Innovation: Needed, But Not Rocket Science

BY SUSAN DENTZER

As the Affordable Care Act’s first birthday approaches, it’s time to get deadly serious about health care delivery system reform. This was always the sketchy stuff in the law; provisions for accountable care organizations (ACOs), pilot programs, and the like created the potential to cut costs and improve care, but begged to be turned into reality.

A year later, the Center for Medicare and Medicaid Innovation is up and running, and a proposed federal regulation giving shape to ACOs is waiting in the wings. “There’s never been a better time to be an innovator in health care,” as Donald Berwick, administrator of the Centers for Medicare and Medicaid Services, says. Now, all we need are big-time results.

FIFTEEN SKETCHES

To that end, we feature this month a series of innovation profiles stemming from our December 2010 conference in Washington, “Innovations across the Nation in Health Care Delivery.” We focus on fifteen organizations—health systems, health plans, and others—that, in different ways and to varying degrees, have put Berwick’s fabled Triple Aim in their sights.

These profiles are not rigorous case studies of the sort that traditional health services research rightly demands. These are, rather, descriptions of what organizations have attempted amid fragmented systems, flawed payment structures, and other constraints—and tantalizing suggestions of what they might be able to accomplish were those constraints removed.

Readers who sift through these profiles will be struck by the commonality and commonsense nature of many of the innovations. To wit: If you want to spend less, focus your efforts on the sickest people whose care is likely to cost the most. Do whatever it takes to keep chronically ill people as healthy as possible and out of the hospital. A team of professionals focused on patients’ varied needs is likely to do a better job than a single physician who isn’t so focused. And many patients with advanced illnesses would often prefer fewer interventions and being out of the hospital, especially if their providers help them devise a plan that can meet their needs.

CHANGE IS HARD

Although none of this is rocket science, that doesn’t mean putting it into practice is easy. Yet our innovation profiles suggest that determined people can succeed. Think about how much more we might accomplish if ACOs and other delivery and payment innovations get up and running soon.

We sincerely thank the foundations and other organizations whose support made possible both our December conference and publication of the innovation profiles. Our platinum sponsors were the American Hospital Association and the Peter G. Peterson Foundation; our gold sponsors were the Aetna Foundation, the American Medical Association, Blue Shield of California Foundation, the California HealthCare Foundation, The Commonwealth Fund, The John A. Hartford Foundation, the Institute for Healthcare Improvement, the Fannie E. Rippel Foundation, The SCAN Foundation, and the United-Health Group.

THE CARE SPAN

In this issue of Health Affairs, we inaugurate a new feature thanks to all-important support from The SCAN Foundation. Under the rubric “The Care Span,” we will publish articles focused on elderly and disabled populations and on the development of an effective continuum of health care, long-term care, and social services and supports.

In the first of two Care Span articles in this issue, Susan Reinhard and colleagues discuss provisions of the Affordable Care Act that will help states move toward better systems of home and community-based services for the aged and disabled.

In a second article, Sean Morrison and colleagues find that the use of palliative care consultation teams helped cut Medicaid spending on hospital stays for patients at four New York State hospitals. With these papers, The Care Span is off to a brilliant start. We are deeply grateful to The SCAN Foundation for its generosity.

ERRATUM

In my “From the Editor-in-Chief” note in our January 2011 issue, I misstated patient satisfaction results from Sutter VNA and Hospice’s advanced illness management program. I wrote that the program had earned far higher patient satisfaction scores than Sutter’s hospice program. I should have written that the scores were better than those from survivors of patients who had died in the hospital. In fact, satisfaction scores for Sutter’s hospice program are already very high. I regret the error.

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