12th National Quality Colloquium
Boot Camp 1

September 18, 2013

David B. Nash, MD, MBA
Dean, Jefferson School of Population Health
Tobacco Smoke Enema (1750s-1810s)
The tobacco enema was used to infuse tobacco smoke into a patient’s rectum for various medical purposes, primarily the resuscitation of drowning victims. A rectal tube inserted into the anus was connected to a fumigator and bellows that forced the smoke towards the rectum. The warmth of the smoke was thought to promote respiration, but doubts about the credibility of tobacco enemas led to the popular phrase “blow smoke up one’s ass.”

This Old Tool has been reintroduced in Washington D.C. by the New Administration.
Are you starting to feel it
Reforming health care

This is going to hurt
Total Hip and Knee Replacements
Fiscal Year 2002: July 1, 2001 to June 30, 2002

Pennsylvania Health Care Cost Containment Council
June 2003
Regional Variation in Rates of Spine Surgery

Total Spine Surgery
There was substantial regional variation in overall spine surgery rates among Medicare enrollees in 2002-03 (Figure 3). Rates varied by a factor of almost six, from 1.6 per 1,000 enrollees to 9.4. Among the hospital referral regions where rates of spine surgery were highest were Casper, Wyoming (9.4); Mason City, Iowa (9.0); Bend, Oregon (8.7); Boise, Idaho (8.2); and Billings, Montana (8.0). Regions with rates lower than the national average of 4.0 spine surgery procedures per 1,000 enrollees included Honolulu (1.6); Newark, New Jersey (1.7); Paterson, New Jersey (1.8); Manhattan (1.8); and East Long Island, New York (1.8).

Map 1. Spine Surgery
In 71 hospital referral regions, rates of spine surgery were at least 30% higher than the United States average of 4.0 per 1,000 Medicare enrollees. In 52 hospital referral regions, rates were more than 25% lower than the national average.
... all hospitals are accountable to the public for their degree of success...

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg
Acute Escalation

1 January 2011 (27 November 2010)

The President, Executive Board, Members and Friends of The International Society for Quality in Health Care and the Editors of the Society’s Journal, announce with sadness the death of Dr. Ahmed El-Banna, one of the Society’s Founding Members and a Life Fellow of ISQua, who died peacefully in his home in Ann Arbor, Michigan, USA, on 1 November 2010.

© 2010 International Society for Quality in Health Care and Oxford University Press
Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work

By John Casey
ARE DOCTORS JUST PLAYING HUNCHES?

We expect them to use hard data. But that's not always the best kind of medicine

By CHRISTINE GEERING

NOT EVERYTHING IS CLEAR-cut, but if there's one thing we ought to be able to rely on, it's that doctors are only looking out for us and don't want to harm us. We trust that certain medicines because they work. Right? We go into the operating room or certain procedures because we believe they’ll make us well, don’t we?

Well, maybe. In some cases, however, doctors are making the same mistakes that are common in other industries. The medical community is notorious for relying on anecdotal evidence and personal experience, which can lead to incorrect or dangerous treatment decisions.

To make a long-term difference in a person’s quality of life or prolong survival, clinicians are more likely to show that they are safe and effective before they are approved by the U.S. Food and Drug Administration. But a clinical trial is not the end of the process. The results must be interpreted and understood in the context of the patient's individual situation.

For example, a study may show that a particular treatment is effective, but it may not be effective for all patients. It's important to consider the patient's specific circumstances and the potential risks and benefits of the treatment.

Some things can't be tested, some things are so obvious, they don't need it.
Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>75.7%</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>68.5%</td>
</tr>
<tr>
<td>CAD</td>
<td>68.0%</td>
</tr>
<tr>
<td>CHF</td>
<td>63.9%</td>
</tr>
<tr>
<td>COPD</td>
<td>58.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45.4%</td>
</tr>
<tr>
<td>CAP</td>
<td>39.0%</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>24.7%</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

Average 54.9%

Number of Indicators: 9, 6, 37, 36, 20, 13, 5, 10, 9

A World of Hurt

Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00–2.33</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2.34–4.66</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4.67–7.00</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>OVERALL RANKING (2010)</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Quality Care</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Effective Care</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Safe Care</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Access</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Long, Healthy, Productive Lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2007</td>
<td>$3,357</td>
<td>$3,895</td>
<td>$3,586</td>
<td>$3,837*</td>
<td>$2,454</td>
<td>$2,992</td>
<td>$7,200</td>
</tr>
</tbody>
</table>

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).
It is possible to improve care
and dramatically lower costs.

Berwick *Annals* 2/98
Getting to 10%

CARE-RELATED COSTS
- Prevent medical errors
- Prevent avoidable hospital admissions
- Prevent avoidable hospital readmissions
- Improve hospital efficiency
- Decrease costs of episodes of care
- Improve targeting of costly services
- Increase shared decision-making

ADMINISTRATIVE COSTS
- Use common billing and claims forms

RELATED REFORMS
- Medical Liability Reform
- Prevent Fraud and Abuse

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation / Improving health
Imperatives of the New Century

- Accountable for the health status of defined populations
- Global Budgets/Targets
- Incentives to actively manage clinical care
- Incentives to provide a coordinated continuum of care
- Incentives for continuous quality improvement
- The demand for value
The Seamless Continuum of Care

COMMUNITY

Patients

Prevention and Wellness
- Occupational Health
- Wellness Centers
- Physician Offices

Primary Care
- Physician Groups

Acute Care
- Physician Groups
- Hospitals
- Ambulatory Surgery Centers

Rehabilitative Care
- Hospitals
- Nursing Homes
- Home Health Agencies

Chronic Care
- Rehab Units
- Physical/Occupational Therapy Centers
- Recovery Centers
- Home Health Centers

Supportive Care
- Hospices
- Home Health Agencies

Jefferson
School of Population Health
Shortell Stages of Integration

- **Functional**
  - bring partners together

- **Physician - System Integration**
  - bring together doctor groups

- **Clinical integration**
What will clinical integration require?

- Centralization of process
- Evidence based medical practice
- Commitment to self evaluation
Cultural Barriers to Integration
(and Industrialization)

- Autonomous decision making
- Socialization
- Uneven evidence about outcomes
- Fear of performance assessment
Definition of Quality
Institute of Medicine

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”
First, Do No Harm

To Err Is Human
Building a Safer Health System

Institute of Medicine
Today's debate: Medical errors

Why do so many still die needlessly in hospitals?

Our view:
Part-voluntary, part-mandatory reporting system can reduce deaths.

When a report came out last week from a private group claiming that nearly 200,000 hospital patients each year face preventable medical errors, it prompted a fierce controversy.

A study by the Institute for Healthcare Improvement found that, on average, 1 in 10 hospital patients suffer an injury due to a preventable error. The report was based on data from 15 hospitals, with an estimated 500,000 cases each year nationwide.

The study also found that hospitals could improve their systems to prevent errors, but many were not doing enough. The report highlighted the need for a system that could track and report errors accurately.

Mistakes cost lives

Highlights from a new study of medical errors among Medicare patients hospitalized from 2006 through 2007:

- Of 27 million hospitalizations, 1.14 million patients incurred errors.
- Of those errors, 1 in 5 were preventable.
- The errors resulted in harm to the patient, including death in 1% of cases.

The study found that hospitals that implemented error-reporting systems had lower rates of errors and better outcomes for patients. But many hospitals still do not have such systems in place.

Six states that have set up similar programs have seen a significant increase in reported errors. But it's not yet clear how to handle the information, and officials are still working on the details.

In this case, the picture will still be woefully incomplete — and patients will remain at risk — unless the reporting of errors that kill or cause the most serious injuries is made mandatory.

Only 22 states currently have mandatory error-reporting systems. The others rely on hospital industry watchdogs or malpractice lawyers to be on the lookout for mistakes.

The argument over numbers is proof that leaving the solution to the courts is not a prescription for eliminating deadly errors.

Five years ago, the IOM recommended a national database of errors that are made mandatory. It is still the most dependable compensation.

The question is why five years have elapsed with so little being done. With tens of thousands dying needlessly every year, the next life at risk may be your own.
| PHYSICAL EXAMINATION | ...
|----------------------|-----------------
| Name:               | MR #          |
| Date:               |               |
| General:            | Weight: 150   |
| Assessment:         | Blood Pressure: 120/80 |
| Age:                | Pulse: 72      |
| Condition:          | Temp: 98.6     |
| Appearance:         | Respirations: 12 |
| Head:               |               |
| Neck:               |               |
| Face:               |               |
| Eyes:               |               |
| Ears:               |               |
| Nose:               |               |
| Mouth:              |               |
| Heart:              |               |
| Vascular:           |               |
| Abdomen:            |               |
| Respiratory:        |               |
| Neurological:       |               |
| Musculoskeletal:    |               |
| Impression:         |               |
| Performed by:       |               |
| Physician (initials): |             |

Reviewed by Physician: [Signature]
No changes. Temperature still indicated.
Significant changes:

- Weight 150 lbs.
- Pulse 72
- Respirations 12
5 BEST PLACES TO LIVE–ABROAD!
Enjoy paradise on next to nothing
Page 32

Dennis Quaid
A medical mistake nearly killed his infant twins—and inspired a personal mission to save lives
Page 48

PLUS
Are you ready for the next market dip?
Page 39

Discover Your Inner Genius
Late-blooming artists tell you now

8 signs your marriage is healthy (or not)
Outfox the airlines!
Meet the real Jane Pauley
How Medical Errors Affect Physicians

Features

Reporting Systems
- The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

Million Lives Campaign
- Miles to Go: An Introduction to the 5 Million Lives Campaign

Teamwork and Communication
- The Continuing Problem of Missed Test Results in an Integrated Health System with an Advanced Electronic Medical Record

Health Professional Education
- How Staff and Medical Student Attitudes Toward Medical Errors and Adverse Events

Methods, Tools, and Strategies
- Awareness and Use of a Cognitive Aid for Anesthesiology

Departments

Rapid Response Systems: The Stories
- Improving Rapid Response Systems: Progress, Issues, and Future Directions
Only 77% wash hands after using the toilet

Advocates are pushing for more frequent scrubplings in health care and non-health care settings.

Victoria Stange Elliott

How clean are your hands? How about the person who just shook yours?

Several presentations at last month’s Interscience Conference on Antimicrobial Agents and Chemotherapy in Chicago suggested that people not only wash their hands less often than they say they do, but the number who really do appears to be decreasing. Also, improving hand hygiene in the health care setting saves money.

“Hand are great distributors of disease, but hand washing is a great intervention,” said Judy Daly, PhD, spokeswoman for the American Society for Microbiology, which organized this meeting. She is also director of the microbiology laboratory at Primary Children’s Medical Center in Salt Lake City.

According to data from observational and telephone surveys by Harris Interactive, which were commissioned by the society as well as the Soap and Detergent Assn, and released at the meeting, 82% of adults say they always wash their hands after using a public restroom. When observed in places such as train stations and sports stadiums, only 77% actually do. This represented a decline from the 83% observed in the 2005 version of this survey.

Significant gender differences also were seen, with only 68% of men soap ing up compared with 88% of women. Similar gaps between men and women also were found by other studies that examined the behavior of doctors and health care professionals.

“Very clearly, guys need to step up to the plate,” said Brian Sanson, vice president of communication for the soap association.

This issue has long concerned medical societies, patient safety organizations and public health agencies. The American Medical Association urges everyone to view hand washing as important. Experts suggest, however, that while this activity is important across the board, more payoff may be gained from programs that focus on health care settings.

“The message about improving hand hygiene is a good message to support, but we will naturally see the greatest result in the places where the sickest people are,” said Dr. M. Lindsey Grayson, vice chair of Austin Hospital/Austin Health in Melbourne, Australia.

In these settings, the benefit of hand hygiene is increasingly being quantified. For instance, a paper presented by Dr. Grayson found that hand hygiene education for health care professionals along with ensuring that alcohol-based hand rubs were available significantly reduced the number of methicillin-resistant Staphylococcus aureus infections. In turn, this resulted in a 55% reduction in hospital charges as compared with a control group.

“We need to change the culture,” Dr. Grayson said. “Those who provide care should feel funny walking up to a patient having not used an alcohol-based hand rub. And the patient should feel pretty funny, too.”

An Argentinean study also found that upping compliance with hand hygiene recommendations in the intensive care unit reduced the device-associated infection rate from nearly 30% to just shy of 5%. But although researchers say these efforts can pay for themselves, improving hand hygiene
WHAT DOCTORS HATE ABOUT HOSPITALS
An insider's view of what goes wrong—and how you can improve your odds of getting the right treatment
BY NANCY LIBBER & AMANDA BOWKER
Institute of Medicine Report 2001

Outlines Key Dimensions of the Healthcare Delivery System:

**Safe**: avoiding injuries to patients from the care that is intended to help them.

**Effective**: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

**Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

**Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.

**Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

**Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.

Source: Institute of Medicine 2001; 5-6
Ten Commandments
Crossing the Quality Chasm

Current Rules
1. Care is based primarily on visits
2. Professional autonomy drives variability
3. Professionals control care
4. Information is a record
5. Decision making is based on training and experience

New Rules
1. Care is based on continuous healing relationships
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge is shared freely
5. Decision making is evidence-based

Don Berwick 2002
## Ten Commandments (cont.d)

<table>
<thead>
<tr>
<th>Current Rules</th>
<th>New Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. “Do no harm” is an individual responsibility</td>
<td>6. Safety is a system property</td>
</tr>
<tr>
<td>7. Secrecy is necessary</td>
<td>7. Transparency is necessary</td>
</tr>
<tr>
<td>8. The system reacts to needs</td>
<td>8. Needs are anticipated</td>
</tr>
<tr>
<td>9. Cost reduction is sought</td>
<td>9. Waste is continuously decreased</td>
</tr>
<tr>
<td>10. Preference is given to professional roles over the system</td>
<td>10. Cooperation among clinicians is a priority</td>
</tr>
</tbody>
</table>

*Don Berwick 2002*
## Commentary

<table>
<thead>
<tr>
<th>Safe</th>
<th>Timely</th>
<th>Effective</th>
<th>Efficient</th>
<th>Equitable</th>
<th>Patient-Centered</th>
</tr>
</thead>
</table>
| - No harm from care  
  (procedural competence, experience, medical knowledge, evidence-based medicine) | - No delays in acute care  
  (pathology, process mapping, team function, information systems, procedural competence) | - Curative of acute illness  
  (basic science, vocabulary, key concepts integrated around biologic homeostasis, pathology, resilience, evidence-based medicine) | - Cost-benefit analysis  
  (epidemiology, economics, statistics) | - Justice  
  (philosophy, public health, business, sociology) | - Cultural beliefs  
  (anthropology) |
| - No errors  
  (anatomy, physiology, pathology, etc., systems engineering, information systems, cognitive psychology) | - Access chronic care  
  (information systems, communications) | - Prevention  
  (epidemiology, evidence-based medicine) | - Reduction of waste  
  (process engineering) | - Finance  
  (economics, business, international health) | - Ethical values  
  (philosophy, religion) |
| - Ongoing preventive care  
  (epidemiology, surveillance) | - Reduce suffering  
  (psychology, religion, procedural competence) | | | | - Communications  
  (psychology, Spanish language skills, humanities) |

**Figure 1** Attributes of the Institute of Medicine quality objectives with related curriculum areas.
A need for unified governance

No American Quality Improvement Community

Develop Performance Measures

Certify Performance Measures

Implement Performance Measures

NCQA
AQA, HQA
CAHPS

NQF

JCAHO
CMS Plans

Multiple Public and Private Sector Stakeholders
100+ different P4P Programs

Source: Tooker/ACP
“Unexplained Clinical Variation”

- Major roadblock to:
  - Lowering costs
  - Improving quality
  - Establishing accountability
The Assumption of Financial Risk

- Creates need for accountability.

- Makes me care what my partners order!

- Most importantly, it obviates need for external control.
  - Yes, but now we have to do it ourselves!
Old Quality Tripod

- Structure
- Process
- Outcome
What is Outcomes Management?

- Three tiered definition
Tier One Outcomes (Traditional)

- Morbidity
- Mortality
- Return to the O.R.
- Nosocomial Infections
Tier Two *Outcomes (Modern)*

- Patient satisfaction
- Functional status
- Return to work
Tier Three *Outcomes* (Ellwood)

- Linking tiers one and two to payment

Tier 1

Tier 2

= Tier 3
Autonomy and Accountability

A Zero Sum Game?
A Real Integrated System

• Performs no scientifically groundless treatments

• Formally searches for effective, proven care practices

• Is the safest health care organization

• Involves patients and families fully in their own care

• Is an open health care organization
Health Reform Builds on the Current Quality Infrastructure

Improved Quality of Care and Lower Overall Costs

- National Quality Improvement Strategy
- Quality Measure Development
- Value-Based Purchasing
- Prevention and Wellness
- New Entities and Authorities

Jefferson
School of Population Health
Report to Congress

National Strategy for Quality Improvement in Health Care

March 2011
The Four Underlying Concepts of Cost Containment Through Payment Reform…….

<table>
<thead>
<tr>
<th>Tying payment to evidence and outcomes rather than per unit of service</th>
<th>“Bundling” payments for physician and hospital services by episode or condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement for the coordination of care in a medical home</td>
<td>Accountability for results - patient management across care settings</td>
</tr>
</tbody>
</table>
Range of Models in Existence or Development

Increasing assumed risk by provider

Increasing coordination/integration required

Current State: Payments for Reporting
Incremental FFS payments for value
Bundled payments for acute episode
Bundled payments for chronic care/disease carve-outs
Accountability for Population Health

P4P, “Never” Events
Range of Models in Existence or Development

Current State: Payments for Reporting
- Incremental FFS payments for value
- Bundled payments for acute episode
- Bundled payments for chronic care/disease carve-outs

Accountability for Population Health

Episode of Care
Range of Models in Existence or Development

- Current State: Payments for Reporting
- Incremental FFS payments for value
- Bundled payments for acute episode
- Bundled payments for chronic care/disease carve-outs
- Accountability for Population Health

Medical Homes
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”

<table>
<thead>
<tr>
<th>Care that is:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Accessible</td>
</tr>
<tr>
<td></td>
<td>• Family-centered</td>
</tr>
<tr>
<td></td>
<td>• Continuous</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive</td>
</tr>
<tr>
<td></td>
<td>• Coordinated</td>
</tr>
<tr>
<td></td>
<td>• Compassionate</td>
</tr>
<tr>
<td></td>
<td>• Culturally effective</td>
</tr>
</tbody>
</table>

and for which the PCP: Shares Responsibility with Patient/Family
Range of Models in Existence or Development

Current State: Payments for Reporting

Incremental FFS payments for value

Bundled payments for acute episode

Bundled payments for chronic care/disease carve-outs

Accountability for Population Health

Accountable Care Organizations
Driving Population Health Through Accountable Care Organizations

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.
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 Four Actions Framework Builds the Foundation for Accountable Care

<table>
<thead>
<tr>
<th>Eliminate</th>
<th>Raise</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Unnecessary and redundant testing</td>
<td></td>
</tr>
<tr>
<td>- Avoidable hospital readmissions</td>
<td></td>
</tr>
<tr>
<td>- Use of paper documentation</td>
<td></td>
</tr>
<tr>
<td>- Hospital-acquired infections</td>
<td></td>
</tr>
<tr>
<td>- Chronic disease management</td>
<td></td>
</tr>
<tr>
<td>- Patient engagement in their care</td>
<td></td>
</tr>
<tr>
<td>- Home monitoring and follow-up</td>
<td></td>
</tr>
<tr>
<td>- Health promotion</td>
<td></td>
</tr>
<tr>
<td>- Screenings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reduce</th>
<th>Create</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fragmented approach to care</td>
<td></td>
</tr>
<tr>
<td>- Overall hospital admissions</td>
<td></td>
</tr>
<tr>
<td>- One-on-one and face-to-face provider visits</td>
<td></td>
</tr>
<tr>
<td>- Poor health maintenance</td>
<td></td>
</tr>
<tr>
<td>- Use of phone and fax</td>
<td></td>
</tr>
<tr>
<td>- Integrated networks</td>
<td></td>
</tr>
<tr>
<td>- Patient care teams</td>
<td></td>
</tr>
<tr>
<td>- Patient registries</td>
<td></td>
</tr>
<tr>
<td>- Patient portals</td>
<td></td>
</tr>
<tr>
<td>- Virtual visits</td>
<td></td>
</tr>
<tr>
<td>- Multiple access points</td>
<td></td>
</tr>
</tbody>
</table>

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
CONTENTS
- Lifestyle Behavior and Emotional Health
- Strategic Response by Providers
- Tobacco Dependence Treatment Guideline Implementation
- Theory-Based Telehealth and Patient Empowerment
- Health-Related Productivity Loss
- Quality of Care for Veterans with Chronic Diseases

Editor-in-Chief
David B. Nash, M.D., M.B.A.

Managing Editor
Deborah Meiris

The Official Journal of CareContinuum Alliance

Mary Ann Liebert, Inc. publishers
“It’s always better to have them in the tent pissing out, than outside the tent pissing in.”

*President, L.B. Johnson*
Nash’s Immutable Rule

High Quality care costs less!
Contact Information

Jefferson School of Population Health
901 Walnut Street, 10th Floor
Philadelphia, PA 19107
215-955-6969 (Office)
David.Nash@jefferson.edu

Visit JSPH online at
Webpage: http://jefferson.edu/population_health
Blog: http://nashhealthpolicy.blogspot.com
Facebook: www.facebook.com/jeffersonjsph
Twitter: https://twitter.com/JeffersonJSPH