Affordable Care Act: Impact on Healthcare Delivery in Michigan and Beyond

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Planning For A Healthcare Model Of The Future

- What is Wrong With Our Current Healthcare System?
- What is included in the Affordable Care Act?
- Is the Future of Healthcare in the Home?
- Potential impact on Healthcare Facility Design
Panelists

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Current Delivery & Reimbursement Models
Since 2003, public spending on health care (Medicare, Medicaid) has grown twice as fast as private spending. This trend is expected to accelerate as baby boomers age.

Healthcare providers are paid more for patient tests and doctor Visits. However, there is a tug of war with health insurance companies as they make more money when they pay providers less for patient visits and tests.

Out-of-pocket healthcare expenditures have increased by 14% over the last 5 years, while household spending in total over the last 5 years has decreased by 1%.
Current Delivery & Reimbursement Models

The U.S. is ranked near the bottom among industrialized nations in quality.

Patient care is hospital-centric and there is poor communication between hospitals, clinics, and patient homes.
Current Delivery & Reimbursement Models

- Challenges in scheduling appointments with health care providers
- Repeating personal and medical information over and over
- Inability to get test results quickly
- Medical information does not follow them from site to site or department to department
- External data and information are overwhelming; patients just want clear information from providers

Patient’s and Patient Families Experiences
Changes Planned For Michigan And The Country
What is Included in the “Affordable Care Act”?

Harvey "Chip" Amoe III, J.D., M.P.A.
Assistant Director, Legislative Network
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Basic Changes For Michigan And The Country “Affordable Care Act”

1. Near Universal Coverage
   - Medicaid Expansion, if Legislature agrees
   - Health Exchanges, with subsidies

2. Insurance Reforms
   - Medical Loss Ratio (80%-85%)
   - Mandated Basic Benefits
   - Disallow “pre-existing conditions”
   - Family Coverage to age 26
   - Individual Mandate (tax penalties)

3. Pilots & Demos in Medicare, Medicaid (Integration is focus)
Changes Planned For Michigan And The Country

• 2013 is Year of Implementation Steps

• States must decide on Medicaid Expansion

• States set up Exchange, or Feds step in
  - Employers begin disclosure of value of health plan and percent paid by employer
  - IRS gearing up to activate tax penalties
  - Lawsuits abound (coverage of contraception, coverage of illegal immigrants, etc)

• Bevy of new quality measures in Medicare set stage for Pay for Performance (hospitals, docs)

  - Basic Benefits defined (required in all plans)
What is the American Hospital Association’s position on the Affordable Care Act (ACA)?

AHA stated mission is “to advance the health of individuals and communities. In 2008, the AHA detailed its vision for reform in a publication titled "Health For Life." This manual emphasizes five essential elements of successful reform:

- Coverage for all (paid for by all);
- A focus on wellness;
- The most efficient and affordable care;
- The highest-quality care;
- The best information.

The Affordable Care Act (ACA) includes a number of provisions that address these five elements.
What to expect in near-term?

- National Deficit Discussions mean continued downward pressure on health care spending & costs, continued scrutiny of delivery system.

- Recent moderation in health care cost increases mean redoubling of efforts designed to maintain this trend (pay for performance strategies, integration, etc.)

- P4P & Integration moves health care out of the hospital to less expensive outpatient care, with more focus on primary care, greater use of physician extenders.

- Bundled payment forces more collaboration among hospitals, doctors & post-acute providers (home health).
Near-term expectations...continued

• Continued Public Debate - Expansion of Medicaid and Individual Mandate make health care costs “everybody’s business” (taxpayers, employers, employees, Legislature)

• Human Behavior Unknowable Ingredient - What will employers do? What will people do? are big unanswered questions on the Individual Mandate.

• Unintended Consequences Abound - Deficit Commissions & Study Groups target special payments (medical education, hospital outpatient services, rural subsidies, etc.), which may harm access, workforce adequacy and safety net missions.

Consumerism & Pricing Transparency pushes non-traditional sources more firmly into the picture (K-Mart clinics, flu shots)
Future Delivery And Reimbursement Models

HOSPITAL

HOME

CLINIC

RETAIL
Is the Future of Healthcare in the Home?

Greg Solecki
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Current State of Healthcare Statistics

- Approximately 86% of the Medicare population has one chronic condition, 66 percent have two or more conditions and 40 percent have three or more chronic conditions.

- Medicare patients with diabetes, COPD or congestive heart failure that used home health care after discharge from the hospital resulted in a $1.7 billion reduction in post-hospital spending and could realize an additional $31.1 billion over the next 10 years. (Avalere, 2009)

- Estimated Medicare spending on hospice exceeded $10 billion in 2007 and is projected to more than double in the next 10 years. (CMS Office of the Actuary, 2008)

- The average cost of inpatient care for the final two years of life is $29,495 while the average home health cost is $2,633 and the average hospice cost is $2,091. (Dartmouth Atlas, 2008)

- Effective October 2012, more than 200 hospitals began losing money (~$300 million in the first year) due to financial penalties for excess readmissions (Kaiser Health News, 2012)
Direction for Payment and Delivery System Reform

Current Payment Systems
- Ambulatory surgical centers
- Clinical laboratory
- Durable medical equipment
- Home health care
- Hospice
- Hospital acute inpatient
- Inpatient rehabilitation
- Long term care hospital
- Outpatient dialysis
- Outpatient hospital
- Physician
- Psychiatric hospital
- Skilled nursing facility

Previous Tools
- Comparative-effectiveness information
- Linking payment to quality
- Reporting resource use
- Bundling payment within a service
- Creating pressure for efficiency through updates

Potential Changes
- Medical home
- Bundling payment across services
- Accountable care organizations
Current Example of Hospital Based Home Healthcare Delivery Model

- 25,000 patients
- 325,000 home visits
- 112,000 hospice days
- 800 team members
- $100 million revenue
Home Health Care System Support

- Hospice
- Self-health
- Home Infusion
- Home Health Care
- e-Home Care
- Extended Care Private Duty
- Medication Therapy Management
- Health Products

- Hospital
- Medical Group
- Physician Network
- Insurance Provider
Transitions of Care Future Support

**Home/Facility**
- Patient education
- Medication reconciliation
- Enroll in telehealth, if needed
- Patient attends follow-up appointments with MD
- Patient enrolled in multi-disciplinary services

**Pre-Admission**
- Discharge and follow-up MD appointment scheduled
- Home medical equipment needs assessed and scheduled
- What to expect and how to take care of self after discharge

**Admission**
- Readmission risk factors assessed
- Discharge needs analysis/assessment of preparedness for discharge
- Medication reconciliation

**Hospitalization**
- Communicate care plans to patient/family
- Implement readmission reduction steps
- Identify need for home health care, SNF, etc.
- Patient/family teach-back
- Hospice/palliative care?

**Post-Discharge**
- MD appt. completion
- Follow-up phone call
- Patient call-in hotline

**Discharge**
- Ensure follow-up MD appointment
- Patient-friendly discharge instructions
- Transition to next care site
- Assessment of patient preparedness

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Impact On Facility Design To Accommodate The Changing Care Models

- Enhance market differentiation by aligning the continuum of care.
- Provide a front-end, single point of contact for patients transitioning from hospital to home.
- Align clinical efforts to put each patient first.
- Extend the branding of system hospitals into the home and community settings.
Benefits

- Enhance patient, family and hospital staff education and awareness.
- Increase retail presence.
- Create customer engagement and loyalty.
- Provide a voice in helping to support the redesign of healthcare delivery.
Positioning for the Future

- Seen as one health care delivery system internally and externally
- Transition the focus of care from hospital to home
- Electronic records interface
- Alignment between high quality care and highly-personalized service
- Use of medical and wellness technology in the home
The Impact on Healthcare Facility Design

Marco Capicchioni, PE
Vice President
Henry Ford Hospital
Impact On Facility Design To Accommodate The Changing Care Models

The Future State of Healthcare Experience

Assumptions In Future Building And Design

• Hospital Design
• Non-Hospital Settings
  • Urgent Care Centers
  • Medical Clinics
• Physician Offices
• Largest provider of walk-in retail medical clinics in the United States.

• Services in more than 600 select CVS/pharmacy locations in 26 states with over 11 million patient visits.

• Delivery model responds to patient needs with the convenience of easy access to pharmacists, prescriptions, and over-the-counter medications.

• Evening and Weekend Hours

• Accept Insurance

• No Appointment Needed
Rite Aid clinics place new twist on "doc-in-a-box"
Rite Aid and OptumHealth joined forces to find a less expensive alternative to traditional clinics, which are staffed by nurse practitioners and physician assistants who are contracted from a local hospital group.
Daily check up for patients with chronic conditions on the way to work?
Future Delivery And Reimbursement Models

- HOSPITAL
  - EMERGENCY
    - OBSERVATION
      - CLINIC / URGENT CARE
        - HOME & RETAIL
          - More Volume
          - More Volume
          - More w/Bathrooms
          - Less Volume
          - Less Volume
Hospital Buildings

- Outdated Hospitals will be torn down due to inefficiency and excessive staffing requirements.
- New Hospitals will be designed for maximum operational efficiency.
Acute Care Hospital Settings

**Inpatient Beds**

- Less chronic care patients
- Less standard Med/Surg
- Surgical stays will decrease
- Percent of private rooms will increase
Acute Care Hospital Settings

**ICU Beds**

- Percent of ICU beds will increase
- Patients who are hospitalized will be the sickest of the sick
- Therapeutic care will continue around the clock
Acute Care Hospital Settings

**Observation/Bedded Recovery**

- Percent of observation beds will increase
- Post procedure recovery beds will increase
Emergency Departments

- Reduced number of exam rooms
- Intensity level of average patient will increase
- Rooms will be larger with attached bathroom to accommodate CDU needs without moving the patient.
Acute Care Hospital Settings

Diagnostic Departments

- Most sophisticated equipment
- Less equipment
- Less duplicate technology
- Reduced utilization
- Extended hours.
Non-Hospital Settings

Urgent Care Centers

- Short term demand increases to accommodate reduced use of ED and influx of new patients with healthcare coverage.
- Long-term will give way to Clinics with “extended hours”
- Medical retail outlets will also decrease the need
Non-Hospital Settings

Medical Clinics

- Full service (One stop shopping.)
- Includes retail services such as pharmacy, phlebotomy, health and wellness products
- Extended hours of operation.
- In-rush of the newly insured
- Time share clinical offices
- Onsite diagnostics
Non-Hospital Settings

Physician Office/Clinics

- Decline of traditional Doctors offices
- Services will be provided online
- Move to walk-in retail medical clinics venues or full service clinic locations
- Many services will be provided in the home
Questions