Case Study Discussion: Learning Activities in Health Systems

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Disclosures

I receive a monthly retainer from Health Catalyst as a part-time (3 days / month) Senior Advisor. I also own Health Catalyst stock.

Beyond that neither I, Brent C. James, nor any family members, have any relevant financial relationships to disclose.
Outline

1. A policy – with proper ethical oversight to embedded research

2. A way of thinking about research that fits into care delivery operations

3. Examples of results
Ethical Oversight Policy for Learning Projects

- AHRQ Hasting Ethics Center grant: The Ethics of Quality Improvement
  - published papers, a book, demonstration projects (MD Anderson Cancer Center, Intermountain Healthcare)

- Presented resulting “test” policy to SACHRP
  (Secretary’s Advisory Committee on Human Research Protections – oversees OHRP) on 27 March 2008

- Distinguishes traditional clinical research from quality improvement
  - QI deploys evidence-based best treatment; doesn’t compare treatments
  - allows clinicians to vary based on patient need (doesn’t interrupt the ethical clinician-patient link)

- Uses a Privacy Board (special type of an IRB established in HIPAA; structurally and functionally identical to an IRB)
  to oversee QI projects (off-loads regular IRBs)
  - almost always uses expedited review (with consent agenda back to the IRB/Privacy Board)

- Relies primarily on “detect controls” rather than “prevent controls”
4 “types” of clinical learning

1. **Rapid impact on care delivery performance** as measured in patient outcomes
   - the “best medical result at the lowest necessary cost”
   - internally funded with “patient-care” (operational) dollars
   - external grant funding, publication = “icing on the cake”

2. **Investigator-initiated research**
   - traditional academic model
   - funded through grants

3. **Collaborations with external investigators**
   - e.g., multi-center trials; investigators at local universities
   - requires an internal “champion”

4. **Industry-based groups** (e.g., big pharma; device manufacturers)
2015 “Type 1” learning production

- 399 articles published in peer-reviewed journals
- ~$688 million in reduced operating costs (13% of total cost of operations)
- Heavy use of quasi-experimental designs
  - cluster randomized and step-wedge designs are common
- Aim: “Evidence-based administration”
Team-Based Care
(3rd generation accountable medical home)

Emergency Room Visits: -11%
Hospital Admits: -22%
Other Avoidable Visits and Admissions: -21%
PCP Visits: +4%
Urgent Care Visits: +13%
Imaging Exams: -11%

An investment of $22 per-member-per year (PMPY) decreased medical expenses by $115 PMPY