TODAY’S ENVIRONMENT: THE CONTEXT FOR DEVELOPING A BUSINESS CASE FOR GERIATRICS

JENNIE CHIN HANSEN

OCTOBER 26, 2011

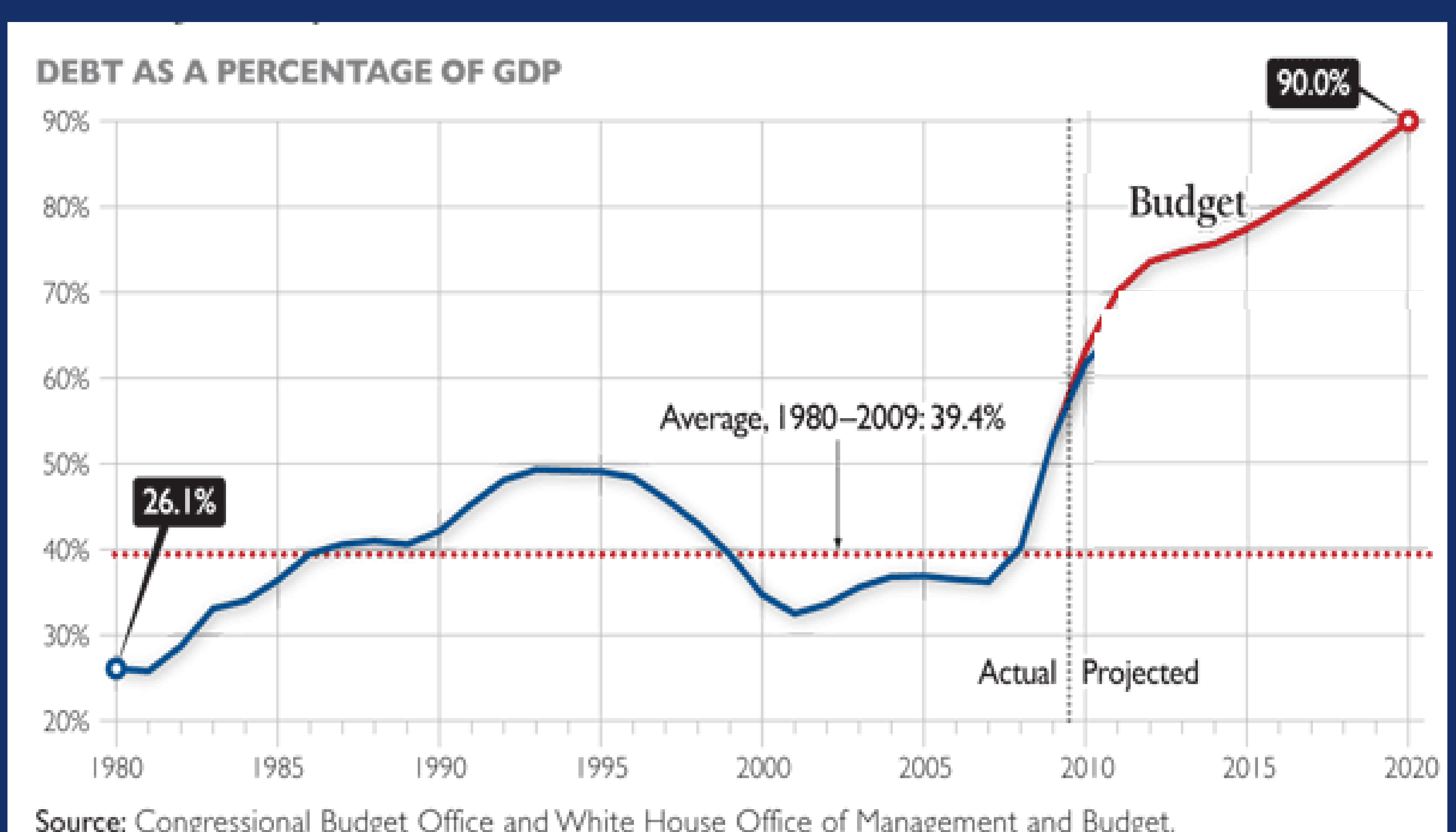
REYNOLDS MEETING

THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading Change. Improving care for older adults.

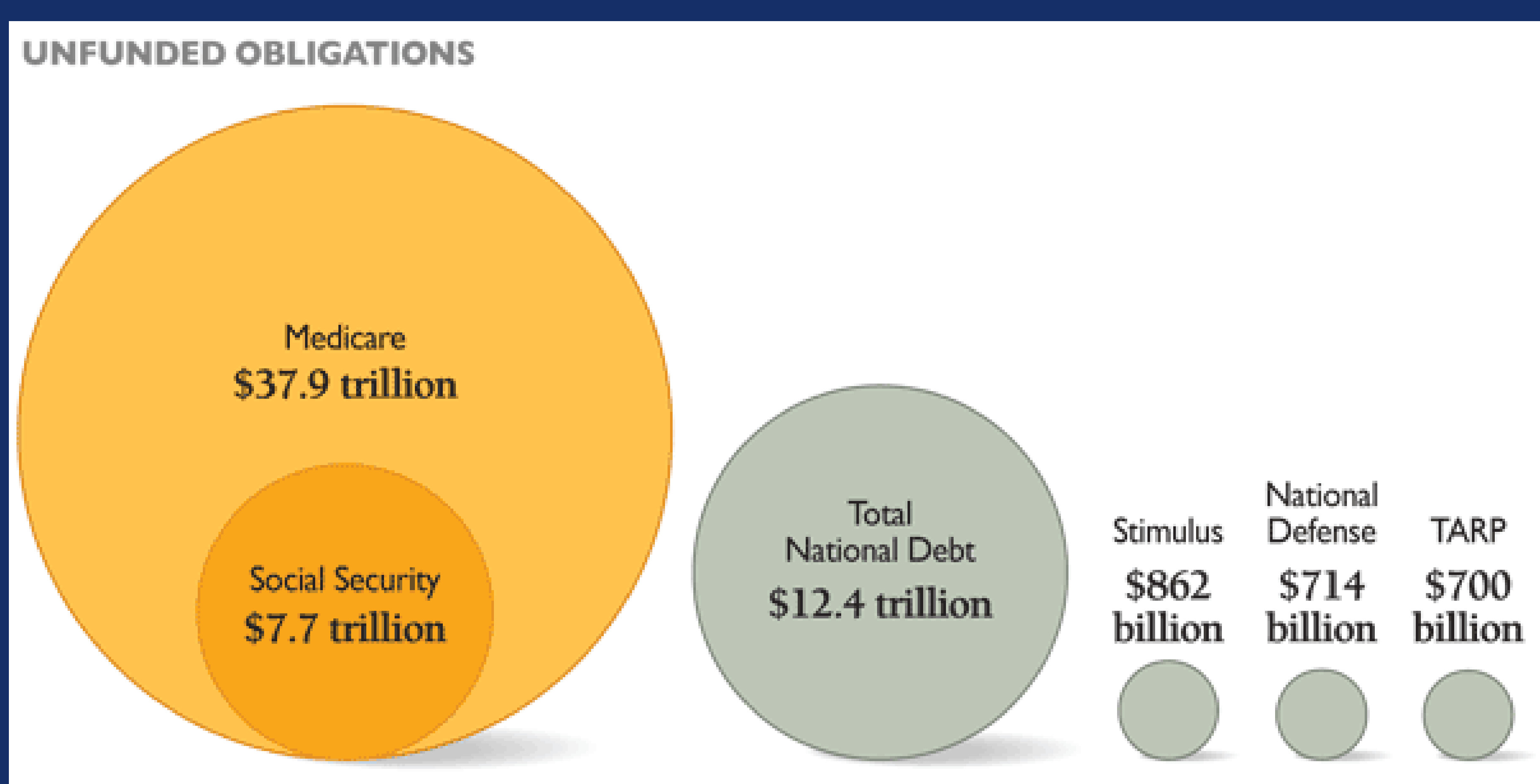
Agenda

- Current financial state
- Implications for Medicare
- Drivers of health care costs in USA
- Policy Work of AGS on Physician Issues
- Patient Protection and Affordable Care Act
  - Implications for beneficiaries, geriatrics and “systems”

How Bad is the Deficit?



It's All About The Math



Projected Medicare Outlays, 2009-2019

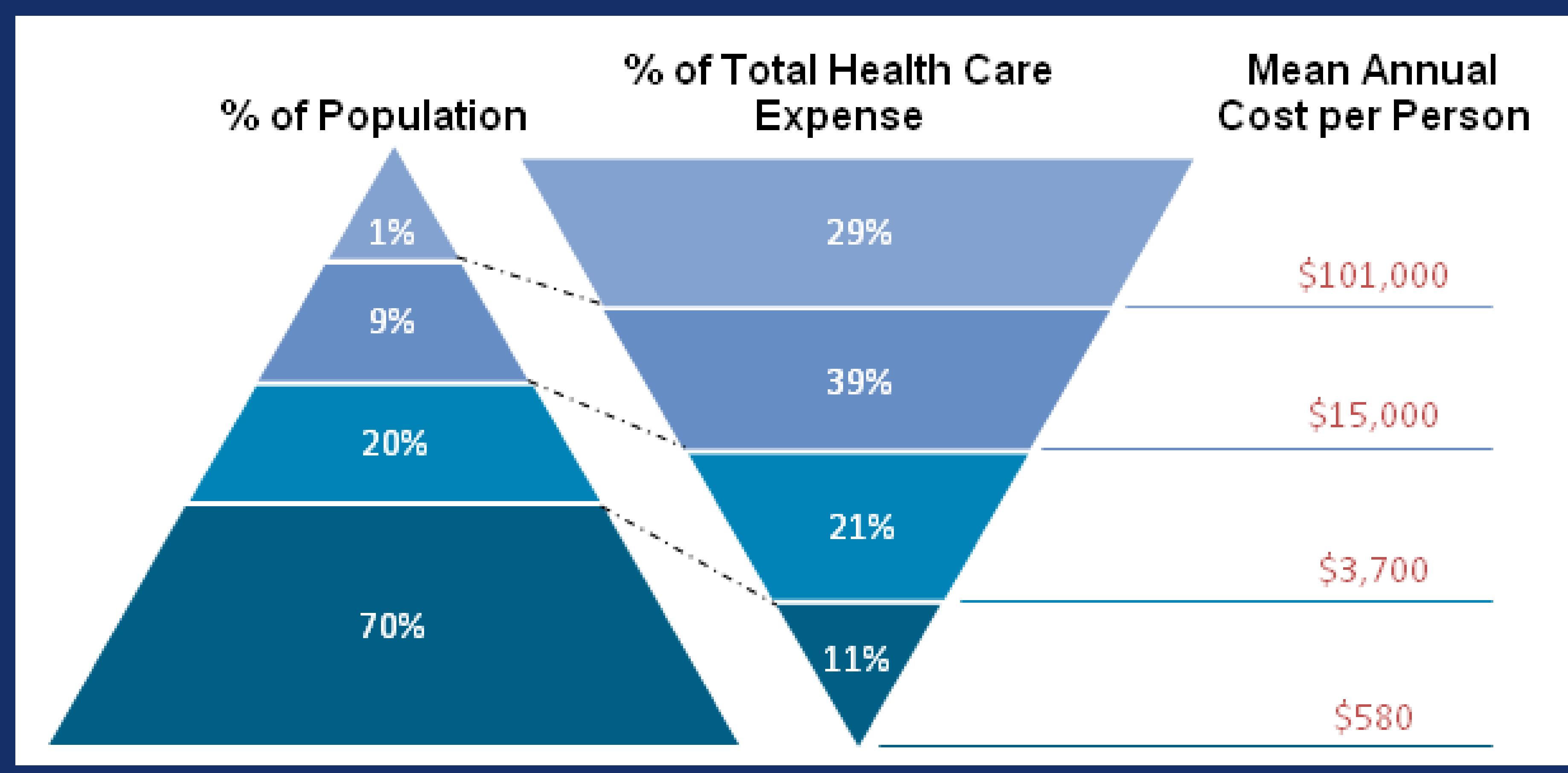
Total outlays in billions:*

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total outlays	$501	$521	$570	$580	$635	$696	$725	$787	$819	$854	$943
Share of:											
Federal Outlays	13%	15%	16%	17%	18%	19%	19%	19%	19%	19%	20%
GDP	3.6%	3.6%	3.8%	3.7%	3.8%	4.0%	4.0%	4.2%	4.2%	4.2%	4.5%

Y-axis: $0, $200, $400, $600, $800, $1,000

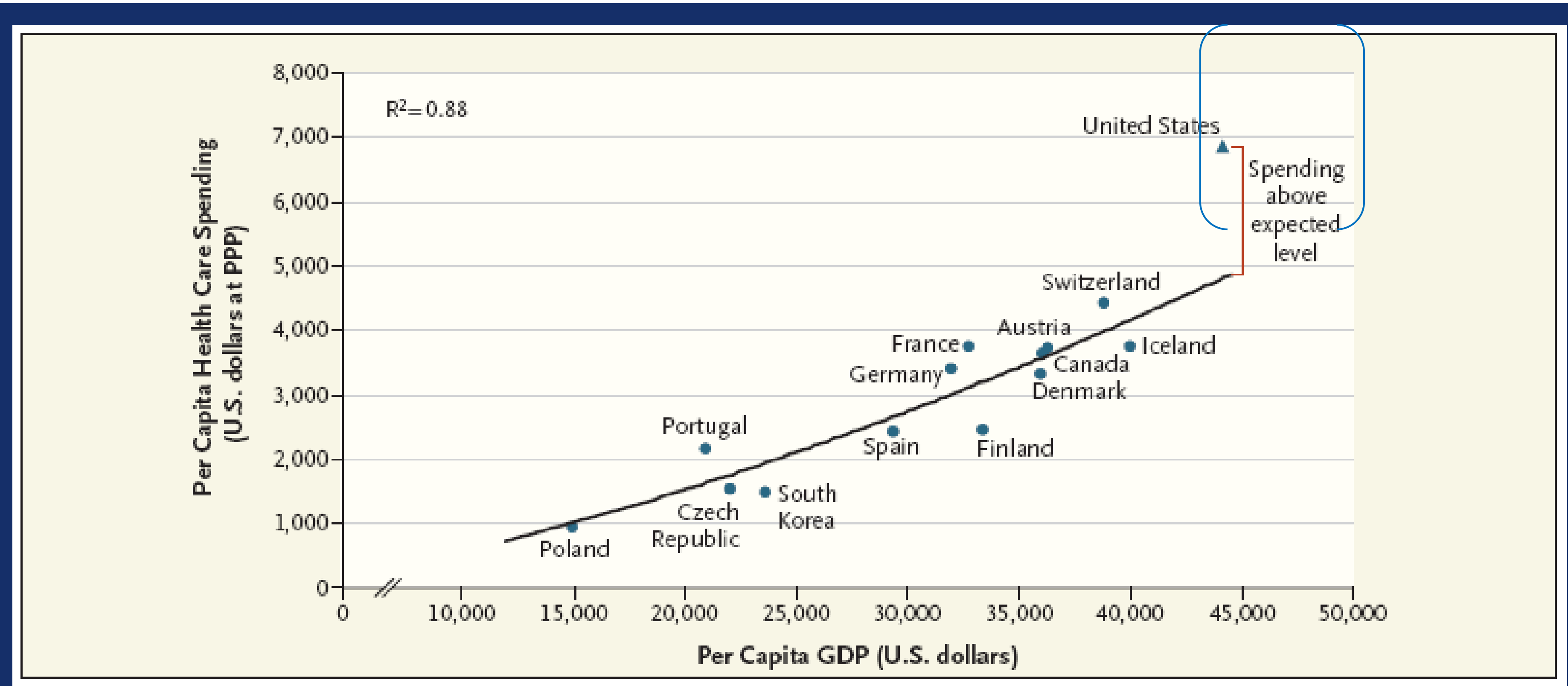
NOTE: Outlays have been rounded to nearest whole number and exclude offsetting receipts.
SOURCE: Kaiser Family Foundation based on data from Congressional Budget Office, March 2009.

Focus on the Few that Cost The Most



Source: Thomson Reuters Marketscan Database

Excess Cost of U.S. Health Care



Per Capita Health Care Spending in Various Countries in 2006, According to the Country's Relative Wealth.

Countries spend more on health care as their wealth increases.
Health care spending in the United States is far above the expected level, even after adjusting for wealth.

Source; McKinsey

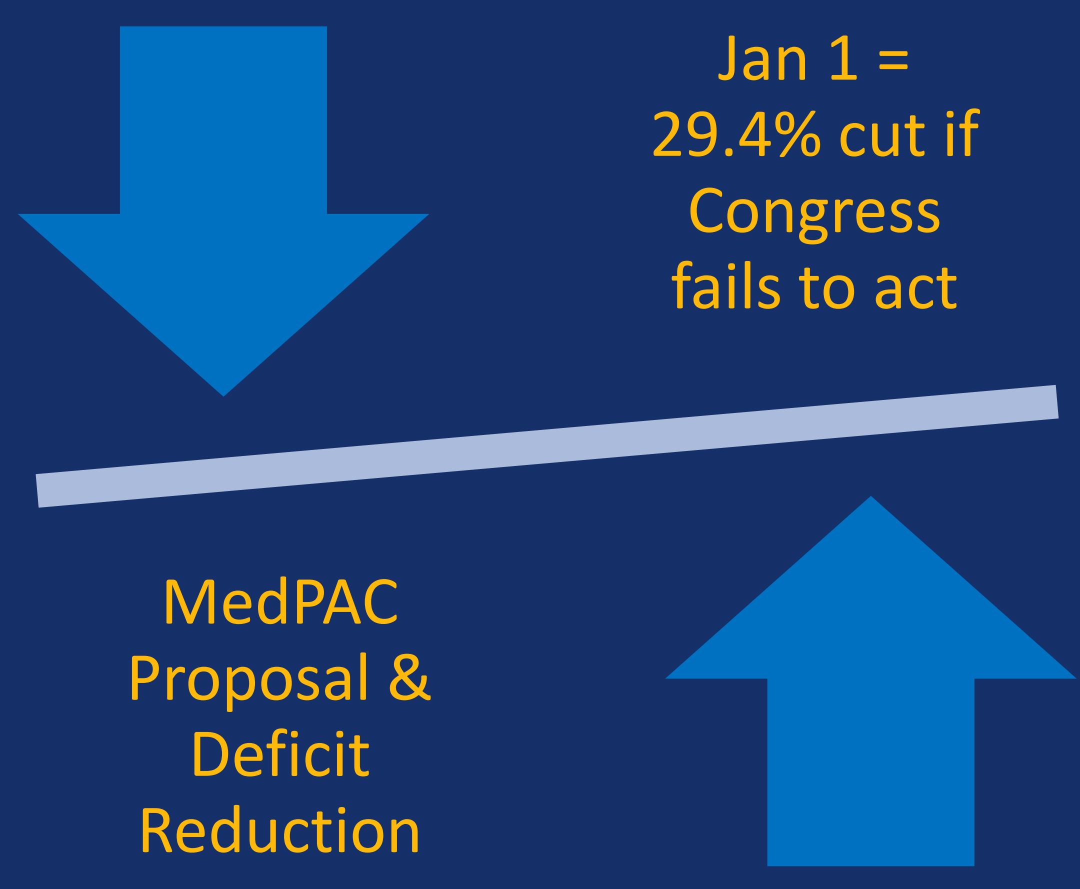
Excess Cost of U.S. Health Care

Why does U.S. health care cost so much more than expected?

- Technology
- Prices are higher in the United States
- Supply-driven elastic demand leading to higher rates of treated disease
- Price insensitivity to end consumer
- Judgment based nature of MD care
- Values and culture

Source, McKinsey

Physician Payment Reform 2011



AGS has asked Congress

AGS Recommends

- Define SGR in terms of total expenditures.
- Support and properly value primary care services
- Transition to a value-based payment model that rewards quality
- Optimally utilize clinicians and support staff, promote the efficacy of care transitions between settings and reduce preventable hospital readmissions.
- Establish stable and predictable updates that accurately reflect increases in provider expenses.

Key Elements of MedPAC SGR Proposal

- Repeal SGR and freeze pay rates for primary care services for 10 years
- Regular data collection, including service volume and work time
- Identify overpriced fee-schedule services and reduce their RVUs accordingly
- Increase shared savings for physicians and health professionals who join or lead two-sided risk ACOs

Ongoing AGS Efforts

Advise	Support	Coalitions
• Senate Finance • Representative Schwartz • Senate and House staff as appropriate	• Rep. Schwartz leading sign on letter to Super Committee • AGS coordinated appeal to representatives to sign – 113 signers	• AMA leads SGR work for MD community • AGS participates in briefings, signs on to letters

What's Hot at the RUC?

AAFP Proposal Around Primary Care

- Proposal includes seat for geriatrics
- RUC is working to address AAFP concerns

Care Coordination & Observation Codes

- RUC/CPT Care Coordination Work Group established
- RUC advised CMS in a letter to begin paying for care coordination immediately on existing codes

How is AGS involved?

Hollmann	Lazaroff	AGS
• Chair CPT Editorial Board • On Care Coordination Workgroup • Participant in AMA visits to CMS	• RUC Advisor • On Admin. subcommittee considering AAFP Proposal • Participant in several meetings with CMS staff representing geriatrics	• Advocated that Geriatrics Seat be an AGS-appointed seat • Leading charge on observation codes • Active on proposal to review all E/M codes (AGS disagrees)

Patient Protection and Affordable Care Act 2010

Health Insurance Reform
- Expand Insurance Coverage
- Expand Consumer Protections
- Reform Industry Practices

Status Quo
- Health Costs Exceed General Inflation
- Sub-Optimal Population Health
- Unexplained Variations in Practice Patterns
- Questions About Evidence Base of Some Procedures

National Goals
- Expand Access to Health Insurance to 95%
- Lower Health Spending Growth Rate
- Incentivize Delivery System Change

Payment Reform, Delivery Systems
- Evolve Medicare Payment Systems from Fee-For-Service to Value Based Payment
- Test new payment methodologies and patient care delivery models for Medicare, Medicaid & CHIP

Source: Health Solutions Division, Manatt, Phelps & Phillips, LLP

AGS Now and Forward-Geriatrics

What Areas Can and Should AGS Focus On Given Health Care Context

And our commitment to Infusing Geriatrics Competency?

Looking Ahead

Current → Future

Current

- Assure most appropriate current reimbursement for our geriatrics competency

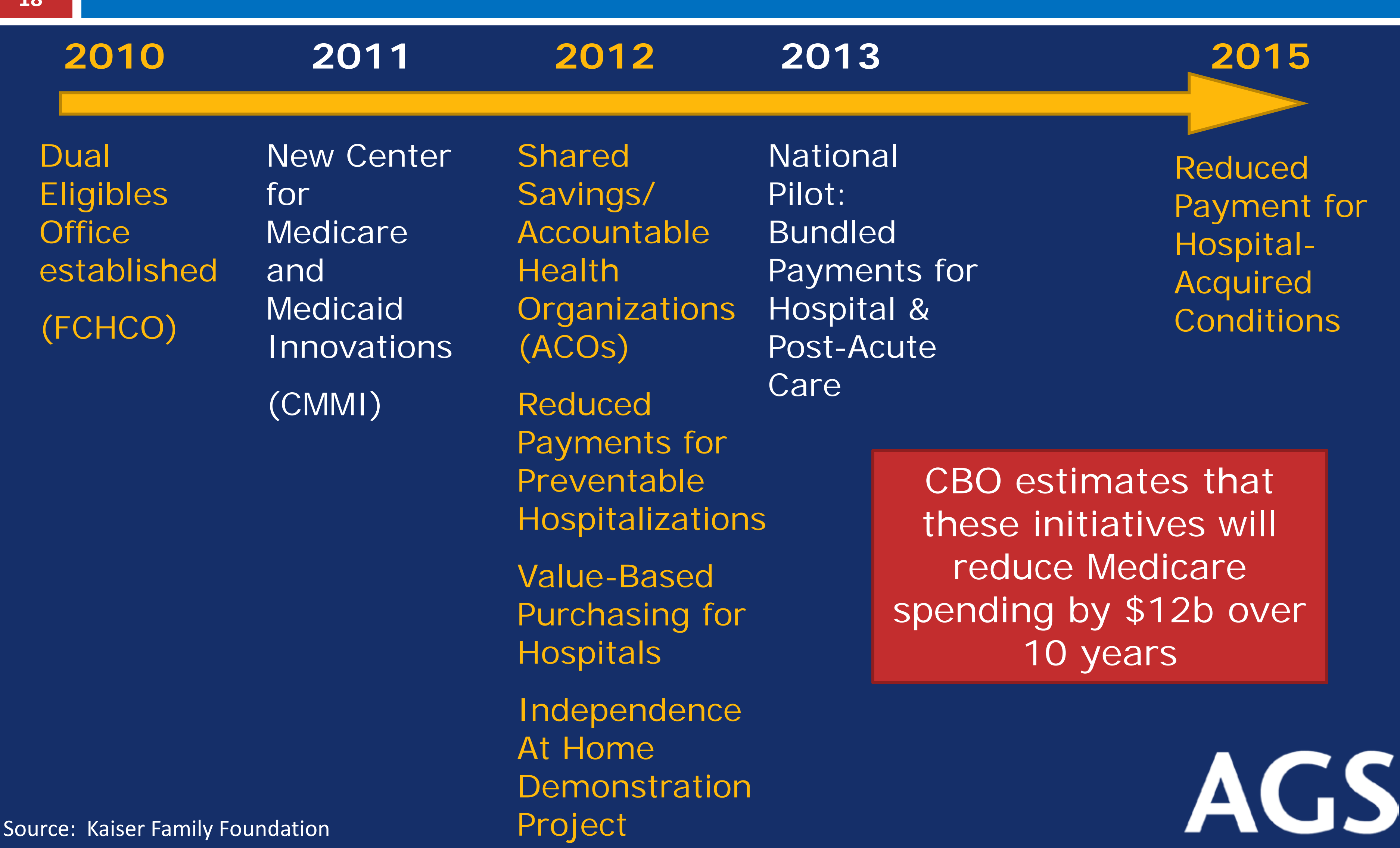
  Impacting Payment
  - AGS participates in AMA RUC/CPT

- Describe Impact and Value of Current Geriatric Models/Initiatives
  - e.g. ACE, eACE, GRACE, CRIT, Guided Care, PACE

Future

- Quality and Safety
- Patient-Centered Primary Care
- Medical Homes
- Accountable Care Organizations (ACOs)
- Federally Qualified Health Centers/Nurse Managed Centers

Payment Reform, Quality, and Delivery System Change Timeline



Source: Kaiser Family Foundation

"Office of Duals" (FCHCO)

of Dual Eligibles

9 million Beneficiaries

5.5 million over 65 yrs

- 15% of Medicaid enrollment, 39% of expenditures
- 21% of Medicare enrollment, 36% of expenditures

PACE enrollment ~ 29K

FCHCO Charge/Actions

- Make programs work better for beneficiaries
- Eliminate regulatory conflicts
- Provide tools to states to improve alignment
- April 2011: 15 states received $1m for demonstration projects (design phase) from CMMI
- State implementation phase: Late 2012

Source: Kaiser Family Foundation; USHHS CMS

Innovation Center (CMMI)

- Research, develop, test payment and delivery models
  - Independence at Home (VCU) Office of Research and Demonstrations
  - PACE-minimizing barriers for growth/other populations

- $10b in funding through 2019 for pilot programs ($1b/year)
- Funding demonstration projects in:
  - Community-Based Care Transitions
  - Advanced Primary Care Practice/PCMH
  - Pioneer ACOs (30 orgs as demonstration…vs. national rollout
  - Integrated Care for Dual Eligibles (15vStates)
  - Medicaid Health Home State Plans
  - Reducing Preventable Hospitalizations, Nursing Facility Residents
  - Bundled Payments for Care Improvement

Source: CMS

AGS

Innovation Center (CMMI)

- 50/50 funding with Community-Based Care Transitions Program (3026)
  - Working with Hospitals and Community Based Organizations
- $1b Partnership for Patients
  - Reduce preventable hospital-acquired conditions 40% by 2013
  - Reduce preventable complications from transitions/readmissions
  - 20% by 2013

NEW CMMI INNOVATION ADVISORS-

Hartford Foundation Application Prep

Webinars this week –due on Nov 15th

Source: CMS

Accountable Care Organizations (ACOs)

Problems

- Poor coordination of care across providers, services, and settings
- Absence of "accountable teams" working across disciplines and organizations
- Incentives for acute care

Provide Incentives for Integration

Shared Saving Program

New category of provider: ACO

- Minimum 5,000 Medicare beneficiaries

Must meet quality measures:

- Clinical processes & outcomes
- Pt. experience
- Care transitions, discharge follow-up

Payment: Global fee or partial capitation/ partial FFS; Bonus payments distributed across providers

Year 1+2, no penalty; Year 3+ two-sided

Business models: Ownership or contractual /networks

Source: Commonwealth Fund, Commission on High Performance Health System, "High Performance Accountable Care" April, 2011

ACO's: How They Will Work

ACO

Hosp

PCP

Spec

Coordinates care for shared patients

Financial bonus from payers

IMPROVED OUTCOMES

- Quality
- Cost

How are Providers responding?

- Integrated systems (Mayo, Intermountain, Geisinger, Cleveland) declined to apply for Pioneer ACO status
- Others are doing it on own, e.g. UPMC
- Likely push for greater consolidation by hospital, more multi-specialty practices
- AHA estimated that starting an ACO could cost a hospital $11M to $26M in first year

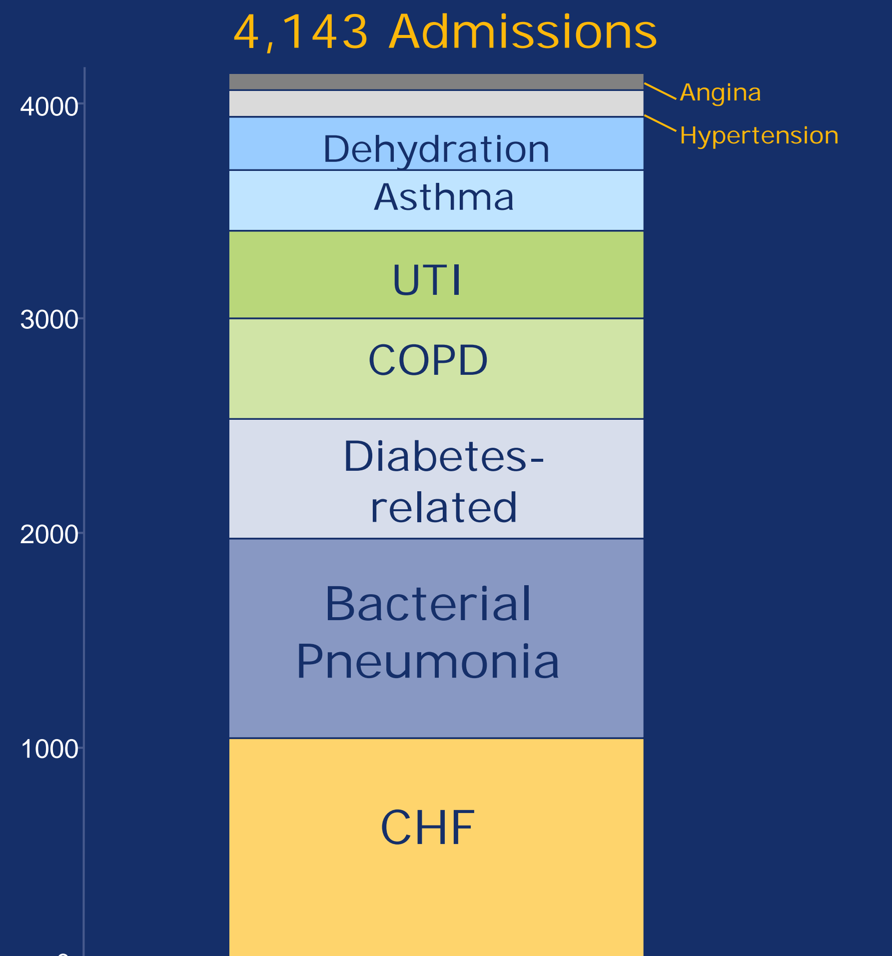
Source: Kaiser Health News, AHA, Commonwealth Fund Report "High Performance Accountable Care, April 2011

Hospital Preventable Admissions

- More than 50% of Medicare patients admitted to hospitals will be readmitted within a year
- Approximately 20% of hospitalized FFS Medicare patients are readmitted within 30 days
- Unplanned readmissions cost Medicare $15.4 billion in 2004
- Wide variation in Medicare readmission rates between hospitals
- ACA will impose financial penalty on hospitals with higher-than-expected rates of re-hospitalization beginning October 2012

Source: Health Research and Education Trust, AHA (summarized Medicare data)

Hospital Potentially Preventable Admissions, 2006



Community-based care transitions program providing $500 M to support partnerships between hospitals and CBOs that provide care to Medicare beneficiaries at high risk of readmission.

Care Transitions Intervention: Implemented in 14 states

Source: Admission data: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2006.

Patient-Centered Medical Home

- Access
  - Evening/weekend hours, agreement with facility for after-hours care
- Coordination of care
  - Information to/from specialists/facilities/patient, update care plan
- Team-based care
  - Defined roles and responsibilities, training, communication
- Role of medical home
  - Discuss roles/expectations for medical home and for patients

Source: NCQA

Patient-Centered Medical Home

- Care management
  - Pre-visit planning, care planning during visit, patient self-care, point of care reminders
  - Medication management
  - Include mental health/substance abuse/behaviors affecting health
- Self-care management with community resources/referrals
- Identify/address population needs/risks
- Quality improvement
  - Performance measurement
  - Patient experience

Source: NCQA

The Time is Now

- The plans and programs that are being proposed have had and do have leaders in geriatrics in leadership positions, e.g. CMS-Rich Baron, Paul McGann, Alice Bonner; Eric Coleman,
- The Time for Our Knowledge and Skills Are Vital and Needed Now More than Ever –the opportunity to make a significant difference for the next 25 years is our frontier!

Questions

- Who has established connections with CMOs, hospital quality and safety?
- Who is entering into ACOs with a geriatrics focus?
- Is anyone doing a geriatrics focused medical home?

AGS TOMORROW: HERE'S WHAT WE'RE THINKING

SHARON BRANGMAN, MD

OCTOBER 26, 2011
REYNOLDS MEETING

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AGS Strategic Priority Review

- Series of conference calls; weekend retreat
- Participants included AGS Board, FHA & ADGAP representatives and invited members of the Society.
- Revisited the Five Highways as well as focused on specific topics.

2006 Strategic Plan
Five Highways

1. Expand understanding of geriatrics healthcare
2. Increase # of healthcare professionals employing geriatrics principles
3. Increase # entering geriatrics practice
4. Change public and private sector policies that impact geriatrics professionals and older adults
5. Increase public understanding/demand

Source: 2006 AGS Strategic Plan

Potential Directions

Membership

- Affirmed that AGS will remain interdisciplinary.
- Recognize that this creates a bigger tent – many voices
- Some areas of focus over next three years are likely to be:
  - Reaching out to geriatrics health professionals who are not currently members to determine needs
  - Look at ways to expand our member benefits
  - Continue the work begun with the Junior Faculty Task Force – engage next generation

Leadership

- Focus on programs we can undertake within available resources
  - Leadership course as pre-conference to AGS Annual Meeting (launch in 2013, possibly 2012)
  - Look at ways members engage with us
  - Work with Junior Faculty leaders to revitalize the mentoring program – to better meet participant needs

Strategic Alliances

Continue to Lead Coalitions	Collaborate on Policy/Guidelines	Participate in Coalitions
• Eldercare Workforce Alliance • Partnership for Health in Aging • Geriatrics-for-Specialists Initiative	• Primary Care work with ACP, AAFP, AAO • Palliative Medicine Education with AAHPM • HIV clinical guidance work with Amer Acad of HIV Medicine	• NIA Leadership Council • AMA Groups • Council of Medical Specialty Societies • Quality Measure Development • Expert Reviewers

Programs & Products: eCommerce

- Focus on enhancing capacity to engage in eCommerce -- wider dissemination of products; enhanced revenue for Society
- People will be able to access products that are right-sized to their needs
- Institutions will be able to access all AGS products via a single site license; platform will be built to enhance integration into intranets
- Intended to compliment POGOe and augment tools available on that platform

Developing a Business Case for Geriatrics

- Look to be sure geriatrics principles are embedded in the Safety and Quality Movement
- Board discussed topic focus and will finalize that in December
  - Medical Home, medication management, hospital clinical service lines
- Early toolkits will likely focus on assisting academic programs in making the geriatrics case.
    - Build tools from these that meet other audience needs
- Will also explore advancing geriatric health professionals as key to quality and safety in larger regulatory world, including Joint Commission

AGS, ADGAP, AND REYNOLDS: NURTURING ACADEMIC GERIATRICIANS

JAMES PACALA, MD, MS
JAN BUSBY-WHITEHEAD, MD

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American Geriatrics Society

- Mission
  - To improve the health, independence and quality of life of all older people
- Vision
  - Every older American will receive high quality patient-centered care
- Founded in 1942
- 5,975 Members
  - 3,889 Physicians
  - 754 Health Care Professionals
  - 1,332 Trainees
- Other Organizations
  - Association of Directors of Academic Programs (ADGAP)
  - Foundation for Health in Aging (FHA)

Snapshot of 2011 Members

Discipline	
Physician	70%
- Geriatrics 59%	
- FM 12%	
- IM 21%	
- Other 8%	
Trainee	12%
Nurse/APN	9%
Pharmacist	4%
Other	3%
Therapist (PT, OT)	1%
Physician Assistant	0.5%
Social Worker	0.5%

Practice Setting (all disciplines)	
University Acad Med Ctr	37%
Private Practice	14%
Other	13.5%
Community Hospital	11%
VA Medical Center	9%
Managed Care Org	6%
LTC Facility	5%
Independent Acad Med Ctr	4.5%

From 2011 survey
n = 1199 / 24.2% response rate
Data fairly consistent across 2007, 2009 surveys

AGS

Funding for Workforce & Research Programs

- FY 2012 Appropriations still in flux

Proposed Funding Levels

	Title VII (in millions)	Title VIII (in millions)	NIA (in billions)	VA ORD (in millions)
House	31.0	0	1.12	508.7
Senate	33.5	4.5	1.08	581.0
FY 2011	33.5	4.5	1.14	581.0
Prez Budget	43.7	5.0	1.29	508.7

AGS

What You and AGS are Doing

Grasstops

Grassroots

Being at the Table

On the Hill

With the Administration

AGS

Graduate Medical Education

- GME cuts on Deficit Commission's radar
- Commission to report recommendations to Congress Nov. 23; Congress to act by Dec. 23
- AGS currently working with appropriate leaders to ensure that GME funding is aligned with the nation's workforce needs

AGS Advances GME Position in Hill Meetings

- AGS advances GME position (Besdine, Supiano participated in creating) during hill visits and other meetings:
  - Geriatric medicine = primary care discipline.
  - Medicare GME funding should be directly linked to the nation's healthcare workforce needs.
  - All health professionals supported by GME dollars should be competent to care for older adults upon completion of training.
  - GME funds should be used to fund pilot projects that are focused on integration of the skills needed for a trained workforce to be competent to care for older adults.

Breakdown of AGS Annual Meeting Sessions

- Clinical Practice
- Education
- Research
- Models of Care
- Other (Ethno, Ethics, etc.)
- All Audiences

AGS Products

Doorway Thoughts
Cross-Cultural Health Care for Older Adults

Geriatric Education for Emergency Medical Services

GNRS
Geriatric Nursing Review Syllabus

GRS7
Audio Companion

GRS
Geriatrics Review Syllabus
Seventh Edition

Assisted Living Nursing
Barbara Resnick | Ethel Mitty

Journal of the American Geriatrics Society
50th Anniversary

2011 Geriatrics At Your Fingertips

Annals of Long-Term Care

The American Journal of Geriatric Pharmacotherapy

Clinical Geriatrics

Getting Involved

Attend

- Relevant Sections
  - Teachers
  - ADGAP Fellowship
- Special Interest Groups
  - eLearning, VA, Interprofessional Edu (new), topic/issue specific

Volunteer

- AM Abstract Review
- AM Symposia Submission Review
- AGS Subcommittees
- Mentoring Program
- To be appointed to serve on technical, quality expert panels

Apply

- Committees --
  - May take a couple of tries – only 15 seats per committee and applications usually exceed seats
  - Be persistent

ADGAP

- Mission
  - Committed to advancing academic geriatrics programs and supporting academic geriatrics program directors in order to benefit and aid patient care, research, and teaching programs in geriatric medicine within accredited medical schools in the US.
- Founded in 1990
- Membership
  - 100 Program Directors (Institutional Members)
  - 30 Fellowship Directors/Other Faculty (Individual Members)

Engagement Opportunities for Academicians

Boards of Directors

American Geriatrics Society

Association of Directors of Geriatric Academic Programs

Committees, AdHoc TF

Education (AGS/ADGAP)

Public Policy (2 ADGAP seats)

Research, Annual Meeting,

And Other Committees

Junior Faculty TF

AGS/ADGAP

AGS & ADGAP Sections

Fellowship Director (ADGAP)

Teacher's Section (AGS)

AGS Special Interest Groups

Junior Faculty Research

Interdisciplinary (new)

+ many others)

Constituents

AGS:

Clinicians

Researchers

Teachers

ADGAP:

Program Directors

Fellowship Directors

Reynolds:

Clinician-Educators

Jr Faculty

Educational Activities

AGS:

Annual Meeting

Products

Jr Faculty Task Force

ADGAP

Fellowship Directors Precon

Leadership Retreat

Members Meeting

Reynolds:

Annual Grantee Meeting

POGOe

AGS AND ADGAP: MEETING THE NEEDS OF ACADEMIC GERIATRICIANS

2011 REYNOLDS MEETING
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Focus of this Session

- Focus Group Identified Needs
- Meeting Needs– What AGS/ADGAP are Planning
- Open Mic

Focus Group Identified Needs

Access/Service/Standards

- Leaders
- Mentors
- Peers
- Service: National Opportunities
- Standards: Nat'l Standard for Clinician Educator Pathway

Skills

- Leadership
- Negotiation
- Conflict resolution
- Team Management
- Budget/business
- Interviewing
- Grant Writing
- Scholarly writing
- Teaching

Sustainability

- Faculty Development
- Mentoring
- Academic pathway for one-year fellowship trained geriatricians (gaps)
- Funding – fundamental underpinnings of profession

Meeting Needs: What AGS/ADGAP are Planning

Retooling AGS Mentoring

- Peer-to-Peer Mentoring
- Mid-level to Junior Faculty Mentoring
- Access to senior advisors for career decisions

Resources

- National Consensus of Geriatrician Clinician Educator Pathway
- Leadership Skills Boot Camp – pre-conference at #AGS12; skills workshop
- Compendium of Leadership Training Opportunities – rated by geriatrician participants

National Services

- Look for existing opportunities to be engaged – abstract, annual meeting review are now open to all AGS members
- AGS is reviewing Committee appointments – limited seats
- SIGS are fertile ground for volunteering, starting to work nationally
- Presentation Opportunities – Looking at How to Meet Needs