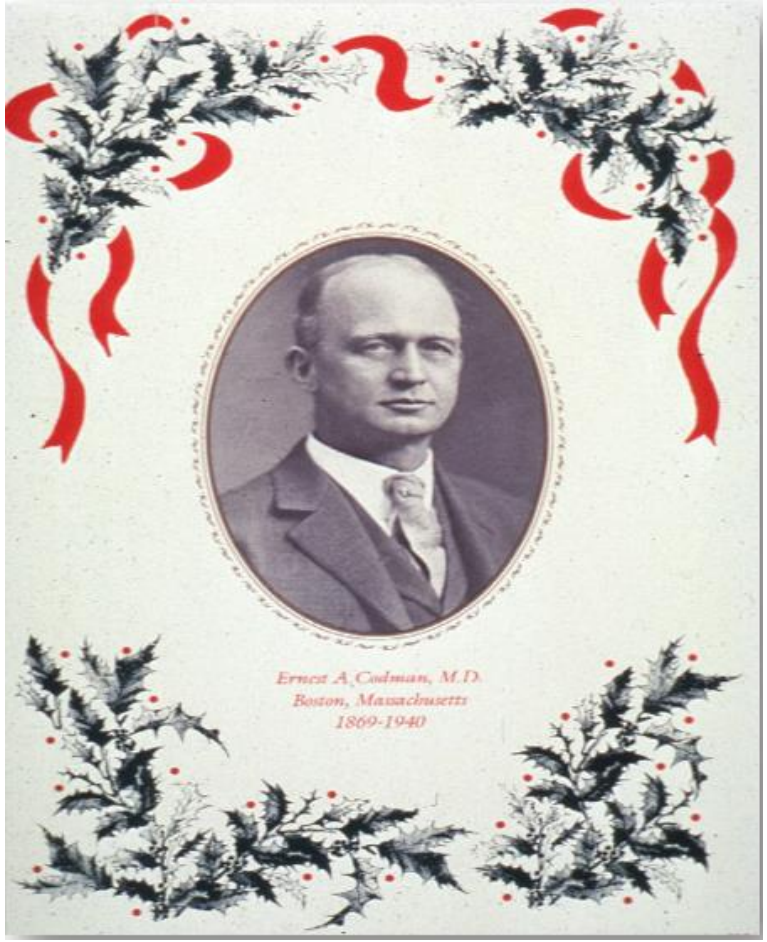

HOW
COVID
CRASHED
THE
SYSTEM
A GUIDE TO FIXING
AMERICAN HEALTH CARE
David B. Nash, MD and Charles Wohlforth
Foreword by Stephen K. Klasko

… all hospitals are accountable to the public for their degree of success…

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg

9


Ernest A. Codman, M.D.
Boston, Massachusetts
1869-1940

Honoring a once-scorned voice for medical openness

By Liz Kowalczyk | GLOBE STAFF JULY 21, 2014

DAVID L. RYAN/GLOBE STAFF

The New York Times

When Hospitals Merge to Save Money, Patients Often Pay More

Jennifer Lamptey, a radiologic technologist, adjusting a CT scan at the Saint Raphael campus of Yale New Haven Hospital, part of a bigger system set to control a quarter of Connecticut's hospital beds. Christopher Capozziello for The New York Times

By Reed Abelson

Nov. 14, 2018

22

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Changes in Quality of Care after Hospital Mergers and Acquisitions

Nancy D. Beaulieu, Ph.D., Leemore S. Dafny, Ph.D., Bruce E. Landon, M.D., M.B.A., Jesse B. Dalton, M.A., Ifedayo Kuye, M.D., M.B.A., and J. Michael McWilliams, M.D., Ph.D.

ABSTRACT

BACKGROUND

The hospital industry has consolidated substantially during the past two decades and at an accelerated pace since 2010. Multiple studies have shown that hospital mergers have led to higher prices for commercially insured patients, but research about effects on quality of care is limited.

METHODS

Using Medicare claims and Hospital Compare data from 2007 through 2016 on performance on four measures of quality of care (a composite of clinical-process measures, a composite of patient-experience measures, mortality, and the rate of readmission after discharge) and data on hospital mergers and acquisitions occurring from 2009 through 2013, we conducted difference-in-differences analyses comparing changes in the performance of acquired hospitals from the time before acquisition to the time after acquisition with concurrent changes for control hospitals that did not have a change in ownership.

RESULTS

The study sample included 246 acquired hospitals and 1986 control hospitals. Being acquired was associated with a modest differential decline in performance on the patient-experience measure (adjusted differential change, −0.17 SD; 95% confidence interval [CI], −0.26 to −0.07; P=0.002; the change was analogous to a fall from the 50th to the 41st percentile) and no significant differential change in 30-day readmission rates (−0.10 percentage points; 95% CI, −0.53 to 0.34; P=0.72) or in 30-day mortality (−0.03 percentage points; 95% CI, −0.20 to 0.14; P=0.72). Acquired hospitals had a significant differential improvement in performance on the clinical-process measure (0.22 SD; 95% CI, 0.05 to 0.38; P=0.03), but this could not be attributed conclusively to a change in ownership because differential improvement occurred before acquisition.

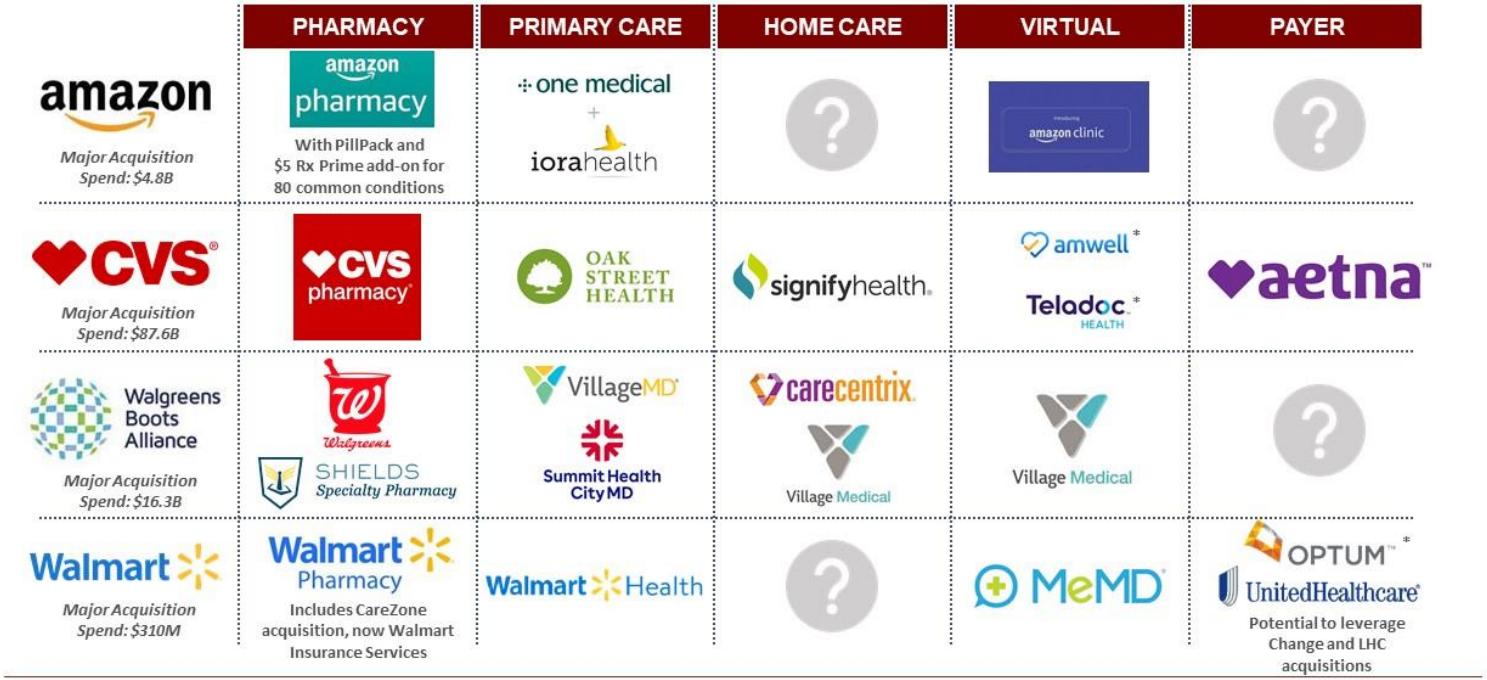
CONCLUSIONS

Hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive. (Funded by the Agency for Healthcare Research and Quality.)

From the Department of Health Care Policy, Harvard Medical School (N.D.B., B.E.L., J.B.D., J.M.M.), Harvard Business School and the National Bureau of Economic Research (L.S.D.), the Division of General Internal Medicine and Primary Care, Department of Medicine, Beth Israel Deaconess Medical Center (B.E.L.), and the Division of General Internal Medicine, Department of Medicine, Brigham and Women's Hospital (I.K., J.M.M.) — all in Boston. Address reprint requests to Dr. McWilliams at the Department of Health Care Policy, Harvard Medical School, 180 Longwood Ave., Boston, MA 02115, or at mcwilliams@hcp.med.harvard.edu.

N Engl J Med 2020;382:51-9.
DOI: 10.1056/NEJMsa1901383

Healthcare's New Big Four



3/2/2023

*Denotes partnership rather than merger/acquisition

1


IMMIGRATION (P.35) | MILLER TIME (P.64) | P&G's BUZZ MOMS (P.32)
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Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work
BY JOHN CAREY (P.72)
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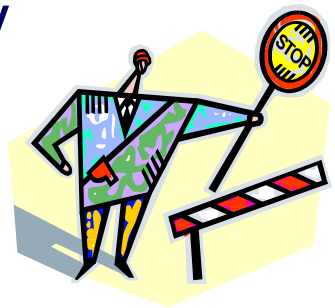
PSYCHIATRY
CHIROPRACTIC
ASPIRIN
REST
WATCH & WAIT
YOGA
SURGERY

15

“Unexplained Clinical Variation”

- Major roadblock to:
  - Lowering costs
  - Improving quality
  - Establishing accountability



Original Article

SDC OPEN

What are Effective Strategies to Reduce Low-Value Care? An Analysis of 121 Randomized Deimplementation Studies

Pauline Heus* • Simone A. van Dulmen* • Jan-Willem Weenink • Christiana A. Naaktgeboren • Toshihiko Takada • Eva W. Verkerk • Isabelle Kamm • Maarten J. van der Laan • Lotty Hooft • Rudolf B. Kool

ABSTRACT

Background: Low-value care is healthcare leading to no or little clinical benefit for the patient. The best (combinations of) interventions to reduce low-value care are unclear.

Purpose: To provide an overview of randomized controlled trials (RCTs) evaluating deimplementation strategies, to quantify the effectiveness and describe different combinations of strategies.

Methods: Analysis of 121 RCTs (1990–2019) evaluating a strategy to reduce low-value care, identified by a systematic review. Deimplementation strategies were described and associations between strategy characteristics and effectiveness explored.

Results: Of 109 trials comparing deimplementation to usual care, 75 (69%) reported a significant reduction of low-value healthcare practices. Seventy-three trials included in a quantitative analysis showed a median relative reduction of 17% (IQR 7%–42%). The effectiveness of deimplementation strategies was not associated with the number and types of interventions applied.

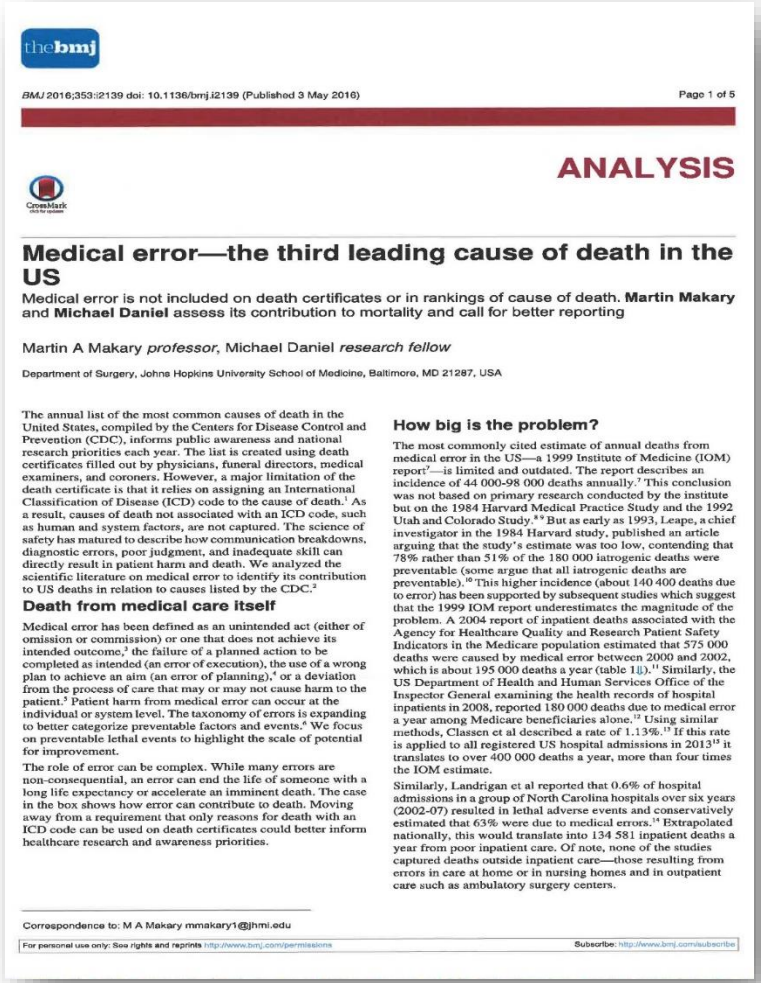
Conclusions and Implications: Most deimplementation strategies achieved a considerable reduction of low-value care. We found no signs that a particular type or number of interventions works best for deimplementation. Future deimplementation studies should map relevant contextual factors, such as the workplace culture or economic factors. Interventions should be tailored to these factors and provide details regarding sustainability of the effect.

Keywords: low-value care, overuse, deimplementation, quality improvement, systematic review

Introduction

Low-value care (LVC) is healthcare that has no or little clinical benefit for the patient, considering the costs, the risks, available alternatives, and patient preferences.[1] Estimates of the volume of LVC range from 10% to 30%, with estimates up to 89% for specific healthcare practices.[1-6]

Low-value care and strategies to reduce it have received increasing attention. In the last decade, several initiatives have been launched that list practices that doctors and patients should question or withhold.[7-10] Yet, raising awareness by presenting lists is not enough to reduce the use of these practices.[11,12] Previous research showed that active



thebmj

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016)

ANALYSIS

Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD 21287, USA

The annual list of the most common causes of death in the United States, compiled by the Centers for Disease Control and Prevention (CDC), informs public awareness and national research priorities each year. The list is created using death certificates filled out by physicians, funeral directors, medical examiners, and coroners. However, a major limitation of the death certificate is that it relies on assigning an International Classification of Disease (ICD) code to the cause of death.[1] As a result, causes of death not associated with an ICD code, such as human and system factors, are not captured. The science of safety has matured to describe how communication breakdowns, diagnostic errors, poor judgment, and inadequate skill can directly result in patient harm and death. We analyzed the scientific literature on medical error to identify its contribution to US deaths in relation to causes listed by the CDC.[2]

Death from medical care itself

Medical error has been defined as an unintended act (either of omission or commission) or one that does not achieve its intended outcome,[3] the failure of a planned action to be completed as intended (an error of execution), the use of a wrong plan to achieve an aim (an error of planning),[4] or a deviation from the process of care that may or may not cause harm to the patient.[5] Patient harm from medical error can occur at the individual or system level. The taxonomy of errors is expanding to better categorize preventable factors and events.[6] We focus on preventable lethal events to highlight the scale of potential for improvement.

The role of error can be complex. While many errors are non-consequential, an error can end the life of someone with a long life expectancy or accelerate an imminent death. The case in the box shows how error can contribute to death. Moving away from a requirement that only reasons for death with an ICD code can be used on death certificates could better inform healthcare research and awareness priorities.

How big is the problem?

The most commonly cited estimate of annual deaths from medical error in the US—a 1999 Institute of Medicine (IOM) report[7]—is limited and outdated. The report describes an incidence of 44 000-98 000 deaths annually.[7] This conclusion was not based on primary research conducted by the institute but on the 1984 Harvard Medical Practice Study and the 1992 Utah and Colorado Study.[8 9] But as early as 1993, Leape, a chief investigator in the 1984 Harvard study, published an article arguing that the study's estimate was too low, contending that 78% rather than 51% of the 180 000 iatrogenic deaths were preventable (some argue that all iatrogenic deaths are preventable).[10] This higher incidence (about 140 400 deaths due to error) has been supported by subsequent studies which suggest that the 1999 IOM report underestimates the magnitude of the problem. A 2004 report of inpatient deaths associated with the Agency for Healthcare Quality and Research Patient Safety Indicators in the Medicare population estimated that 575 000 deaths were caused by medical error between 2000 and 2002, which is about 195 000 deaths a year (table 1⇓).[11] Similarly, the US Department of Health and Human Services Office of the Inspector General examining the health records of hospital inpatients in 2008, reported 180 000 deaths due to medical error a year among Medicare beneficiaries alone.[12] Using similar methods, Classen et al described a rate of 1.13%.[13] If this rate is applied to all registered US hospital admissions in 2013[13] it translates to over 400 000 deaths a year, more than four times the IOM estimate.

Similarly, Landrigan et al reported that 0.6% of hospital admissions in a group of North Carolina hospitals over six years (2002-07) resulted in lethal adverse events and conservatively estimated that 63% were due to medical errors.[14] Extrapolated nationally, this would translate into 134 581 inpatient deaths a year from poor inpatient care. Of note, none of the studies captured deaths outside inpatient care—those resulting from errors in care at home or in nursing homes and in outpatient care such as ambulatory surgery centers.

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Tip of the iceberg: patient safety incidents in primary care

Urmimala Sarkar

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Accepted 13 November 2015
Published Online First
16 December 2015

▸ http://dx.doi.org/10.1136/bmjqs-2015-004178

To cite: Sarkar U. *BMJ Qual Saf* 2016;**25**:477–479.

Primary care in the US model is fraught with safety hazards. Visits are brief and infrequent, patients are largely self-managing, often with multiple comorbid conditions, the extent of healthcare teams varies widely, and the fragmentation of health systems and lack of interoperability among electronic health records (EHRs) means that primary care providers may not have timely, accurate data about patients.[1] Despite these multiple vulnerabilities, significant gaps remain in our understanding of the safety of primary care.[2–4]

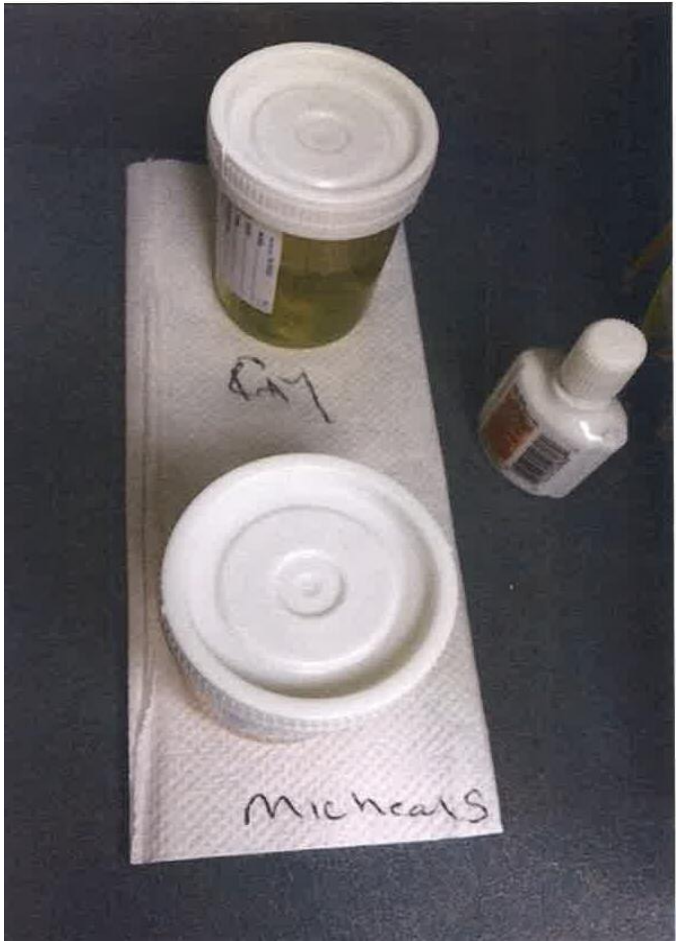
The patient safety movement began in acute-care settings, where adverse events resulting from medical care are more immediately apparent. Even though primary care is the cornerstone of healthcare delivery, relatively less is known about the epidemiology of adverse events in primary care settings.[5] In an effort to address this gap, Panesar *et al*[6] conducted a systematic review of patient safety incidents in primary care.

This paper makes a major contribution to the field by providing an overview of the burden of patient safety incidents in primary care. They found that patient safety incidents are slightly less common in primary care, around 2%–3% of visits, compared with approximately 10% of hospitalisations.[7–9] Given how much larger and healthier the populations using primary care are compared with hospitalised patients, the frequency of safety incidents in primary care is staggeringly high. Fortunately, only a small proportion of these incidents result in severe harm.

This systematic review highlights multiple challenges in studying the safety of primary care. First, even more than a decade into the patient safety movement, definitional challenges remained. Panesar *et al*[6] defined patient safety incident as 'any unintended or unexpected incident that could have or were judged to have led to patient harm'. Within this broad definition, however, the authors chose to include only incidents of commission rather than omission. In effect, they counted events where the wrong thing was done, but did not count events where the right thing was not done. The fast pace and frequent interruptions associated with primary care are known to lead to errors of omission,[10] and omissions are a major culprit in missed and delayed diagnoses,[11] which Panesar *et al* found to be among the most harmful of primary care safety incidents. Therefore, this analysis likely shows us only the tip of the iceberg. The included studies under-represent the frequency of patient safety incidents, and may especially undercount diagnostic errors. It is critical that, going forward, safety surveillance efforts in primary care include incidents involving errors of both commission and omission.

The ascertainment methods for patient safety incidents require further examination.[12] Most of these studies employed record review, while other used incident reporting systems or surveys. Each of these ascertainment methods has limitations. Record review leads to lower estimates of incidents because of suboptimal documentation[13]; incident reporting systems are underused,[14] particularly by physicians[15] and surveys can include incidents which are not related to safety per se.[16] Future studies should employ multiple ascertainment methods for primary care patient safety incidents and contrast the resulting estimates.

Evaluating the extent of harm to primary care patients remains a thorny issue. Expert record review does not always yield agreement about harm.[17] While the authors used a clear definition from the UK National Patient Safety Agency,[18] the variation in the underlying studies suggests that the definition may not have been applied consistently. One example of an incident without harm is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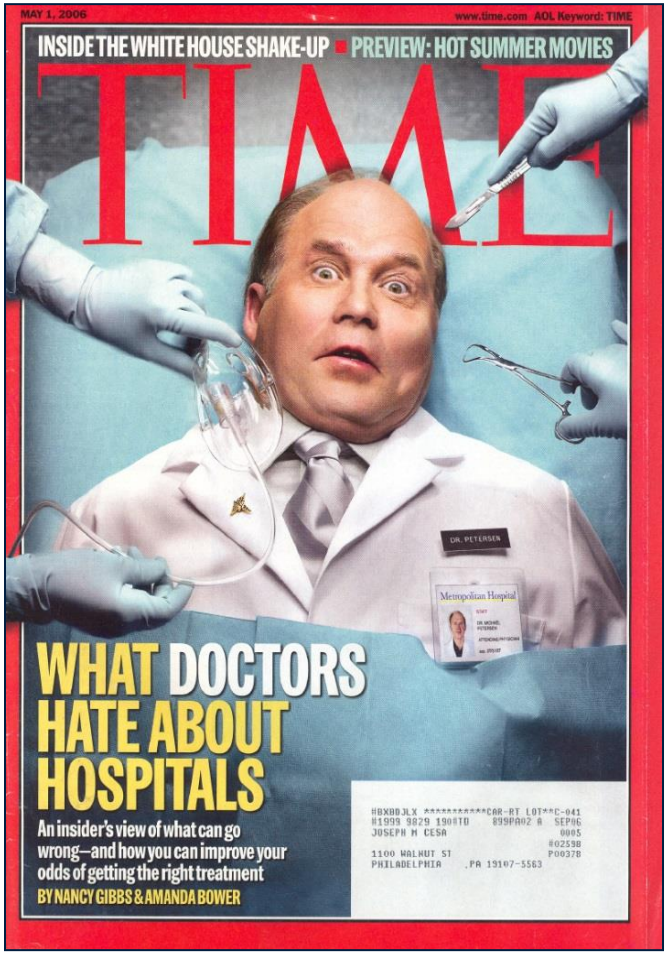
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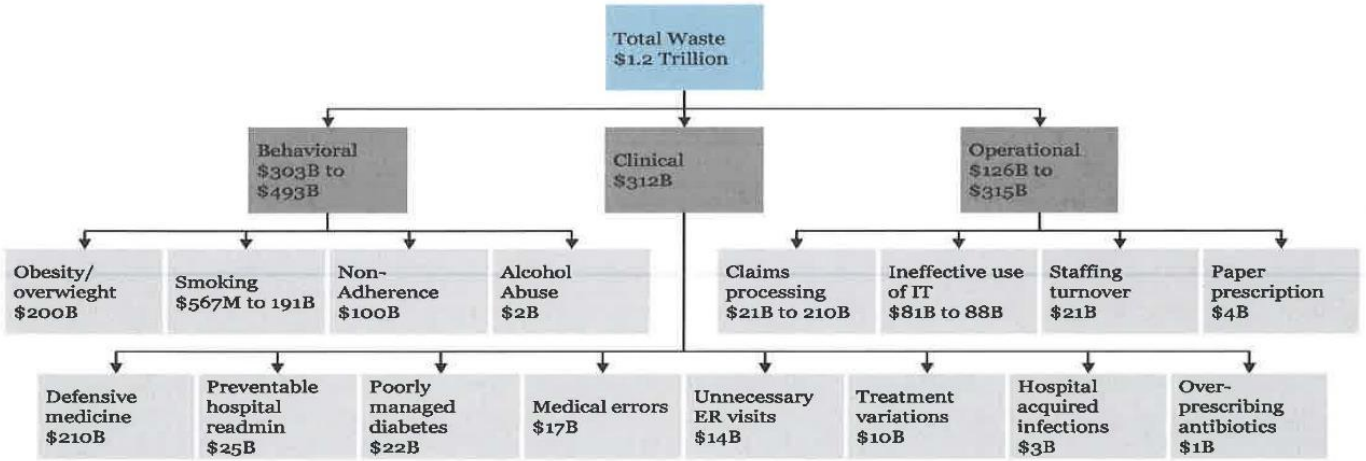
An insider's view of what can go wrong—and how you can improve your odds of getting the right treatment
BY NANCY GIBBS & AMANDA BOWER

Waste in US Healthcare

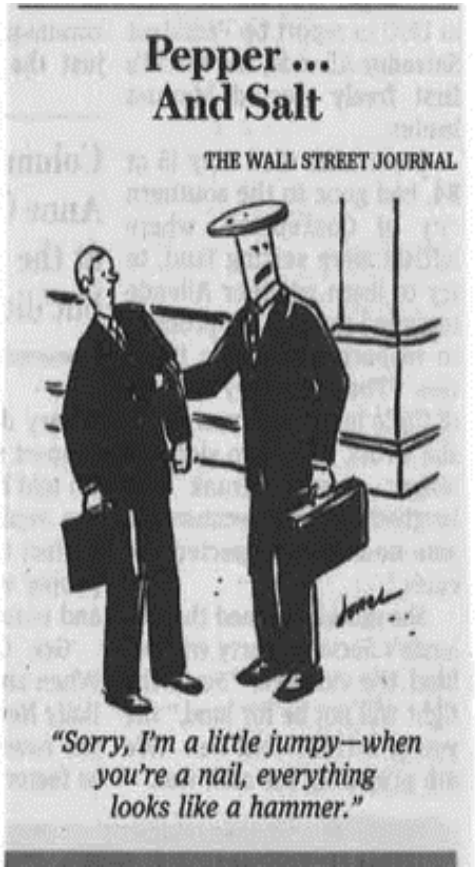
Opportunities to eliminate wasteful spending in healthcare add up to $1.2 trillion of the annual $2.2 trillion spent nationally; these categories overlap



Waste cannot be eliminated immediately. However, by viewing waste in these baskets, the size of opportunities can be prioritized and rewarded. Like health spending itself, these categories overlap. Reducing one basket can affect the size of the others.

Source: Analysis by PwC's Health Research Institute based on published studies on inefficiencies in healthcare.

Sources: 1-National Academy of Medicine (formerly Institute of Medicine), 2012. 2-Choosing Wisely, an initiative of the American Board of Internal Medicine Foundation in partnership with 60 health care organizations, choosingwisely.org


Pepper ...
And Salt
THE WALL STREET JOURNAL
"Sorry, I'm a little jumpy—when you're a nail, everything looks like a hammer."

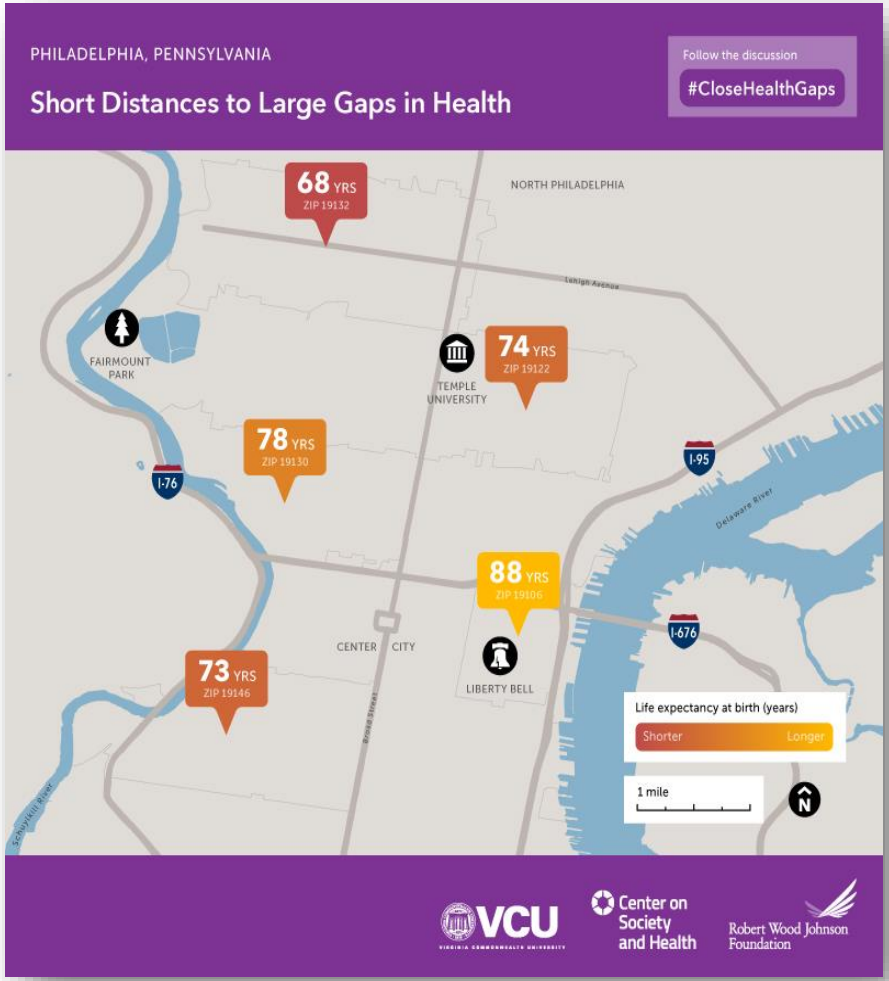

Historical & Current Fee-For-Service
Value-Based Payment & Population Health Management

Is Population Health the Answer?

1. What's the question?

2. Where are we now?

3. Where are we going in the future?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Short Distances to Large Gaps in Health
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I-95
Delaware River
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Shorter
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IN SPORTS

Kurt Busch takes his first Daytona 500

Veteran wins with last-lap pass

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Hospitals look to profit by keeping patients away

Facilities rewarded in host of ways to keep more people healthy

Jayne O'Donnell
@jayneodonnell
USA TODAY

Asked about his health issues, Anthony Tramonte of New Castle, Del., says, "Do you have about an hour?"

It's no wonder: The former postal worker, 72, is on dialysis, has diabetes, heart disease, high blood pressure and eye problems. He's been hospitalized three times for heart failure in the past few years and was blind for a while due to his diabetes.

Tramonte's wife of 50 years, Phyllis, is his full-time caregiver, but she's got help in high places — the Christiana Care health system near their home. There, pharmacist Kelly Ann Steeves is his "care coordinator" after Tramonte is hospitalized to make sure he gets all the medical and social support he needs to avoid a return visit. A monitor checks his heart beat at home and notifies his doctor if it's irregular, which Phyllis says has saved his life twice.

"I sleep easier knowing he's got that care," she says.

Tramonte is one of about 75,000 patients in a Christiana program called Care Link that's funded by a variety of federal grants through the Centers for Medicare and Medicaid Services. Patients have care coordinators such as Steeves who link them with a nurse, pharmacist and social worker. Similar projects around the U.S. are federally funded and share the goal of keeping people healthy and out of the hospital, at least for preventable reasons.

FAMILY PHOTO

Anthony and Phyllis Tramonte of New Castle, Del., get help from Christiana health system's Carelink.

Under the Affordable Care Act, hospitals now get penalized when Medicare patients are re-admitted within 30 days of a visit, but there are a host of other ways they get rewarded when they keep people healthy. Some are funded through CMS' innovation center, such as a reimbursement plan that gives hospitals a set amount for, say, a knee replacement. They get more if they treat the patient for less and lose mon-

▶ STORY CONTINUES ON 2A

TE 4A TRAVEL 4B MARKETPLACE TODAY 7D PUZZLES 7D TONIGHT ON TV 8D WEATHER 6A YOUR SAY 6A

Population Health: Conceptual Framework

Health outcomes and their distribution within a population

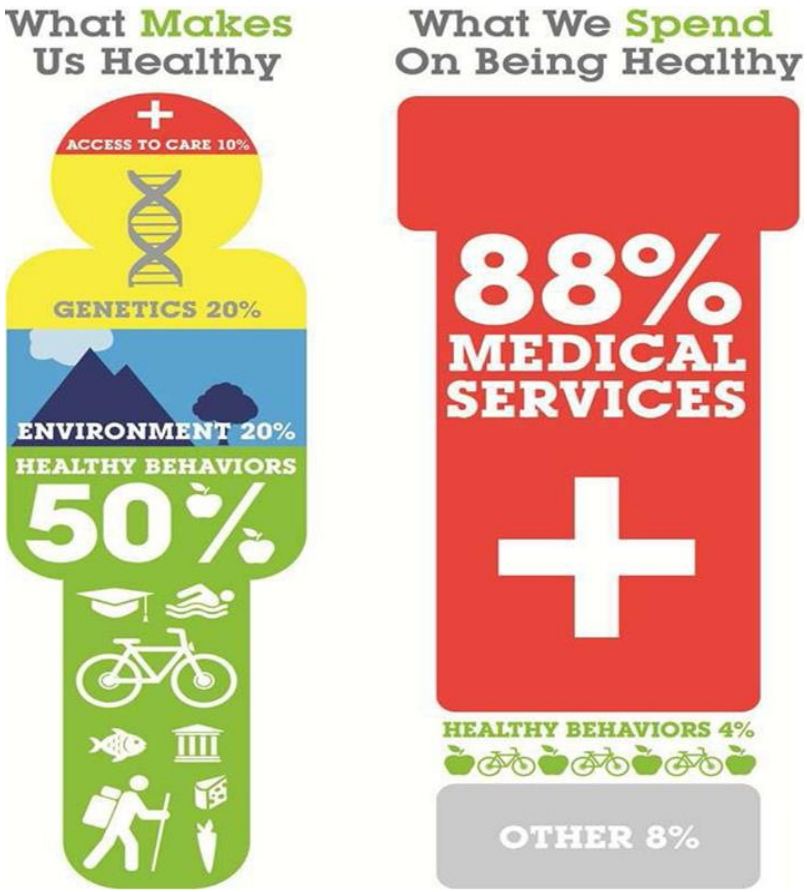
Morbidity
Mortality
Quality of Life

Health determinants that influence distribution

Medical care
Socioeconomic status
Genetics

Policies and interventions that impact these determinants

Social
Environmental
Individual


What Makes Us Healthy
ACCESS TO CARE 10%
GENETICS 20%
ENVIRONMENT 20%
HEALTHY BEHAVIORS
50%
What We Spend On Being Healthy
88%
MEDICAL SERVICES
HEALTHY BEHAVIORS 4%
OTHER 8%

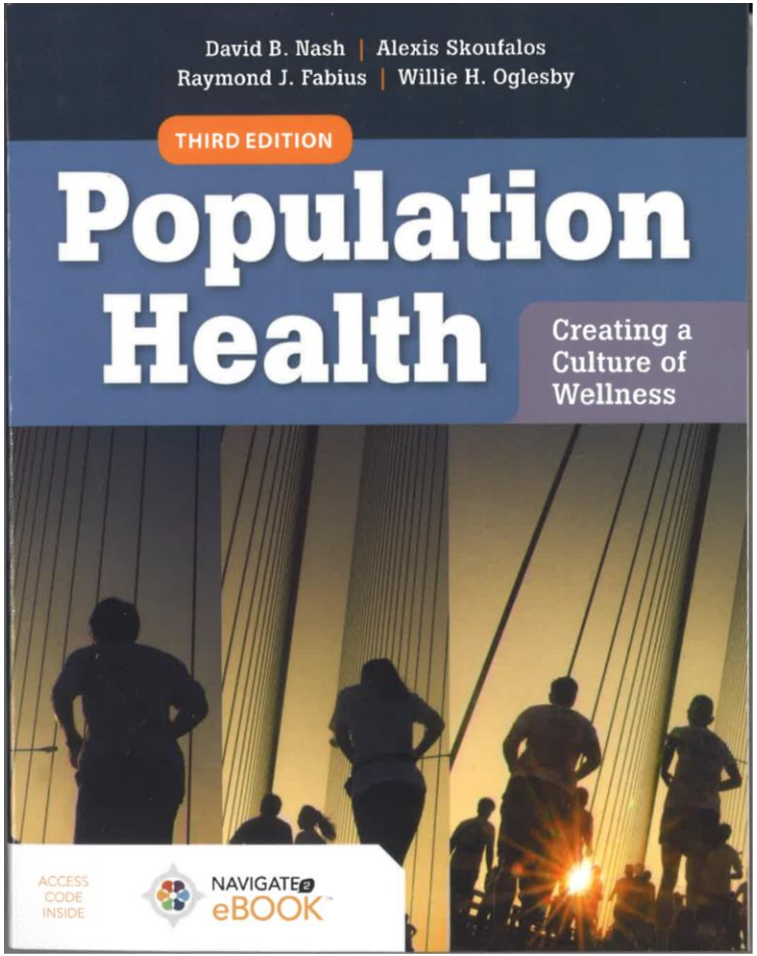
Better Health

…He’s back!

What Percentage of Adult Americans do the Following?

1. Exercise 20 minutes 3 x week
2. Don’t smoke
3. Eat fruits and vegetables regularly
4. Wear seatbelts regularly
5. Are at appropriate BMI

Annals Int Med
April 2006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Population Health Management

CONTENTS

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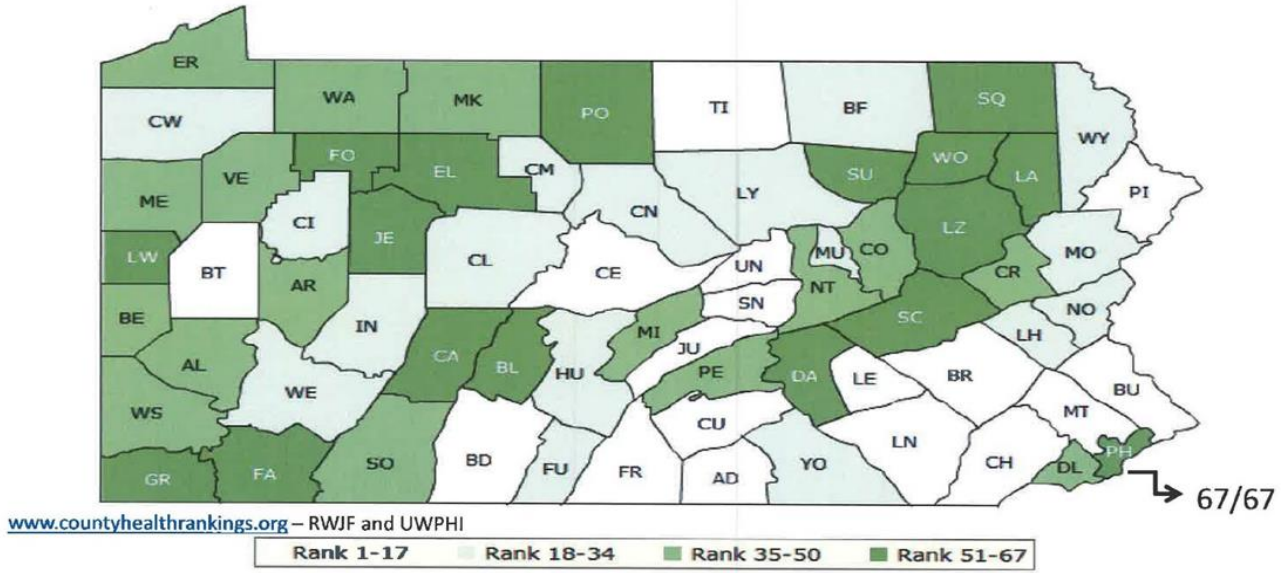
Population Health Measurement

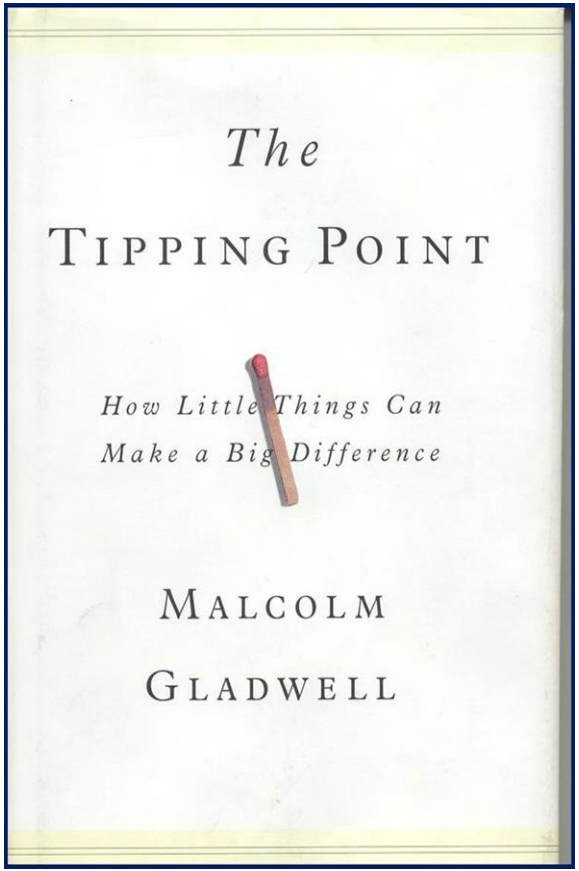
Many population health measures and a variety of core sets exist, such as…

- IOM Vital Signs Core Metrics
- County Health Rankings Measures
- HHS Leading Health Indicators
- RWFJ Culture of Health Measures
- NQF-endorsed Health & Well-Being Measures

…but this can make it challenging for groups in the field to choose specific measures and be able to compare results.

Pennsylvania Health Outcomes Ranks by County

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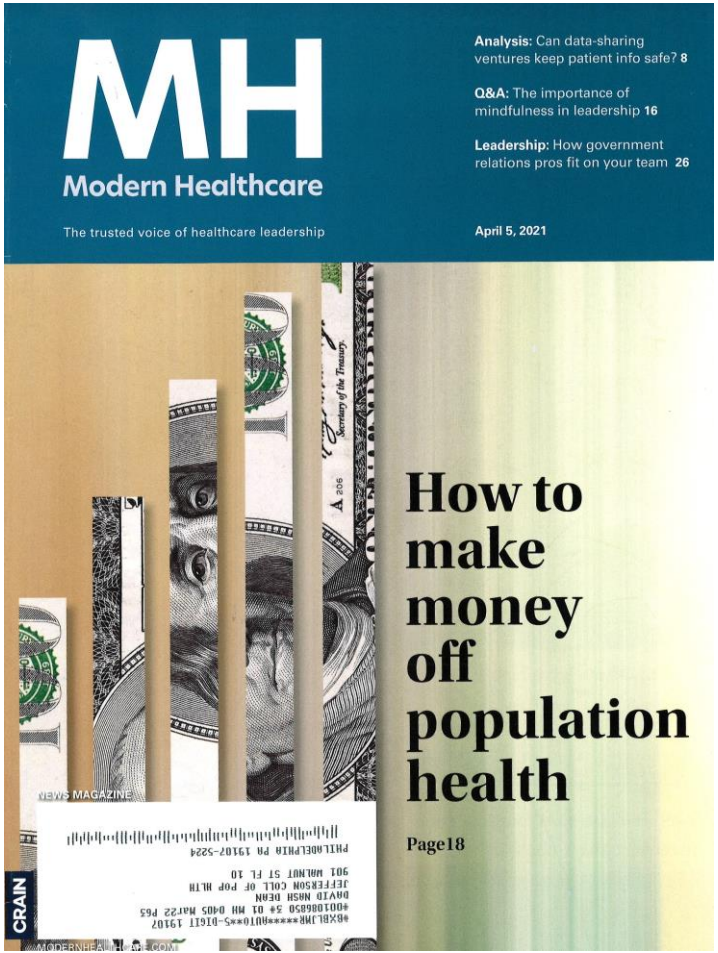
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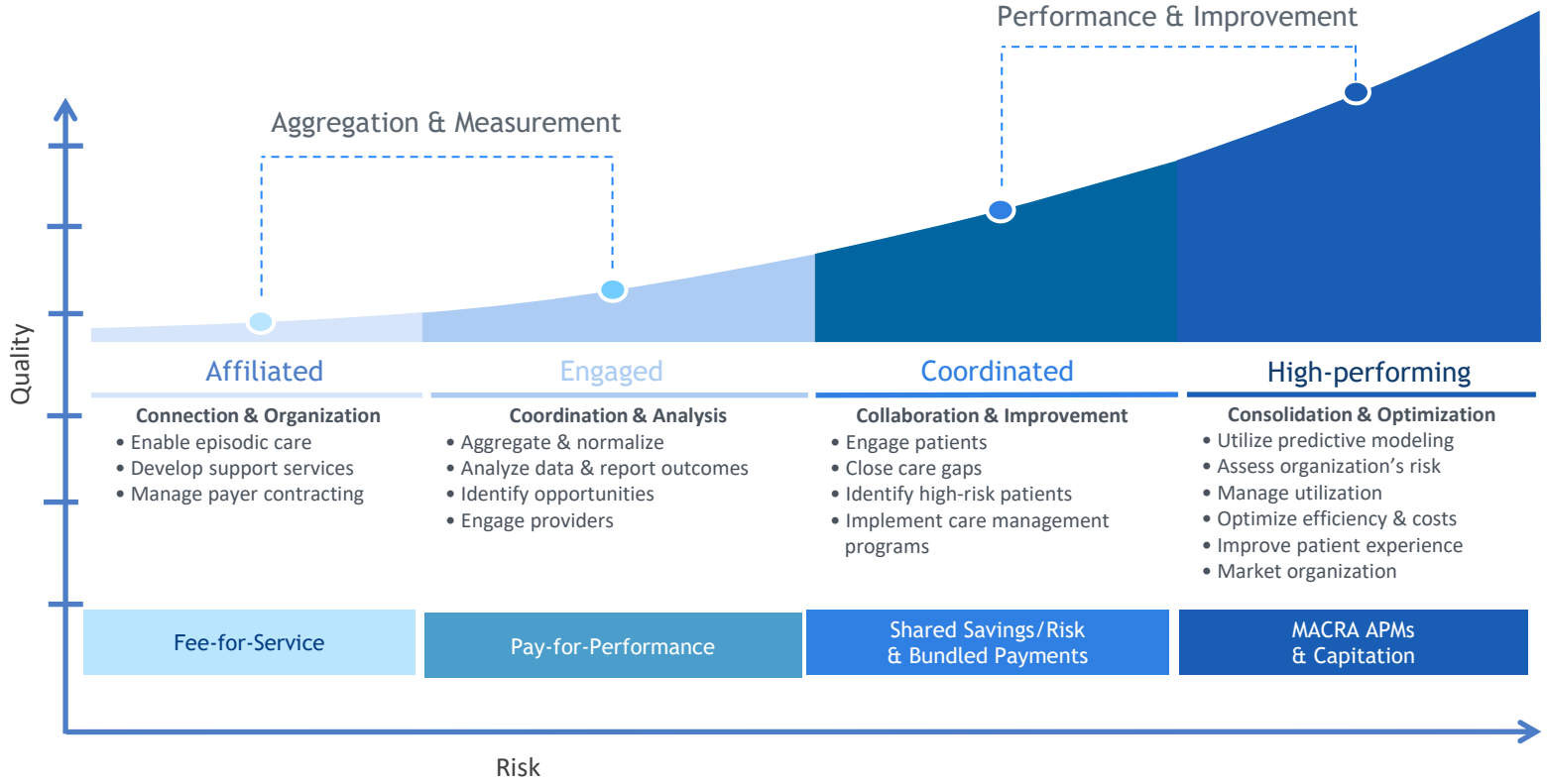


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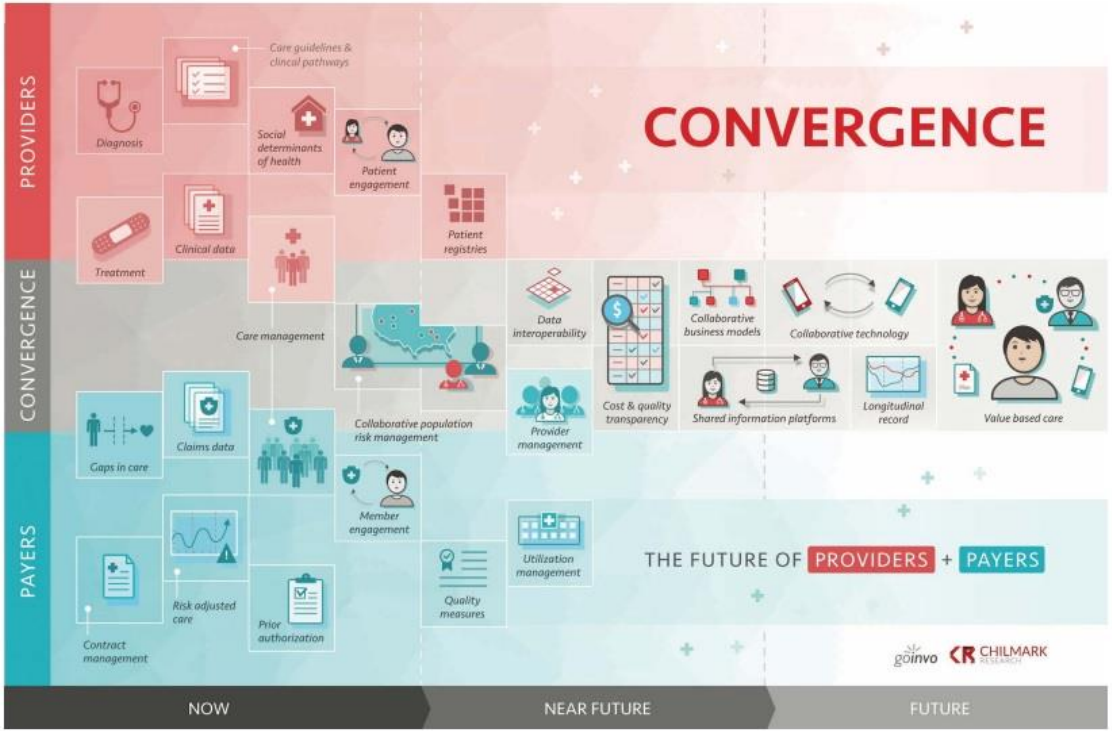

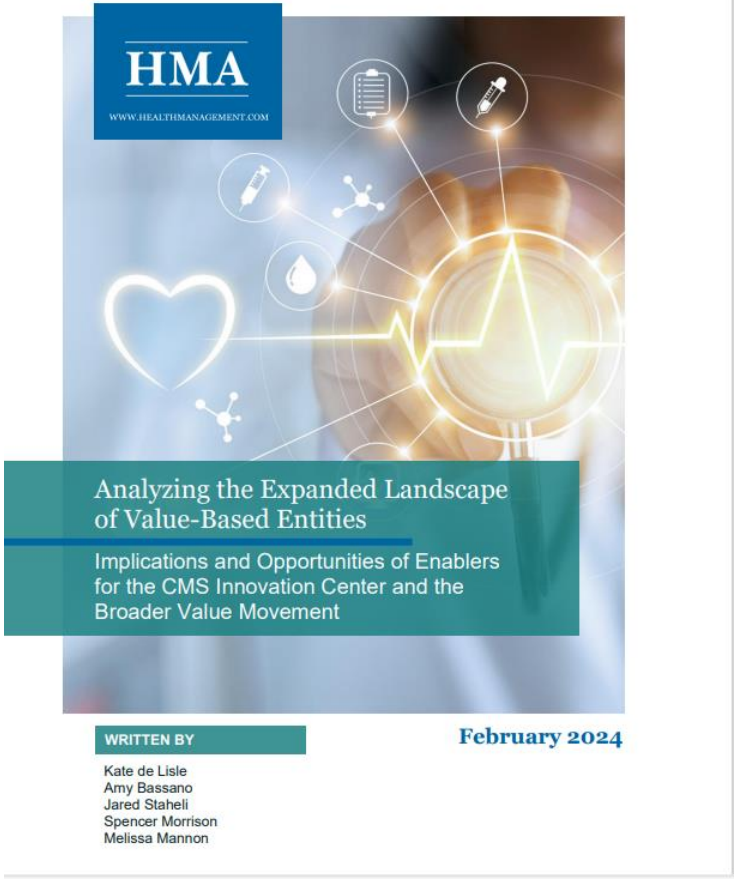
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Analyzing the Expanded Landscape of Value-Based Entities
Implications and Opportunities of Enablers for the CMS Innovation Center and the Broader Value Movement
WRITTEN BY
Kate de Lisle
Amy Bassano
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February 2024

Perspective

AMERICAN COLLEGE OF Medical Quality

The Emerging Value-Based Care Industry: Paving the Road Ahead

Zachary N. Goldberg, BS, BA[1] and David B. Nash, MD, MBA[2]

Value in health care is difficult to define in the United States. Measurement of Quadruple Aim adherence presents an opportunity for value assessment. The 4 components of the Aim include better outcomes, lower costs, enhanced quality, and improved provider experience.[1] The Centers for Medicare and Medicaid Services (CMS) recently released a report from their Innovation Center emphasizing better Quadruple Aim adherence to improve health care value.[2]

A systematic movement towards value-based care (VBC) must start with, and will depend on, decisions made by CMS.[3] The influence of CMS, especially regarding decisions for Medicare and Medicaid, have large implications on the potential for high-value care. VBC also cannot be achieved without widespread provider participation that leads to safe and cost-effective practices that meet the unique care needs of each patient. Health care waste is another key obstacle on the road to VBC: 25 cents of every dollar spent on health care is wasted.[4] Effectively managing these various factors that influence VBC may be realized by improving health care information technology (IT). Health care IT that drives VBC must support care coordination, shared data analytics, and allow for real-time cost and outcome tracking while actively engaging individual practitioners.[5] There is evidence in the literature that health care IT of this type can accelerate the transition to VBC.[6–8] This has sparked a movement to engage entities that provide health care IT interventions focused on improving VBC.

There is now an emerging industry of private, for-profit companies specializing in health care IT and services that assist providers to improve value via care coordination, analytics, and population health management. After presenting this new "Value Based Care Industry's" demographics, sector-specialization, and financial information, the authors will discuss how these companies can be critically evaluated to determine if their interventions enhance the transition to VBC and bring US health care closer to Quadruple Aim adherence.

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American College of Medical Quality XXX Vol. XXX(00) 00-00

DOI: 10.1097/JMQ.0000000000000067

Methods

A search of relevant literature was conducted to identify companies with a core focus of improving value in health care, but no information was identified. The authors then elected to utilize data from CB Insights, a technology platform that researches thousands of companies using artificial intelligence-derived machine learning tools. The authors searched the platform for companies that provided value-based software and IT services to providers that focused on care coordination, data analytics, and population health management. Ninety companies were identified from an initial list of 650. Analyses of various metrics of these companies were conducted, including demographics, sector of specialization, and financial details. After concluding the company analysis, the authors proposed methods to understand how value-based interventions can be critically evaluated and measured. This was done to help inform strategies to determine if these companies drive VBC and improve Quadruple Aim adherence.

The VBC Industry

All 90 VBC companies were located in the United States. Over half of these companies were concentrated to 7 states, and 15% of them were located in Tennessee and Florida. Companies have cited favorable tax climates, available workforce, advanced infrastructure, global connectivity, and business-friendly government policy as key reasons to specifically headquarter in nontraditional states like Tennessee and Florida.[9,10] The companies were organized into the following 3 sectors according to their key focus: care coordination (24), data analytics (33), and population health management (33).

The majority (47, 52.2%) of companies in the industry were founded after 2010 and more than a quarter were founded after 2015. This reflects the industry's rapid growth over the last decade, likely sparked by the passing of the Patient Protection and

150+ private companies enabling value-based care

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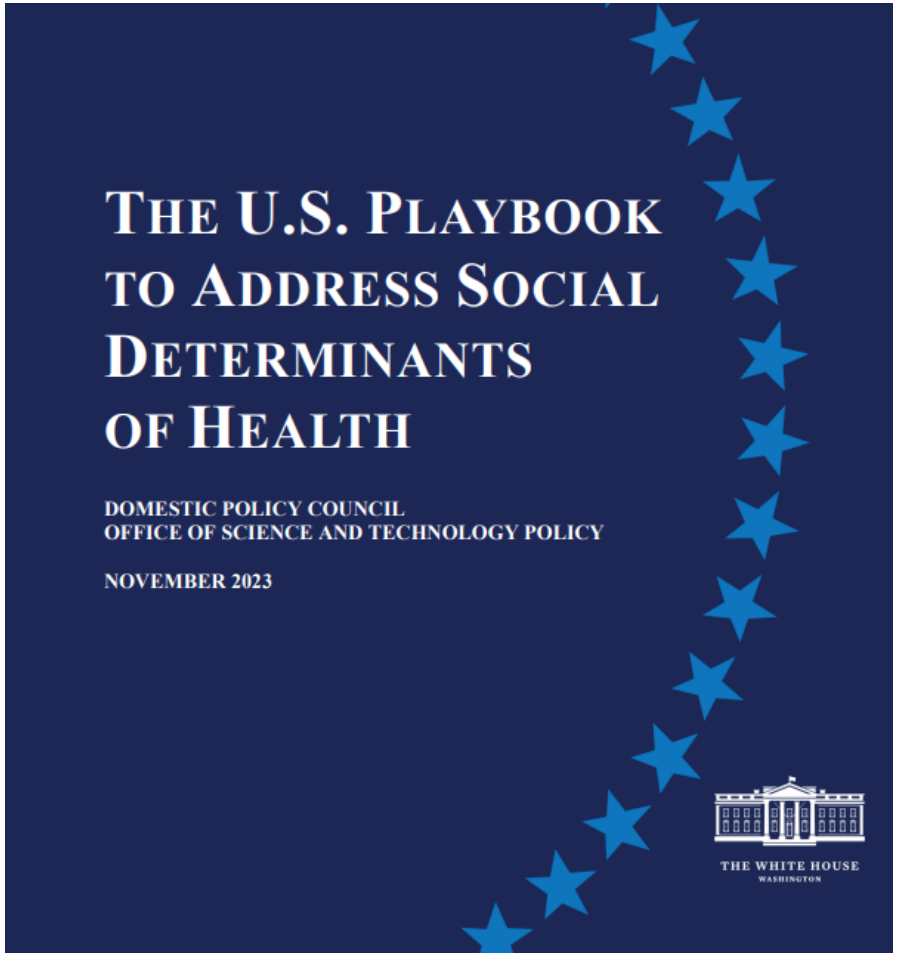
THE U.S. PLAYBOOK TO ADDRESS SOCIAL DETERMINANTS OF HEALTH
DOMESTIC POLICY COUNCIL
OFFICE OF SCIENCE AND TECHNOLOGY POLICY
NOVEMBER 2023
THE WHITE HOUSE
WASHINGTON

CMS Framework for Health Equity 2022–2032

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The Joint Commission

Who We Are | What We Offer | Our Priorities | Standards | Measurement

Home > Standards > Prepublication Standards > Health Care Equity Standard Elevated to National Patient Safety Goal

Health Care Equity Standard Elevated to National Patient Safety Goal

Effective July 1, 2023, Standard LD.04.03.08, which addresses health care disparities as a quality and safety priority, will be elevated to a new National Patient Safety Goal (NPSG), Goal 16: Improve health care equity, and moved to NPSG.16.01.01. As with the original requirement, NPSG.16.01.01 will apply to the following Joint Commission–accredited organizations:

- All critical access hospitals and hospitals
- Ambulatory health care organizations providing primary care within the "Medical Centers" service in the ambulatory health care program
- Behavioral health care and human services organizations providing "Addictions Services," "Eating Disorders Treatment," "Intellectual Disabilities/Developmental Delays," "Mental Health Services," and "Primary Physical Health Care" services.

The new NPSG increases the focus on improving health care equity as a quality and safety priority, but the requirements for accredited organizations are not changing. While the original language of the requirements was revised to focus on improving health care equity rather than reducing health care disparities, the intent behind the standard and associated elements of performance remains the same.

What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income

How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care

Post-Pandemic Physician Leadership

By David B. Nash, MD, MBA
Editor-in-Chief, *American Health & Drug Benefits*
Founding Dean Emeritus, Jefferson College of Population Health, Philadelphia, PA

There appears to be light at the end of the terrible pandemic tunnel. I hope this light is not from an oncoming train, but rather the light means the beginning of a new era. This era will require, in my view, a new type of physician leader. Much has been written about leadership development for physicians; probably the most detailed systematic review dates back to 2014, when several colleagues at the Global Health Leadership Institute at the Yale School of Public Health and others did a deep dive to describe all the extant leadership-training programs that were then available.[1]

These investigators noted that "the term 'leadership development' often encompasses efforts to develop individual leaders as well as to build capacity for leadership within an organization. Leadership development can promote several key functions in organizations, such as performance improvement, succession planning, and organizational change, and the literature on leadership provides evidence that leadership development helps organizations to achieve their goals."[1]

In the post-pandemic era, we must refocus our attention on performance improvement and organizational change at a level that we have never collectively experienced.

In 2019, my colleague and I added to this burgeoning literature on physician leadership with an annotated bibliography.[2] Looking back on that literature is sobering, because the need for a more inclusive and innovative leader is appearing on the near horizon. I believe that the post-pandemic physician leader will need an additional set of skills that have not been previously described in the scholarly literature, including, for example, expertise in digital health, technology transfer, a deeper understanding of the role of private equity in healthcare, sensitivity to the agenda of diversity and inclusion, and most important, reducing disparities and inequities in care.

The post-pandemic physician leader will necessarily come from different backgrounds and cultures. He or she is likely to have an additional degree, such as an MBA, MHA, or MPH, for example. He or she will be a member of the millennial demographic and will be savvy with all types of technology. Where will post-pandemic physician leaders obtain some of these new skills?

Let us review 3 organizations where I believe physician leaders in the post-pandemic era may obtain some of these skills and as a result be better prepared to lead. There are at least 3 leading national organizations in which physicians may obtain some of the key skills for the future.

The post-pandemic physician leader will necessarily come from different backgrounds and cultures. He or she is likely to have an additional degree, such as an MBA, MHA, or MPH, for example. He or she will be a member of the millennial demographic and will be savvy with all types of technology. Where will post-pandemic physician leaders obtain some of these new skills?

The first and most prominent organization is the American Association for Physician Leadership (AAPL). As the preeminent group, given its 45-year history, to date this association has educated more than 250,000 physicians in some fashion, according to its current website.[3] In 2017 alone, the AAPL educated almost 20,000 doctors. More than 3200 physicians have earned what they call the Certified Physician Executive (CPE) credential through a more senior leadership-training program that helps to create a cadre of credentialed physician leaders. In addition, nearly 2000 doctors have graduated from the partnership master's degree programs with AAPL,[3] which include (since 2011) the Master of Science degree in Health Care Quality and Safety from the Jefferson College of Population Health, something of which I am very proud.

I have been on the AAPL faculty since 1993. I estimate that in my work with the organization, I have personally taught more than 5000 emerging physician leaders face to face and another 2000 physicians remotely. Faculty from around the country make up the core teachers who are part of the AAPL, and its agile in-person and online programming has managed to stay just

AI is Good at:

- Variance Analysis
- Pattern Recognition
- Image Analysis
- Automation
- Information Processing

Humans Good at:

- Reasoning
- Judgement
- Imagination
- Creativity
- Problem-Solving

Attribution: Tom Lawry

50/5 is the new 80/20

80%

80% of health care spend has generally been associated with 20% of all patients over the last decade

Population Health Management

but the problem is becoming more precise

50%

50% of high-cost claims are generated by about 5% of patients, many of which are diagnosed with **complex oncologies, rare diseases, and other complex diseases** requiring precision medicines[1]

Precision Medicine Management

and this is just the tipping point

>$1T

>$1T will be required to treat complex and rare diseases alone, by 2030 – 3-5x more than other chronic conditions[1]

$$$

1. Managing the Most Expensive patients. Harvard Business Review. February, 2020.
2. American Society of Cell and Gene Therapy, Gene, Cell, & RNA Therapy Landscape: Q2 2021 (2021).

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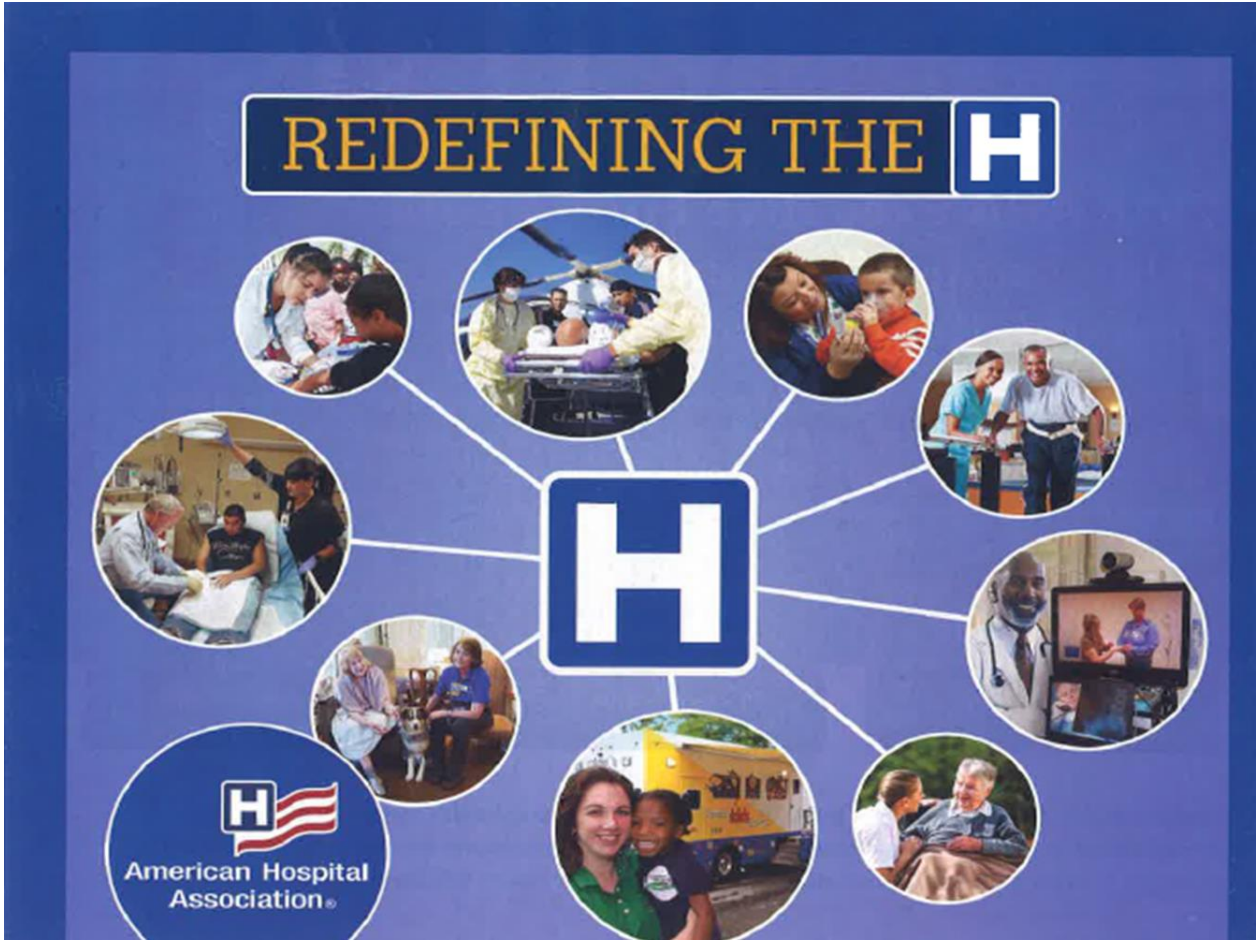
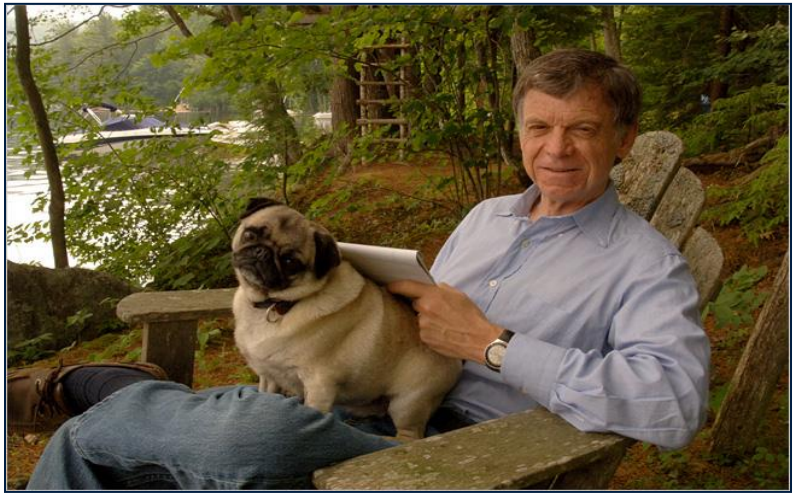

REDEFINING THE H
American Hospital Association

"The institutionalization of leadership training is one of the key attributes of good leadership."



John P. Kotter,
Harvard Business School

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