

FUTURE OF HEALTH CARE: DELIVERY SYSTEM CHANGES

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CURE Activity
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Health Care Reform 2010



- ▣ "The future is not what it use to be"
 - ▣ Yogi Berra

OBJECTIVES:

- ▣ Identify three main drivers of excessive health care costs in US.
- ▣ Describe delivery system reforms in the Patient Protection and Affordable Care Act related to bending the health care cost curve.
- ▣ Describe two payment delivery reforms designed to improve quality and reduce costs.

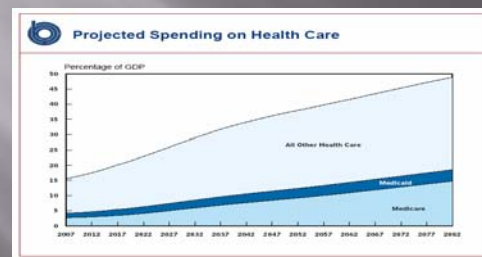
Achievement of Patient Protection and Affordable Health Care Act

- ▣ Landmark Bill Providing a Pathway for Affordable Health Care Coverage for all American Citizens by 2014
- ▣ Instead of 60 million uninsured, an additional 32 million will have coverage

Key Challenge

- ▣ Provide Near Universal Access to Affordable Coverage
- ▣ What about Controlling This Unsustainable Growth Rate in Health Care Costs???

Total health spending will grow from \$2 trillion in 2005 to \$4 trillion in 2015 and continue to consume larger share of GDP for rest of the century



Statement of Peter R. Rossi, Director, Growth in Health Care Costs, Congressional Budget Office, before the Committee on the Budget United States Senate, January 31, 2008
www.cbo.gov/ftpdocs/080408/080408main.pdf

Unsustainable for Average American Family

- By 2017, a middle-income family that earns \$80,000 could end up *spending more than four out of every 10 dollars they earn on health care alone*, before any deductions for taxes or fringe benefits are taken out of their gross wages.

Economist Uwe Reinhardt,

<http://economix.blogs.nytimes.com/2008/11/07/the-health-care-challenge-sailing-into-a-perfect-storm/>

Unsustainable for Our Government

- By 2017, Medicare's Part A trust fund, which pays for hospital care, *will run out of money* and become insolvent.

Social Security Administration,

<http://www.ssa.gov/OACT/TRSUM/index.html>

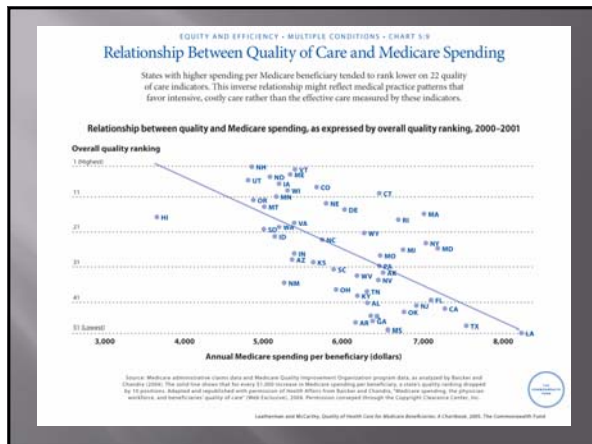
- Why? There will not be enough working taxpayers to support growth in # of beneficiaries.

For Business

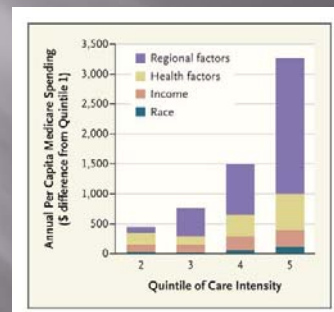
- "The nation's approach to delivering health care is inefficient, ineffective, and unsustainable. For individual patients seeking care as well as for large companies trying to stay competitive and create jobs in the United States, health care costs too much and offers too little value in return."

- Paul Grundy, Global Director of Healthcare Transformation of IBM

Regional Variation in Cost and Quality



Proportion of Higher Regional Medicare Spending Attributable to Differences in Race, Income, Health Factors, and Regional Factors



Sutherland J et al. N Engl J Med 2009;361:1227-1230

Annual Utilization Rates and Spending on Hospital Services and Selected Physician Services in Regions with Various Levels of Intensity of Care

Type of Care	Level of Medicare Spending per Medicare Beneficiary				
	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Inpatient days per beneficiary	1.4	1.6	1.8	2.1	2.1
Physician visits per beneficiary	10.7	12.1	13.0	13.6	14.5
MRIs per 100 beneficiaries	16.6	17.6	19.3	19.7	21.9
CT scans per 100 beneficiaries	46.9	54.0	58.7	61.2	61.4

* Utilization data are from authors' analyses of the 2004 and 2005 Medicare physician (Part B) claims and Medicare Provider Analysis and Review data and represent annual rates of selected services and per-beneficiary spending on physician services (adjusted for regional differences in age, sex, and race). The data on computed tomographic (CT) and magnetic resonance imaging (MRI) scans are numbers per 100 beneficiaries, not numbers of beneficiaries undergoing these procedures; many beneficiaries undergo multiple scans in a single year.

Sutherland J et al. N Engl J Med 2009;361:1227-1230

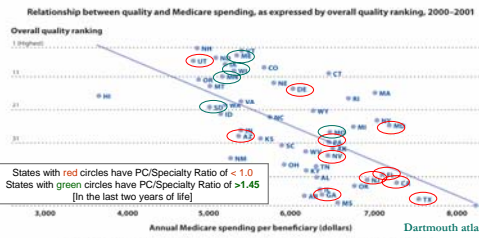
Importance of Primary Care

Primary Care Associated with Decreased Costs

- According to the Center for Evaluative Clinical Sciences at Dartmouth, for patients with severe chronic diseases, those who live U.S. states that relied more on primary care have:
 - Lower Medicare spending (inpatient reimbursements and Part B payments)
 - Lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor)
 - Lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians)
 - Better quality of care (fewer ICU deaths and a higher composite quality score)

Relationship Between Quality of Care and Medicare Spending

States with higher spending per Medicare beneficiary tended to rank lower on 22 quality/cost impact of care indicators. This inverse relationship might reflect medical practice patterns that favor intensive, costly care rather than the effective care measured by these indicators.



Primary Care Strength and Premature Mortality in 18 OECD Countries



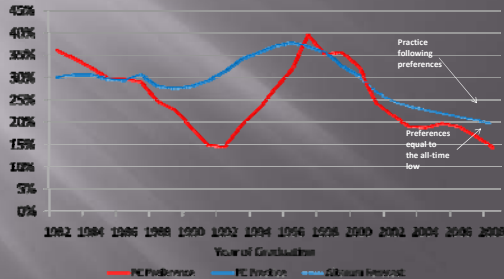
* Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. $R^2(\text{within})=0.77$.
Source: Macinko et al. Health Serv Res 2003; 38:831-65. Starfield 09/04 IC 2953

ACP review of impact of primary care on outcomes and costs

- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke
- An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons
- During the year 2000, an estimated 5 million admissions to U.S. hospitals may have been preventable with high quality primary and preventive care treatment; cost was more than \$26.5 billion.
- A 5 percent decrease in the rate of potentially avoidable hospitalizations could reduce inpatient costs by more than \$1.3 billion

How is a Shortage of Primary Care Physicians Affecting the Cost and Quality of Medical Care: A Comprehensive Literature Review. ACP, 2008

USMGs preferences for primary care



Sources: AAMC Graduation Questionnaire (preferences), AMA Masterfile (practice), Altamur analysis (forecast)

Collapse of Primary Care

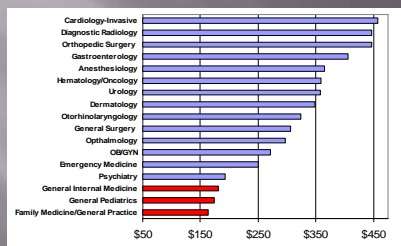
- Over 100 studies show primary care is associated with better outcomes and lower costs of care
American College of Physicians. How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?. Philadelphia: American College of Physicians; 2008; White Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.
- Shortage of 35,000–44,000 adult primary care physicians by 2025. Population growth and aging will increase family physicians' and general internists' workloads by 29% between 2005 and 2025.
Colwill JM, Cultice JM, Kruse RL. Will generalist physician supply meet demands of an increasing and aging population? Health Aff (Millwood). 2008 May-Jun;27(5):w232-41. Epub 2008 Apr 29

FEE FOR SERVICE

Failure of Fee for Service

- Incentivizes volume over value//quantity over quality
 - Exacerbated by the third party payer system
- Specialists over primary care
- Procedures over listening, physical exam, and coordination of care

Primary Care Income Less Than Most Other Specialties Median Salary by Specialty in thousands of dollars, 2006



Source: MGMA Physician Compensation and Production Survey, 2007; slide from AAMC Physician Workforce Research Conference, IM Subspecialty Meeting, April 29, 2009

Source: MGMA Physician Compensation and Production Survey, 2007

Direct Effect on Primary Care

- Reimbursement only for physician provided care
- Reimbursement only for face-to-face care

Direct Effect on Primary Care

Table 1. Volume and Types of Services for an Active Caseload of 8440 Patients at Greenhouse Internists in 2008.[§]

Type of Service	Total No.	No. per Visit	No. per Physician per Day†	No. per Patient per Yr
Visit	16,640	NA	18.1	2.0
Telephone call	21,796	1.31	23.7	2.6
Prescription refill	11,145	0.67	12.1	1.3
E-mail message	15,499	0.93	16.8	1.8
Laboratory report	17,974	1.08	19.5	2.1
Imaging report	10,229	0.61	11.1	1.2
Consultation report	12,822	0.77	13.9	1.5

§ Patients were included in the active caseload if they had any interaction with the practice in the listed categories of activities during calendar year 2008. NA denotes not applicable.
† The values are based on the work of four full-time-equivalent physicians who each worked 50 to 60 hours per week for 230 workdays per year.

Baron R. N Engl J Med 2010;362:1632-1636

PPAAC Provisions for Addressing these Drivers

- ❑ Fee adjustment based on regional variation
- ❑ Increase Primary Care Reimbursement 10%
- ❑ Raise Medicaid rates to that of Medicare for Primary Care 2013-2014.
- ❑ Sec HHS to study and adjust over-valued RBRVS defined services
- ❑ Expand educational training in primary care and availability of scholarships and loan forgiveness programs for primary care
- ❑ Workforce Commission
- ❑ IPAB
- ❑ Center for Medicaid and Medicare Innovation

New Models of Health Care Delivery

- ❑ Patient Centered Medical Home (PCMH)
- ❑ Accountable Care Organizations (ACO)

Patient Centered Medical Home

- ❑ Revitalize Primary Care
 - First contact
 - Continuous
 - Comprehensive
- ❑ 21st Century Responsibilities for Systematically Improving the Health of the Medical Home's population

Joint Principles Patient Centered Medical Home

Personal physician in physician-directed practice

Whole person orientation

Coordinated care, integrated across settings

Quality and safety emphasis

Enhanced patient access to care

Supported by payment structure that recognizes services and value

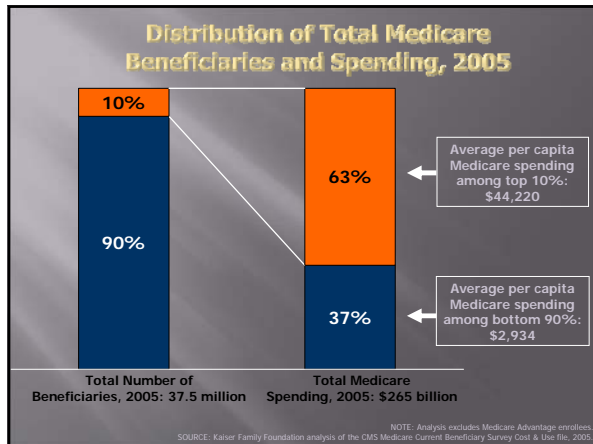
Team-based care:
NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Social Worker
Community resources
DM companies
Others...

PCMH Paradigm Shift

- ❑ Current Goal of Primary Care Provider
 - Get through the day of scheduled patients in time for supper
- ❑ New Goal: What can my primary care team that I lead do today to make our panel of patients as healthy as possible



Margolius D, Bodenheimer T. Transforming Primary Care: From Past Practice to the Practice of the Future. Health Affairs 29, No. 5(2010):779-784.

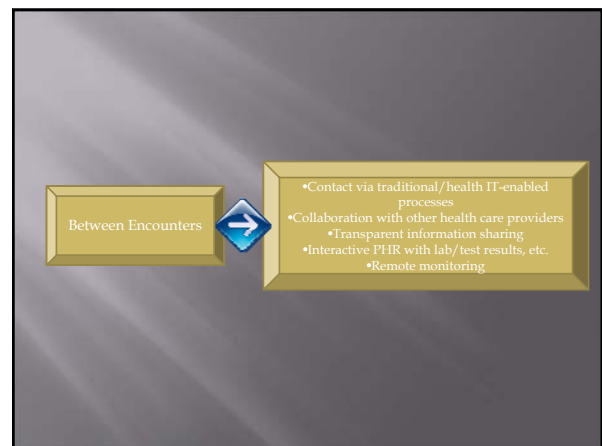


- ### Transition to PCMH
- End the tyranny of the 15 minute visit
 - Expanded access and enhance communication in and out of office
 - Stratification of patient population and role transition of the team
 - HIT
 - Chronic Disease Management
 - Test/Referral Tracking
 - Performance Measurement
 - Workflow redesign

- ### New Physician Roles as Team Leader
- No longer feasible for primary care doctor to take sole responsibility for acute care, chronic disease management, and prevention services
 - Spend time coordinating activities of staff
 - Creating and supervising systematic processes aimed at maximizing the extent to which the practice's entire population of patients received indicated preventive care and care management for chronic illness
 - Spend time using measurements of performance to identify and act on areas for improvement
- Casalino LP. A Martian's Prescription for Primary Care: Overhaul the Physician's Workday. Health Affairs 29, No.5 (2010):785-790.

- ### Four Major Value Generating Elements of PCMH
- Non-physician care coordination
 - Expanded access to physician and team
 - Round the clock availability
 - Non face-to-face methods
 - Accessible real-time data to manage performance and track patients
 - Effective incentive payments

What Does this Look Like - and How Do You Get There?



PCMH/Payment

- 1) "Bundled Care" Coordination Fee
 - Physician/non-physician work outside of face-to-face visits (e.g. email, telephone/group visits)
 - Promoting efficiency rather than volume-based care
 - System infrastructure (e.g. HIT)
 - Encourage coordination of care
 - Risk adjusted
 - Remove incentives to avoid complex or costly patients

PCMH/Payment

- 2) Visit based fee-for-service
 - Incentive to physician to see patients in office when appropriate
- 3) Performance based component
 - Recognize achievement of quality and efficiency

Community Implications of PCMH Projects to Date

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits; 11% reduction in ambulatory care sensitive admissions
- Improvements in diabetes and heart disease care
- Cost neutral after 1 year

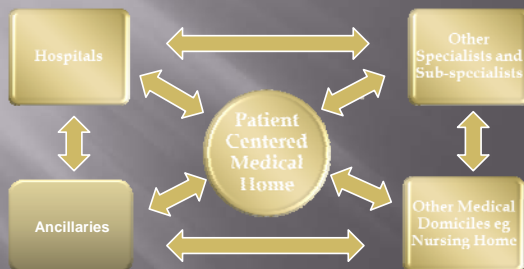
Geisinger Health System

- 39% decrease in ER visits
- 24% decrease in hospital admissions
- Reduction in costs

Accountable Care Organizations

- Requires 3 groups working as a unit
 - Primary Care
 - Specialists and Subspecialists
 - Hospital
- Shared responsibility for quality and cost of care received by ACO's patients
- Quality and Cost targets- If achieved, then ACO eligible for bonus. If not, could be subject to reduced Medicare payments.

Idealized Accountable Care Organization



Key Components

- Define processes to promote care quality, report on costs, and coordinate care
- Develop a management and leadership structure for decision making
- Develop a formal legal structure that allows the organization to receive/distribute bonuses to participating providers
- Include the PCP's of at least 5,000 Medicare beneficiaries

Multiple Payment Structures

- ▣ Preserving Fee-for-Service
 - One-sided shared-savings model
 - Two-sided or symmetric model
- ▣ Partial to full capitation
- ▣ Budget projection using actuarial methods based on historical spending and utilization data of the actual group to establish the target

Physician Organization Structures

- ▣ Integrated Health System
- ▣ Multi-Specialty Group
- ▣ Physician Hospital Organization
- ▣ Independent Provider Association



Questions?

Evaluation

<http://www.surveymonkey.com/s/CURE5>