

# Patient Survival Guide



# Best Hospitals

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## AFTER HEALTH REFORM

# The Hospital, Your Care Coordinator

Some centers now take charge of keeping people healthy and at home

By Catherine Arnst

Hospitals aren't known for making house calls. Once patients get their discharge papers, they take their chances with a family doctor or staffers at a clinic who may or may not know what happened inside the hospital's walls. So Margaret Bennett's experience is pretty rare.

Bennett, 84, who had a stroke 11 years ago and colon cancer in 2007, recently spent two weeks at **Montefiore Medical Center** in the Bronx because of a blood clot in her leg. In many places, such a frail and elderly patient might be hospitalized for weeks or even months, but Bennett's doctor now comes to her. Every two weeks or so, geriatrician Mohamed Aniff visits, lingering for close to an hour in the sunny and spotless apartment she shares with daughter Geraldine, 65—surroundings far cheerier (and more economical) than any hospital room. The Bennetts have Aniff's cellphone number, so they can reach him any time of the day or night, and if they had a computer they could query him by E-mail, as many of his patients do. The costs of the visit are covered by Medicare. By coming to Margaret, Aniff can assess the safety of her environment, discuss her care in depth with Geraldine, and develop the kind of personal relationship rarely found between patients and hospital staff. "He's something else," Margaret says of Aniff, as she grabs his hands and smiles broadly. "He's family."

Why this unusual level of involvement for one elderly New Yorker? **Montefiore** is pioneering a new model of healthcare delivery, endorsed by the architects of health reform, that promises to radically change the current fragmented system in which the family doctor may have no idea what happens during a hospital stay, or a diabetes patient's endocrinologist, internist, and cardiologist never talk to one another. As an "accountable care organization," **Montefiore**, along with Kaiser Permanente in Oakland, Calif., Intermountain Healthcare in Salt Lake City, the Mayo Clinic in Rochester, Minn., and a handful of other medical systems, is experimenting with a novel way to save money and improve patient outcomes by coordinating all of their care, by all of their doctors, whether in the hospital or out.

The ACO idea was born out of discussions in 2006 between Elliott Fisher, director of the Dartmouth Atlas Project, which documents regional disparities in healthcare, and Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission. "Our early work at the Dartmouth Atlas showed that most healthcare is local," says Fisher. "Patients go to their local hospital, and see doctors that work in networks based around that hospital." He and Hackbarth envisioned a model in which a hospital, a large physician group practice, or a combination of the two would be held accountable for the well-being of a community of patients, most likely all those living within a few miles. The organization would receive a flat fee per year from each person's insurer or employer, based on health and age, and then work to keep all as healthy as possible and out of the hospital. The medical provider should thus be able to come out ahead financially. Home visits would become commonplace, as would such 21st-century tools as electronic medical records and sophisticated home health monitoring systems.

If an ACO patient does end up in a hospital bed, it is in the organization's best financial interest to make sure that the care is of high quality, that hospital-acquired infections and medical mistakes don't happen, and that medications are administered correctly, reducing the need for any extra care. Once the patient checks out, doctors affiliated with the organization follow up to make sure he or she doesn't return in short order, since a high readmission rate could lead to cuts in Medicare payments.

ACOs are rare today; there isn't even much agreement on a definition. But provisions in the health reform law call for Medicare to establish an agency that would set up and evaluate different models of coordinated care delivery, including the ACO and the "medical home," a related concept in which a primary care physician coordinates all aspects of a patient's care. Ideally, proponents say, ACOs and medical homes would join forces for the greatest impact.

American medicine looks nothing like that now. The majority of U.S. doctors rarely communicate with one another,

while those connected to hospitals are usually independent contractors who bill patients separately from the institution—which makes it tough to get everyone working together for the good of the patient. Coordination, policy wonks believe, will make healthcare both better and cheaper, and lawmakers clearly think so, too. By Jan. 1, 2012, Medicare must establish a program that would share any money it saves from coordinated care within a community with the ACO responsible for the savings.

Already, there's some evidence that the concept works. Consider the experience of Kaiser Permanente, the nation's largest nonprofit health plan. With 35 hospitals and more than 14,000 doctors in nine states and the District of Columbia, the combination health maintenance organization and medical system pays itself a flat fee per patient. All of its doctors are on salary, so they have no incentive to order extra tests or otherwise try to increase their own income. A study of Kaiser patients with chronic diseases such as asthma and diabetes between 1996 and 2002 found clinical improvements were 10 percent above the national average, while another study calculated that workers compensation insurers in California saved \$395 million from 1996 to 2005 because medical costs at KP were lower than those of other plans.

And it doesn't take an ACO the size of Kaiser to produce savings. Geisinger Health System serves a rural area of Pennsylvania around its home city of Danville. The hospital started charging patients who came in for coronary bypass surgery a

flat fee in 2006. A study of 181 patients treated that first year found that the number readmitted within 30 days fell by 44 percent, while their cost of care dropped by 5 percent.

Little wonder that interest was spreading even before health reform passed. Last November, Baylor Health Care System in Dallas announced that it would convert 13 of its 26 hospitals to an ACO model by 2015. "This is all about ... focusing on wellness, on prevention," says Baylor CEO Joel Allison.

All this coordination may not sound like such a great thing to the public, which could well equate the ACO to the much-maligned health maintenance organizations of the 1990s. HMOs capped payments for various treatments at predetermined levels, which left many patients feeling that hospitals and insurers were refusing to provide needed care because it cut into their profits. "HMOs got a lousy name, and deservedly so, because they were totally about cost, not quality," says David Bronson, chairman of the American Medical Group Association and president of Cleveland Clinic Regional Hospitals. With many HMOs, he says, care decisions were made by the insurance company, which often second-guessed the doctor. An ACO, by contrast, ideally would not have to worry about preset payments for procedures, and would make its own treatment decisions without insurer oversight.

That's how **Montefiore** is set up. The hospital serves one of the poorest urban populations in the country—27 percent of the Bronx's 1.4 million residents (and 40 percent of its children) live below the poverty line. It was forced to hire its own staff physicians back in the 1970s, when the Bronx, famously, was burning. "It was almost impossible to get doctors in private practice to stay here," says CEO Steven Safyer. "We had to repopulate the borough's medical care." By far the largest hospital in the area with 1,500 beds, **Montefiore** today pays about 80 percent of its 2,500 physicians a salary, including 500 primary care physicians based in the community. The hospital also set up its own HMO, with 150,000 enrollees, taking over the care of Bronx residents for a flat annual fee paid by employers or other in-



Every couple of weeks, Margaret Bennett gets a house call from Mohamed Aniff.



Diabetes educator Patricia Farrell tests the strength of a patient being treated after a stroke.

surers. To make sure these HMO members stay healthy, the hospital does extensive community outreach, operating over 100 outpatient offices throughout the Bronx, ranging from school health centers to mobile clinics. The community focus is evident in **Montefiore's** efforts to fight diabetes, which affects 12 percent of the borough's population. Its diabetes center serves over 4,000 patients, with an approach that focuses on teaching them how to take care of themselves. The health of family members of pregnant women with diabetes is evaluated, for example, in an effort to prevent the newborn from developing problems.

The hospital monitors all of its coordinated activities with an extensive electronic medical records system. The system's contribution to coordinated care is especially evident in the 300,000-patient-per-year emergency room, the nation's fifth busiest. The poor and uninsured tend to use **Montefiore's** ER for all their medical needs, emergency or not. So teams of nurses and aides input the vital signs and health status of new arrivals as soon as they enter the ER. Those who have

routine problems are then "fast-tracked" over to internists, who evaluate all their needs to prevent more serious problems down the line and advise them on where to find primary care in the community. ER doctors on duty can quickly scan the computerized list of patients, seeing who needs immediate care and who's been waiting too long.

It will be far from easy for other hospitals to follow **Montefiore's** example if doctors aren't on salary, and most aren't. Policymakers worry that ACOs won't work under the fee-for-service system, which rewards doctors for the number of services rendered, not for quality of the care. "There absolutely has to be a change in fee-for-service to do ACOs properly," says Robert Berenson, an expert in healthcare economics at the Urban Institute, a think tank in Washington, D.C.

But observant doctors may decide that coordinated, continuous care is the more rewarding way. Mohamed Aniff says he can't imagine better working conditions than treating his elderly patients where they're happiest, while keeping them out of the hospital or the nursing home. ●

## THE HEALTH REFORM TIMELINE

On March 23, President Obama signed into law a sweeping reform of the nation's healthcare system. When will the changes that most affect consumers kick in?

### 2010

- Medicare recipients receive a \$250 rebate when they hit the "doughnut hole" gap in Part D drug coverage.
- Businesses that employ fewer than 50 people are eligible for a tax credit equal to 35 percent of health insurance premiums.
- States can choose to establish temporary high-risk pools for people with preexisting conditions, similar to those for car insurance, until new health insurance exchanges are implemented in 2014.
- A federal website debuting this summer, [www.healthcare.gov](http://www.healthcare.gov), is to provide information on health insurance options in each state.
- Effective September 23, insurers cannot exclude children with preexisting conditions from coverage.
- Adult children may remain on their parents' policies until their 26th birthday, although many plans will institute this change only when their new

policy year starts.

- All new policies must cover preventive services such as cancer screening, with no out-of-pocket costs.
- Insurers are barred from canceling coverage when a policyholder becomes ill.
- Insurers can no longer set lifetime limits on the amount of benefits paid; annual limits are restricted and will be phased out.

### 2011

- A voluntary national insurance program will be established to cover home health services for the elderly.
- Those hitting the "doughnut hole" will receive a 50 percent discount on brand-name drugs.
- Medicare will offer free annual wellness visits and personalized prevention plans.
- Small businesses that establish wellness programs will be eligible for grants.
- Chain restaurants and vending machine companies must

disclose the nutritional content of their products.

- Medicare will pay a 10 percent bonus to primary care physicians practicing in areas with doctor shortages.

### 2013

- The Medicare payroll tax rate will rise from 1.45 percent to 2.35 percent on earnings over \$200,000 for individuals and \$250,000 for couples.
- The minimum threshold for claiming deductions for medical expenses will increase from 7.5 percent to 10 percent of adjusted gross income for those under 65.
- Contributions to a flexible spending account will be limited to \$2,500 per year.
- The employer tax deduction for subsidizing Medicare Part D-eligible retirees will be eliminated.

### 2014

- U.S. citizens will be required to buy health insurance or pay a penalty of \$95 per person in 2014, \$325 in 2015, and \$695 or up to 2.5 percent of income in 2016. After 2016, penalties will be

indexed. The working poor may qualify for subsidies.

- Companies with 50 or more employees generally must offer health insurance or pay a penalty of \$2,000 per employee after the first 30.
- Insurers will not be allowed to refuse coverage because of preexisting conditions and cannot charge higher rates because of health status, race, or gender.
- Health insurance exchanges will be available in each state, allowing individuals and small firms to comparison shop for a standardized policy.
- Employers can offer rewards of 30 percent to 50 percent off the cost of coverage to employees who participate in wellness programs.

### 2018

- An excise tax will be imposed on employers who provide their workers costly "Cadillac" health plans, those with premiums beyond \$27,500 annually for family coverage and \$10,200 for individuals. Companies can choose to pay the tax, pass it on to employees, or lower the benefit. -C.A.

[www.montefiore.org](http://www.montefiore.org)