

## THE AFFORDABLE CARE ACT

***Opportunities for Patient & Family Centered Care & Related Quality Initiatives***


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## OUR GOALS

- To Facilitate Participants Knowledge of Healthcare Policy, Its Background, Stakeholders, and The Affordable Care Act Opportunities in Implementing Patient and Family Centered Care
- Etc. Etc. Etc.

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## WE WILL TRAVEL A POTENTIAL HEALTHCARE SOLUTION HIGHWAY™ WITH SELECTED REGULATORY STOPS



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## HOW DID HEALTHCARE GET HERE? (H<sup>3</sup>)

**TO UNDERSTAND THE LAW AND CERTAIN QUALITY INITIATIVES ONE MUST FIRST CONSIDER HOW WE GOT WHERE WE WERE...AND HOW THE LAW AND CERTAIN PROCESSES ARE ATTEMPTING TO ASSIST US IN GETTING SOMEWHERE ELSE... AS WELL AS OUR PERSONAL AND FACILITY OPPORTUNITIES TO PARTICIPATE IN THE PROCESS.**

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## WHO ARE THE STAKEHOLDERS?


- Patients
- Families
- Facilities
- Medical Professionals
- Governments
- Manufacturers
- Pharmaceuticals
- Scientists
- Consultants
- Agencies
- Equipment Providers
- Insurance Companies
- Etc., Etc.

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## ASSUMPTION


- IT IS NOT A PERFECT WORLD
- There are many directions and possibilities



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## IMAGINE PAYING FOR



- Errors
- Consistent Poor Outcomes
- Acquired Infections – Hand Washing Resistance
- Unrealistic Expectations
- Non-collaborative
  - *even contra-indicated care at times*

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## THE HURRICANE IN HEALTHCARE




- Washington sees inefficiencies in the system and applies effort to correct them
  - The uninsured
  - The supply debacle
  - The non collaboration of specialists debacle
  - Hospital acquired infections etc. etc.
- The opportunity--Logic says planning and self correction (preservation) is better than externally mandated correction – complex regulation costs money

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## THE INVOLVED GOALS OF GOVERNMENT EMBEDDED IN PART IN THE AFFORDABLE CARE ACT AND CMS INITIATIVES



- Quality
- Utilization
- Accountability
- Cost Control
- Knowledge
  - Partnership for Patients
  - Where Does Knowledge Come From?
    - Science, Training, Experience, Goal Orientation, Purpose



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## WHAT IS PATIENT AND FAMILY CENTERED CARE?

- Guiding Values
  - Dignity and Respect
  - Information Sharing
  - Participation
  - Collaboration





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## HOW DOES PATIENT AND FAMILY CENTERED CARE FIT IN TO HEALTHCARE POLICY?




- A Few Patient Stories
  - The Nothing is Wrong Syndrome
  - The Change in Mental Status
  - The Prescription




Shared Knowledge is amazing...Lack of it can be devastating...

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## THE BIRTH OF POLICY




- A FEW EXAMPLES -- Medical Home Initiatives
  - e.g. Health Resources and Services Administration **Patient-Centered Medical/Health Home Initiative**
  - **Comprehensive Primary Care Initiative** - Centers for Medicare and Medicaid Services
    - The Comprehensive Primary Care (CPC) **initiative** is a four-year multi-payer **initiative** designed to strengthen primary care. ... Engagement; (5) Coordination of Care across the **Medical Neighborhood**. ... As of October 1, 2014 there are 481 CPC practice sites, distributed across seven CPC regions.
- Non-Payment for Re-Admits within 30 Days
- Reimbursement Linkage to Process and Value in Evidenced Based Care



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## THE BIRTH OF POLICY CONTINUED

- Partners for Patients
- Specialized Units with Specific Participation and Outcome Requirements
- Palliative Care
- HCAPS (2006 to date)
  - Patient Satisfaction
    - Comparable Data
    - Create Incentives to Improve Quality
    - Enhanced Accountability and Transparency
  - Outcome Linkage Process continues to evolve



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## PAY FOR PERFORMANCE



- Medicare and the US Government are instituting pay for performance and payment denial systems to meet certain objectives
  - ACO (Accountable Care Organization)
  - Source: HHS
  - No Pay Policies e.g.,
    - Hospital Acquired Infections
    - Readmissions within 30 Days


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## WHAT IS AN ACO (Accountable Care Organization) or Medical Home ?

- An ACO is a network of doctors and hospitals that shares responsibility for providing care to patients. In the new law, an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.
- There is a debate on how this concept will change-regulations are and were complex, but the concept of a Medical Home with
  - With Wellness Concepts
  - Patient Collaboration and Accountability (i.e. My Chart)
  - Delegation of Duties
 is Alive and Well.....


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## HOW IS AN ACO PAID?



- In Medicare's traditional fee-for-service payment system, doctors and hospitals generally are paid more when they give patients more tests and do more procedures. That drives up costs, experts say.
- ACOs wouldn't do away with fee-for-service completely but would create savings incentives by offering bonuses when providers **keep costs down and meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases.** In other words, providers will be (could be) paid more for keeping their patients healthy and out of the hospital.
- If an ACO is not able to save money, it would be stuck with the costs of investments made to improve care, such as adding new nurse care managers, and also may have to pay a penalty if they don't meet performance and savings benchmarks. The law also gives regulators the ability to devise other payment methods, which would likely ask ACOs to bear more risk. For example, an ACO could be paid a flat fee for each patient it cares for.


REGULATIONS CONTINUE TO DEVELOP



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- Insurance Companies
- Etc., Etc.



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## POLICY CHALLENGES




- Dilemmas of Healthcare Policy
  - Cost
  - Economy
  - Tradition
  - Practice
  - Demographics
  - Tort Law and Litigation
  - Washington Debacle

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## WHO IS NOT INSURED?




- In the first 9 months of 2013, 45.0 million persons of all ages (14.5%) were uninsured at the time of interview, 56.0 million (18.0%) had been uninsured for at least part of the year prior to interview, and 33.7 million (10.8%) had been uninsured for more than a year at the time of interview.  
http://www.cdc.gov/nchs/data/htis/earlyrelease/insur201403.pdf
- 12 Million were eligible for Medicaid but had not enrolled



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## UNIVERSAL COVERAGE AND THE ACA



One of the goals of the ACA is the provision of "Universal Healthcare Coverage" for all Americans. This goal is to be achieved through a combination of efforts between the individual, the government (both state and federal), and employers.


Under ACA, individuals who do not have any healthcare coverage through their employer, or do not have minimal essential coverage, under programs like Medicare or Medicaid, will be able to secure healthcare coverage through the Health Insurance Exchange. If they do not obtain coverage, they will be assessed a penalty. ("The Mandate")

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1501(a)(2)(D), 124 Stat. 119, 243 (2010).  
\* Will a case be promulgated and will the Supreme Court hear a case on this as a "law" issue? The jury is out and the process if it happens is a long long road.



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## NO LIMITS ON PRE-EXISTING CONDITION(S)




**IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION (Health Insurance Market Reforms)**

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1201(2)(A)(a), 124 Stat. 119, 154 (2010).  
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## ESSENTIAL HEALTH BENEFITS



The Health and Human Services Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:


- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management. \*
- (J) Pediatric services, including oral and vision care.

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1302 (b)(1)(A-J), 124 Stat. 119, 163-64 (2010).  
\*HOW THE TERMS WILL BE IMPLEMENTED IS STILL SUBJECT TO INTERPRETATION. THE JURY IS OUT!



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## NO LIFE-TIME LIMITS



A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

- lifetime limits on the dollar value of benefits for any participant or beneficiary;
- MUST PROVIDE COVERAGE THROUGHOUT THE LIFE OF INSURED. NOTE THIS IS A BIG CHANGE AND A BIG DEAL FOR CATASTROPHIC INJURY VICTIMS OR THOSE WITH CHRONIC ILLNESSES... BUT THOSE PARTIES HAVE TO PLAN TO BE ABLE TO PAY THE PREMIUM (Adjusted or Non-Adjusted base**


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**d on Income) TO PARTICIPATE IN Individual ACA.....**

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2711(a)(1), 124 Stat. 119, 131 (2010).

## COVERAGE OF DEPENDENT CHILDREN UP TO AGE 26

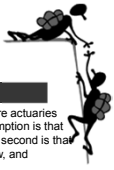
A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age.



Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001, 124 Stat. 119, 132 (2010).

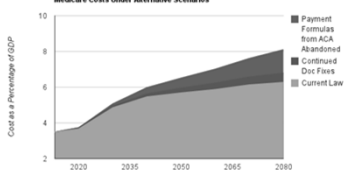
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## CLIMBING HEALTHCARE'S EVEREST



The official projections for Medicare spending follow current law. The Medicare actuaries produce "alternative illustrations" under different assumptions. The first assumption is that the annual payment fixes for doctors continue to get made by Congress. The second is that the payment formulas created by the Affordable Care Act (ACA) prove too low, and Congress ultimately alters them to grow a bit faster than the economy.

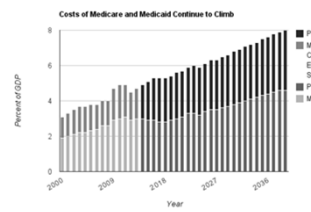
**Medicare Costs Under Alternative Scenarios**



Source: Centers for Medicare and Medicaid Services, July 2014

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## CLIMBING HEALTHCARE'S EVEREST *Continued*




Costs of Medicare and Medicaid Continue to Climb

Source: Congressional Budget Office, July 2014

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## THE REALITIES OF THE FEDERAL BUDGET




- **Social Security Deficit**
- "Social Security's Disability Insurance (DI) program satisfies neither the Trustees' long-range test of close actuarial balance nor their short-range test of financial adequacy and faces the most immediate financing shortfall of any of the separate trust funds. DI Trust Fund reserves expressed as a percent of annual cost (the trust fund ratio) declined to 62 percent at the beginning of 2014, and the Trustees project trust fund depletion late in 2016, the same year projected in the last Trustees Report. DI costs have exceeded non-interest income since 2005 and the trust fund ratio has declined in every year since peaking in 2003. While legislation is needed to address all of Social Security's financial imbalances, the need has become most urgent with respect to the program's disability insurance component. Lawmakers need to act soon to avoid automatic reductions in payments to DI beneficiaries in late 2016."

Source --A SUMMARY OF THE 2014 ANNUAL REPORTS  
Social Security and Medicare Boards of Trustees

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## AFFORDABLE CARE ACT FOCUS



- Universal Health Coverage
  - Healthcare Exchanges
  - Sliding Scale Penalties for not having Coverage
  - Essential Coverage
    - Does not cover extended long term care
- Quality Measures
- Electronic Records
- Collaborative Medicine
- Resulting in - Reduced Reimbursement

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## IMPLEMENTING THE ACA



- **Basic Facts**
  - Reimbursements will be reduced on select procedures, visits
  - Quality in Volume will become critical for reimbursement
  - Families will have less capital and more time
    - Who knows more about the patient?
    - Who can help more if properly questioned and trained?

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## WHERE IS THE KEY TO SUCCESS?



- Healthcare is a zero sum game
- Bias can be framed into any study – Objectivity is key
- Pro-activity vs. Reactivity will better improve outcomes
- Quality Measures are indeed important
- Palliative Care is critical to success

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## BARRIERS TO OPTIMAL QUALITY




- Territories
  - My patient
  - My treatment plan
  - My procedure
  - My room
  - My case
  - My discharge plan

**Patients are people with families and brains!!**

**Quality is Incentivized!!!**

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## BARRIERS CONTINUED



- Tradition
  - This is the way we always have done it
  - Doctor is God
  - Patient does not need to know
  - Family should be provided limited information
  - Nurses serve-not idea generator-subordinate position (See [www.nytimes.com/2011/05/15/opinion/15nurse.html](http://www.nytimes.com/2011/05/15/opinion/15nurse.html))
  - A team of one

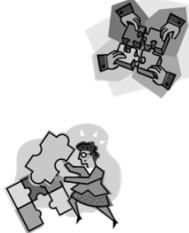
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## THE PATIENT AND FAMILY AS THE GESTALT OF MEDICINE AND CERTAIN EVIDENCE BASED OUTCOMES

- Gestalt (*observing the whole person*) and Documenting What You See
  - Observer (Flagging in Electronic Records-Journals)
  - Historical Reference – Pre-morbidity Function
  - Change
    - Psychological and Physical
  - Care Impact
    - Outcome
    - Cost Containment
    - Peace of Mind

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## THE PATIENT AND FAMILY – TOOLS IN IMPLEMENTING QUALITY AND ACA INITIATIVES



- Input Model
- Communication Model
- Utilization Model
- Conflict Resolution Model
- Ascertain Model
- Respect Model
- Engagement Model
- Delegation Model

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## RESPECT IS KEY



- Care Model
- Monitoring Model
- Support Model

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## THE HOME HEALTH AGENCY OF THE FUTURE-A NECESSARY COST SHIFT?

- The Patient
- The Family
  - Remember Family is often more than Blood Relatives
- The Support System

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## WHO ARE THE TARAHUMARA INDIANS?



- The word for themselves, **Rarámuri**, means "runners on foot" or "those who run fast" in their native tongue according to some early ethnographers like Norwegian Carl Lumholtz, though this interpretation has not been fully agreed upon. With widely dispersed settlements, these people developed a tradition of long-distance running up to 120 miles (190 km) in one session, over a period of two days through their homeland of rough canyon country, for intervillage communication and transportation as well as to hunt.
- The Tarahumara also use the toe strike method of running, which is natural for barefoot running. The long-distance running tradition also has ceremonial and competitive aspects. Often, male runners kick wooden balls as they run in "foot throwing", or *rarajipari* competitions, and females use a stick and hoop. The foot throwing races are relays where the balls are kicked by the runners and relayed to the next runner while teammates run ahead to the next relay point. These races can last anywhere from a few hours to a couple of days without a break.

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## REGULATION OPPORTUNITIES




- Washington Will Dictate Unless We Use Our Heads and Our Voices
- We have to learn to be Tarahumara Healthcare Participants and Heroes
- Change is Inevitable
- Village Solutions are Needed
- Partnering is Possible and can Help Avoid the Politicization of Health Care
- We Can Choose to Win or Choose to Fail

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## YOU ARE AN IMPORTANT KEY TO ACA AND QUALITY PROCESS IMPLEMENTATION

- Patients Need Your Eyes and Ears
- Patients and Families Need to be Listened to
- Your Intervention Can Reduce Significant Future Costs
- Delegation will Continue
- The ACA or its successor and **YOU** save lives!!!




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## ACA FACILITATES SUCCESS IF WE LET IT




- Overcome The Risks
  - Fractionalization
  - Failure (**Failure is not an Option.**)
- Tear Down Appropriate Silos
- Climb The Healthcare Everest Together with Washington
  - Let's not say someday... "We have met the Enemy and it is Us" !!!



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## REMEMBERING WHY

- Remember those six people....this is why we do what we do...for them.... Tearing out pages or those six people in our life's book is not an option....nor is failure to embrace the future.....



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## THANK YOU

- The Healthcare Solution Highway™ Lives in all of us... 
- We can be Healthcare Heroes
  - Take Care.....




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