From Painter’s Pallet to Picture: What Healthcare May Look Like in the Future

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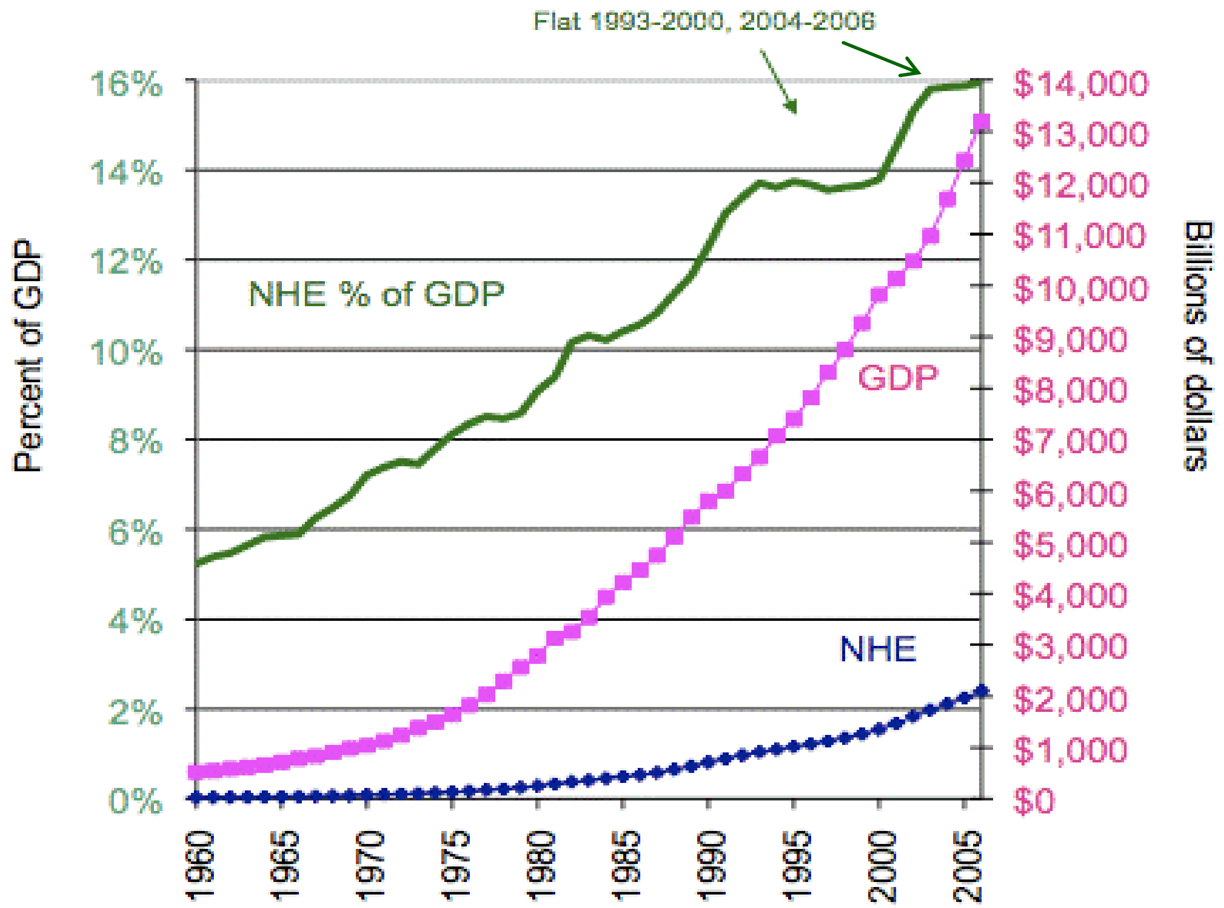
US Expenditures in healthcare are increasing



The green line shows the percentage of the gross national product going to national health expenditure. It is measured by the scale on the left axis.

The purple line, for gross domestic product (GDP)

The blue line, for national health expenditure (NHE), are measured by the right axis scale.

There is a sense that healthcare is a burning platform

- Healthcare expenditures continue to increase
- Lack of clarity and consensus about healthcare reform (PPACA)
- Patients are bearing increased costs...and therefore in some cases not seeking the care they need
- Most of the expenses occur at end of life and we do not know how to manage this
- We are woefully behind in delivering high quality care

There are numerous questions that need to be analyzed before we can figure out what healthcare will look like in 2015

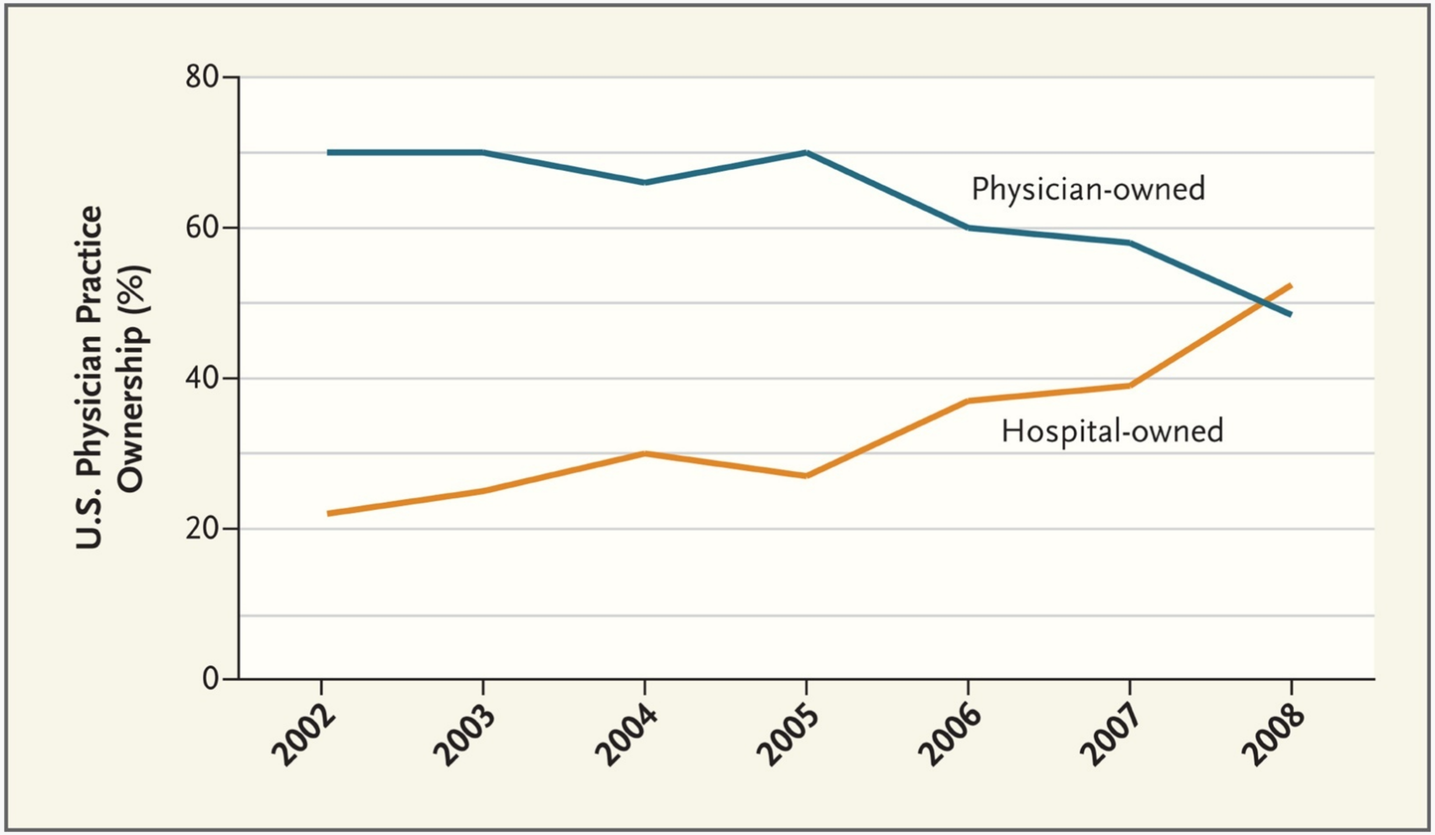
Presentation

- Landscape for stakeholders
  - Providers
  - Patients
  - Payors
  - Government

- What does the future look like

- How can we make it better

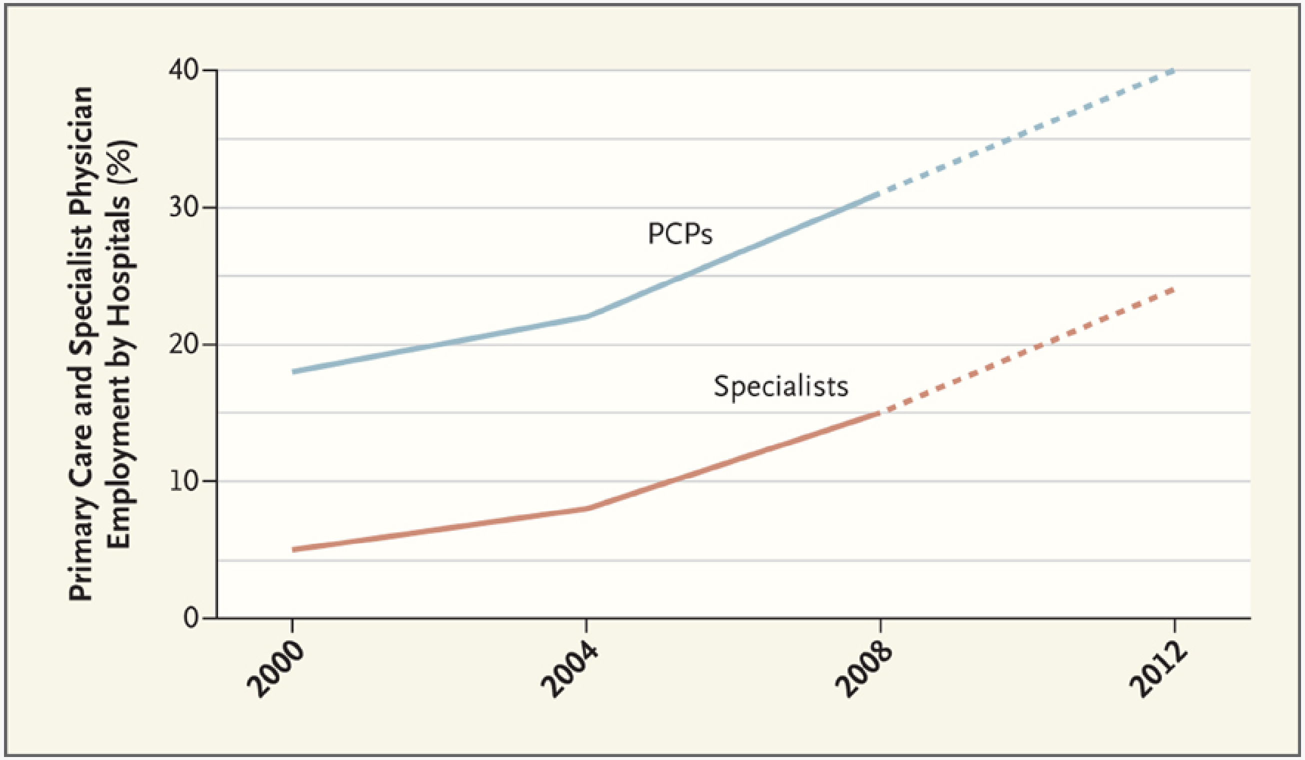
Physicians: the number of independent practices is contracting



75% increase in number of doctors employed by hospitals since 2000

Hospitals' Race to Employ Physicians — The Logic Behind a Money-Losing Proposition
NEJM | March 30, 2011 | Topics: Health Care Delivery

And the trend for hospital employment includes specialists



- In previous graph, 53% of practices were owned by hospitals in 2008
- In 2008, 32% of PCPs are employed by hospitals
- This implies more small practices are being employed by hospitals than large practices.

We are moving towards large independent practices and hospital employed physicians – both are team based.

Hospitals' Race to Employ Physicians — The Logic Behind a Money-Losing Proposition
NEJM | March 30, 2011 | Topics: Health Care Delivery

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There is a looming shortage in non-primary care specialties

HRSA Study Portends a Looming Crisis in Nonprimary Care Subspecialties				
	2000	Projected Supply in 2020	Projected Demand in 2020	Shortage
Primary Care total Includes: General Family Practice, General Internal Medicine, and Pediatrics	267,100	344,700	337,400	7,300
Nonprimary Care total	466,800	521,700	584,100	-62,400
Medical Specialties Includes: Cardiology and Other Internal Medicine	85,400	101,300	119,800	-18,500
Surgical Specialties Includes: General Surgery, OB/GYN, Ophthalmology, Orthopedic Surgery, Other Surgery, Otolaryngology, and Urology	159,400	169,800	205,100	-35,300
Other Specialties Includes: Anesthesiology, Emergency Medicine, Pathology, Psychiatry, Radiology, and Other Specialties	200,900	250,600	259,200	-8,600

Source: Source: U.S. Department of Health and Human Services, Health Resources and Services Administration; http://bhpr.hrsa.gov/healthworkforce/reports/physicianworkforce/adequacy.htm, Exhibit 51, Baseline FTE Supply Projects of Active Physicians, and Exhibit 52, Baseline Physician Requirements Projections

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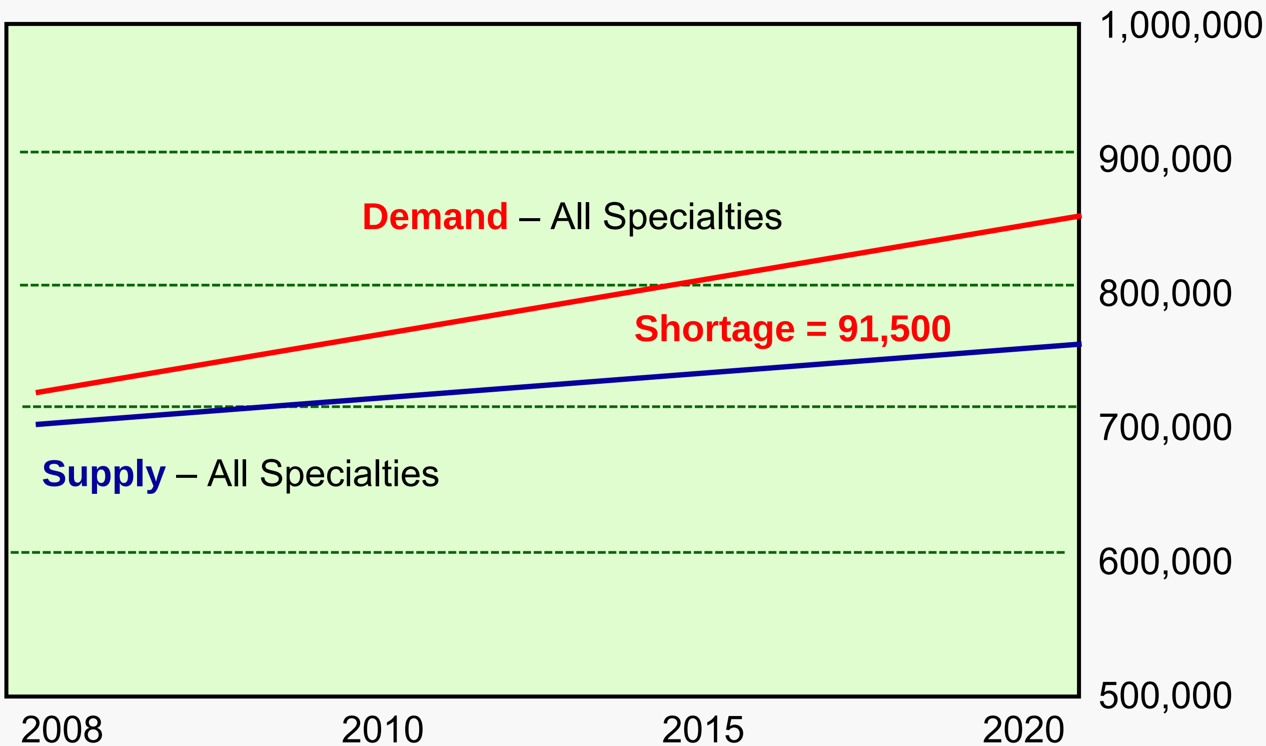
Separate study by AAMC shows an even larger shortage of physicians

Projected Supply and Demand, Physicians, 2008-2020



Source: AAMC Center for Workforce Studies, June 2010 Analysis

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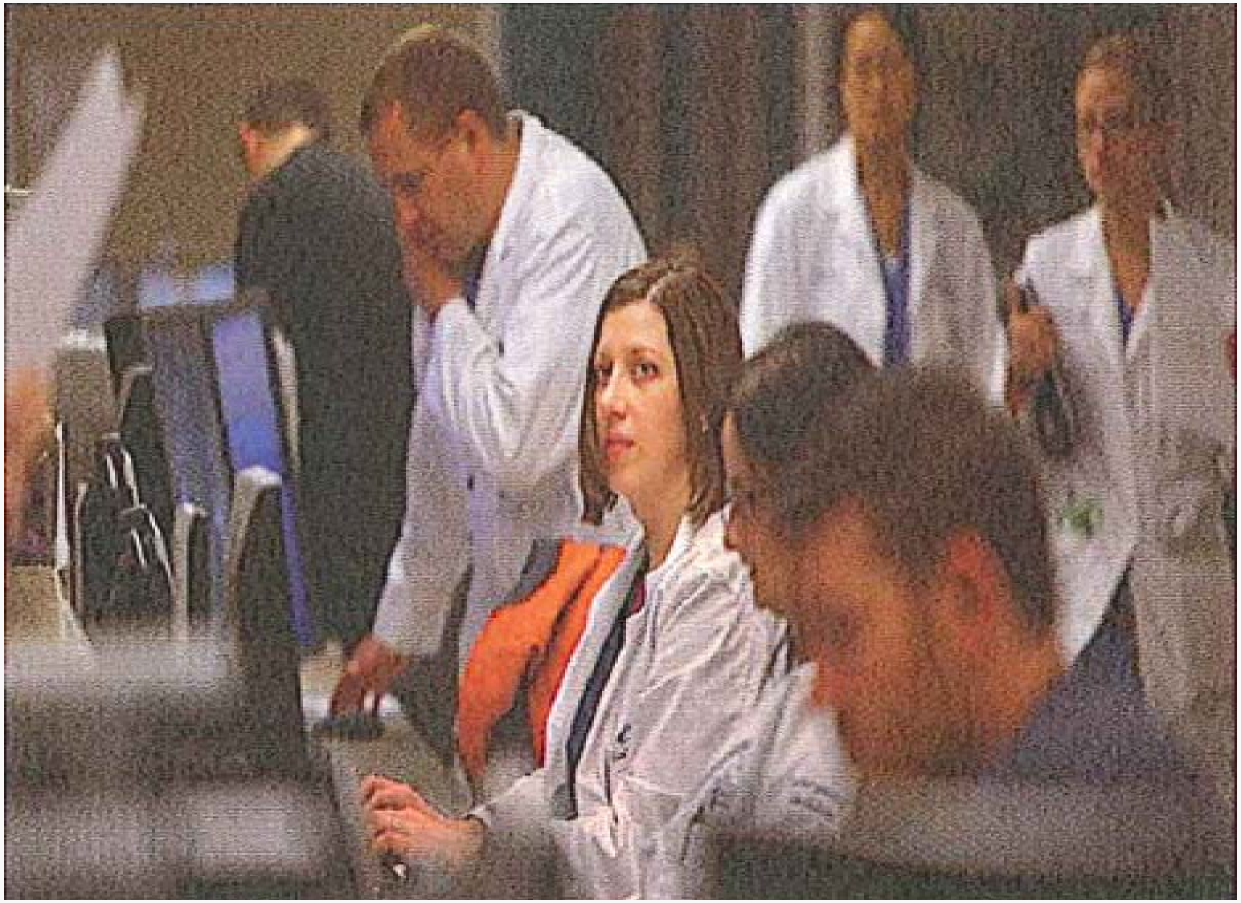
On top of a shortage, physicians are working less hours – they want a life

More Physicians Say No to Endless Workdays



Nicole Bengiveno/The New York Times
Dr. Kate Dewar, daughter of a doctor, chose work in an emergency room over private practice.

New York Times, 4-2-11

Patients: yet demands for medical care are increasing

- PPACA (Patient Protection and Affordable Care Act)
  signed into law on March 23, 2010
  It is estimated that approximately 24 million will purchase through the AHB Exchanges by 2019

  **Congressional Budget Office*

- Aging population:
  3.3 workers per retiree in 2010
  2.0 workers per retired in 2050

  **US Social Security Administration*

The net result of less physician time and more demand is that many patients will go without care

Cuts Leave Patients With Medicaid Cards, but No Specialist to See

Michael Stravato for The New York Times
Dr. Rachel Chatters, right, with Ana Smith, says she begs specialists to see Medicaid patients.

New York Times, 4-2-11

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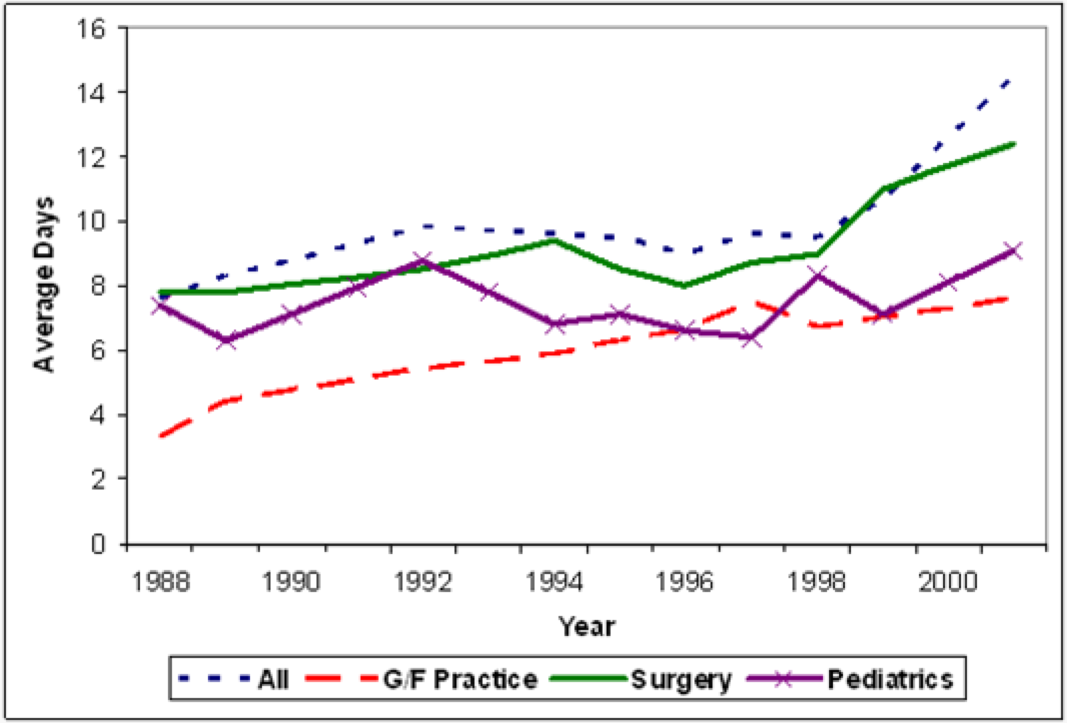
And the decreased total hours of medical coverage is reflected in worsening service

Average Days of Wait for an Appointment by New Patients



Source: AMA Physician Socioeconomic Statistics (various years)

In addition to less access to care, patients are taking on more and more of healthcare costs

- The Boston Globe March 25, 2011
  More opt for low-cost coverage
  Number of Massachusetts residents enrolled in high deductible health insurance plans nearly doubled last year

- Deloitte: Out-of-pocket healthcare April 5, 2011
  Expenses are much higher (20% of household income than previous estimate of 16.3%)

- Hewitt Associates September 27, 2010
  "Healthcare premiums have more than doubled in the past decade and employees' share have more than tripled"

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Payors: carriers are also being squeezed

- Smaller employers may opt out of providing employer sponsored coverage; so employees will shop for more competitive products

- Many larger employers are offering self-funded plans

- Health care exchanges start in 2014 and will increase competition for low-cost products

- PPACA sets medical-loss ratio at 85% which puts pressure on payors to decrease administrative costs

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Government Accountable care organizations

ACO = *Any consultant's opinion*

- Mythical
- Huge powers
- Nobody has ever seen one

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Accountable Care Organizations: Executive Summary

- ACOs are incentives for health care providers to help across systems to lower costs and improve quality of care of Medicare beneficiaries

- Regs came out on March 31, 2011

- Participation is voluntary

- Can be physician or hospital based

- The ACO must take responsibility for at least 5,000 beneficiaries for 3 years

- Amount of shared savings depends on whether the ACO exceeds quality standards

    - ➢ One sided risk model of share in saving for first two years and accountable for any losses in third year
    - ➢ Two sided risk model for more experienced ACOs that shares in savings and risk for all three years

- Could save Medicare $960M over 3 years

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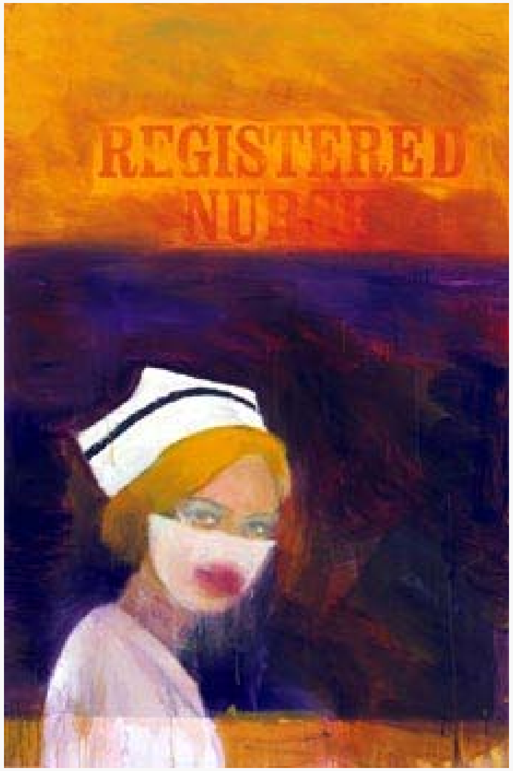
The future picture of healthcare is looking a little eerie



Richard Prince
Registered Nurse, 2002

- Providers get frustrated with 100's of performance metrics to follow and more and more pay at risk
- Patients get less care, including preventive care such as vaccines/cancer screening
- Smaller carriers go under, resulting in less competition
- ACOs get everyone excited, lots of effort goes into them, and they may fail
- Health care as a percentage of GDP continues to increase

What can we do to change this picture?

There are only so many options to address a decreasing supply of physicians yet increasing demands (patients)

- Keep population healthy so they don't need as much care

- Expand definition of provider

- Improve efficiency (i.e. throughput)

Keep population healthy: Centers for Medicare and Medicaid Services Physician Group Demonstration Project

- Goals – Improve efficiency (decrease costs) while improving quality (measured on 32 quality metrics) for assigned vs. comparison group of Medicare beneficiaries in *the same geographic location* getting care from non-site providers
  - Improve coordination b/t Part A & Part B expenditures
  - Align reimbursement with quality
  - Reward for improving health outcomes
- Marshfield Clinic selected as 1 of 10 participating sites nationally
- All are groups of > 200 physicians
- Long term commitment –
  - Application 2003
  - Baseline data 2004
  - Originally 3 years starting 4/1 annually
  - Extended to 5 years (currently in 5th year)

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One of Ten in the Nation

- Dartmouth-Hitchcock Clinic– Hanover, NH
- Deaconess Billings Clinic- Billings, MT
- Forsyth Medical Group– Winston-Salem, NC
- Geisinger Clinic– Danville, PA
- Integrated Resources for Middlesex Area– Middletown, CT
- Marshfield Clinic– Marshfield, WI
- Park Nicollet Health Services– St. Louis Park, MN
- St. John's Health System– Springfield, MO
- The Everett Clinic– Everett, WA
- University of Michigan Faculty Group Practice– Ann Arbor, MI

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CMS PGP PY3 Overall Results

- Marshfield Clinic exceeded 98% of the quality metrics set by the CMS
- Marshfield Clinic earned a performance payment of $13.8 Million while saving the CMS $23 Million.
- Four other sites earned performance payments in the $2 - $4 million range each
- Quality measures have continued to improve while the number of quality metrics have increased

Expand definition of provider: increase use of PA / APNs, RNs…

- Both patients and physicians need to get over “physician centric”

- It makes no sense (including financial sense) for physicians to be spending their time doing something a less expensive healthcare provider can do

- We need to use PA/APNs wiser than we do – there is little literature on best practices on incorporating PA/APNs in care pathways

Remember, medicine is moving towards team based care

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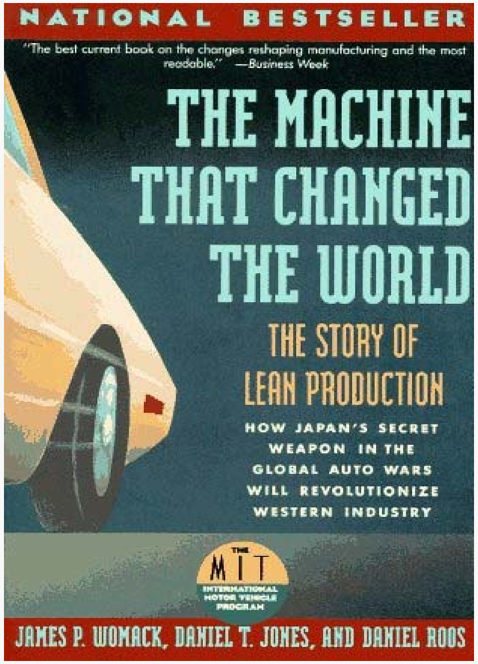
Improve efficiencies through Lean, which is based on based on Toyota Production System

Toyota Production System (TPS)

"This is the manufacturing system developed by Toyota which pursues optimum streamlining throughout the entire system through the **thorough elimination of *Muda* (waste)**, and aims to build quality in at the manufacturing process while recognizing the principle of cost reduction. "

Taichii Ohno



"Lean production" was coined by MIT researcher and publicized in this 1990 book to describe TPS

Lean is about delivering more value with less resources (cost)

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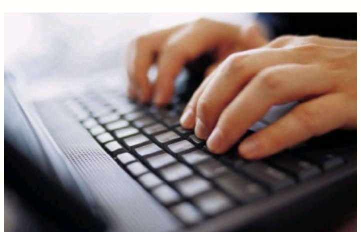
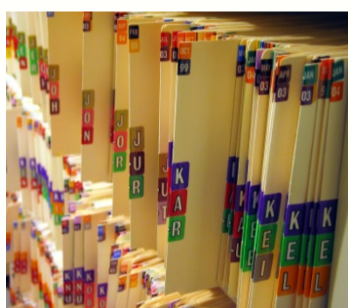
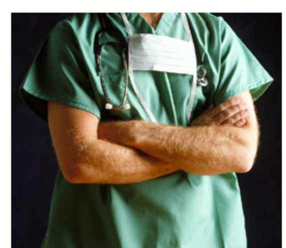
Waste is seen in hospitals in eight common forms

Wasted motion	Wasted transportation	Wasted intellect	Excess inventory
▪ Pharmacy tech spends 15 minutes looking in multiple places for a specific medication 	▪ 30% of patients admitted to 3NT are transferred to a unit with a similar level of care within 36 hours of admission 	▪ Numerous ideas are "lost" only to be rediscovered later 	▪ Medicines held over the shelf-life because of excess ordering 

Rework	Excess processing	Waiting time	Overproduction
▪ Scheduler has to reenter 20% of requests because of wrong side indication 	▪ Nurse records pulse rate on 4 different forms in the chart 	▪ OR team waits 45 minutes for a case to begin, and is not free to do other tasks 	▪ Admissions paperwork having 6 redundant pages out of a 20 page packet 

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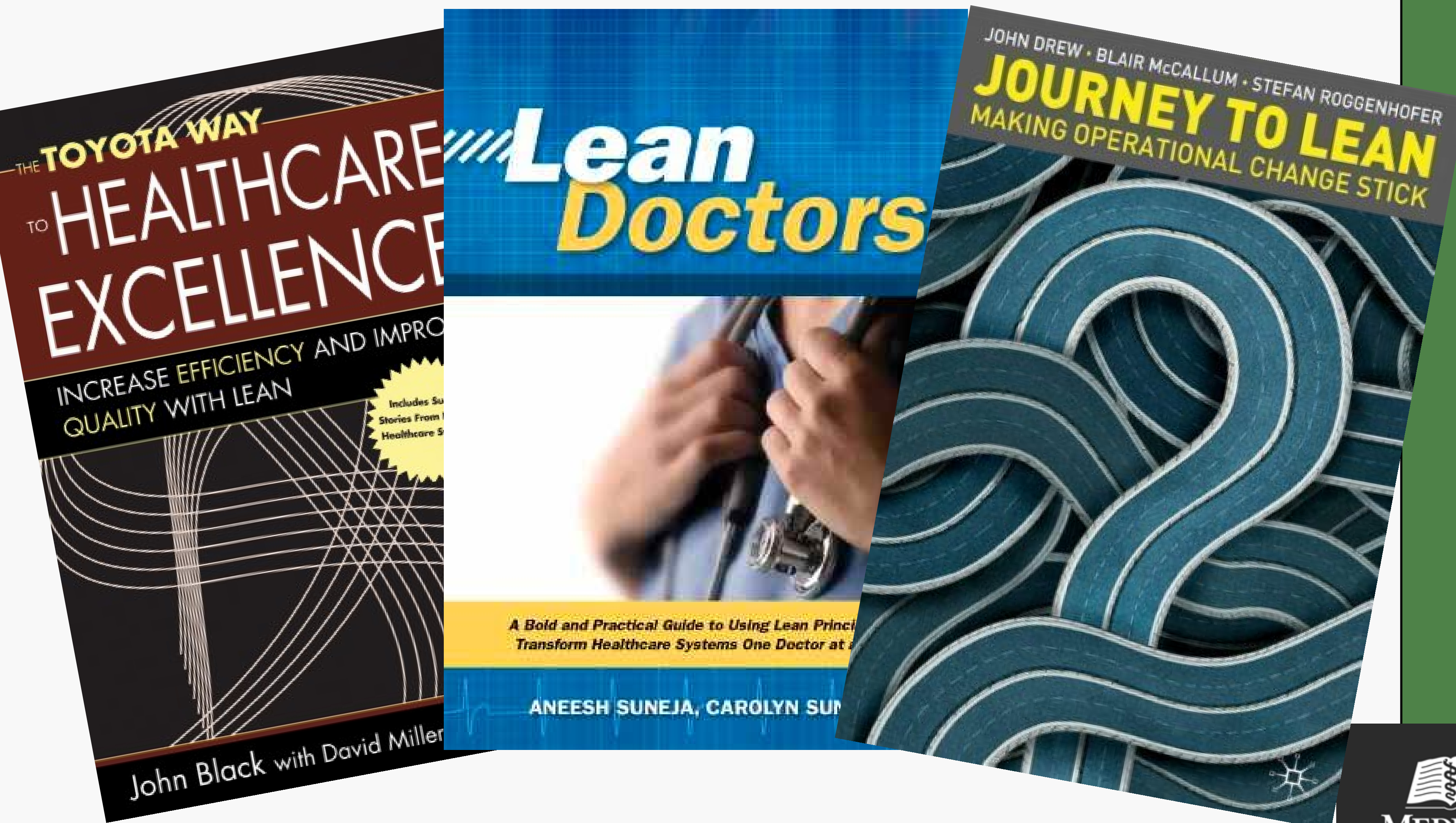
Lean and operations is not complicated: it can be learned and applied by everyone



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When people pay out of pocket they tend to look more carefully at what they are buying than if it was free (or nearly free…as in low deductibles)

When people buy something, they want to know:

- how much will it cost
- what am I getting for my money

…this is value (what I get/cost)

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Patients have increasingly better access to outcomes

Hospital death rates unveiled for first-time comparison

By Bradley C. Bower for USA TODAY
August 20, 2008

Physician Nainesh Patel observes the status of a patient's arteries and heart on a computer screen at Lehigh Valley Hospital in Allentown, Pa. It's one of the top hospitals in the country, according to a new government analysis obtained by USA TODAY.

Patients are going to pay more out-of-pocket for healthcare and that will put pressure on providers to deliver value

Patients will:

- Likely have less elective surgery
- Increase use of generics
- Demand transparency about prices for care
- Take more responsibility for their own health
    - ➢ increase use of internet for fact-finding, self-diagnosing, and treatment tips
    - ➢ use social media to find out how others, with similar problems, take care of themselves
- Need to learn about quality and where to find publically reported quality scorecards

Payors will put more pressure on patients and providers

- There will be more P4P
  - ➢ decrease readmissions
  - ➢ increase use of generics
- More out-of-pocket expenses for patients (not necessarily a bad thing)
- Incentives to push care to ambulatory settings

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And everyone, including payors, are seeing more transparency in hospital/providers quality and cost (utilization rates)

Wisconsin Health Information Organization (WHIO) goals:

- To **aggregate health care data** from sources across the State of Wisconsin
- To **create a single reliable data source** that can be used by multiple stakeholders to examine variations in efficiency, quality, safety and cost
- To improve the quality, cost, safety and efficiency of Wisconsin health care by **sharing the results** with providers, purchases and patients
- To **support provider quality improvement** initiatives
- To **empower patient** to make value-based health care choices

Wisconsin Medical Society
Your Doctor. Your Health.

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WHIO Data Mart Details

- Cost information
  - Actual billed amounts are included and reportable
  - Paid and/or allowed amounts on the claim are standardized to protect confidentiality of the underlying contracts
  - All comparative reporting works from the paid amount field so that the rating compares resource utilization rather than price (contract) variation
- Analytics
  - Impact intelligence Tool attributes (awards) episodes of care to providers, creates peer comparisons and applies a quality and efficiency rating (+/- 1.0)

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WHIO Quality/Cost Index

WHIO - MCW Specialty Index Scores		
Specialty	Quality Index	Cost Index
Cardiology	0.96	1.25
Dermatology	—	1.45
Endocrine	0.92	0.98
Family Practice	0.97	1.01
Gastroenterology	1.04	1.07
General Surgery	—	1.35
Hematology/ Oncology	—	1.14
Internal Medicine	0.97	1.06
Invasive Cardiology	0.97	0.93
Obstetrics / Gynecology	0.88	1.04
Orthopaedic Surgery	1.64	1.19
Otolaryngology	1.06	1.03
Urology	1.04	1.02

- Data from 10/06-9/08
- No quality data Derm, GS, H/O
- Risk adjust

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It may not be the time to be on the leading edge when it comes to ACOs

"Becoming an ACO should be approached as an evolutionary process. We believe that it is best accomplished through incremental steps built on a clinical integration platform."

Kaufman, Hall & Associates

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Some things to think about to improve our picture

- A “burning platform” is the first of Kotters 8 steps to change management. Don’t forget the other 7 steps

- Create urgency
- Form a powerful coalition
- Create a vision for change
- Communicate the vision
- Remove obstacles
- Create short-term wins
- Build on the change
- Anchor the changes in corporate culture

- Take advantage of larger physician/medical teams
  - think standardization of processes, protocols…
  - develop leadership in quality and operations
  - take the “plunge” into EHR
  - share best practices

- Expand use of mid-level providers and use them wisely

- Learn lean

- Focus on improving clinical and service quality
  - use care pathways…forget the “art of medicine” and start thinking standardizing care using EBM
  - read “Best Practice” by Charles Kenney

- Think about your costs, and payor costs – they are all different but related
  - be transparent on costs to the patient
  - focus on utilization using best practices

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Thinking about healthcare issues, and taking a step, even small ones, towards continuous improvement will get us a better picture

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