Health Care Reform and the Future of American Medicine: Implications for Mental Health

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In 2012, the U.S. spent $2.87 TRILLION on Health Care
# Health Care Spending in Context

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP (nominal) in 2012</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>$15.65 trillion</td>
<td>#1</td>
</tr>
<tr>
<td>CHINA</td>
<td>$8.25 trillion</td>
<td>#2</td>
</tr>
<tr>
<td>JAPAN</td>
<td>$5.98 trillion</td>
<td>#3</td>
</tr>
<tr>
<td>GERMANY</td>
<td>$3.37 trillion</td>
<td>#4</td>
</tr>
<tr>
<td>FRANCE</td>
<td>$2.58 trillion</td>
<td>#5</td>
</tr>
<tr>
<td>UK</td>
<td>$2.43 trillion</td>
<td>#6</td>
</tr>
<tr>
<td>BRAZIL</td>
<td>$2.42 trillion</td>
<td>#7</td>
</tr>
</tbody>
</table>

CIA World Factbook, 2012
# Health Care Spending in Context

## Federal Health Care Expenditures, 2011

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$554 billion</td>
</tr>
<tr>
<td>Medicaid/CHIP</td>
<td>$257 billion</td>
</tr>
<tr>
<td>Fed. Public Health</td>
<td>$10 billion</td>
</tr>
<tr>
<td>Fed. Research</td>
<td>$39 billion</td>
</tr>
<tr>
<td>Structure &amp; Equipment</td>
<td>$12 billion</td>
</tr>
<tr>
<td>Other (DoD, VA, FEHBP, etc…)</td>
<td>$107 billion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$979 billion +</strong></td>
</tr>
</tbody>
</table>

Annual Federal Health Care Expenditure is larger than the economies of:

- $623 billion
- $770 billion
- $783 billion
- $895 billion
- $1.15 trillion

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Altarum Institute.
US Spending vs. Other Countries

Per capita health care spending, 2006

$ at PPP*

* Purchasing power parity.

** Estimated Spending According to Wealth.

Source: Organization for Economic Co-operation and Development (OECD)
Chocolate Consumption vs. Nobel Laureates

Figure 1. Correlation between Countries' Annual Per Capita Chocolate Consumption and the Number of Nobel Laureates per 10 Million Population.
US Spending vs. Other Countries

Per capita health care spending, 2006

$ at PPP*

2006 $R^2=0.88$

Per capita GDP ($)

* Purchasing power parity.
** Estimated Spending According to Wealth.
Source: Organization for Economic Co-operation and Development (OECD)
Where is all this money going?

- Insurance companies?
- Drug companies?
- Defensive medicine?
- Demanding patients?
Breakdown of US Costs by Type

$2.87 trillion total

- Hospital Care: $921
- Physician and Clinical Services: $555
- Other Professional Services: $77
- Dental Services: $113
- Home Health Care: $79
- Nursing Home Care: $151
- Prescription Drugs: $280
- Other Medical Products: $93
- Research: $48
- Gov't Public Health: $84

Growth in Health Care Costs

From 2010 to 2011, national spending on health care grew by more than $100 Billion

Source: http://content.healthaffairs.org/content/31/1/208.full.pdf+html
## Causes of Health Care Cost Growth

<table>
<thead>
<tr>
<th>Factor</th>
<th>Proportion of Growth in Real Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging</td>
<td>2%</td>
</tr>
<tr>
<td>Income Growth</td>
<td>5-20%</td>
</tr>
<tr>
<td>Insurance-Induced Demand</td>
<td>10%</td>
</tr>
<tr>
<td>Health Care Prices/Productivity</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>3-10%</td>
</tr>
<tr>
<td>Defensive Medicine</td>
<td>0%</td>
</tr>
<tr>
<td>Technology</td>
<td>38-65%</td>
</tr>
</tbody>
</table>
Rising Health Costs Jeopardize:

1. Coverage and Access
2. State Budgets and Support for Education
3. Middle Class Wages
4. America’s Long-Term Fiscal Stability and Status as a World Power
Cost-Coverage Trade-Off

• There is a cost-coverage trade-off.

• Higher health care costs mean lower coverage.

• Between 2000 and 2008
  ▪ Health care costs increased 80%
  ▪ Employer insurance decreased 69% to 61%
  ▪ Uninsured increased 22% from 38 to 46 million
Cost-Coverage Trade-Off

Cost-Coverage Trade-Off

- Even in the post-ACA world, higher costs mean that some families and businesses will find insurance premiums too expensive, even with subsidies, and will go uninsured.

- Individuals are exempt from the mandate if the lowest cost insurance plan available is >8% of total income.
Without Cost Control, Premiums Will Consume More of Household Income

Source: Lee Newcomer. Health Insurer Perspective for Delivering Affordable Cancer Care. IOM Affordable Cancer Care Workshop. 8 Oct, 2012.
Cuts in State Programs

Changes in General Fund Spending by Category Between Fiscal 2011 and Fiscal 2012

Health Care Spending Continues to Drive General Fund Growth

- Medicaid: $15,862.1 million
- Corrections: 10.3
- K-12: $2,459.3
- Higher Ed: $5,034.1
- Public Assit.: $3,901.0
- Transportation: $212.8

Fiscal 2011 data is based on enacted budgets and fiscal 2012 data is based on governors’ proposed budgets.
Cuts in State Programs

Fiscal 2013 Projected Spending Changes by Category

Source: NASBO Fall 2012 Fiscal Survey
*Projected Medicaid Spending includes a $4.7 billion anticipated supplemental appropriation in Texas
Cuts in State Programs

- High health care costs put strain on state budgets:
  - Higher Medicaid costs
  - Higher state employee insurance premiums
Cuts in State Programs

• States have three choices:
  1. Raise taxes
  2. Restrict Medicaid eligibility
  3. Cut other state programs
Cuts in State Programs

Education is the main target for state cuts.

Over the last decade, in-state tuition at public colleges increased 72% to over $8,200.
Cuts in State Programs

- In 29 states, Medicaid costs exceed funding for primary and secondary education.

- In 14 states, Medicaid costs alone exceed 25% of state budgets.

- Over the last decade, in-state tuition at public colleges increased 72% to over $8,200.
Cuts in State Programs

“Medicaid and other health-care expenses are predicted to grow to as much as 40% of the state budget by 2015. That will force the state to cut higher education funding because there are few other options. ... It certainly seems to be on a collision course.”

John Arnold, Director of the Arizona Office of Strategic Planning and Budgeting
Stagnant Wages

• Over the last 30 years:
  - Health insurance premiums increased by 300% after inflation.
  - Corporate profits increased 200% after taxes.
  - Net worker income in private industries declined by 4%.
Stagnant Wages

Trend of Health Care Costs and Wages

Data are from the Council of Economic Advisers\textsuperscript{6} and Catlin et al.\textsuperscript{7}

“Over the long run, the deficit impact of every other fiscal policy variable is *swamped* by the impact of health-care costs.”

— Peter Orszag, Former Director of OMB & CBO
History of Health Care Reform
Enactment of Health Care Reform

Patient Protection and Affordable Care Act

March 23, 2010
We Need to Reform the Way We Deliver Care
Uneven Distribution of Costs

- 50% of the population spends 3% of all health care costs
- 10% of the population spends 63% of all health care costs

• Key to saving money is prevention.

• Not primary prevention—vaccines and cancer screening, but tertiary prevention.

• Tertiary preventions keeps people with chronic illnesses healthier and out of the emergency room and hospitals.
Reengineering Care: Higher Quality, Lower Cost

- Intense, proactive out-patient care
  - EMRs
  - Standardized Care
  - Staffing changes and task shifting
  - Specialized services such as symptom management
Change in Infrastructure – EMR

- Adoption of Oncology Specific EMR
- Adoption of “home grown” IRIS system with voice recognition software that allows for:
  - Prompt completion of physician notes
  - Electronic prescribing and physician order entry
  - Tracking of tests and physician referrals
  - Tracking of adherence to guidelines
Change in Infrastructure – EMR

- Care plan options are structured to include clinical trials, NCCN based or payer specific chemotherapy guidelines. Deviations require customization.

- Disease specific post-chemo and survivorship care plans are embedded into the progress notes.
Change in Infrastructure – EMR

- Standardized screens with critical clinical information—symptoms, performance status, laboratory values, etc.—to improve efficiency.
Change in Information – Standardization of Care

- Delineate symptom management algorithms for use by triage nurses for common symptoms—nausea and vomiting, dehydration, diarrhea, and insomnia

- Adopt practice-wide, specific, NCCN guideline-approved chemotherapy for each cancer — adjuvant and first line metastatic — and integrate into default EMR treatment care plans.
  - Deviations require customization
Change in Information – Standardization of Care

- Require addressing of goals of care, end of life care, and hospice for all patients who
  - Present with or evolve to Stage IV disease
  - Physician prompted to address declining PS
Change in Infrastructure – Staffing

• Reduce the number of non-physician providers but increase training of staff:
  ▪ Reduce staff from 8.6 non-physician providers per oncologist to 5.5.
  ▪ With EMR eliminate staff who file charts and scan documents.
Change in Infrastructure – Staffing

• Upgrade staff to employ more ONS certified nurses who:
  - Assess outpatients prior to physician examination to document performance status and symptoms using standardized NCI grades.
  - Standardized process of care and data presentation.
Change in Infrastructure – Staffing

- Implementation of nurse-staffed telephone triage for symptom management from 8 am to 6 pm to:
  - Standardize symptom management practices
  - Facilitate early-in-the-day intervention at home or in office before ER visit is utilized.
Change in Infrastructure – Staffing

- Implementation of patient navigators—who are administrative assistants—to:
  - Gather all pertinent clinical data (based on disease site check list).
  - Schedule and track tests and appointments with all other physicians.
  - Immediate re-scheduling of incomplete tests or appointments.
  - Direct patients to community support services such as Cancer Support Community, patient education workshops, psychological support, etc.
Change in Infrastructure – Coordination Among Providers

• Patient records automatically sent to other providers—primary care physicians and referrals.

• Hand-off agreements with primary care physicians for survivorship care after adjuvant therapy.
Change in Infrastructure – Patient Access

- Scripted patient & family engagement
- Extend office hours
- Encourage patient-physician interaction through electronic communication, patient portal, and telephone triage service
- Schedule in-office visit time for same-day unscheduled office visits for symptom control
Results

Triage Line Utilization
Number of Triage Calls per active patient in a given year, 2006-2011

Year:
- 2006: 0.40
- 2007: 0.41
- 2008: 0.49
- 2009: 0.58
- 2010: 0.70
- 2011: 0.80

Calls per active patient per year:
- Range: 0.40 to 0.80

Penn University of Pennsylvania
Results

Outcome of Clinical Phone Calls from 2006-2011

- Manage Symptom(s) at home: 77.42%
- Patient sent for Radiographic Study: 1.51%
- Referred to Primary/Specialist: 5.55%
- Office Visit tomorrow: 4.22%
- Office Visit today: 5.41%
- Go to nearest ER: 5.19%
- Chemo Suite Intervention: 0.59%
- Direct Admission: 0.12%

6.63% of patients were seen in the office within 24 hours of call
Results

- **ER visits**—68% decline
  - 2004—2.6/chemotherapy patient
  - 2011—0.82/chemotherapy patient
- **Hospitalization rate**—51% decline
  - 2004—1.04/chemotherapy patient
  - 2011—0.53/chemotherapy patient
- **Hospice length of stay**—34% increase
  - 2004—26 days
  - 2011—35 days
Milstein’s “Medical Home Runs”

• Physician-led primary care practices with average or above-average quality scores whose care enables their patients to consume 15-20% less in total health care spending per year.
  • Urban Medical Group
  • Leon Medical Centers
  • Redlands Family Practice
  • CareMore Medical Group
Medical Home Runs: CareMore

- 30 care centers across the Southwest, serving more than 70,000 Medicare Advantage patients
How is CareMore Succeeding?

**Structure**

- **Care team** composed of physician, nurse practitioner, care coordinator, health aide
- **Specialized clinics** for common chronic conditions like diabetic wound care and blood thinning
- **CareMore Intervention Teams** (or “SWAT” teams) for severe psychosocial problems
- Work with **select efficient specialists**
SWAT Teams

- Proactive, mobile medical units that can deliver in-home care to severely ill patients
- Equipped to handle psychosocial issues
- Psychologists, social workers
- Lawyers, if necessary
How is CareMore Succeeding?

- **Expanded access** – available 24/7 with patient records
- **Proactive monitoring of physiological risk factors** – like weight, glucose, and pulmonary function
- **Screening for psychiatric conditions** that are associated with high costs – like depression and dementia
- **Data driven tools** to facilitate patient tracking, performance evaluation, and decision-making
CareMore “Healthy Start” Visits

• Many newly joined CareMore members hadn’t seen a primary care physician in years

• Instituted “Healthy Start” visits at beginning of membership to get an accurate health assessment of each individual

• Advanced predictive modeling → Community Assessment Risk Scores (CARS)

  ▪ Patients scores 6+ had a 30% chance of hospitalization in the next year

  ▪ Any patient with a 6+ is sent to an extensivist for further evaluation
CareMore “Healthy Start” Visits

Advantages of Healthy Start

1. Creation of an accurate medical record for each patient

2. Proactive identification of high-risk patients that need more extensive disease management
   - Scores of 6+ are sent directly to their next evaluation; they don’t even need to go home first

3. Any urgently needed services are provided immediately
CareMore “Healthy Start” Visits

• 17% of patients screened have been diagnosed with depression

• Instead of standard referral to a psychiatrist, which can take 2-3 months, patients are seen by a mental health caregiver within 48 hours
Medical Home Runs: CareMore

Disease management programs for chronic conditions:

- Diabetes Care Program and Wound Program
- End Stage Renal Disease
- High Blood Pressure Care Program
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Fall Prevention Program
Medical Home Runs: CareMore

Health management services:

- Exercise and Strength Training
- Home Care
- Mental Health Program
- Social Services
- Podiatry
- Hospice
- Palliative Care
- Wellness Programs
- Transportation
Psychiatric Patients With Major Medical Problems Tend To Use the Most Resources

- Problems compound one-another
- CareMore estimates 4 to 5 times more utilization among these patients
- Of the sickest 2% of dual-eligibles in CareMore, 60% had serious mental health issues
Example: Improving Psychiatric Care for Cancer Patients
Addressing 3 Common Problems in Cancer Care

1. Little Emphasis on Psychosocial Counseling and Care
2. Delays in Treatment Initiation Cause Increased Anxiety and Depression
3. Patients & Families Are Rarely Given Comprehensive Data On Treatment Options and Expected Outcomes
CareMore Pilot Program: Mental Health Evaluations

• Newly diagnosed cancer patients see a mental health professional **even before** they go to an oncologist

• Patients are **screened for psychiatric conditions** that are known to increase costs – like depression, dementia and bipolar disorder

• Patients and families are **given a number to call** if they experience any symptoms related to cancer treatment, including depressive symptoms
CareMore Pilot Program: No Delays to Start of Treatment

- After a tissue diagnosis has been made, first treatment is expedited
- MRI & PET scans within 72 hours of diagnosis
- Eliminate wait times that cause families and patients unnecessary strain
CareMore Pilot Program:
Give Patients the Info They Need

• Show patients and families evidence-based data detailing the treatment they are about to receive

• Make sure patients know what the normal side effects and reactions to treatment are
  ▪ Only about 1/3 of admissions are due to severe complications; most are due to “normal” symptoms: vomiting, diarrhea, etc…

• Provide easy and immediate access to manage symptoms
  ▪ Hire nurses to take calls 24/7 to help patients treat symptoms from home
Medical Home Runs: CareMore

- Hospitalization rate 24% below average
- Hospital stays 38% shorter
- Amputation rate among diabetics 60% lower than average
- Overall member costs 18% below the industry average
- Readmission rate is 25% less than Medicare fee-for-service
- ESRD bed days are about 40% fewer

Source:
Savings

1. Concierge care for the chronically ill to reduce complications from physical illness like:
   - Weight gain
   - High glucose
   - Infections, etc…
Savings

2. Catch symptoms early

3. Reduce ER visits and hospitalizations

4. Refer to efficient specialists
To Get Further Savings...

We will need to tackle psychiatric conditions that cause high use

- Depression
- Anxiety
- Dementia

1. Screen to diagnose
2. Intervene early
• Johnson & Johnson has had employee wellness programs since the 1970s
• HSAs
• Treatment of high blood pressure, high cholesterol, glucose, smoking
• 4% smoking rate
• ~80% participation
Confirmation From Wellness Programs

• But 20% were still not participating

• Who were those 20%?
  ▪ Depressed
  ▪ Anxious
  ▪ Preoccupied
J&J Response: Buying Behavioral Health Companies

- In 2008, J&J purchased HealthMedia Solutions, and LGE Performance Systems, Inc. (the Human Performance Institute)
- Launched a new platform called Wellness + Prevention, Inc.
- Web-based program to help people improve their behaviors in areas like:
  - Weight and stress management
  - Sleep quality
  - Smoking cessation
  - Medical adherence and compliance
J&J Response: Healthy Minds Initiative

- Launched the Healthy Minds Initiative in 2011 through Janssen Pharmaceuticals (a J&J company)
- Support for neuroscience research through the One Mind for Research program and the International Mental Health Research Organization
- Help de-stigmatize mental health disorders and enhance understanding of the science behind them
- Encourage collaboration among biotech, pharmaceutical, and public sector stakeholders
I am an optimist!

- By 2020, American health care will be much better than it is today

- The ACA is a major cause and catalyst for that improvement
The Health Care System Will be Better

• Transitions are not easy.
• The near term future is going to be bumpy.
• However, we will have a much better health care system by 2020.
Psychiatric Health Will Bring the Next Round of Savings

- Once we begin changing the delivery system, payers, providers and the government will begin to see the savings that effective mental health programs can produce.
- Success will breed success.
- We will see more psychiatric engagement among chronically ill patients.
We Will Finally See Parity Between Mental and Physical Health