Health care reform

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Where do we want to go?

How can we get there?

Green Mountain Care Board Charge

Improving the health of the population;	**Better health**
Reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;	**Lower costs**
Enhancing the patient and health care professional experience of care;	**Better Care**
Recruiting and retaining high-quality health care professionals; and	**A great workforce**
Achieving administrative simplification in health care financing and delivery. (Added 2011, No. 48, § 3, eff. May 26, 2011.	**Simpler**

The problem

Where I'm Going

Why so hard?

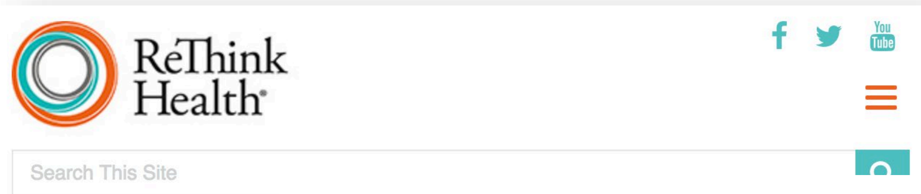
Pessimism

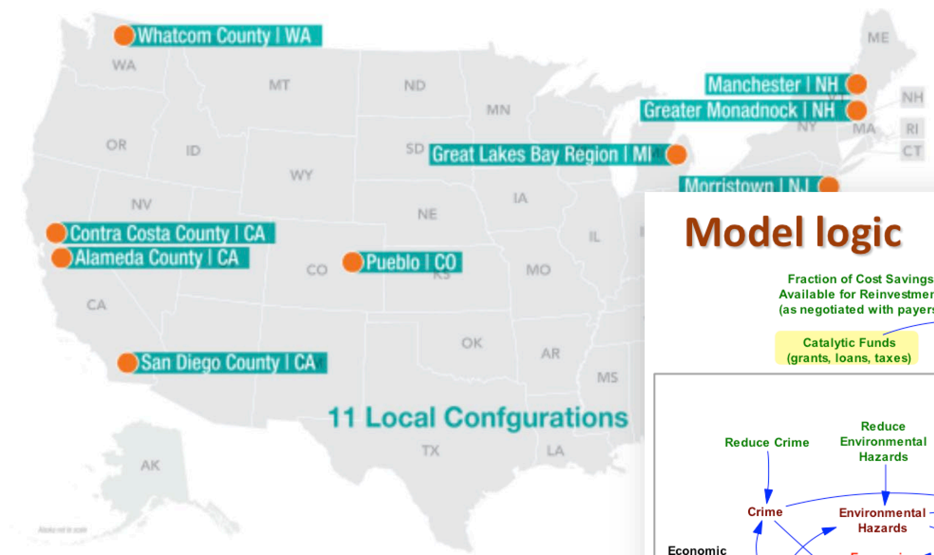
We ignore where the waste is

A fragmented system

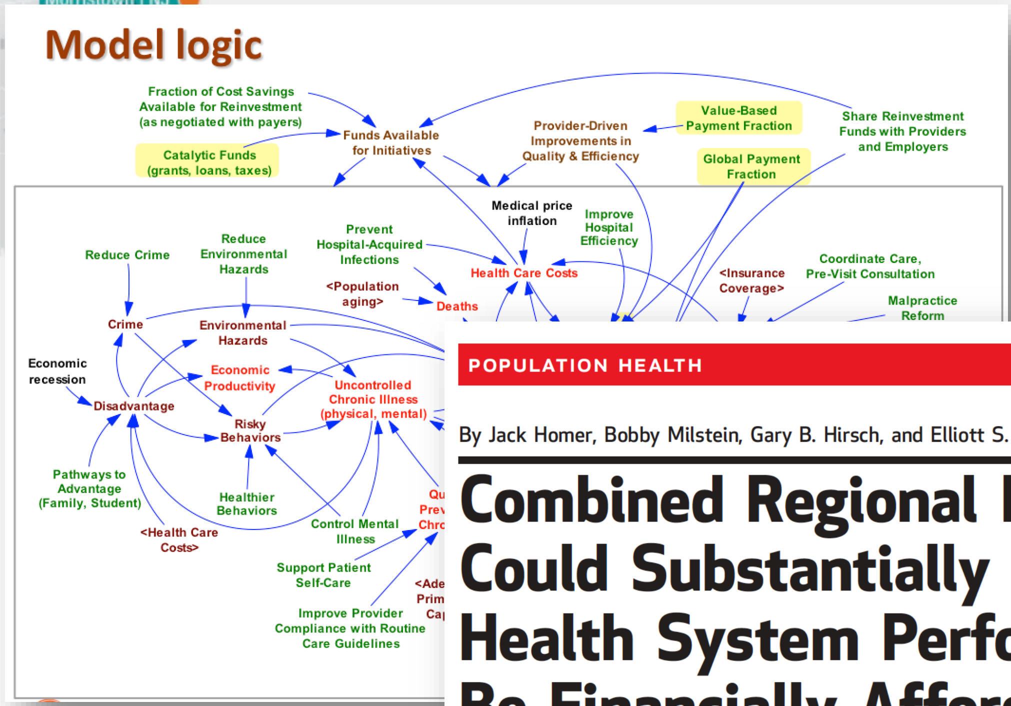
Policy change is hard (many oppose it).

Pessimism? Real gains in system performance are possible





Insights from systems dynamic modelling



POPULATION HEALTH

By Jack Homer, Bobby Milstein, Gary B. Hirsch, and Elliott S. Fisher

Combined Regional Investments Could Substantially Enhance Health System Performance And Be Financially Affordable

Pessimism? Real gains in system performance are possible

Key elements of the strategy

Reduce modifiable health risks

Adopt global payment models;

Support and spread innovation and improvement

Address upstream health determinants: (e.g. early childhood education)

Reinvest early savings to ensure full implementation of programs

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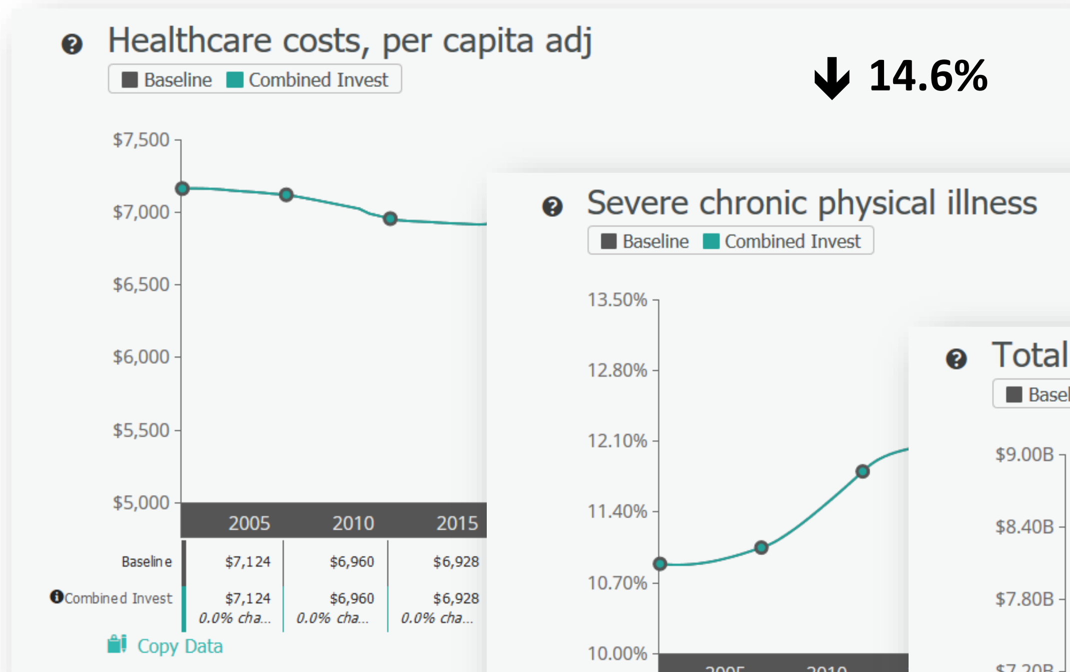
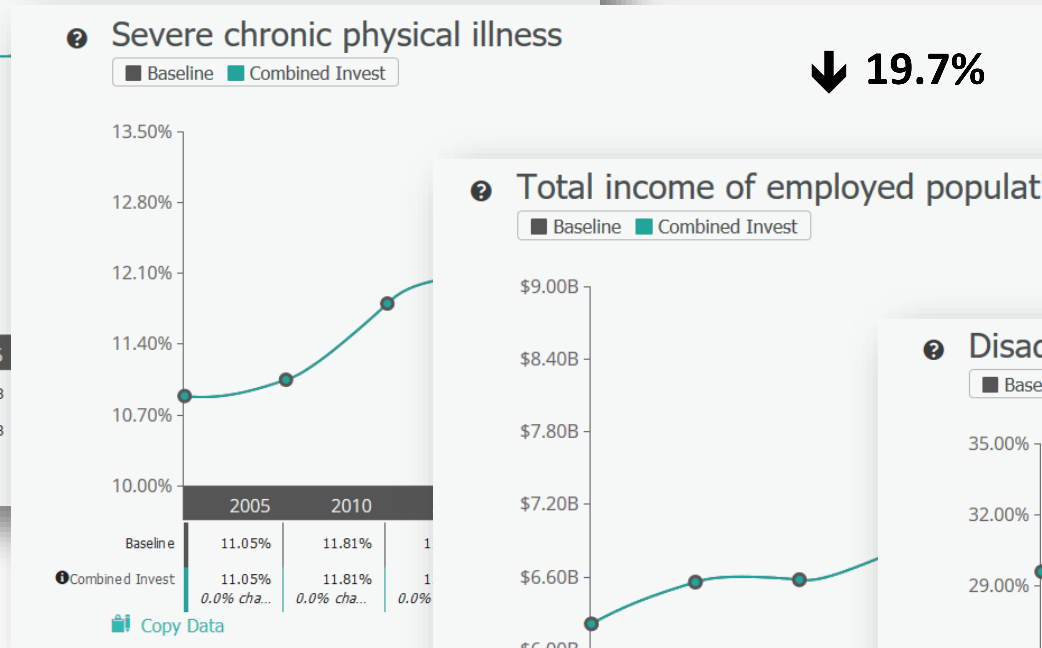
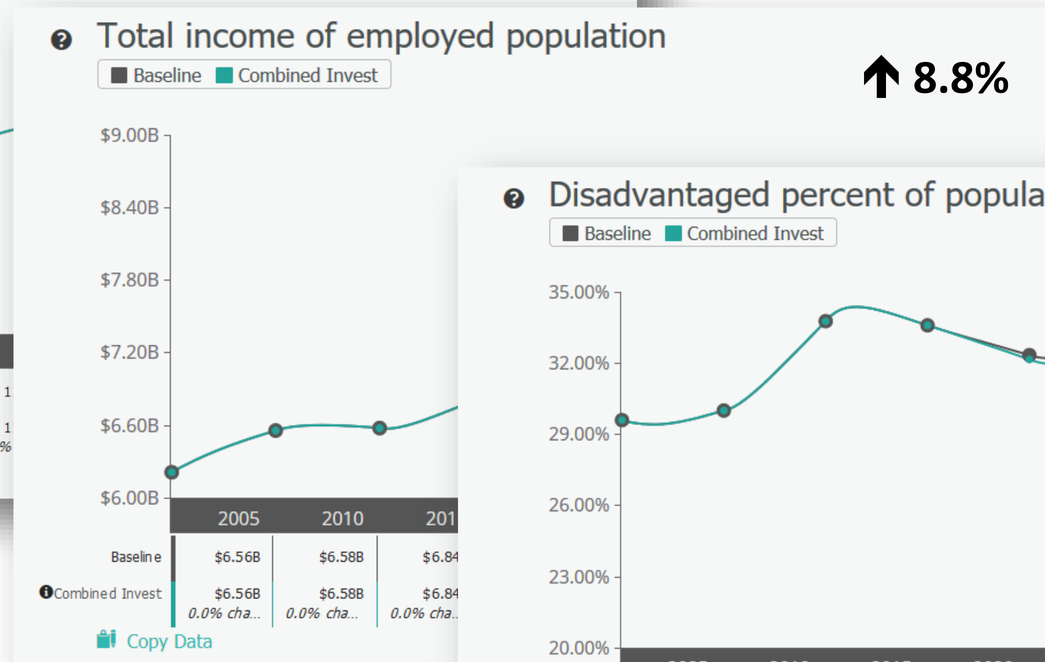
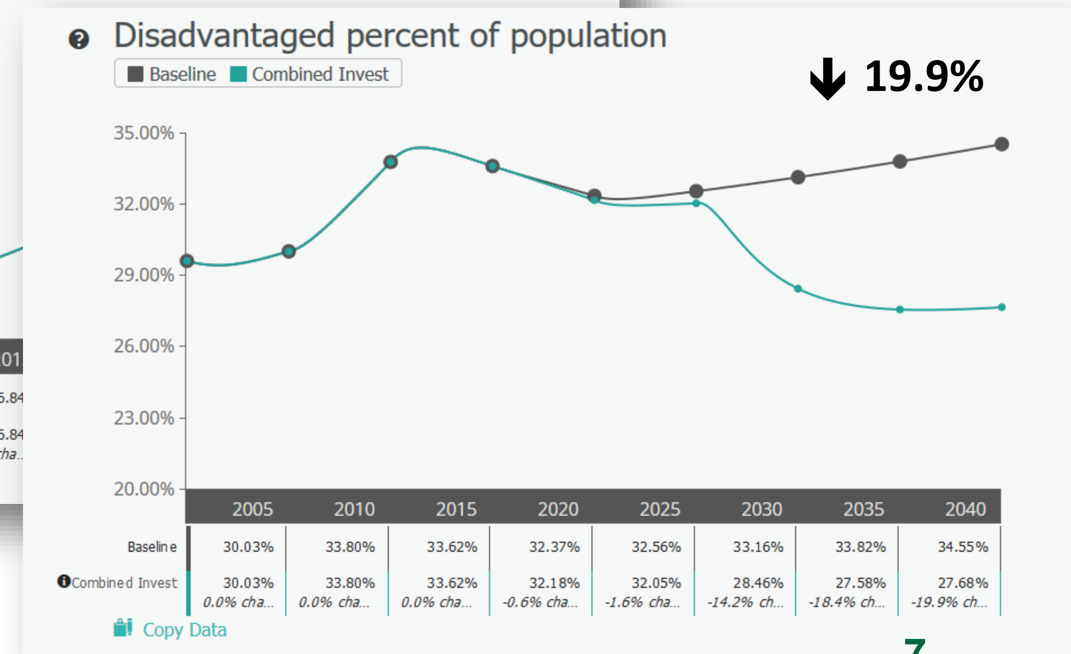








We ignore where the waste is

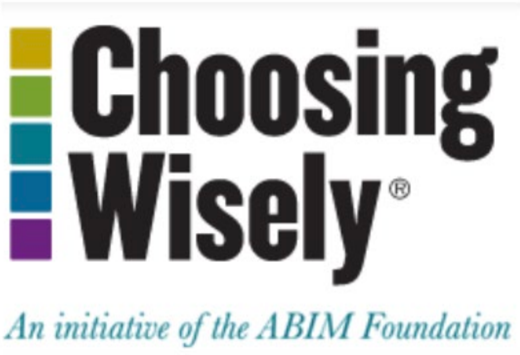
Category of Waste	Estimated Percent of US Spending
Failures of Care Delivery	3.8% – 4.8%
Failures of Care Coordination	0.9% –1.3%
Overtreatment	5.9% – 7.1%
Administrative Complexity	4.0% – 9.2%
Pricing Failures	3.1% – 4.9%
Fraud and Abuse	3.0% – 6.6%
Overall Percent of Spending, US Health Care	**21% – 34%**

Berwick and Hackbarth, JAMA 2012

We ignore where the waste is

Mistake: a narrow focus on specific treatments: tests, drugs, procedures
Why? This is the focus of medical education and practice

Example: Reducing low-value tests, procedures and drugs is widely seen as an effective way to reduce harm and costs.



Choosing Wisely by the Numbers

- Over 80 specialty society partners
- 520 recommendations
- Over 70 consumer and employer groups

Original Investigation | Health Policy

February 16, 2021

Trends in Low-Value Health Service Use and Spending in the US Medicare Fee-for-Service Program, 2014-2018

John N. Mafi, MD, MPH[1,2]; Rachel O. Reid, MD, MS[3,4,5]; Lesley H. Baseman, BA[3]; et al

Author Affiliations | Article Information

JAMA Netw Open. 2021;4(2):e2037328. doi:10.1001/jamanetworkopen.2020.37328

***Also* by the numbers: How Much LVC care? How Much Improvement?**

	2014	2018	Change
Percent of enrollees receiving any LVC	36.3	33.6	8% decrease
Spending on LVC per Medicare enrollee	52	46	10% decrease $6 per enrollee
Total Spending per Medicare enrollee	10,235	10,229	.01% decrease $6 per enrollee

We ignore where the waste is: Care Delivery

Care delivery: Where, by whom and how often treatment is given
Doctors rarely consider – example: when to see this patient again?

Examples:

- Site of care: inpatient, outpatient or home
- By whom: specialist, primary care, nurse, community health worker
- How often: frequency of follow-up physician visits

Driven by supply:

This is where a lot of the the money is (especially Medicare and Medicaid)

We ignore where the waste is: Care Delivery

Variations in the Longitudinal Efficiency of Academic Medical Centers

Methods:

Patients hospitalized for heart attack, hip fracture and colon cancer 1993-5

Why? (1) Similar risk; (2) insights into quality and outcomes of 3 service lines

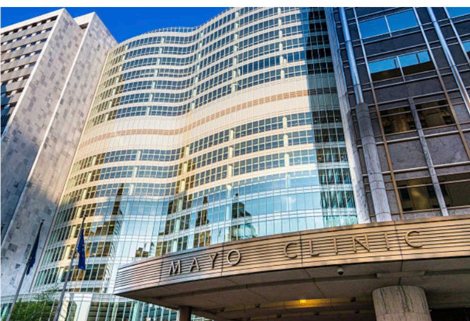
(3) Patterns consistent across diagnoses will reveal shared attributes of “system”

Hospitals included were 299 members of Council of Teaching Hospitals

Why? “Best” hospitals.

Hospitals grouped according to regional measure of intensity (price-adjusted spending)

Low intensity - Mayo



High Intensity - NYU

Health Affairs, 2004

We ignore where the waste is: Care Delivery

Findings: Price-adjusted spending

Spending differences across US Academic Medical Centers					
	Low	**Middle**	**High**	**Ratio**	**Difference**
MD spending, first 6 months					
AMI (acute myocardial infarction)	1120	1234	1742	1.56	622 per person
Colorectal Cancer	962	1094	1548	1.61	586 per person
Hip Fracture	894	1054	1628	1.82	734 per person
Annual Hospital & MD spending, 6m to 5 yrs					
AMI (acute myocardial infarction)	7841	9223	11492	1.47	3651 per person
Colorectal Cancer	6200	7374	9325	1.50	3125 per person
Hip Fracture	4943	6102	7825	1.58	2882 per person

Findings: Quality, Access, Outcomes

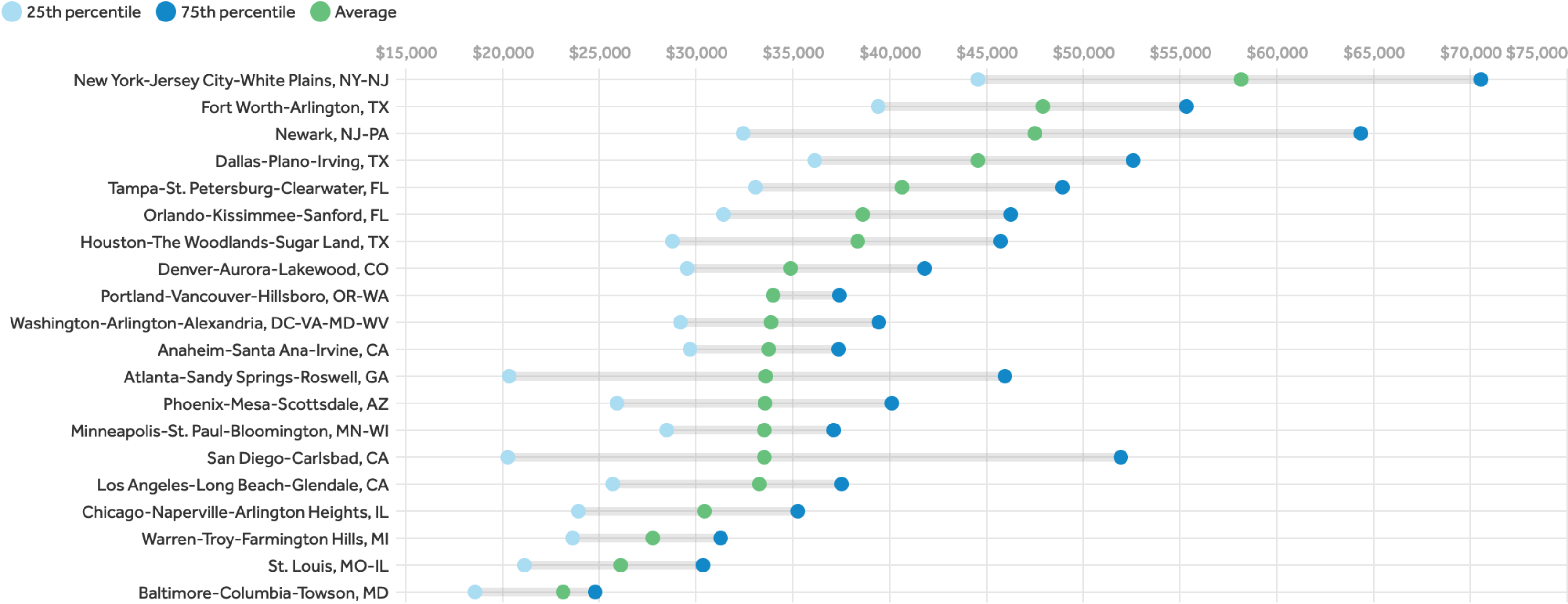
Quality of care: no better (4/6 measures) or worse (2/6 measures) in high intensity hospitals.

Access to care: Patients in high intensity hospitals more likely to see a cardiologist within 30 days; Patients in high intensity hospitals were no more likely to receive PCI or CABG.

Survival: No difference

We ignore where the waste is: high prices (for commercial payers)

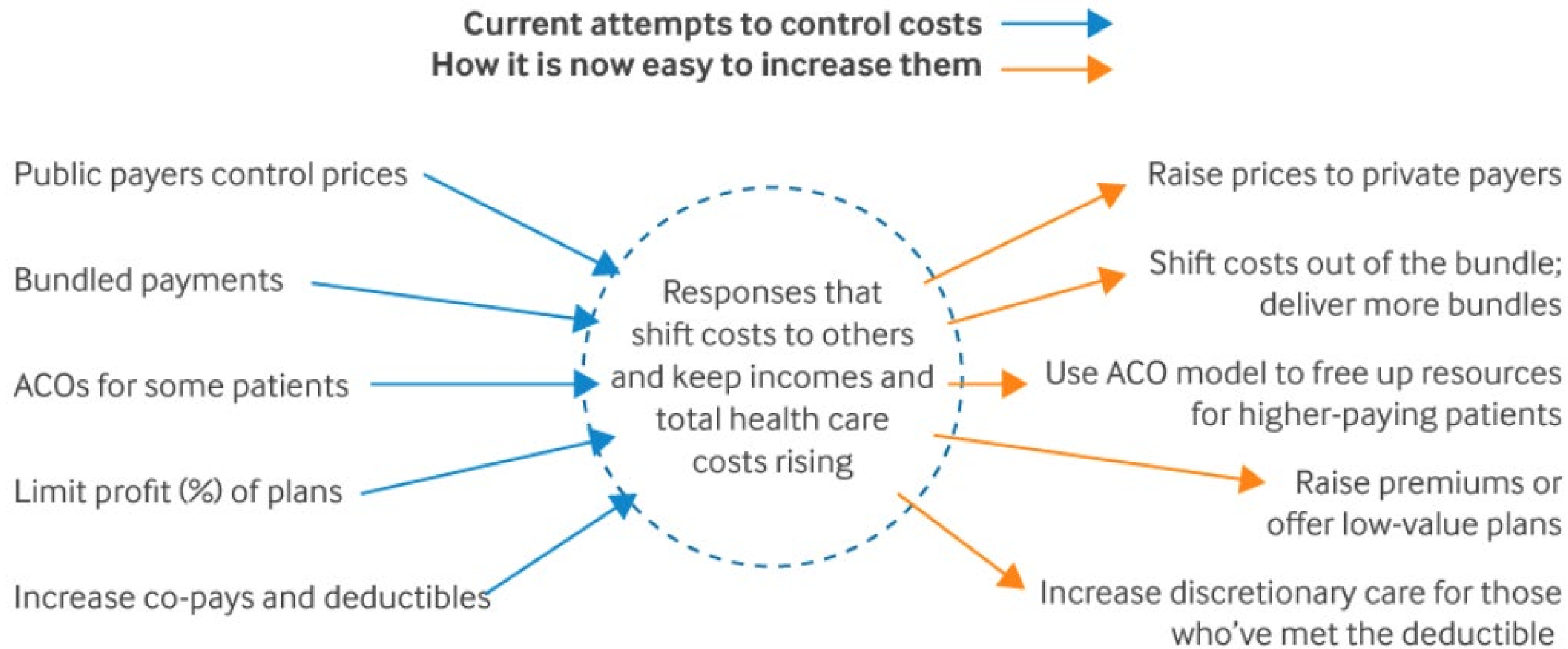
	Average in-network charge
NYC – NJ	$58,000
Baltimore	$23,000



https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/

Why so hard to fix? A fragmented system

Why reduce costs if you don't have to?



All of these (and more) are facilitated by Vermont's fragmented payment system

Total 2019 VT Resident Healthcare Expenditures by Payer ($6,515 M)

Non-APM expenditures ($3,504 M)
All others $1,937 M
Medicaid $1,276 M
Medicare $291 M

APM TCOC ($3,011 M)
Medicare $1,321 M
All others $1,242 M
Medicaid $448 M

Why so hard to fix? A fragmented system

How <u>might</u> we overcome this?

A global budget

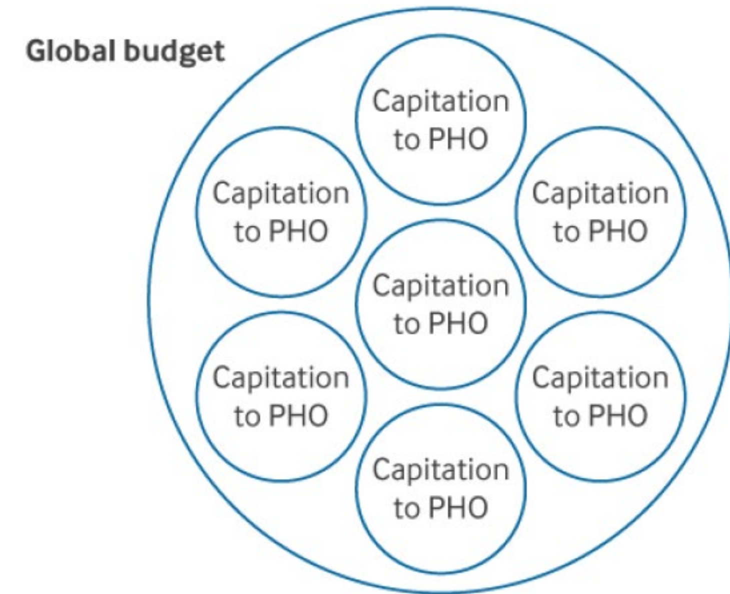
Capitation to population health organizations

Better information – to find the leaks; improve performance

Administrative simplification -- *a single system*

Single payer

Regulated multi-payer, all playing by same rules



ES Fisher Reforming Healthcare: The Single System Solution. NEJM Catalyst, August 19, 2020

But can we? Policy change is hard

Underlying Problem: a process headed for failure

Divergent stakeholder perspectives, many of whom could easily block progress

Current focus is on positions: (e.g.) don't touch hospitals; increase payments to physicians

Decision-making: stakeholders are largely asked to make concessions, which they legitimately resist.

No one has the primary, ongoing responsibility for inventing a creative, feasible solution

Approach: establish a process more likely to succeed

Engage stakeholders in a process specifically designed to make them willing to support a final proposal

Explore interests and create solutions focused on the public good that meet parties core interests

Better: encourage criticism of a working draft and iteratively refine it; final decision is "this, or nothing"

Establish a dedicated team to manage the reform process and develop proposals with broad support

Might this work?

It has

Camp David Accords

And on a much smaller scale…ACOs

Concept 2004-6: BCBS MA, Medicare (McLellan), Dartmouth

MedPAC presentation: naming opportunity; and gained their support

Dartmouth-Brookings "team" to advance federal legislation

Iterative development and refinement

- AHA – from physician-led to provider-led
- Consumer groups: quality measures; no lock-in
- Congress: could it save money? (CB0)
- Waxman: would providers support it? (Pilots, California medical groups

Reform is a process

"..that reconciliation is a process. It's not something that is just an event."

Desmond Tutu

Desmond Tutu discussing the Truth and Reconciliation Commission in South Africa
With Krista Tippet, 2010. https://onbeing.org/programs/remembering-desmond-tutu/#transcript

Might this work here?

Stakeholders hoping for better performance should establish an ongoing reform process.

Summary

The Challenges We Face	Underlying Barriers to Progress	Principles to guide reform	Some Specific Ideas
Access Hospital sustainability Affordability Quality Disparities in health Provider burnout etc	Pessimism	Create shared vision of what is possible	Convene a multistakeholder group using the ReThink Health model
	We ignore where the waste is	Broaden perspectives on opportunities to improve	The model can help
	A fragmented system	Move toward a single system that can improve health, care and costs – while eliminating cost-shifts	Build on all-payer data to track performance and efforts to evade pressure to improve
	Current stakeholders resist change and can block it	Establish a reform process for the long haul that serves up the best feasible solutions.	Seek expert guidance on creating a reform-focused co-design process and team