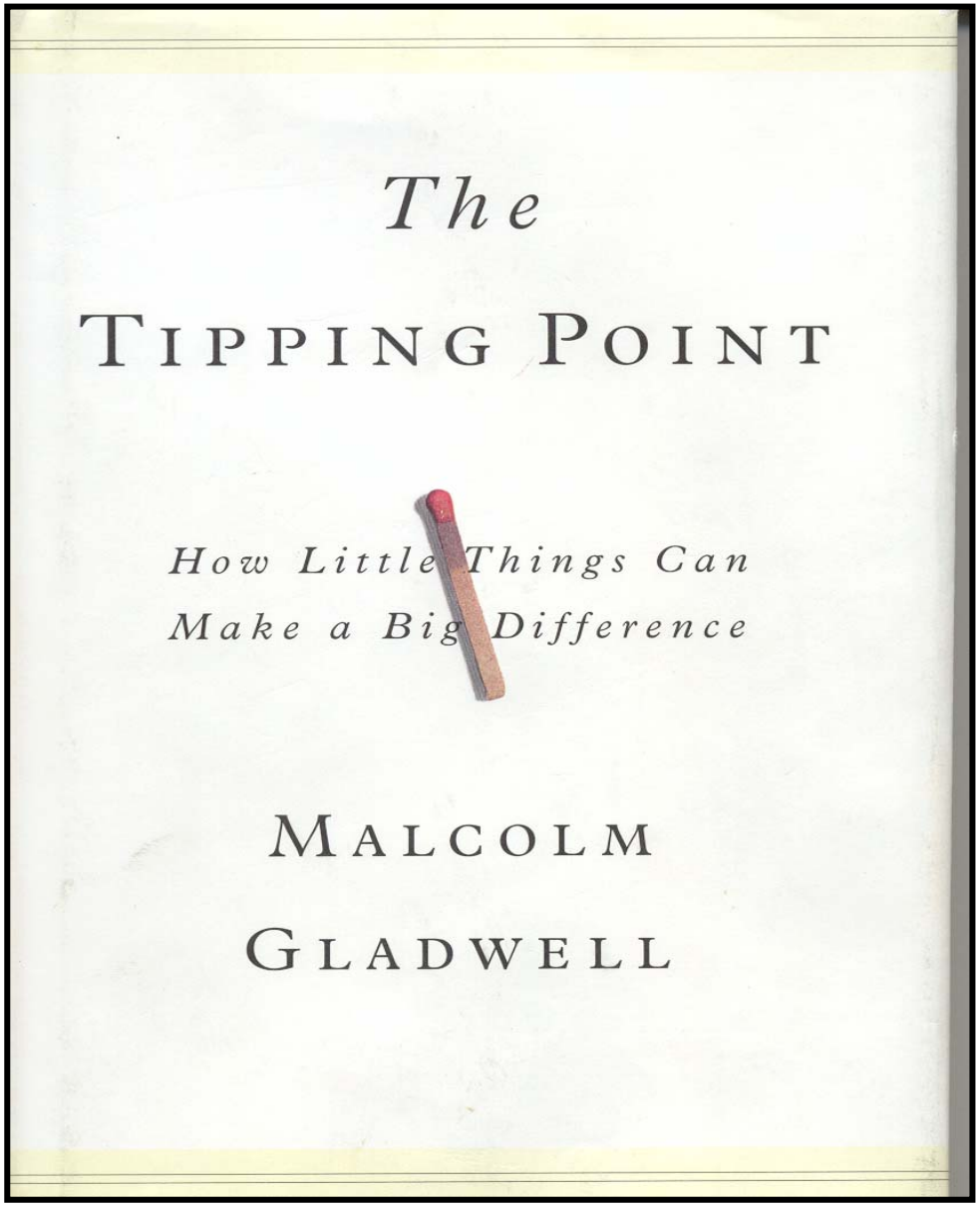
Jefferson
School of Population Health

Closing Session

Successfully Implementing Healthcare Reform

David B. Nash, MD, MBA
Dean
Jefferson School of Population Health

12th Population Health Colloquium
Pre-conference
February 27, 2012

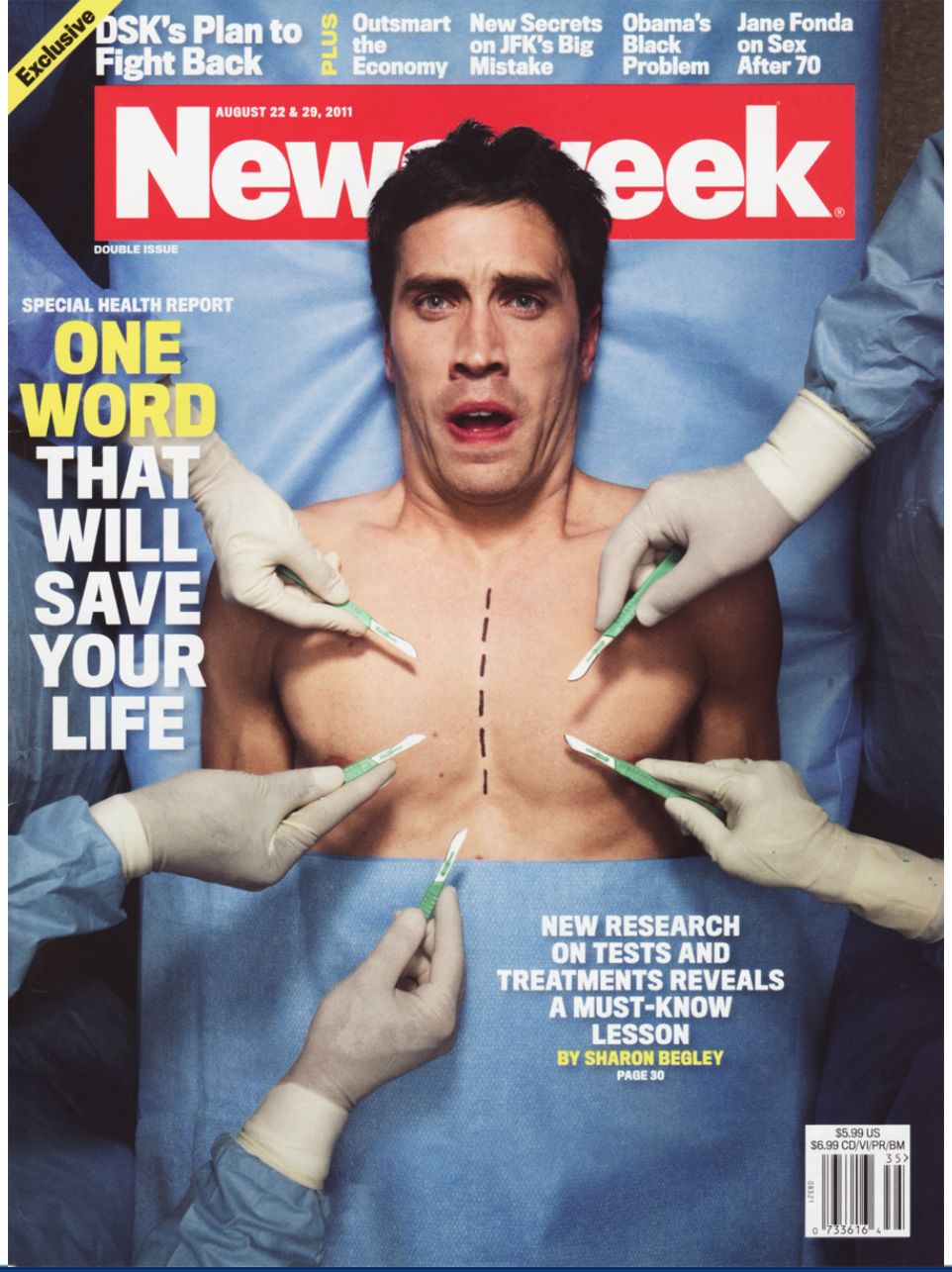

The
TIPPING POINT
How Little Things Can
Make a Big Difference
MALCOLM
GLADWELL

What are the major hurdles?

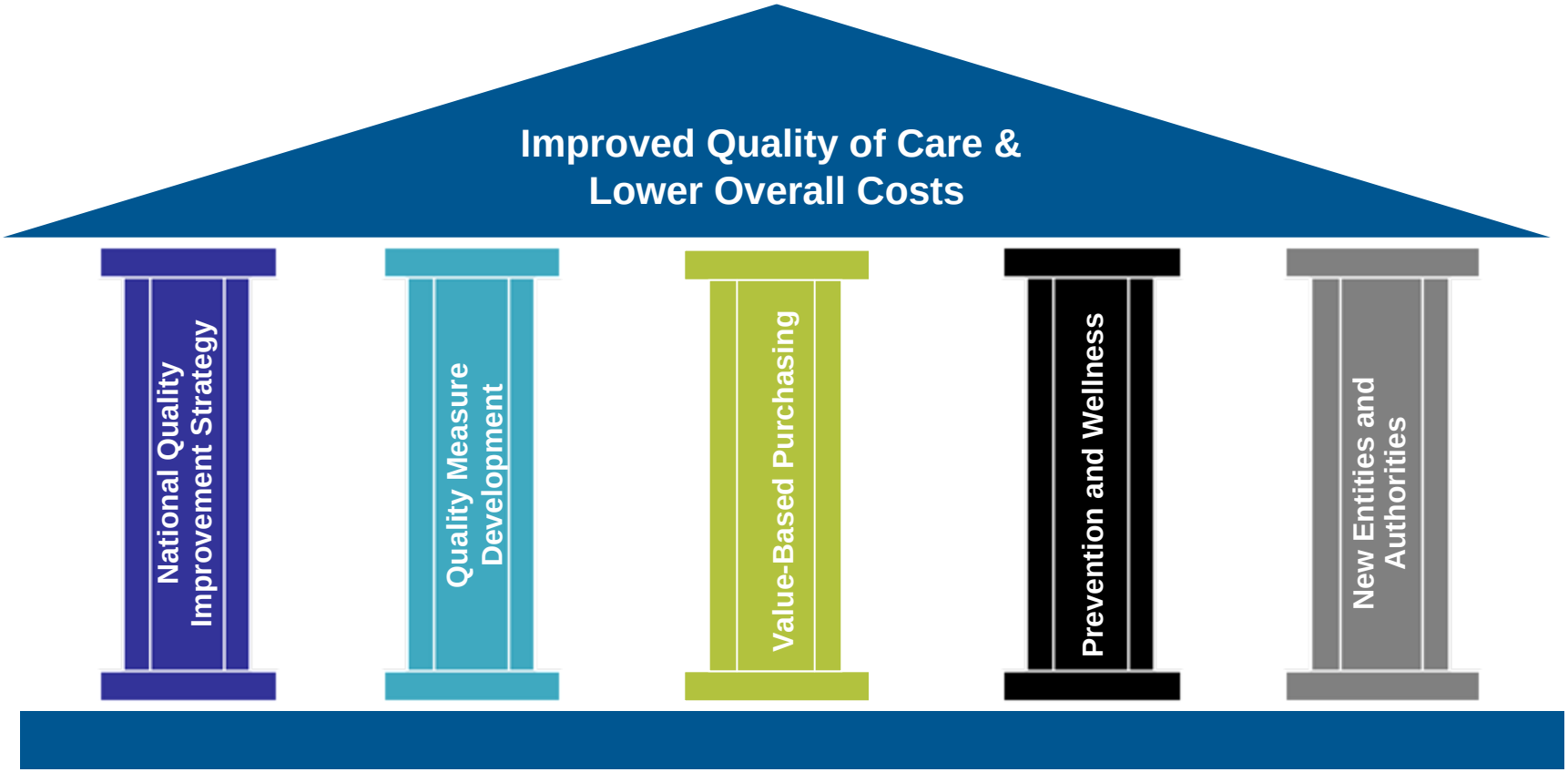
1. Replace pernicious piecework payment system
2. Re-align incentives
3. Create rewards for collaboration, coordination and conservative practice
4. Recognize the cultural barriers

Real Reform: Real Leadership

Current Approach	New Approach
Focus on current medical problem	Focus on all risks
Primary care physicians	Cooperative team of providers
Care based on periodic visits	Continuous healing relationships
Short visits with little information	Emphasis on education and coaching
Decisions by clinical autonomy	Evidence-based decisions
Information restricted	Electronic information flows freely
One size fits all	Care customized to needs/values
Patient a passive participant	Patient/family active participants


Exclusive
DSK's Plan to Fight Back
PLUS
Outsmart the Economy
New Secrets on JFK's Big Mistake
Obama's Black Problem
Jane Fonda on Sex After 70
AUGUST 22 & 29, 2011
Newsweek
DOUBLE ISSUE
SPECIAL HEALTH REPORT
ONE WORD THAT WILL SAVE YOUR LIFE
NEW RESEARCH ON TESTS AND TREATMENTS REVEALS A MUST-KNOW LESSON
BY SHARON BEGLEY
PAGE 30
$5.99 US
$6.99 CD/VI/PR/BM

Health Reform Builds on the Current Quality Infrastructure



Report to Congress

National Strategy for Quality Improvement in Health Care

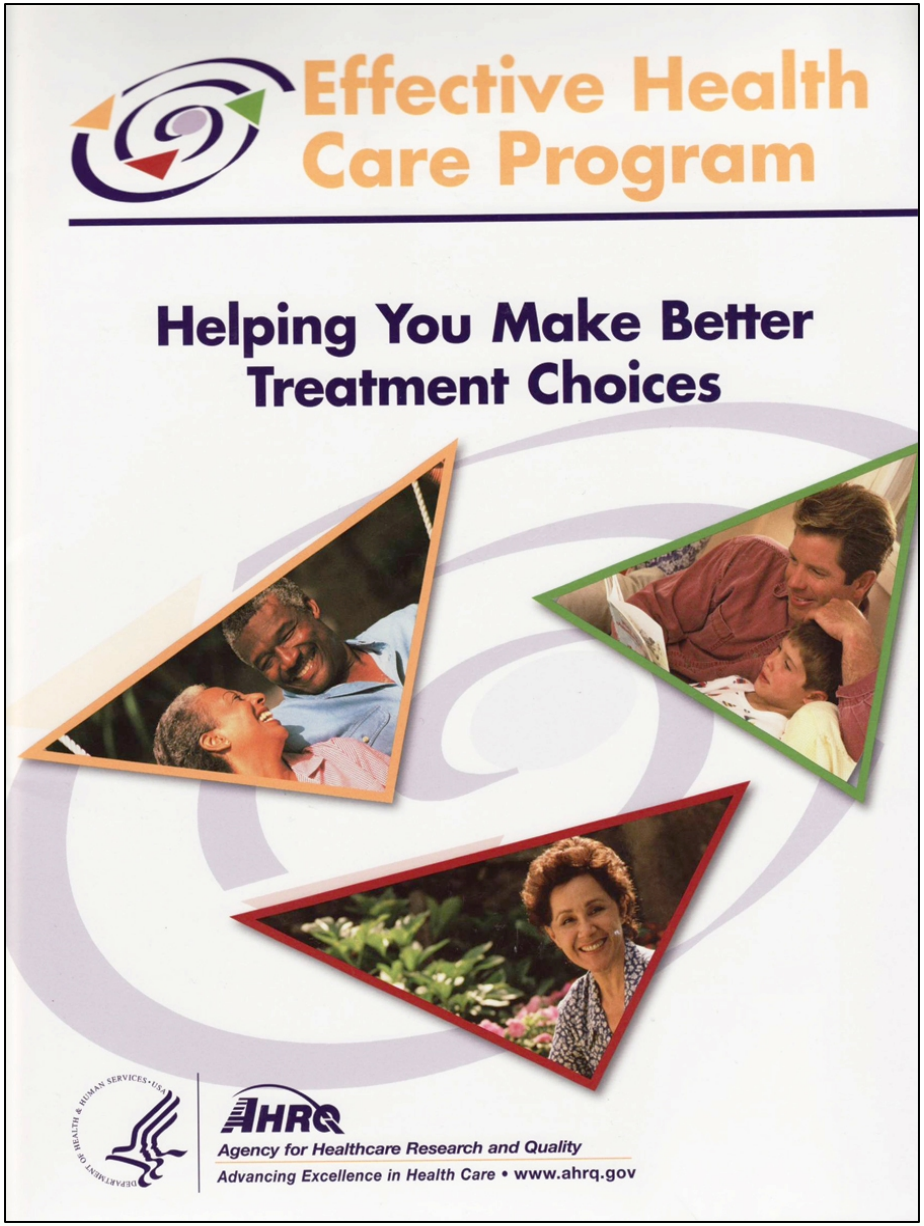
March 2011

HealthCare.gov

Take health care into your own hands

PARTNERSHIP FOR PATIENTS

BETTER CARE, LOWER COSTS


Effective Health Care Program
Helping You Make Better Treatment Choices
AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

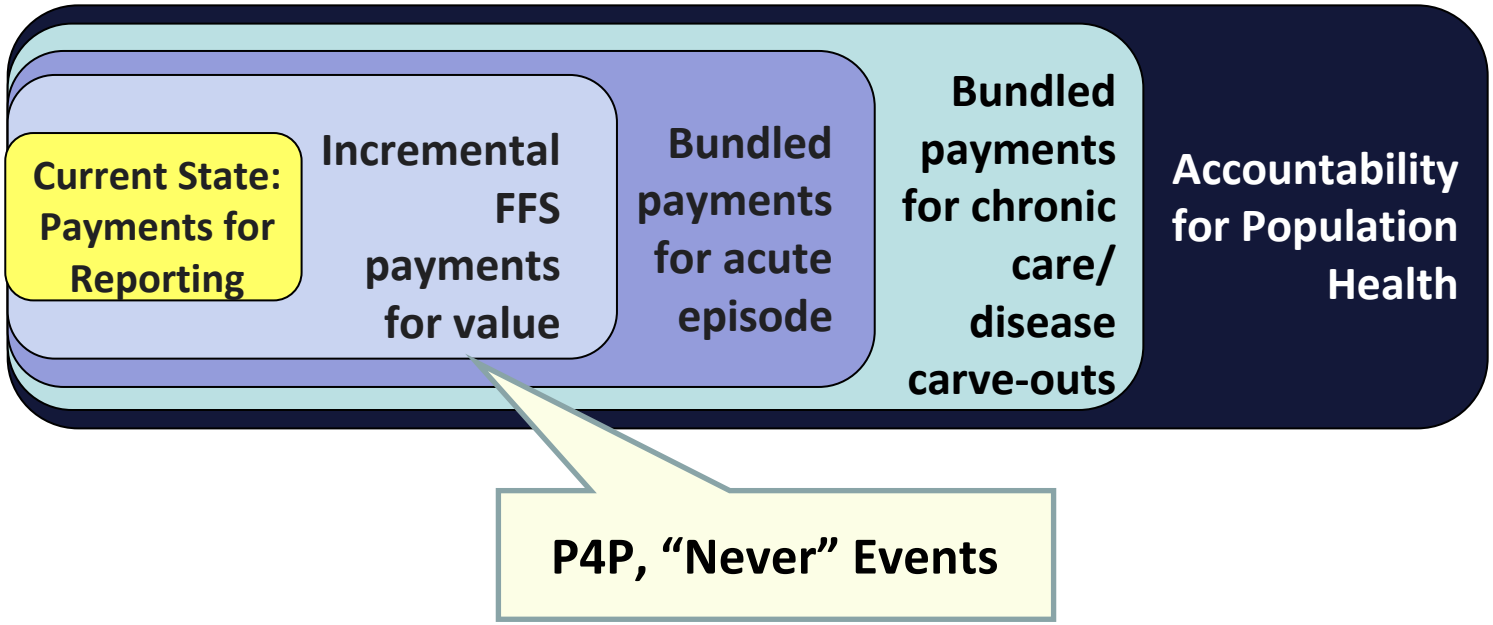
The Four Underlying Concepts of Cost Containment Through Payment Reform…

Tying payment to **evidence and outcomes** rather than per unit of service	**"Bundling" payments** for physician and hospital services by episode or condition
Reimbursement for the **coordination of care** in a medical home	**Accountability for results -** patient management across care settings

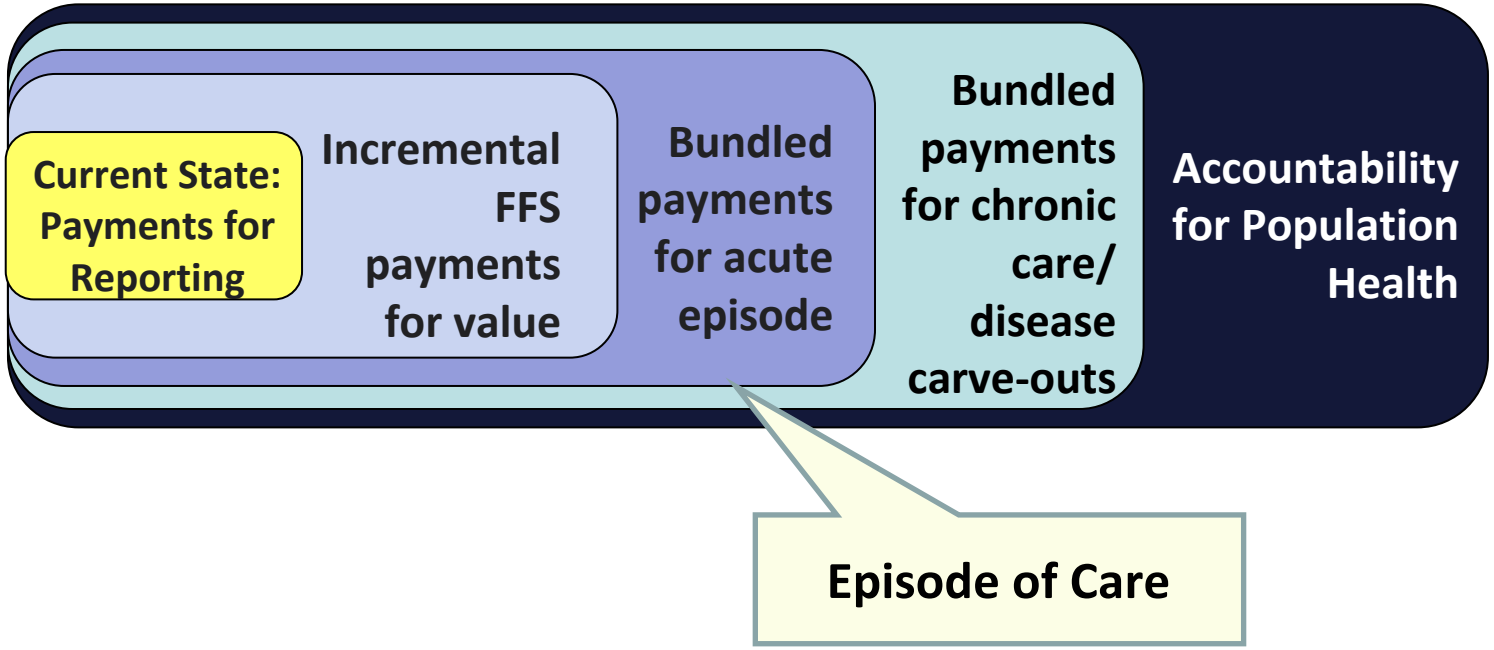
Range of Models in Existence or Development

Increasing assumed risk by provider

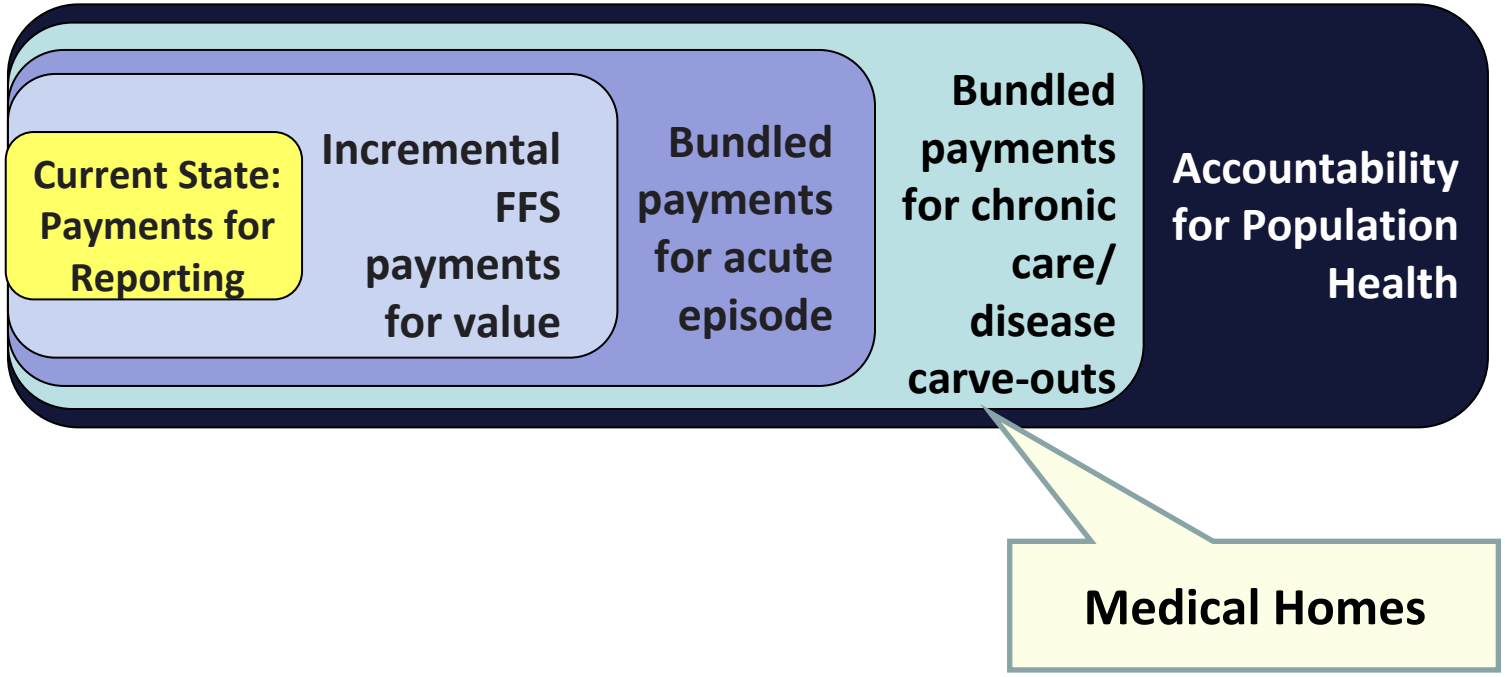
Increasing coordination/integration required



Range of Models in Existence or Development



Range of Models in Existence or Development



What is a Medical Home?

- A Medical Home is “a community-based primary care setting which provides and coordinates high-quality, planned, patient and family-centered health promotion, acute illness care, and chronic condition management”

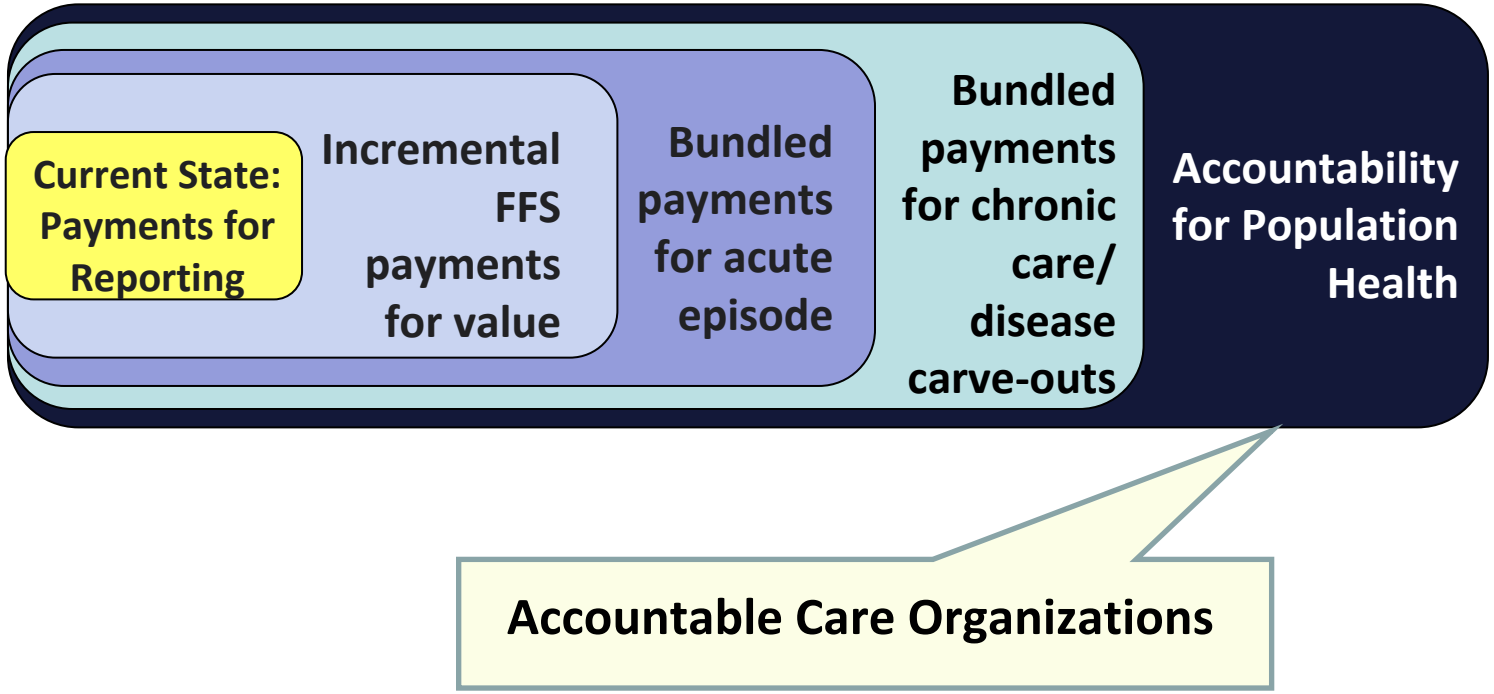
Care that is:

- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally effective

and for which the PCP:

Shares Responsibility with Patient/Family

Range of Models in Existence or Development



The Four Actions Framework Builds the Foundation for Accountable Care

Eliminate	Raise
• Unnecessary and redundant testing • Avoidable hospital readmissions • Use of paper documentation • Hospital-acquired infections	• Chronic disease management • Patient engagement in their care • Home monitoring and follow-up • Health promotion • Screenings
Reduce	**Create**
• Fragmented approach to care • Overall hospital admissions • One-on-one and face-to-face provider visits • Poor health maintenance • Use of phone and fax	• Integrated networks • Patient care teams • Patient registries • Patient portals • Virtual visits • Multiple access points

Driving value up and creating new demand

Source: W. Chan Kim and Renee Mauborgne, *Blue Ocean Strategy: How to Create Uncontested Market Space and Make the Competition Irrelevant*. Harvard Business School Press, Boston , 2005.

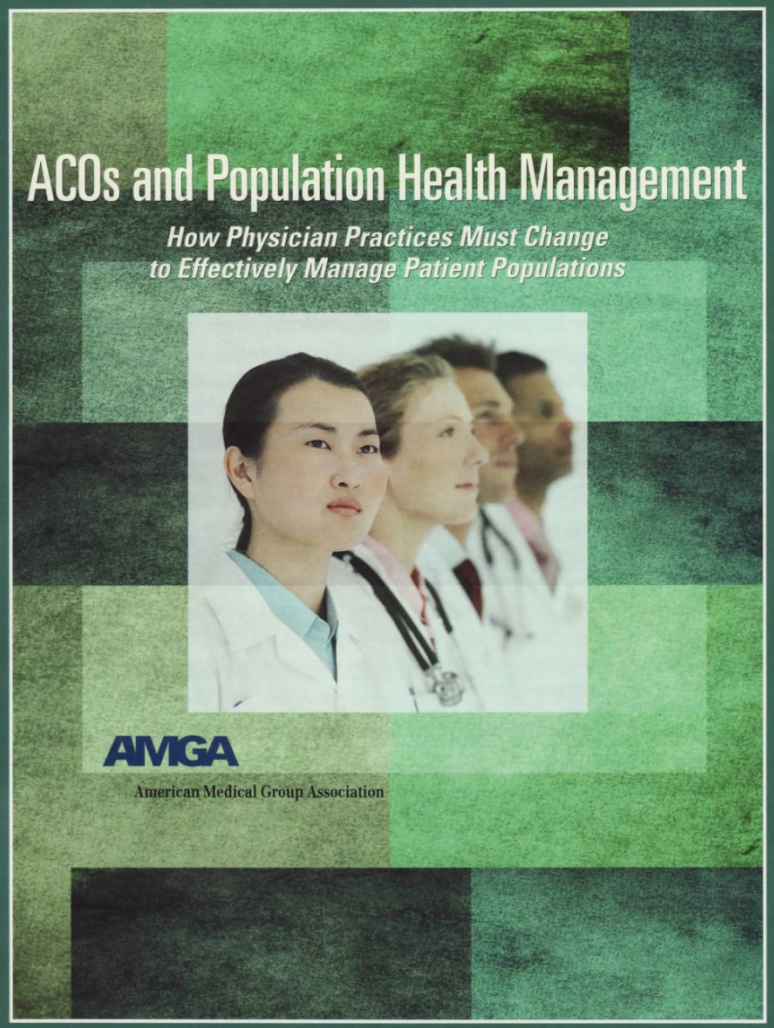
Humana's Accountable Care Organization pilot

- Unites expertise of Humana and Norton Healthcare of Louisville
- One of only five pilots in the U.S. authorized by Dartmouth and Brookings
- Accountability of measured outcomes, cost, and patient delivery
- Industry-standard performance measures including financial, quality, regulatory
- Core principles:
  - Integrated care delivery among provider teams
  - Defined patient population to measure
  - Pay-for-results based on improved outcomes and cost

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

BROOKINGS

NORTON HEALTHCARE



Case Study **Part 1**
Phytel, Inc.

PHYTEL

Help · Kevin Johnson

Population Management System

Search Patients | Go

Patients | Appointments | Outreach | Population Insight | Care Management | PQRS | Hospital Readmission | Reports

Condition Dashboard | Population Benchmarks | Comparison | Population Summary | Data Summary | Patient List | Configuration

Date Range:
Monthly
Quarterly

Recent Reports:
Annual HbA1C
Annual LDL-C testing
Physician Comparison

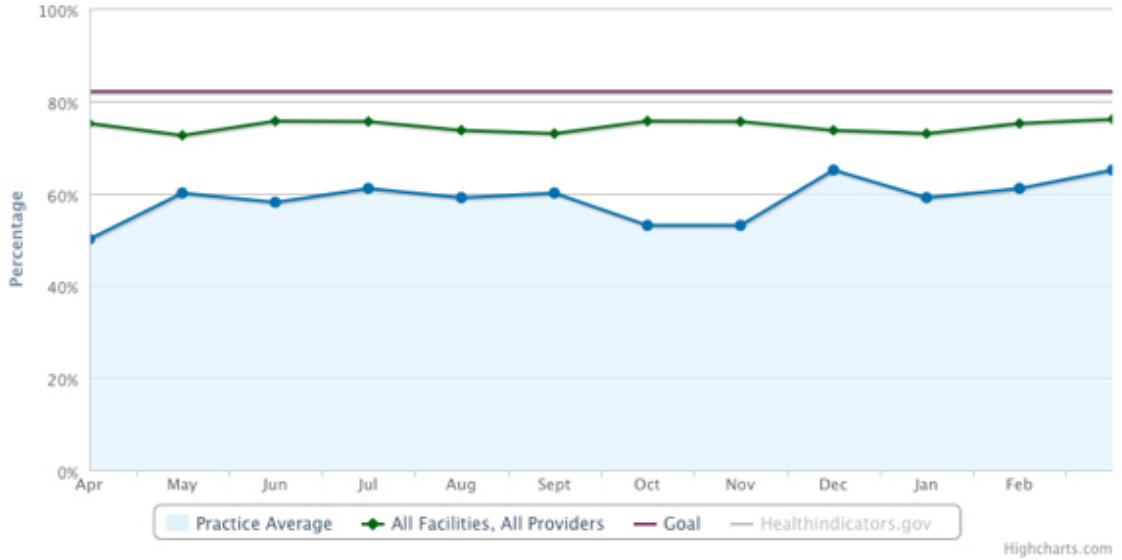
Group: Medical Center, Westside | Provider: 17 Providers

Population Benchmark Report

Export

Report: Quality Initiative | Diabetes | Operational | Annual HbA1C testing

Annual HbA1C testing



Diabetes	Benchmark	QTR 1 (2011)		QTR 4 (2010)		QTR 3 (2010)		QTR 2 (2010)		QTR 1 (2010)		Trend
Identified Population		2,183		2,167		2,180		2,166		2,168		
Measures	%	#	%	#	%	#	%	#	%	#	%	
Annual HbA1c testing	85.3	**1,773**	**80.1**	1,754	81	1,761	81.6	1,752	81	1,764	81.6	↑
HbA1c > 9.0	12.2	**220**	**13.0**	208	12.7	208	13.7	232	12.2	213	18.0	↔
HbA1c < 7.0	45.3	**862**	**40.8**	832	42.5	928	42.4	926	41.9	910	41.5	↓

Jefferson School of Population Health

Implementing Accountable Care Organizations

Ten Potential Mistakes and How to Learn From Them

Sara Singer, PhD, MBA

Stephen M. Shortell, PhD, MPH, MBA

ACHIEVING THE TRIPLE AIMS—HIGHER-QUALITY PATIENT-centered care, improving population health, and moderating per capita costs—will require fundamental change in the US health care system.[1] Accountable care organizations (ACOs) as outlined in the Affordable Care Act represent an early initiative in restructuring health care.[2] Accountable care organizations accept responsibility for the cost and quality of care for defined patient populations. Under the Medicare shared savings program, ACOs will face expenditure targets based on their previous 3 years of Medicare Part A and Part B experience.[3] Qualifying organizations can choose between 2 risk arrangements. The first involves upside potential from shared savings in the first 2 years, adding downside risk only in the third year of operation. In the second arrangement, organizations share a greater percentage of the savings but are responsible for downside risk from the beginning. The shared savings program will require organizations to conduct quality improvement initiatives, care coordination, performance measurement, and public reporting.

To succeed, organizations contemplating participation in ACOs will need to develop and improve organizational capabilities necessary to meet program requirements. Hospitals and physician organizations will need to forge new relationships and take on new responsibilities. Success will require adaptation and change, learning quickly from mistakes, and developing an ability to transfer knowledge among participating entities. This will require ACOs to become learning organizations that can comprehend and expand what works and move to correct things that do not.[4]

In this commentary, we discuss 10 potential mistakes that organizations may experience in becoming ACOs whether with Centers for Medicare & Medicaid Services (CMS) payment or working with private payers.

Overestimation of Organizational Capabilities

1. Overestimation of Ability to Manage Risk. This is perhaps the major lesson to be drawn from the experimentation with capitated managed care in the 1990s.[5] Organizations frequently overestimate their abilities, particularly when potential rewards are at stake. Some physician organizations have the ability to manage and measure ambulatory care. Some hospitals have the ability to manage and measure inpatient care. But the Medicare shared savings program and many private payer demonstrations require a single risk bearing entity, the ACO, to manage the entire care continuum. The challenge will be to merge hospital and physician capabilities, an exercise with which most health care organizations have little experience. Estimates of the start-up cost of developing these capabilities vary widely from $1 million[3] to $12 million per ACO.[6]

2. Overestimation of Ability to Use Electronic Health Records. Implementation of electronic health records will be more challenging than most believe, despite financial support offered by CMS and others. Most clinicians are inadequately trained and supported in the use of electronic health records. This will hinder the ability to report on the cost and quality metrics required for ACOs. Even with adequate support, implementation of electronic health records systems can disrupt practices for 6 months or more.[7] Incompatibility among hospital and physician information systems is a further impediment to achieving the goals of integration.

3. Overestimation of Ability to Report Performance Measures. Experience with pay-for-performance programs suggests the challenge of collecting, analyzing, and reporting performance data. For most ACOs, reporting capability will evolve slowly over time even with the technical assistance provided and will depend on the ability of electronic health records to reliably document the delivery of clinical care.

4. Overestimation of Ability to Implement Standardized Care Management Protocols. The goal of protocols is to eliminate variation and complexity in the care delivery process that do not add value. For protocols to work, clinicians must be substantially involved in their development, data must exist to assess protocol implementation and outcomes, and the protocols must allow for tailoring to individual patient needs and preferences.[8] This takes time and, in the haste to qualify as an ACO, there is the temptation to shortchange the degree of involvement needed.

Author Interview available at www.jama.com.

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By Susan DeVore and R. Wesley Champion

Driving Population Health Through Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0935
HEALTH AFFAIRS 30,
NO. 1 (2011): 41–50

ABSTRACT Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients' satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today's health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.

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R. Wesley Champion is a senior vice president at Premier Consulting Solutions, in Charlotte.

What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income

How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care

Building Upon the Cornerstones

Create Value: *Improve patient outcomes and satisfaction. Decrease medical errors, cost and waste.*

Coordinate Care: *Coordinate patient care across people, functions, locations, and time to increase value. Ensure patients' active participation in the process.*

Reform the Payment System: *Change the way providers are paid in order to improve health and minimize waste.*

Provide Health Insurance for All Americans: *Provide guaranteed, portable health insurance for all citizens, giving them choice, control and peace of mind.*

SelfCare Advancing the *study & understanding* of self-care

WELCOME TO SELFCARE

Volume 2, issue 6 is now published.

Welcome to *SelfCare:* an international journal advancing the study and understanding of self-care.

Highlights in this issue include: an opinion paper proposing extending the reach of self-care into urinary incontinence, a hidden problem with many sufferers unaware of the treatment options available. Also on a urological theme, an original article describing a survey into pharmacists' attitudes surrounding the availability of tamsulosin as a pharmacy medicine for men with symptoms of benign prostatic hyperplasia. And finally a comment from the managing editor of *SelfCare* in this final issue of Volume 2.

UK Community Pharmacists experiences on over-the-counter tamsulosin

Self care in Urinary Incontinence

A note from the Managing Editor

We welcome your submissions, letters to the Editor and opinions.

Have a look at the journal, and let us know what you think.

Professor R W Soller and Professor Peter Noyce
SelfCare Co-editors

Jefferson School of Population Health


CareCoach

Implementing Well-Being For Our Customers

Health Security Purpose Belonging

How can Humana help me stay healthy?

Preventive Campaigns –
Encourage members to utilize preventative services to support healthy lifestyles and keep costs low.

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Interactive case management helps seniors stay healthy, out of the hospital, and at home.

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Conveniently offer members screenings in their areas of residence to boost health and satisfaction.

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Programs like Didget and Famscape help members stay active and healthy through fun games and online connections.

Preparing for the Future:

1. Humana → Concentra
2. Endo Pharma → HealthTronics
3. McKesson → US Oncology
4. Walgreens → Itrax + Take Care

Keep Control of
Your Health Care

Protect Your Right to Prostate Cancer Screenings

Early detection of prostate cancer often depends on a simple test - the PSA Test.

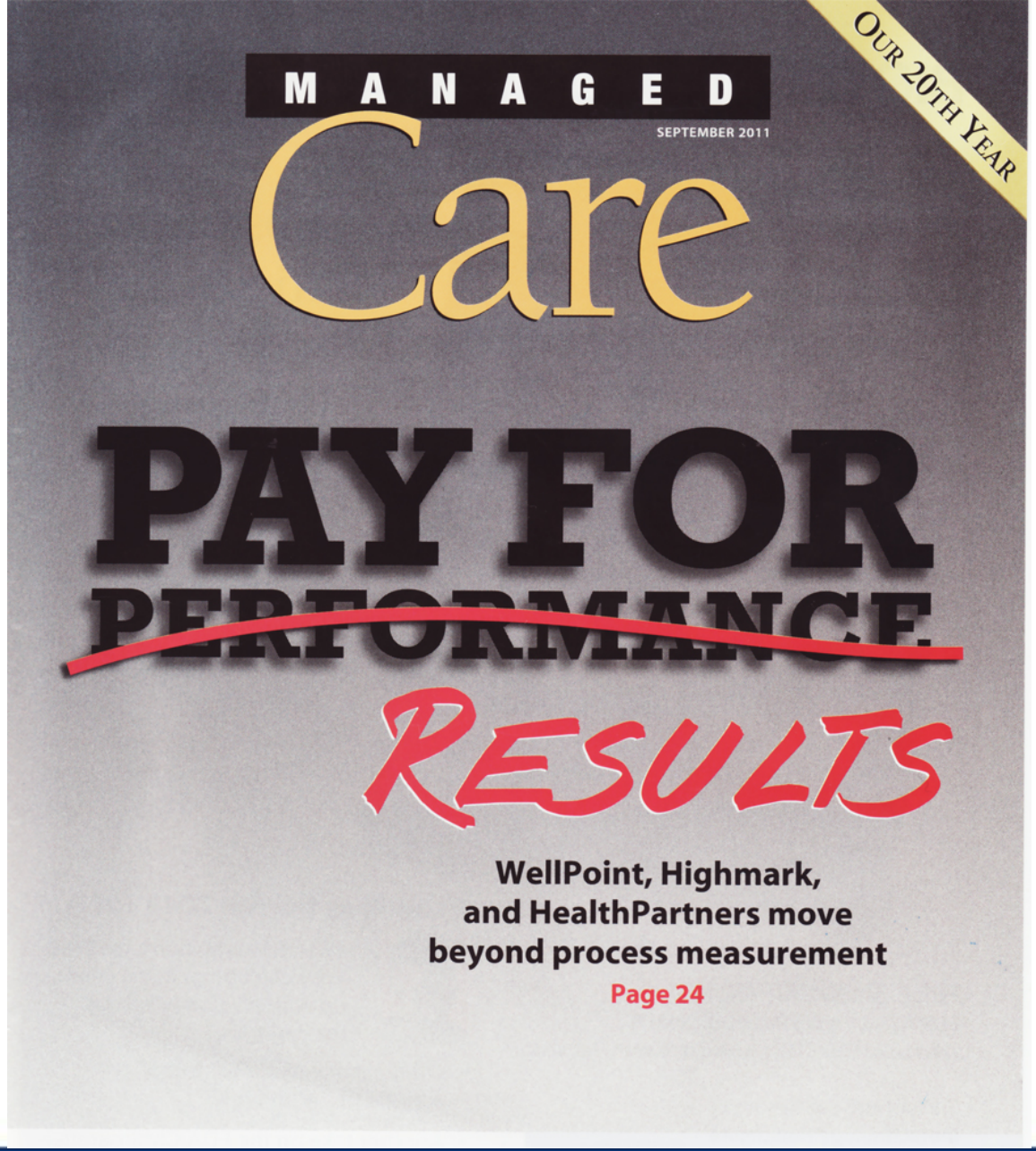
Patients and their doctors are best equipped to decide when a PSA Test is in order.

Oppose U.S. Government Action to Eliminate Prostate Cancer Screening for All Men.

Contact Congress
(202) 224-3121
Urge your representatives to reject the Preventative Services Task Force recommendation to eliminate prostate cancer screening.

AACU
American Association of Clinical Urologists, Inc.

Visit the PSA Test Action Center
www.tinyurl.com/AACU-PSA
Learn more about the PSA test, prostate cancer and send pre-written letters to Congress and local newspapers.


MANAGED
SEPTEMBER 2011
Care
OUR 20TH YEAR
PAY FOR
PERFORMANCE
RESULTS
WellPoint, Highmark,
and HealthPartners move
beyond process measurement
Page 24

"There are no problems we cannot solve together, and very few that we can solve by ourselves."

Lyndon B. Johnson, 36th US President