Health Care Reform
Can we do more than rearrange the deck chairs?

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Where are we now?  
More heat than light

Public debate on health care reform
  Coverage: Public option = who should pay the bills to providers?
  Costs: Lower cost care = rationing
  Quality: Discussion of patients preferences = death panels

The Titanic is sinking
  Costs: Cost of family coverage will double ($12,298 to $23,842) by 2020; Medicare Trust Fund runs dry in 2017
  Quality: Looming collapse of primary care; poor care coordination
  Integrity Of health professions – and academic medicine

Can we do more than rearrange the deck chairs?
Variations in practice and spending

*The Dartmouth Atlas*
Variations in practice and spending

*Back surgery rate per 1000 Medicare enrollees, 2005*

- Boise, ID: 8.8
- Idaho Falls, ID: 8.5
- Billings, MT: 7.9
- Great Falls, MT: 7.4
- Spokane, WA: 6.8
- Missoula, MT: 6.2
- Yakima, WA: 5.5
- Tacoma, WA: 5.4
- Seattle, WA: 4.9
- Olympia, WA: 4.3
- Everett, WA: 4.1
Variations in practice and spending

Medicare spending per enrollee, 2006

Great Falls, MT  $7,446
Tacoma, WA $7,363
Seattle, WA $7,218
Spokane, WA $6,975
Everett, WA $6,905
Olympia, WA $6,716
Boise, ID $6,523
Billings, MT $6,332
Yakima, WA $6,175
Missoula, MT $6,080
Idaho Falls, ID $5,924
Variations in practice and spending
The Dartmouth Atlas

1. The paradox of plenty
2. What’s going on?
3. What might we do?
4. Is there reason for hope?
The paradox of plenty
What do higher spending regions get?

Initial study: Medicare enrollees with heart attacks, colon cancer and hip fracture

Compared content of care, quality and outcomes across high and low spending regions

(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, November 7, 2004
(4) Skinner et al. Health Affairs web exclusives, February 7, 2005
(6) Fowler et al. JAMA: 299: 2406-2412
What do they get more of?

**Effective Care:** *benefit clear for all*
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

**Preference Sensitive:** *values matter*
- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

**Supply sensitive:** *often avoidable care*
- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Evaluation and Management (visits)
- Imaging
- Diagnostic Tests

*If bar on this side higher spending regions get more*
The paradox of plenty
High spending compared to low spending regions

Health Outcomes
- No gain in survival
- No better function

Physician’s Perceptions
- Worse communication
- Greater difficulty ensuring coordination
- Greater perception of scarcity

Patient-Perceived Quality
- Lower satisfaction with hospital care
- Worse access to primary care
- No sense that care is rationed

(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(6) Fowler et al. JAMA: 299: 2406-2412
The paradox of plenty
Pop Quiz....

If we cut spending so that all U.S. regions were receiving the same per-capita amount as the lowest spending regions, which of the following would apply:

1. The Medicare Trust Fund might survive a few years past its predicted collapse in 2017 (the year I become eligible).

2. We could send a third of the U.S. healthcare workforce to Africa and improve the health of both continents.

3. Both of the above.
What’s going on?

Some general attributes of U.S. healthcare:

- Assumption that more is better
- Inadequate information on risks and benefits
- Growing tension between science and professionalism -- and -- market approach (health care as a commodity)

Larson et al. "Advertising by Academic Medical Centers; Arch Int Med: 2005; 165: 645-51"
What’s going on?
Research on causes of variations

- **Patient Demand**: Little difference
- **Malpractice**: Less than 10% of difference
What’s going on?
Research on causes of variations

Cardiologists per 100,000 Residents

Cardiologist Visits per 1,000 Medicare Enrollees

R² = 0.49
What’s going on?

Research on causes of variations

![Graph showing the relationship between Cardiologists per 100,000 Residents and Cardiologist Visits per 1,000 Medicare Enrollees. The R² value is 0.49, indicating a powerful influence but explaining less than 50% of the difference.](image-url)
What’s going on?  
*The role of clinical judgment*

**Evidence-based decisions:**
Doctors sometimes disagreed – but was unrelated to regional differences in spending

**Gray area decisions (more judgment required):**
For a patient with well-controlled high blood pressure and no other medical problems, when would you schedule the next visit?
What’s going on?
Case studies beginning to shed further light

ANNALS OF MEDICINE

THE COST CONUNDRUM

What a Texas town can teach us about health care.
BY ATUL GAWANDE

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What’s going on?  
*Case studies beginning to shed some light*

“Here … a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers.”

Atul Gawande

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“…a culture that focuses on the wellbeing of the community, not just the financial health of our system.”

Jeff Thompson, MD
CEO Gunderson-Lutheran
La Crosse, WI
What’s going on?
*Thinking about redesign: The Institute of Medicine “chain of effect”*

La Crosse       McAllen

**Aims**

**Micro-system**
- How care is provided to each patient

**Organization**
- E.g., capacity, policies, practices, norms

**Environment**
- E.g., payment, regulations, measures, culture

Institute of Medicine: Crossing the Quality Chasm
What’s going on?
*Principles to guide reform*

**Underlying problem**

**Confusion about aims:** what are we trying to achieve?

**Flawed assumptions:** “more is better”; less care = rationing.

**“Autonomy”, fragmented care:** focus on individual responsibility, no accountability for costs, capacity, coordination or outcomes

**Pay for volume:** Payment rewards more care, increased capacity, high margin treatments; penalizes those who improve care and reduce costs

**Key principles**

**Clear aims:** better health, better care, lower costs

**Better information, engaged patients:** Comparative effectiveness; informed choice; system performance measures

**Shared responsibility, organized care**
Establish teams and organizations accountable for aims and capable of improving practice

**Payment for value:** shift toward value-based payment aligned with aims
What might we do?

*Clarifying aims -- and performance measures*

**Emerging alignment on aims**
- National Priorities Partners
  - Improving population health
  - Improving safety & reliability and coordination of care
  - Engaging patients in managing their care and making informed decisions
  - Eliminating overuse

**Performance measurement – the critical lever**

**Key notions**
- **Core issue:** *how did the patient do over the relevant time-course?*
- **Value** best judged from the patient’s perspective and is multidimensional
- Requires organizational accountability – over time
What might we do?
Consider the care of a patient with an Acute Myocardial Infarction

At Risk
- Population at Risk
  - 1st Prevention (no known CAD)
  - 2nd Prevention (CAD no prior AMI)

Acute Care
- PHASE 1
- PHASE 2
- PHASE 3
- PHASE 4

Rehab
- Acute Phase
- Post Acute/Rehabilitation Phase
- 2nd Prevention

Recovery
- Risks reduced
- Good function
- Great care
- Minimal cost

Staying Healthy
- Getting Better
- Living w/ Illness/Disability (T1)
- Coping w/ End of Life (T2)

Onset
- Episode begins – onset of symptoms
- Episode ends – 1 year post AMI

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What might we do?
Consider the care of a patient with an Acute Myocardial Infarction
What might we do?
Teams and organizations capable of measuring and improving care

Emerging evidence on effective redesign (in organized systems)
- Patient-centered medical home (PCMH) pilots; shared EHRs; e-communications
- Population based chronic disease management: diabetes (Intermountain); chronic renal disease (Kaiser) – redesigned roles for specialists
- Cleveland clinic -- re-engineering clinical processes

Barriers (1) fragmented nature of U.S practice; (2) current payment system

A possible path forward: Accountable Care Organizations
- Delivery and payment model to support and reward integration and improved care
- Key notions: (1) Provider group willing to be accountable for continuum of care, built around PCPs; (2) performance measurement and quality bonuses; (3) total cost accountability, with “shared savings

Fisher et al. Creating Accountable Care Organizations, Health Affairs 26(1) 2007:w44-w57.
What might we do?
Accountable Care Organizations – Current status

**Early pilots promising; many organizations supportive**
- Physician Group Practice demonstration successful
- Congressional Budget Office scored as cost-saving
- Support from key stakeholders has solidified

**ACOs accepted as component of current bills**
- Support for extensive pilots, rapid expansion in House bills
- Senate Finance – voluntary program (not pilot) by 2012

**Initiatives at state and local level**
- Brookings-Dartmouth supporting pilot development in multiple sites
- Pilots to start January 2010 in three sites (VA, KY, TX)
- Learning collaborative underway with 40+ health systems
- Massachusetts has ACOs as key component of payment reform
Is there reason to be hopeful?  
**Pessimism in McAllen**

“We are witnessing a battle for the soul of American medicine”

**Three solutions run by Lester Dyke, cardiac surgeon in McAllen**

*Expand public payers’ role:*  
“It won’t make a difference”

*Expand private insurers’ role:*  
“What good would that do?”

*Health savings accounts:*  
“Any plan that relies on the sheep to negotiate with the wolves is doomed to failure.”
Is there reason to be hopeful?
Current legislation includes important elements

Coverage for all is critical -- and seems possible

Center for Innovation
   $10 billion (over ten years) to test and disseminate delivery system innovations

Accountable Care Organizations
   Likely to roll out as national program, 2012

Other important elements
   Increased funding for primary care
   Medical home and bundled payment pilots
   Increased support for quality measurement
Is there reason to be hopeful?
Delivery system reform likely to move forward regardless

**Change in complex systems occurs through:**
- Exploring variation and paradox (tension for change, positive deviants)
- Continual learning: rapid tests of change, adaptation
- New “attractors” (performance measurement, payment, positive deviants)

**Transparency is creating a tension for change, new attractors**
- McAllen vs Grand Junction
- Geisinger Health System: (1) Medicare spending fell by 15% relative to US (92-96) (2) Teachers given $7,000 raise (over 3 years)

**New conversations beginning**
Is there reason to be hopeful?
Delivery system reform likely to move forward regardless

“How do they do that?”
conference

Everett, WA  Portland, ME
Sacramento, CA  Sayre, PA
La Crosse, WI  Richmond, VA
Cedar Rapids, IA  Asheville, NC
Temple, TX  Tallahassee, FL

Common themes
Shared aims, accountable to community
Physician engagement as leaders
Organizational support important
Use of data to drive change

Lighter colors = lower spending
“There, there it is again—the invisible hand of the marketplace giving us the finger.”
Is there reason to be hopeful?
Delivery system reform likely to move forward regardless

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Organizational support important
Use of data to drive change
High self-efficacy; advocacy

Lighter colors = lower spending