Striving for High Value Health Care: Lessons Learned

Made possible through support from:

Learn more about ways to Bend the Curve in health care costs at: www.nehi.net/bendthecurve
Cost Control: Why Do We Care?

NHE was 6.2 percent of GDP

Now 17.9 percent

Going to 25 percent in 2025
Cost Control: Why Should We Care?

Massachusetts Spending Imbalance

Net Change, Fiscal Years 2001-2012
Adjusted for inflation

Source: Massachusetts Budget and Policy Center Budget Browser
2011 NHE: $2.7 Trillion

- Hospitals 33.7%
- Physicians 22.1%
- Rx Drugs 11.6%
- Home Health Care 3.2%
- Nursing Home Care 6.3%
- Other Professional Services 7.4%
- Other Medical Products 3.2%
- Public Health 3.2%
- Gov. & Priv Admin. 7.4%
- Research 2.1%
Bending the Cost Curve: A Third Choice

Services

Premiums
Waste: Where, Why, & How Much?


TANYA G.K. BENTLEY, RACHEL M. EFFROS, KARTIKA PALAR, and EMMETT B. KEELER

RAND Corporation; University of California, Los Angeles

50%?

Accounting for the Cost of Health Care in the United States

McKinsey Global Institute

30%?
NEHI’s Work on Waste

One-third of our health care spending does nothing to improve the quality of health care delivered.
Top Drivers of Waste

A $500+ BILLION OPPORTUNITY

- PREVENTING MEDICATION ERRORS
- PREVENTING HOSPITAL READMISSIONS
- DECREASING ADMISSIONS FOR ACSC (AMBULATORY CARE SENSITIVE CONDITIONS)
- REDUCING EMERGENCY DEPARTMENT OVERUSE
- REDUCING VACCINE UNDERUSE
- REDUCING ANTIBIOTIC OVERUSE
- IMPROVING MEDICATION ADHERENCE
NEHI’s *Bend The Curve* Campaign

**Bend The Curve**
A Health Care Leader’s Guide to High Value Health Care

- Reducing Emergency Department Overuse
- Reducing Antibiotic Overuse
- Improving Patient Medication Adherence
- Eliminating Healthcare Waste
- Preventing Hospital Readmissions
- Operating Hospital Admissions for Ambulatory Care Sensitive Conditions
- Preventing Medication Errors
- Decreasing Hospital Admissions for Ambulatory Care Sensitive Conditions
Reducing ED Overuse:
A $38 Billion Opportunity

Nationally, 56%, or roughly 67 million emergency department visits, are potentially avoidable.


Notes
Reducing Antibiotic Overuse:
A $63 Billion Opportunity

Notes
Improving Patient Medication Adherence: A $290 Billion Opportunity

(IMPROVING PATIENT MEDICATION ADHERENCE)

Of the 187 million Americans who take one or more prescription drugs, up to 50% don’t take them as prescribed.


Notes
Reducing Vaccine Underuse: A $53 Billion Opportunity

One of every five children is not completely up to date on recommended immunizations.

Notes
Preventing Hospital Readmissions: A $25 Billion Opportunity

Preventable hospital readmissions cost the U.S. health care system an estimated $25 billion annually.


Notes
Decreasing Hospital Admissions for Ambulatory Care Sensitive Conditions: A $31 Billion Opportunity

Bacterial pneumonia and congestive heart failure accounted for $15.6 billion of the total hospital costs for all preventable hospitalizations in 2006.


Notes
Preventing Medication Errors: A $21 Billion Opportunity

(PREVENTING MEDICATION ERRORS)

Each year in the U.S., serious preventable medication errors occur in...


Notes
NHE is 17.9 percent of GDP

Going to 25 percent in 2025

Going to ??? Percent in 2025
Keynote Speaker

J. Michael McGinnis, MD
Institute of Medicine
Cutting Health Costs

More than a quick fix

J. Michael McGinnis, MD, MPP
Institute of Medicine

NEHI
January 10, 2013
What have we heard?

• About U.S. health expenditures
• About the implications
• About the waste
• About reducing waste
• About areas needing particular attention
• About prospects for continuous learning health care
### U.S. health expenditures, 2011

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>Amount (%)</th>
<th>Amount (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital care</td>
<td>31</td>
<td>850.6</td>
</tr>
<tr>
<td>Physician services</td>
<td>20</td>
<td>541.4</td>
</tr>
<tr>
<td>Long term and other care</td>
<td>13</td>
<td>356.7</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>10</td>
<td>263.0</td>
</tr>
<tr>
<td>Other clinician services</td>
<td>7</td>
<td>181.6</td>
</tr>
<tr>
<td>Health insurance administration</td>
<td>6</td>
<td>156.4</td>
</tr>
<tr>
<td>Structures and related materials</td>
<td>4</td>
<td>103.7</td>
</tr>
<tr>
<td>Other medical products</td>
<td>3</td>
<td>85.9</td>
</tr>
<tr>
<td>Public health</td>
<td>3</td>
<td>79.0</td>
</tr>
<tr>
<td>Research</td>
<td>2</td>
<td>49.8</td>
</tr>
<tr>
<td>Government administration</td>
<td>1</td>
<td>32.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100 %</strong></td>
<td><strong>$2,700.7</strong></td>
</tr>
</tbody>
</table>
Implications

- Contribution to federal debt
- U.S. commercial competitiveness
- Investment capacity of states
- Household budgets
- Waste and inefficiency
Waste and inefficiency

- Unnecessary services
- Services delivered inefficiently
- Excessive administrative costs
- Prices that are too high
- Missed prevention opportunities
- Fraud

How much too much?—take 1

- Unnecessary services: $210 billion
- Services delivered inefficiently: $130 billion
- Excessive administrative costs: $190 billion
- Prices that are too high: $105 billion
- Missed prevention opportunities: $55 billion
- Fraud: $75 billion


(lower bound of estimates)
How much too much?—take 1

- Domain sums (IOM) $765 billion
How much too much?—take 2

- Domain sums (IOM) $765 billion
- Geographic variation (Dartmouth) $750 billion

Adjusted to 2009
How much too much?—take 3

- Domain sums (IOM)  $765 billion
- Geographic variation (Dartmouth)  $750 billion
- Inter-country comparisons (McKinsey)  $760 billion

Adjusted to 2009
Reducing unnecessary expenditures

- Incentives that reward value
- Evidence-based medicine
- Care process improvement
- Administrative process improvement
- Price reduction
- Health promotion and disease prevention
- Fraud prevention
Low hanging fruit

- **Choosing Wisely’s 37 services**
  - Unnecessary imaging studies (17)
  - Cancer screening tests: low risk situations (7)
  - Other screening test: low risk situations (20)
- **NEHI assessment**
  - Medication errors
  - Hospital readmission levels
  - Antibiotic overuse
  - Vaccine underuse
  - Patient medication adherence
CEO Checklist for high-value health care

• Foundational elements
  ➢ Governance priority
  ➢ Culture of continuous improvement

• Infrastructure fundamentals
  ➢ IT best practices
  ➢ Evidence protocols
  ➢ Resource utilization

• Care delivery priorities
  ➢ Integrated care
  ➢ Shared decision-making
  ➢ Targeted services

• Reliability and feedback
  ➢ Embedded safeguards
  ➢ Internal transparency

Delos Cosgrove et. al. A CEO Checklist for High-Value Health Care (IOM:2012)
Current under-investments

• Transparency on costs and outcomes
• Team-based, patient-driven care culture
• Disruptive diagnostics
• Proximal site care
• Health information technology
Reducing actual costs: disruptive innovation

- In diagnostics
- In treatment
- In delivery
Best Care at Lower Cost

What’s changed since *Quality Chasm*?

- Complexity and excess costs
- New tools and levers
- Continuous learning capacity
- IOM implementation focus

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation / Improving health
Continuous learning health care

- **Science and informatics**
  - Real-time access to knowledge
  - Digital capture of the care experience
- **Patient-clinician partnerships**
  - Engaged, empowered patients
- **Value-oriented incentives**
  - Incentives aligned for value
  - Full transparency
- **Continuous learning culture**
  - Leadership-instilled culture of learning
  - Supportive system competencies
Practitioner Presentations

Eric Weil, MD
Mass General Hospital and
Mass General Physicians Organization

Samuel Nussbaum, MD
WellPoint
Improving the Delivery of Care in a High Risk Population
The MassGeneral Care Management Program
High Cost/High Risk: Population in Concept

20% of Medicare beneficiaries have > 5 chronic conditions

Distribution of Total Medicare Beneficiaries and Spending, 2004

- Total Number of Beneficiaries: 42.9 million
- Total Medicare Spending: $259 billion

- 90% of beneficiaries have up to 4 chronic conditions
- 10% of beneficiaries have > 5 chronic conditions

- 33% of Medicare spending: $6,059
- 67% of Medicare spending: $40,639
High Risk/High Cost: Population in Context

Population Volume

Intensity of Illness

Area of Focus

- Healthy
- Chronic Illnesses
- Medically Complex/High Utilizers

Intensity and Specificity of Intervention
High Cost/High Risk: Population in Reality

• Selection
  – All Primary Care practices (19) with (190+ PCPs)
  – Risk and Cost criteria applied to their claims
  – Inclusion: chronic illnesses
  – Exclusions: ESRD, HMO, geography

• 2500 patients (top 2.5%)
  – Average # Meds = 12.6
  – Average age ~75
  – Average # hospitalizations/year = 3.4
  – Average annual costs = $24,000

• Total annual cost of enrolled patients = $60M/year

• Burden of behavioral health: 56%
Care Management Program: Conceptual Strategy

Outpatient Spend

Inpatient Spend (Acute, Rehab, SNF)

Traditional Fee for Service

Outpatient Spend

Care Coordination Spend

Inpatient Spend

With Enhanced Coordination

Schematic: Not drawn to scale
Care Management Program: Design

- Embedded in Primary Care Practice
- Emphasizes Longitudinal Relationships
- Mass customization: configuring services to fit patient needs
  - End-of-life management
  - Psych/social evaluations and interventions
  - Transition Management
  - Discretionary funds for non-covered services
  - Iterative: modifications based on experience
- Heavy reliance on IT/real time data

Care managers are integrated into all Primary Care Practices

- 12 Care Managers (approx 200 patients/Care Manager)
- Assess Patients - Identifying ‘gaps: ’risks for poor outcome.
- Coordinate care between providers, services
- Facilitate better communication/transitions
- Specialized training and ongoing team based learning

Key Adjectives: Proactive, Assertive, Empowered, Well-Trained
Delivery model incorporates other specialized services to manage specific needs

Key Tenet:
Each team member must be working at the top of their license
### Outcomes

#### Qualitative
- Physician Satisfaction
- Patient Care
- Work-life
- Time
- Staff Satisfaction
- Patient Quality of Life
- Communication

#### Clinical
- Hospitalization rate/1000 was 20% lower than in comparison group
- Emergency department visit rates were 13% lower for enrolled patients
- Annual mortality 16% among enrolled versus 20% among comparison group

#### Cost/Savings
- 12.1% in gross savings among enrolled patients
- 7% in annual net savings among enrolled patients after management fee paid by CMS to MGH
- Return on investment - for every $1 spent, the program saved at least $2.65
Care Management Program: Challenges

- Patients
  - Behavioral Health
  - End of life care

- Care managers
  - Patient load
  - Depth vs. breath
  - Central support/management
  - Local patient and MD contact
  - Workflow software/EMR Integration

- Physicians
  - Specialty Engagement
  - Inpatient collaboration

Broader Questions

- Replicability
- How will this work in Medicaid? Commercial?
- Future Funding
If I were President of the United States I would

make healthcare better.
CareMore: Improving Care Delivery for Seniors

January 10, 2013
NEHI Policymaker Roundtable
Washington, D.C.

Sam Nussbaum, M.D.
Executive Vice President, Clinical Health Policy and Chief Medical Officer
Challenges in the U.S. Health Care System

- Variation in quality, safety, outcomes and cost
- Escalating costs/technology advancements
- Aging population and increased chronic diseases
- Lack of information and infrastructure for optimal care
- Fragmented system: coordination of care; health professional roles

*The Commonwealth Fund – June 2010*
## Estimated Sources of Excess Costs in Health Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Sources</th>
<th>Estimate of Excess Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>• Overuse—beyond evidence-established levels</td>
<td>$210 billion</td>
</tr>
<tr>
<td></td>
<td>• Discretionary use beyond benchmarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unnecessary choice of higher-cost services</td>
<td></td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>• Mistakes—errors, preventable complications</td>
<td>$130 billion</td>
</tr>
<tr>
<td></td>
<td>• Care fragmentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unnecessary use of higher-cost providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Operational inefficiencies at care delivery sites</td>
<td></td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>• Insurance paperwork costs beyond benchmarks</td>
<td>$190 billion</td>
</tr>
<tr>
<td></td>
<td>• Insurers’ administrative inefficiencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Inefficiencies due to care documentation requirements</td>
<td></td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>• Service prices beyond competitive benchmarks</td>
<td>$105 billion</td>
</tr>
<tr>
<td></td>
<td>• Product prices beyond competitive benchmarks</td>
<td></td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>• Primary prevention</td>
<td>$55 billion</td>
</tr>
<tr>
<td></td>
<td>• Secondary prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tertiary prevention</td>
<td></td>
</tr>
<tr>
<td>Fraud</td>
<td>• All sources—payers, clinicians, patients</td>
<td>$75 billion</td>
</tr>
</tbody>
</table>

Source: Institute of Medicine; “Better Care at Lower Cost: The Path to Continuously Learning Health Care in America”
Key Drivers in Variation of Care

- **Reimbursement System**: Rewards volume over quality or outcomes
- **Expanding Capacity**: Increased supply triggers increased demand
- **Patient “Preference”**: Lack of information on effectiveness or alternatives
- **Clinical Decision-Making**: Poor integration and coordination across delivery system
### Insurers and Providers: An Evolving Landscape

<table>
<thead>
<tr>
<th>Insurer/Provider</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highmark</td>
<td>• $475M contribution to 5-hospital West Penn Allegheny</td>
</tr>
<tr>
<td></td>
<td>• This “affiliation” will enable West Penn to move from fee for service to salaries for physicians and offer incentives for quality and efficiency goals</td>
</tr>
<tr>
<td>Humana</td>
<td>• 300 medical centers in 42 states; 240 worksite health-care facilities</td>
</tr>
<tr>
<td></td>
<td>• Will provide urgent care, wellness programs, and physical and occupational therapy to 3 million Humana members near a Concentra center</td>
</tr>
<tr>
<td>UnitedHealth Group</td>
<td>• United’s OptumHealth services unit acquires Monarch: 2300 doctors; 30+ urgent care centers; and NAMM, a Southern California IPA affiliated with 600 PCPs and 1200 specialists</td>
</tr>
<tr>
<td>WellPoint</td>
<td>• Provides Medicare Advantage coverage and coordinated care for 54,000 people in California, Arizona and Nevada</td>
</tr>
<tr>
<td></td>
<td>• CareMore’s 41 Care Centers are models for integrated health care and include a variety of services including medical evaluations and diabetes care</td>
</tr>
</tbody>
</table>

*Concentra, NAMM, and CareMore logos are included in the image.*
Healthcare Costs are Concentrated

- **85% of Beneficiaries = 25% Spending**
  - 23 Million Beneficiaries
  - Spending $1,130 each
  - Total Spending = 5% ($26 B)

- **15% of Beneficiaries = 75% Spending**
  - 16.1 Million Beneficiaries
  - Spending $6,150 each
  - Total Spending = 20% ($104 B)

- **7 Million Beneficiaries**
  - Spending $55,000 each
  - Total Spending = 75% ($391 B)

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2010 Medicare Spending Projection = $522 B
46 Million Beneficiaries
Spending Per Beneficiary = $11,347
Our Mission
To address the complex problems of aging while protecting the precious financial resources of our members and the federal government.
Our Philosophy of Health Care

• Older patients require coordinated care with a care path that takes into account their multiple conditions.

• A physical and human locus of care is required to create care coordination.

• Clinicians in key roles must be confident generalists, persistent and deliberate, with competence as clinical decision makers, communicators and team players.

• All providers have a buy-in for the system of care, not just their individual capabilities.

• A complete care continuum requires equal attention to medical, social, psychological and pharmacological needs of the patient.

• An explicit approach to care is required for each chronic condition, for high-frequency acute episodes, and for end-of-life.

• An obsessive attention to detail in both micro matters (individual care) and macro matters (care programs) permits optimal outcomes.

• A willingness to thoughtfully challenge the status quo provides windows of insight into clinical innovation and care pattern redesign which can optimize patient health and comfort, and conserve financial resources.
The Essentials of CareMore’s Model

**Chronic Care Management**

**Acute Care Management**

**Predictive Modeling & Early Intervention**

**Operating Principals**

- **Clinical Control** – CareMore extensivists determine when a patient requires care services and programs
- **Speedy Deployment** – Services and programs can be deployed within minutes
- **Efficient Allocation of Clinical Resources** – The model replaces physician labor with skilled, allied health professionals such as NPs, MAs, therapists and dieticians
- **Early Intervention** – Predictive modeling allow for early intervention to prevent acute episodes

**Redefining Primary Care**

**Secondary Prevention**

**Redefined Acute Care Episode**
CareMore: Care Innovation

- Care Centers provide a “Healthy Start” initial evaluation and integrated care that combines wellness and medical supervision and offers personalized health planning.
- Extensivists intensively manage chronically ill members.
- Biometric monitoring applied to care management.
CareMore Solution – New Model of Care

Predictive modeling
Integrated IT infrastructure
Longitudinal patient record
Evidence-based protocols
Point-of-care decision support

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End of Life Care
Social / Behavioral Support
Clinical Care Centers (CCC)
PCP
Extensivist
Case Manager/NP
Risk Event Prevention
Secondary Prevention
Chronic Disease Support

Chronic Disease Support

Disease Support

ESRD
CHF
CAD
COPD
Diabetes
Wound Clinic
Healthy Start
Monitoring
Nutritionist
Foot care
Exercise
Pre-Op
Coumadin
Fall
Strength Training
Extensivist Management

Frailty Support

Frailty Support

Hospice
Palliative Care
Social Workers
Mental Health
Extensivist Support

Extensivist Support

PCP
Extensivist
Case Manager/NP
Risk Event Prevention
Secondary Prevention
Chronic Disease Support

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## CareMore Improves Clinical Outcomes For Costly Chronic Conditions

<table>
<thead>
<tr>
<th>Fall Prevention</th>
<th>ESRD</th>
<th>Nursing Home Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status quo</strong></td>
<td><strong>Status quo</strong></td>
<td><strong>Status quo</strong></td>
</tr>
<tr>
<td>More than 1/3 of seniors fall each year and 1/2 of them fall recurrently. 1 in 10 falls result in a serious injury such as hip or other fracture, head injury, or serious soft tissue injury.</td>
<td>Half of all ESRD Admissions were the result of either poor diabetic control or vascular access limits/clogs. Dialysis centers provided no primary care and patients were referred to the ER. Most ER visits resulted in an admission</td>
<td>Inactivity and lack of primary care in facilities resulted in wound development.</td>
</tr>
<tr>
<td><strong>CareMore Redesign</strong></td>
<td><strong>CareMore Redesign</strong></td>
<td><strong>CareMore Redesign</strong></td>
</tr>
<tr>
<td>Any CareMore senior who falls is referred to the CareMore Fall Clinic for an extensive individualized evaluation assessing the multifactorial etiologies for falling. Treatment for medical causes are instituted and referral is made, when appropriate, for physical therapy and strength and balance training.</td>
<td>Established a dedicated case manager and nurse-practitioner who receive referrals from centers in lieu of ER referral. Primary/preventive care is provided and all patients receive monthly preventive access line inspection and, if needed, cleaning.</td>
<td>Deployed nurse practitioner teams to nursing homes weekly to proactively tend to skin or create early intervention in patients likely to develop wounds.</td>
</tr>
<tr>
<td><strong>Result</strong></td>
<td><strong>Result</strong></td>
<td><strong>Result</strong></td>
</tr>
<tr>
<td>Referral to our strength and balance training center has shown decreased falls and fractures in frail seniors.</td>
<td>36% fewer inpatient admissions and 62% less inpatient bed days than the national average.</td>
<td>Only one new wound developed in over three years and more than 600 patients. The usual rate per year for development of pressure ulcers for nursing home patients in California is 13%.</td>
</tr>
</tbody>
</table>
## Dramatically Improved Outcomes for Chronic Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>7.07 average HbA1c for those attending our diabetic clinic and 60% lower amputation rate</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>36% fewer inpatient admissions and 62% less inpatient bed days than the national average</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>56% reduction in hospital admission rate in 3 months</td>
</tr>
</tbody>
</table>
# Superior Clinical Outcomes

<table>
<thead>
<tr>
<th>Metric</th>
<th>CareMore</th>
<th>National Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALOS</strong></td>
<td>3.7 days(^1)</td>
<td>5.4 days</td>
</tr>
<tr>
<td><strong>Bed Days / 1,000</strong></td>
<td>967</td>
<td>1,868</td>
</tr>
<tr>
<td><strong>Admit Rate / 1,000</strong></td>
<td>261</td>
<td>344</td>
</tr>
<tr>
<td><strong>Readmission Rate(^2)</strong></td>
<td>14.1%</td>
<td>19.6%</td>
</tr>
</tbody>
</table>

\(^1\) With contracted facilities  
\(^2\) Excluding ESRD
Challenging the Status Quo

- At least 35% of health care costs for the chronically ill can be avoided
- Prepayment (Capitation) is freedom, not risk
- Primary Care is a “team sport” not an “individual sport”
- For aging adults, Primary Care should be an outbound activity, not an inbound activity
- A high percentage of physician services can be provided by non-physician clinicians
- Patient compliance is more our problem than the patient’s
- Health care systems can and must be replicable; we must create a learning health care system
Break
10:40 – 10:55

Learn more about ways to Bend the Curve in health care costs at: www.nehi.net/bendthecurve
Moving from Policy to Practice

Michael Kelleher
NEHI
Moving from Policy to Practice

Joe Antos, PhD
Helen Darling
William Shrank, MD
Daniel Wolfson
Learn more about ways to Bend the Curve at: www.nehi.net/bendthecurve