MAYO CLINIC
Health Policy Center

MAYO CLINIC HEALTH POLICY CENTER

Creating High-Value Care Delivery

Building Upon the Cornerstones:

- *CREATE VALUE* • *COORDINATE CARE*
- *PROVIDE HEALTH INSURANCE FOR ALL*
- *REFORM THE PAYMENT SYSTEM*

DESIGNING THE SPECIFICATIONS

Participants at Mayo Clinic Health Policy Center's 2008 National Symposium on Health Care Reform recommended several action steps and strategies to further develop the four cornerstones: Create Value • Coordinate Care • Reform the Payment System • Insure Everyone

One action area centered on creating coordinated care programs for patients who need intense, high-cost medical services as well as for those who are nearing the end of their lives. According to the Commonwealth Fund, more than 40 percent of patients report problems with care coordination when dealing with four or more physicians.

Improving care for these groups of patients could have a significant positive impact on quality of life as well as national health care spending. The Partnership to Fight Chronic Disease states that two-thirds of all deaths are caused by one or more of five chronic conditions, and about three-quarters of U.S. health care spending is on some form of chronic condition.

Participants brainstorm ideas for creating high-value care.

CREATING HIGH-VALUE CARE DELIVERY

An Executive Summary

On Oct. 6, 2008, a small group of experts – health care providers from a variety of settings, business-people, academics and a family caregiver – gathered in Denver to further explore how health care providers could improve value by increasing care coordination for patients with chronic conditions and by better managing end-of-life health care. Following is a summary of recommended action steps within these categories:

I. HIGH-VALUE CARE DELIVERY FOR CHRONIC CONDITIONS

- ***Create a system that pays for delivering the desired outcome.*** Participants agreed that the payment system must be redesigned to reward high-value, coordinated care. One attendee suggested a reimbursement system that bundles Medicare Part A and B payments for patients with high-cost, chronic conditions. In such a payment scheme, one lump sum payment for both physicians and the hospital would encourage the two groups to work together to integrate and coordinate patient care services.

- ***Appoint a care coordinator to serve as a consistent navigator.*** Bruce Hamory, M.D., Geisinger Health System, reviewed one of his organization's care coordination initiatives, which features a personal navigator (see sidebar). The personal navigator helps the patient and family caregiver to traverse the health care system efficiently to secure the services that they need. Dr. Hamory noted the important role that Geisinger's health plan has played in the success of the project, providing both nursing staff and analytical support.

Participants acknowledged that the public clearly dislikes the term "medical home" when used to describe care coordination – partly because it is unclear and easily confused with "nursing home." The group agreed that the term "care coordinator" or "navigator" was more specific.

- ***Encourage the use of a common medical record, even if it's not electronic.*** A hallmark of multispecialty medical groups is a common medical record, which allows every physician to see what every other provider has written into that record. Stakeholders strongly endorsed creating interoperable health records to facilitate appropriate sharing of a patient's health information across settings and time.

> *"It's not the private practice of medicine. It's the public practice of medicine because there's one medical record that everyone contributes to."*
>
> *–Don Fisher, Ph.D., AMGA*

- ***Sustainable care coordination models must be in place at the local level, and they must address the entire continuum of care.*** Participants agreed that care coordination should be assigned to a person living within the community – not contracted to a call-center across the country. Attendees also recognized that sustainable care coordination models must span the spectrum of a person's life, including end-of-life care and hospice.

The group felt that appropriate use of resources at the end-of-life would be a natural outgrowth of well-coordinated care.

Darrell Kirch, M.D., Association of American Medical Colleges

INNOVATION IN CARE DELIVERY

Geisinger's Personal Health Navigator

Geisinger's "patient-centered medical home" initiative is designed to deliver value by improving care coordination and optimizing health status for each individual. Components designed to create a functional "Personal Health Navigator" for consumers include round-the-clock primary and specialty care access; a Geisinger Health Plan-funded nurse care coordinator in each practice site; predictive analytics to identify risk trends; virtual care-management support; a person, called a personal care navigator, to respond to consumers' inquiries; and a focus on proactive, evidence-based care to reduce hospitalizations, promote health, and optimize management of chronic disease. Other features include home-based monitoring, interactive voice-response surveillance, and support for end-of-life care decisions.

Excerpted from Health Affairs, *September/October 2008*

The group acknowledged that significant improvement is needed at the "cracks" between sectors of care (for example, from the hospital to the nursing home to the rehab center) and transitions among providers caring for the patient.

II. COMPASSIONATE, APPROPRIATE END-OF-LIFE CARE

- ***Insert the advance directive into the medical record and flag it.*** Attendees strongly concurred that the advance directive should be prominently flagged and inserted directly into the medical record. The group felt that embedding the document into the care process would allow for ongoing discussion of end-of-life care preferences with the primary care provider and/or the care coordinator.

- ***Increase public education and build awareness about the necessity of addressing end-of-life care issues. Regain the public trust, acknowledging and educating the public that supportive care is an option at the end-of-life.*** There was general agreement that neither providers, patients nor family caregivers can easily broach the subject of death – it's a tough conversation to initiate. As a result, studies show that most people don't create an advance directive until 1.2 years before death. The group suggested that communities undertake major educational efforts around this topic. (See "The La Crosse experience.")

DEFINING END-OF-LIFE TERMS

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on.

A living will tells how you feel about care intended to sustain life. You can accept or refuse medical care. There are many issues to address, including

- The use of dialysis and breathing machines
- If you want to be resuscitated if breathing or heartbeat stops
- Tube feeding
- Organ or tissue donation

A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions if you are unable to do so.

Excerpted from the National Cancer Institute and Medline Web sites.

INNOVATION IN END-OF-LIFE CARE

The La Crosse Experience

In 1991, leaders of the major health organizations in La Crosse, Wisconsin collaborated on the development and testing of an improved model of end-of-life planning and decision making. The program was unique because it used an integrated systems approach that not only depended on printed material and videos to educate the community, but also provided the personal assistance of trained staff. This approach was then integrated as the routine standard of care through consistently applied policies and practices.

Realizing that all aspects of end-of-life care needed to be thoroughly and systematically addressed, the La Crosse program also sought support for the project from all community and healthcare leaders and professionals.

After two years of full implementation of the education intervention and system change, the La Crosse project appeared to have had a significant impact on end-of-life planning and decision making. Of the 540 adult deaths in the La Crosse community studied from April 1995 until March 1996, advance directives had been written by 85 percent of those who died. Of those documents, 96 percent were found in their medical records. Treatment preferences expressed in advance directives seemed to be known by family and physician, and were typically followed.

Excerpted from www.respectingchoices.org/history

Darryl Kirch, M.D., Association of American Medical Colleges noted that studies have found that terminally ill patients typically fear pain, being short of oxygen and being abandoned – none of which require huge amounts of resources or sophisticated treatments. He commented that the United States is so enamored of intervention that we have sometimes neglected exploring simple supportive care as an option.

- ***Develop and use shared decision-making tools that prompt an open discussion with appropriate family members about difficult end-of-life issues.*** Participants advocated creating and using shared decision-making tools to "put the right people in the driver's seat." Potential items for discussion include outcomes, quality of life versus survival, and costs versus benefits. Providers commented that patients and family members must also have specific discussions about treatment options such as antibiotic use and tube feeding.

Mary Harrel Lawrence, Glenwood Medical Associates

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