The Future of Health Care

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Our Patient

- 88 year old female
- Lives alone
- History of congestive heart failure and osteoarthritis
- Brought to hospital due to extreme lethargy
- Hospitalist finds she has accidently overdosed on Lasix (her diuretic).
- By day 2 she was feeling a lot better but had difficulty walking
Hospitalist had 2 options:

1. Have her remain another night – although she was medically stable. This costs the hospital money due to the current DRG payment methodology. But it would give her more time to recover and extend her stay for the 3 days required to qualify for SNF.

The hospital thought this was wasteful and increased her risk for a HAC and equally important went against her wishes if the end result was a SNF stay.
2. Hospitalist could send her home, readjust her medications and arrange for HHC agency to see her within 48 hours of discharge. The HHC receives a fixed amount of payment for a 60 day episode of care – something she probably does not need.

This option represents a higher risk of falls and further medication errors but serves the hospital’s and patient’s interest of a reduced LOS and a return back home.
• Both options have a high likelihood of readmission and most importantly neither option encouraged the provision of high quality, high value mix of acute and post acute COORDINATED care services.

• How did we get here?

• What is the physician’s role and how has it changed and what will it look like in the future?
• In the 2\textsuperscript{nd} half of 20\textsuperscript{th} century the physician went from Dr. Marcus Welby the be all and end all to everyone to skilled labor, a specialized shift worker.

• Is today better, worse or just different?

• To answer the question, let’s examine the evolution of medicine itself and the effects of that evolution on the role of the physician.
• Mid-Century physicians experienced the golden age of medicine – at least to them

• Top of revered profession, solely responsible for the management and delivery of care; which was unevenly distributed and closely related to the ability to pay.

• Physician was a priest and a seer. He was a scholar, an alchemist who understood the human body and psyche.

• He was a on a pedestal at the end of the age of pedestals – eg John Wayne

• NOBODY questioned the doctor.
What happened?

• 1961 – study published of x rays being interpreted by radiologists and a computer and they were comparable. The conclusion was that computers were no better than radiologists.

• About the same time some physicians began to wonder about hospital management. How do things work in a hospital? Since I take care of patients, shouldn’t I also take care of a hospital?

• Does that make sense?
• Physicians had social status, financial rewards and were well respected in society.

• No one saw it coming: the replacement of a cottage industry by biotechnology and biomedical engineering – the reading of an x ray by a computer.

• Health care delivery to the medically indigent was left to charity hospitals, municipal hospitals and free care by physicians.
• Emphasis remained on fee for service with some charity care.

• Medicare and Medicaid – 1965 2 things happened:
  
  1. Outrage – talk of socialized medicine and the downfall of private practice.

  2. Medical care previously given gratis would now be reimbursed by the government

  Eventually physicians came to love the beast.
• Technical people in hospitals provided ancillary services in labs and radiology. New professions were created and flourished.

• Surgical technicians were new and by and large registered nurses who filled the positions.

• Then Vietnam happened and a whole new world emerged – physician extenders – medical corpsmen – started performing tasks that simplified the work of physicians. Helicopter medics greatly improved the survival of the wounded and would start using these skills back home.
• Physician Extenders started doing procedures reserved for physicians in the civilian world – start IVs or blood transfusions, some minor surgeries that would mitigate later surgeries.

• They returned home to a new social milieu trying to find ways to cut costs and provide care to the underserved.

• Thus began the dilution of the physicians role as the be all and end all of everything. Soon paramedics appeared and the delegation of medical care outside of hospitals and offices had begun.
• New medications began to compete with generic medications and a new era of medical economics began – the medical industrial complex.

• In the 1980s nurse practitioners became popular with patients and were well received as they spent more time with their patients.

• Computers started to read EKGs – time was saved and the obvious began.
• Labs could now turn out reports with 12 then 25 biochemical tests on smaller and smaller amounts of blood.

• The unanticipated was the significant overuse and overreliance of tests in place of clinical judgment.

• Defensive medicine began and flourished.

• However at the same time medical diagnoses improved by becoming more accurate and efficient.
Then What Happened?

• Cost of care increased like never before

• Medicine became more impersonal yet efficient and effective and less like the beloved family doctor of the past – Dr. Welby.

• Physicians became dependent on technical information and started on the road to becoming skilled labor.

• General unrest began in medicine as the ability to pass a device of some kind into the human body paid more leading to specialization and the proliferation of subspecialties.
Financial Pressures

- Specialties without a medical gimmick (primary care) were forced to increase revenue by many means.

- 1980’s – DRG’s were developed to force physicians into more efficient management

- 1980’s – business people showed up promising that efficient business models would lower the cost of medicine (HMOs and Dr. No).

- Health Care Delivery now involved an incestuous relationship between insurance companies and business conglomerates that managed an ever larger and voracious health care delivery system that replaced the doctor patient relationship with quarterly earnings.

- The physician became an employee of a system
Raising Fees and the 2000s

- Physicians now had to spend time to be sure the chart reflected the weighty thinking that was necessary to justify the top level of billing.

- Doctors became Health Care Providers

- 1990s – business organizations with a hierarchal structure – the big boxes – grew quickly.

- Physicians now had to increase patient visits per unit time, accept lower reimbursement, vie with insurance claims adjusters to carry out diagnostic testing and take more time to defend medicine against the onslaught of accountants, middle managers, directors and executives.

- Independent physicians became the exception not the norm. Insurers payed similar physicians different amounts for providing the same service.
Trouble – the 2000s

• US now spends $4500 per capita for a life expectancy of 77 years. Cuba spends about 11% of that amount for the same life expectancy.

• The US delivery structure is inordinately large, cumbersome, laden with a variety of profit centers and burdened with regulations for both provider and patient.

• The focus became patient care at the lowest possible cost to the payers and caregiver organizations resulting in fragmented care.

• Physicians are by and large mandated to accept governmental intrusion.

• And - the public wants affordable care and choice.
What is right – the 2010s

• Patients have access to more and more information

• Earlier diagnoses and treatment, fewer and less invasive procedures, telemedicine, tailoring of medicine to genome structure, better prenatal diagnoses and new applications of robotic surgery.

• Regenerative medicine will provide new tissues and organs. Medicine will unquestionably be far better going forward.

• Epiphany - The straight line of physician-nurse-patient is gone and will never recur. Dr. Welby is no longer.
• Population Health – what is this?
• Is a health system responsible for the healthcare of a geographic area? Or a population with a particular insurance plan? Or a population who shares physicians/hospitals?

• Need a supply of increasingly complex variety of providers.

• The physician role has become the supervisor in the mosaic of the provision of care.

• The old family doctor was revered, honored, respected and gave of his time. The new doctor has different expectations.

• Great medicine exists – it is the old model that is going, going, gone.
The 2010s

- Population health
- Changing payment paradigms
  - Bundled payments – incident of care
  - ACOs – population health
  - Care Coordination - Inevitable
- Industry consolidation
- Rise of the consumer (transparency)
- Data revolution (driving performance)
- Looming physician shortages
• Dropping inpatient volume despite an aging population
  123.2 inpatient stays /1000 population (1991) to
  111.8/1000 (2011)

• Job cuts

• Closing hospitals

• We have cut costs and reduced staff but have not as yet
done the hard work – re-engineer the way we work.

• What does that look like???
• Medicine has evolved from a proficiency based art to a data driven science, from a freelance physician to a hospital of large mega group employed physicians, from one size fits all community hospitals to vast hospitals networks organized around centers of excellence.

• Are we better off yet????
What's happening? 2010s

• The focus is now Value – Quality/Cost – not just for hospitals, labs, SNFs, etc. but also physicians.

• As an example - The Cleveland Clinic physicians receive a flat salary for a one year appointment. Annual performance reviews are based on 5-7 quality metrics. As a result each year there are leaders, laggards and followers. The bottom 10% will have a cut in salary or be terminated based on quality results.

• This is new and revolutionary.

• Let’s get back together with our patient……..
• What are the newer incentives to deliver cost effective acute and post acute care services?

• Bundled payment – episodic care

• ACO – network of providers who reduce the total cost of care for a defined patient population and meet quality metrics

• Neither will work without changing the outdated 3 day rule or the 60 day rule or the rule that 75% of rehab patients must fall within 13 diagnostic categories

• Improved care requires coordination not alignment
True Coordination of care is defined as the organization of services among:

a. Hospital
b. Physicians
c. Post Acute Care Provider
d. Patient

This requires:
1. team based care and transition programs
2. case management
3. improved patient and family engagement
4. communication protocols for providers across settings
5. investment in post acute care capital needs (telemedicine, transition medical teams).
• We need research into which setting best fits our patient – currently lack of data and quality metrics. Comparative effectiveness research evaluating the most appropriate mix of acute and post acute care services.

• What could have been different for our patient?
• Under an ACO or bundled payment there are financial incentives to provide the right care, at the right place, at the right time – this is something new......

• Comparative research effectiveness would have provided guidance to our hospitalist to provide care without worrying about payment rules and with the support of organizational tools for coordinated care.

• This is a new way at looking at an old problem.
• Example – remain in the hospital for several more days and then receive intensive HHC – frowned upon today as too expensive.

• Or transition to a SNF and receive longitudinal case management services to support a more rapid recovery and ultimate return home - not allowed today without a 3 day stay.

• Other options could develop over time to develop a win – win –win situation that is reduce spending, improve health outcomes and be more consistent with patient preferences.
Changing Role of Physician

- From Marcus Welby to Captain of the team, conductor, skipper, pilot, executive manager, organizer, chief etc....

- From holding patients’ hands to managing an organization support system that allows him to work at the top of his license – be that diagnostician he was trained to be.

- From a pen and paper to a computer assisted and supported professional

- From Episodic Care to Coordinated Care
Extend Entry Points and Monitoring Outside of the Clinic

Re-envisioning Today’s Primary Care Clinic
1. Standardized clinical processes optimize visit time
2. Collaborative environment encourages multidisciplinary care
3. Centralized registration maximizes space
4. Patient-centric exam room fosters engagement
5. Group visits leverage peer support

Expanding the Clinic’s Reach
6. Virtual appointments augment routine office visits
7. Web portals engage patients and improve follow-up efficiency

Scope of Services
Challenge Coordinating New Resources

Patient Solutions Increasing Complexity

- Open Health Market
  - Insurance decisions
- SmartShopper
  - Financial decisions
- Keas
  - Wellness activities
- Fitocracy
  - Fitness activities
- iTriage
  - Access decisions
- WiserTogether
  - Treatment decisions
- SoloHealth
  - Treatment decisions
- CafeWell
  - Wellness activities

Patient Aspirations for Virtual Access and Management

- **72%**
  - Want option of online Appointment scheduling
- **74%**
  - Want to consult physicians via phone
- **88%**
  - Want emailed appointment reminders
Willing to Pay for virtual Access

RapidDoc Enables Remote Service on Patients’ Terms

Patient requests appointment through RapidDoc website

Operator determines if patient need fits e-consult capability and collects patient payment

Altidore Medical Group physician has 15 minutes to respond, then request passed along to RapidDoc physician pool

Small Cost Not to Leave Home

$45
Cost per visit for unsubscribed patients

$19.95
Cost of a monthly subscription to RapidDoc

$199
Cost of an annual subscription to RapidDoc

Case in Brief: Altidore Medical Group\(^1\) / RapidDoc\(^2\)

- Multi-hospital system in the East that partnered with RapidDoc, a virtual health care provider based in the South
- Phone, web, and email visit services include general health, select and pediatric health, as well as mental health consults
Real-Time Patient Access to Physician, Care Providers

- Patients submit clinical questions via mobile wizard or web application
- Photo or video attachments provide detail on ailment
- Physician or care provider recommends next care step

Case in Brief: PINGMD

- Health care technology startup located in New York, NY
- Online platform enables efficient care network communications through secure text, picture, and video messaging; mobile app notifies user when communications are sent, received and resolved
- Platform reports 100% improvement in customer satisfaction
Platform virtually Connects Providers

Preventing Wasted Time from ‘Phone-Tag’ with Specialists, Care Team

More Streamlined Care Coordination Across Networks

- Providers conduct case consults or referrals virtually using group chat
- Improves communication and efficiency between providers
- Prevents readmissions through collaborative care follow-ups
- Automatic documentation ready for export to medical record

55% PINGMD messages replace office visits¹
30 min Median response time from physician to patient on PINGMD²
10 min Median response time between care partners on PINGMD²
50% Physicians saving 15-60+ minutes/day with application
I. How will the next generation use computers when they become the physician leaders of the near future?

II. How will we care for our aging population?

III. Home visits? Palliative Care? End of life doulas?

IV. The role of the physician has changed. From Marcus Welby to orchestra leader, skipper, captain, manager, pilot and yet retain the humanness and the compassion so needed in our profession.

V. The role of the patient has changed from passive recipient to engaged partner.

VI. The future belongs to us all.........