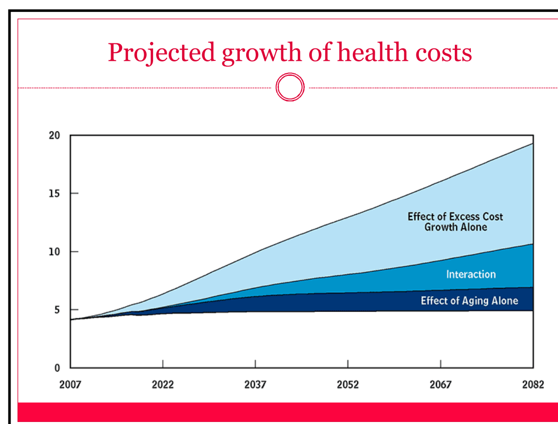
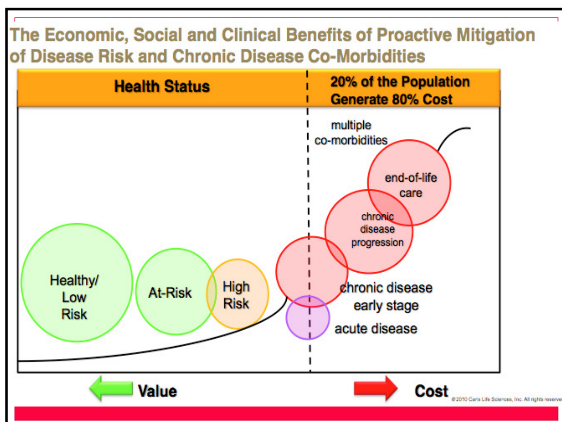
Disclosure

- I will benefit from the new health care law!
  - I will be paid more for what I do
  - I will be able to do the right thing more often
  - I will not be bankrupted by other people

Why is our healthcare so expensive?

- Adminstrative costs are high
- Drug costs are high
- Uninsured people use a lot of resources
- Doctors make a lot of money
- Other contributors
  - “Defensive” medicine
  - End-of-life care
  - Inefficiencies due to record keeping





Where were we?

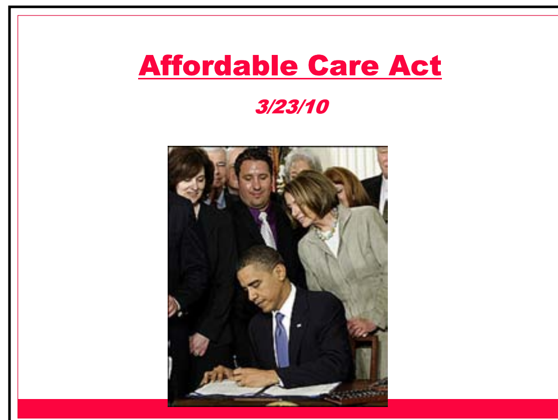
- Silos of episodic FFS care
- Push for EHR and connectivity with only a vague notion of why
- Internet fueled “knowledgeable” patients
- Some accountability for “quality”
- Disconnect between wellness as a preference and illness as a business
- Continuously missed understandings of systems complexity or examples of success

And then there were the patients

- Aging, poorer, yet more demanding
- Looking for help
  - Physical, emotional financial and social well being
- Decreasing loyalty to any system
- Concerned about finances
- Willing to consider different care models

Affordable Care Act

3/23/10

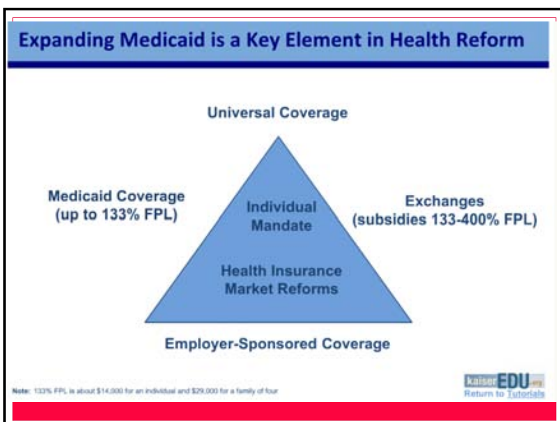


What aspects of the new reality will affect your clinical life?

- Expanded access
  - Community Health Center expansion
  - Medicaid
  - Health Exchanges
- System reform
  - Patient Centered Medical Home
  - Accountable Care Organizations
- Medicare changes
  - Center for Medicare and Medicaid Innovation

Community Health Center funding

Provision	*Patient Protection & Affordable Care Act (HR 3590)*
Health Centers Program Funding & Program Changes	Authorizes and appropriates the following annual amounts to the Community Health Centers program out of a new Public Health and Prevention Trust Fund: • $0.7 billion for FY2011; • $0.8 billion for FY2012; • $1 billion for FY2013; • $1.6 billion for FY2014; • $2.9 billion for FY2015. • TOTAL = $8.5 billion over five years. • Separately authorizes and appropriates $1.5 billion over five years for health center construction and renovation
National Health Service Corps Program Funding & Program Changes	Authorizes and appropriates the following annual amounts for the NHSC: • $290 million for FY 2011; • $295 million for FY 2012; • $300 million for FY 2013; • $305 million for FY 2014; • $310 million for FY 2015. • Allows for teaching to count as clinical practice for up to 50% of



Insurance expansion

- Individual mandate.
  - Exemptions would include religious objectors and undocumented residents.
- Provides for premium and cost-sharing credits.

Insurance expansion

- No denial of coverage
- Essential health benefits defined
  - ambulatory patient services; emergency services; hospitalization; maternity and newborn care; medical and surgical care; mental health and substance abuse; prescription drugs; rehabilitative, habilitative, and laboratory services; preventative and wellness services; pediatric services (including oral and vision).
- Important because it combats people trying to sell bad policies
  - Not able to compete through denial of services

What does this mean for you?

- An additional 1, 785,000 office visits into primary care offices in Alabama
  - Primary care is a growth industry
- More and better insurance in rural Alabama
  - Primary care pays better
- More and better primary care should lead to less other care

Better organized care

Home is the place where, when you have to go there, they have to take you in.

Robert Frost, *The Death of the Hired Man*

What is a PATIENT CENTERED MEDICAL HOME?

BACKGROUND

- Developed in 1967
- Referred to central location of archiving child's medical record
- In 2002, AAP expanded medical home to include these characteristics about a patient's care
  - Accessible
  - Continuous
  - Comprehensive
  - Family centered
  - Coordinated
  - Compassionate
  - Culturally effective

PCMH DEFINED AS…

- Team-based model led by personal physician
- Responsible for all patient's health care needs
- Arranges care with appropriate qualified professionals
- High levels of care
- Access and communication
- Care coordination and integration
- Care quality
- Safety

Source- http://www.acponline.org/running_practice/pcmh/understanding/what.htm/

PRINCIPLES

- *Personal physician*
- *Physician directed medical practice*
- *Whole person orientation*
- *Coordinated/integrated care*
- *QUALITY AND SAFETY*- hallmarks of PCMH
- *Access to care*
- *Payment*

Source- http://www.acponline.org/running_practice/pcmh/

COST of PCMH

- No evidence of additional costs
- Less than a $1-per-month difference in patient costs
- What might this mean?
  - Becoming a PCMH may only require adjustments to how practice inputs are used as opposed to incurring significant additional expenditures

Source- http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/Incremental-Cost-Estimates-For-The-Patient-Centered-Medical-Home.aspx

SUPPORTING DATA

THE STUDY

Redesign of a patient-centered medical home (PCMH) was done with the goals of improving patient experience, lessening staff burnout, improving quality, and reducing downstream costs.

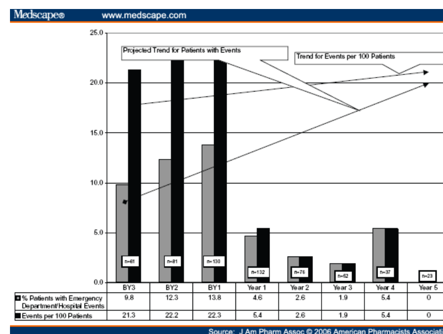
THE RESULTS

- Compared with controls, PCMH patients had a better patient experience, improved quality of care, and less PCMH staff burnout at 12 months.
- At 12 months, there was no significant differences in overall costs between the PCMH and control clinics.

Source- American Journal of Managed Care

What are the results?

- South Carolina,
  - Medical and pharmacy costs 6.5% lower than the control
- North Dakota
  - Hospital admissions reduced by 6%
  - Emergency room visits down by 24%.
  - During that same period, in the control group, hospital admissions were up by 45% and emergency room visits rose by 3%.



	BY3	BY2	BY1	Year 1	Year 2	Year 3	Year 4	Year 5
% Patients with Emergency Department/Hospital Events	9.8	12.3	13.8	4.6	2.6	1.9	5.4	0
Events per 100 Patients	21.3	22.2	22.3	5.4	2.6	1.9	5.4	0

Accountable Care Organizations

ACOs (who are they?)

- Groups of physicians
- Emphasis on quality
- Emphasis on risk
- Must be able to provide primary care for 5000 Medicare beneficiaries

What's being measured

- Patient/caregiver experience of care;
- Care coordination;
- Patient safety;
- Preventive health; and
- At-risk population/frail elderly health.

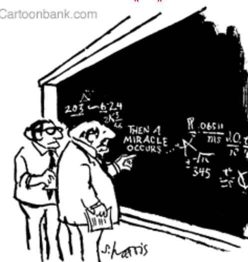
Results?

- Florida group reduced inpatient hospital days by 37% and hospital readmissions by 27%.
- Ohio group reduced inpatient days by 30% and hospital readmissions by 27%.

What does this mean to you?

- Both models primary care driven
- Both models emphasize non-traditional care access models
- Both models utilize Health Information Technology and care coordination
- Bottom Line - Fewer people in the hospital as well as in the ED

Innovation



"I think you should be more explicit here in step two."

Supporting the Triple Aim

- Better care for individuals, described by the six dimensions of health care performance
  - safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.
- Better health for populations,
  - Attack "the upstream causes of so much of our ill health," such poor nutrition, physical inactivity, and substance abuse.
- Reducing per-capita costs.

What does this mean to you?

- Care can change more rapidly
  - Be alert
- Emphasis on quality and efficiency
  - Both driven by cost
- Learn to work efficiently and effectively
  - Clinical parsimony is the key

So where are we going??

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"IF IT HAS THE WORD 'ECTOMY' AFTER IT, I'VE ALREADY HAD IT!"

New Value propositions in healthcare

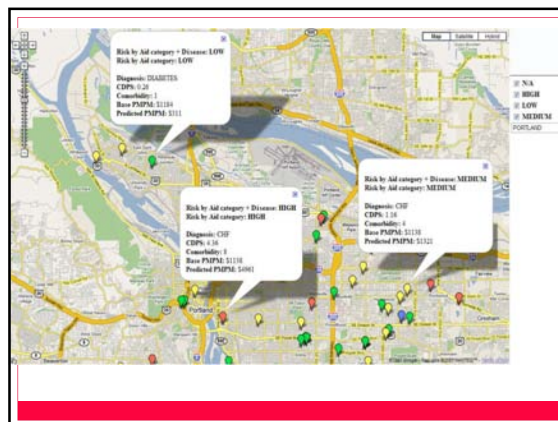
- **social and economic value of reducing disease burden will rise**
  - **earlier disease detection and mitigation**
  - **rational Rx and guaranteed outcomes**
  - **integrated care for complex chronic diseases**
  - **extension of working life**
  - **prospering in an era of increasing constraints**
  - **managing the limit(s) of society's willingness and ability to pay for innovation**

How Do We Effect Change?

- Mobile
- Multimedia
- Monitored
- Measured
- Compared to others like me
- A personalized market of one
- In short patients are capable of being reached more effectively

Major Target Markets for Community Driven Medicine

Disease	*Patients	Parameter
Alzheimer's	5 million	vital signs, location, activity, balance
Asthma	20 million	respiratory rate, FEV, air quality, oximetry, pollen count
Breast CA	3 million	ultrasound self-exam
COPD	10 million	respiratory rate, FEV, air quality, oximetry
Depression	19 million	medication compliance, communication
Diabetes	21 million	glucose, hemoglobin ATC
Heart Failure	5 million	cardiac pressures, weight, blood pressure fluid status
Hypertension	74 million	continuous blood pressure monitoring, medication compliance
Obesity	80 million	smart scales, caloric in/out, activity
Sleep Disorders	15 million	sleep phases, quality, apnea, vital signs



Community Driven Medicine

- Technology is only an enabler, there will be no real change merely from technology without an elevation of ideas
- An emergence of a new organizational structure must also be present
- Change will only occur by overcoming long entrenched behaviors-it's the Culture Not The Strategy
- Change will only come with financial alignment

Final Thoughts (thanks to Carl Taylor)

- Care moves from episodic encounters to continuous interactions
- "Care" space will be increasingly decentralized and migrate away from the hospital or clinic to the personal health space
- The AS IS State of Health Care will end with a new model
- And What is Your Role In the New Model?