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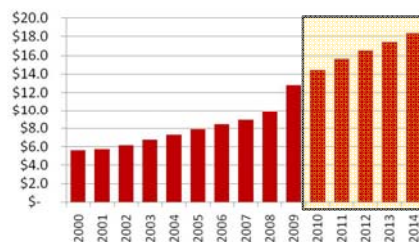
Continuing Medical Education

A Critical Tool in the Redesign of the American Health Care System

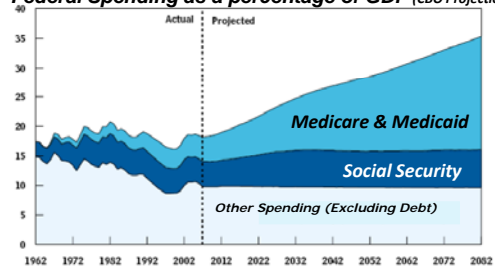
Gary L. Gottlieb, MD, MBA
President and CEO

The Economic Picture

Gross Federal Debt (White House Budget)

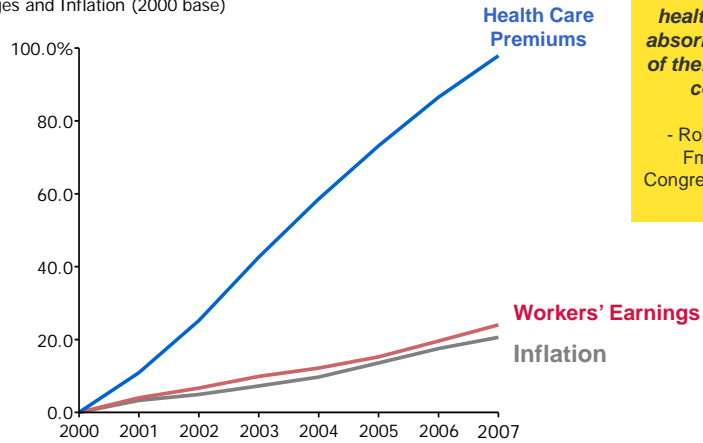


Federal Spending as a percentage of GDP (CBO Projection)



Rising health care costs have been squeezing employers and employees for years

Cumulative increase in Health Care Premiums,
Wages and Inflation (2000 base)



"The growing costs of health insurance have absorbed a large portion of the... increase in total compensation"

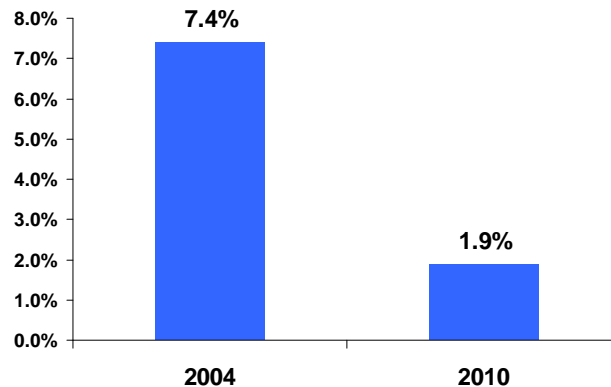
- Robert D. Reischauer
Fmr. Director of the
Congressional Budget Office

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Health Care Reform sets Massachusetts apart

Percentage of MA Uninsured Residents



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There are three ways society is combating rising costs

**Contain
rates through
regulation**

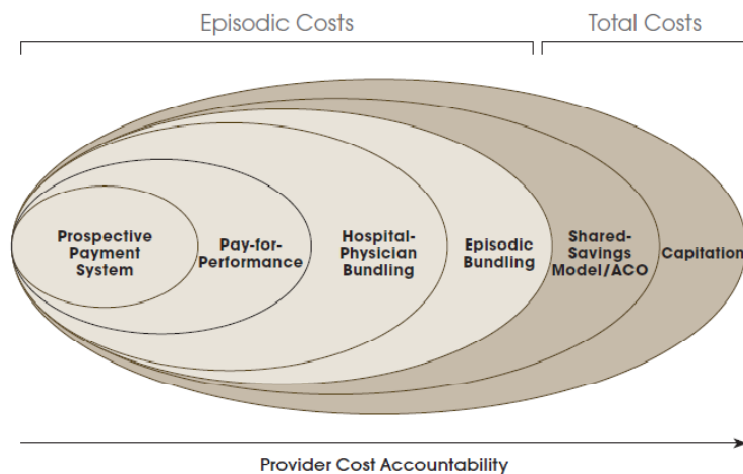
**Implement
payment
reform**

**Turn
patients into
consumers**

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Evolving Reimbursement and Care Models



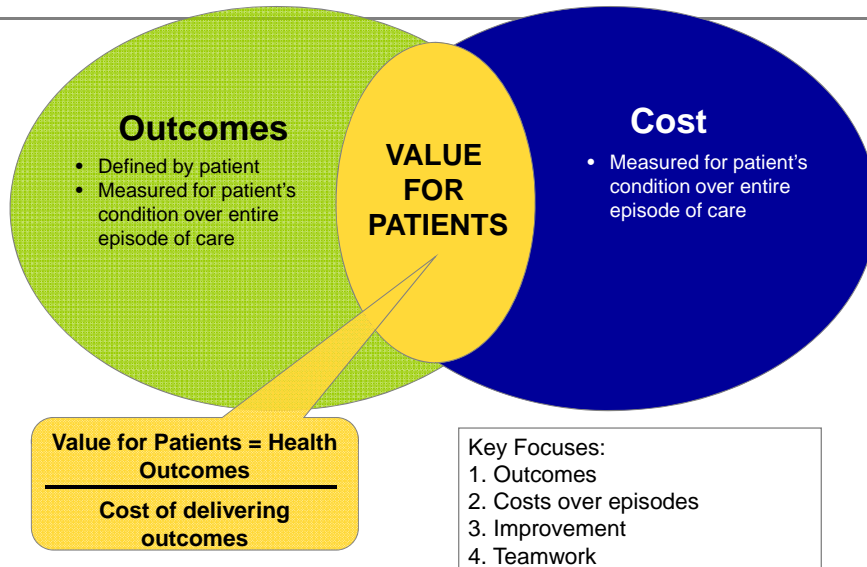
Exact model is unclear, but we are moving away from unfettered fee for service and focusing on value will matter in all models

Source: Health Care Advisory Board, "Promise or Peril? Preparing Your Health System for Success in the New Health Care Economy", 2010

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Value as the Critical Outcome



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Key Tools to Adapt to Clinical Care to New Payment Models

- Care Redesign
 - Population Risk
 - Primary Care/Front End
 - Patient Centered Medical Homes
 - Bundled Payments
 - Specialty/Referral Care
 - Transactions/Visits → Episodes

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Primary Care: Patient Centered Medical Home

TODAY'S CARE

Practice patients are those who make appointments to see the doc

Patients' chief complaints or reasons for visit determines care

Care is determined by today's problem and time available today

Care varies by scheduled time and memory or skill of the doctor

Patients are responsible for coordinating their own care

The doctor knows she delivers ideal care because she is well trained

It's up to the patient to tell the doctor what happened to them

Clinic operations center on meeting the doctor's needs

MEDICAL HOME CARE

Practice patients are those who are registered in the medical home

The practice systematically assesses all patients' health needs to plan care

Care is determined by a proactive plan to meet patient needs without visits

Care is standardized according to evidence-based guidelines

A prepared team of professionals coordinates all patients' care

The practice measures its quality and make rapid changes to improve it

The practice tracks tests & consults, and follows-up after ED & hospital

A multidisciplinary team works at the top of their licenses to serve patients

Slide from Daniel Duffy MD, School of Community Medicine, Tulsa, Oklahoma

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Current Diabetes Care – Expensive Drugs, Poor Results

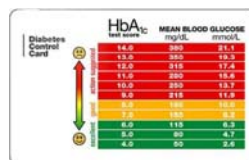
55-year old with
type 2 diabetes



▪Meds:
pioglitazone –
oral and
sitagliptin/
metformin in
AM; in the PM
sitagliptin
\$150/month in
copays



She
experiences
fatigue, blurred
vision, thirst



Her HbA_{1c} is 10.0
with the goal being < 7



Her blood sugar is
not well controlled

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Example: Diabetes Care Redesign Opportunity

Team's Recommendation

In accordance with established treatment guidelines, patients who are unable to achieve glycemic control on two or more oral agents should be moved to insulin; patients and physicians should have access to resources to facilitate insulin initiation and ongoing use

Improved Value

- **Cost:** If we were to move 30% of patients from all brand name meds to generics, pharmacy savings could reach multiple millions
- **Outcome:** Improving HbA1c scores by 1%, reduces risk of microvascular adverse events (kidney and eye) by 35% and macrovascular events (MIs) by about 20%

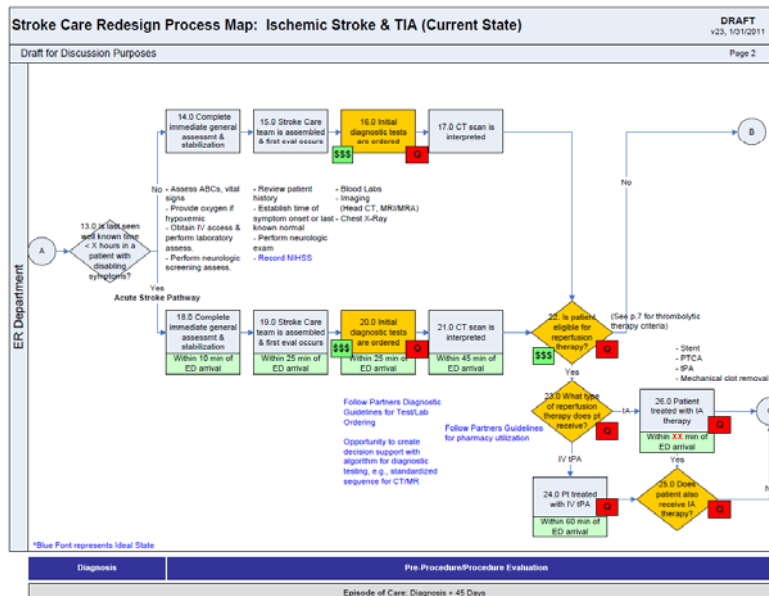
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- Care is proactively managed with decision support and clinical registries
- Non-physicians and electronic communication provide more flexible access points for patients

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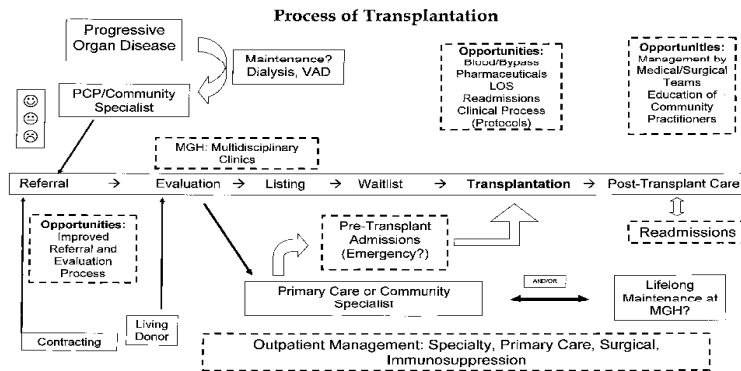
Mapping out the Process of Care: Stroke Care Map Example



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Care Redesign Pathway: Complex Care Solid Organ Transplantation



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Hierarchy of Educational Outcomes - A Perfect Fit



Moore, D, Green, J., Gallis, H. Achieving Desired Results and Improved Outcomes: Integrating Planning and Assessment Throughout Learning Activities. Journal of Continuing Education in the Health Professions. Winter 2009; 29: 1 – 15.

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Core Competency and Maintenance of Certification as Catalysts Supporting Change

Ongoing Assessment of Six Core Competencies

1. Patient Care
2. Medical Knowledge
3. Practice Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems Based Practice

Maintenance of Certification (MOC) Program

1. Professional Standing (Medical License) Includes Communication Assessment Every 5 Years
2. Lifelong Learning and Self Assessment – 25 CME Credits/Year
3. Cognitive Expertise – Proctored Examination Every 7 to 10 Years
4. Practice Performance Assessment – Depending on Board Every 2 to 5 Years

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Opportunities Created by New Approaches to CME

- Performance Based Continuing Medical Education - Continuing Professional Development (CPD)
- Demonstrable Outcomes Closing Health Care Gaps in Practice
- Scalable Platforms to Reach Disenfranchised Providers and Patients
- Alignment with and Reinforcement of New Health Delivery and Reimbursement Models
- Enhanced Regulatory Compliance
- Economies of Scale

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The Mission



Patient Care
Discovery



Teaching
Community

