PLANNING AND STRATEGIC CONTROL FOR PUBLIC HEALTH IN ITALY

WHY YOU SHOULD BE VERY WORRIED ABOUT YOUR FUTURE

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1 March 2011

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TWO MAJOR THEMES

WHERE IS THE ITALIAN HEALTH SYSTEM GOING?
ARE YOU HAPPY ABOUT THESE DIRECTION?
IF NOT, WHAT MUST YOU CHANGE?

HOW CAN ITALIAN LOCAL HEALTH UNITS PLAY A CREATIVE ROLE IN HELPING TO ADDRESS THE NEEDED CHANGES?

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THE CHALLENGE

FOUR ISSUES CONFRONT YOUR HEALTHCARE SYSTEM

THEY WILL BECOME INCREASINGLY SERIOUS
AND COSTLY IN THE NEXT 5 TO 8 YEARS

DEMOGRAPHIC TRENDS
SPENDING IMBALANCES
MORBIDITY PATTERNS
A DYSFUNCTIONAL DELIVERY SYSTEM

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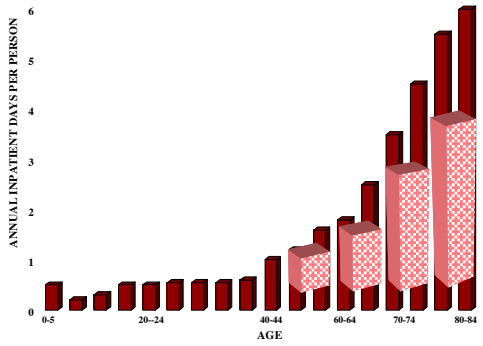
ISSUE #1. DEMOGRAPHIC TRENDS



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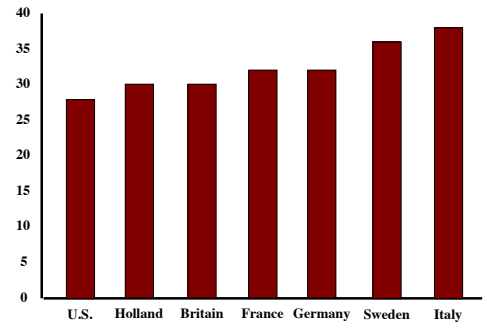
PERCENT OF POPULATION 60 YEARS OLD AND OVER IN 2015



Source: Jagadeesh Gokhale and Berndt Raffelhuschen

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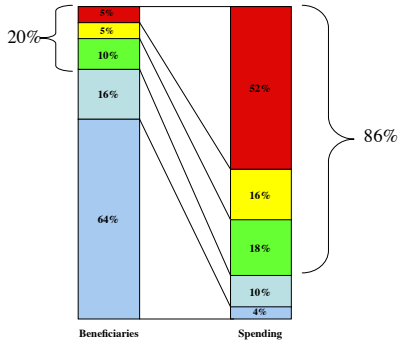
ISSUE #2. SPENDING IMBALANCES

U.S. MEDICARE SPENDING FOR THE OVER 65 POPULATION



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ISSUE #2. SPENDING IMBALANCES

U.S. MEDICARE SPENDING FOR THE OVER 65 POPULATION

Who are these people?
The 20% of the population who account for 86% of the spending?
Mainly the very old, many with chronic conditions

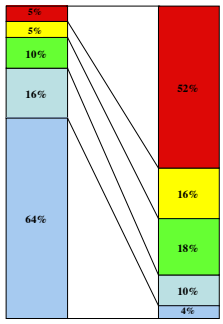
What specialty treats the very old with chronic conditions?

Geriatrics
How many geriatricians are there in Veneto?

A partial solution to the financing problem is clear, but . . .

. . . what would it take for a resident to shift his/her specialty to geriatrics?

What are you doing about this?



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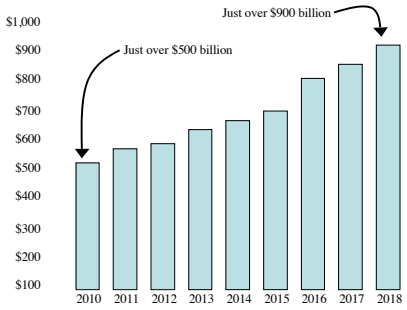
Estimated Medicare Spending (The Over-65 Population)
(In Billions of Dollars)



Source: DGA Analysis of Kaiser Family Foundation "Update on Medicare Spending and Financing Highlights from the 2009 Medicare Trustees' Report, May 2009.

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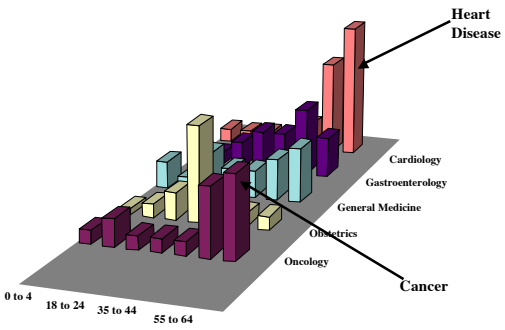
ISSUE #3. MORBIDITY PATTERNS



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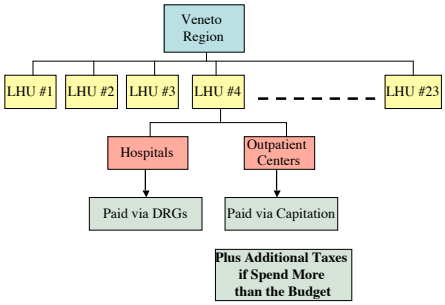
ISSUE #4. THE DELIVERY SYSTEM



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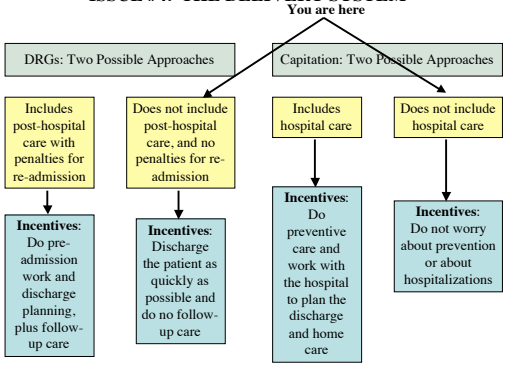
ISSUE #4. THE DELIVERY SYSTEM



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ISSUE #4. THE DELIVERY SYSTEM

The results:

1. **Outpatient centers (the territories) do not worry about prevention because the capitation payment does not include the cost of hospital care**
2. **When a patient is hospitalized the hospital tries to discharge him or her as soon as possible because the DRG payment does not include the cost of follow-up care. That is the responsible of the outpatient centers**
3. **In effect, a patient is a hot potato who everyone is trying to toss to someone else**

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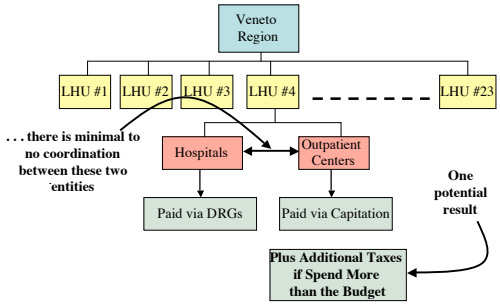
IN EFFECT . . .



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CONCLUSIONS

THERE ARE A DISPROPORTIONATE NUMBER OF PEOPLE CURRENTLY IN THEIR EARLY 60s, WHO WILL DEMAND INCREASINGLY LARGE AMOUNTS OF INPATIENT CARE AS THEY GROW OLDER

SINCE THEY LIVE LONGER THAN THEIR ANCESTORS, THEY WILL BECOME PART OF THE HIGH COST SEGMENT OF THE HEALTH SYSTEM

THEIR CARE WILL BE LARGELY IN AREAS SUCH AS CARDIOLOGY AND ONCOLOGY—AREAS THAT DO NOT LEND THEMSELVES EASILY TO A SHIFT TO OUTPATIENT CARE

THEY ALSO WILL DISPLAY AN INCREASING INCIDENCE OF CHRONIC CONDITIONS, THEREBY INTENSIFYING COST PRESSURES IN OUTPATIENT SETTINGS

RESULT: INTENSE PRESSURES ON COSTS AND A FRAGMENTED DELIVERY SYSTEM THAT DOES NOT HAVE THE INCENTIVES NEEDED TO SLOW THE RATE OF COST GROWTH

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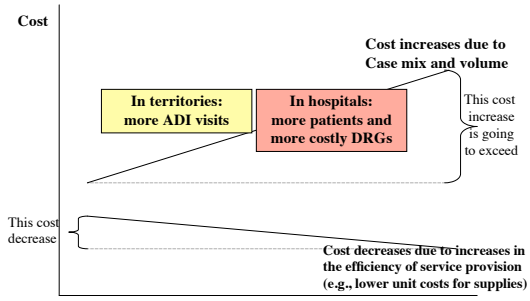
GREATER EFFICIENCY WILL NOT SOLVE THE PROBLEM



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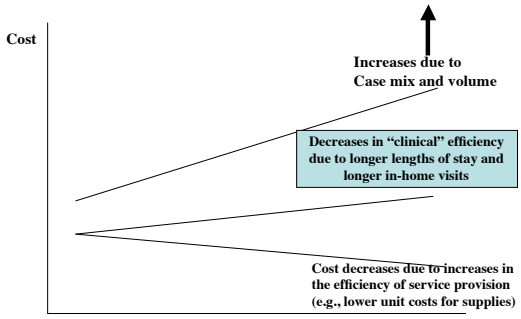
BUT ANOTHER TYPE OF EFFICIENCY WILL POSSIBLY WORSEN



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IN ADDITION TO WORKING TO IMPROVE EFFICIENCY, HOW CAN YOU SOLVE THESE PROBLEMS?

TO BEGIN, YOU MUST RECOGNIZE THAT COSTS ARE DRIVEN BY FIVE FACTORS, AND . . .

. . . YOU MUST REDESIGN THE PAYMENT MECHANISMS IN LHUs TO PROVIDE THE APPROPRIATE INCENTIVES ON BOTH THE OUTPATIENT AND INPATIENT SIDES

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HEALTH CARE COST DRIVERS

Cost Driver		Examples	Controlling Force(s)
Case Mix	Morbidity-Related	Diabetes, cancer, heart disease . . .	Environment, genetics, health habits. Public Health
Volume	Morbidity-Related	10,000 cases diabetes, 15,000 cases cancer. . .	Environment, genetics, health habits.
Resources Per Case	Utilization/Efficiency	8 outpatient visits 2 glucose tests, 2 CBCs . . .	Physicians, clinical protocols, available technology. Operations
Cost Per Resource Unit	Utilization/Efficiency	$40 per OPD visit $25 per glucose test $12 per CBC . . .	Service-providing units.
Fixed Facility Costs	Technology	Plant & equipment depreciation; managerial & administrative staffing.	Senior management, physicians, health policy. Strategy

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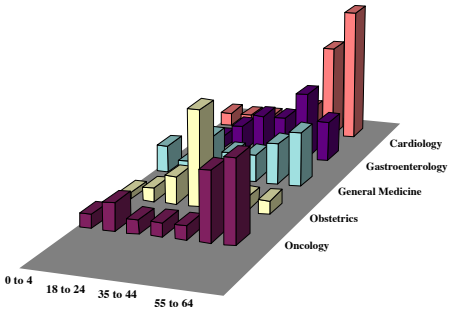
OPTIONS AND CONSEQUENCES

Cost Driver	Option	Consequences
Case Mix	Reduce the incidence or don't treat certain diagnoses	Morbidity may improve, or some patients will suffer and/or die prematurely.
Volume	Don't treat all patients with certain diagnoses	
Resources Per Case	Treat certain case types with a more cost-effective mix of resources	More outpatient care and shorter lengths of stay in hospitals. Perhaps fewer tests and procedures.
Cost Per Resource Unit	Provide resources in a less expensive way	Lower wages, lower supply prices, greater efficiency. Result is fewer staff and/or different skill mixes.
Fixed Facility Costs	Invest in lower cost capital, reduce size/salaries of administrative staff	Less technology, fewer administrators, less qualified administrators.

THE PUBLIC HEALTH OPTION
CAN WE FIX THE MORBIDITY PROBLEM?



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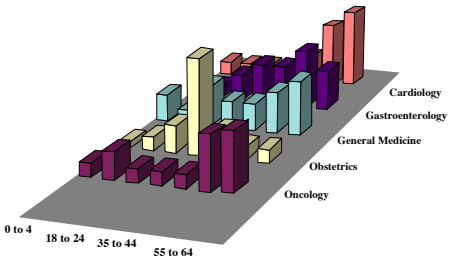
CAN WE FIX THE MORBIDITY PROBLEM?



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BUT . . .

. . . DO PEOPLE *WANT TO* IMPROVE THEIR HEALTH?

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HEALTH INDICATORS IN MASSACHUSETTS
A RELATIVELY "HEALTHY" STATE

	MA %	MA Rank
overweight	52	4th
obese	17	5th
Any exercise in past month	76	13th
fruit and vegetable consumption	31	4th
current smoker	20	8th

1 = best; 50 = worst

Source: Massachusetts Department of Public Health

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Leading causes of death in the United States

- Tobacco: 435,000 deaths, 18.1 % of total U.S. deaths
- Poor diet and physical inactivity: 400,000 deaths, 16.6%
- Alcohol consumption: 85,000 deaths, 3.5%
- Microbial agents: 75,000
- Toxic agents: 55,000
- Motor vehicle crashes: 43,000
- Incidents involving firearms: 29,000
- Sexual behaviors: 20,000
- Illicit use of drugs: 17,000

Almost 35% here

Source: *Journal of the American Medical Association*

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Fixed Facility Costs		Plant & equipment depreciation; managerial & administrative staffing.	Senior management, physicians, health policy.

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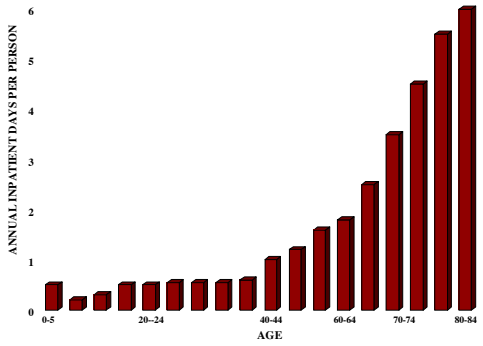
CAN WE FIX THE UTILIZATION PROBLEM?



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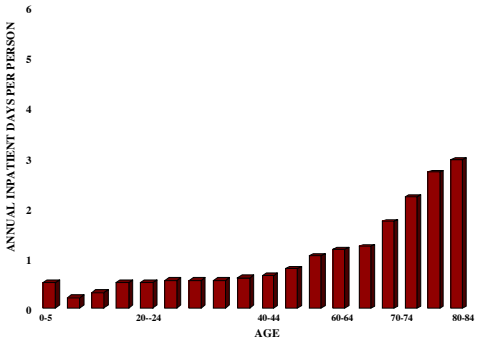

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TO REDUCE UTILIZATION, A LHU NEEDS TO THINK CREATIVELY ABOUT DISEASE MANAGEMENT STRATEGIES

- OUTPATIENT VERSUS INPATIENT TREATMENT
- PHARMACEUTICALS RATHER THAN SURGERY
- PRE-ADMISSION ACTIVITIES TO SHORTEN LENGTH OF STAY
- IN-HOME CARE TO SHORTEN LENGTH OF STAY

Territories Hospitals

BUT IT IS HARD TO DO THIS WHEN THERE IS NO COORDINATION BETWEEN OUTPATIENT AND INPATIENT SERVICES

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MOREOVER, YOU NEED TO REMEMBER SEVERAL IMPORTANT ELEMENTS WHEN YOU BEGIN TO THINK ABOUT STANDARDS:

- A HOSPITAL CAN EXERT SOME CONTROL OVER THE COST OF TREATING A GIVEN DRG (LENGTH OF STAY, TESTS, PROCEDURES, ETC.)

  . . . BUT IT HAS LITTLE CONTROL OVER EITHER THE NUMBER OR MIX OF DRGS THAT IT IS ASKED TO TREAT. THAT IS A RESULT OF MORBIDITY PATTERNS, OVER WHICH THE TERRITORIES (AND PATIENTS THEMSELVES) HAVE MORE CONTROL

- THE TERRITORIES CAN EXERT SOME CONTROL OVER THE EFFICIENCY OF A HOME VISIT (HOW LONG IT TAKES) AND THE MEDICAL SUPPLIES THAT ARE USED FOR THE VISIT . . .

  . . . BUT THEY HAVE LITTLE CONTROL OVER THE NUMBER OF PATIENTS WHO NEED A HOME VISIT. THAT IS A RESULT OF PATIENTS HEALTH-RELATED BEHAVIOR AND THE GENERAL AGING OF THE POPULATION

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IN ADDITION, THE COST OF TREATING A GIVEN DRG IS A COMBINATION OF:

- THE RESOURCES USED TO TREAT THE PATIENT: LENGTH OF STAY, TESTS, PROCEDURES, ETC.)

  WHICH ARE CONTROLLED LARGELY BY PHYSICIANS AND THEIR ORDERING PATTERNS

- THE COST OF EACH RESOURCE UNIT, SUCH AS A LAB TEST OR A DAY OF CARE

  WHICH ARE CONTROLLED BY ADMINISTRATIVE PEOPLE (NURSE MANAGERS, LAB MANAGERS, DIETARY MANAGERS, HOUSEKEEPING MANAGERS, ETC.

  AND WHICH ARE A RESULT OF A COMBINATION OF WAGE RATES, SUPPLY UNIT COSTS, PRODUCTIVITY AND EFFICIENCY

In effect . . .

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. . . YOU NEED TWO SETS OF STANDARDS IN A HOSPITAL:

- RESOURCES PER CASE (LENGTH OF STAY, TESTS, PROCEDURES, ETC.)

  . . . THESE ARE CONTROLLED BY PHYSICIANS

- COST PER RESOURCE UNIT (BED DAY, X-RAY, LAB TEST, ETC.)

  . . . THESE ARE CONTROLLED BY ADMINISTRATIVE PEOPLE, INCLUDING NURSES, X-RAY TECHNICIANS, LABORATORY ADMINISTRATORS, ETC.

AND . . .

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. . . YOU NEED TWO SETS OF COSTS:

- **FULL COST**

  . . . FOR AN OVERALL ASSESSMENT OF HOW YOU ARE DOING ON EACH DRG (REVENUE MINUS FULL COST)

- **DIRECT (OR VARIABLE) COST**

  . . . FOR ASSESSING THE PERFORMANCE OF PHYSICIANS AND ADMINISTRATIVE PEOPLE IN CONTROLLING COSTS.

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THANK YOU!

PLEASE SHARE YOUR THOUGHTS

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Cambridge, Massachusetts 02138
www.thecrimsongroup.org

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PLANNING AND STRATEGIC CONTROL FOR PUBLIC HEALTH IN ITALY

BUDGETING AND PERFORMANCE MEASUREMENT
USING AN ACTIVITY-BASED (OR COST-DRIVER) APPROACH

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TWO MAJOR THEMES

WHERE IS THE HEALTH SYSTEM GOING?
ARE YOU HAPPY ABOUT THESE DIRECTION?
IF NOT, WHAT MUST YOU CHANGE?

. . . HOW CAN ITALIAN LOCAL HEALTH UNITS PLAY A CREATIVE ROLE IN HELPING TO ADDRESS THE NEEDED CHANGES?

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A HOSPITAL OR A CLINICAL DEPARTMENT CAN PREPARE AN EXPENSE BUDGET USING AN ACTIVITY-BASED (OR COST-DRIVER) APPROACH

THE ACTIVITIES (COST DRIVERS)

- CASE MIX
- VOLUME
- RESOURCES PER CASE
- VARIABLE COST PER RESOURCE UNIT
- FIXED COSTS

ACTIVITIES (COST DRIVERS) & CONTROLLING FORCES

Cost Driver	Examples	Controlling Force(s)
Case Mix	Diabetes, liver cancer, heart disease . . .	Environment, genetics, health habits, public health measures
Volume	1,000 cases diabetes, 500 cases cancer. . .	
Resources Per Case	8 outpatient visits 2 glucose tests, 2 CBCs . . .	Physicians, clinical standards, available technology.
Cost Per Resource Unit	$40 per OPD visit $25 per glucose test $12 per CBC . . .	Service-providing units.
Fixed Facility Costs	Plant & equipment depreciation; managerial & administrative staffing.	Senior management, physicians, health policy.

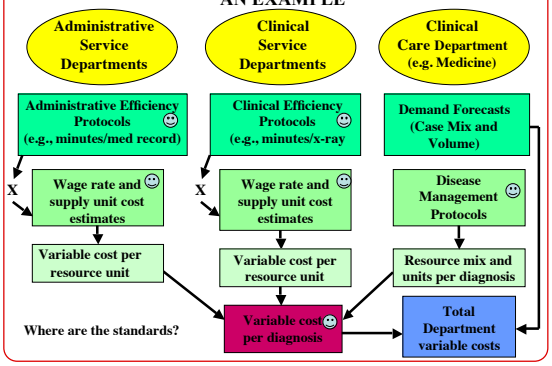
HOW DO WE MAKE IT HAPPEN?

HOW DO WE BEGIN THINKING MORE CREATIVELY ABOUT DISEASE MANAGEMENT STRATEGIES?

A POSSIBLE MANAGEMENT CONTROL RESPONSE:
BUILD BUDGETS FROM THE BOTTOM UP, AND USE ACTIVITIES (OR "COST DRIVERS") TO HELP MAKE COST REDUCTION DECISIONS STRATEGICALLY

WHAT DOES THIS MEAN?

BUDGETING WITH ACTIVITIES AND STANDARDS: AN EXAMPLE



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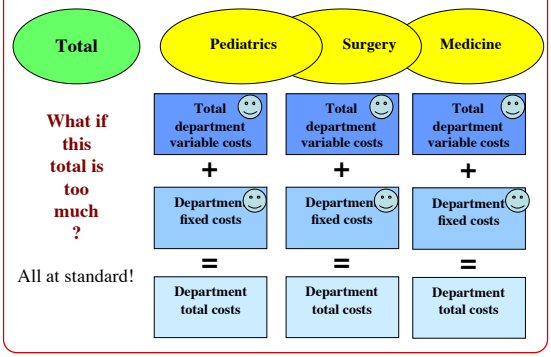

MANAGEMENT CONTROL MEETS DEPARTMENTAL STRATEGY

THERE ARE ONLY FIVE OPTIONS

WILL THEY BE SELECTED BY DESIGN OR DEFAULT?

IF BY DESIGN, WHO CHOOSES?

OPTIONS AND CONSEQUENCES

Cost Driver	Option	Consequences
Case Mix	Reduce the incidence or don't treat certain diagnoses	Morbidity may improve, or some patients will suffer and/or die prematurely.
Volume	Don't treat all patients with certain diagnoses	Some patients will suffer and/or die prematurely.
Resources Per Case	Treat certain case types with a more cost-effective mix of resources	More outpatient care and shorter lengths of stay in hospitals. Perhaps fewer tests and procedures.
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Fixed Facility Costs	Invest in lower cost capital, reduce size/salaries of administrative staff	Less technology, fewer administrators, less qualified administrators.

SOME SIMPLE EFFICIENCY (COST PER RESOURCE) EXAMPLES

SEATTLE CHILDREN'S HOSPITAL IMPROVED INVENTORY CONTROL AND SAVED $23 MILLION IN ONE YEAR

AKRON CHILDREN'S HOSPITAL IMPROVED SCHEDULING FOR ITS MRI DEPARTMENT AND REDUCED WAITING TIME FROM 25 DAYS TO 2 DAYS

SEATTLE CHILDREN'S HOSPITAL BEGAN TO DO MORE SURGERIES ON FRIDAYS SO AS TO USE BEDS THAT WERE FREE ON THE WEEKENDS, THEREBY USING ITS CAPACITY MORE EFFICIENTLY

A SURGICAL FACILITY IN BELLVUE WASHINGTON RESDESIGNED PATIENT AND SUPPLY FLOWS AND WAS ABLE TO REDUCE THE PATIENT AREA NEEDED IN A NEW BUILDING, THEREBY ALLOWING IT TO SAVE $20 MILLION FROM THE ORIGINAL COST ESTIMATE

Source: Julie Weed, "Factory Efficiency Comes to the Hospital," *The New York Times*, 9 July 2010

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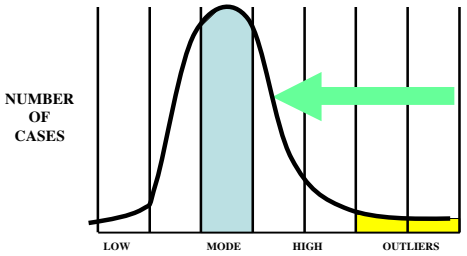
DISEASE MANAGEMENT STRATEGIES FOCUS ON RESOURCES PER CASE, BUT . . .

. . . TO CHANGE RESOURCES PER CASE YOU MUST INVOLVE PHYSICIANS.

HOW DO YOU DO THAT?

AN EXAMPLE OF PHYSICIAN RESPONSIBILITY



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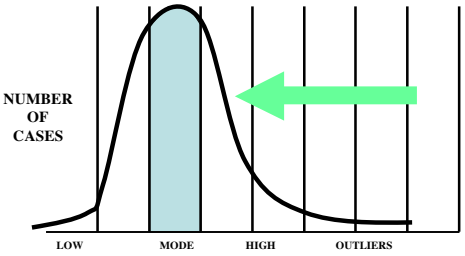
AN EXAMPLE OF PHYSICIAN RESPONSIBILITY



COST PER CASE

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Example of New Inpatient Utilization Pattern

48 YEAR OLD PRESENTING WITH ATYPICAL CHEST PAIN, POSITIVE SMOKING AND FAMILY HISTORY, AND NORMAL EKG

CURRENT PATTERN		OPTIONAL PATTERN	
Admit to Telemetry ALOS = 2.2 days	$2,800	Admit to Observation Unit ALOS = 23 hours	$1,000
Daily EKG x 3	$225	EKG x 2	$150
Enzymes and Full Bloods	$175	Enzymes and Limited Bloods	$75
Cardiology Consult	$150	Cardiology Consult	$150
Echo	$350	Echo	$350
Thallium Stress Test	$450	Non-Thallium Stress Test	$125
TOTAL COST	$4,150	TOTAL COST	$1,850

AT AN INCIDENCE RATE OF 5/1000, THE PURCHASER WOULD SAVE $3.5 MILLION ANNUALLY

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Treatment for Long-Term Chronic Conditions in Last 2 Years of Life Quality of Care is Rated Similar

Most Aggressive Care NYU Langone Medical Center New York		Most Conservative Care Scott & White Memorial Hospital Texas	
Days in Ward	42	Days in Ward	12
Days in ICU	12	Days in ICU	4
Primary Care Visits	34	Primary Care Visits	23
Specialist Visits	97	Specialist Visits	18
Dollars Spent	$105,067	Dollars Spent	$44,090

More than double!

Source: Wennberg, John E. et. al., *Dartmouth Atlas of Health Care*, 2008

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Low Cost Lessons from Grand Junction, Colorado

Medicare Results Compared to Population Overall

Health status	Worse than some areas with higher Medicare costs
CABG surgeries (2005)	60%
Inpatient coronary angiographies (2005)	55%
Inpatient days during last 2 years of life (2005)	61%
Use of Medicare services (2009)	81%
Position among 404 U.S. geographic areas for service use (2009)	9th
Per enrollee expenditures for Medicaid beneficiaries (compared to state average)	37%
Family doctors (versus national average)	185%
Days in hospital during last 6 months of life	60%
Days in hospice	174%
Deaths in hospitals	50%

Explanatory Factors

1. Leadership by the primary care community (culture of incentives for cost control)
2. Payment system involving a risk pool for PCPs (15% withhold)
3. Data on cost profiles for specialists (reduced referrals to high resource utilizers)
4. Physician fees for Medicaid equal to those for other patients (led to reduced use of ED)
5. Regionalization of services (one tertiary care hospital that is fed by secondary hospitals)
6. Primary care providers paid for inpatient visits (led to improved continuity of care)
7. Robust end of life care (including an emphasis on hospice services)

Source: Bodenheimer, Thomas, and David West, "Low Cost Lessons from Grand Junction, Colorado," *New England Journal of Medicine*, September 30, 2010.

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BUT THAT'S ONLY THE FIRST TASK: BUILDING THE BUDGET AND MAKING THE TRADEOFFS TO BRING IT INTO BALANCE WITH AVAILABLE RESOURCES.

BUT . . .

. . . ANYONE CAN BALANCE A *BUDGET*
THE HARD PART IS BALANCING THE *ACTUALS*!

HOW DO YOU DO THAT?

AMONG OTHER THINGS, YOU ALSO NEED A WELL-DESIGNED REPORTING SYSTEM

YOU NEED TO COMPUTE THE VARIANCE BETWEEN THE STANDARD (IN THE BUDGET) AND THE ACTUAL

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SPENSER REHABILITATION HOSPITAL REPORTING HIERARCHY
(In Thousands of Dollars)
For Month of June 2002

FIRST LEVEL REPORT: MACRO PROGRAM ANALYSIS
For Board and Senior Management

Surplus (Deficit)	Actual This Month	Actual Year to date	Over or (under) budget This Month	Over or (under) budget Year to date
Inpatient-Weberg	$2,110	$12,030	$(315)	$35
Inpatient - SRH	**24,525**	**147,280**	**(710)**	**(2,590)**
Outpatient	1,235	7,570	(125)	(210)
Research	1,180	7,045	95	75
Education	3,590	18,960	(235)	35
Ambulance	4,120	25,175	160	(320)
Development	2,245	13,680	180	(160)
Administration	3,630	22,965	(70)	(730)
Total direct	$42,635	$254,705	$(1,020)	$(3,655)

VARIANCE ANALYSIS — Contribution Margin: Revenue Price; Revenue Payer Mix; Expense Volume/Mix; Expense Volume/Mix; Net. Expense: Utilization; Unit Cost

(50) (320) 150 (90) 60 (250) (150)

(710)

SECOND LEVEL REPORT: PRODUCT LINE ANALYSIS
For Board and Senior Management

Inpatient - SRH	Actual This Month	Actual Year to date	Over or (under) budget This Month	Over or (under) budget Year to date
Product Line				
Brain Injury	$5,340	$35,845	$(625)	$(1,380)
Spinal Cord Injury	**3,210**	**19,605**	**(30)**	**(620)**
Stroke Rehabilitation	3,115	18,085	90	175
Post-polio Rehabilitation	5,740	33,635	(65)	(340)
Pediatric Rehabilitation	7,020	40,110	(80)	185
Total direct	$24,525	$147,280	$(710)	$(2,590)

VARIANCE ANALYSIS — Contribution Margin: Revenue Price; Revenue Payer Mix; Expense Volume/Mix; Expense Volume/Mix; Net. Expense: Utilization; Unit Cost

(10) (50) 200 (100) 100 (50) (20)

(30)

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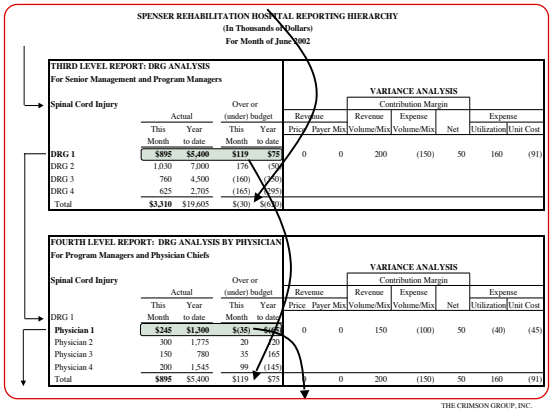

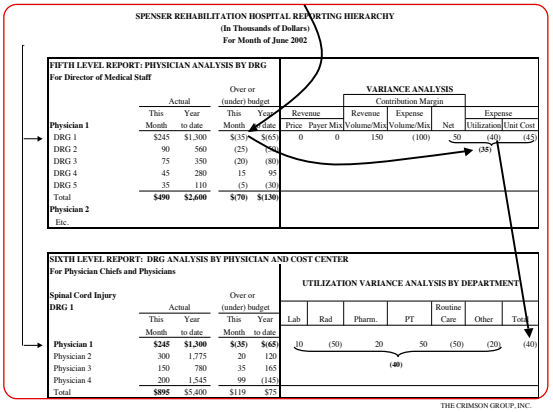

IF YOU CAN'T REPORT ON ACTUAL RESULTS IN THIS OR A SIMLAR WAY, DON'T BOTHER TO DEVELOP STANDARDS AND USE THEM TO BUILD A BUDGET

JUST PRAY!

THIS IS CALLED THE "GOD WILL PROVIDE" THEORY OF MANAGEMENT

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IS IT HARD TO BUDGET AND REPORT SO AS TO PLAN AND MANAGE COSTS BETTER?
YES

CAN IT BE DONE?
YES

IS IT NECESSARY TO ASSURE THAT A LHU DOES THE BEST JOB IT CAN OF PROVIDING HEALTHCARE SERVICES TO THE POPULATION FOR WHICH IT IS RESPONSIBLE?

YES

SO . . . WHY ISN'T IT BEING DONE?

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IT WAS TRIED ONCE, AND IT COULD BE TRIED AGAIN
FOR DETAILS ON THE LAST EFFORT SEE:

Centro Italiano Sviluppo*

A €5 million experimental project that involved 10 local health units situated in 4 regions of Northern Italy that covered between 50,000 and 200,000 people.

At least two reasons why the project didn't succeed:

1. **Too many LHUs. One would have been enough to demonstrate the process and learn about the difficulties**
2. **They didn't have today's IT technology**

* Case study available from The Crimson Press Curriculum Center

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IT'S TIME TO TRY AGAIN
YOU ARE RUNNING OUT OF TIME

GOALS OF THE PROJECT

1. **Link decision making between the territories and the hospitals**
2. **Change the financing methodology to provide incentives to shift care to the outpatient side whenever appropriate**
3. **Build inpatient and outpatient budgets using activities and standards**
4. **Develop reports on actual performance that compute variances, and that have an action orientation**
5. **Decentralize operational decision-making within the hospitals and territories to those close to the action, *including physicians***

Then, when you have done this for several months,
and when you have some good data . . .

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Consider which services and activities can be centralized at the regional level so as to increase efficiency and enhance consistency from one LHU to the next

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THANK YOU!

PLEASE SHARE YOUR THOUGHTS

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