Wye River Group On Health Care

A 21st Century Model of Care: Optimizing Use of Underutilized Services

PHASE I

Data gathering:

- Capture the intellectual thinking within each participating organization on each of the four issue areas
- Organize the work vetted within each organization based on a common set of parameters, to be determined
- Analyze the information and organize it into a comparative document (matrix) for each issue in preparation for the working session

Facilitated working sessions:

- Select dates for 4 sessions over the next 8 months
- Provide a comparative analysis of each organization's thinking on the topic in advance of each meeting
- Use the areas of commonality determined through the analysis as the baseline for exploring collaborative options
- Capture the discussion at each meeting (key themes, areas of agreement, recommended next steps) in a report format to be reviewed and edited by participants

Summary/output session:

- Summarize key areas of agreement arising from each issue meeting
- Determine the appropriate venue for advancing each area of agreement, e.g., regulatory, administrative law, state or federal legislation
- Outline and come to agreement on strategies for advancing the recommendations, e.g., congressional briefings, committee staff meetings, cumulative published report, presentations, etc.

PHASE II

Review and evaluation of innovative care models:

- Working with each participating organization, gather more detailed information on diverse models of care discussed at the working session, based on predefined agreed upon criteria
- Organize the information into a 'case study' format capturing critical success factors, funding, and replicability/scalability

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Conversion of recommendations into public policy goals:

- Work with sponsors and counsel to identify the best venue to advance each recommendation i.e. legislative, regulatory, etc
- Working with counsel, convert the group's recommendations into the necessary format, depending on appropriate areas for advancement using the principle of 'course of least resistance'
- Draft preliminary language to accomplish each objective

Raising awareness:

- Champion shared recommendations through a multi-pronged strategy to be determined by the group, e.g.
  - Congressional briefings
  - Committee staff briefings
  - Press briefings
  - Publications
  - Speaking

TIMELINE PHASE I

- Data gathering and analysis: February 20th to April 30th.
- Four issue meetings on a six week schedule between May and October 2006
- Summary/output session in December 2006

TIMELINE PHASE II : TBD

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January 9th, 2006

1:45pm-5:00pm
City Club of Washington
Columbia Square Building
555 13th St NW (13th & F)

- Introductions and statement of purpose
- Discussion of trends/drivers. How will they impact future healthcare needs? Where are the gaps?
- Discussion of the 'patient experience' today. What should it be in the future?
- How are we as individual organizations functioning today? What needs to change to ensure future patient needs are met?
- Roundtable discussion of opportunities to create a multi-disciplinary alliance around common goals to influence public policy. Consideration of assets & liabilities; incentives & barriers. [Potential areas might include workforce public policy; education and training; reimbursement issues; alternative service delivery models, etc.]

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Participants

Gary Allen, DMD	**Willamette Dental Management Corporation**
Geraldine Bednash, PhD RN	**American Association of Colleges of Nursing**
Jim Bentley	**American Hospital Association**
Rich Bringewatt	**National Alliance of Specialty Healthcare Programs**
Marcia Comstock MD MPH	**WRGH/FAHCL**
Jon Comola	**WRGH/FAHCL**
Lou Diamond, MD	**MedStat**
Larry Fields, MD	**American Academy of Family Physicians**
Rosebud Foster, EdD	**NOVA Southeastern University**
Terry Humo	**Terry Humo Benefit Compliance**
Dave Kendall	**Progressive Policy Institute/DLC**
Brendan Krause	**National Governors' Association**
Cheri Lattimer	**Case Managers Society of America**
Russ Newman, JD PhD	**American Psychological Association**
Fred Ralston, Jr., MD	**American College of Physicians**
Michael Reinemer	**American Association for Homecare**
Christy Schmidt	**American Cancer Society**
Linda Stierle, MSN RN	**American Nurses Association**
Pam Thompson, MS RN	**American Organization of Nurse Executives**
Mary Ann Wagner	**National Association of Chain Drug Stores**
Edwin Webb, PharmD MPH	**American College of Clinical Pharmacy**
Lynn Wegman, MPA	**Bureau of Health Professions, HRSA**
Sunny Yoder	**Association of American Medical Colleges**

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MEETING NOTES

MISALIGNED SYSTEM INCENTIVES

The system is designed from the perspective of providers, when it should be designed from the perspective of patients. The system is both complex and fragile, but it doesn't have to be so complex. Patient navigators can be helpful. Even assertive people can be intimidated by the system!

There are a lot of success stories that can be replicated. For example, the military does what it does quite well. Everyone is clear on his/her role. There is accountability. In the military and in the IHS, the role of pharmacists, as well as payment of and expectations for them as professionals, is different.

10-15% of the population accounts for the majority of spending, except when it comes to end of life care. There are some demonstration projects where physicians are being paid to discuss end of life care with patients.

Current financial incentives support episodic care, not comprehensive or preventive care. We need coordination of care, with a focus on prevention (primary through tertiary.) Hand offs are not clear. There is a need for better technical infrastructure that supports coordination of care along a continuum. Community hospitals and nursing homes don't communicate. There is no clear accountability. There are no incentives for interdisciplinary teamwork.

Trying to integrate siloed cottage industries is not easy! We need leadership in the industry to advance new ideas, rather than cling to the old. Unfortunately, everyone's 2nd choice is always the status quo. In this country we value 'individuals' and 'atomizers.' We don't have a parliamentary system, rather one that is designed not to do things without consensus. How do we engage our society in efforts to change?

But a 'new' model is being practiced in some places. Why isn't it everywhere? We need to identify replicable success stories and disseminate the learning. To enable positive change, the attitudes and culture both of professionals and of the public need to change.

There is a lack of accountability and too much ambiguity especially as it relates to conversion to a demand-driven consumer model. Information technology and performance measures based on the overall system are needed to support the new models. Looking at the individual practitioner may not make the most sense.

BASIC BENEFITS

We need a core level of services for all that includes a continuum of prevention, as well as mental health and oral health.

FINANCING IS FRACTURED

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There is no connection between mental and physical health. The current system is set up to keep funding streams separate, bur mental health should not be carved out. APA is doing some work with AMA to create codes that support more integrated financing.

Similarly pharmacy is carved out, which precludes the ability to demonstrate the impact drugs can have on total costs.

There is agreement on these financing and incentive problems, But everyone's first priority is always to protect 'my piece.'

REGULATORY BARRIERS

There are too man different levels of governance/oversight. The lack of coordination between the federal, state and local levels is one of numerous regulatory barriers to more effective delivery which must be addressed to enable positive change to occur.

CHANGING DEMOGRAPHICS & NEEDS

With the aging of the population, care needs and the appropriate care settings change. There will need to be more focus on the issues associated with chronicity. The continuum of care needs to include all aspects of prevention, survivorship, and end of life care.

We should make the effort to distinguish the needs of the 'younger' old from those of the 'older old.' Too much is spent on futile end of life care.

Patients and families need to be more involved in care and decision-making.

As the population moves to more rural settings, will the providers be there?

WORKFORCE ISSUES

We have a limited workforce that is not well trained to cope with emerging needs. There is increasing responsibility across professions and practice settings without the necessary training. This is having a negative impact on patient safety issues.

We need to revisit the fundamental models of education. Students are learning in a confusing system. Currently health professions education is based on a broken model, with a focus on supply rather than demand. There is better training in the technical/scientific spheres than in socio/cultural dynamics or in how to function as a part of a team. There is a need to develop and deliver curricula across silos in training programs.

There are two separate issues with education and training: one relates to the future workforce, one relates to retraining of those currently in the workforce. It is frustrating for new graduates trained in new ways of functioning to be thrust into the 'real world' which doesn't work the way they were taught.

We need a much greater focus on cultural competency and health literacy.

The workforce is also aging. The average age of case managers is 55.

WHAT IS THE GREATEST FEAR/THREAT?

- We need to change, but we have to live now with the current system. We need to redesign the workforce and how it is used for future hospital care.

- Payment equity/financial incentives. Even with risk adjustment the highest cost quintile is underpaid and the lowest cost quintile is overpaid.

- System-based quality measures. There is not enough evidence to support new models.

- Regulatory fragmentation of Medicare and Medicaid. >200B spent on dual eligibles.

- Scared to let go of the known. Fear that outcome measures will be used as a weapon.

- In the employer community, there is an institutional issue. Don't want employees to know the truth. There is not a lot of confidence in the proposed solution.

- "Building the bridge as we go across it."

- Assume we can't wait for students. Need to also focus on retraining current workforce in new models.

- Loss of autonomy. Lack of social consensus.

- There are advantages in the current pluralism. There are a lot of pieces to 'play off from one another,' so can manage to withstand loss in some area. If things were to become more unitary and there is a loss of autonomy without consensus, then expectations will be too diverse and resources too little.

- We made huge changes after WWII when we trusted the federal government. The prevailing theme today is that candidates run against the very government they want to lead! Stories in medicine tend to highlight what is unique.

- The greatest fear of politicians is that they will have to run healthcare. Democrats intermittently think they want to try. There is no accountability and one party blames the other for healthcare failures. But we DO have checks and balances. The hard work is determining what we want to have happen. That comes from patients and healthcare leaders.

- Where do you target limited resources to start the change? What tables should we be at? We (ANA) are willing to take some risk. Who else is?

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- Greatest fear is that current trends will continue unchecked.

- Concern that members will rebel at positions the organization (ACP) has already taken. The leadership will be thrown off a cliff because of the way the change is implemented.

- Most organizations want the status quo. ADA fears being left out of the debate—mostly by their own choice! Private, for profit companies CAN change. The dental hygienists are more motivated than the dentists (ADA.) They want a basic oral health benefit.

- The ACCP only had 29 members in 1971; now there are >10,000. Have made great strides but fear the status quo will remain and the value of the last 2 decades spent changing training and education programs and working on payment policy for patient care will be lost.

- Lack of resources!!! In academia everyone feels autonomous and all know best what change should occur. There is concern that a particular program can be shut down. It is a conservative environment where everything has to be justified. By the time it is, something new is on the horizon. Another issue is accreditation and its requirements. Still, there is an eagerness to innovate. No one wants assessment of need done for fear of being eliminated.

- Case Management is concerned about being identified as disease management (DM) and losing their autonomy and/or being expected to fulfill too many roles. 9,400 members were surveyed. They are doing DM, discharge planning, social work, pharmacy management, etc. They are moving toward care management. Members' fears brake down along age lines: A small number of younger members embrace change entirely. Another relatively small group are willing to adopt a new way of working but don't know how. A 3rd group resist going back to school for relevant but significant retraining. Unfortunately the largest number, predominantly the older group, just want to hang on until retirement.

- The governors are concerned that they might step up to the plate and try new approaches, which may well fail. They will still have to be paid for. There is a concern that we may be 'overselling' quality.

WHAT CAN WE DO?

Our goal is to see if we can agree on a series of public policy recommendations that would create a 'path of least resistance.' This contrasts with the more common approach of creating public policy positions within the organizational silo. The recommendation is to try and create partnerships, which require genuine trust, in contrast to coalitions.

The group was asked what it would take to get a commitment from their organizations to work on this initiative. Some indicated that timing would be an issue. With large complex organizations the process for gaining concurrence on any policy position that differs from current statements has multiple steps. This is not the case if the position is not significantly different from current 'party line.' Smaller organizations are much more nimble and the CEO or ED can rapidly garner the necessary support.

The group concurred that there is certainly enough to do in healthcare to accommodate all! They seemed to feel that there are areas where the multiplicity of interests represented could work together on recommendations and mutually supported policy statements. However, the greatest strength of the group (diversity/broad representation) is its greatest weakness. There is some concern about how far down the group could constructively 'drill' recognizing that there ARE conflicts among the different groups. It may be that the group needs to stay at a 20,000 foot level to get consensus.

There was general agreement that the time is right for this type of discussion. These ideas have not yet been explored in a broad multi-disciplinary way, and the potential for impact is far greater than with public policy recommendations advanced by any one organization alone. However, there is a need for 'ground rules.' NO organization would be expected to put their name on an end product with which they are not comfortable.

Potential topics for exploration relative to models include:

- Identification and dissemination of existing successful models
- Workforce (sourcing/education/on-going training)
- Incentives
- Regulatory issues

To constructively advance this conversation, we need to understand the desired future state. However, it is not necessary or desirable to 'reinvent the wheel. A good deal of work has been done in 'reenvisioning' the healthcare system, which could be distilled down into a brief summary/description to launch discussions of various models. The basic concept of patient-centric, evidence-based care with information technology was a base is hard to argue with ! We may not be talking about fundamental change, which may not be realistic anyway, as fundamental change is frightening to some people.

It will be critical to 'suspend disbelief' and not design a system within current constraints. We must envision the elimination of barriers. Once there is agreement on a conceptual description of future models, we need to recognize that implementation must be done locally.

There are many on-going discussions among various groups, some cross-sector, that touch on some of these concepts. The uniqueness of this effort may rest on the fact that it is being crafted by a broad spectrum of caregiving professionals. We are talking about defining how to get to the future state through changes in the delivery system. Additional input will need to be derived from patients themselves, but the group is distinguished by its professionalism around patient-centered care—the training, the services, and the arenas in which they practice. All are fundamentally focused on improving the wellness of citizens.

It would probably be helpful to get the various stakeholders to 'sign-off' on the description of the future state, then work to get presidential candidates and other candidates to also formally endorse it. This could create momentum regardless of who wins the next election.

NEXT STEPS

To ensure everyone is comfortable with the goals, methods and intended output of the initiative before proceeding, we will conduct a series of small group teleconferences. During these teleconferences we will outline our ideas for moving this forward through targeted work sessions on the topics identified, and incorporate the ideas of all interested parties. We will also be recruiting organizations missing during the last meeting, briefing them on the initiative and getting their buy-in.

We are sensitive to the need to move forward quickly and plan to schedule the small group teleconferences with in the next few weeks.

We have received much positive feedback since the launch meeting. Many of the participants have expressed support on behalf of their organization in advancing this effort, and their confidence in the approach being taken to build consensus.

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