A Health Care Encounter of the 21st Century

Imagine a 10-year-old child with severe, medication-dependent asthma. In the past year, she missed 10 days of school, was seen in the emergency department 5 evenings, was admitted to the hospital for 36 hours twice, and was seen in a medical clinic 15 times. It’s the same exhausting struggle across the United States for thousands of individuals and their families—people with diabetes, arthritis, obesity, heart disease, neurologic disorders, cancer, AIDS, hepatitis C, transplantation, and renal failure, to name just a few. More patients are now living with multiple chronic conditions, but the health care system today is not equipped, nor has it evolved, to provide the integrated and coordinated care that meets the needs of patients of the 21st century.1

Changing the Way Care Is Provided

Almost 1 in 2 adults of the US population has at least 1 chronic medical condition,2 and people with chronic medical conditions account for more than 75% of health care costs.3 Sudden trips to hospitals and emergency departments are not what these people want, but often, those options are all that are available. Under the current outdated health care delivery system, the acute care setting is the most expensive place to be seen. Changing the way care is provided to patients who are the sickest and require the costliest treatment, in both direct and indirect medical costs and lost productivity, at work or in school, offers the greatest opportunity for improving the population’s health and for reducing the cost of health care. As this evolution occurs, a patient encounter with the health care system will be very different from that of the last century.

What is needed is a keep-you-well care delivery system that improves health for increasing numbers of people with complex conditions. Future patients want care by integrated teams that is coordinated around their needs.

New Care Models

So how do patients and clinicians push the evolution of new care models? First, eliminate the barriers to change. The current payment model is one major barrier. In many cases Medicare, Medicaid, and commercial insurance plans require the patient to see a physician to qualify for reimbursement. Although services in traditional locations, such as a medical office, the emergency department, or hospital, are usually covered, home visits by nurses and other nonphysician health care workers are generally not covered. In addition, telephone, e-mail, text, and telemedicine encounters are not reimbursed.

Despite the lack of reimbursement, some practice groups have started new care models for groups of their most expensive patients. A number of rural, regional, and urban medical systems have set up models of care for uninsured and underinsured patients using health professionals and trained community caregivers. These models of care often involve visiting patients with chronic conditions such as diabetes, congestive heart failure, or asthma in their homes. The continuing home visits help prevent acute episodes that in the past would have resulted in emergency department visits or hospitalizations.

These models are often supported by a health information technology infrastructure that (1) helps with the design and evaluation of a specific patient intervention program and (2) provides information at the point of care, thus reducing the duplication of services and improving the quality of care for a given patient. An example of this approach is the Integrated Care Collaboration (ICC), a coalition of safety-net practitioners and centers in central Texas, founded in 1997 to address access and financing issues of providing care for low-income and uninsured individuals. The coalition maintains a regional health information exchange (ICare) to identify patient needs and design high-touch intervention programs to improve the health outcomes of these
populations. By focusing on the uninsured and implementing programs that keep them healthier (and thus out of the emergency department and the hospital), the ICC helps clinicians and health care centers lose less money. This is not a viable business model in the long run.

A Hospital at Home

In other communities, the concept of a hospital-at-home is developing. One example is the Hospital at Home program administered by Albuquerque-based Presbyterian Healthcare Services (PHS), a private, not-for-profit, integrated health care system that includes the state’s largest health plan. Launched in 2008, the PHS Hospital at Home is based on the model developed in the mid-1990s at the Johns Hopkins University Schools of Medicine and Public Health. Available to Medicare Advantage and Medicaid patients with common acute care diagnoses, the program provides patients with hospital-level care within the comfort of their homes by leveraging dedicated and highly skilled staff supported by advanced technology. Patients within the program show comparable or better clinical outcomes and higher levels of satisfaction when compared with similar hospitalized patients. Moreover, PHS has been able to deliver the Hospital at Home experience at a substantial discount (19% lower overall costs when compared with similar hospitalizations). Despite this record of success, PHS has faced a number of difficulties specific to this subset of patients, which not only focus the new payment model where it is most likely to achieve a cost savings, but also hold clinicians and health care centers accountable for patient outcomes and allow them to gain experience with more financial risk.

Aligning Payment Models and Care Models

To improve the alignment between payments and better models of care, many of the country’s best and most innovative practice groups have been forced to own their own insurance companies or take either full or partial capitation payments for selected patients. The only way they survive financially is by keeping their sickest and most expensive patients healthy and out of physicians’ offices, emergency departments, and hospitals. This is a true alignment between what patients want and how physicians are paid. Payers must recognize that long-term spending for health care will be less than it is in the current fee-for-service model if payments are aligned with these more efficient ways to deliver health care.

Where to start? Start with the sickest groups of patients. A small subset of patients (~20%) drives the majority (~80%) of total health care costs. These might be a subset of high-cost patients with a specific disease or with multiple chronic medical conditions, mental health conditions, or both. The sicker and costlier the patient, the greater the health gains, and the greater savings can be made. By focusing on a specific population, teams of various health workers, with a wide range of skills, can develop patient-centered treatment plans that will emphasize tertiary and quaternary prevention strategies along with close follow-up for each individual in that population. In turn, payers can develop minicapitation payment models specific to this subset of patients, which not only focus the new payment model where it is most likely to achieve a cost savings, but also hold clinicians and health care centers accountable for patient outcomes and allow them to gain experience with more financial risk.

The result will be better health care delivery. The patient will find that new delivery models no longer require a trip to the waiting room for a traditional office visit with the doctor. Patients will not be forced into an unnecessary trip to the emergency department because there are no other options. The future office visit will be any form of encounter that focuses on the best interest of the patient; that demonstrably improves outcomes, safety, and service; and that reduces spending over time. Care will increasingly be proactive with a continuing emphasis on follow-up.

Combining these better models of care with models of reimbursement for clinicians and health care organizations that provide that better care leads to an effective and efficient delivery system for the 21st century.

ARTICLE INFORMATION

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REFERENCES


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