

2010 Military Health System Conference

Integrated Healthcare Delivery

Moderator

Sharing Knowledge: Achieving Breakthrough Performance

Colonel Amir Adolf Edward, USAF, MS, Chief of Staff

25 January 2010



Joint Task Force National Capital Region
Medical

We'll work at breaking down stereotypes



We'll try to put things in perspective



Having a bad day? Not as bad as.....



You got to learn from your past

You got to learn from your past



The People Capable of this...







Are also capable of





TAKEOFF: Holland's bomber minutes into its preparation for an upcoming air show

- This next 45 mins will be about
 - Working Integrated Delivery SystemInto the MHS Business basis and what we need to do

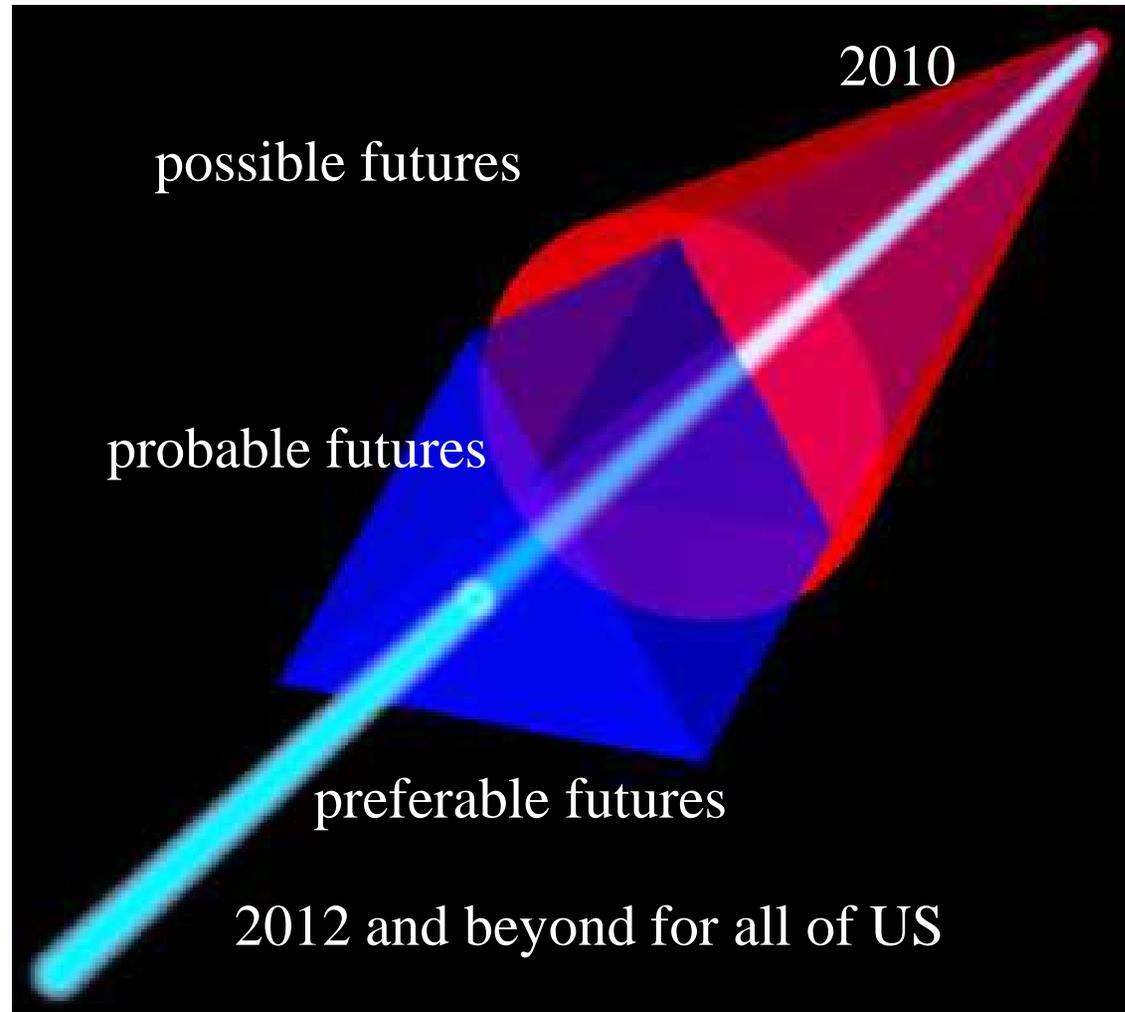
- The topic is serious, but that doesn't mean we can't LEARN
- I want to ask you to assist in moving us forward as a system

Every snowflake in an
avalanche thinks that it
is not responsible.



Envisioning the Future As is.....Desired end

Starting point

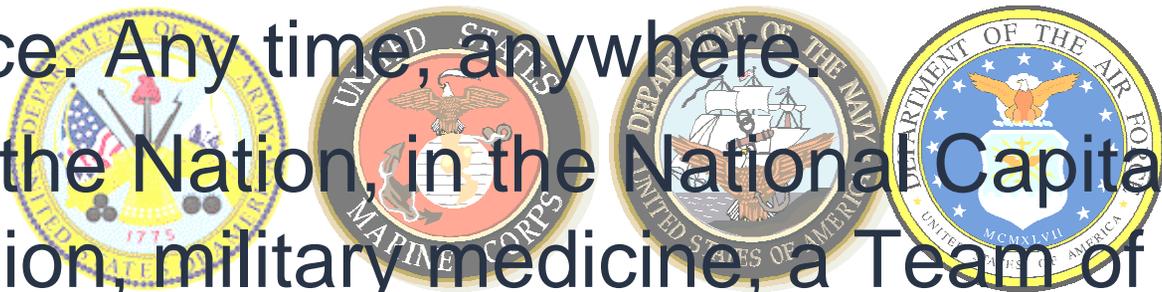


Possible Destination

For Our Nation



- Military medicine delivering capabilities to the Joint warfighters and to the men and women, retirees and family members of the Armed Force. Any time, anywhere.
- For the Nation, in the National Capital Region, military medicine, a Team of Teams, building our world class military medical capability.
- A national treasure we all own.



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Quadruple Aim

Sharing Knowledge: Achieving Breakthrough Performance

Dr. Michael Dinneen

25 January 2010



Office of Strategy Management, OASD(HA)

Overview – The Quadruple Aim

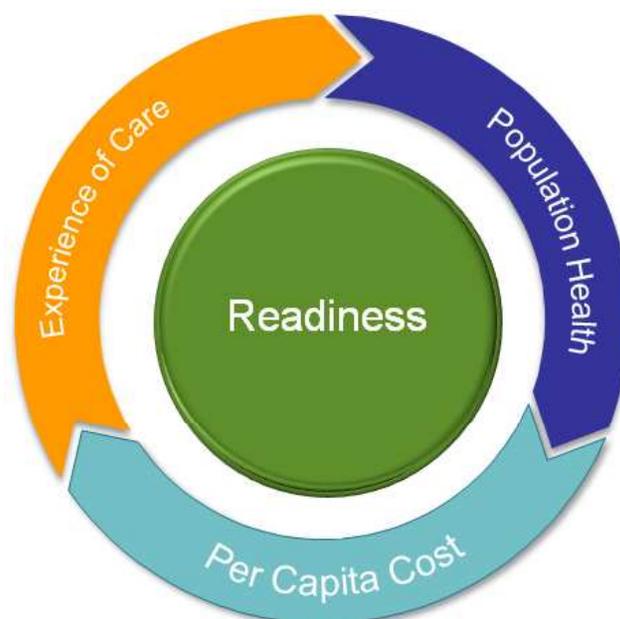


Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.



■ The U.S. healthcare system "...lacks the capacity to integrate its work over time and across sites of care."

Population Health

Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

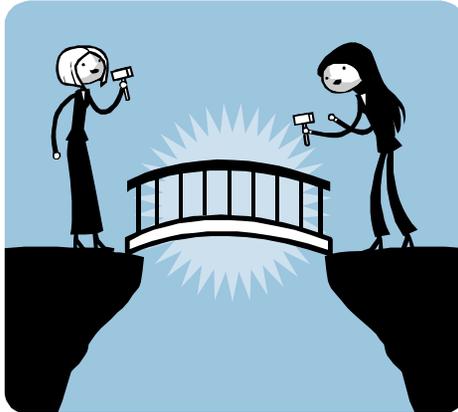
Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Commonwealth Fund



- Scorecard – U.S. scores a 66%
 - U.S. spends nearly double what other developed countries spend on healthcare and gets ...
 - 31st in life expectancy
 - 36th infant mortality
 - 28th in male healthy life expectancy
 - 29th in female healthy life expectancy
 - Can the U.S afford to guarantee universal health insurance to its citizens?



Plan: Bridge Chasm



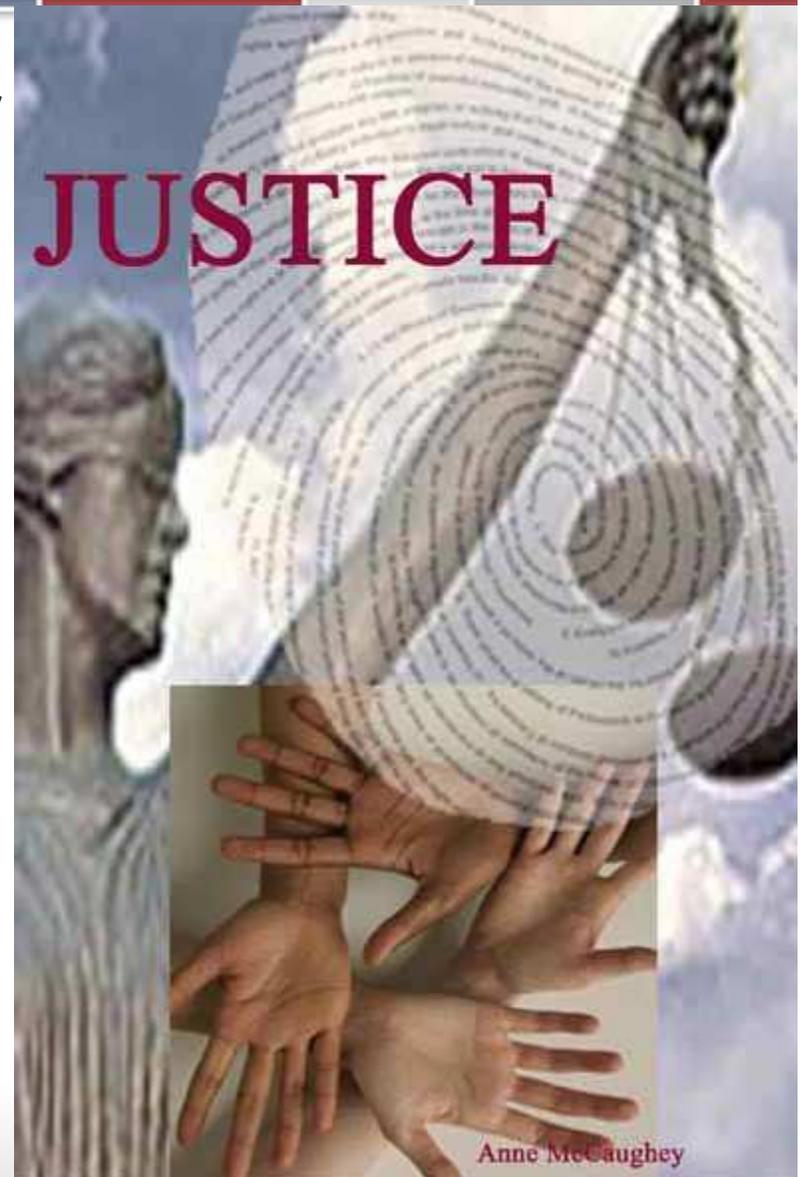
Result: Paper Bridge

- *Crossing the Quality Chasm, 2001.*
Challenge: Improve quality of care at a single site of care by addressing six dimensions ...
 - Safety, effectiveness, patient-centeredness, timeliness, efficiency, equity.
- Initiatives employed: P4P, public reporting
- Results: safe reliable care is not the norm,
“too few improvement efforts to address defects in care across the continuum”.

IHI Triple Aim



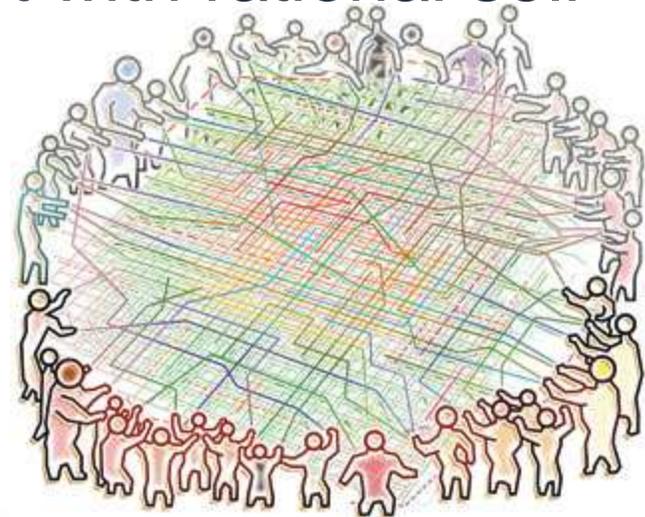
- Link goals across the broader system to achieve high-value health care
 - Improve the individual experience
 - Improve the health of populations
 - Reduce per capita costs
- Interdependent Goals: complex relationships
- Balance through policy that deals with constraints.
- Equity being paramount



Triple Aim & the Business Model



- Today most organizations cannot pursue the Triple Aim except at the peril of their self interest.
 - The Tragedy of the Commons – rational common interest in conflict with rational self interest.
 - Misaligned incentives



Obstacles to the Triple Aim



- Supply-driven demand
- Physician-centric care
- Policies that limit innovative business models
- Lack of health systems: No way to optimize care across venues of care.



Disruptive Innovations: One part of the Solution

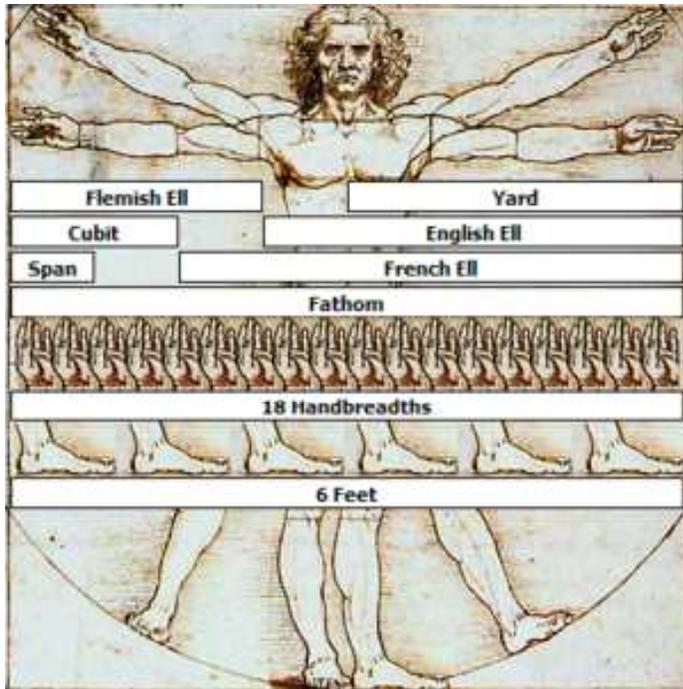


- Patient Centered Medical Home
- Home based care and monitoring
- Provider-patient telecommunication
- Medical tourism
- Lean production technology in hospitals



Ref: The Innovator's Prescription, Clayton Christensen

Measures



- Experience of Care –
 - Quality, Safety and Convenience being measured partly thanks to quality movement
- Population Health
 - Healthy behaviors – measured more by employer than health system
- Cost:
 - Total cost of care over time is not being measured consistently

Preconditions for Change



- Define a population as a unit of concern. *Enrollment* becomes a commitment to healing more than a unit for contracting.
- Applied policy consistently.
- Create an integrator.
- Focus on shared enterprise measures
- Align responsibility with accountability.



Integrator



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- Involves individuals and families: free flow of information
- Redesigns primary care: may not be visit or physician centric
- Manages the health of the population: allocate real resources (people things, processes, oversight) to population
- Manages the money: pay for value

Social Contract / Political Realities



- Patients, governments and payers enter a new contract. Agree to ...
 - Impose global budget caps
 - Measure health status & needs of population
 - Improve standard measures of performance
 - Share financial gains
 - Change professional education & accreditation
 - Engage patients in health, not consumption

Triple Aim Test



- Hospitals trying to get emptier
- Supply-driven dynamic gives way to health-driven dynamic
- Patients say, "They remember me."



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Integrated Healthcare Delivery

What are Integrated Delivery Networks?

Sharing Knowledge: Achieving Breakthrough Performance

Captain Kevin Berry, MC, USN, special studies

25 January 2010



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Integrated Delivery Networks



- Business innovation of the 1990s
- Vertical or horizontal integrated systems
 - Acquisition of primary care physicians
 - Development of Health Maintenance Organizations
 - Strategic alliances with Physician-Hospital Organizations & Management Maintenance Organizations
- Wharton economists say, failed.*

*Lawton R Burns, M V Pauly, "Integrated Delivery Networks: A Detour On The Road To Integrated Health Care?" (*Health Affairs* Vol. 1 No. 4, July/August 2002), p. 128-143.

Vertical Integration



- Objectives:
 - Manage global capitation
 - Diversify risk from large patient/provider pools
 - Improved Access
 - Improved Quality
- Private agendas: Greed and fear. “There are no general results from economic theory that vertical integration leads to greater efficiency or market power on the part of the firm.”

Horizontal Integration



- Objectives
 - Efficiency goals: reduce excess capacity, strengthen financial position
 - Improved access
 - Economy of scale: large patient volumes, sharing equipment and services, group purchasing
- Private agendas: Greed & fear. For-profits firms successfully leveraged capital from equity markets.

Lessons Learned

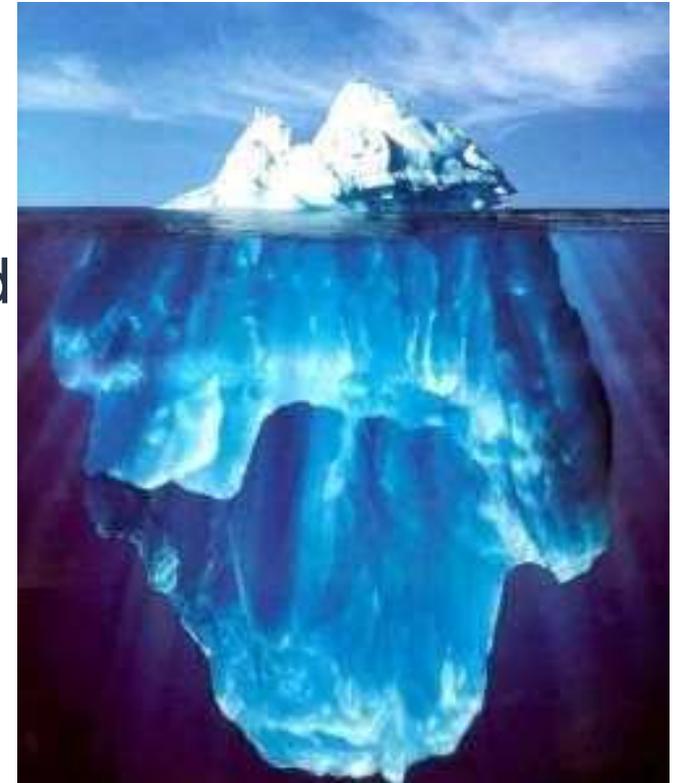


- Hospital executives failed to critically assess assumptions about cost / benefits of integration. And ...
- Then the Balance Budget Act of 1997 squeezed margins. Momentum swung from managing care to deep discounts.
- Leaders rushed to big losses. UCSF-Stanford merger lost \$167 million. Costs greater, margins lower, and debts bigger than expected.

Lessons Learned



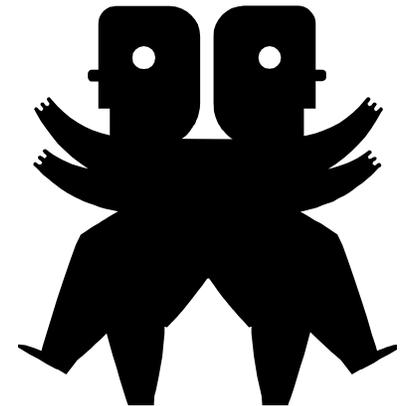
- Developing effective centralized controls takes time, a decade or more. Merged academic medical centers took huge up-front losses and in no less than 7 years gave back small gains.
- Integrating front-office structures didn't change front-line processes. Integration at the clinical chief level failed because substructure integration ignored.



Lessons Learned



- Integration failed to confer competitive advantages.
- Bandwagon effect resulted in everyone pursuing the same strategy at the same time.
- Unbalanced polar opposites led to infighting: physicians vs hospitals; conflicting organizational cultures.



Lessons Learned



- Successful firms blended global and local operations,
 - used centralized planning decentralized execution,
 - top-down and bottom-up planning,
 - Leverage long lived and well earned good will (Mayo Clinic)



Lessons Learned



- 
- IDNs are not solely or primarily about patients; they are about managing money.
 - HMOs viewed IDNs as contracting cartels wanting better pricing for the same job
 - Purchasing IDNs didn't pay for care coordination. Patient black lash against managed care drove open-access and BBA '97 drove down pricing. Customers didn't get care coordinated.

Impact on Consumers



- Unlikely consumer interests served by IDNs.
 - Patients want ease of access and convenience.
 - Not so clear if patients care about the ‘continuum of care.’ Not so important for infrequent users.
 - Consumer generally unaware or indifferent to health and quality measures.
 - Trust in your physician discordant with satisfaction with Health Pan.



Hopeful Models in 2002



- Case / Disease Management: Pharma-Medicaid partnerships for chronic disease. Was the goal to supply pharma's medication or to improve the health of the patient?
- Co-location of care: behavioral health with primary care; GI with colorectal surgery. Might increase costs of both. Requires careful attention to processes.

Hopeful Models in 2002



- Health Information Technology will set us free! EMRs, EHRs, digital hospitals! Oh my!
 - Disappointment ...
 - Many high dollar failures.
 - Fast forward to 2010.



- HIT purpose? ARRA required definition for 'meaningful use'.
- Incentives? None. Slow adoption rates. ARRA incents their use.

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The MHS, is it a military capability or health plan for the military?

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Captain Kevin Berry, MC, USN, special studies

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The Mission



- 2005 Quadrennial Review, Medical Readiness Review and MHS Transformation.
- Threw out the notion the MHS has a dual mission – operational and peacetime healthcare
- The MHS is a military medical capability.



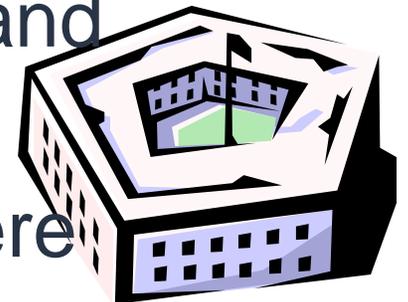
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The Mandate



- Military power is one of four powers inherent in sovereign nations – Diplomatic, Information, Military, Economic.
- At the highest level of strategic planning Military Medicine is the instantiation of military capability applied as needed for National Defense, National Security, and National Health.
- Military Medicine is employed anywhere across the range of military activities.



Three States of the MHS



- In garrison – resourced and managed for reconstitution, readiness, training and innovation activities.
- Deployable (required capabilities drive training & readiness requirement) – capabilities immediately available as assignable forces, for Joint / Service requirements.
- Mobilized – readiness capabilities employed

Military Medical Capabilities



- Readiness is much more than Individual Medical Readiness and Psychological Health.
- Service-specific and Joint capabilities.
 - Army, Marine Corps, Navy, Air Force
 - Air, space, maritime, land
- Determined by the Department and Joint Force Commanders' requirements

Phases of Military Operations



- Capability planning depends on type, phase and outcomes-based branches and sequels of military operations.
- Phases: Shape, deter, seize the initiative, dominate, stabilize, and enable civil authority
- Common themes, basic capabilities, specific applications depend on National Defense, National Security, National Health objectives within the Department, Joint and Service enterprises.

Examples

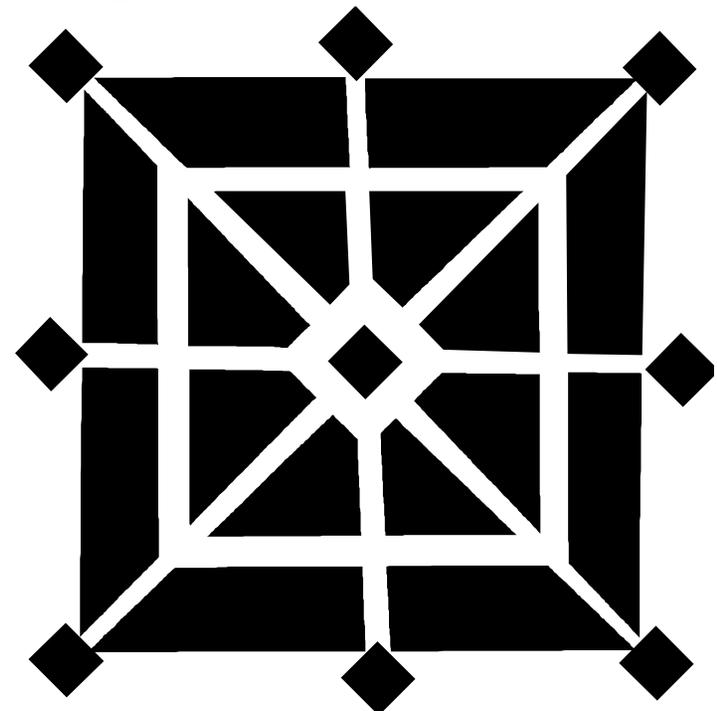


- SOUTHCOM
 - Theater Security Cooperation: Humanitarian Disaster Relief in Haiti
 - Homeland Security: detainee health / medical GITMO
- CENTCOM
 - Stabilize and enable civil authorities: Provisional Reconstruction Teams, combat surgery, casualty care in CONUS MTFs

Military Treatment Facilities



- Comprised of four interlocking indivisible platforms
 - Operational Platform
 - Readiness Platform
 - Training Platform
 - Innovation Platform



Operational Platform



- C2 over assigned forces
- Central planning to coordinate / integrate the four interlocking platforms
- Manages partnerships and alliances
- Health Service Support for local and repatriated Armed Forces, their family members and eligible beneficiaries
- Contingency management – planning and response



Readiness Platform



- Individual and subordinate unit readiness.
- Professional currency: In the healthcare arena healthcare professionals & technicians of all types require access to authentic clinical activities in sufficient volume, flow and complexity to remain at the top of their game.



Training Platform



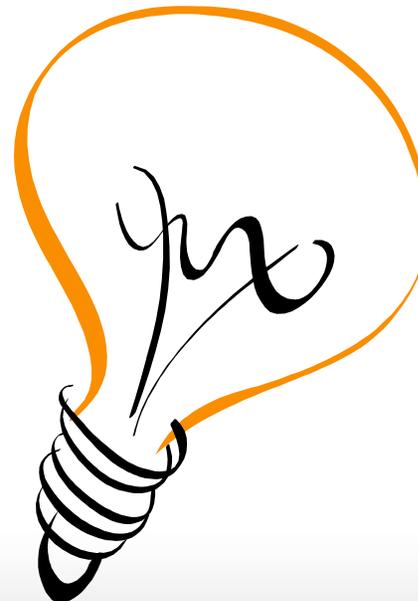
- Technicians, nurses, administrators, allied health scientists and physicians are in training in a pre-deployable status.
- Accruing knowledge, skill, judgment, experience sufficient to
 - matriculate, sit for examination, pass competency reviews, achieve certification.
- All require access to sufficient volumes, flows and complexities of clinical activity.



Innovation Platform



- Not all MTFs operate an innovation platform.
 - Service-specific military medical research
 - Congressionally Directed Research
 - Uniformed Service University of the Health Sciences
 - Partnerships



Relook at the Quadruple Aim



- Must link the What to the How
- The Why is given ... linked to ND, NS, NH
 - Who does What by When and how do we Know
 - Planning and execution
 - Align responsibility & accountability



Mission Focus



- Necessary to achieve objectives and effects.
- Requires Common Operating Picture.
- Anywhere and everywhere in MHS there is a confluence of units and forces operated in Service stovepipes. Military medicine is organized at the level of the Service.

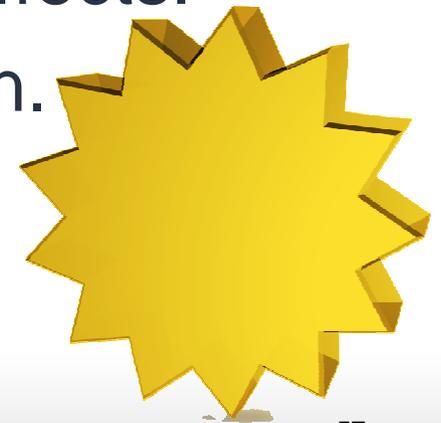


- Unity of Purpose requires sufficient authentic Unity of Command to achieve the objectives and affects

Achieving the Quadruple Aim



- The opportunity to build upon world class to create a national treasure for our Armed Forces.
- The challenge is to develop real capability. It will take time to develop the doctrine, organization, training, materiel, leadership and education, personnel and facilities (DOTMLPF) to achieve clear Quadruple Aim objectives and affects.
- Requirement mandates transformation.



Defense / Service / Joint Success



- To succeed in the Quadruple Aim operating environment we require
 - Robust Common Operating Picture and
 - Sufficient unity of command to achieve unity of purpose

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Unity of Purpose. Joint Task Force CAPMED

Sharing Knowledge: Achieving Breakthrough Performance

Colonel Casper Jones, MS, USA, Director of Operations (J3)

25 January 2010



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Medical

Operating Picture



- Joint Task Force CAPMED: first ever Joint Force Commander for the military medical function
 - Without precedent but with provision
 - Military medical capabilities organized above the level of the Services.
- Aligned under the Secretary of Defense through the Deputy Secretary of Defense



Joint Operational Area



- Defined by the assigned forces and catchment areas of 37 MTFs in 5 States and the District of Columbia. Includes:
 - Military Academic Medical Center anchored by Uniformed Services University of the Health Sciences and Water Reed National Military Medical Center (a Joint command)
 - Fort Belvoir Community Hospital (a Joint Command)
 - Joint Pathology Center

JTF CAPMED Mission



- Integrate healthcare delivery in the NCR
- Establish, organize and operate
 - WRNMMC at Bethesda as Joint Command
 - FBCH at Fort Belvoir as Joint Command
 - Joint Pathology Center
- Oversee MTF NCR BRAC
- Prepare for and response to contingencies
- Perform other tasks as assigned



Joint Mission Essential Tasks



- OP 4.4.3.3 Manage Health Resources in the Joint Operational Area (JOA)
- OP 5.3 Prepare Plans and Orders
- OP 5.1.2 Manage Means of Communicating Operational Information

JMETLs (more)



- OP 7.9 Conduct Consequence Management (CM) Operations in the Joint Operations Areas (JOA)
- OP5.5 Establish and Organize and Operate a Joint Force Headquarters
 - OP 4.6.6 Manage Contracts and Contract Personnel
 - OP 5.8 Provide Public Affairs (PA) in the Joint Operations Area (JOA)

JTF CAPMED Relationships



- TACON of assigned forces – Army, Navy & Air Force Component Commands, 37 MTFs
- OPCON at IOC for WRNMMC, FBCH, JPC
- Direct Support to Joint Force Headquarters / JTF-NCR
- General Support to USNORTHCOM
- MOU with Joint Forces Command, Army, Navy and Air Force – Global Force Management (pending)

Alliances and Partnerships



- HA/TMA/USUHS – military academic medical center
- Naval Installation Command/Naval Support Activity Bethesda – WRNMMC
- Army Installations Management Command/Fort Belvoir Installation Command – FBCH
- US Army MEDCOM/AFIP – Transition to JPC
- Defense Center of Excellence/National Intrepid Center of Excellence – establish clinical capability

Alliances and Partnerships



- TRICARE Regional Office North – MCSC
- HA/TMA – developmental partner (pending)
- Telemedicine & Advanced Technology Research Center (TATRC) – technology transfer (pending)



Contingency Management



- Direct Support to JFHQ/JTF-NCR and General Support to USNORTHCOM
- National Security Mission synchronized to the NORTHCOM mission which is to conduct military operations to:
 - Anticipate, deter, prevent and defeat threats to the United States, its territories and interests within assigned area of responsibility
 - Provide civil support and other assistance to U.S. civil authorities as directed

NORTHCOM Theater Campaign Plan



- JTF CAPMED has Support Plans to NC's Concept of Operation Plans and JFHQ/JTF NCR's Operation Plans
 - 3400 Homeland Defense
 - 3600 Emergency Preparedness in the NCR
 - 3501 Defense Support to Civil Authorities
 - 3500 CBRNE Consequence Management
 - 3591 Pandemic Influenza – Regional

Interagency Coordination*



- JTF CAPMED coordinates with
 - Department Health & Human Services
 - Department of Homeland Security
 - Capitol Police and the Office of the Attending Physician to Congress
 - US Secret Service for NSSE
 - White House Communications Agency



*Director Joint Staff, "Interagency, Intergovernmental Organization, and nongovernmental Organization Coordination During Joint Operations Vol 1 & 2", (Joint Chiefs of Staff, Joint Publication 3.08, Vol & 2), 17 March 2006, 403 pages

Interagency Coordination (more)



- District of Columbia Department of Health, Health Emergency Health Preparedness and Response Administration
- Maryland Institute for Emergency Medical Services Systems
- Northern Virginia Hospital Alliance, Emergency Response Alliance

Quadruple Aim - Readiness



- HA/TMA Readiness Measures
 - IMR and Psychological Health
- Assessing and measuring our readiness requires synchronizing with Joint / Services organizations
- Readiness is much, much more