

# POSITIONING YOUR PHO and/or IDS FOR HEALTH REFORM

AAIHDS Spring Managed Care Forum

April 23, 2009

## AGENDA

- Industry Overview
- Federal Approach to Reform
- Provider Collaboration in Reform
- Provider Role and Process for Reform
- Questions/Discussion

## Federal Persons Charged to Make Reform Happen

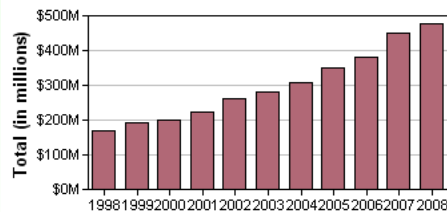
- Secretary of HHS - Kathleen Sebelius
- Director of White House Office of Health Reform - Nancy-Ann DeParle
  - Deputy Director of White House Office of Health Reform - Jeanne Lambrew
- HHS National Coordinator for HIT
  - Dr. David Blumenthal
- Your Elected **CONGRESS**

## Who Shapes Health Reform?

**\$478,530,500** was Spent on Health Lobbying in 2008

Representing 14.8% of the Total \$3.23 Billion Spent in 2008 for All Industries

Pharmaceuticals/Health Products	\$230,926,704
Hospitals/Nursing Homes	\$96,698,287
Health Professionals	\$82,305,968
Health Services/HMOs	\$62,722,992
Misc Health	\$5,876,549



source: OpenSecrets.org

## Health Reform Schools of Thought

- Government-Run Universal Care
  - “Fannie Med” (Medicare for everyone)
- Free Market Patient-Based
  - Choice
  - Competition
  - Accountability
  - Responsibility

## Elements of a National Value-Oriented Health Care Delivery System

- Standards for High Value Health Care
- Information Exchange Networks
- Tools to Promote Adoption of High-Value Care

Jeanne Lambrew, PhD testimony “Getting Better Value in Health Care” before the US House of Representatives Budget Committee on July 16, 2008

## Federal Approach to Create the Infrastructure for a Value-Based System

- Invest in Comparative Effectiveness Research (using EBM and metrics e.g. QALY)
- Create a Federal Reserve-type Board to Set Standards
- Accelerate the Use of HIT
- Mandate Medicare to Align Payment with Value (aka Value-Based Purchasing)
- Make Prevention a Priority

Jeanne Lambrew, PhD testimony "Getting Better Value in Health Care" before the US House of Representatives Budget Committee on July 16, 2008

## Obama's Administration Actions

- Establish a White House Office of Health Reform to create a national value-oriented health care delivery system
- Passage of H.R 1, the "American Recovery and Reinvestment Act of 2009"
- Mandate for Comparative Effectiveness Research (aka CER)

## Comparative Effectiveness Research Funding

- \$1.1 Billion in the Economic Stimulus Package for
  - AHRQ \$300 Million to “scale up” CER
  - NIH \$400 Million to do the same
  - HHS \$400 Million “to accelerate the development and dissemination” of CER

Source: American Medical Association

## Comparative Effectiveness Research

- New advisory council called the Federal Coordinating Council for Comparative Effectiveness Research (FCC4CER)
- FCC4CER - 15 bureaucrats (government employees)
- Improve health care value by enhancing physician clinical decision-making - not dictating it - and fostering the delivery of patient-centered care

## Clinical Effectiveness Research Use of New Metrics & Terms

- Quality Adjusted Life Year:
  - QALY is a measure that takes into account both the quantity and quality of life resulting from medical intervention. It can increase even if a medical intervention does not prolong life but merely enhances the quality of an unchanged remaining lifespan.

## The New Era of Healthcare

- Public Reporting/Transparency
- Consumer Driven Health Care (CDHC)
- Pay-For-Performance (P4P and NP4NO)
- Evidence-Based Medicine (EBM)
- Comparative Effectiveness & Efficacy
- Billy Beane “Sabremetrics”
- Radical Innovation; e.g. cloud computing, Health 2.0
- Business Rule Management System (BRMS)

**Payor’s agenda: VALUE and  
Transparency for Price and Quality**

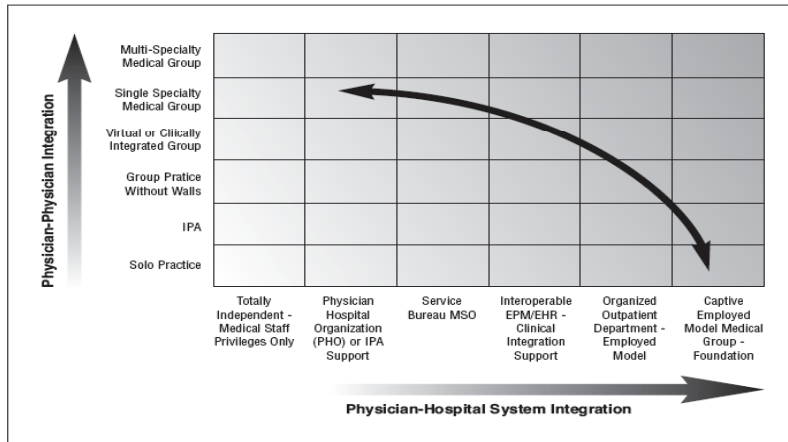
## Importance of Collaboration Among Health Care Providers to Improve Quality and Efficiency

- Hospitals and Physicians are *Interdependent*
  - Independent but rely upon one another
- Each Brings Respective Value to the Relationship

## Importance of Collaboration

- Independent Cooperation Leads to Integration
- Integration Creates Synergy
- Synergy Evolves Through Collaboration
  - Achieve **Physician** Success
  - Achieve **Hospital** Success
  - Provide Great Care to Your **Community**

# Range of Integration Options



Source: JHD Group

## Clinical Integration Defined

Evidenced by “a network implementing an active and ongoing program to evaluate and modify practice patterns by a network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality”

Source: Revised statements of the DOJ & FTC, September 1996

## Heart Attack Deaths Reduced by 73%

*“Technology itself cannot solve the healthcare crisis. [We] achieved quality care results by aligning people and technology in the most efficient care delivery system. It was not newer or more expensive treatments, but an integrated approach to deliver the right care at the right time.”*

George C. Halverson, Chairman and CEO of Kaiser Permanents at “Reforming the Health Care Delivery System : A Team Approach “ briefing in Washington ,DC on March 27, 2009

## Role of Integrated PHO's in Health Care Reform

- Foster collaboration to improve quality of care by creating and implementing standards at the local level
- Improve quality and efficiency for *interdependent* providers
- Provide a vehicle through which an entire episode of care/population of patients can be appropriately managed (prevention, chronic management, etc) via Health Information Technology
- Stabilize hospital/physician relationships by formalizing their shared goals

## Role of Integrated PHO's in Health Care Reform (continued)

- Provide a means whereby hospitals and physicians can align financial incentives with one another, within federal standards, to recognize the value of the services they offer
  - Gainsharing
  - Acute care episode bundled payments
- Provide a credible vehicle through which federal standards for high value care can be modified and implemented based on local standards

## Steps to Achieve Results

- Establish and Articulate Goals for the Clinical Integration Program
- Design the Program's Architecture
- Determine the Program's Clinical Approach
- Facilitate Communication Among and Between Providers
- Develop Mechanisms to Monitor and Control Adherence to Clinical Protocols
- Develop and Implement the Infrastructure

## Requisites to PHO Success

- Strong Leadership
- Effective Management
- Fair Governance
- Accountability
- Trust, Honesty & Integrity
- Shared Values

## Establish and Articulate Goals for the Clinical Integration Program

- Improve quality and consistency of care
- Reduce costs and increase efficiency
- Enhance risk management
- Speed adoption & common use of EMR/HIT
- Cost share for those improvements
- Reduce cost and hassle of dealing with MCO requirements such as pre-certs and UR
- Access to data to negotiate better reimbursement
- Get paid fairly for the value these efforts bring to the payors

## Determine the Program's Clinical Approach (e.g.)

- Best practices clinical protocols using evidence-based medicine and outcomes of comparative effectiveness research
- Disease registries
- Patient reminders
- Health coaching
- Patient education

## Facilitate Communication Among and Between Physicians and Hospitals

- Interoperability that Connects the “Frontend” to the “Backend” (e.g., cloud)
- Barriers to EHR/EMR adoption
- Incentive to adopt EMR with the hospital
- Interface via
  - Regional Health Information Organizations
  - National Health Information Exchanges

## Barriers to EHR/EMR Adoption

- Capital Costs
- Non-availability of suitable system
- Ambiguity about ROI
- System will become outdated

Source: "Electronic Health Records in Ambulatory Care - A National Survey of Physicians", NEJM, 7/3/08

## Incentive to Adopt EMR with Hospital

October 2006 - "Safe Harbor" to start allowing hospitals to "donate" up to 85% of EMR hardware, software, connectivity, training, & support to physicians.

May 11, 2007 - IRS clarified that donation will not pose threat to tax exempt status if:

- Used for Patient Clinical Information
- Interoperable & Certified by CCHIT
- Not tied to Physician volume or referrals
- Recipients contribute 15% of the cost of the items and services
- Agreement in writing

## Determine Which Providers Will be Included in the Program

- Establish criteria for allowing providers into and terminating from the program
  - Delineate specific criteria
  - Interpretation; scrutinize the data
- Exclusivity
  - Legal implications
  - Access implications
- Economic credentialing
  - Align policies in partnership consistent with state & federal laws and clinical standards

## Develop Mechanisms to Monitor, Report and Control Adherence to Clinical Protocols

- Responsible and Accountable
- Metrics and Data = Information
- Report Cards
  - Process Based (procedures appearing on claims)
  - Outcomes Based (clinical metrics from EMR/EHR)
  - ETG's (procedures & cost metrics from claims)
  - Opinion Based (subjective surveys & blogs)

## Adherence Mechanisms (continued)

- Educative Peer-to-Peer Counseling
- Timely Monetary Rewards
  - Individual level
  - Group level
  - Organization level
- Means to Expel Providers Failing to Meet Certain Performance Standards

## Develop and Implement the Infrastructure

- Takes time and money (financial and lots of physician sweat capital)
- Information System Infrastructure
- Knowledgeable and capable clinical (e.g. Medical Director) and administrative staff
- Physician committees supported by adequate administrative support staff
- Governance and decisions affecting clinical outcome by **practicing** physicians

## PHO Business Opportunities

- Group Purchasing (Volume Discounts)
  - Supplies
  - EMR - HIT
  - Insurance
- Revenue Enhancement Intermediary
  - P4P
  - Gainsharing
  - Network Fees

## Summary and Close

- Funding and mandates are Federal
- Health care is local
- Providers must collaborate and work together to prove value
- PHO's are the providers' best vehicle through which providers can retain any control over the way health care is delivered in the future

*“[Physicians] must step forward now in everything we do to try to be part of the solution in transforming our health care system”*

- Ted Epperly MD, AAFP President, February 25, 2009

My parting words ...

You, not the MCO's or the government, need to be masters of your future destiny. The time is now for providers to collaborate and work together to

- Achieve **Physician** success
- Achieve **Hospital** success
- Provide great care to your **Community**

Questions?

Discussion?

Thank You

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