

Health Care 2015 – And How Do We Get There?

The Albert J. Himelfarb Lecture at Sinai Hospital

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It is an honor to give the 2012 Albert J. Himelfarb Lecture – a legacy established by Dr. Himelfarb’s family in memory of a wonderful clinician, teacher, colleague, and citizen.

My topic is “Health Care 2015 – and How Do We Get There?”

Preparing for this topic was not easy ... because my usual time horizon is Tuesday.

I am often entangled in the challenge of the day – whether it is an infectious disease outbreak, personnel issue, policy decision, budget crisis, or... the totally unexpected bureaucratic code blue.

When I was health commissioner of Baltimore, one afternoon I learned there were more than 40 horses in a poorly constructed stable in the middle of the city. We had to relocate the horses on about a day’s notice.

At the Food and Drug Administration, I was involved in the response to a salmonella outbreak – in lion meat.

Last summer, in my present position, I learned late on a Friday from the *Washington Post* that our department had issued a flat prohibition on campers applying sunscreen to one another, even if in the same family ... leading to outrage among parents and dermatologists alike.

To manage urgent issues, both natural and self-inflicted, it is easy to devote 14 hours a day.

So the topic of “Health Care 2015” is a break from my routine and a good opportunity to pause and reflect.

I had a choice in how to put this talk together. One option was to pull together slides with information on cost, quality, metrics, ACOs, NCQA, MCOs, etc.

But then I thought about Dr. Himelfarb – a man who served in World War II in a unit that helped lead the D-Day invasion. A man who loved the Orioles, teaching all his children and grandchildren to keep score. A man who loved reading James Reston and Tom Wicker columns in the New York Times.

I thought he would appreciate a discussion at a high level of what is happening in health care and why.

So in preparing these remarks, I gave myself three rules:

One, no slides.

Two, no acronyms.

And three, no consonants.

Just vowels. A-E-I-O-U.

Access to care. Experience of Care. Incentives. Outcomes. Utilization.

And then I will end with why.

A is for access to care.

By 2015, all Marylanders should have ready access to health coverage at a reasonable cost. This coverage should open the doors to services that support health, prevent illness, and treat disease.

We are not there yet. I can only imagine the access disasters that Sinai Hospital sees every day. More than 700,000 of our friends and neighbors in Maryland have no health insurance at all; lack of insurance is associated with preventable hospitalizations, heart attacks, strokes, and mortality.

While our state's unique hospital financing system provides support to institutions to care for the uninsured, there are still major gaps. For example, those without resources have long had a challenging time accessing outpatient specialty care in Maryland.

There are also gaps in access to primary care. Many safety net clinics are filled to capacity – and beyond. And when clinics are so busy, it is very difficult to serve as an accessible place of care. As a result, many patients often wind up in the Emergency Department when they do not need to. About 20% of the visits by the uninsured to Emergency Departments are not emergent, and another 20% could have been treated in primary care.

Access challenges are not limited to the uninsured. Hundreds of thousands of Marylanders with chronic illnesses cannot leave their jobs for fear of losing coverage in the private market. Many with private coverage now face such high deductibles that it is extremely challenging to pay for care when it is actually needed.

And as far as public insurance, it can be difficult to enroll, and once enrolled, challenging to find needed care in all areas of the state.

Fortunately, just over the horizon known as the Supreme Court and the Presidential election, there are brighter days ahead for health care access.

The Affordable care Act strengthens private coverage and prevents exclusions from pre-existing conditions. It also expands Medicaid to individuals with incomes up to 133% of the federal poverty line.

Between 133% and 400%, the law provides subsidies to purchase private coverage through the health benefit exchange. While some states have not moved forward to establish an exchange, Maryland has come together in support of doing so. Two bills to establish and structure the exchange have passed the state legislature. Scores of stakeholders have participated in developing key policies. We have a board, a staff, and a plan. About 350,000 more Marylanders will access coverage under the law, bringing as much as \$1 billion in insurance subsidies into the state each year.

To make this new system work, we will be replacing a 20 year-old Medicaid eligibility system with a modern web-based program. Online, on the phone, or with navigators ... Marylanders will be able to sign up for health care.

It is vitally important that after all this effort ... the health coverage provided is meaningful.

The Affordable Care Act requires the Exchange to develop a system of grades and metrics for health plans. The usual choices are the basic quality metrics we're familiar with -- such as the immunization rate and the average hemoglobin A1C.

We will also be able to take a step back and ask about other key indicators of access.

Should we track whether all adults have been screened for hypertension and are in primary care being treated? Should we measure satisfaction with care coordination among the chronically ill?

We'll get your input on these and other questions as the Exchange moves forward.

E stands for the experience of care.

With my mom here today, I can say this about patient experience: What we want for all patients is what we want for our own mothers.

In the case of illness, we want her to focus on getting better. We want her to relate well to her health care providers, be spared unnecessary tests and procedures, avoid confusing bills, and make the key decisions about her treatment.

Unfortunately, for many patients, including many mothers, this is not the health care system we have today.

The best that can be said about billing and payment is that it represents a very aggressive mental status exam. When I passed a kidney stone (curiously, right before my wife gave birth our second child), I received bills for about a year for an appendectomy. Only when I offered to drive down to the financial office and prove to them I had no scar was I able to clear it all up. I have very little idea how much care actually costs or what I will be billed in my insurance, and I bet you do not either. A recent study on appendectomy found price variation from \$1,500 to \$180,000 in hospitals across the country.

There is duplication of tests and procedures, by some estimates affecting 1 in 5 hospitalized patients, as a result of inadequate access to prior results.

There are gaps in trust and communication, especially among patients of different races and ethnicities from health care providers. These gaps lead people to disregard medical advice, reduce utilization of preventive health services, and undermine patient satisfaction, and exacerbate disparities.

There are major challenges integrating somatic and behavioral health care for vulnerable patients. In Maryland, we have one financing system to pay for diabetes care, another for severe depression, and a third for alcohol abuse – even though a single patient may have all three conditions.

And there is confusion about end-of-life wishes, which may lead to unnecessary, intrusive interventions.

The good news is that several key efforts are moving our health care system in the right direction. These include:

1. Continued expansion of Maryland's Health Information Exchange – a network which already contains information on every hospital admission and discharge. The Information Exchange will be able to notify primary care providers in real time of Emergency Department visits and admissions. Clinicians will be able to check radiology and labs done at outside institutions. As clinical data accumulates in the exchange, patients will have more access to their own information, enhancing transparency and supporting better communication. And we'll add a registry of advance directives.
2. Greater focus on language access and cultural competence. A state workgroup is developing standards for access to care by individuals whose primary language is not

English, and we expect to help with training materials. Hospitals like Sinai have led the way in many of these areas, and we would like to see wide sharing of best practices across the state.

3. Major reform of our state's approach to the integration of behavioral and somatic health. We're planning to merge our Alcohol and Drug Abuse Administration with our Mental Hygiene Administration and create an agency focused on state behavioral health outcomes. We separately are developing a new financing strategy designed to support integrated care.
4. Rethinking transparency and pricing in health care. It is not radical to suggest that patients should have a good idea of what particular services cost in advance. We may need to develop a common platform across the state to untangle a very confusing system.

I would love to see as much engagement as possible from the clinical community as these and other efforts are launched.

I is for incentives.

In 2015, clinicians and clinical organizations should largely be reimbursed based on the value of their services and not the volume.

For too long, American medicine has been paid fee-for-service. More services, more fees. It is no surprise that such payment has led to unnecessary tests and treatment (by some measures as much as \$700 billion each year) and rising costs.

Recently, I met with the Baltimore Ecumenical Alliance at a church near the Johns Hopkins campus. I had never met with this organization before, so I was a little intimidated when I walked into the room. Everyone was wearing formal, clerical attire.

I had been invited to talk about implementation of health reform in Maryland. At one point, one of the clergy asked me why health care costs so much.

I started by talking about some public health challenges like smoking and obesity. But then I noted that in a system in which doctors and hospitals are paid for every procedure and intervention, it is no surprise that costs keep going up.

I asked them to consider what would happen if each of the clergy assembled were paid by the prayer.

The room became very quiet ... for an uncomfortably long time.

Finally, one minister reached over and grabbed my hand, looked me in the eyes, bowed his head slightly and said: "Let us pray."

Fortunately, we are starting to see the emergence of different types of incentives in Maryland.

Our traditional approach to hospital payment has been to pay for every admission and emergency department visit. A patient with heart failure who was readmitted six times in six months would generate six full reimbursements.

Recently, however, Maryland's unique hospital payment system has incentivized hospitals to reduce readmissions, and some hospitals in rural areas are even working under global budgets. These provide resources to keep patients healthy and out of the hospital, allowing the institution to keep the savings. Hospitals are now seeking to align incentives with hospital-based physicians through special arrangements with Medicare.

In the community, primary care doctors have traditionally been paid by the visit. This approach has provided little support for time-consuming care coordination for the most chronically ill and complex patients.

Recently, patient-centered medical home models have emerged in Maryland. These efforts aim to give extra resources for managing complex illness and to reward clinicians for better clinical outcomes and more efficient care.

Outpatient specialists should know that payment reform will increasingly affect them as well. Emerging ideas include reference pricing, which relies on greater price transparency and insurance reimbursement pegged to a certain percentile cost; and bundled payments, in which specialists are paid a fee by diagnosis and not reimbursed for specific procedures.

These payment reform efforts are far from perfect, but they are movement in the right direction.

What is most exciting to me is the flurry of activity in Maryland aimed at keeping patients healthy. Hospitals are working with nursing homes to reduce bounce-back admissions. Mental health and substance abuse providers are teaming up with health systems to address behavioral health needs. Outreach workers are keeping patients stable at home.

We have set up a website --- <http://dhmh.maryland.gov/innovations> -- to link up health care systems and clinics facing new financial incentives with partners who may be able to help them keep patients healthy. I would highly recommend this site and ask that if you are aware of promising initiatives that should be featured, please let us know.

One final thought on incentives: Patients too should be rewarded for taking steps towards better health. I would like to see patients who access preventive services and make efforts to improve their health see concrete benefits in the short term, not just years down the road.

O stands for outcomes.

In 2015, “health outcomes” should be a broad concept ... encompassing the outcome for a patient, the outcome for a series of patients ... and the outcomes for a community or population.

A patient receives urgent angioplasty for a heart attack and lives to tell the tale as a result. That’s an important outcome.

A hospital has a terrific track record of responding quickly to cardiovascular emergencies with excellent survival rates for presenting patients. That’s another critical outcome.

So too is the rate that individuals in the nearby community are having heart attacks in the first place.

When I was the health commissioner of Baltimore, the RAND Institute did a study finding higher rates of ambulatory care sensitive admissions in our city than in anywhere else they had studied. These are admissions that could have been prevented with timely access to primary care. I said at that time, if you are sick, there is probably no better place to be than Baltimore. But if you want to stay out of the hospital, that’s a different question.

Our state ranks #1 in the country for our educational system, among the top several states for income, and middle of the pack in health. We’re 41st in infant mortality. By some measures of infectious disease, we’re near or at the bottom.

The good news is that our health care systems are starting to think big on health outcomes. Our state’s hospitals helped to support the launch of the State Health Improvement Process. This effort set 39 specific measurable goals in six areas.

Our website features data by county, and by race and ethnicity, for the 39 measures. Across the state, hospitals, health officers, physicians, businesses, and others are coming together in local planning coalitions to develop plans to improve these numbers. These efforts will then align with hospital community benefit plans. You can check out our website at <http://dhmh.maryland.gov/SHIP> for opportunities to participate, and the city’s effort is online at <http://baltimorehealth.org>.

Recently, Lt. Gov. Anthony Brown and Governor Martin O’Malley championed legislation to establish Health Enterprise Zones in Maryland. Significant funding will be available in pilot zones to expand community health and primary care, with the goal of improving outcomes and eliminating disparities. We expect health systems to be major partners across the state in coalitions that seek this funding.

It is exciting for doctors to think about population health. Dr. Himelfarb's grandson, my college classmate Dr. Andy Fine, told me last night of his efforts in Boston to develop a system of real-time epidemiology to help point of care clinical decisionmaking. Figuring out what's behind that sore throat may be easier when you know the results of the last 100 throat swabs at that same location.

There is tremendous room for innovation to improve health outcomes. Recently, we launched a contest with cash prizes for ways to use electronic health data to improve public health outcomes. You can find it at <http://themarylandprize.maryland.spigit.com>. We've already gotten some great ideas – such as an easily accessible registry of transfusion reactions for sickle cell patients, and a predictive algorithm for readmission for Alzheimer's patients.

The deadline to submit ideas or vote is April 30.

U is for utilization.

In 2015, we should expect greater overall utilization of health care services – because of greater access to care – but also a shifting distribution of these services.

As the experience of health care improves, there will be fewer duplicated tests and procedures.

As incentives change, there will be fewer readmissions and procedures of questionable value.

As the system aligns to overall health outcomes, there will be greater investments in prevention and integrated care ... and there will be fewer preventable disasters in the Emergency Department.

Our health care system needs to adapt to provide the right care in the right setting to patients. This shift will have important implications for everything from certificate of need processes, volume-based marketing strategies, physician training, the role of allied health professionals, and patient expectations.

There are signs of progress in this direction. Fewer children are receiving antibiotics for the common cold. Nine medical specialty societies recently called out a list of 45 procedures that need to be curtailed. Some hospitals are even starting to prepare for declining volumes.

This kind of change will be difficult ... and so, I expect to increasingly hear the question, "Why?"

A-E-I-O-U – Why?

There are two approaches to this question.

One is to note that these changes in health care are better than the alternative – getting hit hard by the cost tsunami.

In the public sector, Medicare costs are the single greatest threat to the federal budget, Medicaid costs to the state budget. There is no question that significant cuts are coming.

In the private sector, companies have largely stopped paying for health care cost increases. High deductible plans now represent about two of every three plans sold in the small group market today. Affordability is a driving imperative.

Without expansions in access, improvements in patient experience, the right incentives, better outcomes, and efficient utilization ... the cost curve will batter Maryland and other states.

That will look like rising numbers of uninsured, less coverage in the private sector, enormous burdens from uncompensated care, and worsening health indicators. Hospitals and other safety net institutions will face unprecedented pressures and will struggle to survive. As families forego needed care, the health of our workforce will decline, further jeopardizing our economy.

So the alternative is not a pretty picture. But that is only one side of the coin.

There is another reason to support progress. A better reason ... because it's the right thing.

Health care is in transition. I concede there are all sorts of reasons to be nervous about the change that is coming. But there is also enormous value, and significant opportunities for leadership by doctors and hospitals across the state. Maryland will only succeed to the extent that you are engaged in and support this transition.

Fundamentally, we have a historic opportunity to align the health care system for health.

Let's take it.

I look forward to your questions and comments. Thank you.