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The Future of Women's Health: How to Survive and Thrive Post Accountable Care Act

White Paper

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The passage of the Accountable Care Act (ACA), has resulted in much speculation regarding the future of health care. The ACA will alter the traditional health care system from a fee-for-service illness model to a capitated "gatekeeper" model. Providers will be financially successful if they avoid high cost acute care services and will be penalized in the "pay for performance model" if patients are readmitted, acquire infections or secondary conditions while hospitalized or are not satisfied with their care. There is a myriad of quality outcome measures that will impact payment for acute care services. Women are the major consumers of health care across all specialties and are the "gate keepers" for the family. In fact, 70% of the most frequent surgeries performed and the primary diagnosis for admission are unique to women. They are also the most difficult customer to satisfy and a challenge to impress when seeking improvements in patient satisfaction scores. Men are just happy that you've "saved their lives" whereas women expect impeccable cleanliness, delicious gourmet food and exceptional service at all times. One error can impact her entire view of the experience and send your patient satisfaction scores plummeting. Women's health will be one of the primary drivers of successfully managing the ACA for the reasons listed in Table 1.

Refer to Table 2 for the changes in health care that the ACA will evoke.

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Table 1. Women's Health Impact on the ACA

- Women control 85% of the health care decisions and >90% of health care dollars
- Women's health covered preventive services have expanded dramatically under the ACA
- Majority of the 23 million newly eligible people with health care coverage are women and children
- Women control the health status of the family and are the gatekeepers to care and health information
- "Men's health is a women's health issue" – V. Lucas
- Women utilize more health care services and resources than men throughout their lives
- Women outlive men by >7 years and consume the majority of long term care resources
- Women are 3 – 5 times more likely to have a long term chronic illness which consumes large amounts of health care resources
- Women have higher cardiovascular morbidity and mortality than men which is a high consumption specialty
- The fastest growing population is midlife and senior women which means the highest utilization of the health care system in history

Table 2. Changes in Health Care Evoked By ACA

- Expansion of services to 23 million people
- Expansion of preventive services
- Insurance exchanges
- Population health management
- Patient accountability with higher co-payments requiring the development of collection strategies for ↑ co-pays and deductibles (30 – 40% co-payments for "high cost" services)
- Consumerism
- Pay for performance
- Capitated payment structures
- Accountable Care Organizations (ACOs)
- Cost competition
- Quality competition
- Transparency of outcomes (financial and clinical)
- Destination Health Care Hospitals and Centers (wealthy people opt out of main stream health care and choose a cash pay destination hospital)
- Primary care focus (health, wellness, prevention)
- Shortage of primary care providers
- Physician – hospital integration models
- Gate keeping for "elective" procedures and surgeries
- Alternatives to emergency care
- Increase in less invasive, less aggressive medical management
- Greater control of formularies and pharmacy expenditures

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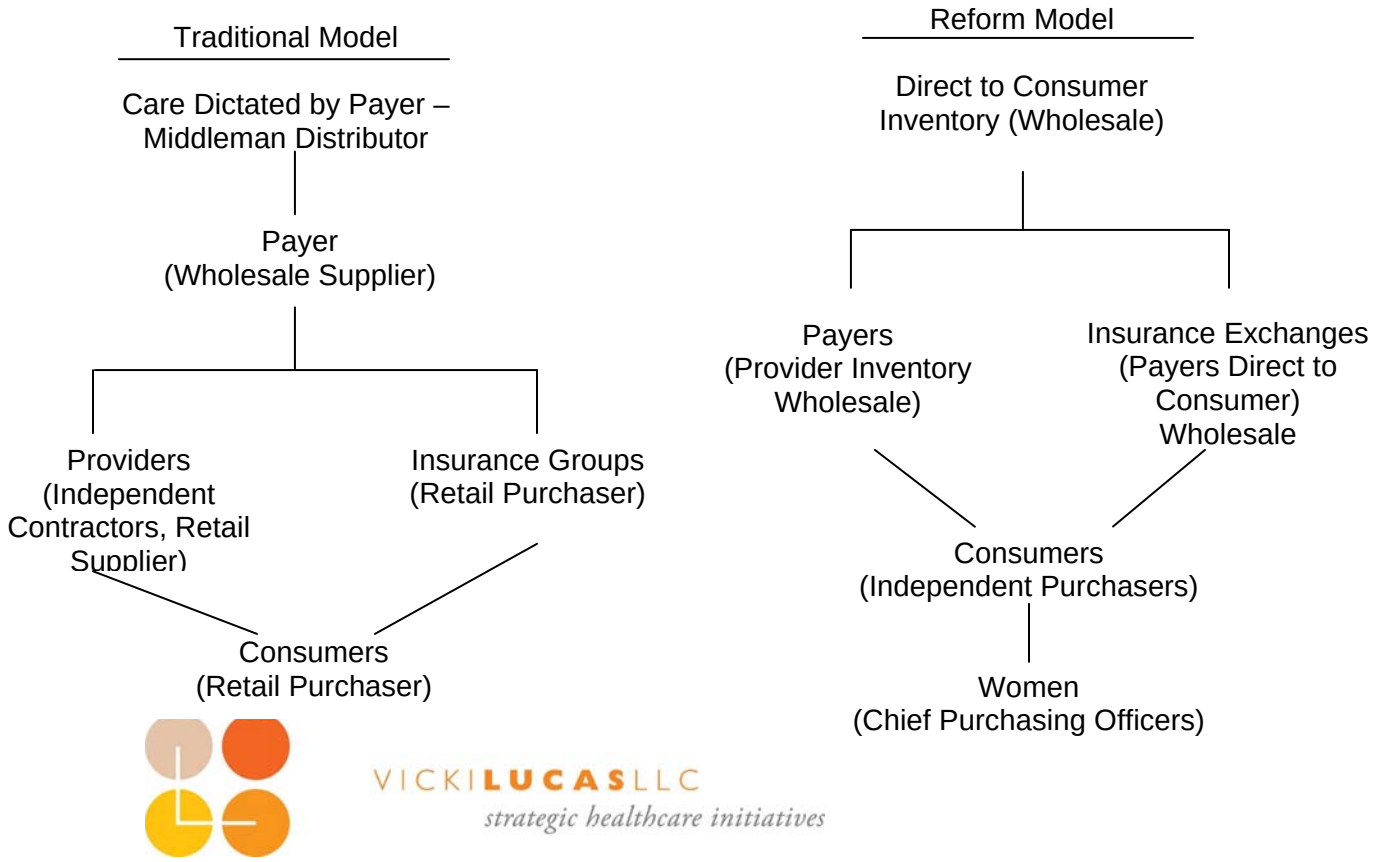
In the most basic sense, health care reform is moving from a closed market/provider driven wholesale model to an open market that is a consumer retail model. The principals of capitalism will finally apply to health care. Insurance exchanges will be the "online" catalogue/store for payers and the payers will be the "E-bay" store for providers. The payers will definitely be prepared to shift the financial risk to the providers through capitated payment models and shared financial risk arrangements. The payers have access to excellent actuarial data and will be well aware of their risk exposure and will be prepared to shift that risk to the providers. It is doubtful that the providers will be prepared to quantify this risk and manage it successfully. The insurance industry manages risk at the core of their business and they will continue to make their projected earnings. The providers, if not prepared strategically, will find themselves in even more financial turmoil than currently. I guess the good news is, like the banks, the health care delivery system is "too large to fail". Although as with the banks, it is likely that the consumers will be the ones to suffer in the end and bail the system out. Refer to Figure 1 that compares the traditional health care model with the health care reform model.

Figure 1. Traditional Health Care Model vs. Health Care Reform Model



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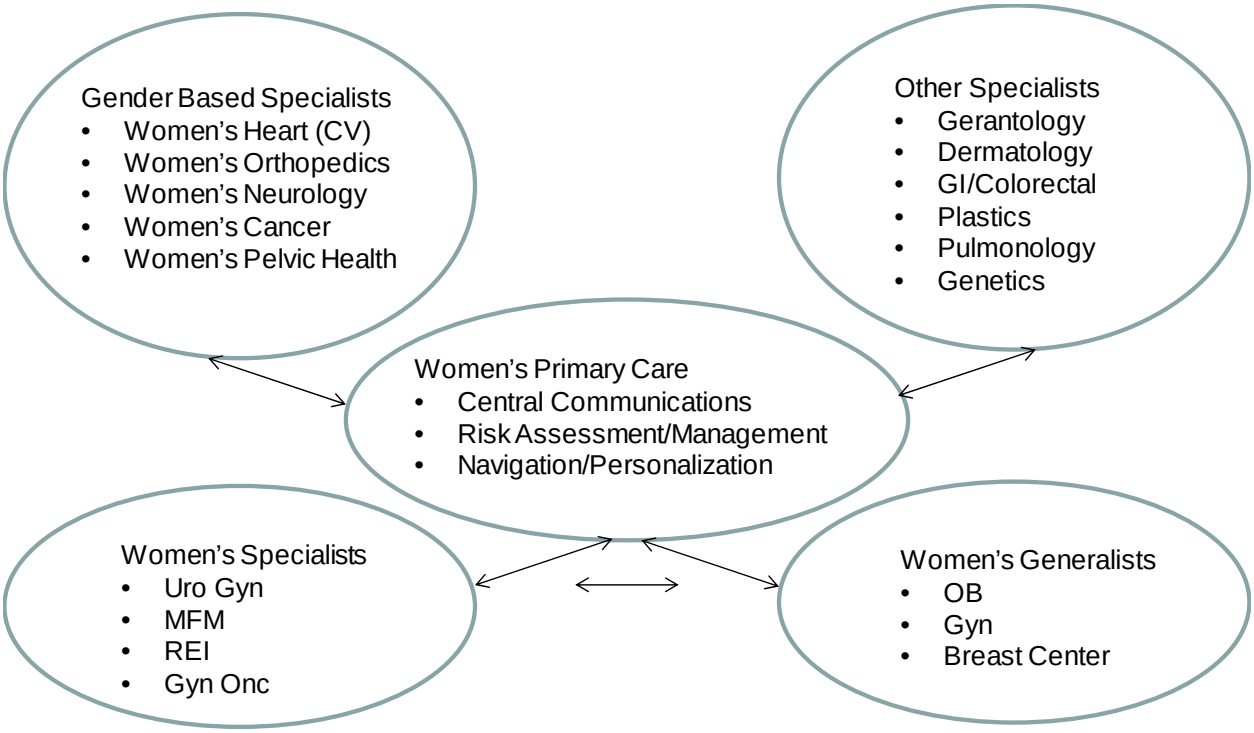
A Women's Health Medical Home ACO model of care will be a critical strategy to identify and mitigate risk, manage the women's population, manage resources and capitation risk and provide high quality cost effective care. Refer to Figure 2 for a proposed model for a Women's Health Medical Home.

Figure 2. Women's Health Medical Home – ACO Model



In an ACO model, physician – hospital integration is also a critical strategy. Physicians must be aligned with hospitals to identify and mitigate the risks and control the resources. Refer to Table 3 for a list of physician incentive strategies to increase their alignment and integration.

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Table 3. Physician Incentive Strategies

• Co-Management Model (pay for performance) • Share of Capitation Dollars Model • Gain Sharing Model • Shared Decision Making Model • Joint Ventures • Overhead Distribution Model • Employment Model • Medical Directorships • "Reading" Fees	• Share of Marketing/PR Resources • MSO Model • Discretionary Fund Account • Recruitment with Loan Forgiveness • GPO Contracting • Managed Care Contracting – Packages, Carve-outs, Credentialing • Hospitalists/Laborists • Physician Referral Network

Capitation payment methodology shifts the financial risk to the providers and this is especially true in women's health due to the high utilization of services and the extraordinary communication resources needed. Women communicate frequently with their health care providers and demand prompt, easy access. Communication strategies in Women's Health ACOs are key success factors and involve everything from off-site phone banks to mobile phone apps. Refer to Tables 4 – 6 for capitation strategies in Women's Health.

Table 4. Capitation Strategies in Women's Health

- LT Contracts (pays for comprehensive testing and risk mitigation, especially in mental health)
- Avoid EDs – off-site urgent care and OB triage
- Risk Assessment (age, stage, Hx (family and personal)
- Risk Management/Mitigation
- Communication Intense (all methods, two-way)
- Access Intense (rapid response, avoid ED)
- Relationship Intense (continuity of care manager)
- Technology Enabled
- Avoid high cost providers (drains cap pool)
- Standardize! (supplies, service, etc.)
- Work at Top of License (all providers)
- Maximize Throughput (team pod office/exam/space)
- Economies of Scale (centering model)
- Staff Mix Adjustments (MA model)
- LEAN Flow (patient and work)
- Reduce space and overhead (eliminate waiting rooms, offices and non-essential clinical space)

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Table 5. Capitation Strategies in Women's Health
Carve in Routine and Medical!

• Primary Care • Mental Health • Routine OB • Routine Gyn • Gyn Surgery • Uro Gyn • Pelvic Health • Cardiology • Gerontology	• Dermatology • Breast Care • Complementary Medicine • Wellness/Prevention • GI • Endocrinology • Ophthalmology • Rheumatology • Sports Medicine • Posiatry

Table 6. Capitation Strategies in Women's Health
Carve Out High Risk and Surgical!

Carve Out (Package)	**Full Risk**
• High Risk OB • NICU • Fetal Anomalies/Defects • Cancer • Infertility • CV Surgery • Plastics • Neurosurgery • Orthopedics	• Stop – Loss Provision • Manage High Risk Aggressively • Seek Out Risk Aggressively • Incentivize Prevention/ Wellness • Promote Access and Communication – Centering Care – Support Groups – Mental Health Group Therapy

Health Risk Assessment (HRA) is a critical component to Women's Health risk identification and mitigation. Refer to Table 7 for information on HRA strategies. Figure 3 demonstrates that in a capitated model, the lower the risk and acuity, the higher the dollars earned.

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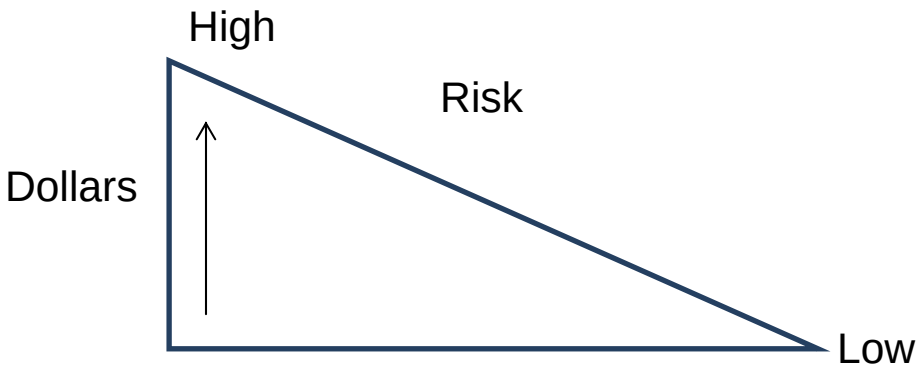
Table 7. Women's Health Risk Assessment Strategies

• Electronic – Website – Social Media – E-mail – Webinars – Intranet – Patient Portal – EMR – EMR Chip – Kiosk – Phone Apps	• Standard Processes – On-site – Point of Care – Care Management Review – Care Management Relationship – Navigation – Targeted Education – Reminders – Updates – Targeted Outreach – Group Education

Figure 3. Risk: Money Model



In order to be successful in the new model of health care, providers must have productivity targets that are unique to Women's Health. Refer to Table 8 for Women's Health Productivity benchmarks.

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Table 8. Women's Health Productivity Benchmarks

- Billable MDs (15 minute appts, 21 ppd, 1 procedure/day, 3 phone appt or e-consults/day, all patient e-mail)
- Billable midlevel providers (CNMs, PAs) (20 minute appts, 18 ppd, 2 phone appt/day, manage all patient e-mail)
- Billable RNs (Level I E+M) (80 calls/day counseling/education)
- Billable LPNs (injections)
  - Support MDs and MAs with injections, phlebotomy, follow-up calls, e-mails, routine education
  - Recover patients from conscious sedation under MD supervision
- Non-billable MAs
  - Closely aligned with MDs, MD protocols
  - Outreach to schedule 20 appts/week (mammo, paps, PP visits)
- Non-billable Call Center Staff (90 calls/day/staff)
- Bill outside of OB global payment for extra visits, etc., if non-capitated

Additionally to be successful in the new model of health care, providers must have staffing and experience benchmarks that are unique to Women' Health. Refer to Table 9 for Women's Health staffing and experience benchmarks.

Table 9. Women's Health Staffing and Experience Benchmarks

- Staffing ratios
  - Large Physician Owned HMO (MAs closely aligned with MDs, not RNs)
    - .6 RN/1FTE MD (IM = .4 RN/MD, Peds = .5 RN/MD)
    - .7 MA/1FTE MD
    - .25 Receptionist/1 FTE MD
    - .1 LPN/1FTE MD
    - 0 Midlevel providers
- Robotic Surgeries
  - 90% Closed Cases (CA)
  - 80% Outpatient (23 Hour ALOS)
  - Minimally 60 Cases/Year

Population health management will be a challenge for providers in managing women across their lifespan. The initial step is HRA which was addressed earlier, but what should be the expectations for preventive screening and education for women at every age and stage? Refer to Tables 10 – 11 for pay for performance quality measures

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essential for population health management in women. These measures will also be utilized for Women's Health report card transparency along with financial and clinical outcomes.

Table 10. Pay for Performance Measures in Women's Health I

Women's Health & Wellness Coordination throughout the Life Span						
Immunizations (CDC, 2012)	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza	One dose annually					
Tetanus, diphtheria, pertussis (Tdap/ TD)	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 years					
Human papillomavirus (HPV)	3 doses					
Zoster						
Measles, Mumps, Rubella (MMR)	Rubella immunity for women of childbearing age should be determined. 1 or 2 doses if lack documentation of vaccination or no evidence of previous infection					
Pneumococcal	1 or 2 doses if risk factors present					1 dose
Meningococcal	1 or more doses if risk factors present					
Hepatitis A	2 doses if risk factors present					
Hepatitis B	3 doses if risk factors present					
Screening & education	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Reproductive health & planning (AHRQ, 2012; Association of Reproductive Health Professionals, 2011)	Contraception, pregnancy planning, peri-menopause (ages >45 years), sexual health. Folic acid supplement for women planning pregnancy or capable of becoming pregnant (AHRQ, 2012).			Menopause, sexual health		
Blood pressure (AHRQ, 2012)	Screen every 2 years with BP < 120/80. Screen every year with SBP of 120-139 mmHg or DBP of 80-90 mmHg.					
Cholesterol (US HHS, 2012) & Lipid Disorder (AHRQ, 2012)	Starting at age 20, test regularly if at increased risk for heart disease (US HHS, 2012).		Ages ≥ 45 years with increased risk heart disease, strongly recommended (AHRQ, 2012).			
Heart health education (weight management, fitness & exercise, diet, risk factors, signs & symptoms MI (US HHS, 2012; AHA, 2012)	Educate all women on prevention of heart disease, risk factors, healthy lifestyle.					

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Table 11. Pay for Performance Measures in Women's Health II

Women's Health & Wellness Coordination throughout the Life Span						
Diabetes (AHRQ, 2012) (excludes pregnancy)	Screen for diabetes in asymptomatic women with sustained BP > 135/80.					
Breast cancer- self exam & mammography (AHRQ, 2012)	Breast self-exam; promote and support breastfeeding					
		Ages 40-49 individualize	Age 50-74 Screen every two years			
Cervical cancer (AHRQ, 2012)	Ages 21- 65 screen with cytology every 3 years					
Colorectal cancer (AHRQ, 2012)				Screen ages 50-75 (fecal occult blood testing, sigmoidoscopy or colonoscopy		
Screening & education	**19-21 years**	**22-26 years**	**27-49 years**	**50-59 years**	**60-64 years**	**≥ 65 years**
Substance use (tobacco, alcohol, prescription and non-prescription drugs, herbs, illegal substances (AHRQ, 2012)	Ask about tobacco use. Provide tobacco cessation interventions to those who use tobacco product. Review all medical and supplement use. Evaluate for signs & symptoms of illicit drug use. Screening strategies appropriate for clinical setting and population.					
Domestic violence (Family Violence Prevention Fund, 1999)	Culturally competent routine screening should be done whether or not symptoms or signs present or provider suspects abuse has occurred.					
Depression and mental health (ACOG, 2010)	Screen for depression during & after pregnancy with appropriate tool (ACOG, 2010).			Any positive finding should prompt appropriate referral to mental health specialist		
	Any positive finding should prompt appropriate referral to mental health specialist					
Osteoporosis (AHRQ, 2012; TJC, 2008)	Education on prevention age related & secondary causes bone loss					Screen ≥ 65 yrs
	Women < 65 years with risk; postmenopausal women.					

In summary, the ACA was discussed specifically related to its impact on Women's Health Care. Unique women's health strategies were shared that will insure success for providers in the post ACA era. These strategies included:

- Women's Health ACO Model
- Physician Alignment Strategies
- Capitation and Contracting Strategies
- Health Risk Assessment Enabled by Technology and Standard Processes
- Women's Health Benchmarks and Productivity Targets
- Women's Health Quality and Pay for Performance Measures

Women are the major consumers and purchasers of health care, therefor health care organizations must have a specific plan that addresses Women's Health. The traditional view of "gender neutral" health care will insure failure rather than success in this new model of health care. A gender specific Women's Health strategic plan does not exclude men and children because "Men's and children's health are women's health issues" – V. Lucas. Focusing on women's health in this new environment will be a key driver of success.

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About Dr. Vicki Lucas

Dr. Lucas is the President of Vicki Lucas, LLC, a full service consulting firm specializing in Business Development in Women's and Children's Services. Vicki Lucas, LLC is the market leader in Women's Health Business Consulting and has hundreds of clients throughout the world including Johns Hopkins, LSU, University of Iowa, Texas Children's Hospital, Beth Israel/Deaconess/Harvard and many more.

For the past 25 years, Dr. Lucas has been recognized as one of the foremost leaders in Women's and Children's Health. She has served on the boards of every major women's health organization, including: International Congress on Women's Health, National Association of Women's Health, American Hospital Association Maternal Child Governing Council, Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN) Consulting Group, Spirit of Women National Foundation and Ireland Report on Women's Health. Dr. Lucas was Chairman of the Division of Women and Childbearing Families at the University of Texas and has held academic appointments at six major universities throughout the United States. Dr. Lucas is currently adjunct faculty at Johns Hopkins University. She co-edited AWHONN's book on Women's Health and has published more than fifty articles and chapters on women's and children's health in peer reviewed publications. She is highly sought after as a keynote speaker and has presented more than 250 speeches across the United States and abroad. Dr. Lucas has served in senior executive positions over the past 15 years in Women's and Children's Services in two large health systems each with more than 11,000 annual births. She has been responsible for $800M in annual revenue and has managed major building projects of $75M and above. Dr. Lucas has provided consultation services to hundreds of clients across the United States and Europe and has procured over $5M in grant funds throughout her career.

Her combined expertise in clinical, finance and business allows her to successfully bridge the gap between business and clinical concerns. Dr. Lucas has extensive experience in strategic planning, risk reduction, business development, process improvement, market research, market planning, brand identification, facility planning, program development, product development, provider development, integration strategies and women's and children's service line development. She has conducted extensive market research and maintains a clearinghouse of data, white papers and strategies. Dr. Lucas has served as an advisor for the following organizations: CDC, NIH, HHS, State of Texas, State of Maryland, State of Pennsylvania, ANA, AHA, Center for American Nurses, The Advisory Board, The Jacobs Institute, The Snowmass Institute, The Ireland Report on Women's Health, Spirit of Women Hospital Network, American Medical Exchange, AAP, ACOG and AWHONN.

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About Vicki Lucas, LLC

- Market Leader in Women's and Children's Health Consulting
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  - Strategic planning
  - Facility design
  - Provider development
  - Operations improvement
  - Physician – Hospital integration
- Specialized in Women's and Children's Services – That's all we do!
- Proven track record >30 years – We've done it all before!
- >150 clients throughout the world
- Most experienced firm in US
- Proprietary Women's and Children's Health Data Base with financial, clinical and operations benchmarks
- Extensive professional network for benchmarking and site visits

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