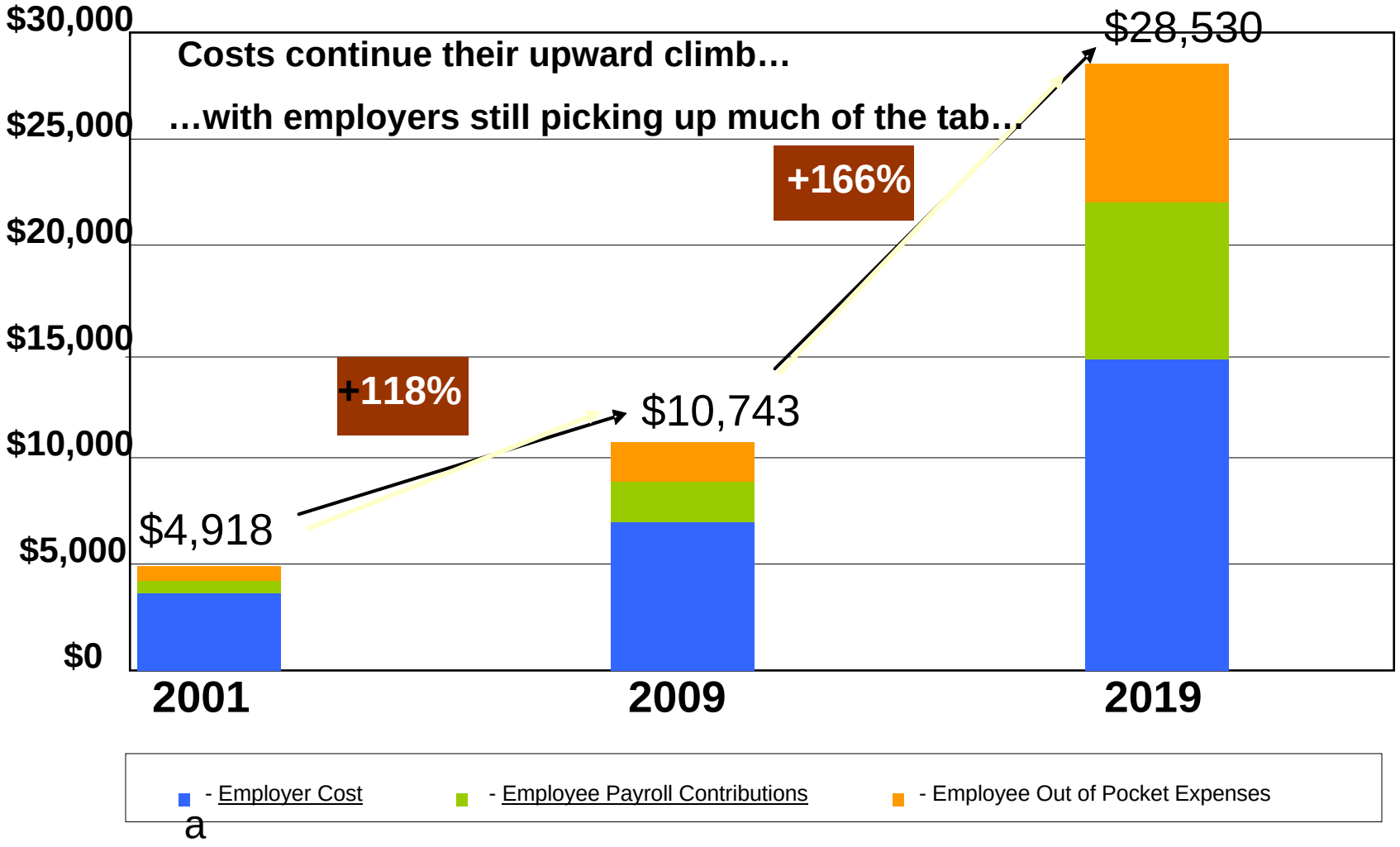
Who was the Shooter's Doctor?

You Tube Video

Why Innovate → Affordability

The Elephant in the room



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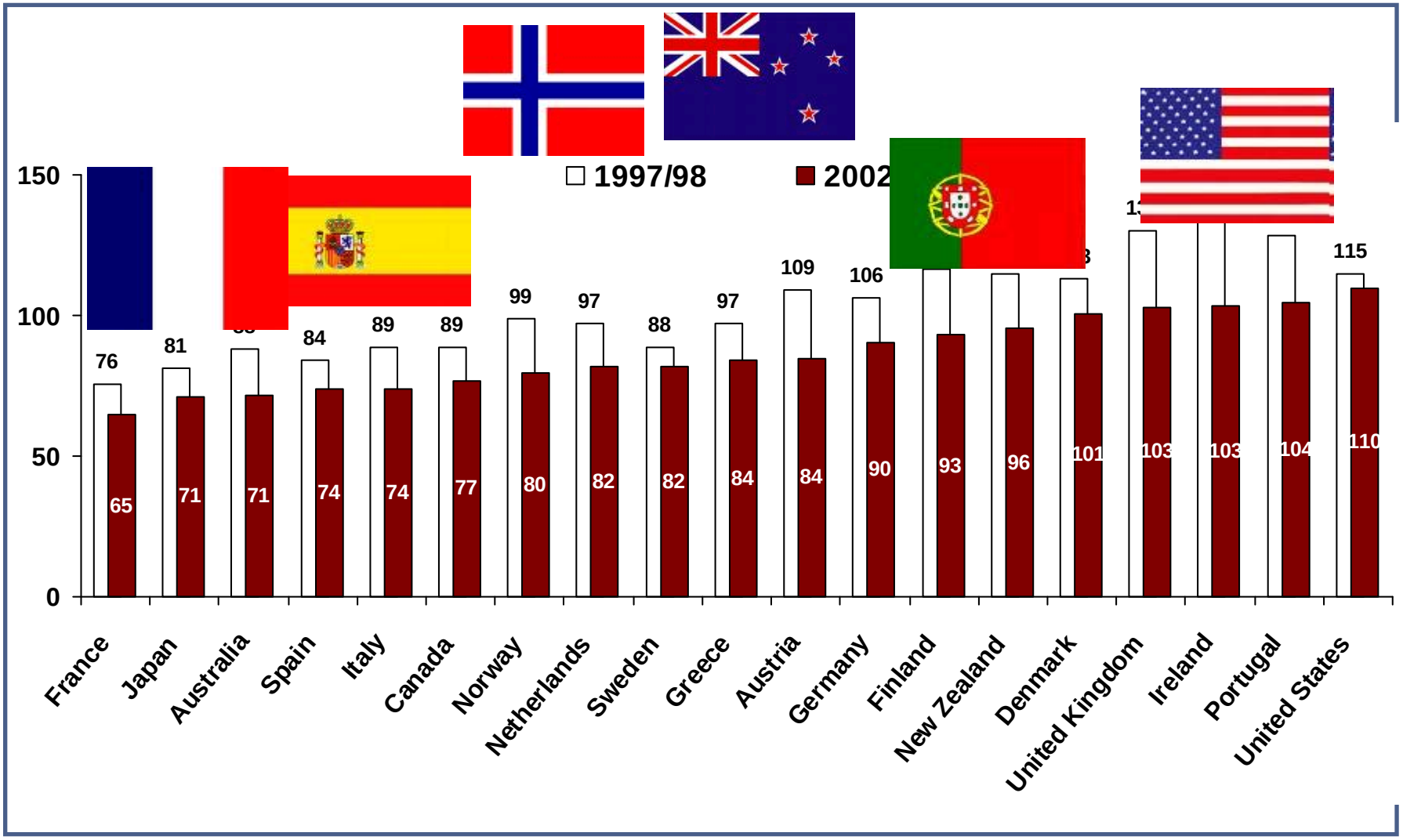
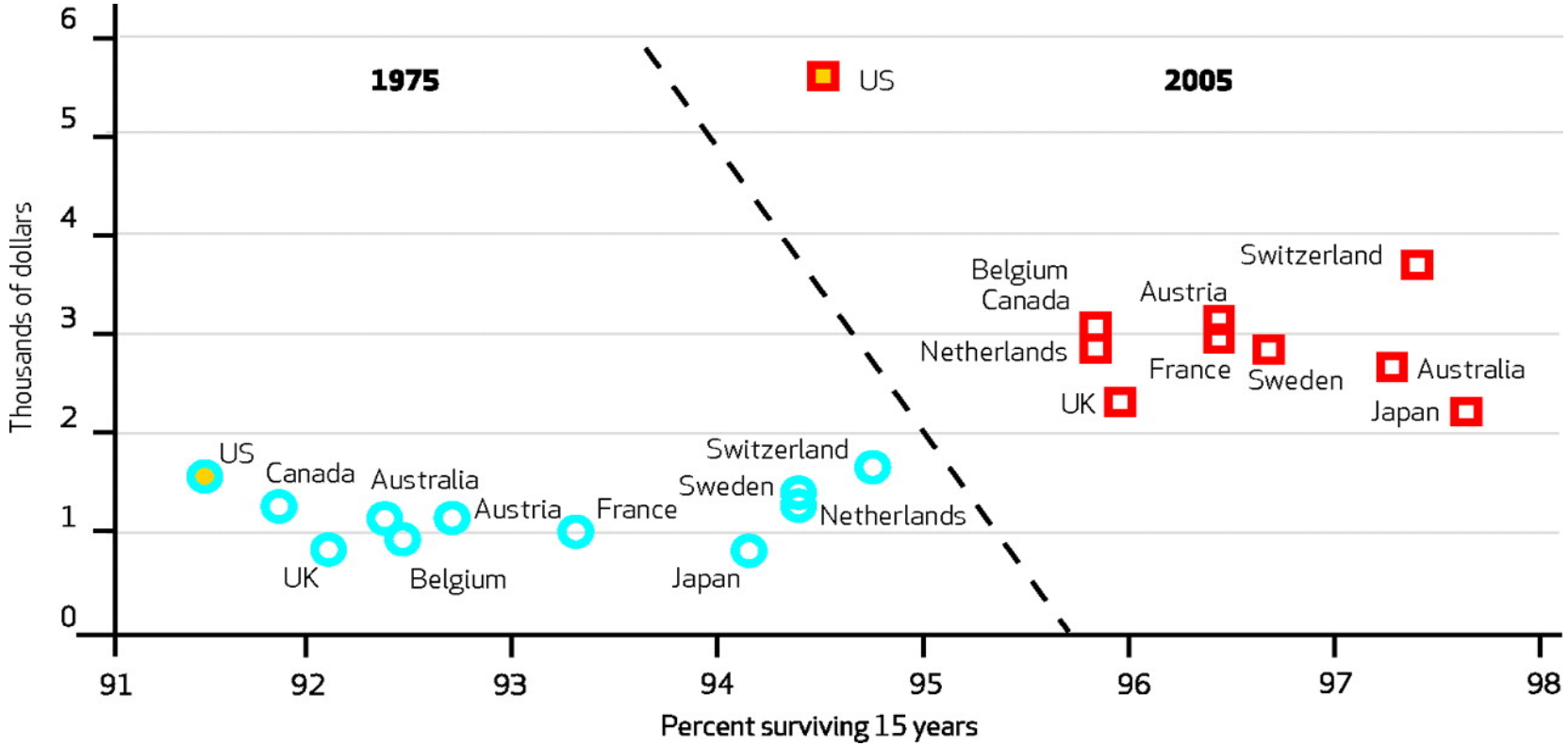
The World Health Organizations ranks the U.S. as the 37th best overall healthcare system in the world



Countries' age-standardized death rates, list of conditions considered amenable to health care Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008, 27(1):58–71

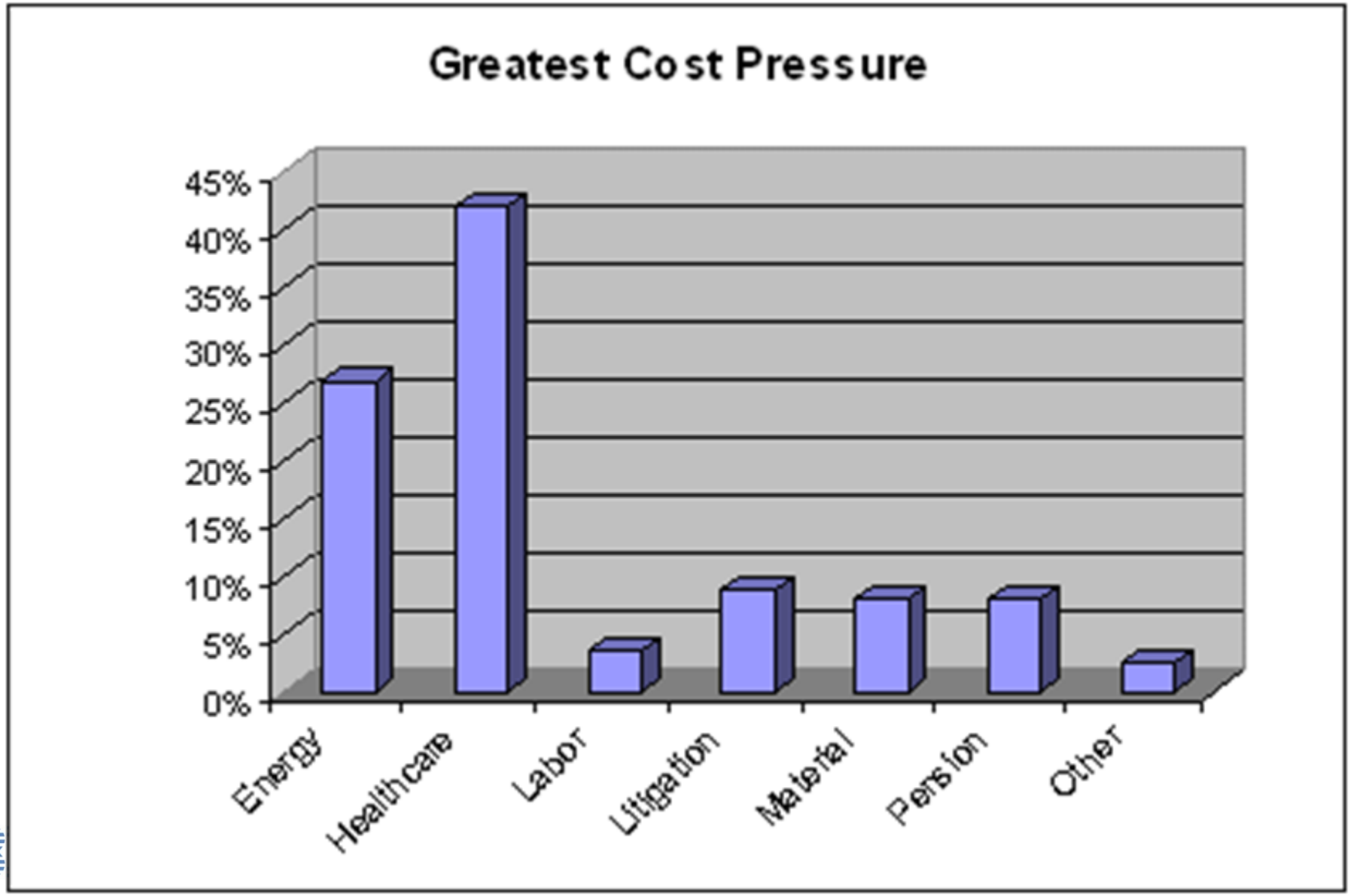


The Cause? Mostly due to unregulated fee-for-service payments and an over reliance on rescue/specialty care. This is stark evidence that the U.S. health care Industry has been failing us for years “Commonly cited causes for the nation's poor performance are not to blame - it is the failure of the deliver 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**

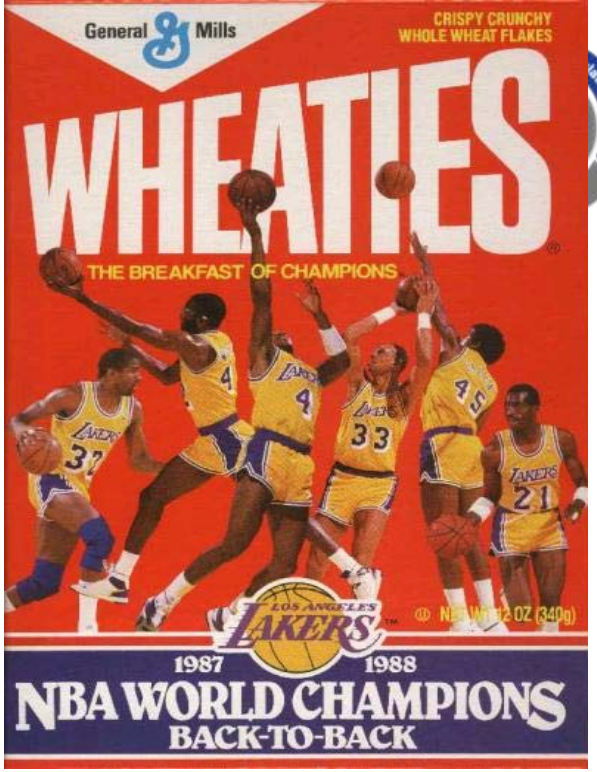
Health care is a business issue, not a benefits issue



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

IBM

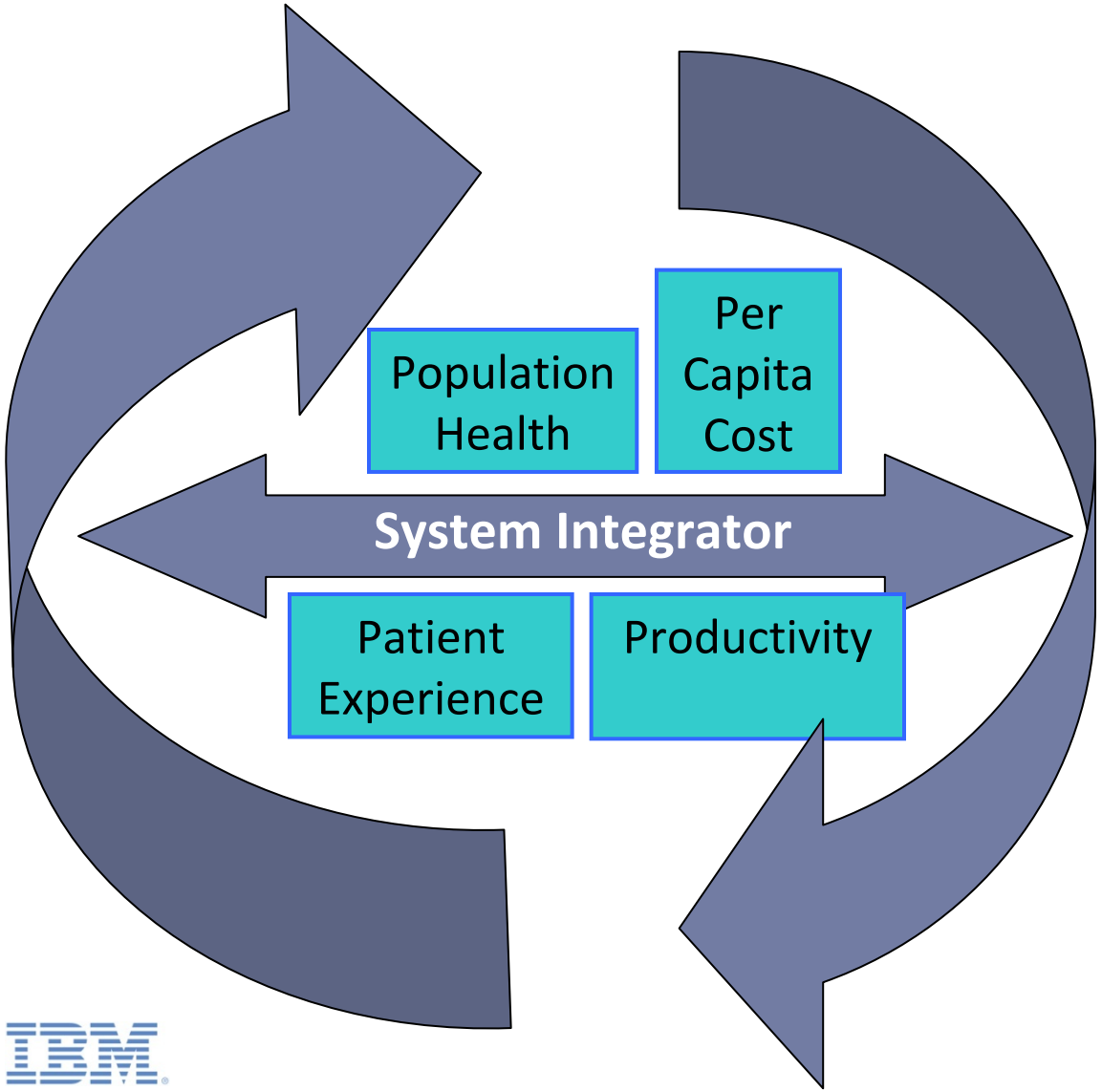
"We do heart surgery more often than anyone, **but we need to**, because patients are not given the kind of **coordinated primary care** that would prevent chronic heart disease from becoming acute."

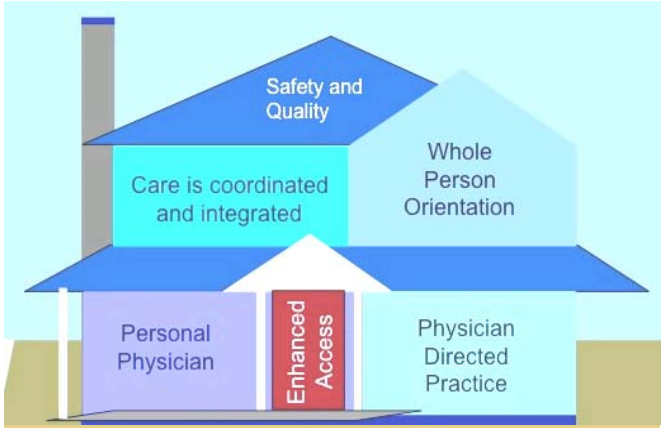
George Halvorson (CEO Kaiser)
from "*Healthcare Reform Now*"

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

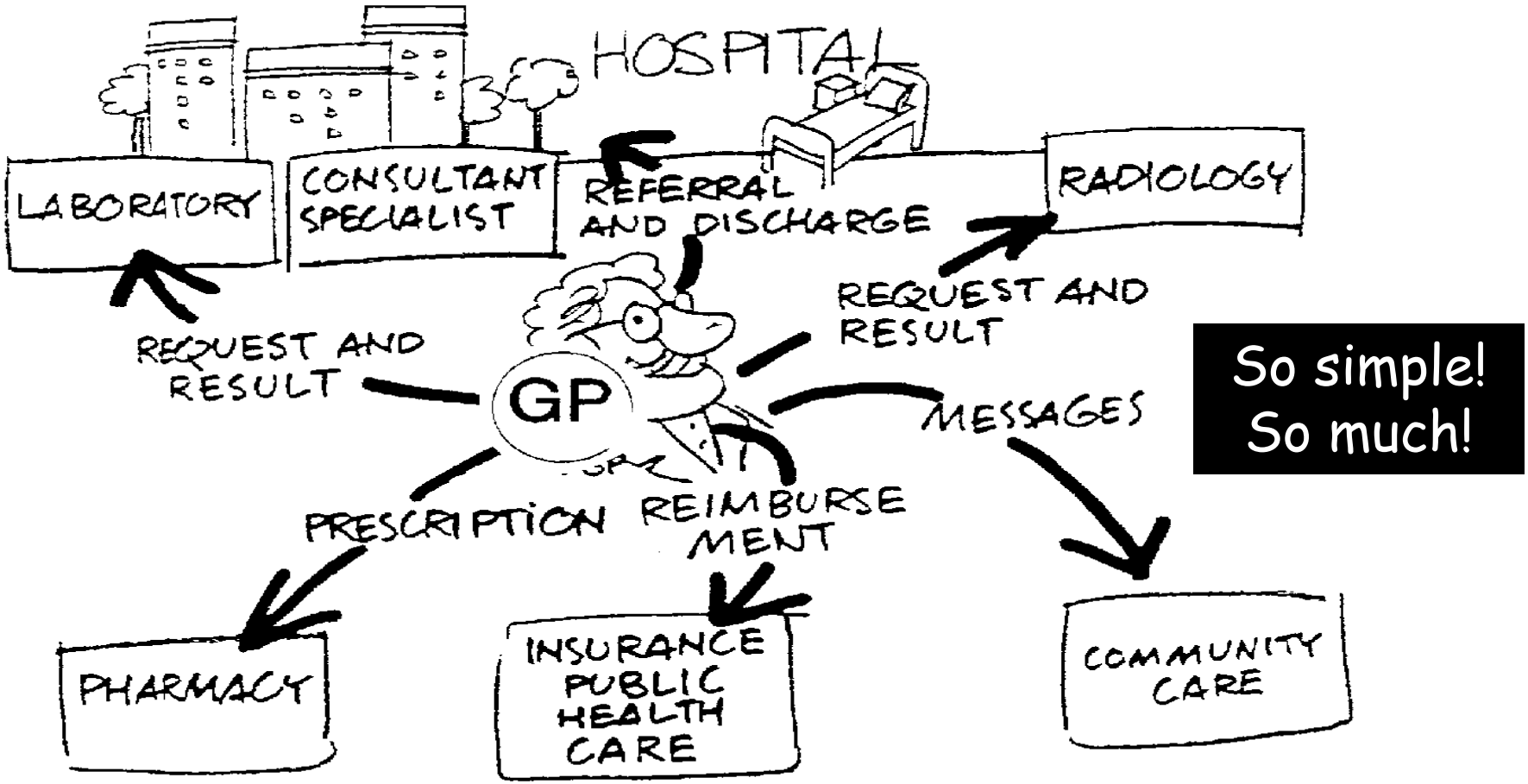
Drives PCMH primary care redesign

Offers a utility for population health and financial management

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.



So simple!
So much!

The Joint Principles: Patient Centered Medical Home

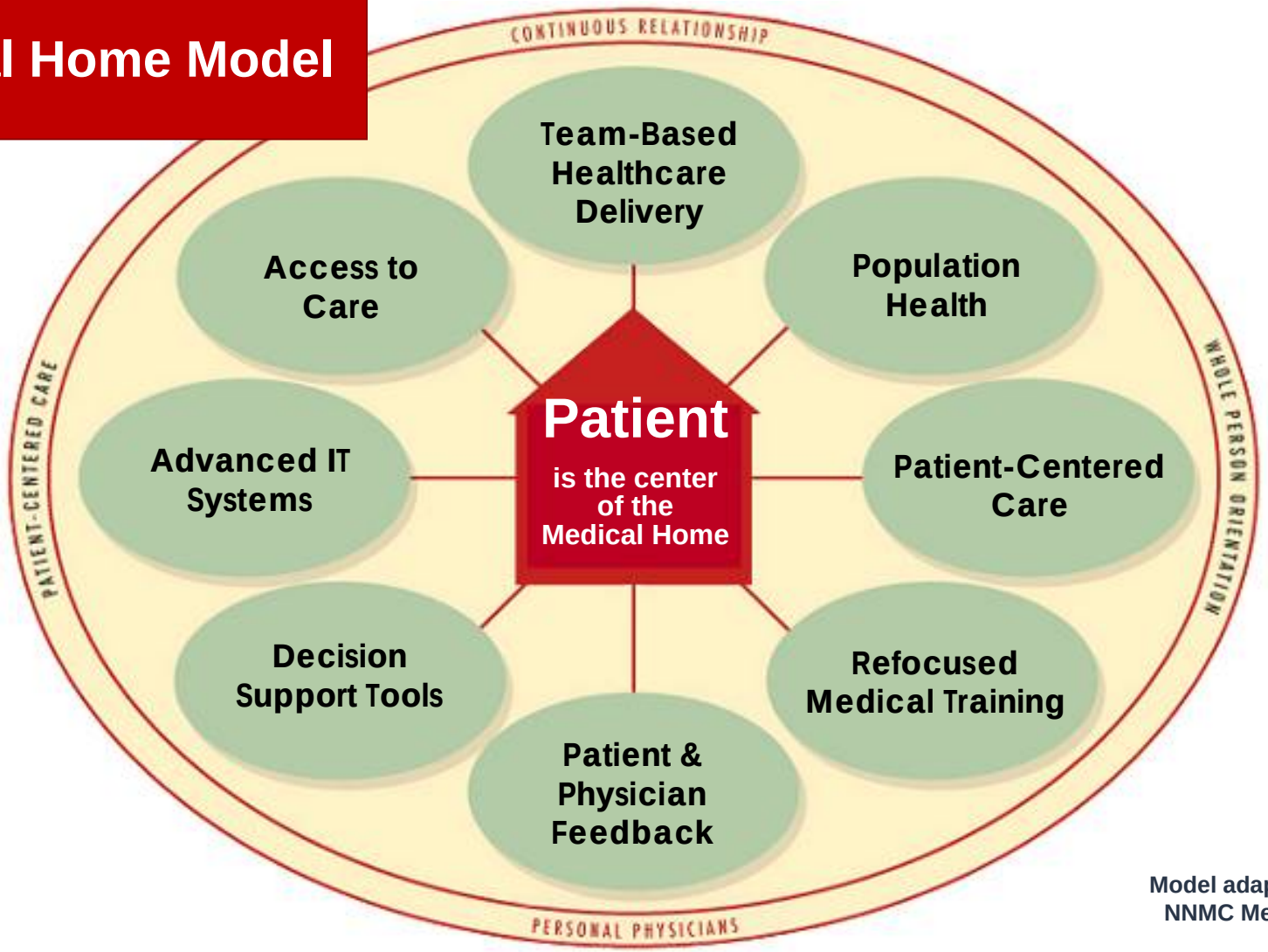
- **Personal physician -** each patient has an ongoing relationship with a personal physician trained to provide first contact, and continuous and comprehensive care
- **Physician directed medical practice –** the personal physician leads a team of individuals at the practice level who collectively take 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

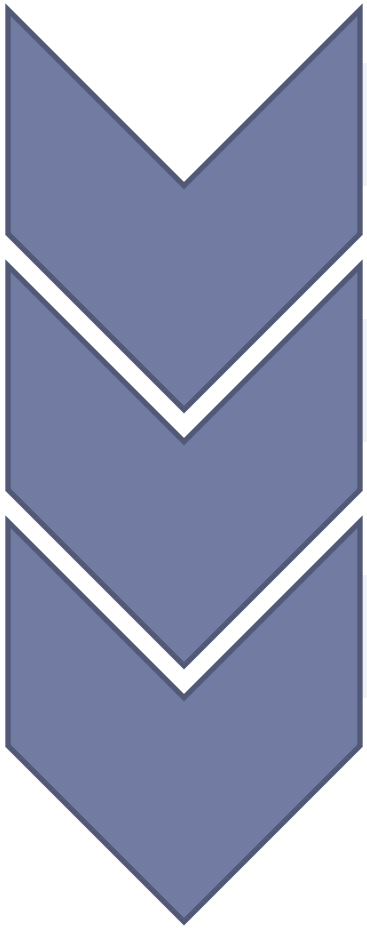
Medical Home Model



Model adapted from the NNMC Medical Home

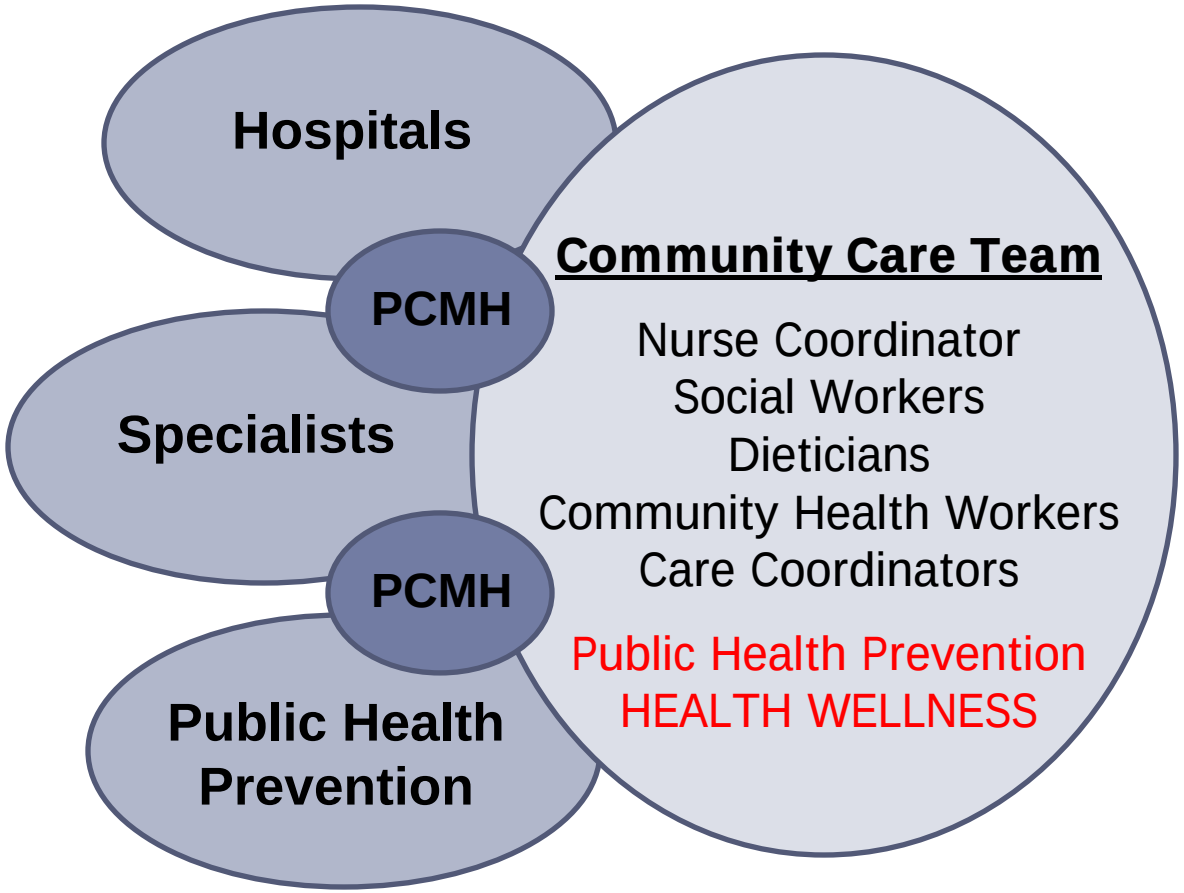
Defining the Care

- 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



A Coordinated Health System

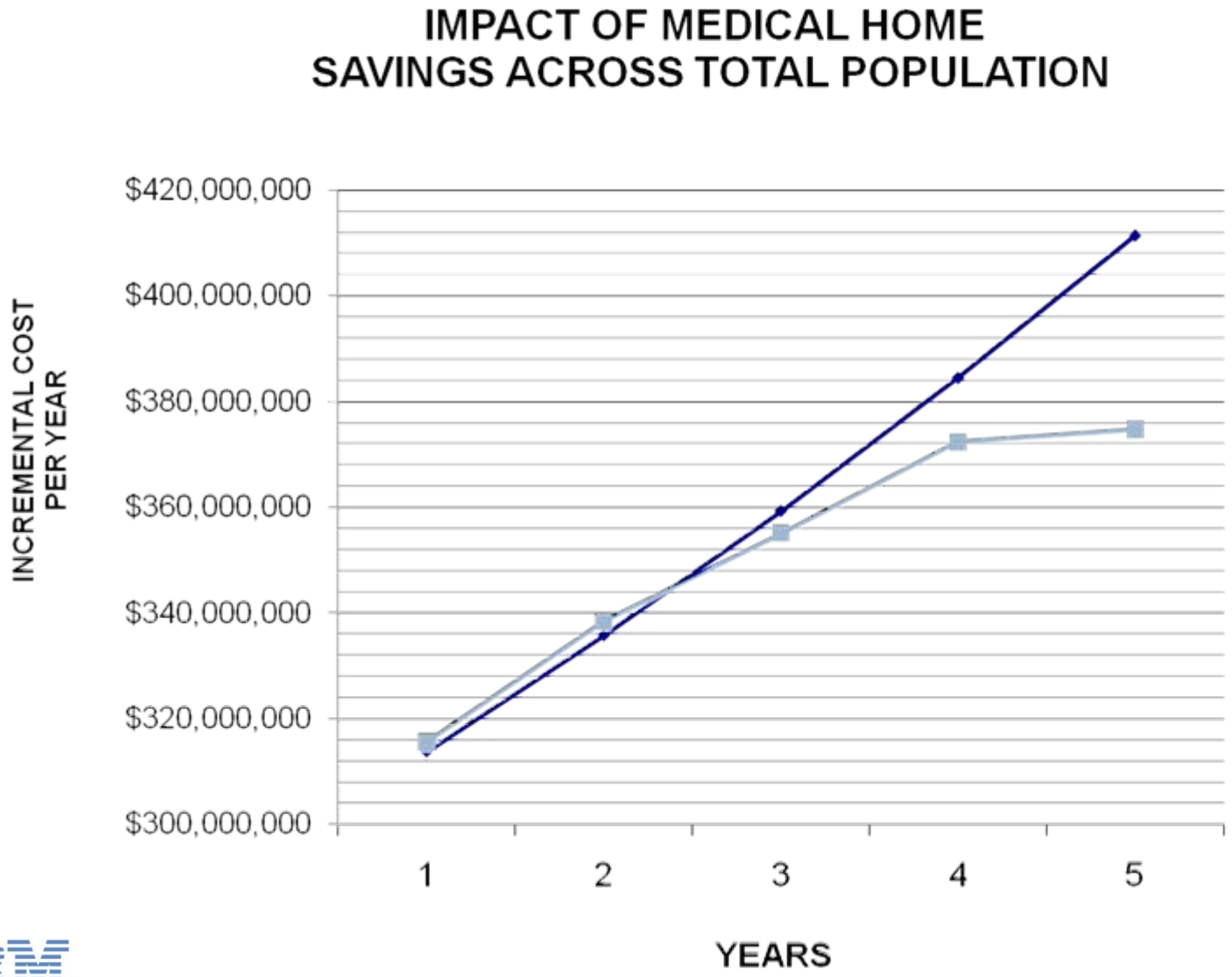
Health IT Framework

Global Information Framework

Evaluation Framework

Operations

Vermont Financial Impact



Smarter Healthcare...

36.3% Drop in hospital days

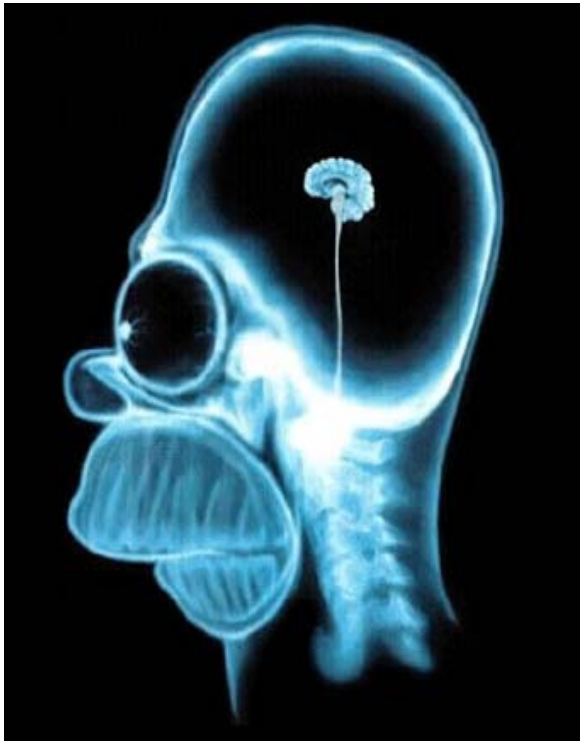
32.2% Drop in ER use

9.6% Total cost

10.5% Inpatient specialty care costs are down

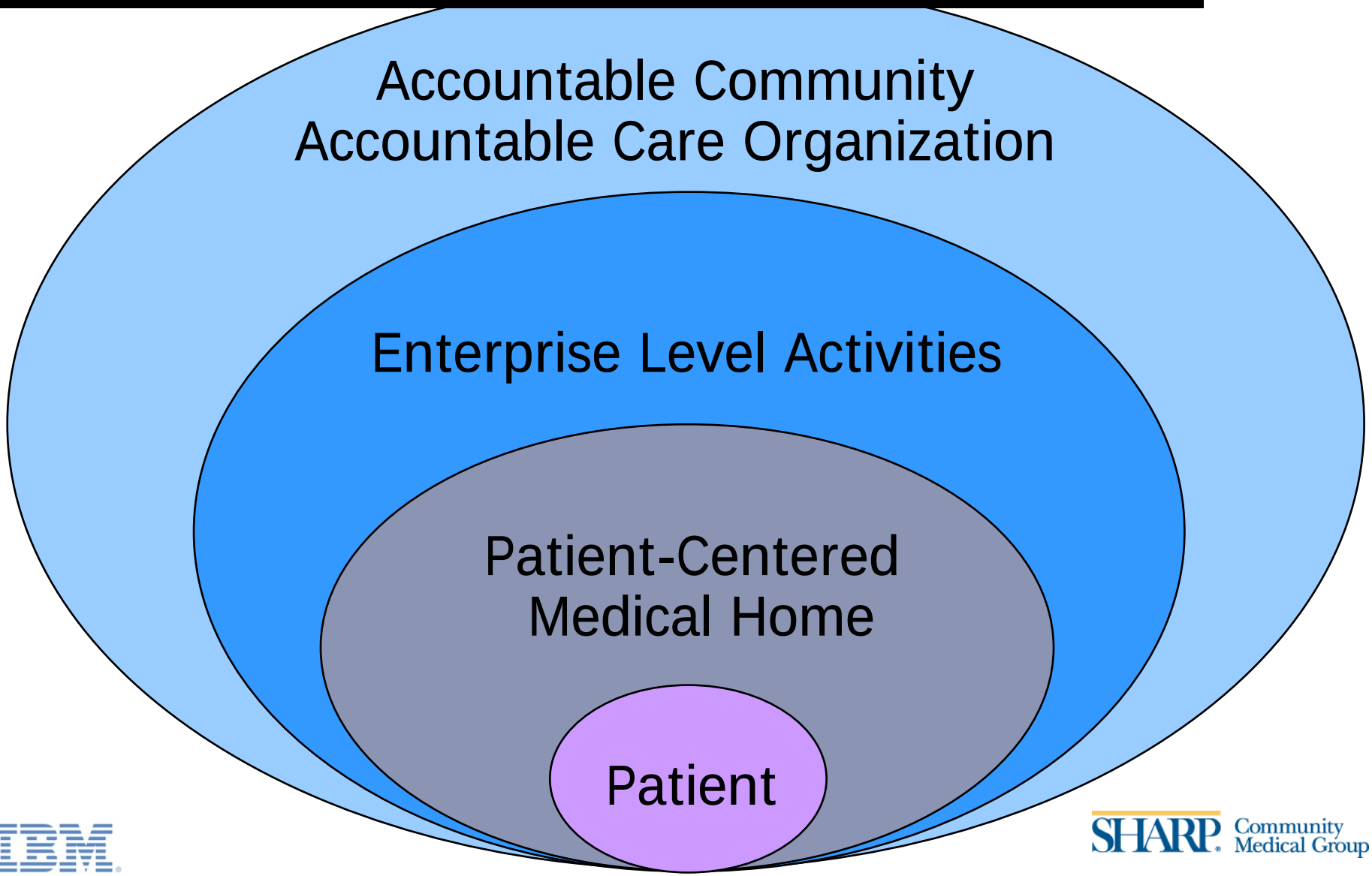
18.9% Ancillary costs down

15.0% Outpatient specialty down



Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US, K. Grumbach & P. Grundy, November 16th 2010

Sharp Community Medical Group: Care Transformation Model



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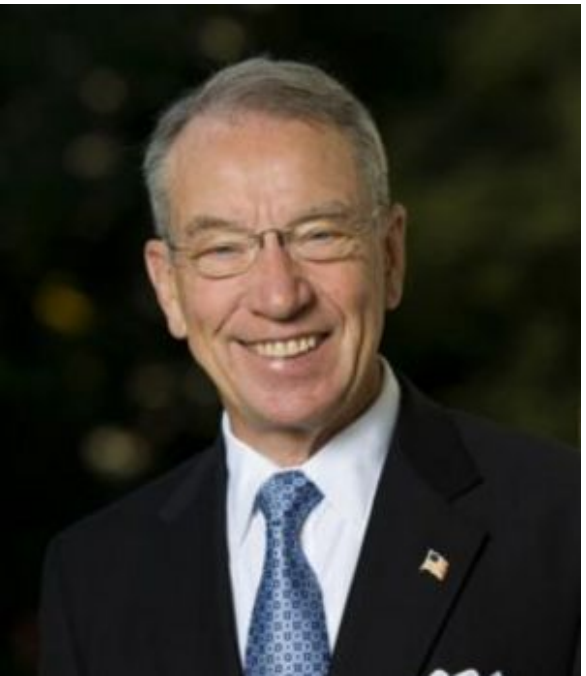
SHARP Community Medical Group

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.”

...Requires a Smarter Healthcare Workforce

Where do you train the MHS Workforce?

OR?

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

"Meaningful Use Enablement"

- Digitization & Interoperability
- Identify gaps in care

"Clinical Integration Enablement"

- Team based care and workflow
- Enable Patients
- Manage populations
- Manage performance

"Accountable Care Enablement"

- Price / manage risk
- Create a sustainable economic model

IBM

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 form 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!