The ABCs of ACOs
Thomas Koshy, Ph.D. Sr. Director for Scientific Affairs

November 5, 2012
US Health Care = Bad Restaurant?
US Health Care = Auto Repair?

- Transactional, reactional care for a specific “repair”
  - FFS, not FFV
- Ironically, the same repair shop can provide the preventive services that would reduce high cost transactions
- We need to transition from transactional care to preventive care and coordination of care, especially for chronic conditions.
The Care We Get…
“Flip of the Coin” Health Care Quality, 6-6-03

Impediments

- Fee for service reimbursement rewards: volume>value, cure>care
- Scale, scope, complexity of health sector and political realities of change
- Technophilic society and MDs
- Slow adoption of innovation
- Selection and socialization of MDs as Lone Rangers
- Lack of systems thinking in design of health delivery
- Emphasis on treating organ systems, not whole organisms
- Poor application of behavior science into delivery system

"Our results indicate that, on average, Americans receive about half of recommended medical care processes"
Nearly 70,000 Americans die needlessly each year because they are not given optimal heart failure therapy.

“Nearly 70,000 Americans die each year because they do not receive optimal therapy as called for in guidelines promoted by national health authorities, researchers said Monday. Physicians have been slow to implement many of the procedures called for in the guidelines, according to the first national study of adherence to the treatment goals, the team reported in the June edition of the American Heart Journal.”
# Heart of the Matter

How angioplasty procedures in the U.S. rated, according to appropriateness guidelines, based on 500,000 cases:

<table>
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<tr>
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Source: Journal of the American Medical Association
Because unaccountable care is no longer sustainable

It just comes down to who the accountable party is...
• Whether participating in Medicare’s ACO program or collaborating with private payors, virtually all health systems are on some pathway to greater accountability.

• This journey goes by many names: clinical integration, integrated care, collaborative patient-centered care, physician-hospital alignment, but their fundamental goals invariably include improving clinical outcomes, efficiency, and satisfaction with care.
What Is Accountable Care About?

Moving away from FFS, volume-based reimbursement to value-based compensation (P4P, risk sharing, global budgets)

Proactive anticipation of individual patient needs, and plan to address these needs in coordinated, expeditious manner

Taking responsibility for care processes and care outcomes, including cost, quality, and experience of care

Built on a strong base of primary care, ideally arranged as “patient-centered medical homes” or similar forms using care teams to coordinate and deliver care

Connecting interoperable data from all care sites, providers, institutions into a longitudinal, personal health record with health decision guidance/support for patients, in addition to clinical decision support for providers
Stepwise Path to Accountable Health

Accountable Health Outcomes Management

Accountable Care Organization

Collaboration Among Multiple Providers
- Shared Risk
- Reporting Against Quality, Cost, and Patient Experience

Patient-Centered Medical Home

- Team-Based Care
- Incentive Payments (P4P)
- Quality Reporting

Meaningful Use

- Single Provider
- Office Transformation
- FFS + Bonus
- Data Capture

- Population Health Risk Assessment
- Health Risk Mitigation Workflows/Coaching
- Care Coordination Workflows
- Chronic Condition Monitoring
- Treatment Plan/Rx Adherence Monitoring
- Field-based Complex Case Management
Stepwise Path to Accountable Health

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Population Health Risk Assessment

Health Risk Mitigation Workflows / Coaching

Care Coordination Workflows

Chronic Condition Management

Meaningful Use

Incentive Payments (P4P)

Quality Reporting

Single Provider Office Transformation

FFS + Bonus

Data Capture

Chronic Condition Monitoring

Treatment Plan / Rx Adherence Monitoring

Field-based Complex Case Management

HIT / HIE / HIT / HIE / Registries

Structure

Process

Outcomes

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Data Information Action
Meaningful Use

EHR

PQRS
The Physician Quality Reporting System (PQRS)

Incentive payments and payment adjustments to promote reporting of quality information by eligible healthcare professionals. The program provides incentive payments for reporting data on quality measures.

Beginning in 2015, the program also applies a payment adjustment to professionals who do not satisfactorily report data on quality measures for covered professional services.
<table>
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<tr>
<th>Year</th>
<th>Medicare PQRS Payment Adjustments</th>
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<tr>
<td>2011</td>
<td>1-1.5% bonus payment</td>
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Clinical Registry and Guidelines

Connected registries facilitate the creation of coordinated care teams, who all have access to care plans and status. Customizable evidence-based guidelines suggest recommended care. Integration with EMRs/EHRs and HIEs through connectivity capability.

Supports and provides extensive reporting and analytics. Facilitates development and deployment of Patient-Centered Medical Homes and ACOs.

- Heart failure
- Pediatric obesity
- Hypertension
- COPD
- Pediatric ADHD
- Diabetes
- Heart / stroke
- Adult and pediatric prevention
- Adult and pediatric asthma
Collaborative Care Platform® (CCP)

- Enables greater connectivity, clinical data transfer and collaboration between and among clinicians
- Provider-facing portal to other Alere services
- Integration with major lab services
- Referral management
- Automation of routine communication
- Secure clinical data sharing
- Enables and supports PCMH

3k Number of physicians using the CCP daily
8k Number of non-physician clinical

Clinical registry
Care alerts
Support for PQRI & other incentive programs
Support for NCQA PCMH recognition

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Another Example

Data

Secure Data Storage

ICUTracker®

Data Mining

HOSPITAL PC

HOSPITAL PC

HOSPITAL PC

Data
Report Examples
Ventilator Days Over Time

Quarter 2010 - 2012
Report Examples
Unit Mortality (%) Over Time
Success Takes More Than EHRs

Installing EHRs and exchanging data is not enough; ACOs must have the right information at the point of care to support care decisions and to properly intervene in ways that address patients holistically

- Predictive modeling to define risk strata
- Evidence-based gaps in care information
- Real-time data access across care settings
- Care coordination among providers, staff, patients
- Patient-facing care plans, education, motivation, skills
- Remote telemedicine for monitoring high risk populations
- Primary care extenders, tools to manage select subpopulations
- Analytic tools for managing operational, clinical, financial metrics
- Tracking and managing quality metrics for operations, reporting, CQI
Heart Failure Readmission Rates

50 percent of patients re-hospitalized within 30 days did not have a physician visit after discharge*
Lack of a supportive palliative care program led to increased readmission rates*
Poor communication and coordination during patient “hand-offs”
Lack of case management support or poor coordination with case management
Communities with high admission rates were found to have high readmission rates*
Fragmentation of the medical staff structure/culture

*NEJM 2009;360:1418-28
AHFS Patient on Discharge...

Often discharged without complete resolution of the “deranged physiology” causing decompensation

Signs and symptoms lag behind worsening physiology
  • Weight, shortness of breath, edema

“...the post-acute care period is one of great risk; this is specially true in the very first days following hospital discharge”
Hospital Readmission Avoidance

Identify at-risk patients and manage their comorbidities to avoid preventable hospital readmissions
Assist patients to optimize care transition post discharge
Provide data-driven technology / services for better care handoffs & coordination

Readmissions avoidance lowers costs & CMS penalties for hospitals
Strengthens hospital-provider, patient-provider relationships
Reduces patient hardship and morbidity from avoidable hospitalizations
Incorporates BNP level as acuity marker for individualizing follow-up services
Optional onsite and telephonic nurse coaching, monitoring, coordination

Care management workflow platform
Array of telehealth monitoring devices for chronic care
Multimodal communication with patients per their choice
Seamless electronic data transfer
Training, support of, and collaboration with hospital discharge staff

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Alere/ACO-like HF Readmission Avoidance studies

- BNP in the home
- Home Monitoring
- Discharge BNP
Yin & Yang of an Optimal Care System
How Opposing Forces are Interdependent & Balanced

Specialization
- Reductionist
- Cartesian view
- Essence defined by parts (machine)
- Scientific method
- Chemistry, physics
- Organ-centered care
- Disease focus
- Curing orientation
- Fragmenting

Integration
- Holistic
- Aristotelian view
- Whole is greater than sum of its parts
- Systems theory
- Complexity, chaos
- Patient-centered care
- Health focus
- Prevention orientation
- Defragmenting
Our Unbalanced Health Care System

Specialization Without Better Integration is Unsustainable

**Specialization**
- Uncoordinated care
- Process focus
- Poor handoffs
- Navigation hard
- Continuity lacking
- Little data exchange
- Waste, duplication
- Curing vs. caring
- Volume-based pay
- Incentives to do more

**Integration**
- Teamwork
- Triple Aim
- Care transitions
- EMR, PHR, HIE
- Accountable care
- Medical homes
- Participatory care
- Cost-effectiveness
- Value-based pay
- Incentives to do better

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Support Across Continuum of Health

Comprehensive, Integrated Approach to Improving Population Health

- **Health & Wellness**
  - Health Portal
  - HRA
  - Online Education
  - Telephonic Coaching
  - Tobacco Cessation
  - Screenings
  - Wt/Fitness

- **Condition Mgmt**
  - Asthma
  - Diabetes
  - CAD
  - Anticoag Mgmt
  - Heart Failure
  - COPD
  - Chronic Pain
  - Depression
  - Nurse 24

- **Diagnostics**
  - Lipids
  - Glucose, A1C
  - Coagulation
  - Blood gases

- **Biometrics**
  - Wt, activity
  - Pulse oximetry
  - Blood pressure
  - Glucose
  - Symptoms

- **Case Mgmt**
  - Complex Care
  - Oncology
  - Catastrophic Cases
  - Intensive Care
  - Transitional Care
  - Readmission Avoidance
  - Home visits

- **Women’s & Children’s**
  - Preconception
  - OB Risk Assmt /Education
  - OB Case Mgmt /Homecare
  - Perinatal Screening
  - NICU Case Mgmt

- **Healthcare Technology**
  - Communication
  - Data Exchange
  - Clinical Registry
  - Care Plans
  - Physician Tools
  - Patient Tools
  - Telemonitoring
  - Decision Support

- **Integration**
- **Personal Data**
- **Health Support**
- **Technology**

- **Connected Health Ecosystem**
- **Point of Care Health Decision Support**
- **Personal Health Support Services**

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Personal Health Support Model

Our Patient-Centric Approach Adapts to Needs of Individuals

Collaborative consumer-centric model delivers care and measurable value across the health care continuum
It’s Not Easy Being Patient-Centric

Even For Patients Who Are Striving for Optimal Health

Primary care
Specialty care referrals
Ancillary care providers
Online health information
Wellness health coach
Fitness center
Care coordinator
Personal health record
Electronic health record
Public report cards
Urgent care facility
Nutritionist
Retail clinic
Care reminders
Worksite health program
Imaging center

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This Would Be Nice

- Primary care “home”
- Electronic health record
- Specialty care referrals
- Public report cards
- Ancillary care providers
- Urgent care facility
- Online health information
- Nutritionist
- Wellness health coach
- Retail clinic
- Fitness center
- Care reminders
- Care coordinator
- Worksite health program
- Personal health record
- Imaging center

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This is What We Want!

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Value Chain For Accountable Care

A Virtuous Cycle of Population Health Management

Complete Population Health Data

Integration & EBM Gap Analyses

Impactful Health Decision Support

Shared Care Plans w/ Better Use of What Works

Information, Motivation, Behavioral Skills

Better Health Behaviors

Improved Health Outcomes
It Takes More than Health Care Providers

Factors Contributing to Health
Based on figures from the National Center for Health Services, Centers for Disease Control and National Institutes for Health.

- Heredity 20%
- Medical Care System 10%
- Environment 20%
- Personal Lifestyle Choices 50%

Proportional Contribution to Premature Death

- Behavioral patterns 40%
- Genetic predisposition 30%
- Social circumstances 15%
- Environmental exposure 5%
- Health care 10%

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Why Do We Behave As We Do?

Health Behaviors Are Multifactorial and Resistant to Change

- Do you know WHAT to change and WHY to change?
- Do you WANT to change?
- Do you know HOW to change?

Successful health behavior change typically requires information, motivation, and behavioral skills.

The health system must provide all three to achieve a high probability of sustained health behavior change over time.

Why Doesn’t Care Change Behavior?

Information is a prerequisite for changing behavior, but itself is insufficient; sustained motivation and appropriate behavioral skills are also necessary.

The classic “medical model” focuses on providing information via hierarchical authority and expertise, with little attention to motivation and requisite skills.

When unsuccessful, clinicians tend to add shame, guilt, &/or intimidation to the message, further demotivating patients and defeating our original purpose.

Most physicians and nurses are not ideally socialized, trained, or supported to provide sustained motivation and good behavioral skills.
Needed: “Care As If Health Matters”
That Is, Care That Is Accountable for Determinants of Health

- Treating people as the human, fallible, habit-prone, adaptable, stubborn, resilient, irrational, complex creatures that we are
- Shaping unhealthy beliefs into healthy ones
- Changing unhealthy behaviors into healthy behaviors
- Supporting change of unhealthy behaviors into healthy behaviors
- Mitigating morbidity & disability while supporting growth and empowerment
(2) Leavitt Partners ACO report, June 2012
Who Is Leading the Way?

PPACA suggested that CMS would take national lead on defining the evolution to accountable care through MSSP.

Early provider response to CMS ACO program was tepid, now warming up with addition of other CMMI approaches such as Bundled Payment Model, Pioneer ACO, Advanced Primary Care model, etc.

Commercial health plans are already participating in many ACO “pilots” and “demonstrations” testing value-based contract structures, P4P, new collaborations and technologies.

It appears that national payors are amassing the requisite resources to be key strategic partners with ACOs.

It seems likely that commercial plans will lead the way for the next few years, even if it still requires CMS’s offering of a viable ACO pathway to achieve “critical mass” on national scale.
What are ACOs Gonna Look Like?

Group of independent physicians together through an independent practice association in affiliation with other providers

Group practice (primary care or multispecialty)

Physician/hospital organization

TBD

Health system where the physicians are employees

IDNs with hospital owned practices, physician employees, etc.
What are ACOs Gonna Look Like?

- Group of independent physicians together through an independent practice association in affiliation with other providers
- Group practice (primary care or multispecialty)
- Physician/hospital organization
- Health system where the physicians are employees
- IDNs with hospital owned practices, physician employees, etc.
- TBD
How Might Payors Structure This?

- **Stand-alone Product**
  - Reductions derived from lower HC costs
  - For members who opt into the program
  - Separate health plan option offered alongside the traditional benefits
  - Lower premiums due to coordinated care
  - Narrower list of providers

- **Reduce Premiums**
  - Better benefits? Lower co-pays?

- **Tiered Networks**
  - Different co-payments with ACO providers that show improved quality/cost performance
  - Reductions derived from lower HC costs
  - For members who opt into the program

HMOs
• Ended up focusing on contracts and setting payment rates

ACOs
• Intend to use incentives and long term arrangements to improve quality in ways that reduce costs.

# HMOs vs. ACOs: Another Difference

## Quality/Patient Experience Required Measures

### Preventive Health
- Influenza immunization
- Pneumococcal vaccination
- Adult weight screening/Follow up
- Tobacco use assessment and cessation
- Depression screening
- Colorectal cancer screening
- Mammography screening
- Proportion of adults with blood pressure screen in past two years

### At-Risk Populations
- Diabetes
  - A1c control
  - Low density lipoprotein
  - Blood pressure
  - Tobacco non-use
  - Aspirin use
  - Hemoglobin A1c
- Hypertension
  - Blood pressure control
- IVD
  - Complete lipid profile and LDL control
  - Use of aspirin/antithrombotic
- Heart Failure – Beta Blocker for LVSD
- CAD
  - Drug Therapy for Cholesterol
  - ACE and ARB Therapies

### Care Coordination/Safety
- COPD (PQI#5)
- Congestive heart failure (PQI#8)
- Risk standardized, all condition readmission
- % of PCP qualify for EHR incentive payment
- Med reconciliation after inpatient discharge
- Screening for fall risk

### Patient Experience (CAHPS)
- Timely care, appointments & info
- Doctor communication
- Patient rating of doctor
- Access to specialists
- Health promotion & education
- Shared decision making
- Health status/Functional status
Early Report: Blue Shield, CA

Dignity Health, Blue Shield of CA and Hill Physicians ACO collaboration begun in Jan 2010

Each organization shares clinical and case management information in order to tightly coordinate care.

They agreed to contribute to cost savings and bear the financial risk for any variance from the project’s cost reduction goals.

Success depends on taking cost out of the delivery system, not by shifting risk to other partners.
Cost-saving strategies

- Manage utilization through coordinated operational infrastructure and clinical processes.
- Personalize care and disease management to eliminate unnecessary utilization and noncompliance with evidence-based care.
- Reduce physician clinical and resource variation through quantitative analysis and targeted interventions.
- Reduce pharmacy costs through directed member outreach, drug purchasing and contracting strategies.
- Facilitate communication of patient medical information through integrated electronic health information.
\begin{itemize}
  \item In patient readmissions: 15% 
  \item Inpatient days: 15% 
  \item Inpatient stays of 20+ days: 50% 
  \item Half day reduction in average LOS 
\end{itemize}

$15.5$ Million saved

In 2010-2011 the parties shared a savings pot of $8$ Million
Another Success Story

- Reduce LDL targets for high risk patients.
  - 100 mg/dL → 70 mg/mL

However

- Several studies show only 15-30% reach this goal

NCEP

Kaiser (Denver) project

- 7427 patients managed by nurses, pharmacy and MDs
- Meds, diet and lifestyle
- EHR and disease registries were key to coordinate patient care

Results

- 43% achieved target goal
- 87% could use generic drugs

Credit

Authors credit the integrated care delivery model, supported by electronic medical records and health information technology

ACE Bundle Demonstration

CMS project  Acute Care Episodes  Jan 2009

5 health systems  Specific DRGs (cardiac and orthopaedic)  Inpatient costs only
Bundle Demonstration Sites

- Baptist Health System
  San Antonio
- Oklahoma Heart Hospital
  Oklahoma City
- Exempla Saint Joseph Hospital
  Denver
- Hillcrest Medical Center
  Tulsa
- Lovelace Health System
  Albuquerque
## ACE Bundle Demo Scope

<table>
<thead>
<tr>
<th># DRGs</th>
<th>Acute Care Episode</th>
</tr>
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<tbody>
<tr>
<td>6</td>
<td>Cardiac Valve and other Major Cardiothoracic Procedures</td>
</tr>
<tr>
<td>2</td>
<td>Cardiac Defibrillator Implant</td>
</tr>
<tr>
<td>6</td>
<td>Coronary Bypass</td>
</tr>
<tr>
<td>8</td>
<td>Pacemaker Procedures</td>
</tr>
<tr>
<td>6</td>
<td>Percutaneous Cardiovascular Procedure</td>
</tr>
<tr>
<td>2</td>
<td>Bilateral or multiple major joint procedures of lower extremity</td>
</tr>
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ACE Bundle Results-Hillcrest

$1.59 MM savings in cardiac and orthopaedic services

CMS is paying $450 less per knee replacement

Key quality measurements remained strong, and some — such as readmission rates, use of prophylactic antibiotics and length of stay — improved

ACE Bundle Results-Hillcrest and Lovelace

7 percent savings on orthopedics implants

$300,000 per year

Similar savings were achieved on cardiology implants

Observations

Bundled payments create a tighter connection to physicians

- "Probably the most significant area of [success] was physician involvement,"
- When physicians see the costs and ramifications of the entire episode of care, they are more likely to be more economical and efficient in their choice of implants, testing and other areas of clinical decision making

Cost Savings without rationing of care

- Level of treatment and quality measures were unaffected.
- Outcomes metrics are unchanged
- Standardizing processes reduces variability in outcomes and improves quality

The ROI for standardization has its limits

- Bundling will be a greater challenge for complex medical cases such as diabetes, congestive heart failure and other chronic conditions

What Else Might we Need?

- Tort reform
- Payment reform
- Personal Accountability
The Obesity Epidemic

2030: Adult Obesity Rates if the Current Trajectory Continues

Increased # Cases/100,000

- Type 2 Diabetes
- CHD/Stroke
- Hypertension
- Arthritis
- Obesity related cancer

Current Trend (Utah)
Current Trend (W. Va or Maine)

Increased # Cases/100,000

- Type 2 Diabetes
- CHD/Stroke
- Hypertension
- Arthritis
- Obesity related cancer

- Current Trend (Utah)
- 5% reduction in trend
- Current Trend (W. Va or Maine)
- 5% reduction in trend2

$120 billion!

The Care We Get...
“Flip of the Coin” Health Care Quality, 6-6-03

Our results indicate that, on average, Americans receive about half of recommended medical care processes.

Mean performance

Closing the Gap

Nearly 70,000 Americans die needlessly each year because they are not given optimal heart failure therapy.
The Care We Shouldn’t Get…

JAMA, 7-6-11

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Source: Journal of the American Medical Association
The Care We Want…

*Organized Around a Person-Centric Health Ecosystem*

- **Aligns** care services/providers by being person-centered
- **Defragments** health silos
- **Personalizes** health decision support for each individual
- **Links**
  - Sites of care, all care over time
  - Integrated care plans via PHRs
- **Delivers**
  - Ease of use, clear navigation
  - Effective information, motivation, health skills support
  - Shared accountability between delivery system and patients
- **Provides**
  - High value, sustainable system to optimize individual / societal health

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“We can't sustain a system that rewards how much is done to patients instead of how much is accomplished for patients.

The Affordable Care Act will help us pay for quality and outcomes, not volume, with innovative tools such as bundled payments, incentives for hospitals that prevent readmissions, and accountable care organizations in which health-care providers who work in teams deliver better care with lower costs.”

Donald M. Berwick
CMS Administrator
September 3, 2010
Op-Ed in The Washington Post
Questions?

Thank You!

Today is the youngest you’ll be for the rest of your life. Act like it.