RUSH

Executive Briefings: Implementing Health Reform

Variation in Health Care: More than Geography

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RUSH IN BRIEF

Date founded	1837
Medical staff	890
Professional nursing staff	1,153
Residents and fellows	650
Employees	8,426

STAFFED BEDS

Rush University Medical Center	600
Johnston R. Bowman Health Center	58
Rush Oak Park Hospital	128

BIRTHS

Rush University Medical Center	2,054
Rush Oak Park Hospital	N/A

ADMISSIONS

Rush University Medical Center	30,699
Rush Oak Park Hospital	4,324

AVERAGE LENGTH OF STAY (DAYS)

Rush University Medical Center	5.74
Rush Oak Park Hospital	6.45

PATIENT DAYS

Rush University Medical Center	176,200
Rush Oak Park Hospital	27,877

OPERATIONS PERFORMED (inpatient and outpatient)

Rush University Medical Center	20,405
Rush Surgicenter	5,231
Rush Oak Park Hospital	4,899

EMERGENCY ROOM VISITS

Rush University Medical Center	47,767
Rush Oak Park Hospital	21,807

RUSH

About Rush University Medical Center

An academic medical center based in Chicago

Health sciences university

Recognized for quality, ambition to be a leader

What did we set out to do?

- Slow down growth in expenses
  - "bend the cost curve"
- Find opportunities for growth in revenue
- Intrigued by the notion of variations
  - Do local variations in care affect cost and quality?
  - Can we reduce variations not driven by patient needs?

Context for our work

- External
  - Payment reform, healthcare reform
  - Dynamic market, many local players
- Internal
  - Strategic focus on quality, safety and efficiency
  - Campus transformation – new Tower
  - Investment in electronic health record

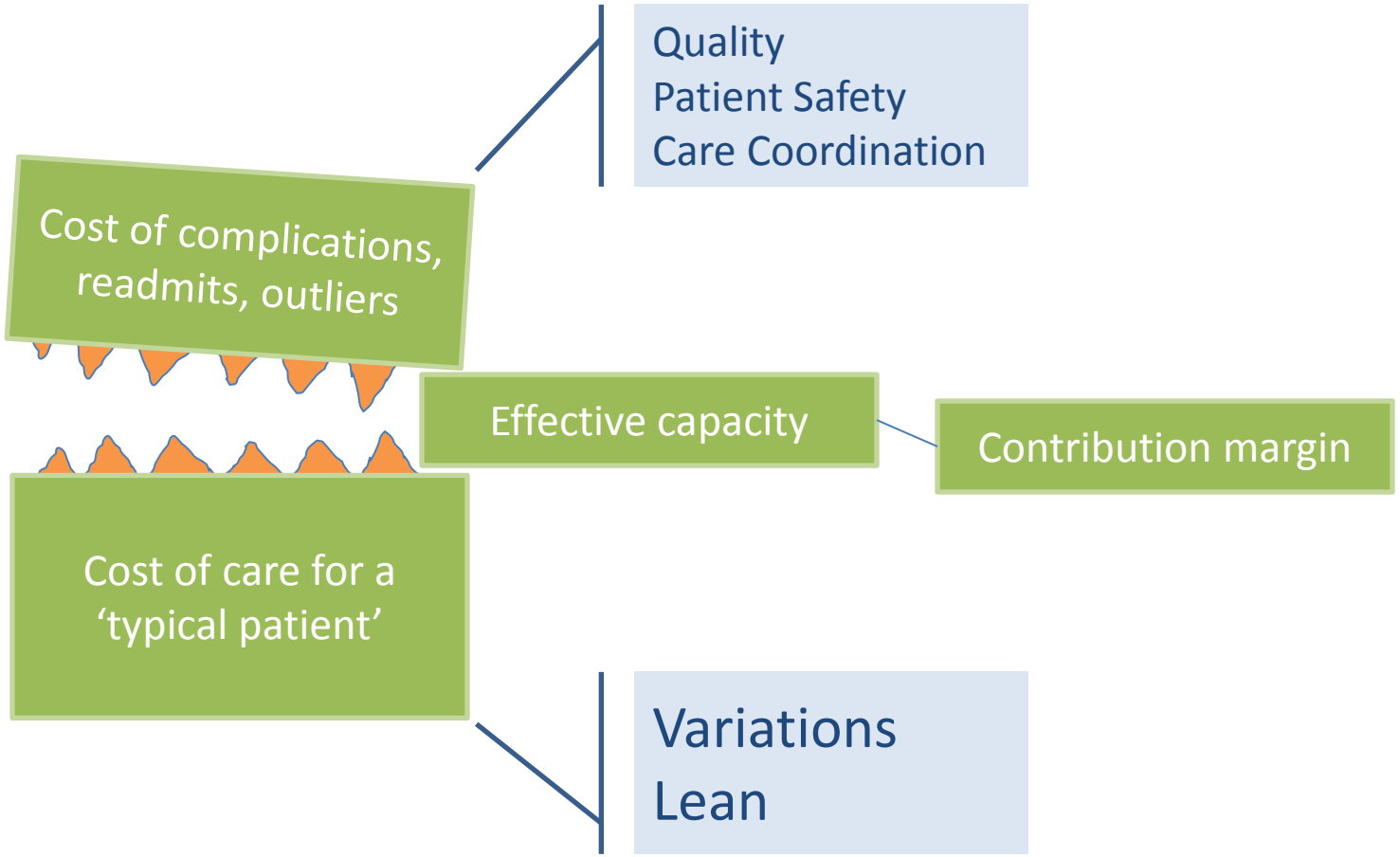
Guiding principles

- Maintain or improve quality and safety
- Prepare for payment reform and emerging reimbursement models
- This is not a short-term initiative, we want to hardwire new ways of thinking about care delivery

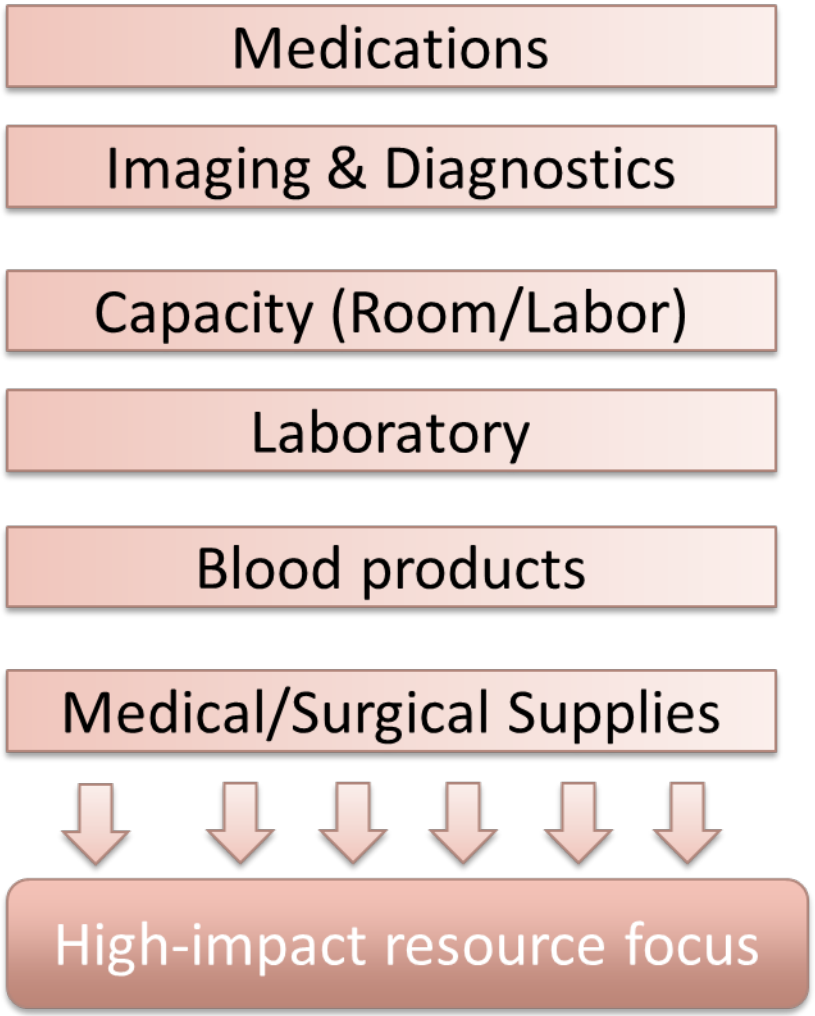
Approach

- Minimize variations unless driven by patient needs
- No “top down” mandate to “cut costs by x%”
- Initiatives led by physician leaders of clinical programs
- Multi-disciplinary teams, plus
  - Medical leadership, Quality and Finance

Taming the ‘cost dragon’



Cross-cutting initiatives focus on high cost

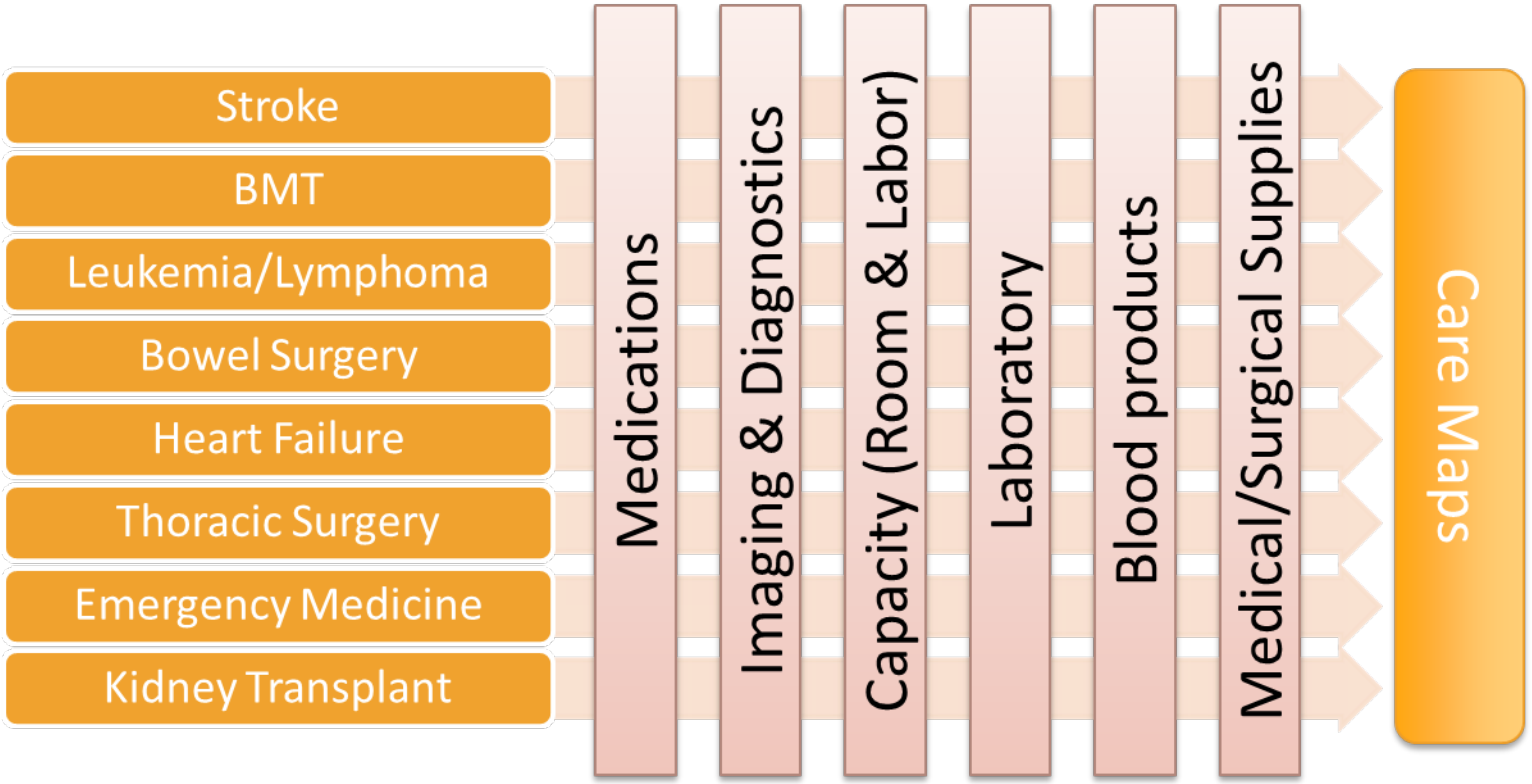


Examples:
Factor VIIa
Low molecular weight heparin
Fibrin sealants

Examples:
Red blood cells
Platelets

Examples:
Surgical staplers

Programmatic focus – quality, cost *and growth*



The unit of analysis is the program – easier to engage physicians; allows use of a systems approach and a chance to identify growth opportunities

Selecting programs

Definable clinical population

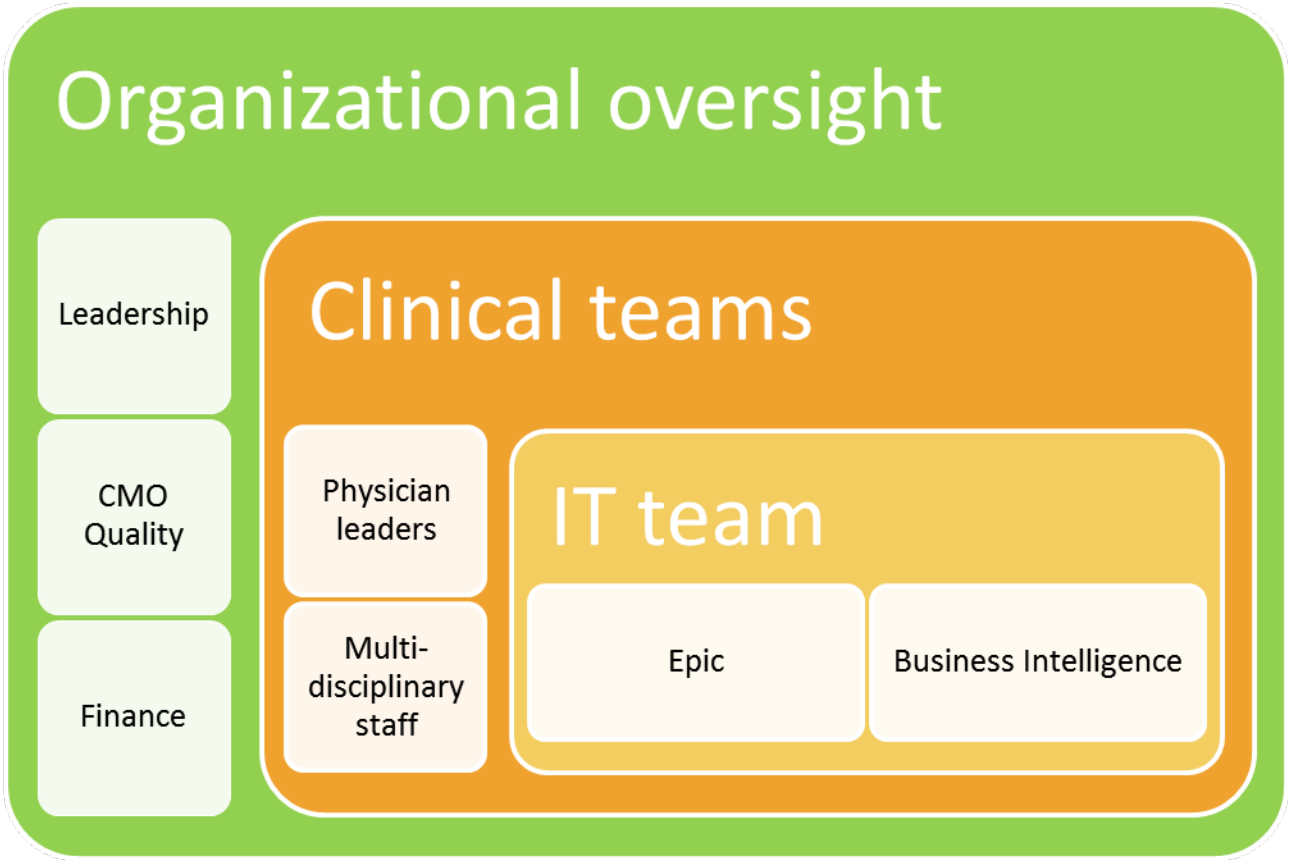
High-volume, and/or relatively high cost per case

Variations in resource use

Start with engaged physicians and staff

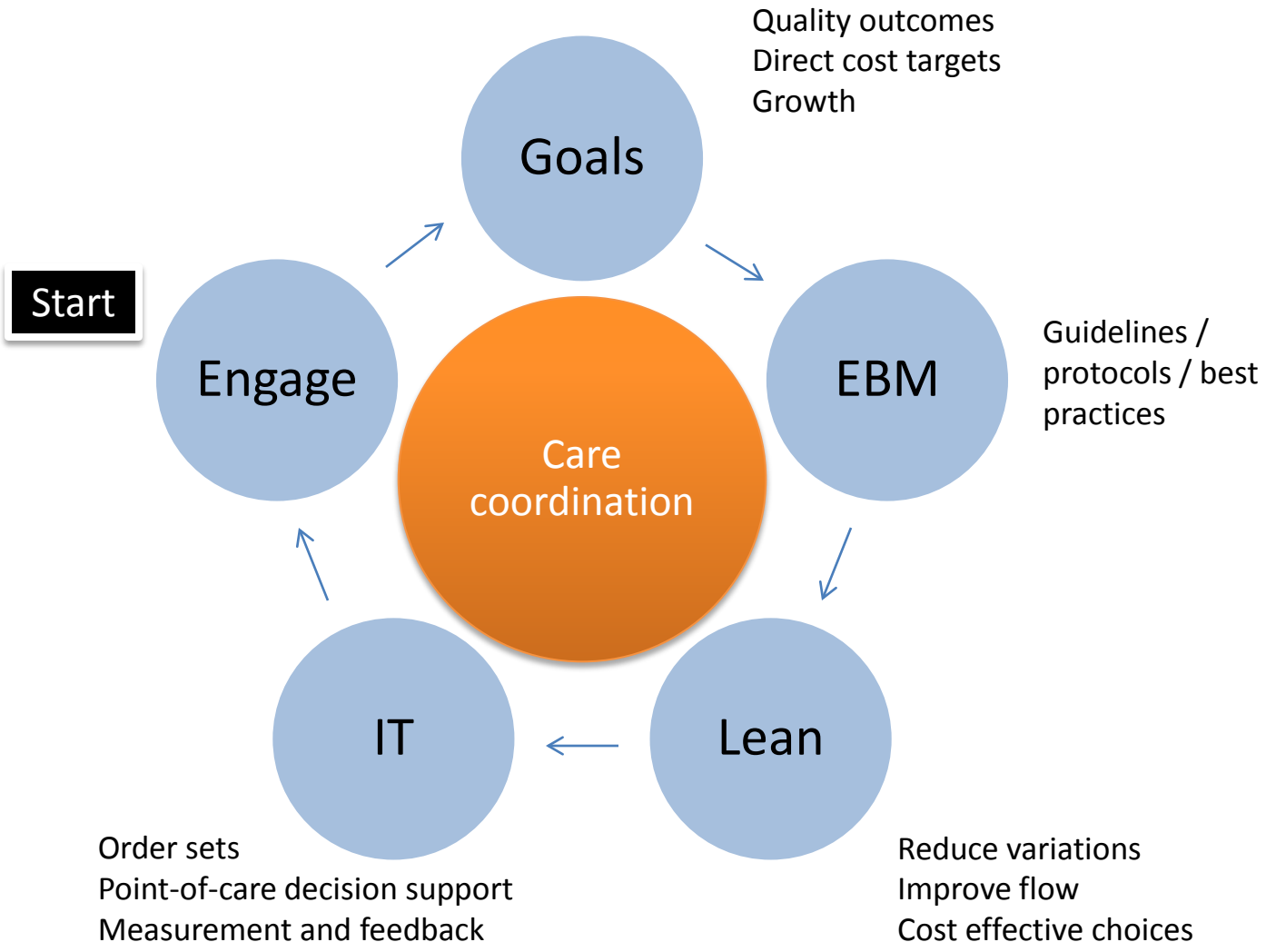
Message is clear: Being selected is not a bad thing

Management structure



Framework for action

Evidence-based, Lean Care Maps



Engaging physicians

Most physicians do not know how much treatments and tests cost

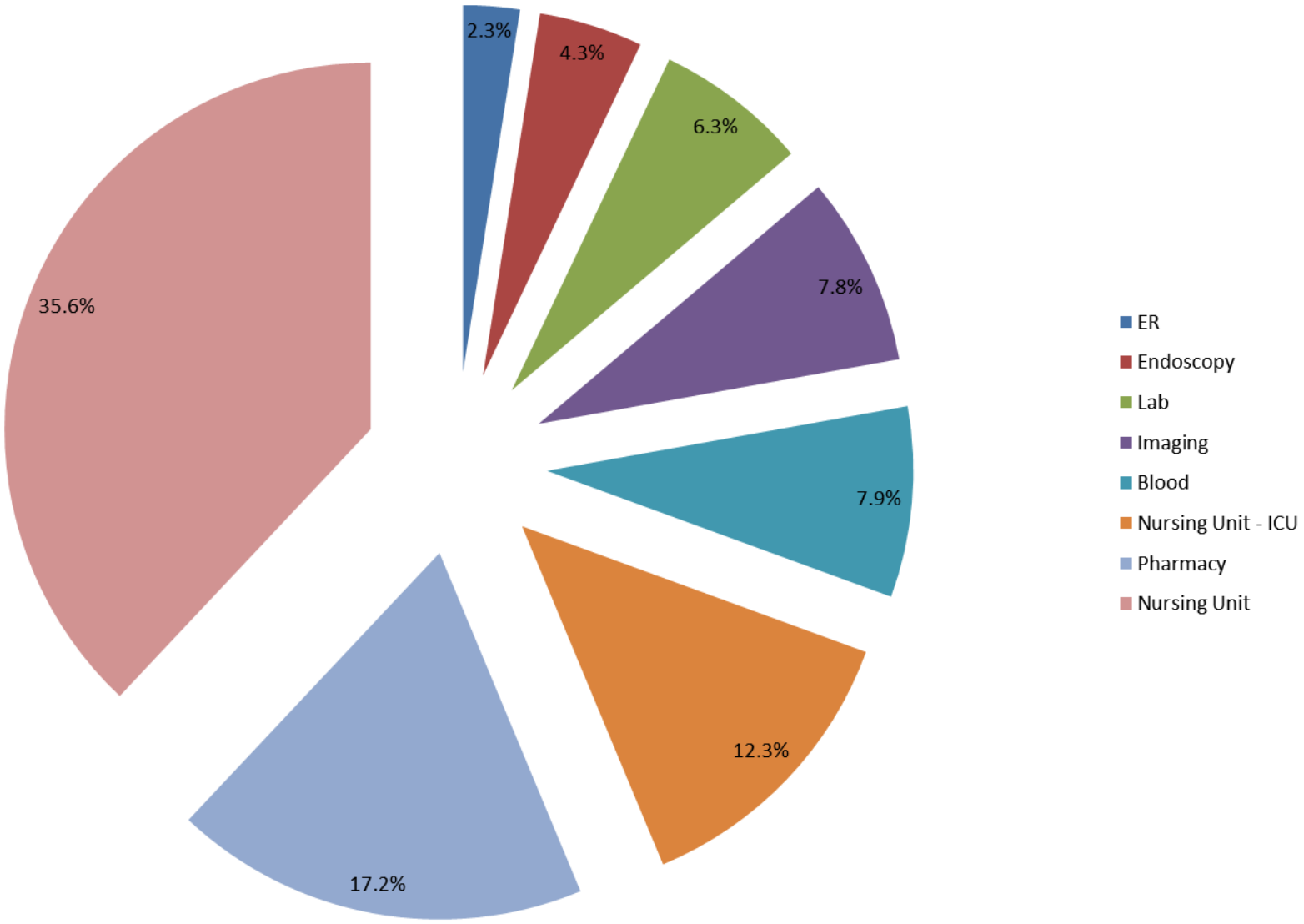
Start with "screening data" – crude, high-level

- Total direct cost for patient population
- Costs broken down by major components
  - pharmacy, nursing, laboratory, radiology, etc.
- Data on clinical outcomes

Ask for input, design analysis together
Invite peers who have gone through this to the kickoff

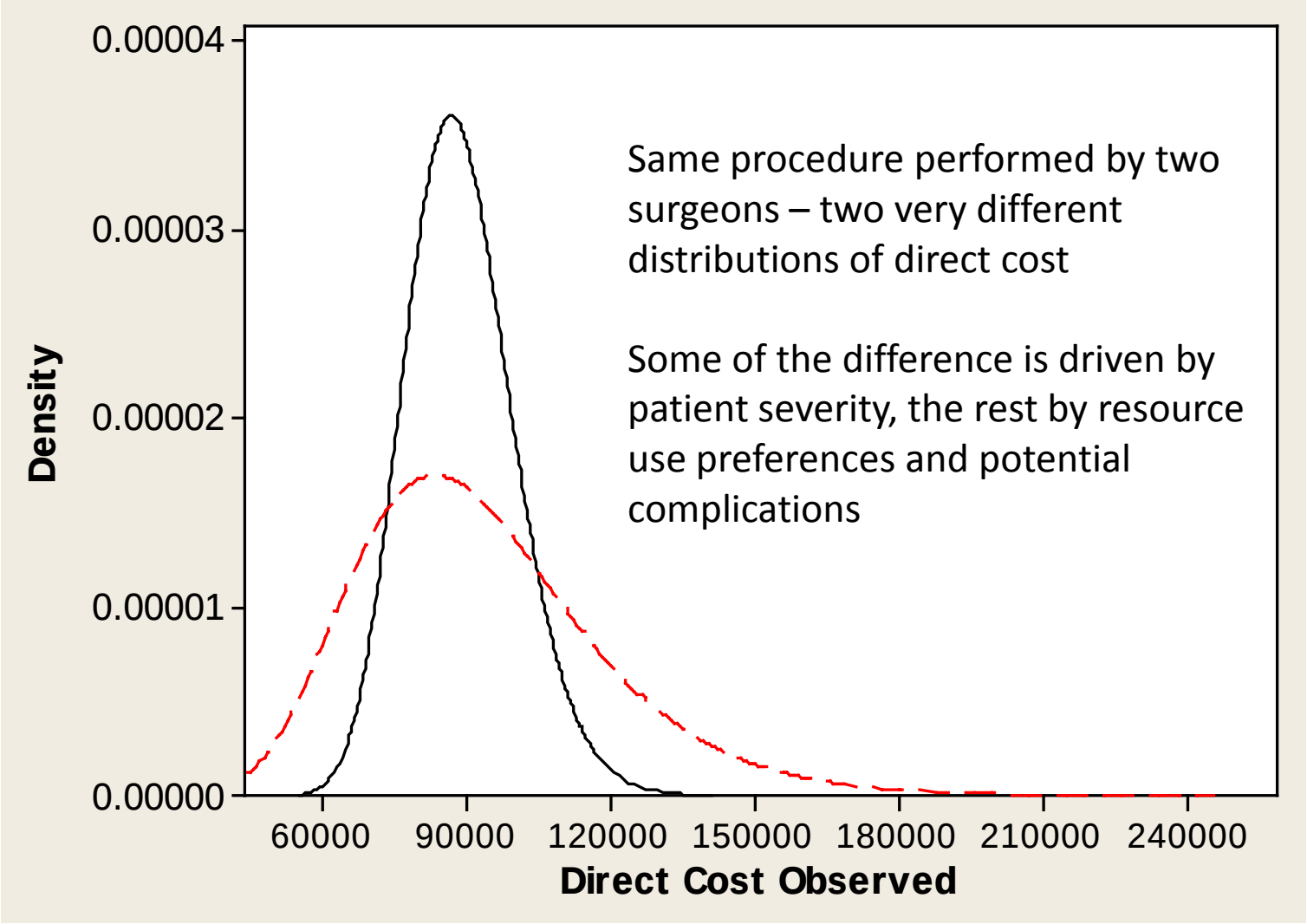
Tone cannot be "You are spending too much!"

Relative contributors to cost in Hepatology

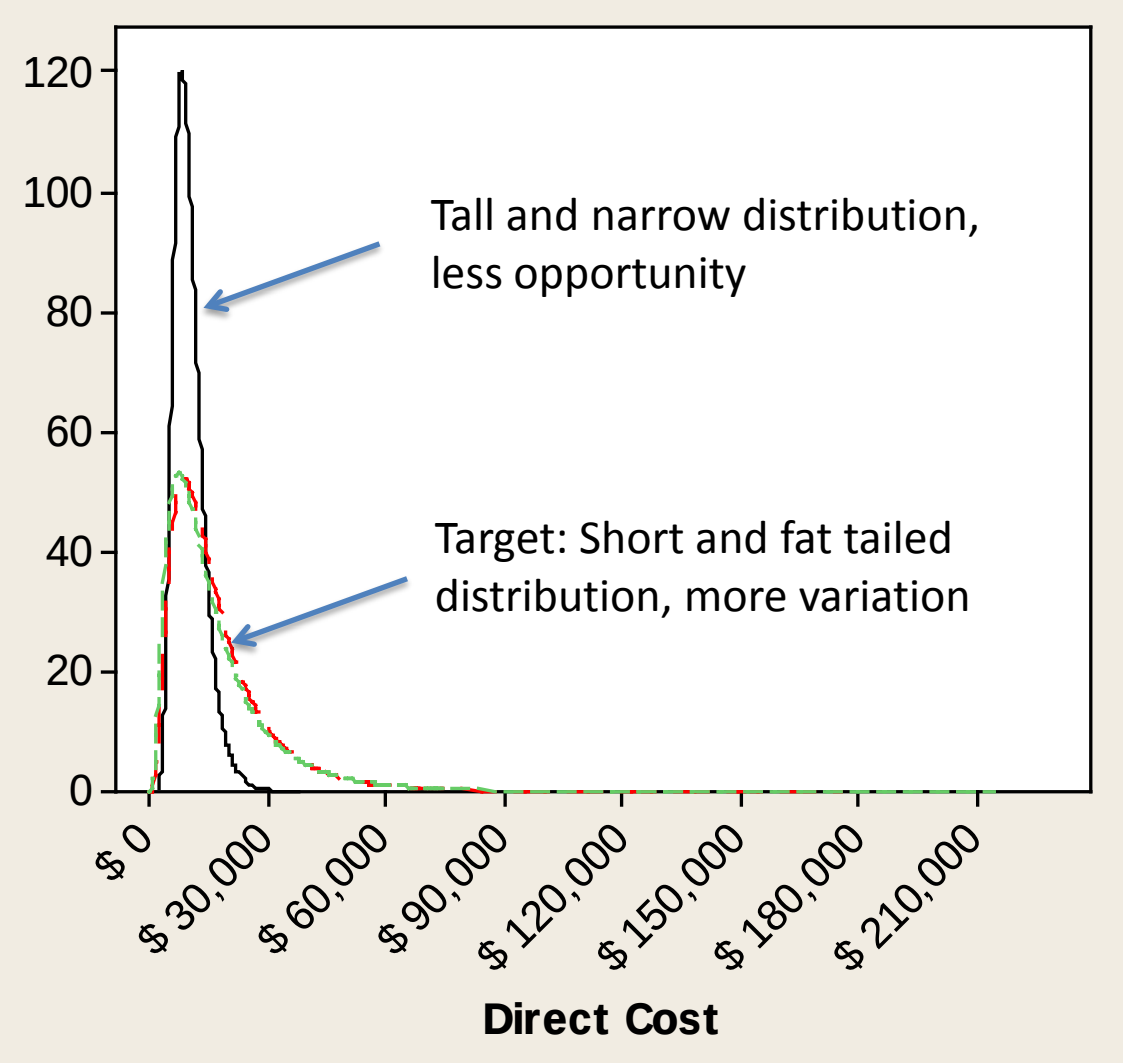


Use of data to understand variations and key drivers

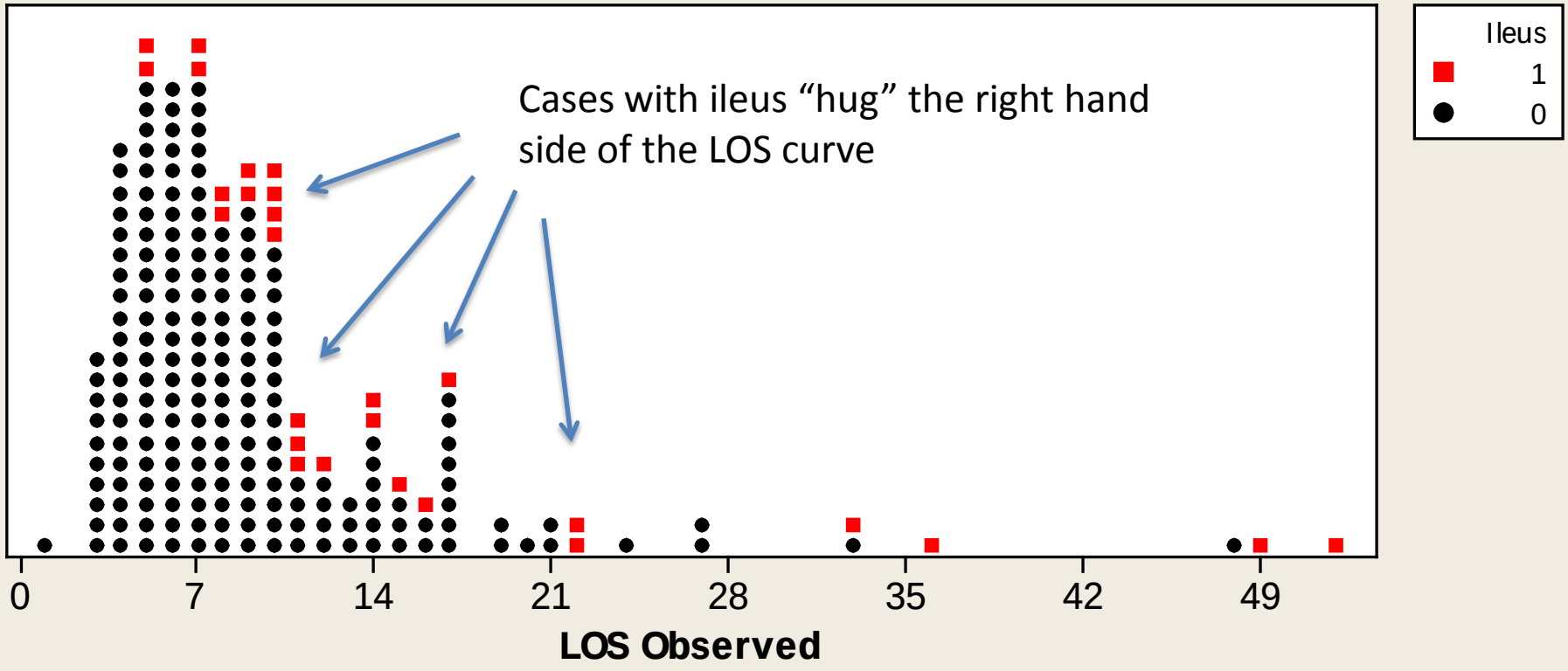
Physician-to-physician variations in cost



Finding target areas with greater variation and opportunity



Impact of *potential* complications: Distribution of post-op ileus cases



Action Plan Outline

Review quality, costs and current process

Identify evidence-based care standards

Reduce variations in practice and resource use not driven by patient needs

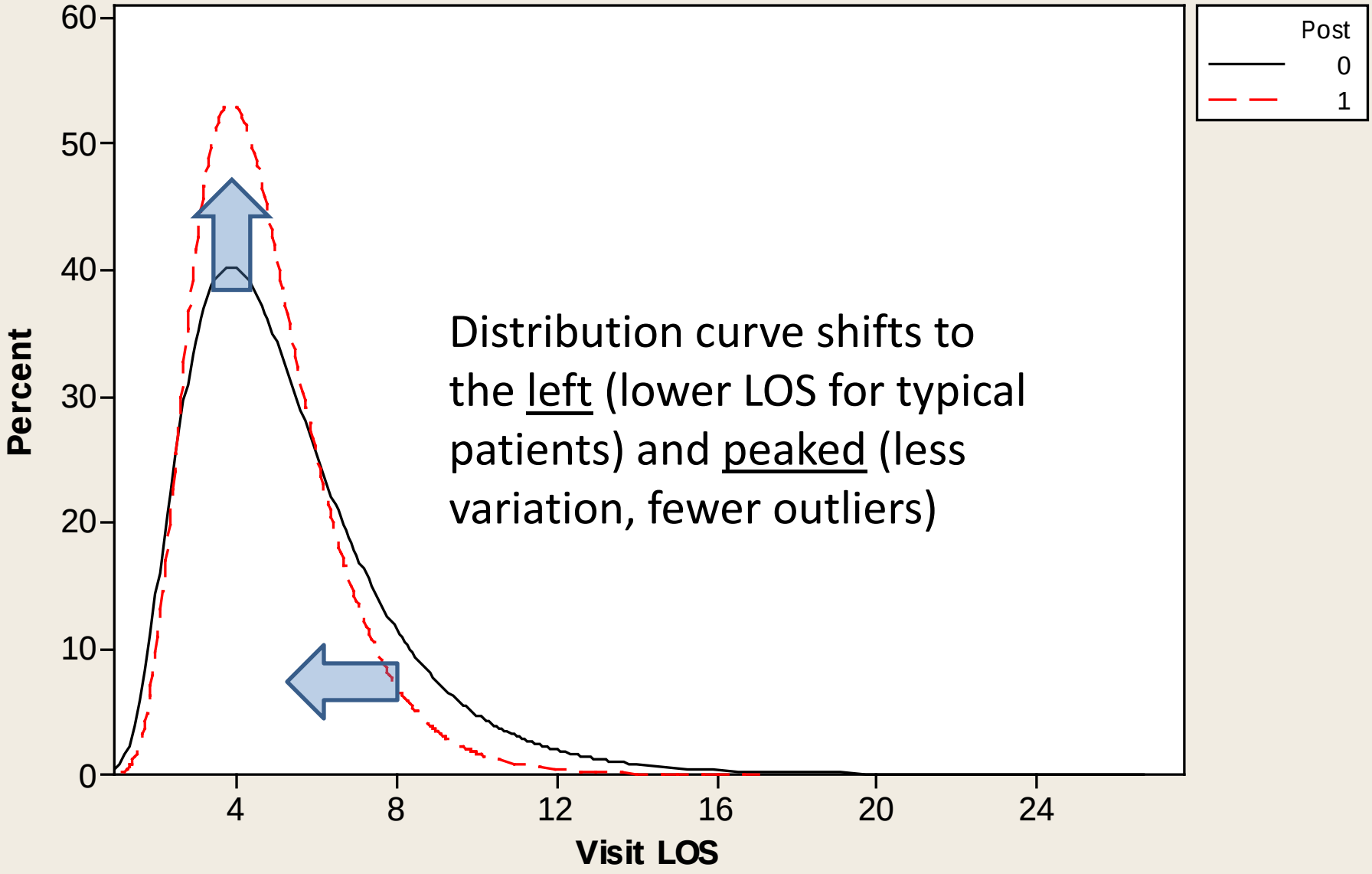
Improve efficiency, remove inefficiencies that do not add value to patient care

Hardwire and measure care standards, provide feedback

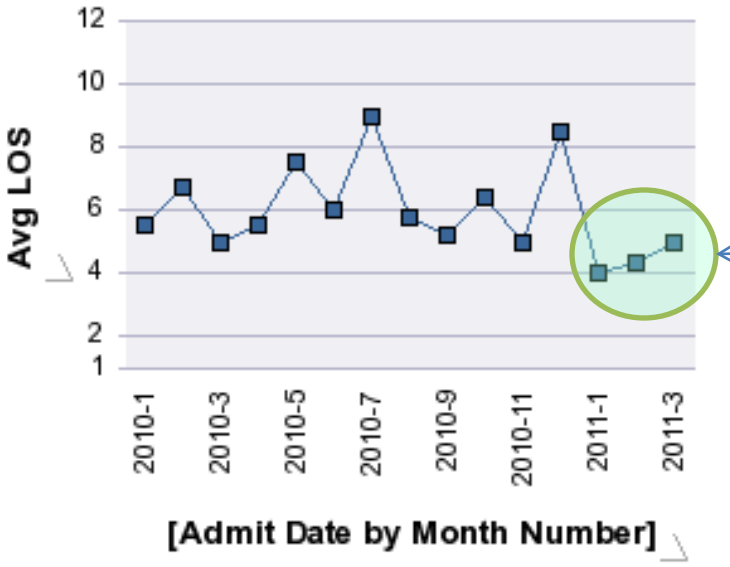
Lower expenses, quality impact positive or neutral

Examining impact

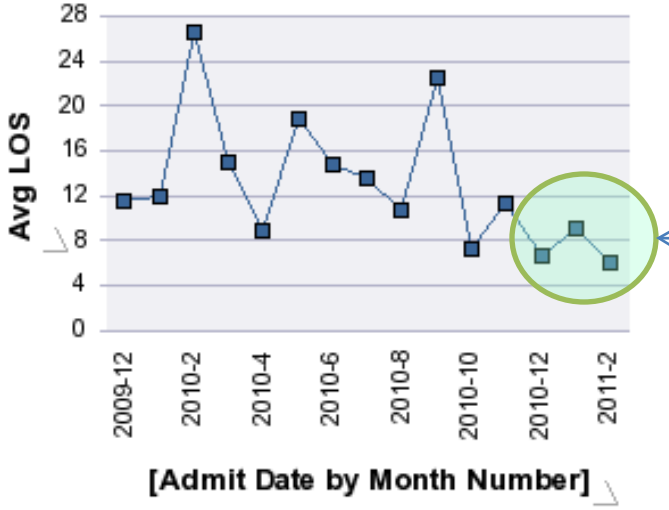
Are we making a difference? Laparoscopic colectomy (pre/post)



Bowel Surgery: Impact on Length of Stay

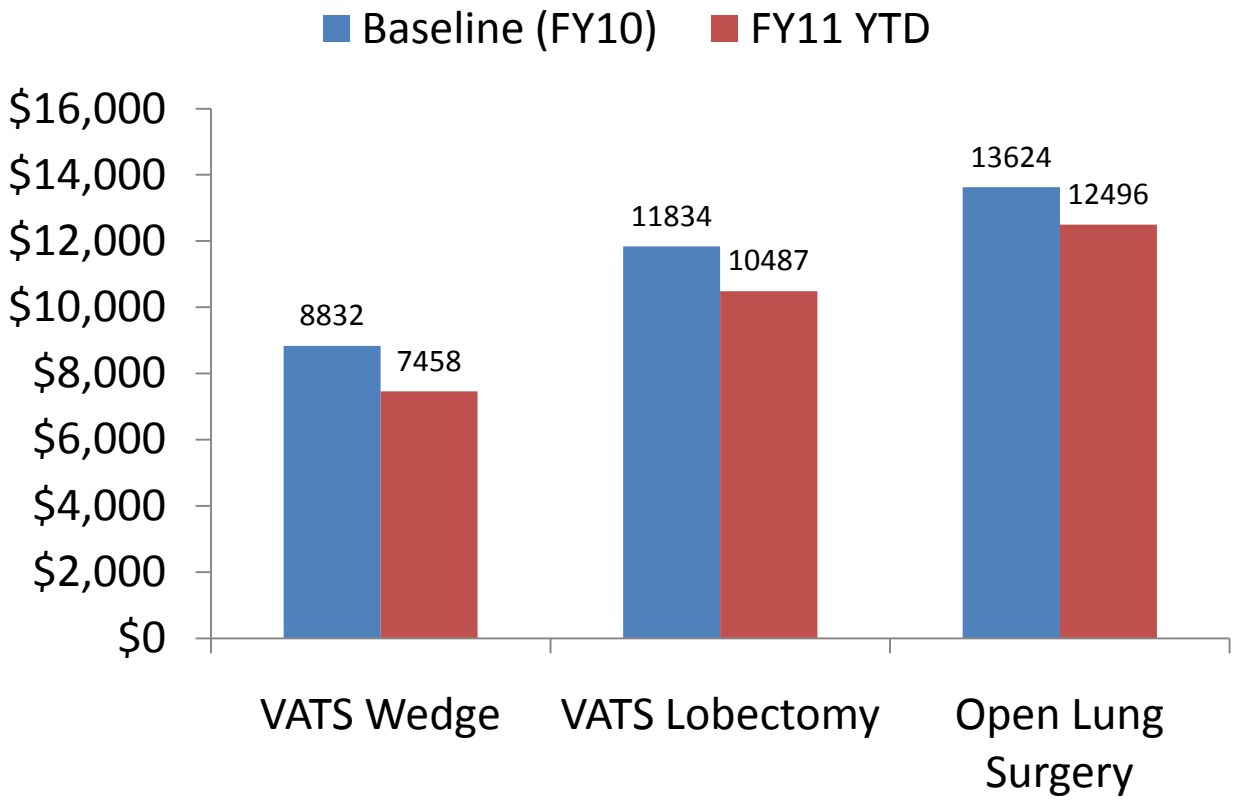


Laparoscopic colectomy:
Reduced average LOS; reduced variability after implementation of new protocols



Open colectomy:
Reduced average LOS; reduced variability after implementation of new protocols

Thoracic Surgery: Impact on direct cost per case (preliminary)



Reduction in direct cost per case of $1100-$1300 in each procedure group

Overall impact to date

- Financial impact in Year 1 and 2 over $5 million
- Examples of program-specific improvements
  - Reduced readmissions and central line infections in BMT
  - Reduced drug utilization in stroke, BMT
  - Lower LOS in bowel surgery, thoracic surgery
  - Program growth in stroke
- Gradual shift in culture

Key Lessons

- Reducing variations is only half of the game – new choices must be lean and hardwired
- Physician engagement is essential
- Instead of telling physicians what to do, ask what can be done differently – and provide support
- Medical leadership and collaboration with Finance are essential for success
- Internal benchmarks are good enough
- Don’t wait for perfect IT systems or perfect data, use what you have and get started