Health Care Reform 2012

The History of US Health Policy

1940s: Employer-sponsored Health Care

1960s: Government-sponsored Health Care

To provide coverage for the elderly as well as poor women and children, Congress enacted Medicare & Medicaid in the mid-1960s.

1980s: Health Care for All

2006: Medicare Expanded

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires hospitals to screen and stabilize (treat) every patient who comes to the hospital ED seeking care, regardless of the patient’s ability to pay and regardless of what it costs the hospital to provide the care.
2010: Health Care Reform

The Affordable Care Act:
Nuts and Bolts

Six Strategic Directions

- Coverage
- Insurance Reforms
- Delivery System Reforms
- Payment Reforms
- Transparency
- Health IT

Implications for Hospitals

- Achieve solid clinical alignment between hospital and physicians
- Deliver superior outcomes
- Reduce costs
- Develop integrated information systems
- Form strategic alliances
- Prepare for new payment models

Implications for Physicians

- Apply evidence-based practices to achieve best clinical results
- Deliver the right care... at the least cost
- Coordinate your patients’ care with other providers
- Learn to manage risk in partnership with hospital and physician colleagues

payment reforms

- ACOs – better care, lower growth in health care spending
- Bundled payments – single payment for multiple services to improve coordination and manage costs
- Readmissions – reduction of payments to hospitals with “high rates” of readmissions
- HAC – non-payment of a healthcare associated condition acquired as a result of hospitalization
- Value based purchasing- payment for actual performance vs. payment for reporting performance.
The Aftermath...

Reform & the Constitution

On March 26th, the U.S. Supreme Court will begin to hear oral arguments on four questions.

1. Does Congress have the constitutional authority to require individuals to buy health insurance?
2. If the individual mandate is unconstitutional, is the rest of the reform law invalid?
3. Is the mandate actually a tax, and does that mean it cannot be challenged until after it becomes effective in 2014?
4. Does Congress have the power to coerce states to expand Medicaid by withholding federal matching funds?

Republican Vision for Health Care: Repeal Obamacare!

Tired of the Uncertainty of Health Care Reform?

What We Know

1. Deficit reduction will reduce Medicare payments
2. The uncertainty surrounding health care in America will continue for at least two more years
3. State and federal budgets will remain volatile
4. Whether or not the Affordable Care Act is repealed, the marketplace will require hospitals to improve quality and reduce costs

How SC Businesses are Rethinking the Way They Deliver Care
National Priorities Partnership

- Health care must become highly reliable.
- Patients must be more engaged.
- We must deliver compassionate and patient-centered care at the end of life.
- We must improve health status and reduce health disparities.
- We must improve efficiency and reduce waste.
- We must improve coordination of care.

Key strategic aims to a healthy SC

1. Establish highly-reliable systems of care that continuously provide evidence-based, patient-centered care in a safe and efficient environment.
2. Effectively improve the health status and outcomes of our state’s population while reducing the major areas of health disparity.
3. Ensure access for every patient to well coordinated care across all care settings and all stages of life, including compassionate care at the end of life.
4. Develop and implement reimbursement models and performance incentives that effectively align with and actively promote innovations and specific improvement efforts under other the strategic aims.

How Leading SC Hospitals are Reengineering the Way They Deliver Care

Mission: Lifeline Data

Door to Balloon Average Time: (2007-2010)

Stop BSI Collaborative a Success

The STEMI-receiving hospitals participated in the registry and sent SCHA data monthly.
Safe Surgery 2015

**Goal:** 100% of South Carolina’s acute care hospitals using the surgical checklist in every operating room for every surgical patient by 12/31/2013

working well: nutrition, tobacco prevention & physical activity

- assist hospitals to assess, implement, and maintain evidence-based and effective policies designed around the three pillars of an effective worksite wellness environment:
  - tobacco-free people and places
  - delicious and affordable healthy food environments
  - access and opportunity for physical activity during the workday

making the pitch: investing in wellness

<table>
<thead>
<tr>
<th>Avg. Cost Savings of a Comprehensive Worksite Wellness Program</th>
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</thead>
<tbody>
<tr>
<td>Health Care Costs</td>
<td>26% reduction</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>27% reduction in sick leave</td>
</tr>
<tr>
<td>Disability/Worker’s Compensation</td>
<td>32% reduction</td>
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</tbody>
</table>

- $5.81-$1 avg. savings-to-cost ratio of implementing a comprehensive worksite wellness program

accesshealth sc

- 9 networks/17 counties operational
- Networks:
  - Richland Care (15% reduction in IP use; 36% reduction in ED)
  - AccessHealth Spartanburg (149% return on community investment)

State Snapshot: South Carolina

<table>
<thead>
<tr>
<th>Process Quality</th>
<th>National Average</th>
<th>Return State</th>
<th>SOUTH CAROLINA</th>
<th>Top State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>National Average</td>
<td>Return State</td>
<td>SOUTH CAROLINA</td>
<td>Top State</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>National Average</td>
<td>Return State</td>
<td>SOUTH CAROLINA</td>
<td>Top State</td>
</tr>
</tbody>
</table>

Overall Score = 83.6%
Rank = 13 out of 51

Partnership for Prevention / Leading by Example. The Value of Worksite Health Promotion to Small and Medium Sized Employers, 2011.
Four Steps for Hospital Leaders

1. Examine your hospital’s current rate of readmissions.
2. Assess and prioritize your improvement opportunities.
3. Develop an action plan of strategies to implement.
4. Monitor your hospital’s progress.

Strategies to Implement Along Care Continuum

To effectively implement the strategies identified in the three tables, hospitals may need to involve key stakeholders in the care delivery process: patients, physicians, pharmacists, social services, nutritionists, physical therapists, and the community.

Table 1: During Hospitalization
- Risk screen patients and tailor care
- Establish communication with primary care physician (PCP), family, and home care
- Use “teach-back” to educate patient/caregiver about diagnosis and care
- Use interdisciplinary/multi-disciplinary clinical team
- Coordinates patient care with the interdisciplinary care team
- Discuss end-of-life treatment wishes

Table 2: At Discharge
- Implement comprehensive discharge planning
- Educate patient/caregiver using “teach-back”
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge information and partnerships with nursing home practitioners
- Patient and family education

Table 3: Post-Discharge
- Promote patient self-management
- Conduct patient home visit
- Follow-up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care

Reducing Preventable Readmissions

- In 2010, Welvista partnered with a handful of SC hospitals to reduce preventable readmissions
- Theory: uninsured patients are less likely to comply with drug therapy; improving access to med is likely to increase compliance and reduce preventable ED and inpatient visits
- Results to date have met or exceeded expectations

First Annual Report
30-365 days pre-post Welvista enrollment
Decreases in Visits & Charges

- Emergency (-25% reduction in visits)
- $1,126/Patient
- Inpatient (-60% reduction in visits)
- $23,755/Patient
### Comparative Sample

**Self-pays (no Welvista) 30-365d pre-post**

Increases in Visits & Charges

- **$596/Patient**
- **$6,579/Patient**

(501 IP or ER patients in 9 months)

- **Emergency (14% increase in visits)**
- **Inpatient (62% increase in visits)**

### Welvista Patients vs. Comparative Sample with no Welvista

**Pre-Post Charge Comparison**

- ROI $P$-tests sig. at $p<.001$

### ROI

**Welvista Charge savings = $3,433,655**
**Welvista Cost Savings = $515,048**
**Hospital Investment in Welvista = $250,000**

ROI = 206%

- Charge Avoidance = $904,388
- Cost Avoidance = $135,658

Net Cost Return = $650,706

NROI = 260%

### Additional Pharmacy Strategies under Consideration

- Revising formularies and adopting drug interchange programs to cope with drug shortages
- Antibiotic stewardship initiatives
- 340(b) programs