Our Changing & Challenging Health Care Landscape: A Brief Overview

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Executive Vice President, Patient Care Svcs/CNO
Our Changing & Challenging Health Care Landscape: A Brief Overview

Focus:

- Issues, Trends & Shifts in Health Care
- Coordinating Care across a Continuum, CMS’ New Payment models & Rethinking Care Roles

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Holy Name Medical Center
So What’s the Problem?

✓ FEDERAL GOVERNMENT is running out of money for Medicare (“CMS”) programs

✓ STATE MEDICAID programs are unsustainable, regardless of highly touted Federal matches.

✓ BUSINESSES are finding the cost of health care to be too much of a burden

✓ CONSUMERS are unable to shoulder the out-of-pocket costs of health care, and certain populations that fall outside the ACA’s insurance guarantees (e.g., undocumented persons) will still flood ERs, many unable to pay for care.
What drives these costs?

- Aging population
- Uninsured, underinsured
- Fragmented care
- High $ Technology
- Fee-for-Service Medicine
- Excessive paperwork
- Everything costs too much!
According to Milliman, every US family pays the dollar equivalent of a new Chevy Cruze in health care costs. Every year.

Milliman Medical Index
(Family of 4, per year)
Medicare Population to Double by 2040

Aging population has the potential to “swamp” the system

Projected U.S. Population Aged 65 and Older (in Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (Millions)</th>
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<tbody>
<tr>
<td>2005</td>
<td>36.7</td>
</tr>
<tr>
<td>2006</td>
<td>37.2</td>
</tr>
<tr>
<td>2007</td>
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<td>2045</td>
<td>84.5</td>
</tr>
<tr>
<td>2050</td>
<td>88.5</td>
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</tbody>
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Workers per Medicare Retiree

<table>
<thead>
<tr>
<th>Year</th>
<th>Workers/Retiree</th>
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<tbody>
<tr>
<td>2005</td>
<td>5.0</td>
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<tr>
<td>2006</td>
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<td>2.8</td>
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<tr>
<td>2050</td>
<td>2.8</td>
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</tbody>
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Source: Population Division, US Census Bureau, released 8/14/08
The Aging Population

Annual Per Capita Healthcare Costs by Age

- US
- Germany
- UK
- Sweden
- Spain

Assembled by Prof Paul Fischbeck Carnegie Mellon University; reported by Mark Roth of the Pittsburgh Post-Gazette, Dec., 2009.
**Good News:** Spending continues to increase, but the rate of such increases has slowed

% Increase in National Health Care Spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Increase</th>
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<tbody>
<tr>
<td>2003-2011</td>
<td>7.1% 6.8% 6.5% 6.2% 4.7% 3.9% 3.9% 3.9% 3.9% 0.0%</td>
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Medicare Spending Growth per Beneficiary

<table>
<thead>
<tr>
<th>Year</th>
<th>Increase</th>
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<tbody>
<tr>
<td>2010-2012</td>
<td>3.6% 1.8% 0.4%</td>
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Significant Outpatient Shift

MEDICARE Volume Growth
Cumulative % Change

2004 2011
Outpatient Services per FFS Part B Beneficiary
Inpatient Discharges per FFS Part A Beneficiary

34%
(8%)

ALL PAYER Volume Growth Projections
2012-2017

Cardiac Services (10.5%) 10.7%
Vascular Services (4.1%) 13.8%
Orthopedics 5.0% 14.8%
Neurosurgery 14.0% 19.9%

The Jury is Still Out . . .

Although improved since its difficult debut, the target enrollment for the Affordable Care Act (ACA) is far from ensured. The promise of ObamaCare will be unfulfilled & collapse financially:

✓ If an insufficient # of paying people signed up
✓ If enrollees are mostly Medicaid
✓ If younger, healthier people who require fewer resources didn’t join (& pay)
CMS/Medicare (and other payers) expect to see measured outcomes and quality for their dollars.

- Value-based Purchasing
- Accountable Care Organizations ("ACO’s")
- Medical Home Model (on-going, patient-centric care coordination)
- Bundled Payments
  - Sharing savings among providers
  - Taking on financial risk re meeting financial and quality targets.
A shift in focus — from single sites to a coordinated plan & follow-through from site to site.

Achieving measurable success in the new model will take time as providers learn to communicate & work together.
CMS is testing new methods of care delivery and payment by using demonstration projects such as:

- **Accountable Care Organizations ("ACO’s")**: which makes hospitals responsible for all costs & services other than drugs – hospital, doctors, ASCs, nursing homes, therapy, home care, etc. – for the patient during the year, regardless of whether the hospital provided the care; and,

- **Bundled Payments for Care Improvement ("BPCI")**: Same concept as the ACO, but limited to specific conditions (e.g., hip replacement), covering the hospital stay and all care/services, doctors, etc. during the 90 days after discharge.
Accountability & Pay for Performance

Regardless of demonstration, the core tenets are the same:

- Care must be managed & coordinated across the continuum.
- Total billings by all providers (hospitals, doctors, nursing homes, rehabs, home health, outpatient settings, etc.) must be lower than in the past.
  - Otherwise, the hospital is at risk to pay back the difference to CMS.
- Patients must express satisfaction.
  - Otherwise, payments may be reduced.
- Quality targets must be achieved.
  - Otherwise, payments may be reduced.
ACO/BPCI Care Strategy & Workforce

- **Primary Care MD (ACO)** / **Attending MD/Surgeon (BPCI)** must manage care efficiently & effectively, and avoid too many ($ billing) consultants.

- **Technology/IT** is crucial for effective and efficient management.

- **RNs** assume responsibilities previously provided by MDs. **Advanced Practice Nurses (APNs)** take on significant roles.

- The **patient** must be assume active responsibility for his care & wellness.

- **New roles** such as “Navigators” arise, coordinating care and ensuring communication among all providers, care sites, and the patient.

- “**Post-Acute Care**” shifts from expensive nursing homes/sub-acute facilities (which may keep the patient the maximum days allowed by Medicare, and too often return the patient for a repeat hospitalization) to managing the patient at **home** with home health care services.
  - Hospitals are ramping up size/capability of their home health services.
  - Nursing homes that won’t improve their approach are **avoided**.
Challenges

- Long-term, Federal & State governments will continue to cut payment rates, and Commercial payers will demand the same. Greater value for the $$$ will be demanded by all.

- Fee-for-service will be replaced with results-based payment system.

- Bundled payments and responsibility for “episodes of care” and “covered lives,” rather than single-site events. Controlling care across the continuum will be key.

- The ability to manage risk will be crucial.
Game Plan / Finale: Seek Opportunities

- Embrace technology.
- Cooperate and collaborate.
- Achieve an integrated continuum of care.
- Focus on wellness vs. illness; and life management vs. disease management.
- Manage chronic disease (and end-of-life care).
- Teach and empower the patient to take responsibility for his health.
- Seek best practice from every provider and measure outcomes and quality.
- Achieve population health, satisfaction and low cost.
Questions & Discussion

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