Who was the Shooter’s Doctor?
You Tube Video
Why Innovate  Affordability

The Elephant in the room

Costs continue their upward climb…
…with employers still picking up much of the tab…

$4,918  $10,743  $28,530
2001  2009  2019

+118%  +166%

- Employer Cost  - Employee Payroll Contributions  - Employee Out of Pocket Expenses
The World Health Organization ranks the U.S. as the 37th best overall healthcare system in the world.

Countries’ age-standardized death rates, list of conditions considered amenable to health care
The Cause? Mostly due to unregulated fee-for-service payments and an over reliance on rescue/specialty care. This is stark evidence that the U.S. health care Industry has been failing us for years “Commonly cited causes for the nation's poor performance are not to blame - it is the failure of the deliver system!!” *

You the DOD are part of the delivery system - you are trained at Unaccountable Care Organizations, you act as if you are paid the same way and for TRICARE you do pay the same way.

* Peter A. Muennig and Sherry A. Glied Health Affairs Oct. 7, 2010
Health care is a business issue, not a benefits issue.
Don’t handle your care needs in a BAD MEDICAL NEIGHBORHOOD!!

Unaccountable care, lack of organization, DO NOT GO THERE ALONE !!

Be wise when you pay for care, KNOW WHAT YOU BUY!!
Coordination -- we do NOT know how to play as a team

“We don't have a health care delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, micro systems, each performing in ways that too often create sub-optimal performance, both for the overall health care infrastructure and for individual patients.” George Halvorson, from “Healthcare Reform Now

Saudi Arabia’s King Abdulaziz traveled to the U.S. to receive treatment slipped disc
“We do heart surgery more often than anyone, but we need to, because patients are not given the kind of coordinated primary care that would prevent chronic heart disease from becoming acute.”

George Halvorson (CEO Kaiser) from “Healthcare Reform Now”
A long-term comprehensive relationship with your Personal Physician empowered with the right tools and linked to your care team can result in better overall family health...
The Quadruple Aim
Readiness, Experience of Care, Population Health, Cost

The System Integrator

- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management

System Integrator

- Population Health
- Per Capita Cost
- Patient Experience
- Productivity

Safety and Quality
Whole Person Orientation
Care is coordinated and integrated
Enhanced Access
Physician Directed Practice
Personal Physician

IBM
• You need a Captain for the ship

• You need a place of command and control

• You need a horizontal platform from which to launch vertical weapon systems

• You need somewhere and someone to hold accountable
If you scan the world for value based healthcare, you will find a common element: a relationship-based team with a **project manager**! A **comprehensivist** that can command and control in an accountable system.
The Joint Principles: Patient Centered Medical Home

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, and continuous and comprehensive care.

- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or arranging care with other qualified professionals.

- **Care is coordinated and integrated across all elements of the complex healthcare community** - coordination is enabled by registries, information technology, and health information exchanges.

- **Quality and safety are hallmarks of the medical home** - Evidence-based medicine and clinical decision-support tools guide decision-making; Physicians in the practice accept accountability voluntary engagement in performance measurement and improvement.

**Enhanced access to care is available** - systems such as open scheduling, expanded hours, and new communication paths between patients, their personal physician, and practice staff are used.

- **Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home** - providers and employers work together to achieve payment reform.
Enhancing Health and the Patient Experience

Medical Home Model

Patient is the center of the Medical Home

- Team-Based Healthcare Delivery
- Population Health
- Patient-Centered Care
- Refocused Medical Training
- Patient & Physician Feedback
- Decision Support Tools
- Advanced IT Systems
- Access to Care

Model adapted from the NNMC Medical Home
Defining the Care

- Superb Access to Care
- Patient Engagement in Care
- Clinical Information Systems
- Care Coordination

- Team Care
- Patient Feedback
- Publically Available Information
PCMH in Action
Vermont “Blueprint” model

Community Care Team
- Nurse Coordinator
- Social Workers
- Dieticians
- Community Health Workers
- Care Coordinators
- Public Health Prevention

A Coordinated Health System
- Health IT Framework
- Global Information Framework
- Evaluation Framework
- Operations

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Vermont Financial Impact

IMPACT OF MEDICAL HOME SAVINGS ACROSS TOTAL POPULATION

INCREMENTAL COST PER YEAR

$300,000,000
$320,000,000
$340,000,000
$360,000,000
$380,000,000
$400,000,000
$420,000,000

YEARS

1  2  3  4  5
Smarter Healthcare...

36.3%  Drop in hospital days
32.2%  Drop in ER use
9.6%   Total cost
10.5%  Inpatient specialty care costs are down
18.9%  Ancillary costs down
15.0%  Outpatient specialty down

Sharp Community Medical Group: Care Transformation Model

Accountable Community Accountable Care Organization

Enterprise Level Activities

Patient-Centered Medical Home

Patient
PCMH is non-political – the right POV for delivery transformation

“We never abandoned advocating new Models of care. We’ve long pushed folks to realize that Delivery reform is the key.” The patient-centered medical home is core.

“We included the attached chapter on PCMH in our book and have a new publication on ACOs coming out in January.”
Where do you train the MHS Workforce?

…Requires a Smarter Healthcare Workforce
Payment reform requires more than one method, you have dials, adjust them!!!

fee for health

“fee for outcome”

“fee for process”

“fee for belonging

“fee for service”

“fee for satisfaction”
Technology Enables the Progression to Clinical Integration and Accountable Care

"Accountable Care Enablement"
- Risk, UM & Care Management
- Financial & Utilization Analytics
- Care Management
- Patient Health Record

"Clinical Integration Enablement"
- Financial & Utilization Analytics
- Care Management
- Patient Health Record
- Clinical Quality Metrics
- Registry & Population Mgmt

"Meaningful Use Enablement"
- Clinical Quality Metrics
- Registry & Population Mgmt
- EMR / PMS
- Digitization & Interoperability
- Identify gaps in care

- Team based care and workflow
- Enable Patients
- Manage populations
- Manage performance
- Price / manage risk
- Create a sustainable economic model
Recommendations

• Build the foundation, the horizontal platform, a place of accountability - PCMH

• Really engage your patients find out what they need and become very patient centered

• Integrate value base purchasing with PCMH in your plan designee

• Stop buying from unaccountable care organizations unwilling to transform. Move your jobs away from those places fast.

• Stop buying from HC plans that are not rolling out PCMH level care

• Integrate Health and Sick care

• GIVE US LEADERSHIP - SHOW US THE WAY!