Why Should You Care?

- The federal health systems do not operate in a vacuum
  - Trends in civilian healthcare increasingly impact the MHS (including healthcare reform efforts through the ACA)
  - Civilian healthcare will be the lens through which MHS care is viewed under the microscope of oversight
- Federal health programs are seen as test beds and demonstration sites for innovations in care (IOM Report – *Leadership by Example*).
- The MHS requires increasing interaction, interoperability, and in some cases interdependence, with civilian healthcare programs
  - Strategies, tactics, and tools (e.g. High Reliability) are becoming increasingly similar between civilian and federal healthcare
- It is unlikely that you will be working in the MHS for your entire career
  - Transitioning leadership in the MHS arena to the civilian sector is a well worn path but it requires contextual awareness
  - You have some important advantages in terms of experience but you need to know them well
Mission: “To enhance DoD and our Nation’s security by providing health support for the full range of military operations and maximizing the health of all those entrusted to our care.”

Vision: “The integrated Military Health System delivers a coordinated continuum of preventive and curative services to eligible beneficiaries and is accountable for health outcomes while supporting the Services' warfighter requirements.”
Mission: “To enhance DoD and our Nation’s security by providing health support for the full range of military operations and maximizing the health of all those entrusted to our care.”

Vision: “The integrated Military Health System delivers a coordinated continuum of preventive and curative services to eligible beneficiaries and is accountable for health outcomes while supporting the Services’ warfighter requirements.”

Civilian vs. MHS STRATEGY MAP – FOCUS AREAS

**Readiness**
- PLS1 Medically Ready Force
- PLS2 Ready Medical Force
- IP1 Improve Global Health Engagement
- IP2 Improve Operational Medicine
- IP3 Enhance Emerging Medical Capabilities in a Joint Environment
- IP4 Enhance Strategic Partnerships

**Better Health**
- PLS3 Healthy People
- IP5 Improve Healthy Behaviors
- IP6 Expand the Boundaries of Healthcare
- IP7 Improve Condition-Based Quality Care
- IP8 Improve Comprehensive Primary Care

**Better Care**
- IP9 Improve Safety
- IP10 Optimize & Standardize Access & Other Care Support Processes
- IP11 Reform TRICARE
- IP12 Align Incentives to Achieve Outcomes

**Lower Cost**
- PLS4 Improve Clinical Outcomes and Consistent Patient Experience
- PLS5 Improve Stewardship
- OC1 Recruit, Train, & Develop the Total Force to Meet Future Challenges
- OC2 Improve Information Infrastructure
- OC3 Optimize DHA as a Support Organization
- OC4 Improve Process-Based Management
- OC5 Align Facilities, Personnel, and Capabilities to Optimize Market Performance

**MEANS**
- Financial
- Organizational Capability
- Internal Process

**ENDS**
- Patient/Leader/Stakeholder
- Medical force ready to deliver health services anywhere, anytime, so that the total force is medically ready for, and protected during, any operational mission
- Provide safe and effective patient centered healthcare that improves clinical outcomes
- Reducing the total cost of the MHS by continuously improving efficiency and eliminating waste

**WAYS**
- Improve Stewardship
- Improve Comprehensive Primary Care
What type of evolutionary era are we in?

- Gradualism versus punctuated equilibrium
  - Environmental assessment as the key to what we will look like
  - Technical Revolution and Cultural Revolution
- Globalization of healthcare, disruptive forces, ongoing global financial challenges, increasing coverage in the face of physician shortages, and the ACA – Health reform is a process, not an event
MGH Mortality rate vs Patient Care Cost per discharge (2010 dollars), 1821 - 2010

% Mortality vs Patient Care Cost per discharge (2010 $)
The Cost Landscape

- Per capita health care costs have grown steadily for 40 years.
- Private insurance payers subsidize underpayments by Medicare, Medicaid and the uninsured.
- Chronic disease and technology are the primary drivers of cost.
- Proposals to extend health insurance coverage don’t alleviate cost pressures.
Two Competing* Views of Healthcare Costs.....
Both are correct*

Medicare cost trends are unsustainably high and threaten to bankrupt the Federal Government (along with a few other things)

Inadequate payment rates from the government threaten the viability of hospitals, access of elderly patients to needed care and are driving unprecedented cost shifting to the private sector

• BTW the healthcare sector is a driver of local economies
One Model of the Last Decade’s Evolution of Healthcare

- **Market sensitivity to hospital/MD quality & TCO**
  - **Clinical re-engineering by MDs, hospitals & suppliers**
    - Q $\uparrow$ 50 ppts
    - $ \downarrow$ 40 ppts

**Key Evolutionary Steps**

- **Performance comparisons for hospitals, MDs & Tx**
- **Consumerism & P4P**
  - Market sensitivity to hospital/MD quality & TCO
- **Chasm Crossing**
  - Q $\uparrow$ 50 ppts
  - $ \downarrow$ 40 ppts

**Value of Health Benefits**

- **Performance Disclosure**
- **Value of Health Benefits**

**2002 to 2012**

- **Q** = compliance with guidelines
- **$** = annual health benefits cost

Reproduced with permission of Arnold Milstein, MD (Mercer/Stanford)
Massachusetts General Hospital

- Ranked #1 in the nation overall
- Only other Massachusetts Hospital in the top 10 MGH’s partner institution, the Brigham and Women’s Hospital.
- 7 HealthGrades awards
- Ranked as the 9th best hospital in Boston
- One of the lowest rated hospitals in Boston
- “There are wide disparities in hospital payments but no real difference in quality.”
To palliate congenital aortic stenosis, the valve is dilated with a balloon

**Therapeutic success** is achieved by maximizing the amount of dilation/gradient relief -- *use a bigger balloon*

**Safety** is achieved by avoiding rupture/damage to the valve -- *use a smaller balloon*

Do not measure quality of aortic valvuloplasty purely by procedural morbidity/mortality, need a measure of efficacy and long term benefit as well, otherwise the incentive is purely to use a smaller balloon

The new face of transparency

### INPATIENT SERVICES

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Coronary bypass</th>
<th>Hip replacement</th>
<th>Pneumonia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts General Hospital</td>
<td>$51,522</td>
<td>$23,197</td>
<td>$6,789</td>
</tr>
<tr>
<td>Brigham and Women's Hospital</td>
<td>$47,138</td>
<td>$24,552</td>
<td>$7,935</td>
</tr>
<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>$33,988</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Lahey Clinic</td>
<td>$43,514</td>
<td>$21,627</td>
<td>$5,595</td>
</tr>
<tr>
<td>Northeast Health System, Shrewsbury Hospital</td>
<td>NA</td>
<td>$70,175</td>
<td>$6,184</td>
</tr>
<tr>
<td>South Shore Hospital</td>
<td>NA</td>
<td>$16,798</td>
<td>$5,492</td>
</tr>
<tr>
<td>Boston Medical Center</td>
<td>$40,486</td>
<td>$16,299</td>
<td>$5,032</td>
</tr>
<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>$43,514</td>
<td>$17,880</td>
<td>$4,814</td>
</tr>
<tr>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

### OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th>Hospital</th>
<th>MRI of the brain</th>
<th>CT-scan of chest</th>
<th>Ultrasound, first trimester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts General Hospital</td>
<td>$1,153</td>
<td>$482</td>
<td>NA</td>
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<tr>
<td>Brigham and Women's Hospital</td>
<td>$1,218</td>
<td>$338</td>
<td>$184</td>
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<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>$263</td>
<td>$138</td>
<td>$117</td>
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<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>$557</td>
<td>$147</td>
<td>$86</td>
</tr>
<tr>
<td>Boston Medical Center</td>
<td>$557</td>
<td>$147</td>
<td>$86</td>
</tr>
<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>$455</td>
<td>$147</td>
<td>$86</td>
</tr>
</tbody>
</table>

*The most recent government quality data indicates average mortality rates for all of the inpatient procedures below with the single exception of MRI, which scored above average for its treatment of pneumonia, meaning it had been patient deaths than expected.*

---

**The Leader in Health Care Transparency**

Castlight Health provides the most comprehensive information about price and quality, helping companies save money and improve care.

[See Castlight in action]
One Model of the Last Decade’s Evolution of Healthcare

Key Evolutionary Steps

Performance comparison s for hospitals, MDs & Tx

Market sensitivity to hospital/MD quality & TCO

P4P & Consumerism

Clinical re-engineering by MDs, hospitals & suppliers

Chasm Crossing

Value of Health Benefits

High

Low

2002

2012

Q = compliance with guidelines
$ = annual health benefits cost

Q ↑ 50 ppts
$ ↓ 40 ppts
What is Payment for Performance?

Payment for Performance = Concrete financial incentives (either “bonuses” or “return of withholds”) for meeting negotiated targets on quality and efficiency

Goals include:

1. **Efficiency** (managing utilization and costs)
   - Inpatient days or admissions or readmissions
   - High cost imaging utilization
   - Pharmacy costs
   - Emergency Room utilization
   - Management of High Risk Patients

2. **Quality** (improving patient safety and quality care)
   - Pediatric asthmatic use of controller medications
   - Adult diabetes population HbA1c testing and control
   - Chlamydia testing in young adult women
   - Cardiac Care
   - Reporting of healthcare acquired infections

3. **Infrastructure**
   - Electronic Medical Record (EMR) implementation by PCPs and Specialists (accelerated by HITECH and ARRA)
   - Computerized Physician Order Entry (CPOE) implementation
   - Safety system implementation
   - Patient Centered Medical Home implementation
### Impact of pay for value programs: once fully implemented (FY ’17) for one unnamed New England Hospital

<table>
<thead>
<tr>
<th>CMS Program</th>
<th>Start Year</th>
<th>Payment mechanism</th>
<th>Annual risk* $M</th>
<th>Cum risk thru FY 17 $M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Quality Reporting</td>
<td>2010</td>
<td>MB penalty for failure to report</td>
<td>$9 M</td>
<td>$63 M</td>
</tr>
<tr>
<td>Value Based Purchasing</td>
<td>2013</td>
<td>MB reduction with option to earn back based on performance</td>
<td>$4 M</td>
<td>$15 M</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>2015</td>
<td>MB penalty for bottom quartile performance</td>
<td>$3 M</td>
<td>$9 M</td>
</tr>
<tr>
<td>Reducing Readmissions</td>
<td>2013</td>
<td>MB penalty for performance (stratified)</td>
<td>$9 M</td>
<td>$34 M</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>2015</td>
<td>MB penalty if failure to meet MU requirements</td>
<td>$6 M</td>
<td>$24 M</td>
</tr>
<tr>
<td><strong>Total Financial Risk</strong></td>
<td></td>
<td></td>
<td><strong>$31 M</strong></td>
<td><strong>$145 M</strong></td>
</tr>
</tbody>
</table>

* Annual risk when fully implemented
Employers are offering their employees alternative insurance products

**AWARENESS AND USAGE OF NEW HEALTH PLANS**

High Deductible and Tiered most popular new products

- 96% heard of
- 80% understand well or somewhat well

47% of large employers offer Tiered products

- 89% of employers offer Tiered products
- 84% of employers offer Limited Network
- 87% of employers offer Defined Contribution

Employer Study A2: The past few years in Massachusetts have seen the emergence of new health plan designs that are intended to lower premiums. Have you heard of each of the following before today?

Employer Study A3: Do you offer or have you considered offering any of these types of plans for your employees?
Selective contracting (restricted networks) is the next step and a key characteristic of exchange products.
Some large and mid-sized employers are resorting to the exchange

• To minimize the variability of healthcare costs, a number of large employers are using defined contributions to send their employees/beneficiaries to the market to shop for their care and mid sized employers are following suit:

Companies sending Retirees to a exchange:

GE
IBM
TIME WARNER CABLE

Companies sending current employees to a exchange:

Walgreens
THE HOME DEPOT
SEARS
Market Evolution Requires New Approach to Compete Successfully

### Traditional Market
- Passive employer
- Broad, open networks
- Fee for service
- Government subsidized by commercial
- Price-insulated employee
- Fragmented providers

### Emerging Market
- Activist employer look at options (i.e.: use private exchange & COEs)
- Narrow, tiered networks
- Reference pricing
- Public payer dominant
- Payment reform
- Price sensitive, shopping for convenience & quality
- Provider consolidation
- Population management
- Increase in provider-sponsored insurance

#### Key Points
1. **Employers seek employee “skin in the game”**
2. **Increased plan options & transparency**
3. **US aging, increased regulation & reform**
4. **Patient act as retail customer**
5. **Provider M&A, creation of networks, ACOs, increased population management; vertical integration into insurance plans**

Source: Adapted from Health Care Advisory Board interviews and analysis.
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2002

2012

Key Evolutionary Steps
The 20 Year Perspective

Version 0.0

Your Future Health Plan

By DAVE ASPESI

The American Health Security Act reduces the burden of government and administrative expenses, regulating requirements, and consumers experience a strengthened and singular system.

—Introduction to draft of Clinton health plan

As with the budget earlier this year, there is a disparity between what the administration claims about its health care plan and what it does. A new analysis of the 230-page draft circulating on Capitol Hill reveals that the Clinton health plan would create 13 new federal programs or improvements, spend 32 billion, impose 73 new federal mandates, and make major changes to the tax code.

The accompanying chart is a simplified version of the plan. The accompanying glossary cites specific references to the page number of the draft where the functions of an agency or program are described, where there are too many references to mention (or count level functioning or the functions are not described in detail more local functions.

In essence, the plan should be noted that not the basics on the chart are new creations. Some are existing agencies or programs.

Version 1.0

Your New Health Care System

Secretary

Health & Human Services

Chairman of the House Republican Conference.

Ford

Chrysler

GM

Starbucks

Uniformed Services University

of the Health Science
## Accountable Care – Cliff Notes Version

<table>
<thead>
<tr>
<th>Health Care Environmental Paradigm</th>
<th>Fee for Service</th>
<th>DRG / Quality Cost Incentives</th>
<th>Accountable Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Volume</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of Stay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ancillary Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System formation and expansion, market consolidation, Volume driven primary and specialty care</td>
<td>Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued expansion, Emergence of quality and safety processes and metrics, Increased transparency on pricing and outcomes</td>
<td>Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The “Triple Aim” (Value)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Improve the experience of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve the health of populations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce the per capita costs of health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept “integrator” role</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Two-way risk sharing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MACRA creates 2 tracks of Medicare payment

**Track I) MIPS**  
Merit-Based Incentive Payment System

- **2015:H2 – 2019:** 0.5% annual update
- **2018:** Last year of separate MU, PQRS, and VBM penalties
- **2020 – 2025:** Frozen payment rates
  - **2020:** -5% to +15% at risk
  - **2022 and on:** -9% to +27% at risk
- **2019:** Combine PQRS, MU, & VBM programs: -4% to +12% at risk
- **2021:** -7% to +21% at risk
- **2026 and on:** 0.25% annual update

**Track II) APMs**  
Advanced Alternative Payment Models

- **2015:H2 – 2019:** 0.5% annual update
- **2019 - 2024:** 5% participation bonus
- **2019 - 2020:** 25% Medicare revenue requirement
- **2021 and on:** Ramped up Medicare or all-payer revenue requirements
- **2026 and on:** 0.75% annual update

*While MIPS has higher bonus potential for a limited number of physicians, APMs is generally the more favorable track to be in.*
I’ve Seen This Movie Before And I Did Not Like The Ending: Not the 1990s Redux
The ACA Leaves No Spectators

Macro Forces Changing the Commercial Market

Fundamental market forces prompted ACA, and in combination the two have reshaped the future commercial market. All stakeholders are responding to these changes.

Macro Forces

- Demographics
- Uninsured
- Costs
- Technology

Commercial Market Impact

- Rate Pressure from all Payers
- Expanded Low Reimbursement Populations
- More Self-Insured
- More Individual Purchasers
- Low Cost Benefit Design / Pricing
- Tiered / Narrow Networks
- Fed Exchange Impacts
- Demands for Transparency

Market Responses

- Diversifying Business Portfolio
- Pushing Risk to Providers
- Cost Transparency
- Technological Innovations
- Vertical Integration
- Expanding Product Portfolio
- Exchange Strategy

- Cost Shifting to Employees
- Offering Tiered / Narrow Networks
- Offering more High Deductible Products
- Offering Products with Deductibles
- Requiring Cost Transparency
- Continue to Move Toward Self-Insured
- Requiring Convenience - Technology

- Taking on Risk
- Entering the Health Plan Business
- Moving to Population Health
- Focusing on Quality Reporting
- Technological Innovations
- Medicare & Medicaid Strategies
- Exchange Strategy
Market pressures continue to intensify, requiring system approach to compete successfully.

Cost pressure, impetus to prove value

Increased accountability: rewards for longitudinal solutions (value) vs. rewards for “clicks” (volume)

Increased competition: ACOs, rationalization

Health systems competing directly to sell value to employers & consumers
<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Example</th>
<th>Goals of a payment method</th>
<th>Possible optimal method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple self limiting disease</td>
<td>Recurrent UTI in sexually active woman &gt; 18</td>
<td>1. Rationalization of utilization</td>
<td>Fee for service with self pay (Retail Health)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Ease of access</td>
<td></td>
</tr>
<tr>
<td>Minor trauma</td>
<td>Fractured forearm</td>
<td>1. Rationalization of utilization</td>
<td>Fee for service with co-pay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Ease of access</td>
<td></td>
</tr>
<tr>
<td>Stable chronic disease</td>
<td>Congestive heart failure</td>
<td>1. Rationalization of utilization</td>
<td>Capitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Reduction of hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Investment in infrastructure</td>
<td></td>
</tr>
<tr>
<td>Major single illness</td>
<td>Breast cancer</td>
<td>1. Coordination of multiple providers within a team</td>
<td>Episode of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Investment in infrastructure including staff</td>
<td></td>
</tr>
<tr>
<td>Emergency, major trauma</td>
<td>Motor vehicle accident</td>
<td>1. Universal access</td>
<td>Public Utility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Maintenance of surge capacity</td>
<td></td>
</tr>
</tbody>
</table>

**Key Capability:** Provide high quality patient centered care appropriately and efficiently (i.e. High Value)
Provide high quality patient centered care efficiently

Population Management Imperative*

Goals
- Demonstrably higher quality
- Decreased unit cost
- Savings to purchasers

Approach
- Improve quality (patient outcomes)
- Reduce unit costs
- Redesign care (fewer units/patient)
- Improve access (more patients)

*I This is what you do!
Getting From Here To There Is Going To Be Expensive

- Volume focused
- Size / market share may sustain better payment rates for some period of time
- Many AHCs are content in this space for now

- Value focused
- Rationally distribute resources to meet population needs
- Scale to spread risk and needed infrastructure cost (IT, care coord.)

- Volume focused, but high risk
- Small population to spread risk and infrastructure cost
- Managed Care in the 1990s
## Key Capabilities Required to Provide High Value

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Primary Care</strong></td>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td>Patient portal/physician portal</td>
<td>Hospital Access Center</td>
<td></td>
</tr>
<tr>
<td>Extended hours/same day appointments</td>
<td>Reduced low acuity admissions</td>
<td></td>
</tr>
<tr>
<td>Expand virtual visit options</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Design of care</th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
</tr>
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<tbody>
<tr>
<td></td>
<td><strong>Primary Care</strong></td>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td>Defined process standards in priority conditions (multidisciplinary teams)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk care management</td>
<td>Shared decision making</td>
<td>Re-admissions</td>
</tr>
<tr>
<td>100% preventive services</td>
<td>Appropriateness</td>
<td>Hospital Acquired Conditions</td>
</tr>
<tr>
<td>EHR with decision support and order entry</td>
<td></td>
<td>Hand-off standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incentive programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>Primary Care</strong></td>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td>Variance reporting/performance dashboards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality metrics: clinical outcomes, satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs/population</td>
<td>Costs/episode</td>
<td></td>
</tr>
</tbody>
</table>
Sutton’s Law And Healthcare

Opportunity

10% of Medicare patients account for nearly 70% of spending

20% of Medicare patients have 5 or more chronic conditions

- Congestive heart failure
- Chronic pulmonary disease
- Coronary disease
- Diabetes
- Depression

Results

Successful Enrollment 87% of eligible beneficiaries enrolled

- High patient and physician satisfaction
- Hospitalization rate among enrolled patients was 20% lower than comparison*
- ED visit rates were 25% lower for enrolled patients
- Annual mortality 16% among enrolled and 20% among comparison
- 7.1% annual net savings (12.1% gross) for enrolled patients
- For every $1 spent, the program saved at least $2.65
## Key Capabilities Required to Provide High Value

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
<th>Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>Expand virtual visit options</td>
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</table>

**Design of care**

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<tr>
<td><strong>High risk care management</strong></td>
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<td></td>
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<tr>
<td><strong>Shared decision making</strong></td>
<td></td>
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<td>Re-admissions</td>
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<tr>
<td><strong>100% preventive services</strong></td>
<td>Appropriateness</td>
<td></td>
<td>Hospital Acquired Conditions</td>
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<td>Hand-off standards</td>
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</tbody>
</table>

**Measurement**

<table>
<thead>
<tr>
<th></th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
<th>Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variance reporting/performance dashboards</strong></td>
<td></td>
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<tr>
<td><strong>Quality metrics: clinical outcomes, satisfaction</strong></td>
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<tr>
<td><strong>Costs/population</strong></td>
<td></td>
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<td>Costs/episode</td>
</tr>
</tbody>
</table>
The HRO Need

Medicare Post-Acute Reimbursements for Total Knee Replacements (30-day episodes)

High-Reliability Health Care: Getting There from Here

MARK R. CHASSIN and JEROD M. LOEB

The Joint Commission

Context: Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day. Hospitals find improvement difficult to sustain, and they suffer "project fatigue" because so many problems need attention. No hospitals or health systems have achieved consistent excellence throughout their institutions. High-reliability science is
Five Principles of High Reliability Organizations

Anticipation - “Stay Out of Trouble”
• 1. Preoccupation with failure
• 2. Sensitivity to operations
• 3. Reluctance to simplify

Containment - “Get Out of Trouble”
• 4. Commitment to resilience
• 5. Deference to expertise
### Center Projects

<table>
<thead>
<tr>
<th>Center Projects</th>
<th>Results(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
<td>71↑</td>
</tr>
<tr>
<td>Hand-off communication failures</td>
<td>56↓</td>
</tr>
<tr>
<td>Wrong site surgery risks</td>
<td></td>
</tr>
<tr>
<td>• Scheduling</td>
<td>46↓</td>
</tr>
<tr>
<td>• Pre-op</td>
<td>63↓</td>
</tr>
<tr>
<td>• Operating Room</td>
<td>51↓</td>
</tr>
<tr>
<td>Colorectal SSIs</td>
<td>32↓</td>
</tr>
<tr>
<td>Falls with injury</td>
<td>62↓</td>
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</tbody>
</table>

*But Does It Work?*

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The New “Good Doctor”

• “In the past, a stereotypical good doctor was independent and always available, had encyclopedic knowledge, and was a master of rescue care. Today, a good doctor must have a solid fund of knowledge and sound decision-making skills but also must be emotionally intelligent, a team player, able to obtain information from colleagues and technological sources, embrace quality improvement as well as public reporting, and reliably deliver evidence-based care, using scientifically informed guidelines in a personal, compassionate, patient-centered manner.”
Things Are Changing - Current Landscape: Rate of Healthcare Spending Growth

- 41.3M to 30M uninsured (of whom 48% are eligible for some assistance)
- Between January 2012 and December 2013 there have been 150,000 fewer readmissions
- Amount spent per Medicare beneficiary has declined in real terms for $12000 in 2011 to $11200 in 2014

Source: Martin A B et al. Health Affairs January 2014
Recession Explains Only One-Third of Slow Down

Estimate of economic downturn contributing to decreased healthcare spending range from 37 – 77% - no matter what the real number there are other factors at play

- **55%**
  - Other factors such as:
    - Reduction in new technology like imaging and Rx
    - Increased patient cost-sharing
    - Greater provider efficiency

- **37%**
  - Recession

- **5%**
  - Medicare payment reform

- **3%**
  - Payer mix change (without recession)

Source: Cutler DM, Sahni RS, Health Affairs, May 2013
From various estimates, a reasonable consolidated approximation for the U.S. population as a whole looks something like (see McGinnis 2002):

- 40 percent attributable to behavior patterns (drawn from epidemiological literature on the roles of different behaviors in various diseases)
- 5 percent attributable to the physical environment (drawn largely from epidemiological literature on the contributions of different environmental exposures to certain diseases)
- 15 percent attributable to social circumstances (drawn from studies of the impact of neighborhoods, social class, and social change on mortality rates)
- 10 percent attributable to deficiencies in medical care access and delivery (drawn from a 1975 CDC assessment of field contributions, the 2002 IOM study To Err is Human, and other related assessments)
- 30 percent attributable to genetics (the residual)
Disruptions of Traditional Models

“Many companies see the disruption unleashed by the reforms as the business opportunity of a lifetime”

Economist – 7 March 2015

• Walgreens is working with Theranos, a diagnostics firms, which offers a range of tests from a tiny drop of blood.

• Walmart intends to become one of the leading sellers of affordable health services (just like everything else they sell)

• Urgent care offers lower cost ED alternative

• Vitals offers a cash reward and a taxi fare if you agree to be treated at a lower cost provider

Financial incentives OK’d for workplace wellness programs

By Associated Press | April 17, 2015

In a victory for business, federal regulators said Thursday that employers can continue to use financial penalties and rewards to nudge staff to participate in fast-growing workplace wellness programs.
Disruptions of Traditional Models

• Cohealo – AirBnB of expensive hospital equipment
• Kyruus – match.com for doctors
• Low cost providers (imaging and lab)
• Telehealth
• Disintermediation
  • Provider based plans
  • Direct contracting with employers
Conclusions

- Civilian marketplace has shifted its focus from quality to value
- Payment for performance and new contracting models have transformed into value-based purchasing but taking on greater financial risk is likely to emerge as dominant mode of market reform
  - Increased out of pocket costs with tiering
  - Selective contracting
  - Shared savings plans
  - Re-emergence of forms of capitation
- Health reform (national, state, and local) will be seen as a value re-engineering opportunity
  - Providing high quality patient centered care efficiently (i.e. High Value) will be the key differentiator of successful healthcare organizations in the civilian marketplace
  - Focusing on key capabilities (HRO) and shifting from an individual to a population based focus are the imperatives in the civilian marketplace
    - Some of these have been a longstanding focus in the MHS
- We are likely to experience a continuing period of punctuated equilibrium in the evolution of the healthcare marketplace in the next few years—further incremental healthcare reform is coming (focused on payment, delivery and financing)
“It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.”

- Charles Darwin
1809 - 1882