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The Healthcare Value Conundrum Explained

John Davidson, MBA, PA-C
Sr. Director, Advanced Practice Providers
NYU Langone Health

Disclosures

I have no relevant relationships with ineligible companies to disclose within the past 24 months.

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Education Objectives

At the conclusion of the session participants should be able to:

- Define the healthcare value equation
- Identify actionable plans to improve healthcare value
- Describe the way in which PAs and NPs contribute to value in healthcare

How do you define value?

VALUE=QUALITY/COST

Quality

CROSSING THE QUALITY CHASM

A New Health System for the 21st Century

Committee on Quality of Health Care in America

INSTITUTE OF MEDICINE

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Aims for the 21st Century Healthcare System

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

Redesign Health Care

- Systems thinking
- Prioritize needs of patients, health care staff, and the community
- Evidence based decisions
- Respect societal values and priorities
- Integrated and coordinated care
- Anticipatory and predictive use of technology
- Promote integrity, stewardship, and accountability
- Transparent and easy navigation
- Empower patients and health care staff
- Collaboration between patients and health care staff
- Driven by continuous feedback, learning, and improvement
- Resource and support a multidisciplinary approach
- Invested leaders

"Summary." National Academies of Sciences, Engineering, and Medicine. 2018. Crossing the Global Quality Chasm: Improving Health Care Worldwide. Washington, DC: The National Academies Press. doi: 10.17226/25152

Health Care Quality Measures

Structural	Process	Outcome

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The Joint Commission


NCQA
Measuring quality.
Improving health care.


CMS.gov
Centers for Medicare & Medicaid Services


NATIONAL
QUALITY FORUM
Driving measurable health
improvements together


AHRQ
Agency for Healthcare
Research and Quality


AMA


urac®

Cost

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“We have to be weaned from this volume-driven system, and no longer asking, ‘How much did we do today?’ but ‘How much did we help today?’ ”

- **Donald Berwick, MD, MPP**

President Emeritus and Senior Fellow, Institute for Healthcare Improvement; Former Administrator of the Centers for Medicare & Medicaid Services

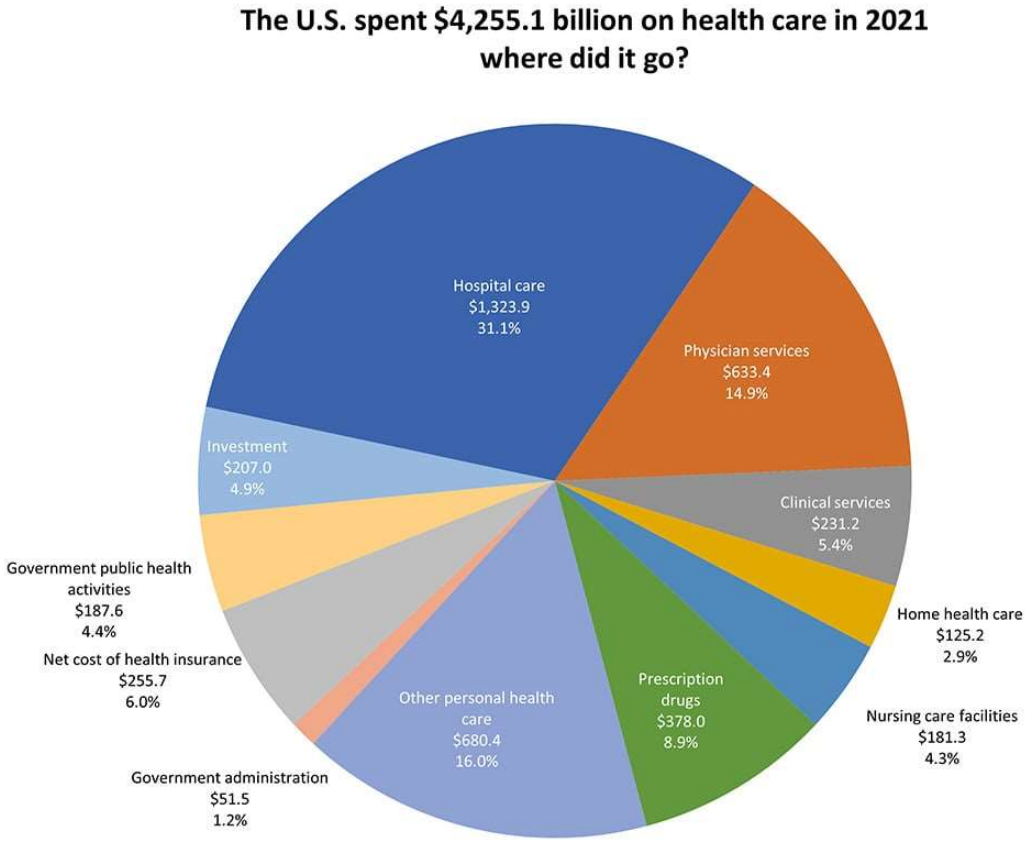
Americans' Challenges with Health Care Costs

Lunna Lopes, Marley Presiado, and Liz Hamel

Published: Dec 21, 2023

For many years, KFF polling has found that the high cost of health care is a burden on U.S. families, and that health care costs factor into decisions about insurance coverage and care seeking. These costs rank as a top financial worry and health care affordability is one of the top issues that voters want to hear candidates talk about during the 2024 election. This data note summarizes recent KFF polling on the

https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/



https://www.ama-assn.org/about/research/trends-health-care-spending

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Case Study

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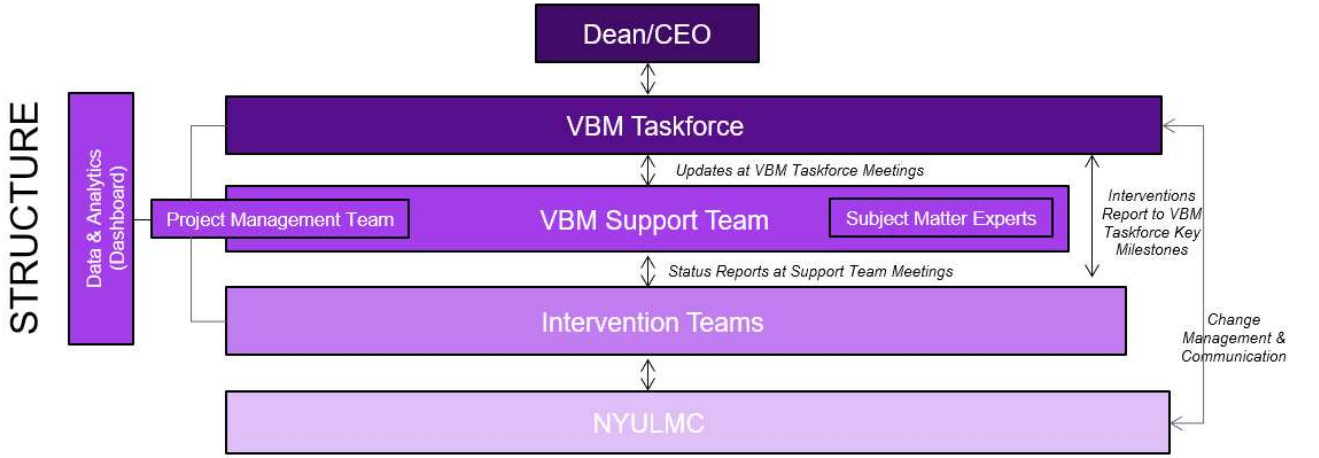
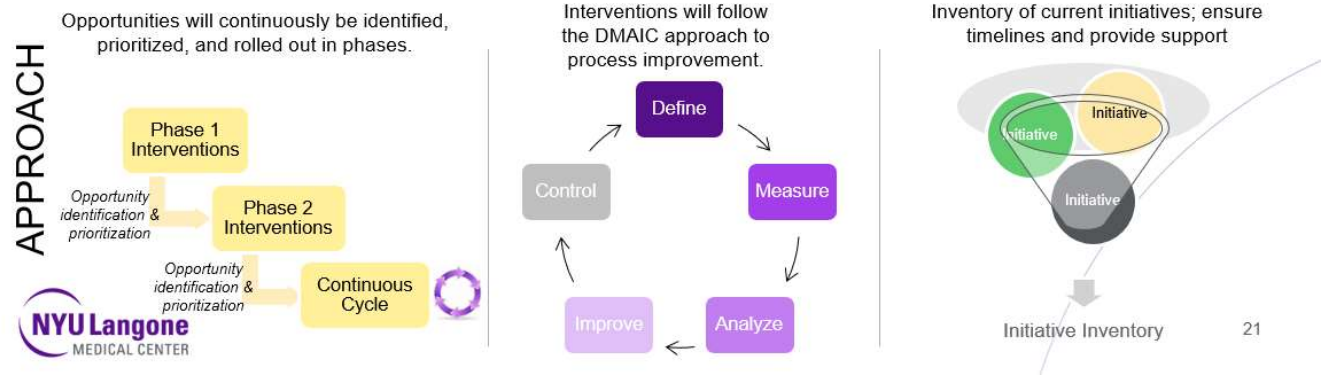
How did we do it?

- Executive sponsorship
- Institutional support
- Dedicated resources
- Data/metrics
- Shared incentives

VBM Structure and Approach





Example: VBM Initiatives

For Discussion Purposes Only

$$Value = \frac{Quality}{Cost}$$

VBM Surgical Committee Initiatives

	Initiative	Expected Impact	DMAIC Phase
	High Potential Initiatives		
1	**Supply Chain Strategic Partnerships and Alignment**	• **Establishing strategic partnerships with major vendors and alignment with organizational priorities**	**Define**
	Current Initiatives		
1	**Clinical Pathways (Colon, ENT, Lap Sleeve)**	▪ **Standardizing care for select surgical procedures has resulted in significant reductions in LOS, and consequently cost**	**Control**
2	Routine Post Op Rule Out MI Reduction	▪ Clinical guidelines outlining appropriate utilization of Post Op MI Rule Out labs (i.e. troponin and EKG) will reduce the prevalence of unnecessary labs, prevent potential overutilization of care (in terms of consults, monitored bed time, etc.), and drive cost reduction	Control
3	Appropriate Utilization of Care Settings	▪ By transitioning additional patient populations to ambulatory surgery centers, we can better utilize care settings and create capacity for higher acuity cases in Tisch and HJD ORs	Control
4	Reprocessing	▪ Reprocessing products that are intended for single use reduce supply costs (compared with the alternative of purchasing of OEMs)	Control
5	**Preference Cards**	• **Improving variation across preference cards for like procedures will drive reduction in supply waste and cost across all NYULMC ORs**	**Improve**
6	**Guided Patient Services (GPS)**	• **Creating a standardized pre-operative outreach process to manage patient expectations for LOS, thereby increasing patient satisfaction, reducing LOS, and reducing variable direct costs**	**Improve**
7	Surgical Case Request Enhancement	• Create more efficient process for scheduling surgeries on EPIC	Improve
8	Predictive O/E LOS Tool	• Creating a real-time O/E LOS trigger within Epic will not only improve clinical documentation, but facilitate more effective discharge planning	Improve
9	Surgical Clinical Documentation	• Revising the model for clinical documentation across surgical services (establishing NP/PA Clinical Documentation liaisons, etc.) will help drive revenue and better represent patient CMI	Improve
10	Supply Chain: Supplier Pricing and Standardization	• Exploring opportunities to improve supplier pricing and utilization through contract negotiations and supplier standardization	Improve
11	Hospitalist Co-management of Surgical Patients	• Identifying triggers for the co-management of surgical patients will improve care for complex surgical patients, and subsequently reduce LOS	Improve
12	Long Term Acute Care Hospital Utilization	• By better utilizing LTACH facilities, we provide a strategy for caring for critically ill patients in a safe and more appropriate manner	Improve
13	**GI Bleed Protocol**	• **Providing clinical guidelines for the interdisciplinary management of GI bleeds would improve efficiency of care as well as clinical outcomes across various specialties (Medicine, Gastroenterology, Acute Care Surgery, Colorectal Surgery, and Interventional Radiology)**	**Improve**
14	Length of Stay Reduction for ACDF and Fusions and ACF Patients	• Improving operational workflows for the discharge of ambulatory patients and inpatients will reduce the length of stay for ACDF and ACF patients	Improve

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Example: Clinical Pathway Charter

Charter Summary For: Clinical Pathways for Head and Neck Service

DRAFT

$$Value = \frac{Quality}{Cost}$$

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Mission: To improve clinical outcomes, while reducing variability and length of stay for the Head and Neck service by developing a clinical pathway.

Project Dates:
DMA: TBD
IC:

Background/Problem Statement: The Head and Neck service has seen an increase in level of acuity, which has resulted in an increase in length of stay. In order to more efficiently treat these cases, a series of clinical pathways has been developed.

Sponsor(s): Dr. Robert Press, Dr. Paresh Shah

Champion(s): Dr. Thomas Roland

Objectives:
- To create a standardized process of care for inpatient head and neck cases (radical neck dissection, total laryngectomy, and total thyroidectomy).
- To build and implement an evidence-based, best practice pathway for these head and neck cases.
- To successfully implement the pathway and obtain buy-in from attending surgeons, residents, NPs, PAs, nurses, care managers, social workers, etc.
- Influence and reduce variability with respect to key metrics on these head and neck cases, including: length of stay, readmissions, and variable direct cost.

Team Leader(s): Dr. Mark Persky

Team Members:
- Head and Neck APP(s)
- Head and Neck Care Management
- Head and Neck Nursing

Value Proposition:
Efficiency Metrics: Average Length of Stay, O/E LOS, Variable Direct Cost
Quality Metrics: Readmissions
Neck Dissections: Decreased incidence of postoperative atelectasis with concentration on incentive spirometry, chest PT and early mobilization of patient.
Thyroidectomy: improved management of hypocalcemia and associated symptoms, postoperative airway observation improved, earlier recognition of postoperative hematoma representing a potential airway compromise.
Total Laryngectomy: Earlier initiation of patient self-care of tracheostoma, earlier intervention of social worker to provide home care so necessary in postoperative period

Subject Matter Experts:
- Dr. Jonathan Austrian (Epic)

Scope: Inpatient Neck Dissections, Thyroidectomy, and Total Laryngectomy cases at Tisch

VBM or Departmental PM(s): TBD

Develop Measurement Metrics

Immediate Focus Areas to Drive OR Efficiency

Focus Area	Project	Description	Metrics
Scheduling of Surgical Cases	Locking the Schedule	• No changes allowed after 2pm day prior • Scheduling changes only allowed if procedure type does not change	• # scheduling changes made*
Scheduling of Surgical Cases	Case Requests	• All surgeons to utilize Epic case request and case entry workflow • Surgeons to enter estimated OR case time • Surgeons to enter estimated blood loss	• % cases booked with case request form** • Scheduling accuracy
Instrument Processing	Instrumentation	• Instrumentation picked for 1st case night prior • Disposable supplies picked for 1st case night prior	• on-time and accurate case cart delivery
Instrument Processing	Preference Cards & Instrumentation	• Surgical divisions to review preference cards for 3 most common procedures by department • Surgical divisions to review, reduce and consolidate instrument trays	• # trays reviewed • % instrument reduction • % tray reduction
Instrument Processing	Team Transparency & Accountability	• OR nurse to wash off instruments and repackage in containers prior to returning instruments to CSPD • OR nurse to place name card on case cart returning to CSPD • OR nurse to throw away all disposables	• % trays returned clean** • % trays returned with name card complete**
Transparency	CSPD Team	• CSPD staff who picked instruments to be noted in Epic (TBD) and accountable for accuracy	• % case carts with name cards complete**
Transparency	OR Team	• Scrub nurse and circulating nurse assignments to be posted night prior	
Transparency	SEQI	• Fully vet all complication wounds, infections, hospital acquired conditions and reported complications to ensure they are coded correctly • Incorporate these measures into department specific SEQI	• Surgeon's Efficiency and Quality Index (SEQI)

*Being tracked by OR schedulers (effective 10/22/18)

** Tracking mechanism to be developed and/or added to PMC analytics work group

Key Takeaways

1. Value = Quality/Cost
2. Quality of care has room for improvement
3. Current healthcare spending is not sustainable
4. Value improvement is possible
5. PAs & NPs must be involved in value improvement initiatives

References/Readings

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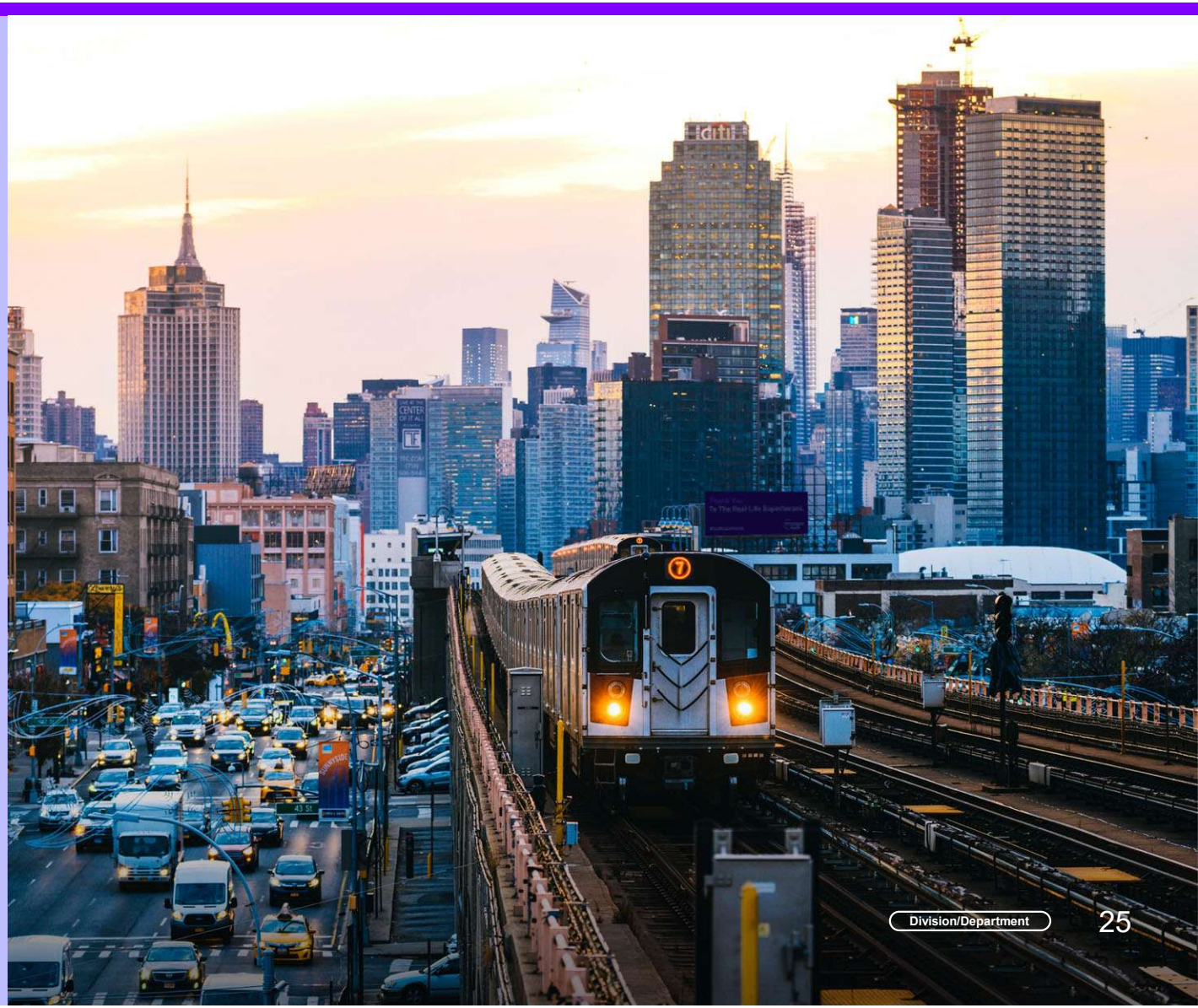
- https://nap.nationalacademies.org/read/10027/chapter/1
- https://www.ahrq.gov/talkingquality/measures/types.html
- Chatfield SC, Volpicelli FM, Adler NM, et al; Bending the cost curve: time series analysis of a value transformation programme at an academic medical centre; BMJ Quality & Safety 2019;28:449-458

Q&A



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Thank you