Health Care Reform

Improving Governance Effectiveness

Health Care Reform Resources and Reports

c|h|a
Colorado Hospital Association

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Compiled by
The Walker Company Healthcare Consulting

Since enactment of the Affordable Care Act, multiple resources have been developed to provide hospitals and health systems with valuable health care delivery system intelligence. To help trustees access the most valuable and reliable health care reform and delivery system transformation intelligence, The Walker Company recommends the following list of publications and resources that we believe may assist organizations and their governing boards in understanding the impacts and implications of the emerging health care transformation.

## The American Hospital Association

The American Hospital Association (AHA), in conjunction with its partners, Hospitals in Pursuit of Excellence (HPOE), Health Research & Educational Trust (HRET), AHA Solutions, American Organization of Nurse Executives (AONE), Personal Membership Groups, Center for Healthcare Governance, The Institute for Diversity, Health Forum and more, have created a number of guides and reports designed to provide hospitals and health systems with valuable health care delivery system intelligence. *HPOE: A Compendiums of Guides* provides lists and executive summaries for the guides (http://www.hpoe.org/resources/hpoehretaha-guides/1655). Examples of recent guides include:
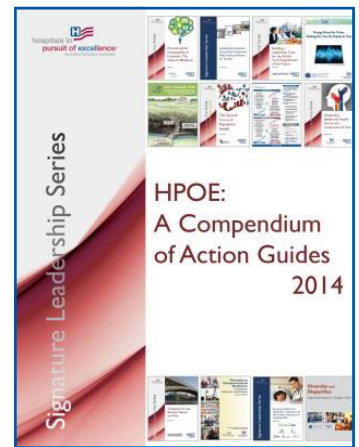
Hospitals and Care Systems of the Future

September 2011

www.aha.org/about/org/hospitals-care-systems-future.shtml
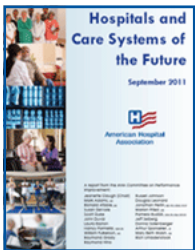
In the current regulatory and economic environment, hospitals must focus their efforts on performance initiatives that are essential in the short term and that will also remain critical for long-term success. The inaugural report of the AHA Committee on Performance Improvement details "Hospitals and Care Systems of the Future." The team conducted exploratory interviews and analyzed the results to identify must-do, priority strategies and core organizational competencies organizations should establish to remain successful in this time of sweeping change.

Metrics for the Second Curve of Health Care (Report) and Second Curve Road Map for Health Care (Road Map)

April 2013

http://www.hpoe.org/resources/hpoehretaha-guides/1357
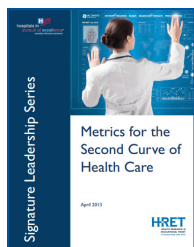
The report expands on four strategies originally identified in the report, "Hospitals and Care Systems of the Future." These strategies were identified as major priorities for hospitals and health care organizations moving from the volume-based first curve to the value-based second curve.

- Aligning hospitals, physicians and other clinical providers across the continuum of care
- Utilizing evidence-based practices to improve quality and patient safety
- Improving efficiency through productivity and financial management
- Developing integrated information systems

To further assist leaders trying to implement these major strategies, HPOE created a road map for leaders to implement major strategies and to assess their organization's progress.

Navigating the Gap Between Volume and Value

*June 2014*

www.hpoe.org/volume-value-gap
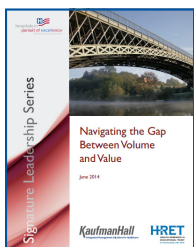
Building off the 2013 HPOE guide on value-based contracting this guide provides additional financial resources. Hospital executives will find a step-by-step information on the financial planning process and how it can help your organization evaluate the impact of repositioning initiatives as you move toward value-based care and payment.

Your Hospital's Path to the Second Curve: Integration and Transformation

January 2014

www.aha.org/paths-to-second-curve
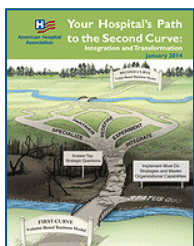
To navigate the evolving health care environment, the 2013 AHA Committee on Research developed the report Your Hospital's Path to the Second Curve: Integration and Transformation. This report outlines must-do strategies, organizational capabilities to master and 10 strategic questions that every organization should answer to begin a transformational journey. The report's "guiding questions" will help hospitals and care systems reflect and gain new perspectives on the benefits and value of integration. A comprehensive assessment, also found in the report, may lead health care organizations toward a customized path or series of paths to successfully transform for the future.

The Second Curve of Population Health

March 2014

www.hpoe.org/pophealthsecondcurve
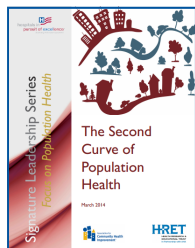
This guide builds upon prior American Hospital Association reports that outline a road map for hospitals and care systems to use as they transition to the second curve of population health. Though the extent to which hospitals and care systems engage in population health may vary, a significant shift toward population health initiatives is anticipated in the next three to five years. The tactics described in this guide provide a framework for initiatives that hospitals and care systems could pursue to develop an institutional infrastructure that supports population health.

Trends in Hospital-Based Population Health Infrastructure: Results from and Association for Community Health Improvement and American Hospital Association Survey

December 2013

http://www.hpoe.org/resources/hpoehretaha-guides/1467

Many factors, most notably the Affordable Care Act, are driving hospitals and care systems to expand their scope to focus on population health management. This change requires hospitals to realign their organizational infrastructure to be congruent with a population health approach. In response to increasing interest, the American Hospital Association and the Association for Community Health Improvement conducted a national survey of hospitals' organizational infrastructure and staffing as they pertain to population health.

Survey results detailed in this report reveal great heterogeneity in how hospitals and care systems structure and implement population health management. The findings reinforce the need for further education and professional training in population health management. This report provides insight into the field's development and can serve as a baseline to assess the infrastructure of hospital-based population health initiatives in the future.

Value-Based Contracting

June 2013

www.hpoe.org/value-contracting

This guide provides specific guidance related to assessment, and financial, operational and implementation issues organizations should examine as they consider value-based contracting arrangements.

Integrating Behavioral Health Across the Continuum of Care

February 2014

www.hpoe.org/integratingbehavioralhealth

This Hospitals in Pursuit of Excellence guide explains the value of integrating physical and behavioral health services and the importance of measuring integration efforts. It offers several frameworks and models to use for behavioral health integration and provides a list of strategic questions for hospital and care system leaders to begin integrating behavioral health or to enhance current efforts.

Building a Leadership Team for the Health Care Organization of the Future

April 2014

www.hpoe.org/futureleadershipcompetencies
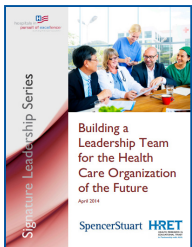
Moving from a volume-based payment model to a value-based payment model requires a new set of management skills that encourage systems thinking and align clinical and operational resources to improve outcomes and efficiencies. A survey of senior hospital and care system executives and additional interviews with more than two dozen leaders in the field reveal the ways health care organizations are responding to changes within the field and building the teams needed to achieve their strategic priorities.

Managing an Intergenerational Workforce: Strategies for Health Care Transformation

January 2014

www.aha.org/managing-intergenerational-workforce
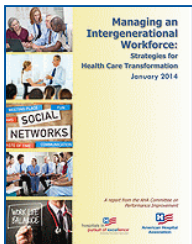
Generational diversity is rapidly changing workforce dynamics. Each generation has different priorities, attitudes, communication styles, work approaches and ways to interact with colleagues, which influence organizational culture and performance. There are also common and unifying characteristics across all generations that can be leveraged to create optimal teams, critical for future health care models.

Leveraging these generational strengths and differences will give hospital and care system leaders an edge as the health care field moves from the "first curve," where hospitals operate in a volume-based environment, to the "second curve," a value-based care system and business model. Leaders that develop robust and productive multigenerational teams, leveraging each cohort's strengths, will be well positioned to handle "life in the gap," the transition between the two curves.

Becoming a Culturally Competent Health Care Organization

June 2013

www.hpoe.org/becoming-culturally-competent
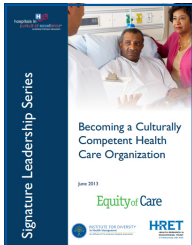
It is imperative hospitals and health care systems not only understand the diverse patients and communities they serve but the benefits of becoming a culturally competent
organization. This guide describes the benefits, steps and educational techniques of becoming a culturally competent health care organization.

These free resources are available in digital and mobile format:

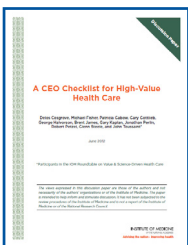www.hpoe.org/resources

www.aha.org

Android Market: and Apple App Store: search for HPOE or Hospitals In Pursuit of Excellence

The Institute of Medicine

A CEO Checklist for High-Value Health Care
June 2012

www.iom.edu/Global/Perspectives/2012/CEOChecklist.aspx.

As leaders of health care organizations, we are acutely aware of the pressures that rising health care costs place on individuals, employers, and the government, as we are of unacceptable shortfalls in the quality and efficiency of care. But we have also learned, through experiences in our own institutions and through communication and collaboration with colleagues in others, that better outcomes at lower costs can be achieved through care transformation initiatives that yield improved results, more satisfied patients, and cultures of continuous learning. These transformation efforts have generated certain foundational lessons relevant to every CEO and Board member, and the health care delivery organizations they lead.

The authors of this IOM discussion paper have assembled these lessons as a *A CEO Checklist for High-Value Health Care* to describe touchstone principles, illustrated with case examples, central not only to their work to date, but to sustaining and reinforcing the system-wide transformation necessary for continuous improvement in the face of rapidly increasing pressures, demands, and market changes.

Financing Population Health Improvement–Workshop Summary

July 2014

www.iom.edu/Reports/2014/Financing-Population-Health-Improvement.aspx
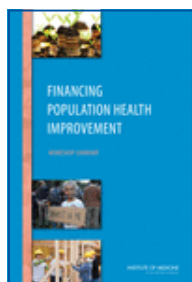
Despite spending far more on medical care than any other nation and despite having seen a century of unparalleled improvement in population health and longevity, the United States has fallen behind many of its global counterparts and competitors in such health outcomes as overall life expectancy and rates of preventable diseases and injuries. A fundamental but often overlooked driver of the imbalance between spending and outcomes is the nation's inadequate investment in non-clinical strategies that promote health and prevent disease and injury population-wide, strategies that fall under the rubric of "population health."

To explore the range of resources that might be available to provide a secure funding stream for non-clinical actions to enhance health, the Roundtable on Population Health Improvement held a public workshop on February 6, 2014, that featured a number of presentations and discussions, beginning with an overview of the range of potential resources (for example, financial, human, and community) and followed by an in-depth exploration of several dimensions related to financial resources.

The Impacts of the Affordable Care Act on Preparedness Resources and Programs–Workshop Summary

June 2014

www.iom.edu/Reports/2014/The-Impacts-of-the-Affordable-Care-Act-on-Preparedness-Resources-and-Programs.aspx

Many of the elements of the Affordable Care Act (ACA) went into effect in 2014, and with the establishment of many new rules and regulations, there will continue to be significant changes to the U.S. health care system. It is unclear what impact these changes will have on medical and public health preparedness programs around the country. There is a commonly held notion that disaster preparedness is separate and distinct from everyday operations, and that it only affects emergency departments. However, catastrophic events can challenge the entire health care and public health spectrum. The implementation of the ACA provides an opportunity to consider how to better incorporate preparedness into all aspects of the evolving health care system and daily delivery of care.

On November 18-19, 2013, the IOM Forum on Medical and Public Health Preparedness for Catastrophic Events held a workshop to discuss how changes to the health system as a result of the ACA might impact medical and public health preparedness programs across the nation. This document summarizes the workshop.

Population Health Implications of the Affordable Care Act—Workshop Summary

October 2013

www.iom.edu/Reports/2013/Population-Health-Implications-of-the-Affordable-Care-Act.aspx

On June 13, 2013, the IOM Roundtable on Population Health Improvement held a workshop to explore the likely impact on population health improvement of various provisions within the ACA. This document summarizes the workshop. Several provisions of the Affordable Care Act (ACA) offer an unprecedented opportunity to shift the focus of health experts, policy makers, and the public beyond health care delivery to the broader array of factors that play a role in shaping health outcomes. The shift includes a growing recognition that the health care delivery system is responsible for only a modest proportion of what makes and keeps Americans healthy, and that health care providers and organizations could accept and embrace a richer role in communities, working in partnership with public health agencies, community-based organizations, schools, businesses, and many others to identify and solve the problems that contribute to poor health.

The Henry J. Kaiser Family Foundation

Health Reform Source: Implementation Timeline

http://kff.org/interactive/implementation-timeline/
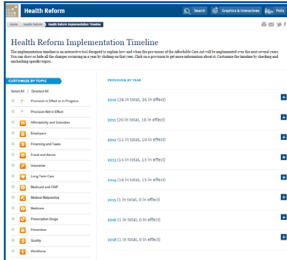
The implementation timeline is an interactive tool designed to explain how and when the provisions of the health reform law will be implemented over the next several years.

You can show or hide all the changes occurring in a year by clicking on that year. Click on a provision to get more information about it. Customize the timeline by checking and unchecking specific topics.

Summary of the Affordable Care Act

April 2013

www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act
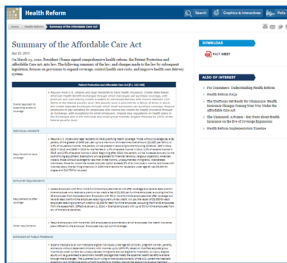
This fact sheet summary of the Affordable Care Act, and subsequent changes to the law, focuses on provision to expand coverage, control health care costs, and improve the health care delivery system.

Also available via the Kaiser Family Foundation website:

- **Health Reform Frequently Asked Questions**—www.kff.org/health-reform/faq/health-reform-frequently-asked-questions/

- **Employer Responsibility Under the Affordable Care Act**—www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/

# Centers for Medicare & Medicaid Services Innovation Center

The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.

Congress provided the Secretary of Health and Human Services (HHS) with the authority to expand the scope and duration of a model being tested through rulemaking, including the option of testing on a nationwide basis. In order for the Secretary to exercise this authority, a model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits. These determinations are made based on evaluations performed by the Centers for Medicare & Medicaid Services (CMS) and the certification of CMS's Chief Actuary with respect to spending.

Innovation Models

Accessed August 2014

http://innovation.cms.gov/
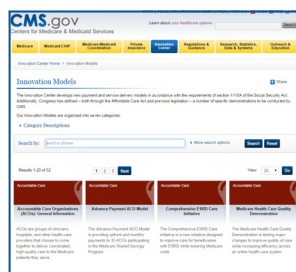
The Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS. Innovation Models are organized into seven categories: Accountable Care, Bundled Payments for Care Improvement, Primary Care Transformation, Initiatives Focused on the Medicaid and Children's Health Insurance Program Population, Initiative Focused on the Medicare-Medicaid Enrollees, Initiatives to Speed the Adoption of Best Practices, and Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Information about the various models being conducted in each of the categories may be found at the Innovation Center.

Where Innovation is Happening

Accessed August 2014

www.innovation.cms.gov/initiatives/map/index.html

Where Innovation is Happening is an interactive map of the United States designed to show where various Innovation Models are being conducted at the state level as well as the health care facilities where models are being tested.

Click on a menu of states, models, or categories to show the locals of the Innovation Models. Click on the locales indicated on the map for brief facts and links to additional information about a specific model.

Data and Reports

CMS Innovation Center develops and distributes a number of reports and datasets, which are available on their website. Available reports include:

Medicare Gainsharing Demonstration—Final Report to Congress

June 2014

The evaluation of this Demonstration suggests that there is value in further testing of alternative payment approaches such as bundling, gain-sharing, and other efforts to align institutional and physician incentives.

Partnership for Patients Preliminary Evaluation Report

June 2014

The Partnership for Patients initiative was launched in 2011 with the goals of reducing preventable hospital acquired conditions by 40 percent and 30-day readmissions by 20 percent by the end of 2014.

Patient Safety Results—Preliminary Report

May 2014

This report presents data showing a nine percent decrease in harms experienced by patients in hospitals in 2012 compared to the 2010 baseline, and that the Medicare Fee-for-Service 30-day readmissions rate dropped to 17.6 percent in 2013. National reductions in adverse drug events, falls, infections and other forms of harm are estimated to have prevented nearly 15,000 deaths in hospitals, saved $4.1 billion in costs, and prevented 560,000 patient harms in 2011 and 2012.

Evaluation of the Medicare Care Management Performance Demonstration—Report to Congress

March 2014

The Medicare Care Management Performance (MCMP) demonstration was designed and conducted by the Centers for Medicare & Medicaid Services (CMS) as the first federally funded initiative to assess the impact of pay-for-performance on quality of care for small- and medium-sized primary care practices. The goals of the demonstration were to use financial incentives to improve the quality of care provided to eligible fee-for-service Medicare beneficiaries and encourage the implementation and use of health information technology (health IT) among primary care physicians. The specific objectives were to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes among fee-for-service Medicare beneficiaries. This report summarizes the findings from the demonstration program.

Using Qualitative Comparative Analysis (QCA) to Study Patient-Centered Medical Homes

September 2013

This guide provides an in-depth introduction to using qualitative comparative analysis (QCA) in medical home evaluations to identify practice-level "conditions" (e.g., specific practice characteristics, medical home care processes) that are linked to an outcome of interest (e.g., improved care quality, higher patient satisfaction ratings, or reduced health care utilization or expenditures). This guide provides an overview of the QCA approach and key analytic steps.

Evaluation of the Medicare Acute Care Episode (ACE) Demonstration—Final Evaluation Report

May 2013

The Medicare ACE Demonstration used a global payment for a single episode of care as an alternative approach to payment for service delivery under traditional Medicare fee-for-service (FFS). The episode of care was defined as the bundle of Part A and Part B services provided to Medicare FFS beneficiaries during an inpatient stay for included Medicare Severity Diagnosis Related Groups (MS-DRGs), specifically, Cardiac Valve and Other Major Cardiothoracic Valve (valve), Cardiac Defibrillator Implant (defibrillator), Coronary Artery Bypass Graft (CABG), Cardiac Pacemaker Implant or Revision (pacemaker), Percutaneous Coronary Intervention (PCI), and Hip or Knee Replacement or Revision (hip/knee). This report presents the findings of the evaluation of a bundled payment demonstration for selected cardiovascular and orthopedic procedures, which was implemented at five sites in four states

Hospital Acquired Conditions (HAC) - Report to Congress

December 2012

The report describes the HAC program, summarizes the findings of the study that RTI International conducted under a contract with the Centers for Medicare & Medicaid Services (CMS), and presents the Secretary's recommendations. These recommendations include development of additional measures of conditions acquired in a variety of health care settings, in alignment with the National Quality Strategy and Inpatient Quality Reporting Program, and exploration of other payment policies that help reduce the occurrence of these conditions.

The Healthcare Finance Management Association (HFMA)

Value Project

https://www.hfma.org/valueproject/

HFMA's Value Project has been developed to help health care organizations in the transformation to a value-based health care delivery system.

HFMA's three phase Value Project brings together resources , healthcare finance leaders and clinical partners to assist organizations to:

- Define the practices of providers who are leading the way toward a value-based healthcare system

- Describe the primary capabilities that healthcare organizations will need to develop in the areas of people and culture, business intelligence, performance improvement, and contract and risk management to improve the value of care provided

- Provide specific strategies, tactics, and tools that healthcare organizations can use to build, enhance, and communicate their value capabilities

- Identify the trends today that are defining the future state of value in health care and describe new care delivery models that could help healthcare organizations create value