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The New Face of Health Care

A new system rewards doctors and hospitals for taking better care of patients at lower costs.

By: [Patricia Barry](#) | Source: From the AARP Bulletin print edition | April 1, 2009



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As the Obama administration and Congress rev up to tackle the Herculean task of reforming the health care system, one major goal is encapsulated in a phrase the president and others often use: "to improve the quality of American health care while lowering its cost." The idea seems a contradiction. How do we get more for less? Doesn't "better" always cost more?



Not in health, it seems. The United States spends about \$8,000 per person a year—more than twice as much as other Western countries that have universal health coverage and better results. That amount "does not appear to buy us outstanding health," Paul Ginsburg,

president of the [Center for Studying Health System Change](#), told the Senate last year. "By almost any measure, ranging from infant mortality to preventable deaths, the United States does not measure up well against other developed nations."

How to reverse that damning report card has preoccupied health policy brains for years. But increasingly eyes have turned to a few medical centers around the country as possible models for national reform, building on our current system. These centers—among them the [Mayo Clinic](#), the [Cleveland Clinic](#) and the [Geisinger Health System](#) in Pennsylvania—have developed systems that change the way health care is delivered and paid for.

It's a new way of doing business that rewards doctors and hospitals for taking much better care of patients—instead of paying them for the number of patients they see and the individual services they use, as the widespread fee-for-service system does. The results, experts say, suggest that increasing quality may actually be the best way of reducing costs.



Care team

Joaquin Mathew (left) talks with his doctor, Karl Luxardo, and case manager Maureen Conner at the Bloomsburg medical home.

"That's the key, in my opinion, to getting the clinicians [on board]," says Len Nichols, director of health policy at the [New America Foundation](#), a Washington think tank. "If it's just about cost, there's no way they'll buy into it. But if it's also about improving patient care, then you can motivate them, because that's why they went to med school."

So how do these incentives work, and how do they cut costs? And what do patients think about them? To find out, the *AARP Bulletin* visited with staff and patients at the award-winning nonprofit Geisinger Health System, which has 750 physicians serving 2.6 million patients across 43 counties in rural Pennsylvania. Its flagship medical center, which began as a 70-bed hospital in 1915, dominates the small town of Danville in a Susquehanna River valley.

In recent years Geisinger has begun several strategies designed to integrate its operations into a system that gives better care at less cost.

Those strategies are a new kind of coordinated primary health system; electronic medical records; hospital surgery that comes with a warranty; and involving patients to improve their own health. Obama's proposals for reforming health care also advance these core principles.

Coordinating primary care

This model—the focus of experiment in pockets across the country and endorsed by some leading physicians' organizations—is usually known as the "patient-centered medical home." Geisinger calls it the "personal health navigator" because it aims to help patients manage all the complexities of their care in one setting, typically a family practice or clinic.

"It's focused on putting patients and their families at the center of care, instead of doing what's convenient for the provider," says Janet Tomcavage, a registered nurse who is vice president of medical operations in Geisinger's own health insurance plan.

The approach requires a team effort—doctors, nurses, technicians and a case manager who coordinates it all—that constantly monitors patients' needs, especially those with chronic conditions like heart failure, diabetes and lung disease. The team also helps patients navigate transitions into and out of the hospital or nursing home—though the aim is to keep them out of both as far as possible—and if necessary puts them in contact with social services in the community.

The system has features unheard of in regular primary care. High-risk patients, for example, can call their case manager's cellphone anytime. Those with incipient heart failure are given special scales that electronically transmit their daily weight directly from home to the clinic. If there's a spike indicating fluid retention, the team is alerted and can take quick action to prevent a hospital emergency. "We're seeing a 12 to 13 percent reduction in heart failure admissions," Tomcavage says, not all because of the scales, but they help.

At the Geisinger primary care medical home in Bloomsburg, one care team is headed by physician Karl O. Luxardo and Maureen Conner, the case manager. Both say the system introduces "another layer of care" that allows them to help many patients avoid medical complications—not only

because of the monitoring but because of having the time to train patients themselves to manage their conditions more effectively.

"Maureen is another set of eyes and ears for me," Luxardo says. "She knows the patients as well as I do and helps them understand the disease processes. She's making phone calls and spending the extra time on patients' questions and concerns that I might not have been able to address during the visit or that the patient may have forgotten to ask." It allows him more quality time with the patient too.

Conner, a registered nurse who formerly worked in a cardiac intensive care unit, says that getting patients involved in their own care is a cornerstone of the medical home concept. "It's a big process," she says. "You have to gain their trust and get a relationship going." But ultimately, she says, having a case manager embedded in the primary care practice, instead of off in some separate place, pays off. "It's a huge deal that we're right here at the site to help patients. You just get to know them on a more personal level."

Joaquin Mathew of Greenwood, a 71-year-old former paratrooper, has multiple health conditions: lupus, rheumatoid arthritis and heart problems. He calls Conner "my guardian angel" and "my lifeline." He looks after himself carefully, "but as soon as I sense anything is wrong, I call Maureen." It's that constant availability between scheduled appointments, Mathew says, that he appreciates most. "I try not to bother them with insignificant items, but it's good to know they're there," he says. "The connection's always maintained." The way the system's set up, he adds, "I get the feeling I'm special."

But how does this system, which requires considerable investment, actually save money? One reason is that Geisinger has changed the financial incentives for primary care doctors who work for its insurance plan. It compares the costs of practices that have become medical homes to those that have not, and if they've achieved savings—such as by reducing hospital admissions and unnecessary tests—they can get half of that amount back. But there's a catch. They only get the money if they've also met a whole checklist of quality measures for preventive care, chronic disease management and so on, says Ronald Paulus, M.D., Geisinger's chief technology and innovation officer. "So if they've saved \$100,000, and

have achieved 100 percent of the quality goals, they'd earn \$50,000. If they've achieved 25 percent, they'd earn one fourth of that amount, [\$12,500]."

In this way, Paulus says, the primary care practice is rewarded for efficiency but not at the price of sacrificing quality. "We didn't want the doctors and nurses to skimp on care to save in the short run but not have the patient do the best in the long run." In other words, this payment setup aims to achieve the direct opposite of those "perverse incentives where often providers of care make more money if they do poorly than if they do well," Paulus explains. Those would include the rushed 15-minute doctor visit and other examples of short-shrift care that patients nationwide so often complain about.

The other half of the savings goes to Geisinger's own health plan that funds the extra services that create the medical homes. The incentives have paid off, Paulus says. In a region where patients are older, poorer and sicker than the national average, "the health plan earned 2.5 times its investment back in the very first year."

Hospital care with a warranty

Nationally, Medicare patients who are admitted to the hospital have nearly an 18 percent chance of having to go back in within 30 days, at a cost of \$15 billion in 2005, according to [MedPAC](#), the official panel that advises Congress on Medicare expenditures. Typically the surgeon does another operation and sends in a second bill, which the insurer or Medicare pays without question (except in the case of some preventable medical errors).

"You'd never do that with your car," says Alfred S. Casale, M.D., director of cardiothoracic surgery at Geisinger Medical Center. "If you brought your car in, told them to rebuild the transmission and a week later the reverse gear was slipping, you'd demand they fix it because you paid them good money to fix it the first time. Yet in health care, examples [of repayments] abound."

In 2006, Geisinger embarked on a bold gamble to reduce that waste of money and improve patient outcomes. Starting with elective coronary bypass surgery, Casale and others drew up a 40-point checklist of best surgical practices developed by the [American College of Cardiology](#) and the

[American Heart Association](#). Each point on the list, hard-wired into the computer system, has to be checked off before a procedure begins, or the surgery is canceled. Then Geisinger offered insurers a deal that is, in effect, a warranty: Pay a flat price for each operation (hospital and surgeons' fees combined) and any further treatment arising from complications that put the patient back in the hospital within 90 days would be free.

This system, dubbed ProvenCare, has so far succeeded in lowering the readmission rate by 44 percent and raised net hospital revenue by 7.8 percent. It's attracting interest from other hospitals and policymakers, together with some criticism that the checklist serves as "cookbook medicine."

Casale rejects the charge, saying that any surgeon has the right to exercise clinical judgment and omit any of the 40 points—but must document, in the record, why. That's happened only five times so far, he adds. "As soon as surgeons realized they didn't have to depend on brute-force memory to keep in mind all those things that were important, they thought this was the best thing since sliced bread."

Geisinger has expanded the ProvenCare method to other surgical specialties—among them, so far, angioplasty, hip replacement, cataracts and bariatric surgery for weight loss. A new venture also applies the checklist process to pregnancy care, with more than 60 obstetric teams in 40 clinics giving antenatal care to women over the whole nine months. In this case, the checklist of 40 best practices (or "promises" as Geisinger calls them) has grown to over 200. "Each new thing has tested the applicability of the concept in a different way," Casale says.

Electronic health records

At the heart of the Geisinger medical center is a vast room filled with tall black consoles, quietly humming away. This is the hub of the electronic health record system. It allows, Paulus says, "every one of our 750 doctors, whether they're spread across 20,000 square miles or right down the hall from one another, to use the same health record with all the information about a patient available at the click of a mouse." The reorganized primary care system and the hospital warranty couldn't work without that instant access, he says.

Many patients are sold on it, too. About 119,000 have so far signed up to access their own records through personal portals. They use it to keep track of their medical test results, monitor their own progress, schedule appointments and e-mail their doctors—from anywhere they happen to be.

Hariteeny Fritz, a 79-year-old retired banker from Bloomsburg, recalls the time she was away from home visiting Bar Harbor, Maine, and suddenly developed double vision. Taken to a clinic there, she told the staff they could access her entire medical record by logging on to the Internet with her password. "There was this kind of disbelief," she says. "But they went online, and it saved them a good deal of time."

Donna Coombs, 56, of Sweet Valley finds the system both a convenience and a comfort whenever she has a flare-up of rheumatoid arthritis. "Knowing what my test results are, having that quick communication with my doctor—because anytime of the day or night you can e-mail your doctor—is pretty good," she says. "Normally you call the doctor's office and have to wait until they're open, but this is available 24/7."

Patients don't see everything in their records that the doctor does. "One of the things we don't share is physicians' notes," e-health manager Jodi Norman says. Lab test results can be seen quickly, but must be released by the doctor first, she explains. Sensitive results, such as HIV tests or just bad news, are withheld so that the doctor can discuss them in person with the patient.

As long as doctors, hospitals and other providers share the same computerized system—something that remains a distant goal nationally—electronic health records improve care and save money, their proponents say. Patients who see multiple physicians are less likely to be sent for unnecessary tests that have been done before, or fall victim to medical errors or be overprescribed medications, all of which add to the nation's health care tab.

Patient involvement

"In the long run, where costs can really come down is in more engaged patients doing more preventive care for themselves," says Paulus. With the epidemic in obesity especially gobbling up health care dollars, that need is widely recognized. But lifestyle changes—such as losing weight—are often

required, a tall order for many people.

But gradual education from medical home staff like Maureen Conner can persuade patients to see the value of their own efforts—quite often with the subtle prod of seeing a cool graphic in their electronic health record showing their progress, or not.

In another Geisinger innovation, groups of patients facing hip and knee replacement surgery are offered a two-hour class in which the whole team—surgeon, anesthetist, pharmacist, therapist and a social worker who helps plan their return home after surgery—demonstrate what's in store and how they can quicken their own recovery.

Linda McGrail, a registered nurse who organizes the classes, often uses her late grandmother as an example of what not to do: "She was very surprised to find out that it was her job to make her total knee replacement strong and flexible. She thought it was the surgeon's job." The classes get people started on exercises even before surgery because, McGrail says, "if they're used to doing them pre-op, they bounce back more quickly afterward."

"There's a lot of apprehension," before surgery, says Nancy Tobin, 62, of Danville, now recovering at home from a right knee replacement. "Having this class, and then having the notebook of information to bring home so that you can read it at your leisure, I just found it very, very helpful." Knowing what to expect before going into the hospital, she says, made her more confident of coming out. And she does her exercises religiously.

The cost-effective payoff here is that patients who do all the right things for themselves are less likely to need readmission to a hospital. Also, patients who've taken the class usually seem ready to leave the hospital earlier, typically two to three days after surgery. "We didn't expect that," McGrail says.

She thinks it's mainly because patients who come to class are carefully screened about the setup that awaits them back home after hip or knee replacements. How many stairs must they navigate? Will anyone be there to give help? Will their insurance pay for home care, rehab or a skilled nursing facility if necessary? "These are things the social worker helps them work out realistically before the surgery," McGrail says. With a

discharge plan in place, once they're medically able to leave, they're more positive about doing so.

Could it be done at the national level?

Making these principles work in integrated systems like Geisinger and others—which typically are nonprofit, pay their doctors' salaries and have the flexibility to divert resources into areas such as primary care where they're most needed—is one thing. Translating them to the fragmented, mainly fee-for-service and for-profit system elsewhere is another.

"It's harder, but not impossible. But it seems to me that we need to do this, and we can do it, if we start now," says Nichols of the New America Foundation. "If we do absolutely nothing, I don't see how we avoid having in 10 years 60 or 70 million uninsured and a Medicare program under intense budget pressure."

Nichols observes that in Pennsylvania, primary care physicians who are not Geisinger employees but refer patients to its hospitals are being subtly drawn into the system. "They, too, are now plugged into electronic records and are beginning to implement these processes of care in their own offices," he says. "And that, I think, is the technique by which we can spread these practices around the country."

Medicare may also contribute to that spread. In January 2010 the agency is scheduled to begin a three-year medical home pilot project involving 400 primary care practices in eight centers around the nation giving care to some 400,000 beneficiaries who are currently enrolled in the traditional fee-for-service Medicare program. The aim is to find out if giving physicians bonuses for meeting quality measures would, over time, save Medicare money and achieve better care.

[Obama's budget proposal](#) notes that currently the United States spends more than \$2.2 trillion a year on health care, yet high-cost areas do not achieve better quality. "Some researchers believe that health care costs could be reduced by a stunning 30 percent—or about \$700 billion a year—without harming quality if we moved as a nation toward the proven and successful practice adopted by the lower-cost areas and hospitals," the proposal said.

Those practices, it added, include "expanding the use of health information technology; more aggressively studying what works and what doesn't; experimenting with different payment systems to health care providers; and promoting prevention and healthy living."

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