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Health Reform at the Retail Level: Community by Community, State by State

August 19th, 2010



by [Karen Feinstein](#)

Our discussions at the recent health funders' retreat at Brandeis University drove home an important point. The Affordable Care Act is a lot more than a series of provisions to assure access to health care coverage for millions of uninsured Americans. The new health reform law creates opportunities to develop fundamental and complementary payment and delivery system reforms that can reduce costs by raising quality of care.

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Even those who had doubts about enacting the Affordable Care Act should be rooting for it to drive major progress on costs and quality of care. If health care costs continue to rise rapidly and quality improvement proceeds at a glacial pace, the fiscal and human consequences will be dire. But cookie-cutter models from Washington, D.C., won't get the job done. Flexible policies that allow adaptation in light of local delivery systems and market conditions are crucial to successful change.

It's the Seniors, Stupid!

Except for the access provisions in the legislation, the group that will be most affected by the Affordable Care Act is senior citizens. Seniors are the largest—and fastest growing—population, with complex and expensive health care needs. As we go down the list of problems that drive health care costs, all of them affect elderly patients disproportionately: rising incidence of lifestyle-related chronic conditions; simultaneous existence of physical and behavioral health issues; ineffective chronic disease management; poor coordination of care across health care settings; frequent emergency department visits, hospitalizations, and re-hospitalizations, because of inconsistent transitions of care (from hospital to home or nursing home or rehab facility) and inadequate post-discharge follow-up; recurring, preventable hospital-acquired infections; and medication errors and discrepancies that occur because of lack of systematic medication review and reconciliation. Also, poor support for palliative care or end-of-life decision making adds cost and suffering to our health care system.

The Pittsburgh area has one of the highest proportions of elderly people in the United States. Even before the Affordable Care Act, some national (such as the [John A. Hartford Foundation](#) and the [Robert Wood Johnson Foundation](#)) and local (such as the [Jewish Healthcare Foundation](#)) foundations, leading health care organizations, and private and public payers were already exploring new ways to advance quality of care and efficiency in the above areas. For example, independent community hospitals and small primary care practices are essential parts of our region's delivery system. A successful readmission reduction project for patients with advanced lung disease at two local hospitals has led to development of accountable care pilots among three other community hospitals and small aligned practices. Also, because it isn't practical for every small primary care practice to offer comprehensive services and resources, we are exploring the potential for community hospitals and/or federally qualified health centers to serve as primary care support centers (offering,

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for example, behavioral health services or chronic disease clinics).

Regional Healthcare Improvement Coalitions

In kicking off our discussions at Brandeis, Atul Gawande pointed out the need for community-by-community portfolios of integrated improvements: Any community that presents as a model of value-driven health care, he explained, “will be a model for the rest of the nation.” He stressed that everything hinges on whether this occurs. The importance of a single model community may be up for debate, but the message is clear: communities must be the laboratories for testing health reform strategies.

Local and regional health foundations can bring critical resources to bear, and most of them also have natural local partners in the more than fifty nonprofit regional healthcare improvement coalitions (RHICs). Although often overlooked by national policy experts, RHICs, including the [Institute for Clinical Systems Improvement](#), in Minnesota; [Massachusetts Health Quality Partners](#); [Quality Counts](#), in Maine; [Puget Sound Health Alliance](#), in Seattle; and [Pittsburgh Regional Health Initiative](#) (which the Jewish Healthcare Foundation supports), have significant experience in key areas: development of new payment and delivery models, integration of care across settings, patient safety, consumer engagement, and value-based purchasing. They should be encouraged and supported to participate in impending pilots and experiments that have been authorized by the Affordable Care Act, and related state government-sponsored and locally inspired projects.

Strengthening the Community Safety Net

A major topic of discussion at Brandeis was the importance of supporting cash-strapped states and safety-net organizations to enable them to take advantage of the grants and pilots included in the new federal health reform law. Unless you “support your carpenter,” as Michael Doonan, assistant professor at the Heller School for Social Policy and Management at Brandeis University, suggested, your house, or system of health care reform, will not be built.

But what is your state’s or region’s priority? Effective enrollment programs? Safety net expansion? Inclusion of dental and behavioral care? There are many entry points to building your state’s and region’s response to the Affordable Care Act. Models of successful programs to support states and safety-net agencies abound. Look to [Blue Cross Blue Shield of Michigan Foundation](#) (\$5,000 grants to support large grant applications); [Missouri Foundation for Health \(Missouri Capture\)](#); and the [California HealthCare Foundation](#), which created an [office in Sacramento](#) to provide support to policymakers and the media and linkage to experts and resources at the foundation, and made a \$550,000 grant to Manatt Phelps and Phillips, LLP “to support the California Health and Human Services Agency by developing and implementing a statewide plan in accordance with the provisions of the Health Information Technology Economic and Clinical Health (HITECH) Act.”

Work Force Development

If health care delivery is local, health care work force development is no less so. Delivery and finance system redesign requires changes to the work force. There are great opportunities in health care to provide not just jobs, but careers and career ladders to those with a high school degree and just some college. Health information technology (HIT) also provides a host of opportunities. Think about it: Where will we get the new HIT professionals to implement and manage electronic health records in every private practice across the country? Also, a number of states around the country restrict the work of physician extenders, especially in primary and behavioral care, even as severe shortages in these fields continue. There is an important informational role for foundations to play with consumers, purchasers, health care professionals, and policy makers.

Where We Go from Here

Every region will have different priorities, but we must start somewhere. I know where we will begin in southwestern Pennsylvania—working to achieve a system of care for seniors in which (1) their care is integrated, (2) there is effective management of chronic disease, (3) consumers and their caregivers are engaged and educated, and (4) end-of-life planning is the norm. Echoing the words of Gawande, the community that is able to put these pieces together will not only be a model, but will save the individuals, families, businesses, and taxpayers billions, if not trillions, of dollars.

Read [another GrantWatch Blog post by Karen Feinstein](#).

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