From the Director…

The 119th Interagency Institute had a very definite “Commonwealth” flavor because, in addition to the participants from the United Kingdom and Canada, our Lessons From Other Countries session was once again held at the Embassy of Australia. We were most fortunate to have the Australian Ambassador, HE the Hon Kim Beazley, AC, open the session with a most interesting and comprehensive historical review of Australia-USA relationships. I am also grateful to Lt Col Mitch Kent, Assistant Military Attaché, who coordinated all the arrangements at the embassy for this session.

Dr. Anthony Cordesman, who holds the Arleigh A. Burke Chair in Strategy at the Center for Strategic and International Studies research group, gave the opening address, Can the Current Strategy Work in Afghanistan? “We have made real progress, but it’s tactical progress. We don’t know whether we can sustain the security of these areas,” he said. He emphasized that Afghan governance and institutions have not yet been able to show evidence that the civilian leadership can sustain the military over several more years,” he cautioned, “so term.”

It was a pleasure for Janet and me to have a great group of participants at the 119th Institute. We appreciated their active participation throughout the two weeks and we hope that they found the program to be intellectually stimulating and informative. It is important, however, to remind ourselves that one of the goals of the Institutes is to give senior federal health care executives the opportunity to examine the most pressing current issues affecting health care, and to discuss the ‘interagency imperative’ as these issues impact our everyday health care environment, in whichever part of the federal health services our participants are employed. Sometimes, I hear the comment that we should focus on more applied issues and provide ‘solutions’ to problems such as how to design a better electronic health record or the resolution of specific personnel and financial challenges. I believe that we have a reasonable balance between theory and applied topics in each Institute program. To focus solely on immediate problem-solving questions would reduce the value of this continuing professional development program.

Janet and I were especially impressed by the amount of time and hard work generated by the small group activities. The presentations on the final day were of high quality and we are very pleased to include the reports from the groups in this newsletter.

For some time now, the Annual Meeting of the Alumni Association has been held at the AMSUS Annual Meetings. Recently, the attendance at these breakfast sessions has been less than previous years, so we are encouraging the FHCEIAA leadership to explore the possibility of holding a meeting during the Military Health System Conference which seems to attract a larger group of our alumni/ae.

With best wishes.

Richard F. Southby, Ph.D., F.F.P.H., F.C.H.S.E.
Director
Dear Colleagues,

Congratulations to the graduates of the 119th Interagency Institute (IAI)! It was an absolute pleasure to meet many students, alumni and cherished friends during the Institute cocktail hour and dinner. On behalf of fellow Alumni, I welcome new members to the Federal Health Care Institute Alumni Association (FHCEIAA) and encourage you to become active in FHCEIAA activities. I had a great opportunity to tell the group about the benefits of joining the FHCEIAA in terms of networking and meeting our goal of promoting and fostering joint federal health care collaboration and education. In addition to our hosts, Drs. Janet and Richard Southby, we were joined by Maj. Gen. (Dr.) Douglas J. Robb, the Joint Staff Surgeon on Admiral Mullen’s staff at the Pentagon. Maj. Gen. Robb’s lively and informative presentation included remarks highlighting our joint atmosphere where we leverage each other’s strengths to provide comprehensive care to our service members and beneficiaries. He shared many insights and initiatives on this rapidly changing federal health care landscape.

The FHCEIAA Annual Business Meeting was held on 2 November 2010 at the annual Association of Military Surgeons of the United States (AMSUS) meeting in Phoenix AZ. We were so very fortunate to have MG David A. Rubenstein, the commander of AMEDD Center and School at Fort Sam Houston TX, as our guest speaker. He shared a variety of current issues from his most recent role as Army Deputy Surgeon General as well as from his new role as the Commander, AMEDD Center and School. His remarks were highlighted with current news about the upcoming joint service facility nearing completion at Fort Sam Houston that will house the majority of Triservice medical training. An alumnus himself, we are indebted to MG Rubenstein for taking time out of his incredibly busy schedule to spend the morning with us. A second very important event was the opportunity to recognize the recipient of the 2010 Distinguished Service Award Recipient, Colonel (R) Steven C. Mirick, Deputy Executive Director, AMSUS. He was recognized for his stellar Air Force career and continued service in AMSUS and Military Officers Association of America (MOAA) among other myriad volunteer activities. He was acknowledged for his tireless efforts with the FHCEIAA for many years. His support and coordination for FHCEIAA has been invaluable and frankly irreplaceable. In true humble and selfless fashion, upon presentation of his plaque and honorarium; Col Mirick quietly returned his honorarium to the FHCEIAA scholarship fund. Our deepest thanks for his generosity and he did tell me he will cherish the standing ovation, our recognition and the beautiful plaque.

The alumni association provides wonderful benefits in addition to great networking. We receive the “Record” after each IAI course which provides feedback and information from key speakers and workgroup reports. We have updated our FHCEIAA Website with current information and accessibility to our membership roster. The NEW Web site address is www.fhceiaa.org. Please visit it and let me know what you think! Our Web site offers you an opportunity to connect with alumni and submit updates on assignments, address changes, successes, et cetera, to president@fhceiaa.org or rah4bucs@comcast.net. Our board is always in search of opportunities for improvement of YOUR alumni association so please do NOT hesitate to share those recommendations. The FHCEIAA annually awards a $1000 scholarship to the son/daughter or dependent grandchild of an alumnus. Information and applications can be found at www.fhceiaa.org. Applications should be sent no later than 1 July 2011 to COL (R) Roy A. Harris, 9865 Diversified Lane, Ellicott City MD 21042.

Please continue to keep our deployed service members and civilians in your daily thoughts and prayers, particularly as we observe Memorial Day.

Have a great summer. Carpe Diem!

Roy A. Harris RN, PhD
COL, USA, Ret
President, Federal Health Care Executives Institute Alumni Association
The dinner program for the 119th Institute was held in Capitol View Room of the Key Bridge Marriott in Rosslyn, VA. The event, kindly sponsored by Delta Dental of California, was attended by 79 persons.

The speaker for the evening, Major General Douglas J. Robb, USAF, MC, spoke on the topic, “Joint Support to the War Fighter.” His remarks included a review of Admiral Michael G. Mullen’s priorities as Chairman, Joint Chiefs of Staff:

1. Defend Our Vital National Interests in the Broader Middle East and South Central Asia
2. Improve the Health of the Force through resetting, revitalizing and reconstituting the Armed Forces
3. Balance Global Strategic Risk (The Chairman has placed significant emphasis on the expansion of counter-insurgency warfare training and resources and was an early advocate for a greater focus on operations in Afghanistan - now the U.S. military’s "main effort.")

Full spectrum health care of Wounded Warriors during current operations has translated to:

- The Lowest Disease Non-Battle Injury Rates in recent conflicts
  - Gulf War 65/1000 personnel per week
  - Operation Iraqi Freedom (OIF)
    - 52/1000 War Phase
    - 40/1000 Stabilization Phase
- The Lowest Lethality Rates in recorded conflict
  - World War II 30%
  - Vietnam/Gulf War 24%
  - Operation Enduring Freedom (Afghanistan)/OIF/Operation New Dawn (Iraq since 1 Sep 10) <10%

He also addressed the Chairman’s comment: “I am extremely concerned about the rise in personnel costs and inside that, the rise in health care costs... as least as it’s currently projected, it’s just not sustainable.” The cost of the Military Health System (MHS) has risen over the past 10 years, but total out of pocket expense for beneficiaries has not increased. For example, the annual cost of behavioral health care for the force and their families has increased from 500 million to over $1 billion since 2005.

In response, the following efficiency initiatives are under consideration for the MHS to reduce costs by $7.8 billion:

- Improved internal efficiencies saves ($1.3B savings) - Reduce 760 contractors at TMA and implement next generation TRICARE contract (T4) & Medical Home
- Simplify; make administration more equitable across the country - Treat all beneficiary groups and providers the same, Phase out Uniformed Services Family Health Plan - future patients will use Medicare, but does not impact current 100K enrollees ($3.2B savings); Pay Sole Community Hospitals Medicare rates ($400M savings)
- Gradually implement modest changes to benefits - Modest increase in retiree enrollment fees; $2.50/month for individuals and $5/month for families; index rates in the out years ($435M savings); Use most effective outlet for prescriptions; reduces mail-order costs; make small adjustments in pharmacy co pays ($2.5B savings).
**Group I Project Report: Patient-Centered Medical Home (PCMH)**

**Project:** The concept of the ‘Patient-Centered Medical Home’ is attracting much attention in the health care community although its origins can be traced back to health reform discussions in the UK and the USA in the 1920’s. Describe how implementing this concept will impact federal health care and outline the potential advantages and disadvantages. What may be major obstacles in implementation beyond the pilot sites over the next two years?

**Group Members:** COL Heidi Warrington, USA; CAPT Al Siewertsen, USN; Col(s) Bruce Roehm, USAF; Ms Karen Malebranche, VHA; Col Susan Jano, USAF; CAPT Howard Hays, USPHS; Gp Capt Alan Cowan, RAF; COL Linda Carmen, USA; Col Charlie Carlton, USAF; COL Chuck Callahan, USA; CAPT Steve Brasington, USN; CAPT Kristen Atterbury, USN; CDR Martin Anerino, USN: COL Randall Anderson, USA

**Response:** US Federal Healthcare is responding to America’s cry for health care reform to provide quality care, better access and controlled costs. Patient-Centered Medical Home (PCMH) originated in reform discussions back in the 1920s in the United States and United Kingdom and centers around a health care team focused on providing optimum health and a positive experience for the patient. This partnership empowers the patient to decide appropriate health interventions, convenient and appropriate, including long term health maintenance and wellness goals.

The impact of this provider-led team is improved health through patient/provider collaboration to coordinate services, track referrals, and provide health education. PCMH provides a comprehensive system of care that maximizes appropriate delivery of care at each patient interaction. This relationship offers many advantages for patients, but requires significant cultural changes to processes in the federal health system.

Americans want to see the same healthcare provider with improved access at a lower cost. Although federal health beneficiaries experience minimal direct costs, a lack of provider continuity remains a challenge due to provider deployments, frequent moves and an acute care/episodic system, in part the result of our protracted war that shifted care by necessity to acutely wounded Warriors. PCMH has the opportunity by its design to provide beneficiaries with what they want with improved outcomes at a cost savings.

The advantage of PCMH is the ability to shift federal beneficiaries into a system that improves the population’s health at a cost savings. Although similar in concept to primary care, PCMH changes the design of healthcare by placing the patient and their health needs in the center of the health system with care revolving around ease of access to and a personal relationship with an identified small team.

The patient can access a member of their personal team who directs them through the system the same day. Appointment demand decreases because the team coordinates preventive screening concurrent with the acute visit. Improved patient/provider communication leads to efficiencies and greater continuity, including interdisciplinary communication, resulting in reduced testing and medical errors. This improves both patient and provider satisfaction.
Better provider access may lead to decreased purchased care since the patient will have confidence their health needs are being addressed in a timely manner. PCMH provides integrated care for disease prevention and improved disease management, resulting in decreased emergency and urgent care use. For our nation’s Warriors, the result is measurable improved readiness.

Despite the obvious advantages, the transition to PCMH presents disadvantages as well. Initial start-up costs which may persist include longer patient appointments to facilitate relationship building with the team, time to coordinate preventive screening and provide health education. This decreases amount of patients seen/day or lengthens the duty day and will require additional human resources until back-log is caught up. PCMH also requires improved access beyond normal clinic hours for 24/7 access to care.

Other disadvantages exist such as changing current patient clinic alignments to ensure distribution of complex cases across teams which may not coincide with provider talents. With two providers per team, this creates some flexibility to meet patient expectations when one provider deploys/rotates. There may be a cost shift to purchased care when teams cannot meet access. The same standard of care and continuity are difficult to meet for must-see patients assigned for short periods such as activated reserve component beneficiaries, students and trainees.

Future obstacles to PCMH can be viewed as opportunities to change federal healthcare. Once solved, they will significantly change the federal healthcare culture and realign assets in order to empower the patient as an active participant in their healthcare choices. Resistance to change for patient engagement will need to be overcome, as well as elevating primary care physicians and their obligation to advocate patient selected health interventions which may be contrary to specialty care recommendations.

Other obstacles to be managed include the need for continuum of care beyond the federal health service with network episodic care, transition to Veterans health facilities and access from remote locations once federal service is retired. Improved access through team coordination prior to departure with one electronic medical record used throughout the federal health system accessible to civilian teams will be instrumental in achieving continuity. Building joint facilities with Veterans Affairs is another way to facilitate integrated care, especially for wounded Warriors in transition to civilian life.

PCMH will fundamentally change the delivery of federal healthcare. The design of PCMH meets society’s need for greater personal responsibility for their health-related behaviors that will improve quality care, create better access and control costs. The expansion of the primary team to include mental health/spiritual support and how to measure evidence based practices when patient interactions will increasingly be via phone, text messaging, internet, etc. will be critical in the success of the PCMH.
Group II Project Report: Health Professional Education

Project: The traditional ‘silo model’ for educating health professionals is being constantly challenged by the renewed emphasis on the importance of teamwork and a diverse workforce in providing health services in an environment of ever-increasing expectations, increasing costs and declining resources. How should the structure and instructional methodologies of health professional education and training emerge over the next decade in the United States to adapt to these pressures?

Group Members: CAPT Annette Beadle USN; COL Brian Canfield, USA; Col Billy Cecil, USAF; CAPT Glen Crawford, USN; Ms Kristin Cunningham, VHA; CDR Mary Dott, USPHS; COL Michael Doyle, USA; Col Dale Ferguson, USAF; COL Carolyn Jolitz, USA; CAPT Jeffrey Korsnes, USN; Col Mike Paston, USAF; LTC Thomas Steinbach, USA; Col Sarady Tan, USAF; Cdr Dave Wilcox, Canadian Forces.

Background: Though evolving, the U.S. health system is strongly based within the medical/disease model of care. Education of health professionals is essentially rooted in the same model. Worldwide, over one million physicians, nurses and allied health professionals are trained each year; occasionally poorly trained because of fragmented and outdated curriculums. “The problems are systemic: mismatch of competencies to patient and population needs; poor teamwork; persistent gender stratification of professional status; narrow technical focus without broader contextual understanding; episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labor market; and weak leadership to improve health-system performance.” (The Lancet Commission report, November 2010).

Education: The challenge of educational programs is to recognize the tendencies of professionals to act in isolation from each other and to reconcile those tendencies into more of a collaborative, interdisciplinary model. “A silo approach to education; distinct professional codes of ethics; and the drawing of boundaries around uni-professional knowledge, all undermine respectful awareness of the knowledge and skills of other disciplines and fuel interdisciplinary rivalry.” (McNair, R., March 2010, “Breaking down the silos: interprofessional education and interprofessionalism for an effective rural health care workforce”).

The more progressive training programs that are trying to get ahead of the future health care constraints (delivering care with limited resources, curtailing rising costs and recognizing a patient population with higher expectations) are integrating an Interprofessional Education (IPE) concept into their organizations. In the USA, the Institute of Medicine issued a landmark report in 2003 titled, “Health Professions Education: A Bridge to Quality”, which emphasized the need for interprofessional education and collaborative practice. This concept was an initiative by the World Health Organization in 2007 and has gained some traction worldwide in the past several years. Such programs are not geared to remove the specialized training/education that form the foundation of different disciplines, but rather bring students together from various disciplines to learn from and with each other so that the patient will benefit from a more effective and collegial healthcare team while quality is enhanced and cost is better contained.

Ultimately, interprofessional education and collaborative practice are about people: the health workers who provide services and work together to ensure patients and the community receive the best treatment as efficiently as possible; the educators who understand the importance of bringing together students from a range of disciplines to learn about, from and with one another; the health leaders and policy-makers who strive to ensure there are no barriers to implementing collaborative practice within institutions; and most impor-
tantly, the individuals who require and use health-services, trusting that their health workers are working together to provide them with the best services possible. (Framework for Action on Interprofessional Education and Collaborative Practice, World Health Organization, 2010). IPE is not only an opportunity to change the way we educate health professionals, but also a way to change the way we deliver health care throughout the entire country.

**Organizationally:** One of the benefits of implementing interprofessional education and collaborative practice is that these strategies change the way health workers interact with one another to deliver care. The growing evidence and research base continues to identify interprofessional collaboration as beneficial to health workers, systems, and communities. To implement such programs and change the way we educate our health care professionals, we need to change the country's model for health care delivery to include creating clear governance models, structured protocols, and financial support to execute. Organizationally, we as a country need to engage a diverse and knowledgeable panel of experts who can critically assess the health needs/challenges of the United States and set priorities for health care, nationally and regionally, based on that assessment. Collaborative practice will work best when it supports the needs of the population being served and it is implemented in a culture where members value and understand the importance of each professional as a member of the health team. Institutional programs can shape the way a team of people work collaboratively, creating synergy instead of fragmentation.

**The Future:** Our team envisions that improvements must be made over time, in multiple phases, and recognizes that collaborative education must occur in the context of a health care system based on the same values. In the short-term, the health care industry and education systems should expand upon already existing efforts – such as selecting students for pre-paid professional school positions in exchange for service commitment in needed specialties or geographic areas or broadening the use of telehealth to reach distant populations. In the mid-range time-frame, the payment structure will need to be changed to reward collaborative efforts – for example, changes to the Medicare Prospective Payment System (PPS) to ensure payment for services that fall into the Medical Home care concept and using the PPS to incentivize particular specialties to relocate to medically underserved areas. In the long-term time-frame, we recommend that education accrediting bodies (such as ACGME) define competencies that incorporate collaborative approaches and oversight bodies (such as JC) include objective measures of collaborative practice in the health care accreditation process.

**References:**

**Conclusions/Recommendations**
- Have to critically assess the issues and invest in new, innovative ideas for change.
- Commitment by the policy makers, educators, health care professionals, and other stakeholders to support reform efforts.
- Without a collaborative approach, will be unable to control costs, quality and access to care in the future.
- Improvements should be made over time, in multiple phases.
Group III Project Report: Diversity in the Workplace

Project: After reading The Loudest Duck, how will you apply your leadership knowledge to ensure a "level playing field" in your organization where no one gets subtle advantages or disadvantages? Discuss these dynamics in organizations, giving illustrations from your experiences, where you "hire for difference and fire because they are not the same." How, as leaders, do you get the most out of diverse organizations, particularly when it comes to cognitive diversity - the differing ways people think and solve problems?

Group Members: COL Frank Allara, USAF; CAPT Lori Frank, USN; LTC Paul Goymerac, USA; CAPT Walter Greenhalgh, USN; Ms Sandra Gregar, VHA; COL Mark Harris, USA; CDR Janet Hawkins, USPHS; Col Mark Mavity, USAF; LTC Jennifer Peters, USA; Col Chet Roshetko, USAF; CAPT Dave Service, USN; Col Scott Sprenger, USAF; COL Laurie Sweet, USA; CDR Michael Wray, USN.

Report: The Federal Healthcare workforce is diverse, composed of people of varying age, gender, race, ethnicity and religion. Each person brings their own rituals, beliefs and personal experiences to the workplace. Our varied backgrounds shape our attitudes and tendencies which in turn affect our opinions and decision making. Quite often our attitudes and opinions operate at an unconscious level. We evaluate people and their potential contribution to the team with unconscious perceptions. Effective leadership requires consciously building awareness of the dynamics of difference. Proactively recognizing our differences and diligence in giving each person equal opportunity/importance to contribute will help to level the playing field within the organization.

“The Loudest Duck” by Laura Liswood presents a different perspective on diversity. This report will present, from a Federal Health Care perspective, how leadership knowledge can be applied in various situations to ensure a “level playing field” and how leaders can get the most out of a diverse organization, particularly when it comes to cognitive diversity – the different ways people think and solve problems.

Where does diversity begin? Many would argue that it begins when the selection process that it begins when the gurdless of one’s perspective or recognition itself. Without not strive to create change example, a fellow officer of a medical school admissions and experiences insure a diverse medical tion of many factors goes ethnicity/socioeconomic in ensuring a class has an nity at large. Yet, we con- nantly academic achieve- and Medical College Admis-

It is well documented that means for discriminating represented ethnic/cultural with “traditional” back-
strong students based on poor test scores. There is no getting around the fact that nearly every school in this country prides itself not so much on how diverse its classes are, but on the average GPA and MCAT scores of admitted students. These raw numbers are still the criteria that schools are judged, with the most competitive schools obviously having admitted students with the highest average scores but usually the least diverse student body.

How does one apply leadership knowledge to ensure a "level playing field" exists, where nobody in the organization gets subtle advantages or disadvantages? A key function of leadership within organizations is to establish “culture”. Culture defines the boundaries of the organization's playing field. In almost all organizations, especially in the healthcare industry, workplace relationships are a shared responsibility of all members within the organization and everyone must learn to adapt to subordinates, peers and superiors alike. This approach is even more difficult for an organizations leadership. For example, cognitive diversity creates different viewpoints, different methods of problem solving, and different ways of examining the world and its problems in general. Incorporating cognitive diversity may seem counterintuitive in strengthening bonds in a homogeneous organization; however, in reality this conflict of perspectives can produce creative solutions to unique problems. As leaders, we can help “level the playing field” by furthering the identification and recognition of these biases which can potentially result in unfair advantages and disadvantages. Enlightening members of an organization of these subtle discriminators may reduce their resulting impact and create more true diversity.

Leaders can also use a number of simple tools to encourage cognitive diversity. Publishing agendas before meetings will help those individuals who are not natural "off the cuff" speakers to prepare thoughts and comments. Go around the room and invite conversation from all participants. In a military environment, go to the junior person at the table first and ask, "what do you think about XX" before going to the senior person. If you start with the senior person, you risk the chance of not receiving varied answers.

Another tool is to be very careful with one’s words, and how one interprets the words of others. Remember, unconscious attitudes based on diverse backgrounds and experiences translate comments differently for certain groups of people. What is meant to be motivational, encouraging or constructive criticism may be interpreted with confusion and resentment if one is not paying close attention to their audience. Be conscious of who is speaking and who isn’t. Recognize the silent team members since they too have something to say. There are always dominant groups or personalities that will usually have something to say. Explore ways to ensure that everyone is heard; otherwise you may be getting only part of the solution to a problem.

Finally, results determine the benefit of diversity. Problem solving can be approached by many ways. The more ways there are, the better the decision making can be. Don't limit success by limiting creativity and relying on defaulted ways of thinking. The Federal Healthcare System is an incredibly fertile ground for diversity. In order to fully harness the power of our differences, we as leaders must learn to ensure we have a level playing field within our organizations. In addition, there are a number of important tools we can use to maximize the problem solving capability of our team. Cognitive diversity approach to finding demanding change.

WHY IS RECOGNITION OF DIVERSITY KEY?

- Increases leveling of the playing field
- Investment in organization’s most important asset...human capital
- Brings broader perspective to decision making
- Increases organizational knowledge
- Builds the team

The Federal Healthcare System is an incredibly fertile ground for diversity. In order to fully harness the power of our differences, we as leaders must learn to ensure we have a level playing field within our organizations. In addition, there are a number of important tools we can use to maximize the problem solving capability of our team. Cognitive diversity approach to finding demanding change.
Group IV Project Report: Patient Protection and Affordable Care Act (PPACA)

Project: Given the changed political landscape, at the state and federal levels, outline what you foresee as major modifications to the ‘Patient Protection and Affordable Care Act’ over the next two years. What and who will be the main drivers of these changes?

Group Members: Col Dean Borsos, USAF; COL Roger Fiedler, USA; CAPT Beth Fritsch, USPHS; Col Robin Hunt, USAF; COL Thirsa Martinez, USA; Lt Col Susan Moran, USAF; CAPT Matthew Newton, USN; Ms Linda Reynolds, VHA; CAPT Mary Riggs, USN; COL Pat Sargent, USA; CAPT John Shapira, USN; Col Bob Tetla, USAF; Ms Judy Trawick, FOH/PSC/HHS; Dr Windia Wilbert, VHA.

Report: The Patient Protection and Affordable Care Act (PPACA) is the most comprehensive and complex health care law passed in almost 50 years. Accordingly it will experience numerous modifications over the next few years; some pertain to interpretations as the law is implemented while others will be driven by industry interests, state concerns and the political environment as Congress debates the role of the government and fiscal problems.

Focusing on the law as it exists, defining the Accountable Care Organizations and national standards or basic plan requirements for American Health Benefit Exchanges drive the need for more regulations to clarify their operations. In addition, endeavors to refine how to fill the “donut hole” for Medicare prescription drug coverage could result in changes to the original intent or desired outcomes of the law as lobbyist for consumer groups and health care industry agencies attempt to influence the effects of the law’s operations. The pharmaceutical industry, America’s Health Insurance Plans, American Medical Association and other physician organizations, American Hospital Association (AHA), AARP, etc., all have a financial stake in the outcome. Likewise, the American Health Care Administration will want to ensure the nursing home industry’s interests are considered while the transition to home and community-based services are drafted in the Community First Choice Option and voluntary long-term care insurance program. Similarly, health care agencies such as the AHA may seek to delay or “phase in” implementation of the hospital Value-Based Purchasing program in traditional Medicare programs.

An inadequate supply of primary care providers could also drive modifications to the law as consumers may not be able to access needed health care; this could be localized or systemic. The law addresses the need for increasing the number of primary care providers but does not have dedicated funding to fully resolve the issue. The drivers for change could come from a variety of aspects, including demands by patients and their advocacy groups if they perceive a rationing of health care.

Additionally, modifications could occur as states begin implementation because of their responsibility for enactment of the law’s provisions, especially those concerning insurance exchanges and the transition of Medicaid clients into the comprehensive system created under the law. Changes in Medicaid growth and the need for better defined or standardized coverages could drive increased expenditures, thus states may request delays in the implementation timeline, augmentation of their budgets or other benefit or eligibility considerations. Furthermore, while the “individual mandate” does not take effect until 2014, the law requires states to have insurance exchanges ready to operate prior to then. If a state does not develop its own insurance exchange, and considering many states are challenging the law, the federal government must establish an insurance exchange in that state...doing such would likely occur within the next two years.

As part of the current political landscape, several Republican governors sent a letter to the Health and Human Services Secretary requesting modifications, including: complete flexibility on operating the exchange and deciding which insurers are permitted to offer products; states chose benefit rules; waive provisions
affecting consumer-driven health plans, such as health savings accounts; ability to move non-disabled Medi-
caid beneficiaries into exchanges; comprehensive plan for verifying incomes and subsidy amounts for
exchange participants that is fully funded by the federal government; and evaluation of persons transitioning
to insurance exchanges with an estimation of the costs.

Consistent with the provision of health care over the past one hundred years, other factors such as
technology and pharmacology could affect implementation. This would likely occur more at the operational
than strategic level, nonetheless the introduction of new technologies and research can influence practice
patterns, demand and costs...perhaps for the better such as many surgeries that are now performed in an
ambulatory instead of an inpatient setting, but not always due to consumer demand for use of services. The
AHA and others may request delayed implementation of the standardized Electronic Health Record and
Electronic Health Information Exchange until a universally accepted industry standard is developed.
Likewise, advances in pharmaceuticals can affect practice patterns by enabling treatment of patients on an
outpatient or primary care basis vice needing surgery.

Some have referenced the need to repeal the law based upon fiscal concerns and budget deficits. Others
reference the need to refine implementation of the law based upon funds that will be lost, as savings have
already been programmed in reimbursement rates, if the law is repealed and suggest pursuing the portions
of the $1.2 trillion identified as health care waste as a means to further substantiate fiscal viability. Said
areas which could be addressed by the Independent Payment Advisory Board or other government entities
include behavioral (i.e., life style aspects of obesity, smoking, alcohol abuse), clinical (i.e., medical errors,
defensive medicine, treatment variations, preventable readmissions) and operational (i.e., claims processing
and fraud, staffing, system inefficiencies).

Timing driven by partisan politics could also influence the final state of the law. The 2012 election and oppo-
sition to the law could impede implementation via attempts to make it ineffective by de-funding aspects and
processes critical to enforcement of the components.

Outcomes more significant than modification could exist as legal challenges for the law continue. State and
federal authorities have conflicting interpretations as it pertains to implementation and constitutionality of
the law. To date, 26 cases against the law have been filed in state courts. While many have been dismissed,
five have reached a constitutional mandate and two of those are continuing through the appropriate Federal
Appeals courts for further adjudication. These cases will likely reach the level of the U.S. Supreme Court
for final resolution on the constitutionality of the law. Expert legal opinion on both the timing and final outcome
of said cases are divergent. As such, some in Congress may be willing to make modifications to the law to
ensure constitutionality. However, the strength of those against the law may render any evidence of support
or willingness to compromise politically untenable for Republican lawmakers.

In summary, the PPACA could extend access to insurance coverage to millions of Americans who are unin-
sured and end some controversial insurance industry practices. Due to its complexity and cost, however,
there are going to be legal challenges to the health care industry and the political drive or influence a-
tions. Likewise, the debt, operational issues groups could affect aspects of the PPACA as

Drivers for modification of PPACA at multiple levels:

✓ Federal
  - Divided legislature with energetic opposition
  - Constitutional challenge at Supreme Court
✓ States
  - Major elements of implementation
  - Profound implications for budget/autonomy
✓ Business and Professional interest groups
  - Radical re-shaping of long established business rules

“Lessons Learned from Other Countries,” session hosted at the Australian Embassy, March 31, 2011. In photo, L to R, Mr. Brendan Wall, Director, Cultural Relations; Col Jeff Quirk, Chief of Staff and Assistant Defence Attaché; Ambassador Kim Beazley; Lt Col Mitch Kent, Assistant Military Attaché; Dr. Richard Southby, Director, IAI; and Dr. Lesley Russell, Visiting Fellow at the Center for American Progress.