



Innovative Models of Care Delivery: Addressing Transitions Across The Care Continuum

With the ongoing transformation of health care delivery, new care models that partner physicians and hospitals as co-leaders of the clinical enterprise are rapidly emerging. The AHA's Physician Leadership Forum, along with the American Society of Anesthesiologists (ASA), hosted an afternoon session on Innovative Models of Care Delivery in conjunction with the Health Forum/AHA Leadership Summit. Attendees, clinical leaders and hospital executives, gathered to learn about two care models that ease transitions across the continuum of care: the Perioperative Surgical Home and Hospital at Home.[®]

Faculty

Terry Belmont, MPH, Chief Executive Officer & Associate Chancellor, UC Irvine Health, Orange, CA

Michael Caravelli, MD, The Center: Orthopedic and Neurosurgical Care and Research, Bend, OR

John R. Combes, MD, Senior Vice President, AHA, Chicago, IL

Kathy Davis, RN, SVP and Chief Nursing Officer, Presbyterian Healthcare Services, Albuquerque, NM

Zeev N. Kain, MD, MBA, Professor and Chair of Anesthesiology, Associate Dean for Clinical Operations and Acting CMO, UC Irvine Health, Orange, CA

Peggy L. Naas, MD, MBA, Orthopedic surgeon physician consultant, Chanhassen, MN

Mike Schweitzer, MD, MBA, Vice President of Healthcare Delivery System Transformation, VHA Southeast, Tampa, FL

Jeff Selberg, Executive Director, Peterson Foundation, New York, NY

Stanley Stead, MD, MBA, Vice President, Professional Affairs, ASA, Encino, CA

Keynote Address

Innovative Care Delivery

Jeff Selberg, executive director of the Peter G. Peterson Foundation, set the stage for the day, discussing how new models fit in with the changing environment of health care. Mr. Selberg spoke about the state of health care in the U.S., three features of successful models and how to “install” new models of care.

The Peterson Foundation’s mission is to increase public awareness on the nature and urgency of key economic challenges threatening America’s future and to accelerate action. It aims to develop and grow initiatives fostering better care for lower cost by being a catalyst for change. In close collaboration with others, the Peterson Foundation hopes to speed improvement by discovering and spreading the adoption of breakthrough innovations that significantly improve health care outcomes while lowering cost. The Peterson Foundation’s strategy is to identify high-impact, proven solutions in the U.S., develop conditions for change and facilitate broad-scale adoption.

Health Care in the U.S.

While at the Institute for Healthcare Improvement (IHI), Mr. Selberg would welcome a steady stream of leaders from high performing health systems from around the world eager to learn from U.S. health care. Given the U.S.’s lower ranking in overall health among developed nations, he often asked why. Most pointed to the

pockets of excellence they wanted to learn about and bring back to their respective countries.

While the U.S. health care system has pockets of excellence, there is room to improve the value proposition. Allan Detsky¹ wrote, “Many Americans are aware that the United States spends much more on health care than any other country in the world. But fewer people know that the health of Americans—by many different measures—is actually worse than the health of citizens in other wealthy countries.” For the amount of money spent on health care in the U.S. our outcomes should be better.

The U.S. has improved upon healthy-life expectancy over the past two decades, but the rate of improvement is slower than the other 33 countries that make up the Organization for Economic Cooperation and Development (OECD). In 1990, the U.S. ranked 14 out of 34 in healthy-life expectancy. In 2010, the U.S. fell to 26. Further, of the 17 highest income countries in the world, the U.S. has the highest rate of infant mortality and the lowest chance of surviving to age five.²

¹ Detsky, A. (2014 June 11). Why America is losing the health race. *New Yorker*.

² National Research Council and Institute of Medicine. (2013). *U.S. health in international perspective: shorter lives, poorer health*.



Health Care Performance

Health Outcome	U.S. Rank (1 st is preferable)
Heart Attack Fatalities Deaths per 100,000 people	12 th out of 32
Life Expectancy Expected age of death for individuals currently age 65	
Men	22 nd out of 34
Women	25 th out of 34
Infant Mortality Deaths per 1,000 births	31 st out of 34
Unmanaged Asthma Hospital admission rates, adjusted for age and sex, per 100,000 people	27 th out of 28
Surgical Complications Accidental puncture or laceration, rates per 100,000	16 th out of 19

SOURCE: OECD, Health Data 2013, June 2013.
NOTE: Data for 2011 or latest available.

Yet, despite these high costs, our health outcomes are average, at best.

www.pgpf.org



In addition to the statistical measures putting U.S. health care on the low end of the performance spectrum, U.S. health care delivery is often seen as unwilling or unable to keep pace with advancing technology and societal changes. Other industries, such as banking and retail, have been able to adapt to changes in the environment driven by consumer expectations. As the Institute of Medicine (IOM) reported in *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*:

If banking were like health care, automated teller machine transactions would take not seconds but perhaps days or longer as a result of unavail-

able or misplaced records. If home building were like health care, carpenters, electricians and plumbers each would work with different blueprints, with very little coordination... If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all. (p. 5-6)

Despite all of these flaws, Mr. Selberg indicated there is hope. There are opportunities to improve health care, to develop dreams into a vision and finally a vision into a reality. One method is searching out those alternative care models that have both medical and social service attributes

and identifying the features that drive high performance. Successful care should be customized based on the partnership between patient and clinician to foster shared decision making.

Features of Excellence

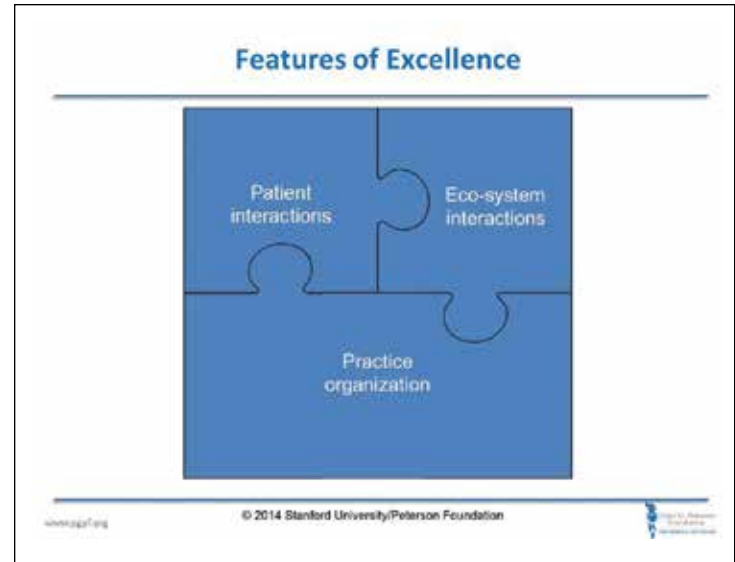
The Peterson Foundation is collaborating with Stanford University to identify, disseminate, replicate and scale features of exceptionally high-value mainstream U.S. health care models. The first phase of the project focuses on primary care physician practices who had upper quartile performance for the National Committee on Quality Assurance (NCQA) HEDIS measures and lower quartile performance for “all in” per capita costs metrics. As part of the project, the team conducted site visits and interviews with physicians, care providers and patients. From this research, three “feature bundles” of successful models emerged: patient interactions, eco-system interactions and practice organization.

Patient Interactions

A hallmark characteristic of a high-value system is the ability to establish deep and real connections with patients and maintaining continuity of care no matter where the patient is in the health care system. Successful systems have a shared decision-making approach with patients, as well as a deep connection. They seek out feedback from patients, and translate criticisms into real improvements.

Eco-system Interactions

High-value systems try to do as much as they can themselves. They conserve resources



conscientiously – developing and adhering to guidelines, as well as being mindful of tests and treatments in order to prevent duplication and avoidable harm.

Practice Organization

A high-value system utilizes staff well, capitalizing on strengths and promoting staff internally to more challenging roles with greater responsibilities. Workstations are bee hives, and delivery of care is a team effort.

Additional and more detailed information regarding the three features of successful models will soon be shared by Stanford’s Center for Clinical Excellence Research. The Peterson Foundation and Stanford will disseminate the findings and build awareness of the models and then work to develop pilot projects to “install” the key features. Using the results of the pilot projects, they plan to develop a change package that can be implemented nationwide.

“Installing” Effective Care Models

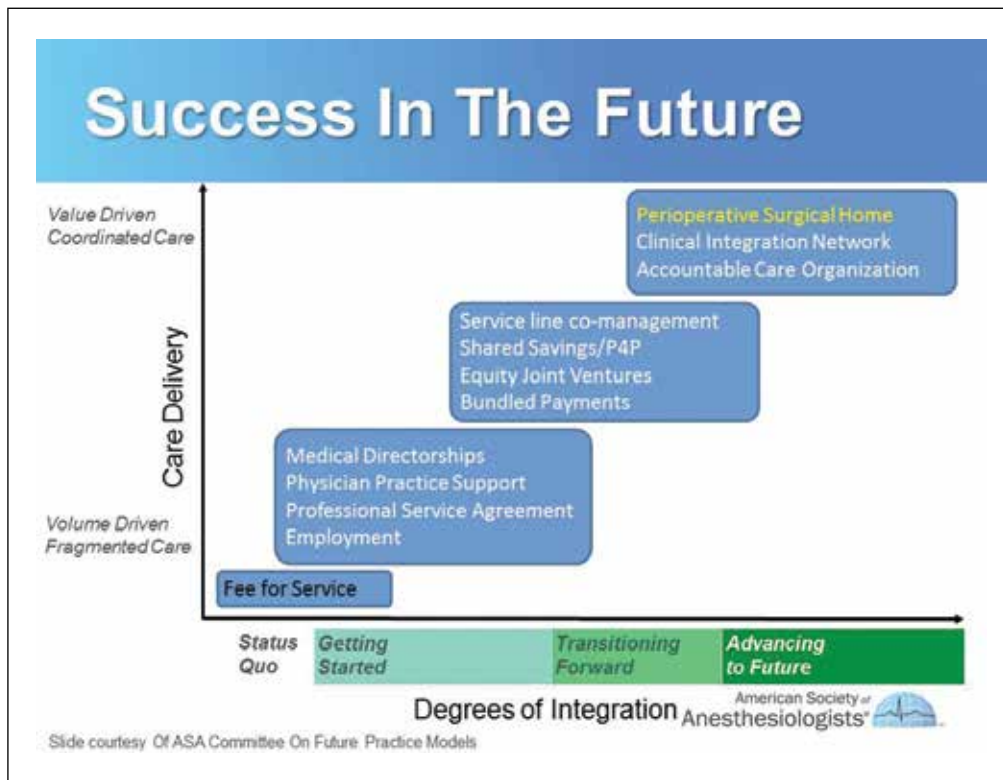
Once successful features of innovative care models and practices are identified, they need to be “installed.” The concept of “install” is meant to be provocative. Installation must be driven by a performance based culture as well as systems and processes that support the features bundle. Installation consists of three key strategies: building will, harvesting ideas, and execution. Building will is establishing an environment ripe for improvement. Within such an environment, ideas can be harvested and executed. The three components of installing successful features must occur at every level and throughout the organization.

Building Will

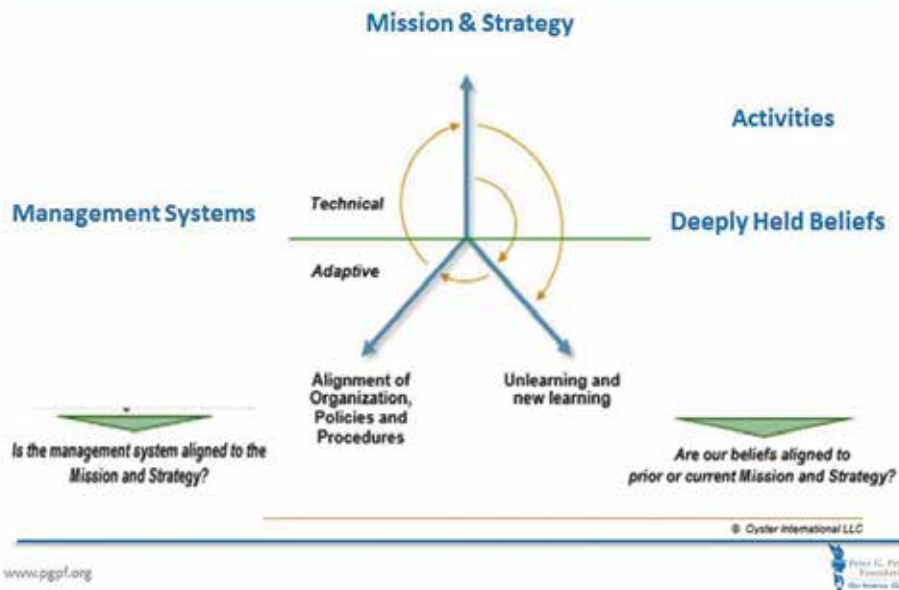
Building will is fostering alignment around strategy, process and purpose, and about how and why disruption should occur. There must be conversation at every level of the organization about alternative models, incentives, and data transparency.

Harvesting Ideas

Successful installation of effective care models cannot stop at building will. Models identified can be focused on a condition like diabetes, a type of patient like a frail elder, or a setting like an intensive care unit or a clinic. Examples of new models might include patient-centered medical homes, building capacity in primary care to integrate behavioral health and chronic



Installing Effective Care Models



disease management, and integrating telemedicine with home care while engaging consumers to enable self-care.

Execution

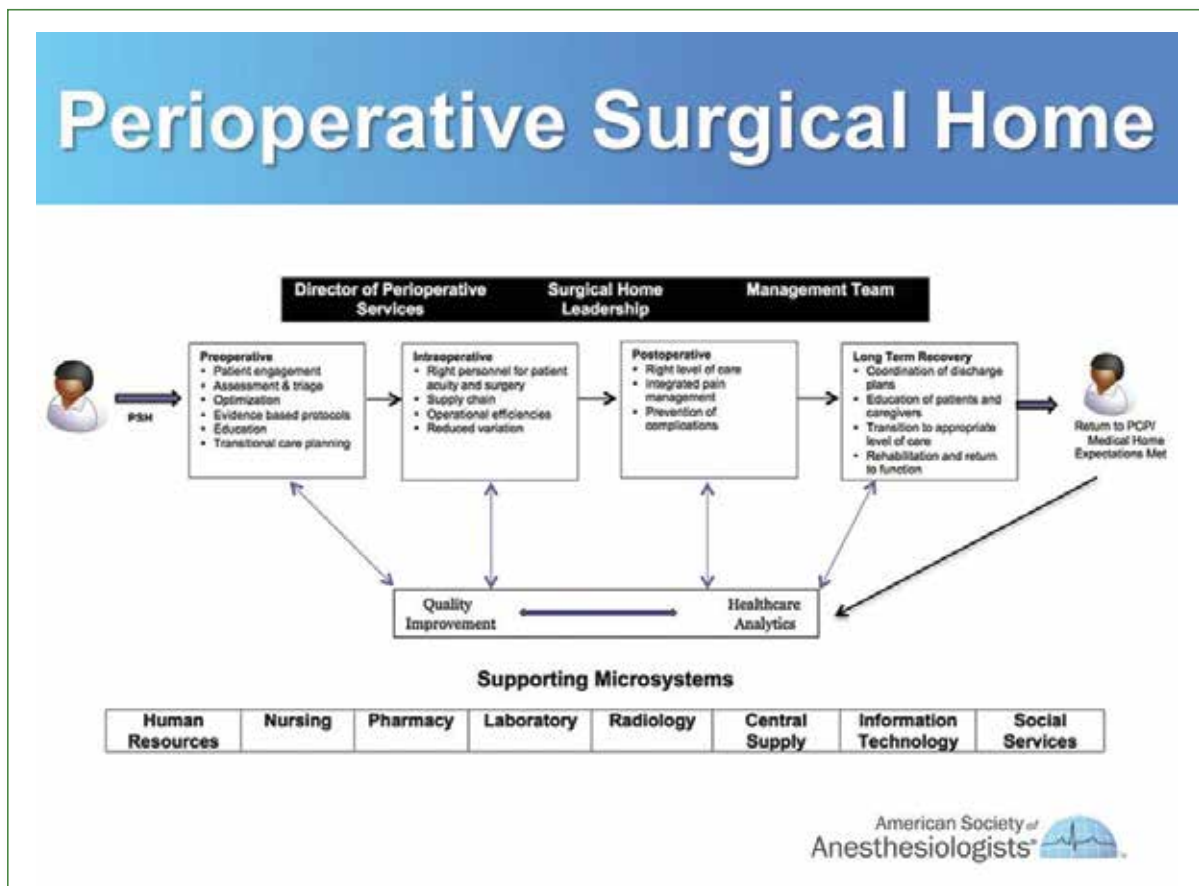
Deming's Theory of Profound Knowledge is a useful tool to develop an installation strategy. The theory has four parts: appreciation for a system, knowledge about variation, theory of knowledge, and psychology. The first step is to develop a deep knowledge of the system that must be changed or disrupted. Paul Batalden, MD, renowned health policy expert, coined the phrase, "every system is perfectly designed to get the results it gets." This provides context to the definition of insanity, which is doing exactly the same thing and expecting a different result. The second step is to establish the metrics that will measure the results achieved. You cannot manage what you don't measure. Metrics also enable variation analysis, which is essential to determine if changes to the system resulted in improved results. The third step employs the concept of learning through application. Deming championed the Plan-Do-Study-Act (PDSA)

cycle as a systematic and dynamic process of learning through doing. The key is to make the changes small enough to be willing to test them rather than large scale changes that constitute too much risk to actually apply. Finally, one must understand the human factor or psychology of change. Disrupting systems also means disrupting the people who manage them. Managing requires a significant investment in communication to elicit the level of cooperation required in any improvement process.

Health care is a vital sector of the U.S. economy that must improve its value proposition. Performance outcomes as a nation need to improve, but much can be learned from the pockets of excellence that exist. Features of high-value systems, such as patient interactions, eco-system interactions, and practice organization, need to be installed by building will, harvesting ideas, and finally, execution.

The Perioperative Surgical Home: Setting the Stage

Stanley Stead, MD, ASA's vice president, professional affairs, introduced the Perioperative Surgical Home (PSH) by describing it as a coordinated optimization of patient transitions from the decision to operate through full recovery.



Using data from the Centers for Medicare & Medicaid Services, Dr. Stead demonstrated the vast variability in cost per beneficiary across the country. He posited that variability is largely due to improper preparation of patients and a lack of or inconsistent follow up. Once a decision is

made to operate, patients should be properly prepared and assessed to determine the best course of treatment that will provide the most successful surgical outcome and the best recovery path. While addressing inpatient length of stay is important in managing cost, post-



The Perioperative Surgical Home: Perspectives Panel

operative care and care needed for clinical complications result in the highest percentage of cost variations. Addressing the patient's post-operative needs and readiness for home care versus rehabilitation care can provide significant savings, but these decisions must be patient-centered to ensure optimal outcomes. The goal is not to eliminate all variation but to eliminate non-value-added variation.

Implementing a PSH requires many different components – most important, quality systems where metrics are measured, and integration across a variety of systems in the hospital. Health care delivery cannot be accomplished by one person, but rather requires a team effort.

A PSH is patient-centric and requires team-based, coordinated work, and shared decision-making built on the patient's goals and desired outcomes. With an aligned vision, each team member can contribute their knowledge and expertise on meeting those outcomes. A PSH moves an organization toward value-based care by aligning patients, physicians, acute and post-acute care.

The continuum of care begins at home, and extends to the community through wellness centers, retail pharmacies, physician offices, diagnostic imaging, and urgent care centers, to the hospital. Beyond the hospital are post-acute care, home care and rehabilitation. Roughly 45 percent of the cost associated with surgery is in the post-acute phase. If improvements do not focus on the entire system nearly half of the opportunity is missed.

CEO Perspective

As an introduction to the three perspectives on PSH, Terry Belmont, MPH, chief executive officer and associate chancellor, University of California (UC) Irvine, stressed the urgency for change.

To respond proactively to the Affordable Care Act and adapt to market change, UC Irvine underwent a strategic planning process to transform care delivery within their organization and strengthen the partnerships with other providers in the continuum. UC Irvine's culture of innovation and inclusion allowed the organization to transform. That culture is founded on a clear mission of excellence in patient care, research and education and a vision to be among the top health care centers and

one of the top academic institutions. One of the elements resulting from the strategic plan and transformation is the PSH.

Mr. Belmont likened implementing a new care model to surfing. One must stay far enough ahead of the wave to not get swallowed up, but not get too far ahead and lose momentum. As a CEO, the challenge is to stay on the wave and not go too far in front or too far behind.

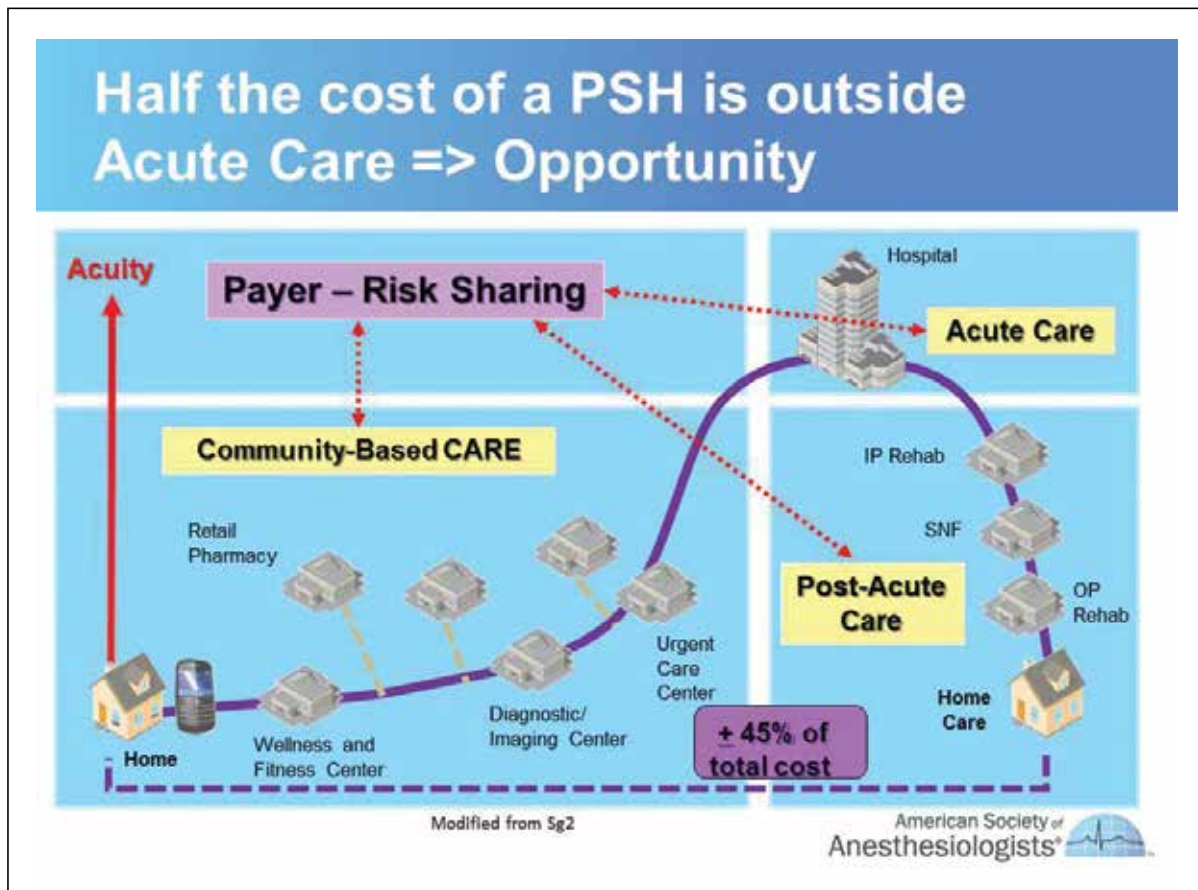
Surgeon Perspective


Peggy L. Naas, MD, MBA, emphasized the importance of moving past professional divisions, as well as developing and adhering to standards so that daily performance runs smoothly and as planned rather than in a reactive and chaotic manner.

Surgeons, anesthesiologists, the care team and the patient need to make decisions together. When surgeons and anesthesiologists

collaborate, a patient can be properly pre-optimized (“pre-habbed”), minimizing unanticipated and unexpected complications or poor outcomes post-operatively. Because anesthesiologists and surgeons have the same goals – the benefit of the patient – common care pathways ought to be developed. The patient must always be the central focus for all caregivers involved.

Each specialty understands risk stratification, based on evidence, about what will jeopardize or negatively influence the ability to deliver outcomes. But it should not be assumed that the orthopedic surgeon’s specialized knowledge is the same as the anesthesiologist’s. Common and shared knowledge are key to optimal outcomes for all involved. Collaboration ensures individual characteristics of a patient are identified to better “pre-habilitate” and ultimately care for the patient. “Pre-habilitation” of a patient is purposefully and proactively mitigating the





factors that drive complications, expenses, readmission, and poor outcomes.

No two patients are the same medically, nor share the same life circumstances. Whether or not a patient receiving total joint replacement will be discharged to a third-floor walk-up matters. The goal should be not to eliminate all variation, but to eliminate non-value added variation, or variation that is driven from physician or care provider personal proclivities or experiences. Non-value added variations that can and should be addressed include eliminating cancellations, delays and waste. Minimizing such variation leads to increased productivity and allows for focused attention to variations which patients bring to the operative theater.

Surgeons and anesthesiologists should communicate and plan cases together; however, sometimes rivalry and competition in the operating room prevent good communication. Egos and individual needs must be put aside. There needs to be a clear line of sight and shared purpose, shared team performance measures and a transparent and predictive process with, and for, the patient.

Anesthesiologist Perspective

Mike Schweitzer, MD, MBA, VHA Southeast's vice president of Healthcare Delivery System Transformation highlighted the fact that care of patients – and cost to the system – extends beyond the four walls of the hospital. Dr. Schweitzer addressed three areas needing attention; pre-optimization, post-discharge and alignment.

Pre-optimization


Traditionally, lab tests and consults are completed shortly before the surgery, identifying patient needs pre- and post-operatively. This common practice of flurried activity prior to surgery does not, however, improve patient recovery. Patients need to be pre-optimized, which occurs in the pre-operative stage. Pre-optimization is not only medical management addressing issues such as anemia, nutrition or physical therapy, it also addresses social elements such as what resources the patient has at home. Pre-optimizing a patient may include getting a social worker or care manager involved before the patient comes into the hospital. Coordination across the whole continuum of pre-operative, intra-operative, post-operative and long-term care is essential. A team, including the primary care physician, surgeon and anesthesiologist must communicate with one another and with the patient to develop a proper care plan.

Pre-operative clinics can expand to post-discharge clinics. After identifying the most medically complex patients, completing risk stratification, working with care managers and social workers, it will be clear which patients will require more intense post-discharge support.

Post-discharge

Those who prepared the patient pre-operatively can continue care post-discharge. When post-operative care occurs where pre-operative care took place, there is no need for new people, or new units, and cost is reduced.

The appropriate post-operative setting for patients must be considered. A skilled nursing



facility is necessary in some instances while in others, a hospital home health agency (HHA) may be viable. For example, hospitals might examine what the percentage of patients having total joint replacements are being discharged to nursing homes. If just a fraction of those can be identified a few weeks prior to surgery and pre-optimized with resources so they can go from hospital to home with home health care there is an opportunity to cut costs, as studies have shown a HHA can be cost effective and reduce readmissions.

Alignment

The Patient Centered Medical Home (PCMH) was identified in the primary care literature in 1967; however, it took another 45 years before PCMH began to gain traction, primarily due to lack of payment support options. While bundled payments seem to fit well with PSH, there are many payment options to consider. Key to the model is aligned incentives to fully manage all of the care, pre-operatively, intra-operatively, post-operatively and post-discharge.

Beyond payment, successful establishment of a PSH lies in identifying champions: the physician champion, nurse champion and administrative champion who will drive change forward, execute the performance improvement plan, understand project management, can drive from start to finish and make continuous improvement.

The ASA is embarking on a PSH national collaborative of 45 health care organizations from across the country, to learn together how to improve the patient experience before, during and after surgery. Because buy-in and alignment are so critical to successful implementation of an effective care model, such as the PSH, the health care organizations involved in the collaborative are represented by teams, with specific champions identified. “The PSH learning collaborative involves clinical and administrative staff from health care facilities working together to redesign their systems to become more patient-focused and efficient for patients undergoing surgical procedures.”³ The three goals of the collaborative are to develop:

- care delivery models,
- payment models; and
- a toolkit to rapidly implement the delivery and payment models for academic, community and pediatric hospitals.

³ <http://www.asahq.org/psh>

The Perioperative Surgical Home: From Concept to Successful Implementation

Zeev N. Kain, MD, MBA, UC Irvine Health's professor and chair of anesthesiology, associate dean for clinical operations and acting chief medical officer, detailed a successful PSH model from the initial concept, through implementation, to ongoing monitoring of results at UC Irvine.

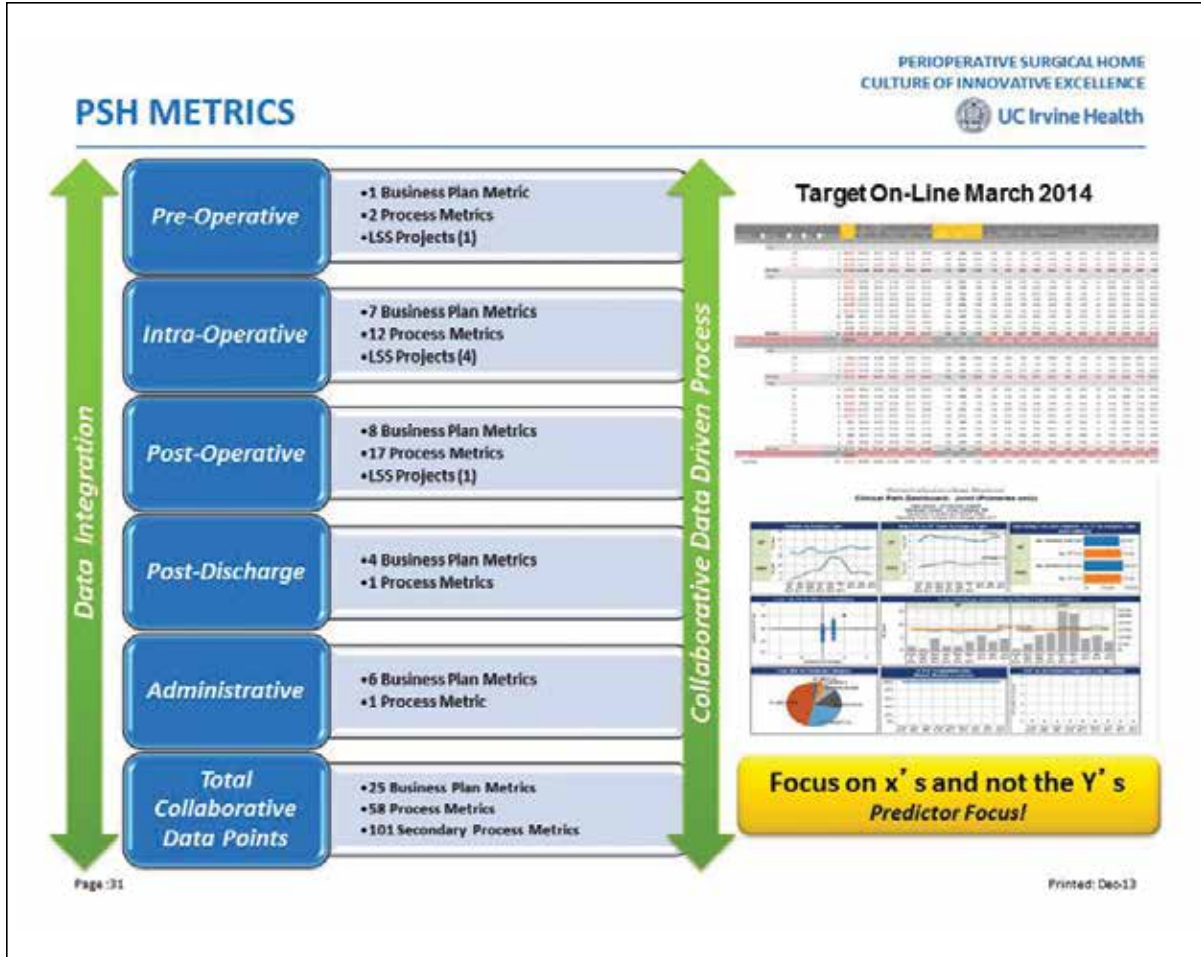
Evident in his presentation was the importance of honoring and respecting what has already been done, building innovation into the current system, and then learning from the system. Keys to success include coordinating care, breaking down barriers and working together as a team. The PSH at UC Irvine is a multi-departmental initiative aimed at transforming surgical care by improving quality, increasing patient and provider satisfaction and reducing cost of care.

Pre-operative, intra-operative, post-operative and post-discharge stages are separate systems in the perioperative process. Many people work in each phase, and prior to the implementation of the PSH, there was a lack of communication which often resulted in disjointed care. The high variability in care leads to delays and inefficiencies, high cost, dissatisfied patients and suboptimal outcomes. To address the discontinuity of communication and care UC Irvine identified champions – the chair of the department of orthopedic surgery, the chief operating officer, and the chief of anesthesiology – to spearhead the new model of care. As a first stage in the project, all stakeholders were

identified and brought together in weekly meetings. These included not only anesthesiologists, surgeons and nurses but also hospitalists, decision support experts, nutrition experts, IT support, case management and others. The team was organized into the various phases of the surgical journey and all team leaders underwent training in LEAN Six Sigma.

They also established a PSH advisory board, including members of the C-suite as well as steering committees, oversight committees, task forces and teams. In order for change to occur, communication within and among these structures was essential. A dashboard was developed that executives look at once a quarter for specific services lines of the PSH. The dashboard includes pre-operative, intra-operative and post-operative measures, but also business and process measures.

After one year and 300 patients, metrics for the PSH at UC Irvine include unplanned 30-day readmissions at 0.5 percent, cancellation rate at 0.5 percent and on-time first case starts at 90.9 percent.



A PSH has to be adapted to the local environment, and be an organic process. The PSH goals at UC Irvine are closely aligned to those of the hospital. If change management is not based on the organization and culture, it's not going to happen.

The Perioperative Surgical Home: Health Transformation Fellowship

Michael Caravelli, MD, The Center: Orthopedic and Neurosurgical Care and Research, shared how to get a PSH started by establishing goals that are patient-centered, evidence-based, aim to reduce practice variation and are built within a system of accountability.

St. Charles Health System

St. Charles is an integrated delivery system providing quality, evidence-based care across the tri-county area of Bend, Oregon. Historically, the system operated with the classic fragmented care model – less than optimal communication and limited provider alignment. There can often be disconnect between patients and their primary care physician following the decision to operate. Cost of service and incidence of complication are both high which is frustrating for care providers, patients and family. Finally, there are incomplete transitions to and from perioperative surgical care to a medical home or primary care, sometimes accompanied by complications.

Perioperative Surgical Home

Early Stages

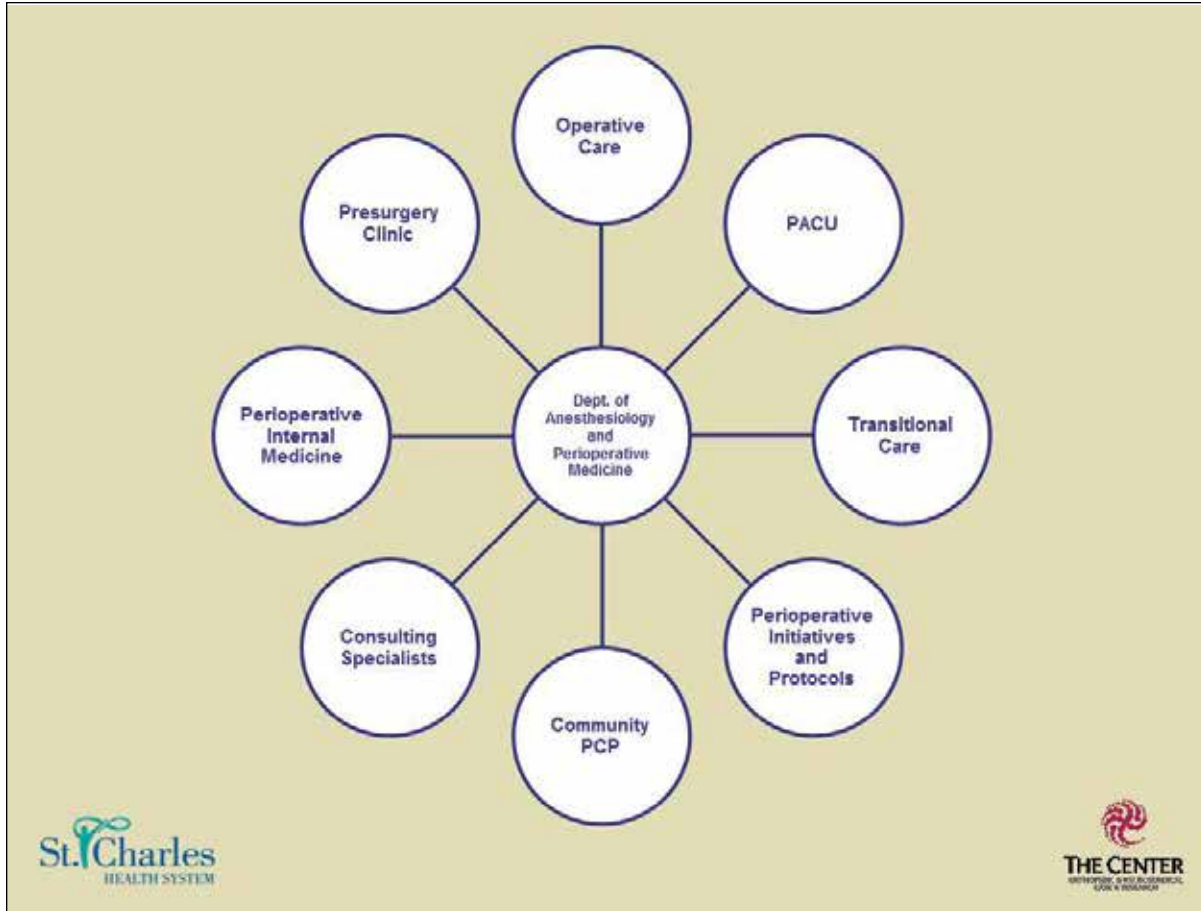
In January 2013, St. Charles embarked on the process of establishing a PSH and building the will necessary for successful installation of a new care model. Building will continues, as currently there is a struggle being able to execute. The struggle to execute exists because not everyone is ready to accept change. Harvesting ideas continues as well, robustly

trying to grow these ideas and grow the number of people who are willing to support this model.

The collaborative goals for the PSH are to develop better, more consistent practices, and coordinated care to the population. There is a need to create new delivery models as care extends beyond the surgical episode, and includes addressing social needs. Thus far, however, implementation has been slow.

Next Steps

A charter has been developed to define provider goals. The next steps are defining patient-centered goals and developing regional best practice guidelines. Defining patient-centered goals will address access, problem resolution, satisfaction, safety and value. Regional best practice guidelines will include quantifying service-specific variation in practice, identifying the roles of each service line in the care delivery pathway, developing best practices and sharing knowledge. Additionally, alternative payment methodologies for participating groups and providers need to be developed. One of the most difficult aspects of installing the PSH care model has been determining how care delivery can be funded.



This project has been accepted by the ASA PSH collaborative with the goal of fostering alignment and buy-in by the institution as a whole. Going forward, the PSH workgroup plans to focus on standardizing high-value care delivery in the community and driving down cost through reduction of unnecessary services, overuse of services, waste and preventable harm.

St. Charles in Bend, Oregon is one hospital, and the PSH is one care model. While there is more to be done, the results so far have been positive and improvement has been seen.

Hospital at Home[®]: Innovation in Practice

Kathy Davis, RN, Presbyterian Healthcare Services' senior vice president and chief nursing officer, concluded the session with an example of not only decreasing cost, but improving health of the community. The Hospital at Home[®] program improves individual experience of care, not just by the patient, but by the caregivers.

Presbyterian Healthcare Services

Presbyterian Healthcare Services (PHS) in New Mexico is an integrated system of hospitals, health care providers and insurance plans. PHS's strategy embodies the Triple Aim, with the goal of engaging patients, health plan members, and the community with innovative health care delivery and financing to achieve better health, exceptional experience and cost leadership.

Innosight Institute selected PHS for a case study in order "to uncover how integrated systems appear to think, act, and innovate differently."⁴ The report identifies what drives an organization to disruptive innovation. It was observed that areas in which PHS was most innovative were due to scarcity, which "is often the mother of disruptive innovation." Even though the innovation of Hospital at Home[®] would be disruptive to hospital revenue in a traditional sense, PHS was motivated to move in that direction because hospital beds were full. Under conditions of scarcity, change is more apt to be piloted. In addition to the conditions of scarcity driving change, having a health plan in an integrated model was key to the success of Hospital at Home[®].

Hospital at Home[®]

The Hospital at Home[®] model was first developed at Johns Hopkins. In 2008, Hopkins approached PHS to pilot the model in the private sector. Developing infrastructure necessary for a model of this magnitude can be time-consuming and costly; fortunately, PHS could turn to the large home care and hospice operations already in place. Hospital at Home[®] opened in 2008 and has served 900 patients to date. Because the PHS health plan is currently the only payer for Hospital at Home[®], it has been difficult to scale the program to larger numbers.

Patients remain in their home and are treated as if they are in the hospital, receiving core measure elements for heart failure and pneumonia. There have been no falls and no restraints have been needed. Readmissions from the program are less than 3 percent at 30 days, and less than 8 percent at 90 days, which for these segments of the population are often upwards of 20-25 percent. The average length of stay for patients is 3.2 days, compared to the average inpatient hospital stay at PHS of 4.5 days. Cost of care is 19 percent less than an equivalent hospital episode.

⁴ Vijayaraghavan, V. (2011). *Disruptive innovation in integrated care delivery systems*. Retrieved from <http://www.christenseninstitute.org/publications/disruptive-innovation/#sthash.hPT6qG1H.dpuf>

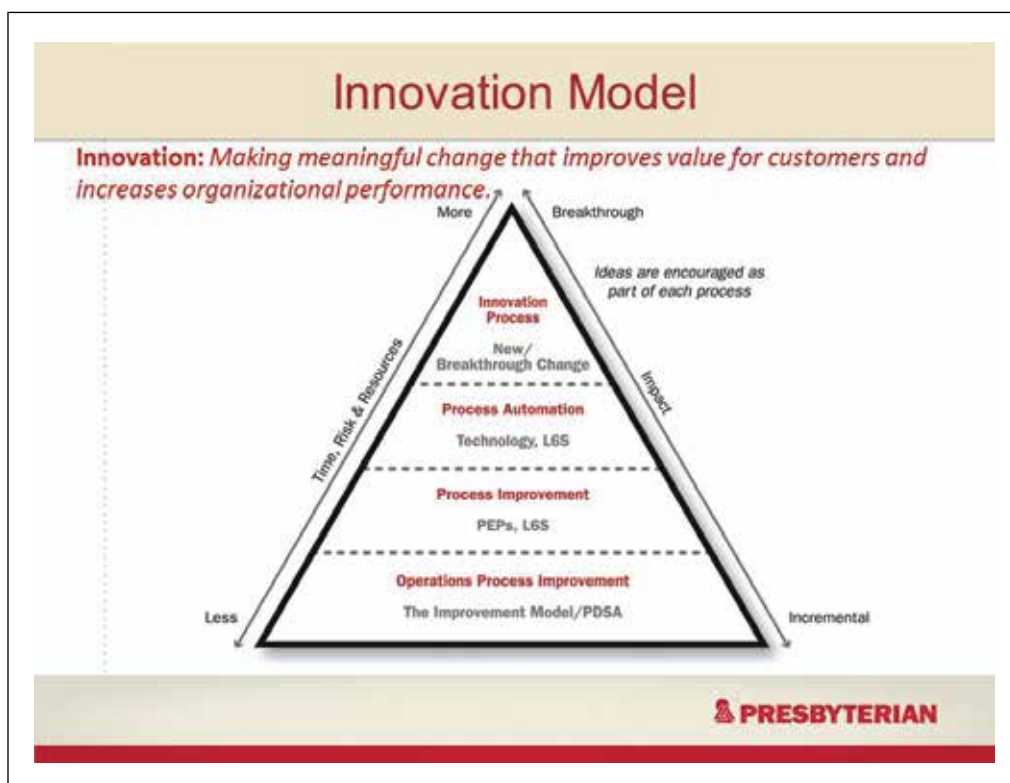
Hospital at Home[®] is a lower cost alternative in a capitated environment. As an alternative to traditional hospital admission, Hospital at Home[®] focuses on the aging population and treatment of chronic diseases, such as congestive heart failure, chronic obstructive pulmonary disease, and community-acquired pneumonia. Patients are directly admitted either from the emergency department, clinic, home, or from early hospital discharge. Patients admitted to the home are scored like any other patient using INTERQUAL, to determine whether they meet criteria for hospitalization.

The Hospital at Home[®] team consists of physicians and nurses who make daily visits to patients, home health aides, and customer service representatives who address needs of patients, such as scheduling appointments or getting prescriptions filled. The team also includes social workers, chaplains and physical therapy as needed. Many community partners are involved in Hospital at Home[®], working as part of the team to meet needs such as durable medical equipment.

Care Models

For PHS, the need for and developing new care models gives voice to the need for change. PHS has found it important to address integration at the macro-level, not merely destructing and improving care delivery one service line at a time. Work needs to be aligned and integrated, and success of the evolving business model requires innovative approaches. It is easy to allow a business model to determine how care is provided, designing care models to fit into how payment is received. However, it is important to conceptualize the care and business models as working together and focused on patient care.

In many markets there is significant pressure being placed on future revenue streams. In moving to value-based payment models, as the level of financial risk increases so does the degree to which provider integration and accountability is needed. Because of the multiple revenue streams, PHS has the flexibility to operate across all stages of the risk continuum and support providers as it becomes more





Conclusion

accountable for cost, quality and consumer experience outcomes.

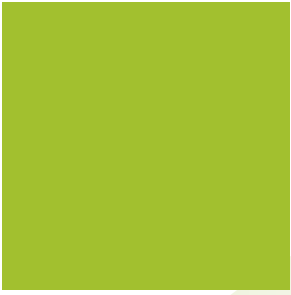
Innovation

To support continued change and growth, PHS developed an innovation model. Operations improvement is at the base of the pyramid, where PDSA models are employed. Leaders and teams are expected to be able to do PDSA as part of on-going improvement efforts. Advancing from there is a more formal improvement platform where process excellence projects (PEPs) are implemented. Advancing further is automation, which is where technology is involved. It is hard to automate a process that does not function well. At the peak is innovation, which is breakthroughs, and are rare in the system. These types of innovations may come from process improvement, as the Hospital at Home[®] model did.

Innovative care models require transitions. PHS envisions care that is proactive and ready. Proactive means not wondering why patients are non-compliant or non-adherent, but rather what is it about the care system that is not enabling them to take full advantage of it. PHS's leadership feels models need to transition from ownership of an encounter to ownership of the continuum, as well as move from care that is fragmented to a more coordinated and cohesive approach.

Health care faces opportunity for improvement, particularly in the areas of performance outcomes and patient satisfaction. There are pockets of excellence and care models employed in the U.S. to be learned from such as the Perioperative Surgical Home and Hospital at Home[®]. These two examples of disruptive innovation embody the Triple Aim of simultaneously improving the health of populations; improving the patient experience of care; and reducing the per capita cost of health care.

Installing innovative care models, such as the Perioperative Surgical Home and Hospital at Home[®], involves an entire system, not just one service line or one specialty. Installation requires disruption, with a cultural context to support it. A culture within which disruption can occur is one built on alignment, shared vision, shared purpose, communication, identified champions and continuity of care.



**American Hospital
Association's
PHYSICIAN LEADERSHIP FORUM**

American Hospital Association
155 North Wacker Drive • Chicago, IL 60606
www.ahaphysicianforum.org