Transforming the Practice of Medicine

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“It’s tough to make predictions, especially about the future.”

- Yogi Berra
SOURCE ORIENTED MEDICAL RECORD

NARRATIVE CHARTING
(TRADITIONAL CLIENT RECORD)

- Most flexible of all methods and is usable in any clinical setting.

Five Basic components of a Traditional Client Record

- admission sheet
- physician's order sheet
- Medical history
- Nurse's notes
- Special records and reports (e.g., X-rays, pathology, lab results, flow sheets)

FRONT-END/BACK-END SPEECH RECOGNITION

There are two types of Speech Recognition Technology (SRT) systems. Front-end Speech Recognition (SRT) is where the speech is digitally recorded on a PC and the voice is converted to text concurrently and the text is sent to the record. The resulting document is then stored in the electronic medical record. The SRT systems have been widely accepted by clinicians and nurses. While speech technology is rapidly advancing, the integration of SRT technology into the clinical workflow is a continuing process.

Although there is an immediate improvement in the accuracy of the dictation, it is important to consider the overall workflow implications of using the system. The system should be integrated into the workflow of the clinicians as a tool to improve their efficiency and effectiveness.

Even though many SRTs and NMTs technology providers have taken steps to provide solutions that address the needs of clinicians, the integration of these technologies into the clinical workflow is a continuous process. The integration of SRT into the clinical workflow requires ongoing evaluation and adaptation to meet the needs of the clinicians.
Volume Reimbursement

- Step 1
- Step 2
High Value Healthcare Collaborative

Maps showing health care collaborative regions across the United States.
Quantity > Quality  ... getting paid by the mile

(Winner – 2006: “It’s Not My Job Award”)
# Death in the United States

**Martin Makary, MD: 100K/yr → 250K/yr**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>614,348</td>
</tr>
<tr>
<td>Cancer</td>
<td>591,699</td>
</tr>
<tr>
<td><strong>Medical error</strong></td>
<td><strong>251,454</strong></td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>147,101</td>
</tr>
<tr>
<td>Accidents</td>
<td>136,053</td>
</tr>
<tr>
<td>Stroke</td>
<td>133,103</td>
</tr>
<tr>
<td>Alzheimer's</td>
<td>93,541</td>
</tr>
<tr>
<td>Diabetes</td>
<td>76,488</td>
</tr>
<tr>
<td>Flu/pneumonia</td>
<td>55,227</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>48,146</td>
</tr>
<tr>
<td>Suicide</td>
<td>42,773</td>
</tr>
</tbody>
</table>

Source: National Center for Health Statistics, BMJ

THE WASHINGTON POST
US Government Spending 2015

BILLIONS OF DOLLARS

$ Billions

Congressional Budget Office 2016
What is Driving the Change in Healthcare?

- Common Belief: The Affordable Care act and new Accountable Care Organizations.
- Reality: The Affordable Care Act primarily changed insurance models. High costs and low quality will drive change in payment models.
Can we afford to provide Health Care with a focus on VALUE?

➢ Yes. In fact, we cannot afford to continue to focus on volume > value.

“We now spend more money as a nation on the overhead of the healthcare payment system than we do on cardiac care. This must change.”

-- Allan Weiss, MD – CEO NCH Healthcare System
ACA to MACRA

- Overwhelming Bipartisan Consensus – eliminate SGR replace with MACRA
- Transforms Medicare physician payment – drive higher quality more efficient care within constraints of budget neutrality.
- Major provisions:
  - Value-Based Care
    - Establishment of pathways for reimbursement based on value and efficiency not volume
  - Measures
    - Support for measure development and maintenance
  - Provider Data
    - Expansion of the release of provider-related data
Proposed Medicare Payment Model Change 2015-2018

Quality based payment programs
- Hospital Value-Based Purchasing
- Hospital Readmissions Reduction
- Hospital-Acquired Condition Reduction
- End-Stage Renal Disease (ESRD)
- Quality Incentive
- Value-Based Modifier

Alternative payment programs
- Pioneer Accountable Care Organization
- Medicare Shared Savings Program
- Bundled Payments for Care Improvement
- Comprehensive Primary Care Initiative
- Patient Centered Medical Homes

All Medicare payments
Percentage of payments linked to quality programs
Percentage of payments linked to alternative programs

Current
80%
20%

By 2016
85%
30%

By 2018
90%
50%

Source: PwC Health Research Institute analysis, Centers for Medicare & Medicaid Services
# Medicare Bonus and Penalties SRP to MIPS 2016-2020

<table>
<thead>
<tr>
<th>Bonus and Penalties</th>
<th>2016</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>-2%</td>
<td>-4% to +4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS *</td>
<td>-2%</td>
<td>-2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value Modifier **</td>
<td>-2 % to +2%</td>
<td>-4% to +4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIPs***</td>
<td></td>
<td>-4% to +4%</td>
<td>-5% to +5%</td>
<td>-9% to +9%</td>
<td></td>
</tr>
<tr>
<td>Alternate Payment Model 2019-2024</td>
<td></td>
<td>5% based on prior year CMS expenditure</td>
<td></td>
<td></td>
<td></td>
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- Physician Quality Reporting System- CMS quality and safety measures
- Value Based Modifier Measures- CMS resource use and efficiency measures
- Medicare Incentive Payment System- Planned consolidation of meaningful use, PQRS, and VBM measures . (Exceptional performance bonus of +10% proposed)

MN Medicine November 2015
Where are we Headed?

• We will see/take care of more patients and reimbursement for their care will decrease.

• Patients will no longer require a visit for care.

• We will be accountable for the value of our care and our results.

• We will be at risk for cost, quality, and outcome.

Compensation Models Will Change
What do we mean by VALUE?

Value = Q+S+S/ Cost Over Time

- Value Based Payment models reward good outcomes that meet performance targets for cost
- They transfer some risk to providers or offer shared savings if the performance goal is met
- Most plans assign responsibility for a “population” of patients to a provider or payer group
Where are we Headed and …
How do we get there?

Fundamental requirements for success:

- A network of providers
  - Physical or virtual
  - Governance model

- Alignment of purpose

- Coordinated care delivery

- Practice analytics

- Financial alignment
VALUE
Value of Care: Measuring ➔ Improving

- Scientific Approach
- Care Delivery & Outcomes
- Cost
Use of Home Telemonitoring in the Elderly to Prevent Readmissions
Comparison: Telemonitoring + Versus Usual Care

Telemonitoring Intervention

- RN/MD team oversaw appx 100 patients and communicated with them via phone or video-conference if alerts arose
- Daily telemonitoring sessions (5-10 minutes) including weekends and holidays
- Collected weight, blood pressure, blood sugar, pulse and peak flow data
- Could arrange outpatient visits
## Results: Telemonitoring + Versus Usual Care

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<th>Telemonitoring +</th>
<th>Usual Care</th>
<th>Statistics</th>
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<td>Emergency Dept Visits</td>
<td>35%</td>
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<tr>
<td>Hospitalization</td>
<td>52%</td>
<td>44%</td>
<td>No difference</td>
</tr>
<tr>
<td>ED + Hospitalization</td>
<td>64%</td>
<td>57%</td>
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Note: Results are for a one-year period
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<td>Deaths</td>
<td>15%</td>
<td>4%</td>
<td>Very significant</td>
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Note: Results are for a one-year period; Takahashi et al Arch Intern Med 2012;172;773-9.
Epilogue – What Next?

Not ready for prime-time
Value of Care: Measuring → Improving

- Scientific Approach
- Care Delivery & Outcomes
- Cost

Value Framework

Patient
Provider
Payer

Quality (outcomes, safety, service)
Cost over time
Determining/Comparing/Competing Quality & Costs are generally good for:

- Patients
- Physicians/Provider teams/Hospitals
- Payers

Use a scientific approach to collect/manage/analyze data and outcomes