Moving from Volume to Value: A Provider’s Perspective on Preparing for Payment Reform

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Chief Quality Officer – OU Physicians
Medical Director – Clinical Skills Education and Testing Center

April 19, 2016

brought to you by:

• Healthcentric Advisors
  – Focus areas: MA, ME, RI

• Qualidigm
  – Focus areas: CT, NH, VT

For more information please contact:
John DeStefano: jdestefano@smcpartners.com
Presentation Outline

• Payment reform – it was inevitable
• Changing models of healthcare payment
• Performance measurement and ambulatory care
• Preparing to promote the health of a population
Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

* 2012.
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.

### EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>COUNTRY RANKINGS</th>
<th>Top 2*</th>
<th>Middle</th>
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</thead>
<tbody>
<tr>
<td>Quality Care</td>
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<td>Effective Care</td>
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<td>Cost-Related Problem</td>
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<td>Timeliness of Care</td>
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<td>Efficiency</td>
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<tr>
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<tr>
<td>Healthy Lives</td>
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<tr>
<td>Health Expenditures/Capita, 2011**</td>
<td>$3,800</td>
<td>$4,522</td>
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Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Payment Reform

• We have a payment system that has rewarded more care, regardless of the value (or quality) of that care.

• Payment models have not promoted coordination of care across settings

No test, treatment, or procedure is risk free – sometimes they cause patient harm!
CT Scans Get a Closer Look

Neil Wagner

CT scans have benefits, but they also have some very real cancer risks.

While CT (computed tomography) scans are undeniably useful, it may be time to reassess when they are necessary. Each scan exposes the patient to high amounts of radiation. This radiation is likely causing a large number of additional cancers. Because cancer from radiation takes a number of years to develop, it is particularly important to minimize unnecessary CT scans in younger patients.

The average radiation dose from a single CT scan was as high as what an individual would receive from 74 mammograms or 442 chest x-rays.
Consumers are demanding transparency!

• Consumer groups are demanding transparency – particularly about quality and costs of care
Congress Reacts

• When consumer groups have a consistent message, legislators respond...
  – The Medicare Program and other agencies then are required to adopt standardized measures that reflect the quality of medical practice

• Multiple laws passed since 2003 require the Secretary of HHS to measure, publicly report, and to adjust payment based on quality of care
Growing Recognition

• US has the best “sick care” (not chronic care) system in the world
  – High tech
  – Complex care
  – Heavily hospital- and specialty-based
  – Very costly

• But........
  – Our population is not healthy
Affordable Care Act Accelerates the Move

Move to “Value”

Value = Quality (and Service)/Costs

Goal: We want the highest quality of care (and service) at the lowest costs
Transparency!

Healthcare quality is in the public domain for most settings of care!
Range of Models in Existence or Development

Incremental FFS payments for value
Bundled payments for acute episode
Bundled payments for chronic care/disease carve-outs
Accountability for Population Health

Increasing assumed risk by provider
Increasing coordination/integration required

From…. ..get paid more for doing more
To…. ..profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

Historical Performance vs. Goals

- **2011**
  - FFS linked to quality (Categories 2-4): 68%
  - All Medicare FFS (Categories 1-4): 0%

- **2014**
  - FFS linked to quality (Categories 2-4): 22%
  - Alternative payment models (Categories 3-4): 85%

- **2016**
  - FFS linked to quality (Categories 2-4): 85%
  - Alternative payment models (Categories 3-4): 30%

- **2018**
  - FFS linked to quality (Categories 2-4): 90%
  - Alternative payment models (Categories 3-4): 50%
Bundled Payments for Care Improvement (BPCI) Initiative: General Information

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.

Select anywhere on the map below to view the interactive version.
Comprehensive Care for Joint Replacement Model

The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

The proposed rule for the CJR model was published on July 9, 2015, with the comment period ending September 8, 2015. After reviewing nearly 400 comments from the public on the proposed rule, several major changes were made from the proposed rule, including changing the model start date to April 1, 2016. The final rule was placed on display on November 16, 2015 and can be viewed at the Federal Register.

Background

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. In 2014, there were more than 400,000 procedures, costing more than $7 billion for the hospitalizations alone. Despite the high volume of these surgeries, quality and costs of care for these hip and knee replacement surgeries still vary greatly among providers.
The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation. The initiative is designed to support more than 140,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely. It aligns with the criteria for innovative models set forth in the Affordable Care Act:

- Promoting broad payment and practice reform in primary care and specialty care,
- Promoting care coordination between providers of services and suppliers,
- Establishing community-based health teams to support chronic care management, and
- Promoting improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.

Practice Transformation Networks
Select anywhere on the map below to view the interactive version

- 0 PTNs
- 1 PTN
- 2 PTNs
- 3 PTNs
- 4 PTNs
- 5+ PTNs

Where Health Care Innovation is Happening
See who's working with CMS to implement new payment and service delivery models.

Get the Widget
Oncology Care Model

The Center for Medicare and Medicaid Innovation (CMS Innovation Center) is developing new payment and delivery models designed to improve the effectiveness and efficiency of specialty care. Among those specialty models is the Oncology Care Model, an innovative new payment model for physician practices administering chemotherapy. Under the Oncology Care Model (OCM), practices will enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. The Centers for Medicare and Medicaid Services (CMS) is also seeking the participation of other payers in the model. This model aims to provide higher quality, more highly coordinated oncology care at a lower cost to Medicare.

Background

Cancer diagnoses comprise some of the most common and devastating diseases in the United States, with 1.6 million new cases diagnosed in 2015 and over 580,000 cancer-related deaths. Through

Model Summary

Stage: Applications Under Review
Number of Participants: N/A
Category: Episode-based Payment Initiatives
Authority: Section 3021 of the Affordable Care Act

Milestones & Updates

Jun 30, 2015
Updated: Application submission deadline
Comprehensive Primary Care Plus

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.). The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making.

CPC+ is a five-year model that will begin in January 2017.

Background

Strengthening primary care is critical to promoting health and reducing overall health care costs in the U.S. CPC+ builds on the foundation of the Comprehensive Primary Care (CPC) initiative, a model tested through the Center for Medicare & Medicaid Innovation that runs from October 2012 through December 31, 2016. CPC+ integrates many lessons learned from CPC, including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, necessary health information technology, and claims data sharing with practices.

Model Summary

Stage: Announced
Number of Participants: N/A
Category: Primary Care Transformation
Authority: Section 3021 of the Affordable Care Act

Milestones & Updates

Apr 11, 2016
Announced: National primary care medical home model aims to strengthen primary care through regionally-based multi-payer transformation

Where Health Care Innovation is Happening

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/
Will a change in the administration (the President) make these payment models go away?
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Republican controlled
Senate and House:

Senate vote: 92 yea; 8 nay

House vote: 392 yea; 37 nay

House sponsor: Michael C. Burgess, MD [R]

Repealed the SGR!

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf
TITLE I—SGR Repeal and Medicare Provider Payment Modernization

• PQRS, VBM, and EHR Meaningful Use all “sunset” at the end of 2018

• Replaced with the Merit-based Incentive Payment System (MIPS) in 2019
  – (first year of performance data on your practice will be CY 2017)
TITLE I—SGR Repeal and Medicare Provider Payment Modernization

• Creates incentives to use alternate payment models (APMs)
  – ACOs
  – Medical Homes
  – Bundled payment arrangements
  – Other (being developed)

• Financial incentives to participate in APMs as well as exclusion from the MIPS assessment

“Approved” APMs....to be defined

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf
TITLE I—SGR Repeal and Medicare Provider Payment Modernization

Eligible Professional

Alternate Payment Mechanisms
- “Substantial portion” of revenues* from “approved” alternate payment models
  - 5% bonus each year from 2019-2024
  - 0.75% increase per year beginning in 2026

Merit-based Incentive Payment System†
- Providers receive a score of 0-100
- Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers
  - Providers scoring below the threshold will be subject to payment reductions (capped at 4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023).
  - Providers scoring above the threshold will receive bonus payments (up to three times the annual penalty cap)

*25% of Medicare payments 2019-2020
50% of Medicare payments 2021-2022
75% of Medicare payments 2023 and beyond

†Scores will be posted to Physician Compare website
MIPS Scoring

• Up to 25 points for meeting meaningful use objectives *(Use of a certified EMR)*
• Up to 30 points based on PQRS and VM quality measures *(Quality)*
• Up to 30 points for the resource use VM metrics *(Efficiency)*
• Up to 15 points for clinical practice improvement activities *(Performance improvement)*
**MIPS- Clinical Practice Improvement Activities:**

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, some of which are:

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
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<tbody>
<tr>
<td>• Same day appointments for urgent needs</td>
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<tr>
<td>• After hours clinician advice</td>
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<td>• Monitoring health conditions &amp; providing timely intervention</td>
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<td>• Participation in a qualified clinical data registry</td>
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<td>• Timely communication of test results</td>
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<tr>
<td>• Timely exchange of clinical information with patients AND providers</td>
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<td>• Use of remote monitoring</td>
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<td>• Use of tele-health</td>
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<td>• Establishing care plans for complex patients</td>
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<tr>
<td>• Beneficiary self-management assessment &amp; training</td>
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<tr>
<td>• Employing shared decision making</td>
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Secretary shall solicit suggestions from stakeholders to identify activities. Sec. retains discretion. Secretary shall give consideration to practices <15 EPs, rural practices, & EPs in under served areas.
Scoring under MIPS

*Threshold established by CMS annually based on prior year’s scoring

Threshold* (No Payment Adjustment)

Points

100

Additional Incentive

Maximum Penalty

4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023

("exceptional performance")

(“exceptional performance”)

Points
Measurement of quality and efficiency does not go away just because you participate in alternate payment models

• Before an ACO can share in any savings created under this new payment model, the ACO must demonstrate that it meets the quality performance standard for that year.
  – 33 performance measures that fall into four key domains
“.....shifting 75% of their business to contracts with incentives for quality and lower-cost healthcare.”
Performace Measurement in Ambulatory Practice

• ACA requires that CMS report and use the value-modifier to adjust all Medicare payments beginning in 2017 regardless of practice size
• Virtually all Medicare Advantage plans already hold providers accountable for quality of care
• Many private payers now reward quality and efficiency
## Physician Quality Reporting System (PQRS)

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<th>Not Successful</th>
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<tr>
<td>2010</td>
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<tr>
<td>2011</td>
<td>1.0%</td>
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<tr>
<td>2012</td>
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<td>2013</td>
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<td>2014</td>
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<td>2015</td>
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<td>2016+</td>
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[Link to CMS website](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/)
Physician Medicare Value Modifier

**VALUE-MODIFIER SCORING**

- Measures will be weighted equally within each domain;
- Domains will be weighted equally to form composites;
- Where a group does not report measures in a particular domain, the remaining domains will be weighted equally.

**QUALITY DOMAINS**

- Clinical Care/Effectiveness
- Patient Experience
- Patient Safety
- Care Coordination
- Efficiency
- Population Health

**COST DOMAINS**

- Total Per Capita Costs of Care
- Total Per Capita Costs for Patients with Specific Conditions

**Value Modifier Amount**

**Quality Composite Score**

**Cost Composite Score**
Nine percent (9%) of a physician’s Medicare payment in 2017 is tied to performance on PQRS measures, meaningful use, and the physician value modifier for care provided in 2015.
2014 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2016 VALUE MODIFIER FOR PAYMENT
UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

BOARD OF REGENTS OF THE UNIVERSITY OF OKLAHOMA-OU PHYSICIANS
Last Four Digits of Your Taxpayer Identification Number (TIN): 7155

PERFORMANCE PERIOD: 01/01/2014 – 12/31/2014

ABOUT THIS REPORT FROM MEDICARE

- The Centers for Medicare & Medicaid Services (CMS) is continuing to phase in a Value Modifier under the Medicare Physician Fee Schedule.
- This Annual Quality and Resource Use Report shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in 2014 on the quality and cost measures used to calculate the Value Modifier in 2016. Any applicable Value Modifier payment adjustment is separate from payment adjustments made under the Physician Quality Reporting System (PQRS) or other Medicare programs.
- The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS’ discretion, including, but not limited to, circumstances in which an error is discovered.

HOW THE 2016 VALUE MODIFIER APPLIES TO YOUR TIN

- The 2016 Value Modifier will apply to your TIN because
  - at least 10 eligible professionals (including at least one physician) were in your TIN in 2014, and
  - no physicians billing under your TIN participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014.
- In 2014, your TIN registered to report quality data to the Physician Quality Reporting System (PQRS) through the Group Practice Reporting Option (GPRO) via a qualified registry, and your TIN met the criteria to avoid the PQRS payment adjustment in 2016.
Quality and Resource Use Report (QRUR)

The Physician Practice Medicare Report Card

- Majority of metrics on costs and quality based on Medicare claims data.
- Reports do now include PQRS self-reported measures
- Moving to inclusion of CG-CAHPS data as more groups collect and submit

The scatter plot below displays your TIN’s quality and cost performance (“You” diamond), relative to that of your peers.

Note: The scatter plot reflects the performance of a representative sample of your peers.
The Value Modifier based on 2015 Performance – Affects 2017 Payment

<table>
<thead>
<tr>
<th></th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
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<td>+4.0x*</td>
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<tr>
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<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0.0%</td>
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</table>

Based on performance during calendar year 2015.
Getting Ready

• Use the resources provided (for example, the QRUR)
• Measure quality on those metrics likely to drive value-based contracting
• Be transparent
• Make sure your staff understand the changes that are coming
Measure Quality on Metrics that Matter

Influenza Vaccination Rate

 Implemented a flu vaccine screening process in EMR;
 Offered central influenza immunization clinics in OUCP and OUPB for patients and visitors

Expanded central influenza immunization clinics to cancer center for patients and visitors

Month

Percent
The Core Quality Measure Collaborative, led by the America’s Health Insurance Plans (AHIP) and its member plans’ Chief Medical Officers, leaders from CMS and the National Quality Forum (NQF), as well as national physician organizations, employers and consumers, worked hard to reach consensus on core performance measures.

## Pillar Goal Report

**FAMILY MEDICINE continued**

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<td>Maxima</td>
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<td>28.6%</td>
<td>15.8%</td>
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Transparency to the Public

Steven E Smith, MD

Family Medicine

4.9 / 5  ★★★★★  562 Ratings  |  23 Comments

Facility:
Devon Onsite Clinic

Phone: 405-271-8880

To Schedule an Appointment or Request an Account, Click Here:

Facility  MAP
Devon Onsite Clinic
101 N Robinson Ave., Suite 200
Oklahoma City, OK 73104
405-271-8880

Certification
American Board of Family Medicine

http://findadoc.oumedicine.com/steven-e-smith
My Public Health Slide:

**The Health Impact Pyramid**

1. **Socioeconomic factors**
   - Poverty, education, housing, inequality

2. **Changing the context**
   - To make individuals’ default decisions healthier

3. **Long-lasting protective interventions**

4. **Clinical interventions**
   - Medication for high blood pressure, high cholesterol, diabetes

5. **Counseling & education**
   - Eat healthy, be physically active

- **Examples**
  - Immunizations, brief intervention, cessation of treatment, colonoscopy
  - Fluoridation, 0g trans fat, iodization, smoke-free laws
  - CDC
The Four Actions Framework Builds the Foundation for Accountable Care

<table>
<thead>
<tr>
<th>Eliminate</th>
<th>Raise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unnecessary and redundant testing</td>
<td>• Chronic disease management</td>
</tr>
<tr>
<td>• Avoidable hospital readmissions</td>
<td>• Patient engagement in their care</td>
</tr>
<tr>
<td>• Use of paper documentation</td>
<td>• Home monitoring and follow-up</td>
</tr>
<tr>
<td>• Hospital-acquired infections</td>
<td>• Health promotion</td>
</tr>
<tr>
<td></td>
<td>• Screenings</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reduce</th>
<th>Create</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fragmented approach to care</td>
<td>• Integrated networks</td>
</tr>
<tr>
<td>• Overall hospital admissions</td>
<td>• Patient care teams</td>
</tr>
<tr>
<td>• One-on-one and face-to-face provider visits</td>
<td>• Patient registries</td>
</tr>
<tr>
<td>• Poor health maintenance</td>
<td>• Patient portals</td>
</tr>
<tr>
<td>• Use of phone and fax</td>
<td>• Virtual visits</td>
</tr>
<tr>
<td></td>
<td>• Multiple access points</td>
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</tbody>
</table>