Emerging Health Care Issues
Value of QI

Healthcare Reform

What's Wrong?

- Agreement that costs are too high and quality inconsistent and low
- Care is fragmented, variation in practice patterns, volume based payment systems

What's Important?

- Strong primary care infrastructure is important
- Care management, Care coordination and Management of transitions in care are critical success factors
- A strong focus on healthcare systems
- PCMH Initiative in Kansas, KanCare in Kansas Medicaid, HITECH act, Medicare Center for Innovation, ACO pilots and private sector and Medicaid pilots
- New models of payment is a foregone assumption

Drivers of Healthcare Reform

- Policymakers understand that
  - the major portion of health care costs originate with the provider- regardless of where care takes place
- Providers, not insurers, are in the best position to make the changes necessary to improve outcomes and control costs
  - Wrong incentives
  - Compliance with guidelines

Evolution of Expectations

- Team-based care
- Improved communication
- Improved data flow & access
- Right patient at the right time
- Patient-centered aligned incentives – outcomes, quality, cost
- Accountability – outcomes, quality, cost

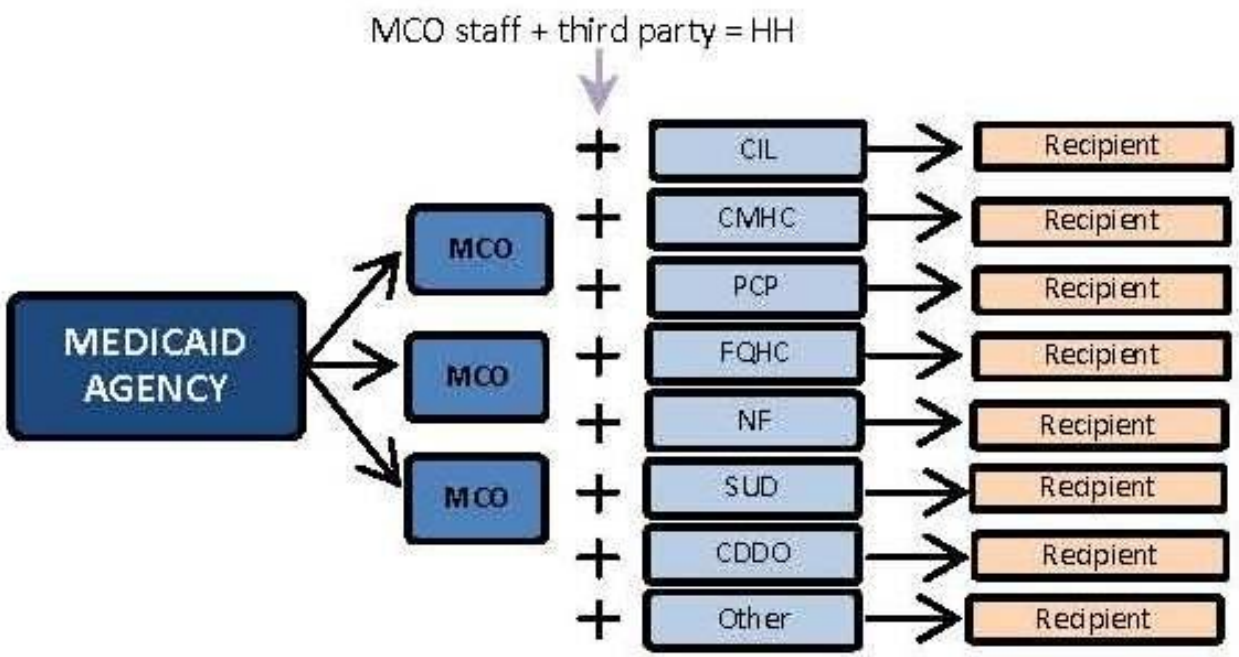
Where are we now?

- Let’s Not Forget Where We Started
- Goals for transformation –
  - Fragmented, not patient centered, poor outcomes, no accountability and high year-to-year cost increases.

KanCare

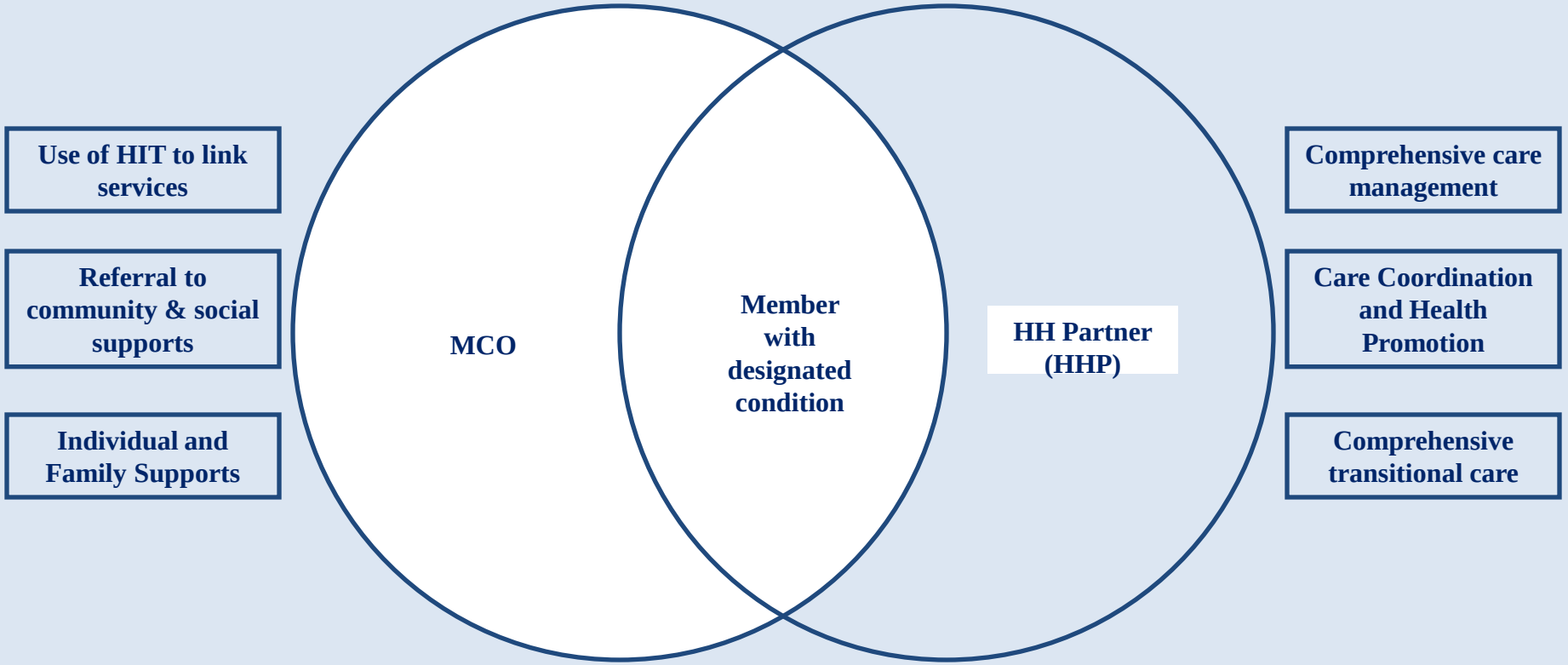
- Considering Transition
  - Not without concerns; not the finish line
  - Looking for systemic issues
  - Time for ramping up training and experience
  - We remain committed to our goals of improving care and outcomes
- Next Steps
  - Health Homes
  - I/DD Pilot
  - DSRIP

KanCare Health Home Model



Kansas Department of Health and Environment
Division of Health Care Finance

SERVICE STRUCTURE



Patient Centered Medical Home

- Principles
  - personal physician or provider,
  - physician-directed team,
  - whole-person orientation,
  - coordination of care,
  - quality and safety, and
  - enhanced access
- Focus Needs to extend beyond the PCMH practice population
  - **Care Coordination within the Medical (Primary Care) Neighborhood**

Why Integrated Models - for the provider?

- Improve the quality of care
- Lower the cost of care to the healthcare system
- Reduce unnecessary and duplicated care
- Focus on populations of patients
- Improve provider compensation
- Improve work/life balance
- Allowing physicians to do “doctor things” and other providers to contribute to the collaborative effort

Why Integrated Models - for the hospital?

- Improve the quality of care
- Lower the cost to provide care for the healthcare system
  - Reduce unnecessary and duplicated care
  - Reduce readmission penalties
- Focus on populations of patients
- Improve provider compensation
- Reduce Malpractice Liability
- Allowing other providers to contribute to the collaborative effort

FOUR CRITICAL FACTORS FOR SUCCESS

- Teamwork
- Change Management
- Leadership
- Communication

HEALTHCARE REFORM

- It’s not going away!

Integrating Primary Care and Public Health

Kansas
Department of Health and Environment

What Do We Mean By **Integration**?

Variables Used by the Committee:

Level	**Partners**
Action	**Degree**

Degrees of Integration:

Drivers – HIT and Meaningful Use

- Stage 1 is mostly designed to capture data and start sharing it,
- Stage 2 adds advanced care processes and decision support
  - Slated to begin early 2014, MU2 is a significant milestone for eligible providers and hospitals (EP/EH).
- Stage 3 will improve outcomes through population-based approaches.

Drivers – Resource Limitations

- Employers, Insurance Companies, and Patient Expectations
- Will Require Collaborations Across Community
  - Each group plays to their strengths
    - Public Health – Prevention/Promotion/Education
    - Clinical Health – Care Plan, Interventions, Coordination
    - Community – Address Social Factors
      - Housing, Education, Income, Social Connections, Neighborhood

Drivers - QI

3 Core Functions of Public Health

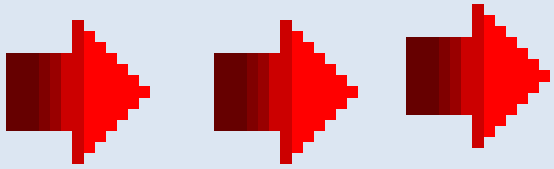
- Assessment
  - Based on Standards (Performance Management)
  - Improvement plan based on gap analysis
- Policy Development
- Assurance

Defining Quality Improvement

- **Doing the right thing well**
  - What is the right thing?
    - Evidence based practice
    - Regulatory guidelines
    - Standards of practice
  - What is well?
    - Benchmarking
  - **At all LEVELS**
    - Process Analysis and Improvement

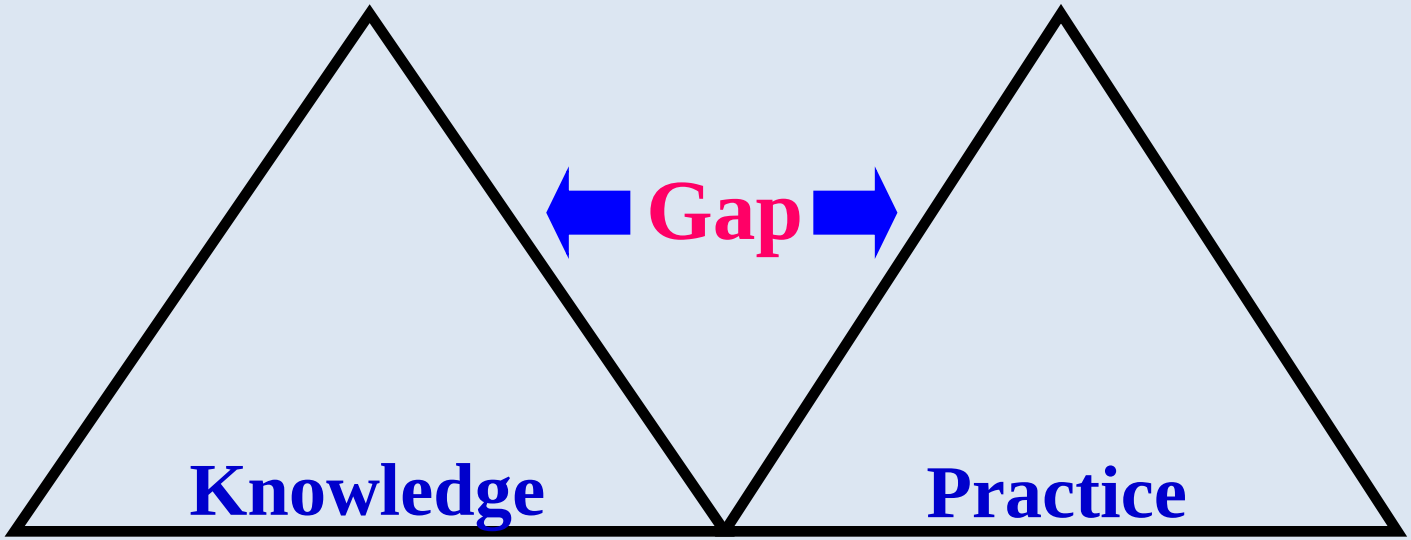
Quality Improvement

Turning what we know

into 

everyday practice

Opportunities to Improve . . .



. . . are identified where there is a gap between what you know and how you practice

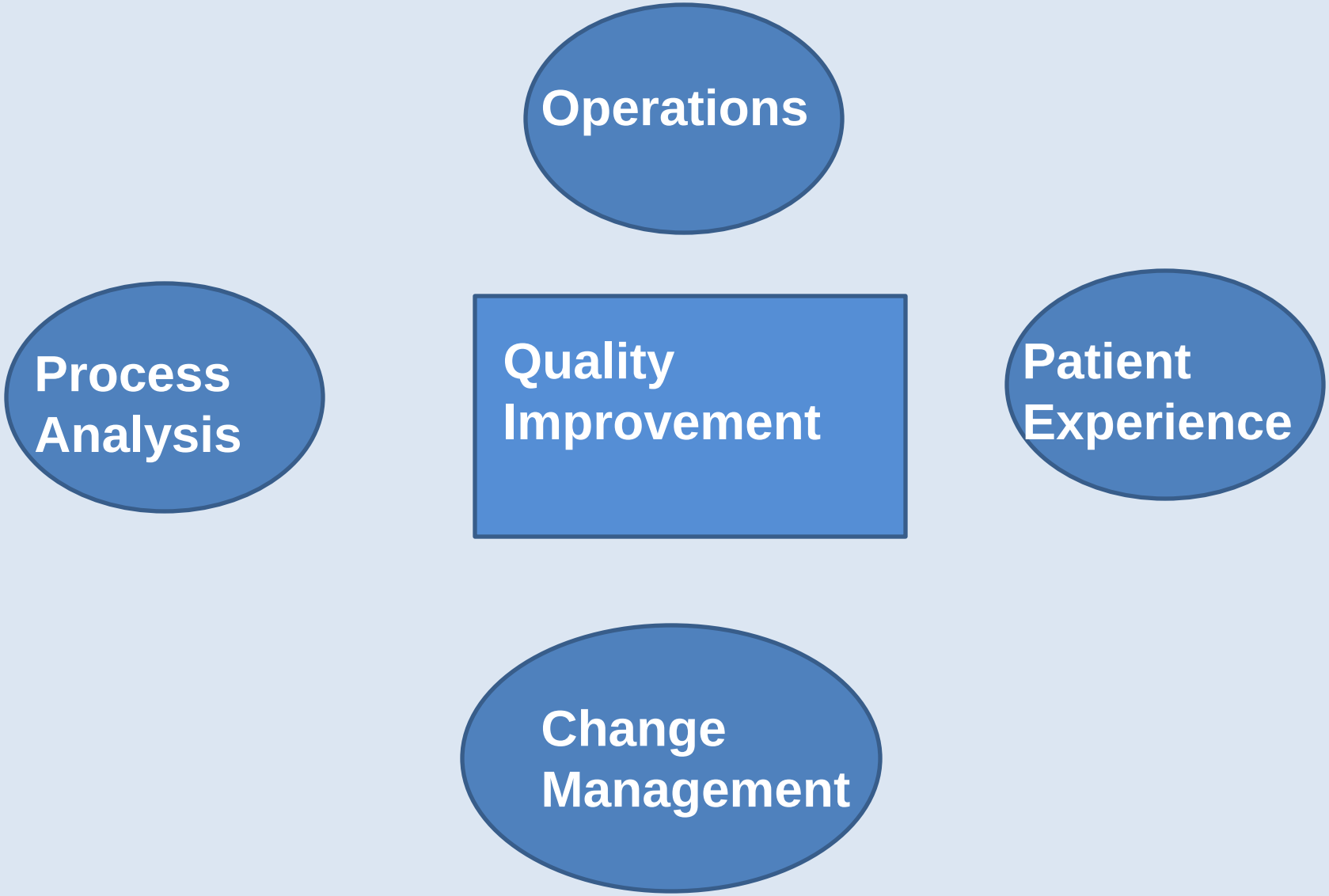
Quality Assurance vs. Quality Improvement

	QA	QI
Model	Monitor and correct performance outliers	Processes/systems are in place that will affect performance today
Program Scope	Focused on organizational mistakes	Focused on outcomes and processes of organizational services
Population	Problem prone areas	High-risk, high-volume, problem prone areas
Data Collection	Retrospective data collection	Concurrent data collection Proactive risk reduction

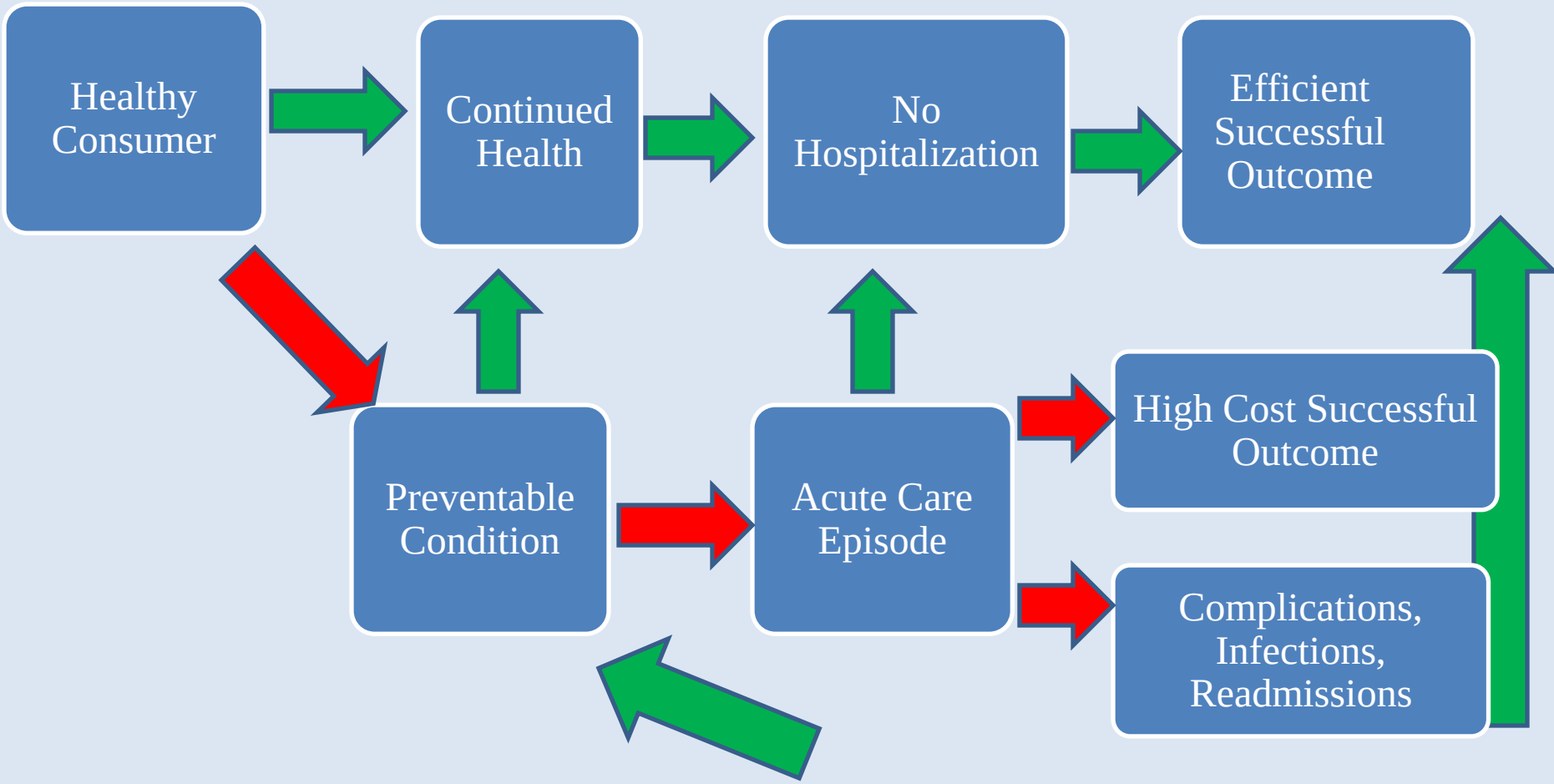
From QA to QI

QA	QI
Monitoring crash cart checks	Developing a code blue evaluation process: ■ Adequate number/type of staff response ■ Timeliness of team member response ■ Equipment availability/malfunction ■ ACLS guidelines followed? ■ Mock code blue drills

Many Areas to Focus Improvement



Reducing Healthcare Costs
The Focus Must Be Upstream



Déjà Vu Again

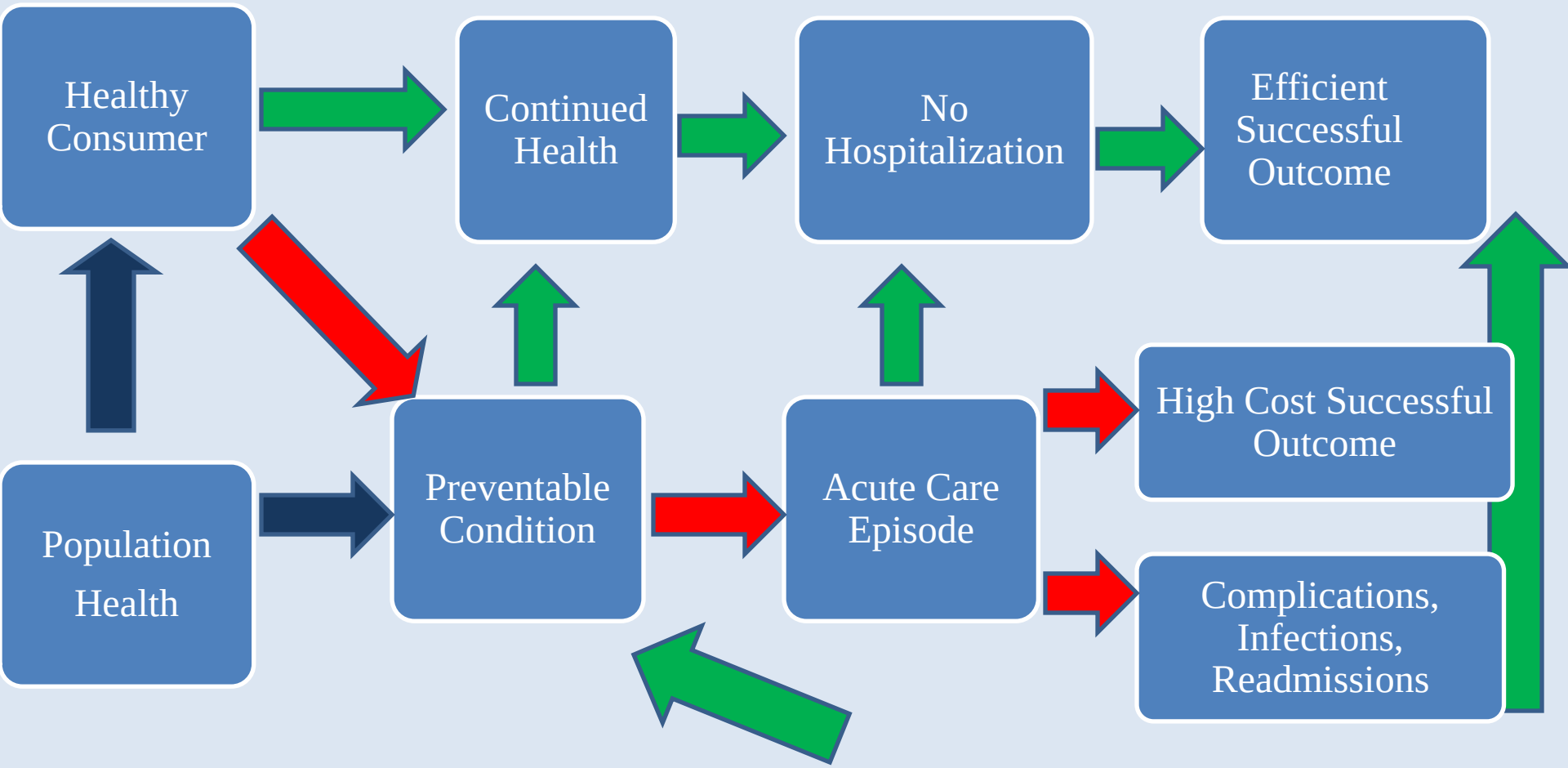
- **Historical Perspective of PC and PH Integration**
  - **Folsom Report** 1967
    - Community Health Centers
  - **Medicine and Public Health - the power of collaboration**
    - AMA and APHA effort 1997
  - **Primary Care and Public Health: Exploring Integration to Improve Population Health**
    - IOM March 2012 Report

Risk Factors for Chronic Disease in Kansas

Risk Factor	Current Prevalence	Estimated Number of Adults	Trend over Last Nine Years	Comparison with National Pattern
Hypertension	28.7%	600,000	Increasing (by 24%)	Similar
High Cholesterol among those who were tested	38.6%	640,000	Increasing (by32%)	Similar
Smoking	17.8%	376,000	Declined in last 4 years and now stable	Similar
Diabetes	*8.4%	*179,000	Increasing (by 42%)	Similar
Overweight or Obesity	64.6%	1.4 million	OW – stable; OB - increasing (by 33%)	Similar
Less than 5 times F/V Consumption	81.4%	1.7 million	Stable	Similar
No physical Activity	23.2%	490,000	Declining (by 13%)	Similar

Source: 2001-2009 Kansas BRFSS. Bureau of Health Promotion, KDHE. *2010 KS BRFSS.

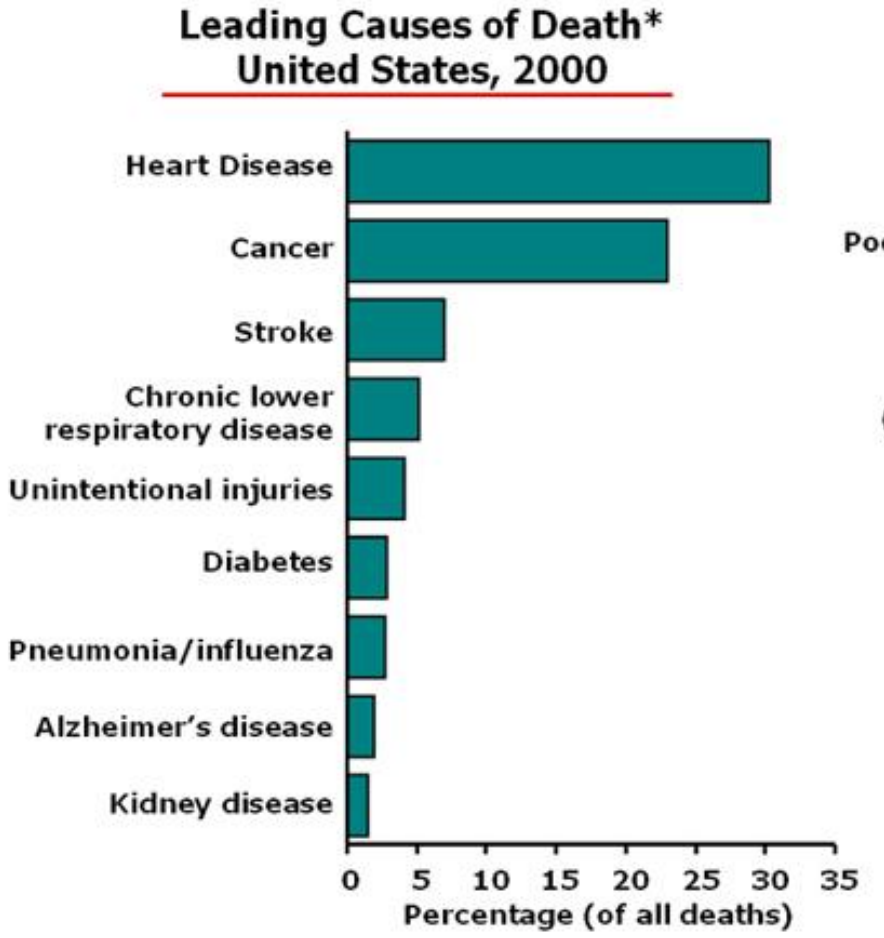
Reducing Healthcare Costs
The Focus Must Be Upstream

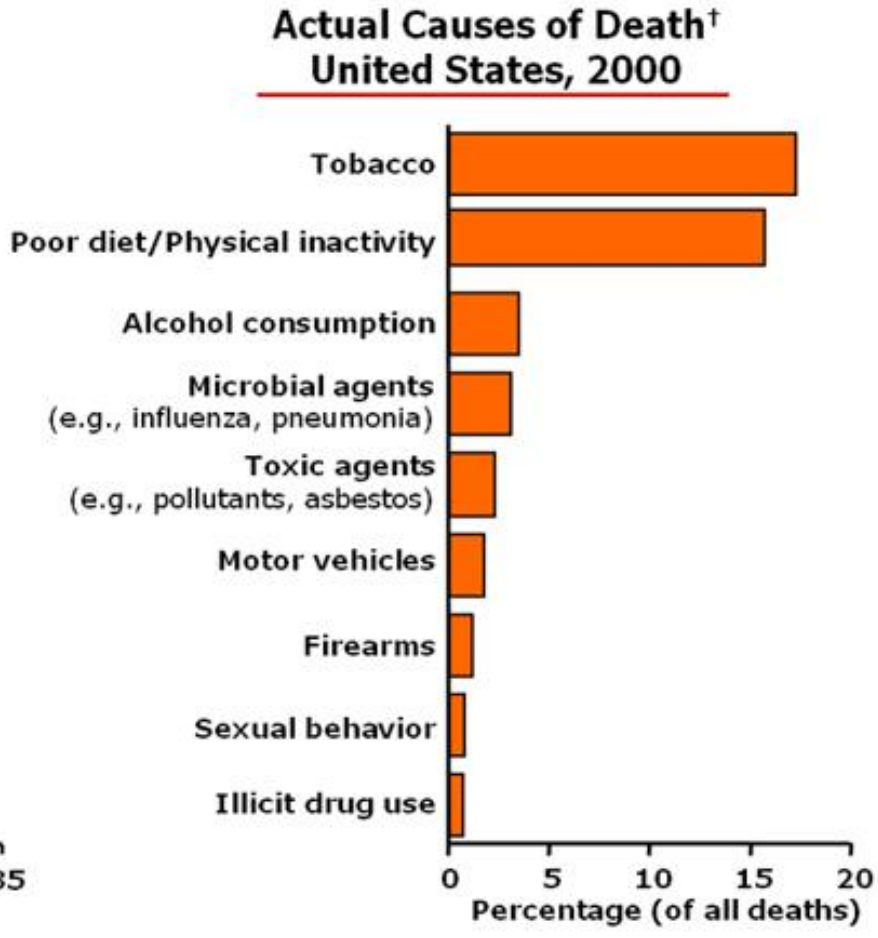


What are Determinants of Health?

- Income and social status
- Social support networks
- Education
- Employment/working conditions
- Social and physical environments
- Culture
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender

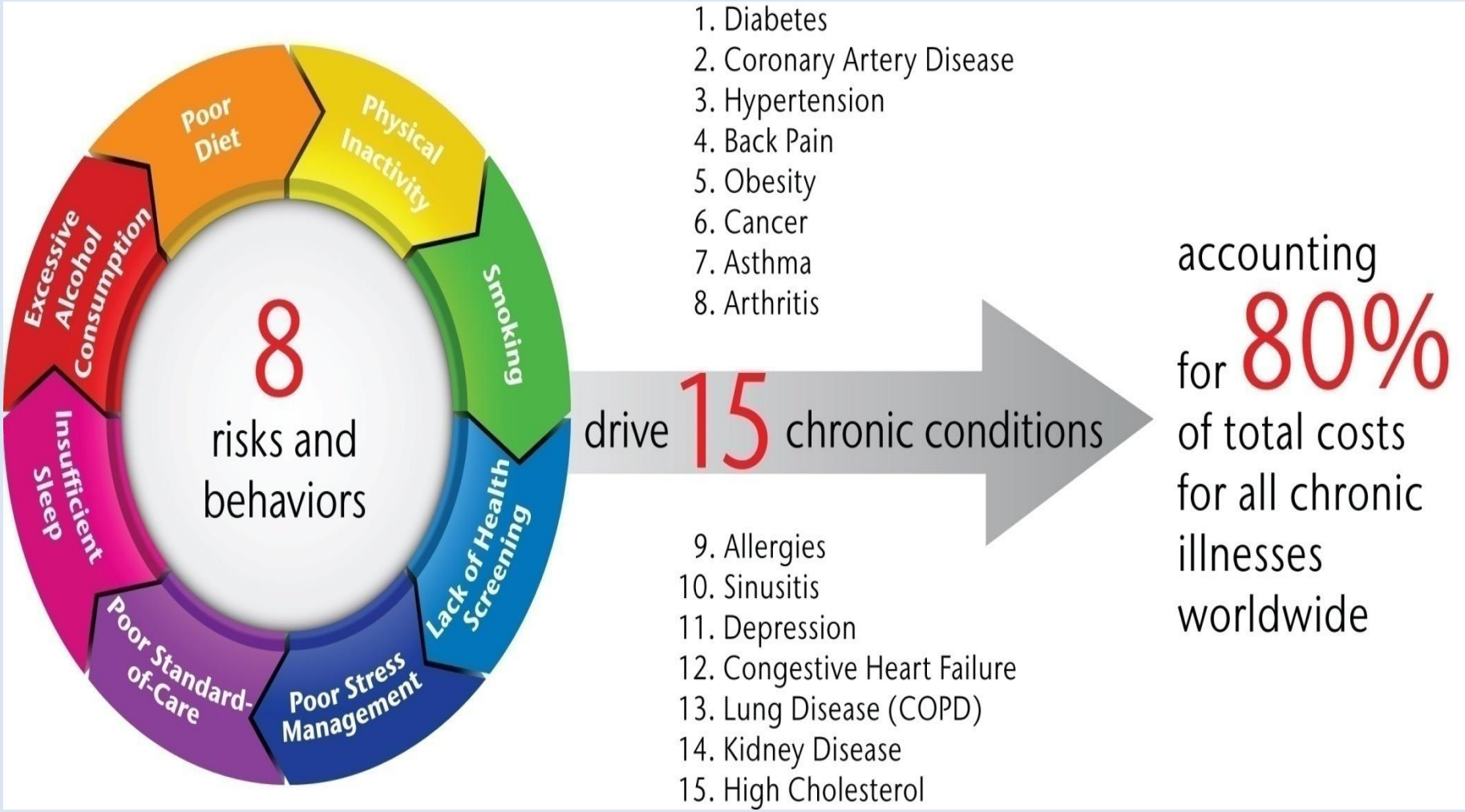
Clinical Prevention and Public Health: Actual Causes of Death



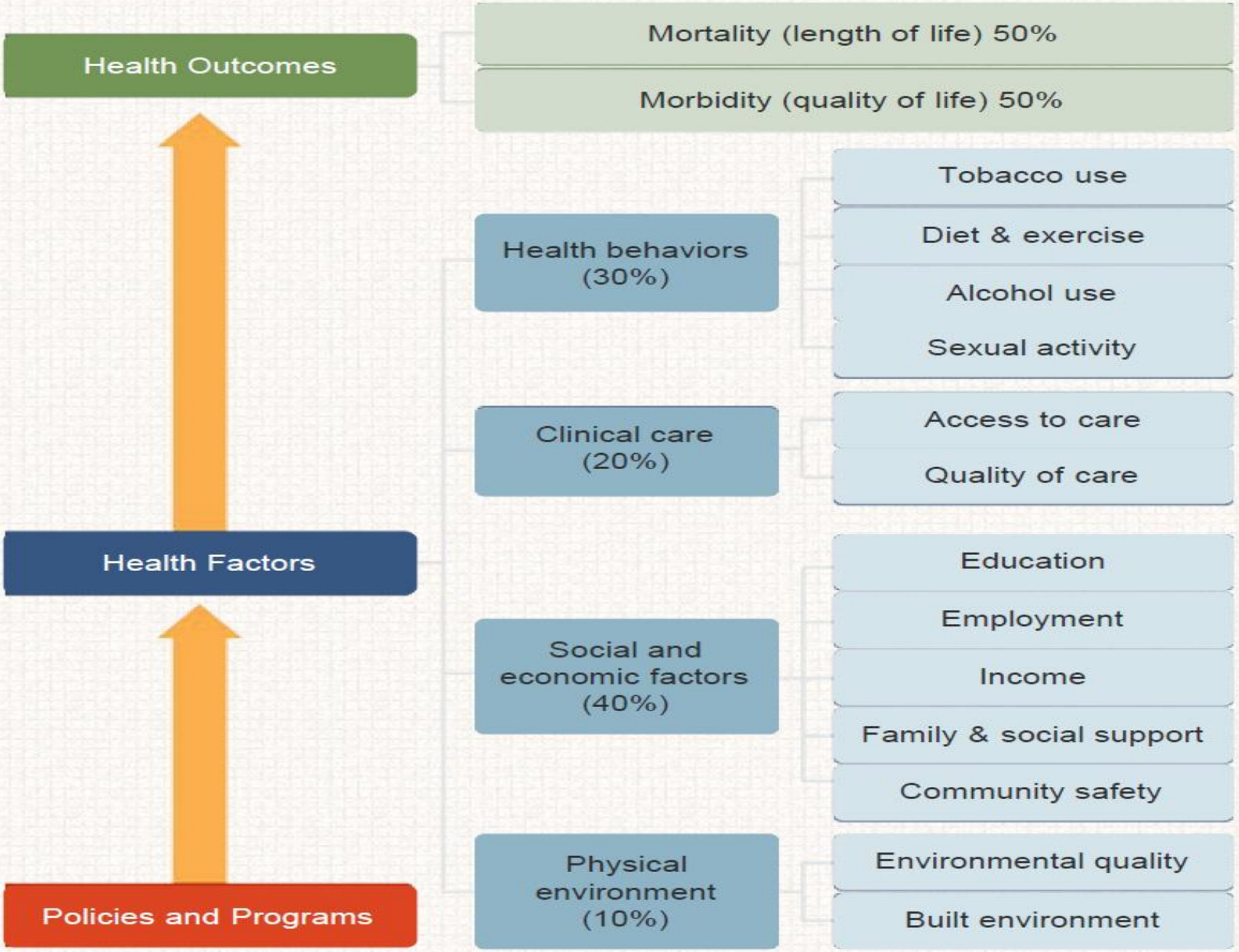


* Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.
† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

Impact of Chronic Disease



***Source**: 2010 World Economic Forum*

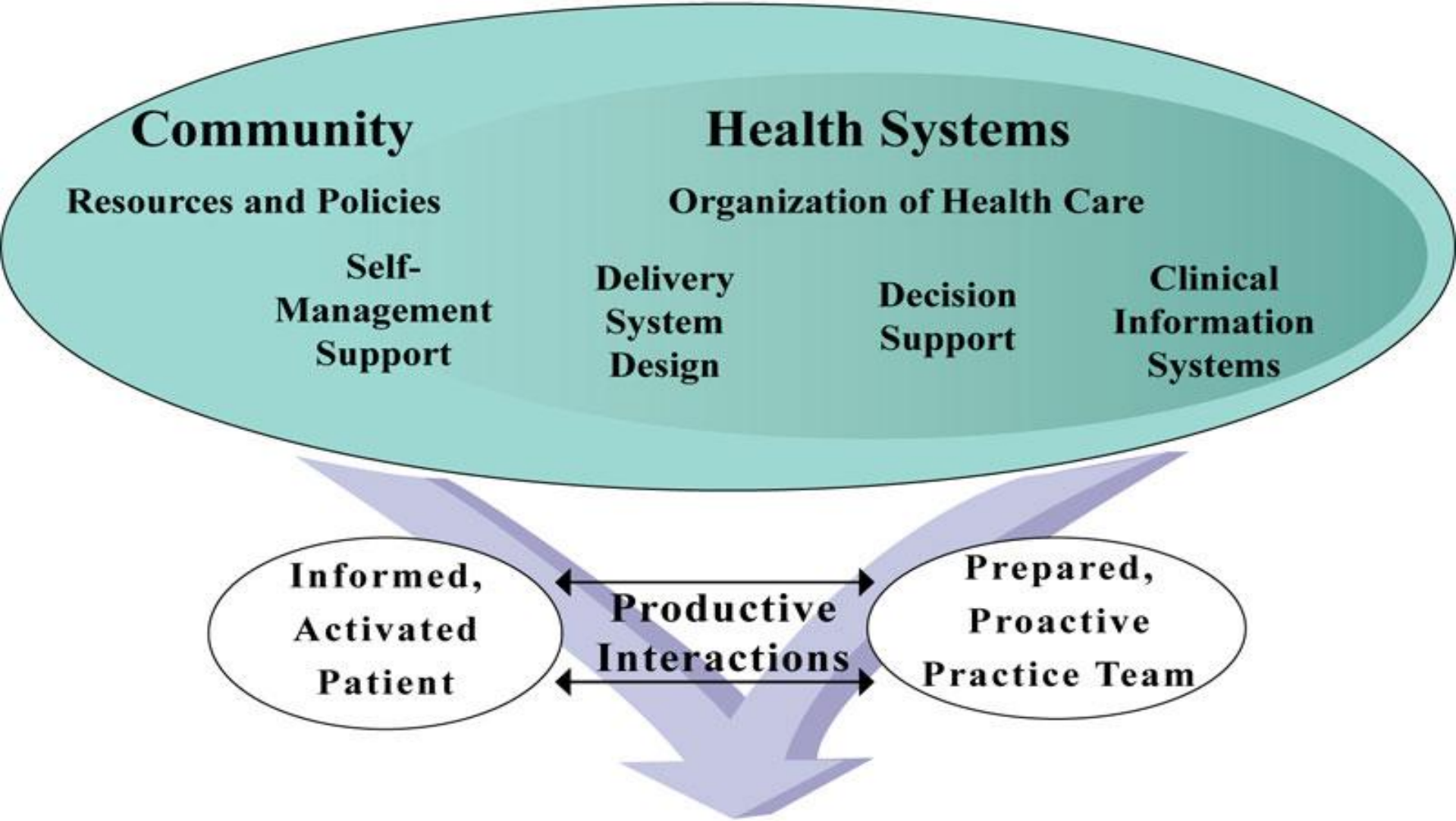


County Health Rankings model ©2012 UWPHI

The Solution?

- Public Health and Primary Care Integration
  - Learn from previous attempts
- Utilize Population Health Management
  - Define the “Population”
  - Identify Stakeholders
  - Determine “Status” and Gap Analysis
  - Determine Strategies and Tactics to Address
  - Determine measures

The Chronic Care Model



Improved Outcomes

Healthy Kansans 2020 Strategy Ranking

Healthy Living	Healthy Communities	Access to Services
Promote physical activity	Promote access to healthy foods, & support policies that promote healthy food choices	Improve access to services that address the root causes to poor health
Promote healthy eating		
Incentivize Kansans to participate in health & wellness programs	Support policies that make the default choice the healthy choice	Effectively & efficiently use population health management through health information technology (HIT)
Promote tobacco use prevention & control		
Improve supports for the social & emotional development of children & families	Promote environments & community design that impact health & support healthy behaviors	Promote integrated health care delivery, including integrated behavioral health, social services & medical care

HK2020 Action Plan Template

Healthy Living	Promote Physical Activity
Goal One	
Primary Objective(s)	
Activities	

Population Health in the Future

- Population Health Management -A culture of shared responsibility
  - Use of multidisciplinary care teams;
    - coordination across care settings;
    - enhanced access to primary care;
    - centralized resource planning for implementation
    - continuous care, both in and outside of office visits; patient self-management education;
    - a focus on health behavior and lifestyle changes;
    - use of health information technology
      - data access and reporting for communication among providers and between providers and patients
- Select Right Focus

Recommended Readings

- **Primary Care and Public Health: Exploring Integration to Improve Population Health;** IOM Report March 2012
  - http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx
- **Communities of Solution: The Folsom Report Revisited;** Griswold, KS; *Ann Fam Med May/June 2012 vol. 10 no. 3 250-260*
  - **http://www.annfammed.org/content/10/3/250.full**
- **A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years;** Trust For America's Health Report, January 2013
  - **http://healthyamericans.org/report/104/**

Recommended Readings

- **Making a Powerful Connection: The Health of the Public and the National Information Infrastructure**
  - Report of the U.S. Public Health Service Public Health Data Policy Coordinating Committee (July 6, 1995); Lasker R, Humphreys B, and Braithwaite W.
- **Medicine and Public Health, the power of collaboration**
  - Lasker, R and the Committee on Medicine and Public Health; New York Academy of Medicine, 1997.