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Leadership Group Offers Employers, Orgs Roadmap for Complying With Reform

BY LES C. MEYER, MBA

The Patient Protection and Affordable Care Act has been maligned as a law that, despite its good intentions, will bloat government bureaucracy in a sluggish economy and set the stage for a federal takeover of the nation's healthcare system.

Some pundits say that "trusted clinician" provider efforts to address operational inefficiencies that would eliminate $3.6 trillion in healthcare waste and avoid costs make up "a dismal history" and that accountable care organizations (ACOs) that try to do so are unlikely to accomplish their objective to create health through collaborative neighborhood health assurance initiatives.

NO MORE BUSINESS AS USUAL

The nation of "disruptive improvement" is genuinely shaped by population health impact design methods and imaginative innovations that improve everyone's economic well-being and quality of life.

Streetwise change agents realize that health and performance improvement continuous value enhancement is not just a law – it's a robust movement to market-based transformation by fixing healthcare on the frontlines along the road to complying with this law. A recent cost-benefit analysis by the U.S. Social Security Advisory Board advised business leaders and consumers: "We do not underestimate the difficulty of what needs to be done. Nor do we underestimate the need to do it. The need is urgent. It is time to begin."

If you are trying to avoid cost, you've got to become heavily involved in prevention. "Sick care" costs money. Prevention saves. It's that simple. While Congress recently voted to repeal this landmark legislation, entrepreneurs, CEOs and their business-savvy workforces will continue to "bend the trend" on one valuable truth: "Necessity is the mother of all invention."

The ACA could prove to be an inertia-busting catalyst for breathtaking change that brings together employers, employees, physicians, medical group practices and hospital systems. The upshot is that market forces would enable each of these key stakeholders to innovate and function as coherent organizations that facilitate real-time information exchange at the point of care, improve safety and operating efficiency, and provide advanced comparative effectiveness pathways and timely, world-class care to American citizens.

What's more, the Congressional Budget Office predicts that if the ACA disruptive improvement were repealed it would ratchet up the federal deficit by about $230 billion over the next decade and leave 32 million more Americans uninsured.

It's understandable that major work remains to be completed in defining and instituting the regulatory systems authorized by the ACA law. "The actuaries believe that regulatory systems will better anticipate future systemic risk by incorporating sound risk management principles. Any new regime should employ the appropriate oversight, expertise and accountability necessary to mitigate the effects of risks that could threaten the stability of the nation's financial system," says Andrew Simonelli, assistant director of communications for the American Academy of Actuaries.

"Despite the uncertainty and controversy it has generated, the ACA has sown the seeds for a major reorganization of the U.S. healthcare delivery system," says Thomas L. Greaney, J.D., Chester A. Myers professor of law at Saint Louis University.

As a strategic imperative and serious economic strategy, the offshoots of the ACA include epidemic community health and performance improvement failures and wasteful behaviors in neighborhoods that drive operational inefficiencies in healthcare. The overarching objective for consumers to thrive is to achieve population health and performance improvement continuous value enhancement. Large financial considerations also are at risk.

"Repealing health reform would increase medical spending by $125 billion by the end of this decade and add nearly $2,000 annually to family insurance premiums; destroy 250,000 to 400,000 jobs annually over the next decade; and reduce the share of workers who start new businesses, move to new jobs, or otherwise invest in themselves and the economy," says David Cutler, health economist, Harvard University, Department of Economics.

The ACA presents an opportunity to galvanize community leaders for a reinvention of healthcare through consumer-centered, neighborhood health assurance improvement initiatives that achieve healthy change. But the key to success will be changing the way they think. "There will be parties out there who wish to take advantage of the law, and the vocabulary to relabel what they already do and repackage the status quo," said Dr. Donald Berwick, administrator of the Centers for Medicare & Medicaid Services, during a recent meeting at the Brookings Institution in Washington, D.C. "I don't think that will be enough – not at scale. We are going to have to find a way to deliver care better, and that means change. And the question will be looking forward as we migrate into this terrain that seems to be, are you really in the game? Do you really want to provide better care at lower cost through improvement? Or are you simply taking what you already do and calling it something new, because that's the game of today. That is the question I think we'll be facing case by case and probably all together."

'TOO IMPORTANT TO FAIL'

While fear-mongering about the ACA's impact persists, some industry insiders not only believe that clear heads will prevail, they also are providing a strategic roadmap to help corporate America chart a course to better cost-containment and improved healthcare outcomes in a post-healthcare reform environment.

One such example is a cross-section of leaders from high-performance hospitals, clinics and ACOs called the Informed Opinion Leadership Action Group (IOLAG), which recently published a major study of the U.S. workplace suggesting how hospitals and physicians can best prepare for the ACA. The IOLAG – Employer Market Sector employer resource tool entitled, "Necessity Prompts Strategic Adaptation," was profiled in a 24-page supplement in the January/February 2011 issue of the *American Journal of Medical Quality*. The group advocates a population health approach to market-based transformation by fixing healthcare on the frontlines.

"The opinions from the national leadership group can be summarized in my view as a clarion call for a renewed commitment to making hard choices that require we abandon the status quo, not just modify it," said David B. Nash, M.D., MBA, AJMQ's editor in chief and dean of the Jefferson School of Population Health.

Jason Hwang, MD, MBA, executive director of healthcare at Innosight Institute, praised the IOLAG for offering "motivation and guidance to healthcare leaders who wish to challenge long-standing notions of what comprises a healthcare system and how health services can become convenient and affordable enough such that anyone can access them. ACA is only the latest wakeup call to re-examine our healthcare business models. We cannot afford to hit the snooze button again."

Dr. Paul H. Keckley, executive director of the Deloitte Center for Health Solutions, perhaps said it best when he noted that "the healthcare industry will thrive because it's too important to fail."

A STRATEGIC VISION AND ROADMAP

America's employers, hospitals and physicians now face a dramatically different healthcare financing and delivery landscape under the ACA. The U.S. Secretary of Health and Human Services has wide discretion to develop, implement and evaluate new care models that include, but are not limited to, ACOs, a national hospital-physician payment bundling pilot, patient-centered medical homes, reimbursement reductions for "avoidable" readmissions and comparative effectiveness improvements. This effort also includes other criteria for performance excellence execution to improve the economic well-being of companies and achieve value-centric strategic business adaptation alliances.

The ACA will serve as the vehicle by which costs are contained and quality of care is preserved or improved for the estimated 95 percent of Americans who are expected to have health insurance by 2020. Hospitals, of course, are grappling with strategies to determine the best way to care for another 30 million prospective patients who presumably will have access to affordable health insurance. Their response to any overwhelming demand for services will not only affect how care is delivered, but also forever alter the relationship among doctors, hospitals and insurance payers as part of the most sweeping changes in healthcare delivery and financing since the 1960s.

The IOLAG has produced a strategic roadmap to help C-Suite employer

executives, physician leaders and various community stakeholders optimize key business and clinical processes that neighborhood hospitals with their physician partners need to redesign for the new delivery and reimbursement environments created by the ACA, including a list of do's and don'ts.

The IOLAG's hospital market sector team leader, Dr. James B. Couch, created a set of 17 open-ended questions with the IOLAG's chairman that were used to obtain input from all co-contributors based on their experiences. The approach was intended to elicit recommendations on how hospitals and physicians would need to change their fundamental way of doing business to evolve, achieve and thrive in the emerging, value-focused group purchasing arrangements and ACO climate created by the ACA.

As healthcare delivery continues to change, one promising path to healthier communities will be through population health improvement tools, techniques and best practices that power "neighborhood cultures of health" and well-being. The IOLAG has suggested that hospitals need to integrate their work with local communities to create these cultures of health through strategic adaptation business alliances and determine how best to meet the highly anticipated increased demand from consumers for their services.

"The aim behind all of this is to reward value instead of volume and intensity by making providers eligible to share in the savings that result if they are able to take steps that reduce overall healthcare costs while maintaining or improving quality of care," says Dr. Mark McClellan, Director, Engelberg Center for Health Care Reform, The Brookings Institution.

CEOs of hospitals, clinics, health plans and ACOs are at a crossroad. With dramatic opportunities looming on the horizon, leaders are preparing for the uncertainty by understanding how to advance disruptive improvement to ensure lasting success.

The key is to adopt clinical integration criteria strategies to align hospitals' interests with those of its staff physicians and trusted clinicians to guide insightful decision making and create the most value in a way consumers can use. There is an inextricable link between quality-focused clinical integration criteria and effective healthcare options to help consumers better understand the pros and cons of different interventions in order to make distinctive choices regarding evidence-based treatments in the lifelong continuum of patient-centered care.

CRITERIA FOR PERFORMANCE ACHIEVEMENT EXCELLENCE

Over the next eight years the ACA will phase in a series of comprehensive healthcare reforms that were nearly a century in the making following failed attempts by scores of U.S. presidents and sessions of Congress. One of the most significant steps in this process takes place this year with the establishment of the Center for Medicare and Medicaid Innovation, which will seek to reduce the cost of these federal entitlement programs without skimping on quality. In anticipation of these changes, IOLAG members sought recommendations from 20 forward thinkers in the healthcare industry as to how hospitals and their physicians should reform the delivery and financing of care. The group homed in on five key points that include:

1. Reimbursement reductions to hospitals for being "readmission outliers."
2. Value-based purchasing of healthcare services.
3. Bundling payments for services to hospitals across episodes of care.
4. ACOs as part of Medicare's "Shared Savings Program."
5. Integrated electronic health information technology (HIT) systems.

Under the ACA, hospitals whose readmission rates exceed a severity-adjusted "excess ratio" will receive successive 1 percent reductions in the base-operating DRG payment beginning in federal fiscal years 2013 through 2015, according to the group.

As part of the ACA's Hospital Value-Based Purchasing Program, incentive payments would be tied to performance standards for treating Medicare patients as part of a three-year pilot program from October 2012 to 2015 that could be made permanent by 2017. Conditions would include acute myocardial infarction, pneumonia and surgical care. Proponents of population health improvement believe this approach gives patients more control over their healthcare decisions, producing trusted accountability systems and verifiable community health assurance outcomes that hold healthcare providers accountable for cost, quality and value.

As a corollary to value-based purchasing, the IOLAG pointed out that "culture of health" programs and other tools can help savvy employers prevent a host of chronic conditions, as well as improve outcomes and quality of life. A broader application produces neighborhood culture of health efforts that foster prudent lifestyle, health and wellness choices across larger populations in the community at large, resulting from a convergence of interests and support systems, structures and processes.

"The difficulty in maintaining an individual's focus on the adoption and persistence in achieving a healthy lifestyle lies at the heart of our healthcare crisis," notes Mark Bloomberg, M.D., chief medical officer of HealthNEXT and an adjunct lecturer in health policy and management at the Harvard School of Public Health. "We spend almost half of our waking hours at work and yet the workplace remains for the most part an uninvolved and even hostile environment for the promotion of favorable lifestyle choices. Moreover, there is often no coordination between what health benefits an employer provides and what, if any, incentives employees are offered to make healthier choices. Making matters much

worse, there is minimal effort to influence what community practices do to promote better health and, if addressed at all, such efforts rarely integrate with programs that might be offered at work. Identifying all employees and dependents as a defined population to whom a series of aligned efforts can be offered holds the key to creating a well-developed culture of health, which will absolutely achieve serious reductions in both direct and indirect healthcare costs."

Neighborhood cultures of health is the solution Americans have been searching for all along to achieve a work-life balance of physical, emotional, intellectual, social and spiritual health with consumers who long for improving their economic well-being and quality of life.

Informed opinion leaders believe value is built on four essential elements: trustworthiness and trust, engagement and incentive alignment, relevant information, and distinct choices. The IOLAG defines value (and value creation) and the convergence of population health promotion pillars as meaningful productive interactions and personalized experiences of consumers that result in thriving people.

Population health promotion means that individuals will have greater control over decisions affecting their optimal health realization and are motivated by recognized population well-being elements: optimal health, financial security, work-life balance achievement and total well-being.

"Health promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health," says Dr. Michael P. O'Donnell, editor in chief of the *American Journal of Health Promotion.*

Defining optimal health as "a dynamic balance of physical, emotional, social, spiritual and intellectual health," he says lifestyle change can be facilitated through learning experiences that enhance awareness, increase motivation and build skills, as well as opportunities that open access to environments that make positive health practices the easiest choice.

A national pilot program on payment bundling is slated to launch no later than January 1, 2013, when hospitals, physicians, skilled nursing facilities, home health agencies and others who treat patients across the continuum of care must submit data on quality and other measures to be paid for the services they

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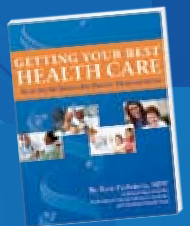

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provide. The conduit for such payment will be a "Qualified Electronic Medical Record" as defined by the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009.

"Electronic medical records serve as the core HIT systems to capture the clinical data to be used for the new quality improvement programs that are needed to support bundled payment and other new payment methodologies," says Dr. Ron Parton, chief medical officer of Symphony Corporation.

Providers of services and supplies may band together as ACOs no later than January 1, 2012, to manage and coordinate the quality, cost and overall care of groups involving at least 5,000 Medicare beneficiaries. It's worth noting that since the end of last summer, 40 health systems joined Premier Healthcare Alliance's ACO Readiness Collaborative to prepare for their new role under the ACA.

While the IOLAG noted that the ACA does not specifically address HIT, its inclusion in the HITECH portion of the ARRA is expected to help drive transformational changes in the delivery and financing of care. In essence, hospitals and physicians will be expected to use health information technologies to more freely exchange information en route to reducing cost and improving patient care. With new reimbursement methodologies rewarding the use of HIT, the group believes information technology can burnish value-based purchasing by fairly compensating hospitals and physicians for investing in a more efficient delivery system.

Parton explains that ACOs will develop more highly integrated clinical data warehouse and sophisticated population HIT technologies to improve quality and reduce unnecessary medical costs. "An ACO must be able to identify high-risk groups of patients, provide them with effective nurse case management and educational programs, and measure the effectiveness of their care by systematically tracking interventions and measuring outcomes," he says.

PEARLS OF WISDOM

Several common themes emerged based on a detailed analysis of IOLAG member responses in the aggregate, as well as individual advice about the best way for their peers to proceed. The group identified 20 non-duplicative processes that needed to be redesigned in order for hospitals and their physicians to succeed while the ACA is implemented.

These leaders collectively observed that there's room for improvement in the way hospital executives and clinicians evaluate and oversee the implementation of processes to continuously improve the quality, safety and value of integrated medical and behavioral care. They also recommended that hospitals partner with local communities to create neighborhood cultures of health through strategic adaptation business alliances and determine how best to meet the highly anticipated increased demand from consumers for their services. Another suggestion was that hospitals integrate electronically with their physicians, laboratories, imaging centers and pharmacies, as well as patients and home health caregivers through personal health records wherever possible.

In addition, a list of 30 individual observations was compiled to help offer hospital executives and clinicians a reality check along the road to ACA compliance. Among some of the more pithy comments: "Those who need incentives to improve the quality and value of their care are in the wrong business." and "The new world in healthcare will be driven by outcomes: 'No outcome, no income.'" There were many substantive examples, too. One IOLAG member, for instance, wrote about the potential for pharmaceutical firms and health plans to become "valuable partners to address the value-driven challenges of healthcare reform only if they focus less on their own bottom lines and more on how they can provide specific expertise to help close gaps in hospital and physician performance." Another remarked that the movement toward neighborhood health and performance improvement continuous value enhancement by purchasers and patients alike "will drive hospitals and physicians into progressively larger groups and integrated systems that will have the financial wherewithal to maintain the latest integrated electronic record technologies and clinical decision support systems."

MOVING AGENDA TO ACTION

Hospitals and physicians need to change their fundamental way of doing business to evolve, achieve and thrive. Community hospital CEOs and neighborhood physician leaders recognize the meaningful use of health as a core competency and pathway to economic well-being and strategic imperative to achieve short-term growth, profit goals and sustain long-term competitive advantage.

The IOLAG concluded that while every hospital facility and physician practice is unique, their commonalities suggest enough traction in the industry's response thus far to challenges under the ACA that what they have to say should be considered a valuable addition to the growing healthcare literature. However, the group cautioned that any such recommendations for complying with the new healthcare reform law should not be undertaken without a careful review of their applicability to each institution's personnel, technological resources and time limits to effect the required changes. Also, conclusions drawn from this report could be turned into courses through which hospital executives and physicians could receive continuing medical education credit, but that in order to obtain accreditation from governing bodies such as the Accreditation Council for Continuing Medical Education, the IOLAG said these programs must be able to demonstrate that they close identified performance gaps.

Hospital administrators, physician leaders and other healthcare execu-

tives were urged to prioritize their long-term response to challenges under the ACA from both a personnel and technological standpoint over the coming months. One recommendation was to hold town hall meetings in local neighborhoods and conduct implementation planning to determine the steps necessary to undertake each initiative, including the required capabilities and resources, as well as which leaders would champion those efforts to comply with the law's significant milestones during the next few years.

American ingenuity works. It's now up to the nation's hospitals and trusted clinicians to prove it within the context of healthcare reform by implementing cultures of performance excellence and primary prevention as a first line of defense to help neighborhood employers succeed.

ABOUT THE INFORMED OPINION LEADERSHIP ACTION GROUP

The IOLAG was formed to gather breakthrough ideas from independent leaders with deep expertise in their field who create meaningful distinctions in the healthcare market and suggest an insightful exchange of information for sound decision making. Members of the group include CEOs and COOs of major hospitals and health systems, deans of schools of medicine and population health, senior executives of major national healthcare delivery and purchasing associations, medical group practice leadership, culture-of-health enterprises and managed care organizations. Their input, which was compiled during June and July 2010, was derived from a standardized set of 17 open-ended questions designed to elicit practical, reliable and relevant information about how hospitals and their physicians could best prepare for parts of the ACA that will have the greatest impact on the delivery and financing of care. CIP

Les C. Meyer, MBA, is a vice president of HealthNEXT and senior fellow, Jefferson School of Population Health. He is also a board member of the American Institute of Healthcare Innovation and Professional Patient Advocate Institute, as well as an active workgroup member of the American Hospital Association, American Society for Healthcare Human Resources Administration: "A Call to Action: Creating a Culture of Health."
Contact: Les.Meyer@HealthAndPerformance.info