Payment Reform Working Group
October 14
1:30 PM

Outline

Focus on Frail Elderly

The story of Edith Elder

Root Problems and Solutions

Geriatric Services of Minnesota (GSM)

Deploying a value-driven physician workforce utilizing alternative payment methods.

Focus on Frail Elderly

- High cost Medicare chatter
  - 80/20 rule
  - 10/70
  - Last 6 months = 40-50% Medicare Dollars
- Expanding Demographic
- Frailty as a syndrome
- Physician performance is poor

Focus on Frail Elderly

- Physicians are the Problem
- Docs are disconnected from their personal impact on quality and cost
- Physicians are the Cure
- Docs can treat patients like they are their own loved ones, and like they are paying for it personally

Edith Elder

- Lives in her own home
- Normal mental health
- Almost never takes meds until lately
- Trusts her Doctor
- Insomnia, leaky bladder
- Quit driving
- More phone work, less clinic visits
- Son helps with bank

Dr John Goodparent

- Job shares with Dr Rachel Kakeneitit
- “Healthier” training and avoid career choices of older docs
- Fixed hours and benefits
- Shift work
- Large call groups with high intensity
- Less entrepreneurialism

Connie Konsern

- Daughter lives in Colorado
  - school nurse
  - Phone calls for 2 years
  - Tremor, swollen ankles
  - fall, isolated confusion
- Parkinsons vs “Mini-Strokes”
- Neurology

Connie Konsern

- Visits Edith
  - No Banana Cream Pie
  - Depressed
- SSRI and Antibiotic
- LOA
  - Cooks, cleans, companionship
- Better = resolved UTI

Medicare Financial Driver Domain-Clinic

- Physician Incentives
  - Worst payor
  - Global management not valued
  - Call uncompensated
  - Discourages Geriatric specialization
    - Low production/high maintenance partner

Edith Elder

3 weeks later

- Connie sends her brother
- Weak
- not herself
- Smells of urine again

Edith Elder in the ER

- Dr Saverlife
- 86 Yr old WF
- Weakness and low grade fever
- PMH:
  - Parkinson's
  - HTN
  - CHF
  - "Ministrokes"
  - Afib
  - Recent UTI's
  - Depresssion

Medications

- Sinemet 25/100 TID
- Lexapro 10 QD
- Lasix 20 QD
- KCL 10 meq QD
- Restoril 15 QD
- ASA 81
- Plavix 75 QD
- Digoxin 0.125 mg QD
- Detrol 2 mg QD

Edith Elder in the ER

- Exam
  - Vitals: BP 110/60, HR 95 irreg, T 99.5, “looks dry”
  - 2+ dep edema
  - WBC 10,500, Hgb 11.2, Na 130, K+ 3.7
  - Cr 1.6, BUN 45, CXR Cardiomegaly
  - Urine “dirty”
- Diagnosis: recurrent UTI , mild CHF flare
- IV fluid, Levaquin and 2 extra doses of lasix

Edith back Home

- Son makes extra trips, not recovering well
- Daughter calls Dr Kakenietit
- UA: trace +leukocyte esterace, +nitrates
- UC: 50,000 gram neg resistant to ampicillin and others, sensitive to quinolones
- Continue Levaquin, see Dr Goodparent

Edith Elder in the Hospital

- 10 Day hospital stay
  - Clostridium Difficile Colitis (antibiotic induced)
  - Poor rate control afib and CHF
  - Incontinent of bowel and bladder
  - Mention of confusion in records
- Physicians
  - Hospital Medicine, GI, Urology, Cardiology
  - Echocardiogram, Abd CT, Colonoscopy, blood transfusion
- Home with Homecare
  - RN meds, PT, aid bathing

New Med List for E. Elder

- Sinemet 25/100 TID
- Lexapro 20 QD (increased)
- Lasix 20 QD
- KCL 10 meq QD
- Restoril 7.5 QD (lower)
- ASA 81 (restarted)
- Plavix 75 QD (restarted0
- Digoxin 0.125 mg QD
- Detrol 4 mg QD (increase)

- New Meds
  - Flagyl 500 TID
  - Toprol XL 50 QD
  - Prevacid 30 QD
  - Seroquel 25 QHS
  - Lipitor 10 QHS

Medicare Financial Driver Domain-Hospital

- Hospital incentives
  - Medicare Part A driven
    - Diagnosis related (DRG)
    - Manage resources
    - Turn the Bed!!
    - Avoid the Bounce back
- Physician Incentives
  - Medicare Part B driven
    - Paid by visit and procedures.
    - Holistic and Cognitive consults not valued
    - Volume is rewarded

Edith Elder Bounces Back

- Hip Fracture
- 10 day hospital stay
  - Delerium
    - » Ativan PRN
    - » Seroquel increased 25mg BID
  - Transfusion
  - CHF/afib
  - Delayed transfers
  - Off 1:1 x 24 hrs
  - IV fluids up to last day

Edith Elder to the NH # 1

- On admission at 3 PM
  - Stable vitals
  - Hospital H & P from 10 days ago
  - DC orders
    - TTWB and computer generated med list
  - Orders need clarifying
    - Dx, stop dates, “call primary” on plavix and lovenox, standing orders, multiple PRN’s, No script for the narcs, no scheduled pain meds, Foley, Hep lock, Pneumovax, code status,
  - Poor service
  - Rounding Doctor here in 3 weeks

Edith Elder NH #1

- Participates poorly in Rehab
- Behaviors generate phone calls
- UA/UC done off the Foley
- Seroquel increased
- Levaquin added again
- Unstable on day 3

Medical Domain-Nursing Home

- Facility Incentives
- Medicare A
  - Per Diem
  - 5,15,30 day assessments
- Physician Incentives
- Medicare B
  - FFS
  - Uncompensated
  - No resource management

Edith’s Bounce back

- Rescue Therapy Pathways
  - Stroke
  - Pneumonia
  - Acute Coronary Syndrome
  - Sepsis
  - Psychosis and Psychiatric unit
- Revolving Door

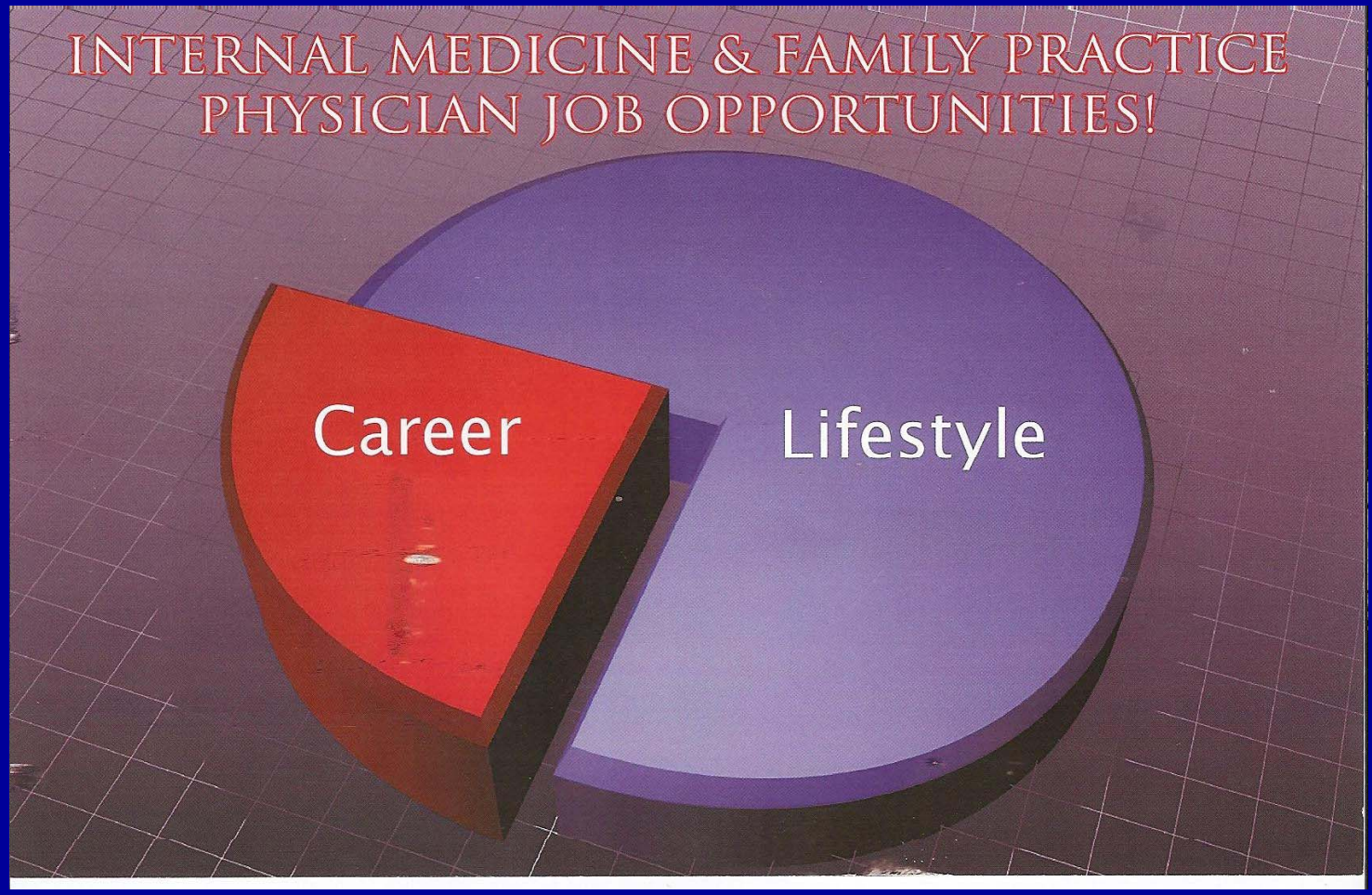
Edith and the Revolving Door

- Rescue, Rehab, and Relapse
- Poor Quality
  - Loss of choice
  - Little patient autonomy
  - Marginal informed consent
  - Drug cascades and AME
- High Cost
- Unprofessional service by physicians

What Are the Root Problems?

- Doctor's are a big part of the problem
  - Our business models
    - Fee For Service
    - Primary Care sells off
    - Subspecialty maintains ownership
  - Limited Accountability
    - Limited Peer evaluations
    - Little incentive for case discussions
  - The success of industry bias on our practice patterns
  - Failure of Training Methodologies
    - CC/HPI/PMH etc.. Does not fit with comorbidities
    - Comorbidities are the rule
    - Hospital and Clinic based
  - Wacky Vocational Flow

Work/Life Balance



How the Specialties Stack Up

Dermatology and plastic surgery are among the most competitive residencies.

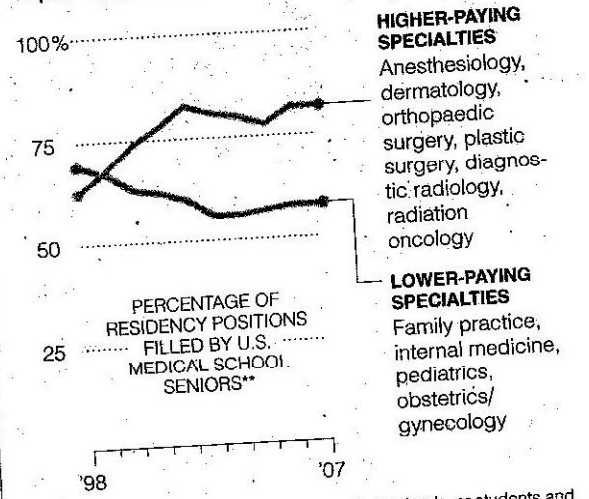
	U.S. SENIORS WHO MATCHED IN 2007				
	PCT. MATCHED TO PREFERRED SPECIALTY	NUMBER OF RESIDENCIES OFFERED	PCT. IN HONORS SOCIETY	MEDIAN STEP 1 SCORE*	AVERAGE SALARY FOR DOCTORS
Dermatology	61%	320	47%	240	$390,274
Plastic surgery	63	92	36	243	408,065
Orthopaedic surgery	80	616	31	234	475,781
Otolaryngology	82	270	39	239	369,154
Radiation oncology	82	142	24	236	486,734
Obstetrics/gynecology	89	1,146	12	213	296,699
General surgery	90	1,057	12	222	330,215
Diagnostic radiology	91	1,035	26	235	449,664
Emergency medicine	92	1,384	12	221	258,088
Anesthesiology	94	1,334	7	220	371,913
Neurology	96	539	15	218	254,558
Pediatrics	97	2,424	12	217	188,496
Internal medicine	98	5,517	13	222	191,525
Family medicine	99	2,603	6	209	178,859

Sources: National Resident Match Program; Association of American Medical Colleges; Medical Group Management Association

*Basic science concepts test

Trends in U.S. Residencies

U.S. medical school seniors, who are typically the most sought-after by residency programs, are moving away from general practice and choosing specialties that offer higher pay, including those dealing with appearance. They are being replaced in part by graduates of foreign medical schools.



**Does not include graduates of U.S. medical schools, or students and graduates of osteopathic schools and of international medical schools.

HAEYOUN PARK, ANDREW W. LEHREN/THE NEW YORK TIMES

Other Root Causes

- General Knowledge
  - More Complexity and Depth
  - Ignorance is not the issue
  - The Check List Manifesto, Dr Atul Gawande
- Paucity Geriatric Specific Knowledge
- Financial Drivers
  - Little reward to Docs for delivering value
  - Inside or across silos of care

Solutions

- Take Collective Ownership of the fact we provide marginal value
    - Redesign the Care
    - Elevate performance of primary care
    - Reward better primary care performance
    - Place Subspecialty care back where it belongs
        - (on a back pedestal)
    - Change business models
    - Accept risk and drive accountability (ACO's)
    - Welcome peer review (maintains ethics)
    - Recommit to education and Professional Principles

Recommit to Professional Principles

- Beneficence
- Nonmaleficence
- Autonomy
- Social Justice

Edith's Happy Ending

- Geriatric Short Stay
  - Geriatrician
    - On site Medical management
    - Polypharmacy
    - Drug Cascading
    - Recognizes risk of iatrogenic illness
    - Part of IDT (if not leading it!)
    - Goals of Care (time with family and staff)
  - Medical, Functional and Cognitive assessments
    - Alzheimer's disease
    - ADL independent
    - Moderate fall risk
    - Allen levels 4.7

Edith’s Happy Ending

- Discharge from NH
  - Med management
  - Walker
  - MOW
  - BID saftey checks, Lifeline
  - Look for ALF
  - Enrolls in physician case management (small panel size, specialized call group, direct access)
  - Boutique care for the high risk elder

Geriatric Services of Minnesota (GSM)

Deploying a value-driven physician workforce utilizing alternative payment methods.

GSM Mission

- Quality of Care
- Financial Performance for All
- Improve Professionalism

Three Core Services

- LTC
  - Primary care
  - Scheduled FC (5 step process)
  - Artfully crafted GOC
  - Specific ACP
  - 24-7 specialized coverage

Short Stay Service

- Consultant Role
- Expertise in transitions
  - Address polypharmacy and the drivers of RRR's
- Coach reasonable GOC
  - Communicate them to SNF team and hand off to PCP after discharge
- Manage per diem
- Prevent bounce backs
  - From SNF (5-8%) and after discharge

Physician Case Management

- High Risk Community Dweller
  - Not always highest cost
- Primary Care
  - Small panel size
  - Hospital coverage by specialized-same team
  - Alternative tools for unnecessary hospitalizations
  - Better value out of appropriate hospitalizations
    - » (subspecialist as consultants)
    - » (primary Doc not a triage Doc)

GSM and Physican Accountability

- Physician Accountability
  - Upfront expectation to improve expertise in Geriatrics
  - Peer group development
    - Clinical Decision Meeting
    - Call Standards
  - Evaluations
  - Compensation formulas aligned with mission-sensitive incentives
    - Panel size for base
    - Bonus for performance/evaluation
    - Physician supervisor (Boss)

GSM Financial Drivers

- Non-Fee for Service
  - Minnesota Seniors Health Option (MSHO)
  - Medicare Advantage
  - Hospice
  - Physician Case Management Fees
    - Short Stay/TCU
    - Hospice
    - Home visits
- FFS: Non-FFS = >2:1

Payment Reform

- Fee for Service doesn’t work for complex or costly care
- Open minded to any non-FFS models
- ACO’s need physician drivers
- Factors for success of non-FFS methodologies
  - Recruit and retrain Physicians with the right skill set
  - Compensate them in patient centered and cost sensitive methods
  - Hold them accountable for performance

What can State do?

- Recognize care of the frail elderly is a national and local crisis
- Support MSHO
- Support training & retraining (mid-career) clinical Geriatricians
- Encourage risk sharing relationships that fuel physician investment and accountability

What can State do?

- Support ACO's committed to physician driven solutions
- Incent/encourage health plans & ACO's to participate in Medicare innovation
- Mandate a menu of options ranging from protective downside floors to delegating full risk
- Hold Health Plans accountable to nonprofit missions
- Less emphasis on market share
- More emphasis on developing a Geriatric physician work force that is invested in providing better global value.

- Questions
- Comments

Thank You