The Unfinished Business of the Baby Boom Generation: Healthcare for the 21st Century

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The Greatest Generation

- Won Second World War
- Built system of Higher Education
- Created interstate highway system
- Built the transmission grid
- Went to the moon
- Cured polio and eradicated smallpox
- Put in place the great programs of the 20th Century
  - Social Security
  - GI Bill
  - Medicare
  - Medicaid
The Unfinished Business of the Baby Boom Generation
To resolve crisis need:

- Agreed upon system objectives
- Accurate diagnosis of problem – why current system is not achieving those objectives
- Clear description of the design elements necessary to achieve objectives
Objectives

Health vs. Health Care
System Objectives

The Triple Aim

(Institute for Healthcare Improvement)

1. Improve population health
2. Reduce per capita cost
3. Improve patient experience
   - Outcome
   - Safety
   - Satisfaction
Health Field Model
Influence Factors on Health Status

CATEGORICAL ELIGIBILITY
EVOLUTION OF CURRENT ELIGIBILITY AND FINANCING STRUCTURE

- 1954 Tax Reform Act - Granting preferential tax treatment to employer sponsored coverage
- 1965 – Enactment of Medicare
- 1965 – Enactment of Medicaid
COVERAGE GAP

- Public
  - Medicaid
  - Medicare

- Private
  - Employment-based coverage

Those who don’t fit into a category
COST SHIFTING
(Shifting Accountability)

Change Eligibility

Drop Coverage

Public

Private

ER
Who has the responsibility to pay for the health care needs of those who cannot afford to do so themselves?
Chronic Disease*

People with chronic diseases → 70% HC spending

- Diabetes
- Coronary Artery Disease
- Congestive Heart Failure
- Asthma
- Mental health / chemical dependency

* George Halvorson Health Care Reform Now
Distribution of Health Care Expenditures*

1% of population → 35% of HC spending
5% of population → 60% of HC spending
10% of population → 70% of HC spending

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Managing Chronic Disease

Preventable
Progressive
We know how to intervene to prevent complications.

Requires
- Care team to coordinate care and share information
- Most important care giver is patient and family
- Well educated patients who can recognize early warning signs of a complication
- Rapid response
- Not everyone has the same capacity for self-care
Problems in the Delivery System

- Acute care “infectious disease” model
- Solo or small group practices working independently
- Lack of Data

Most people with chronic conditions

- Interact with the care system only in crisis
- Get the appropriate care only 50% of the time
Financial Incentives*

Financial incentives reward acute care interventions and discourage reorganization around chronic care management.

9,000 individual billing codes

- No code for a cure
- No billing code for prevention
- No billing code for health improvement

... *These are not billable events*

*George Halvorson Health Care Reform Now*
Transformational Change
Financing

Must explicitly answer question:

Who has the responsibility to pay for the health care needs of those who cannot afford to do so themselves?

- Public Sector Responsibility
  …But not an open ended responsibility

- Eliminate Categorical Eligibility

- Publicly financed Floor

- Defined benefit
  Prioritization process (Oregon Health Plan)
Value Based Cost Sharing
(Two Tiers)

Co-payments used to drive individual behavior and personal accountability

Little or no cost-sharing for services which are highly effective and rank high in terms of population health

Higher cost-sharing for elective and/or discretionary services and those which rank lower in terms of population health
Organization of Care

The basic level of care must be organized around “Families of Conditions”

1. Pregnancy, childbirth and early childhood
2. Chronic Life Threatening (e.g., diabetes)
3. Acute Life Threatening (e.g., trauma, acute MI)
4. Acute episodic non-Life Threatening (e.g., UTI)
5. End of Life Care
The New Delivery Model

Revenue flows to risk bearing entities at the regional or local level each of which would bear economic risk and assume responsibility for the health of a defined population.

- A hospital with an affiliated physician group
- A large primary care group practice
- Visionary health plan
- New entity
Risk Bearing Entity

1. Recognizes local and regional differences

2. Provides “single point of contact” (advocate, case manager) for each individual within defined population

3. Serves as an “integrator”
Payment

**Subscription payment**
For maintaining the relationship with each individual.
- Patient education
- Maintaining an electronic record
- Individual case management
- Coordinating care
- Office visits
- 24/7 consultation

**Bundled payment**
For managing complex conditions – especially those requiring hospitalization.

**Performance bonus payment**
For high quality care (i.e., reducing complications, hospitalizations, etc.)
Economic Stakeholders

- Uninsured
- Workers with good employer-sponsored coverage
- Seniors on Medicare
- Those with disabilities and other special needs
- Employers
- Doctors, hospitals and other providers
- Insurers and health plans
- Pharmaceutical manufacturers
- Medical device manufacturers
- Others...
The Future State – Most Can Be Winners (D. Berwick, M.D., IHI)
The Transition State – Hard for All

(D. Berwick, MD., IHI)
Shift Focus from Where We Want to End Up to How We Get There

(D. Berwick, MD., IHI)
Agreeing on a Shared Vision

“No wind is the right wind if you don’t know what port you are sailing for.”

-- Seneca
Accountable Care Organizations*

Local integrated delivery systems
- Accountable for health/cost across defined population
- Large enough to support performance measurement
- Able to provide/manage full continuum of care

Participate in Shared Savings
- Interim step toward fundamental payment reform

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Leadership Starts with Us
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