The Humboldt-Del Norte County Medical Society Discussions on Health Care System Reform

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Executive Summary

The state of health care in Humboldt County became the focus of concern early in 2006 with the announcement of financial problems at St. Joseph Hospital. Examination of the problems at St. Joseph was undertaken in a series of focus groups, initially within the hospital itself, and later in the broader community. One of these groups was the Humboldt-Del Norte County Medical Society. The Medical Society convened interested physicians and advanced practice clinicians in a series of eight brainstorming sessions. About 70 providers, mostly physicians, informed the process. Providers told each other of severe financial problems threatening their ability to stay in practice and to recruit new clinicians to the area. Various reasons for the current predicament were examined.

We recognize that there are three elements necessary to the success of the health care system: Infrastructure, Financing and Access, and Workforce. While we touched on all of these interrelated elements, we are primarily concerned here with the workforce and with the delivery of care designed to improve the health care of the community as a whole. There was great interest in building a new organization to provide excellent care in a setting which would also provide clinicians with a collegial working environment where cooperation, rather than competition, is valued.

New models of care delivery show great promise in providing broad access to quality care. These models are not applicable to our present system of fragmented care, dominated by solo and small group practices. An integrated team-based model offers a realistic prospect of improved health care in our community. This new organization is designed as a multi-specialty, multidisciplinary organization which is patient-centered and primary care based, offering a medical home to all of the patients in its care.

Essential to this model is an information system that would link all aspects of the medical care system: physician offices, hospitals, imaging centers, labs, emergency medical services, public health, hospice and home health, and skilled nursing facilities. Smooth handoffs between all of these elements of the system would be facilitated by the information system and coordinated by providers who know the patient best.

We explored the operating principles which could drive the planning and operation of the new system. We also explored the obstacles to the creation of this large group practice. There is great interest in beginning the planning process as soon as possible.

We will continue to be part of the Community Health Alliance process as we work toward development of this new practice setting. If we succeed in this effort, the system will result in seamless high-quality efficient care that respects patient autonomy and rights.

History of the Process

The Humboldt-Del Norte community became aware of serious problems at St. Joseph Hospital in January 2006. During the following months, extensive discussions took place, and the public was made aware of the problems in local health care. The Humboldt County Board of Supervisors charged the Community Health Alliance (CHA), along with Ann Lindsay, MD, Public Health Officer, to coordinate input regarding both the decisions to be made by the St. Joseph System regarding its Eureka facility, and by the community about the larger problems in overall medical services. Sessions were scheduled with business leaders, community health officials, the media, physicians, nurses, the CHA board and others to solicit opinions on both issues. In response, the Medical Society was charged with the task of leading discussions by front-line providers about challenges facing our profession. Eight brainstorming sessions were held over 2 months from mid-June to mid-August, involving more than 70 physicians and advanced practice clinicians (physician assistants and nurse practitioners). Some, unable to attend one or more brainstorming sessions, weighed in verbally or by email.

This paper is a report of ideas generated by physicians and advanced practice clinicians for creation of a new entity which we hope will help solve some of the problems we face, but we are the first to admit that we do not have the whole solution. The overall process of assessment of the health care system in Humboldt County will be reported elsewhere by the Community Health Alliance.

Brief Description of the Challenges Facing Medical Care Providers

The “Golden Era” of Medical Care in the United States began when financially strapped hospitals sponsored legislation creating Blue Cross and Blue Shield during the Great Depression. The previous fee-for-service system began to be replaced by third party payors. These payors did not interfere with the patient-physician relationship and who arguably paid doctors more reliably than the patients had. Health insurance became popular as a benefit. Companies began offering it to their employees in lieu of pay hikes which were limited by wage controls during and after World War II. The idea grew with support from the union movement, and from the government which changed tax laws to make insurance even more attractive to employers. In the 1960s the federal government became directly involved in paying for health care with the establishment of Medicare and Medicaid. Pharmaceutical companies and medical device developers flourished. In the following decades, our current system of paying for health care was developed. It is a system in which consumers came to expect unlimited access to state0of-the-art care, with little or no idea of the actual cost of that care. As costs spiral upward, a large and growing number of Americans find themselves without insurance coverage or access to medical care.

The current system of paying for medical care is also having a serious negative impact on physicians, particularly those working in rural communities. Among the factors leading to the current difficulty of sustaining a medical practice in a rural area are

1) Insurance companies, for profit and convenience, have tied their reimbursement to the Medicare fee schedule, which favors urban and suburban areas. Medical care providers who choose to work in rural areas are paid less for the same work under Medicare, and therefore are paid less by the private insurers. The insurance companies have gradually and steadily cut their reimbursement to all medical care providers and put other barriers to payment in place, increasing the procedures and paperwork required to obtain payment. The resulting profit is passed along to the shareholders and executive staff. All of these factors disproportionately affect small practices, common in rural areas, with limited budgets for administration and without power to negotiate contract terms.
2) The Medicare payment system is "budget neutral", or in other words, a zero sum game every year. That means that any time any region negotiates a raise with the Medicare system, other areas are cut further. Rural areas do not have political clout and historically have been cut each time growth in suburban areas leads to a pay raise for the doctors in those areas. To make the situation worse, when Medicare payments drop to any provider area, rates from all payors, including private insurance companies who tie their reimbursement to the Medicare fee schedule, tend to drop also. HMO payment rates which track Medicare's are 30% less than the national average in California, and rural areas have payment rates that are up to 30% less than that low rate.
   All segments of the health care system, except for doctors, have their Medicare payments adjusted each year according to the Medicare Economic Index (MEI). This usually results in a small increase each year, comparable to the Consumer Price Index (CPI). Physicians are paid according to a different formula, the Sustainable Growth Rate (SGR) which usually results in a decrease each year. As a result reimbursement to physicians continues to fall in absolute as well as comparative terms. This payment structure was intended to prevent physicians from creating additional patient encounters and procedures to create more income. The projected cuts will result in an additional 5.1% on January 1, 2007. If this happens, physician payment rates will have fallen 20% below the government's conservative measure of inflation in medical practice costs in the past 6 years, resulting in a significant cut in physicians' take-home pay. Meanwhile, physician employees, landlords, benefit providers, liability insurers and all suppliers have received raises in their payments, further reducing the margin between income and expenses for a medical practice. The general cumulative rise in the cost of living applies to

physicians and their families also, further eroding real income. The 2004 Medicare Trustees report projected the cumulative reduction in physician fees of more than 31% from 2005 to 2012, during which time the costs to physicians for providing services are projected to rise at least 19%. The Medicare Payment Advisory Commission and the Centers for Medicare and Medicaid Services Administrator have agreed the physician payment system must be reformed, but so far, Congress has not taken action. By contrast, the hospitals expect a 3.6% increase on January 1, 2007; the health plans 7%, and nursing homes 3.5%. Since these increases do not keep pace with the increasing costs of providing care, hospitals tend to defer costly mandates like seismic retrofits year after year.

3) MediCal fees in California are near the bottom of Medicaid payments nationwide, and MediCal pays less per eligible beneficiary than any other state. MediCal has not given physicians a meaningful raise in over 20 years. There has been a net increase of about 5% since 1985, during which the CPI has risen about 88%, and the cost of medical practice has risen faster. Enhanced reimbursement is available to some primary care providers in the Rural Health Clinic and Federally Qualified Health Centers, but these programs are not available to specialists or to most individual offices. The standard MediCal payment for care is less than the cost of the rent for the office for the time of the visit. It is no wonder that most practitioners have limited the number of MediCal patients they can see in a week, since they lose money in actual costs when they do. The California Medical Association has prepared a list of comparative payments for MediCal services in their publication “Where Do Patients Go?” Several dramatic examples are given. For example, payment for setting a broken leg is $177 for MediCal, where veterinarians receive $800-$1400 to set a dog’s leg. Treatment of a knife or gunshot wound to the chest pays $112, while Roto-Rooter charges $121/hour to unclog a drain.
4) As incomes fall, physicians cannot take advantage of health information technology or other measures which might lower the cost of staying in business and improve care. Some physicians work longer hours or delay capital investments to make up the gap; some have gone without health insurance themselves, cut cost of living raises for their staff, used up their savings, or taken on chores usually done by staff, further increasing fatigue and burnout. Both private and government payors have raised the hassle factor with programs requiring extensive documentation of their practices, and different payors have different procedures for documentation, billing and appeal, making the system unnecessarily complex. Attempts to solve these payor/provider problems on a national level have failed, though the California Medical Association has successfully challenged the health insurance industry under RICO statutes for some of their more outrageous business practices. Some physicians have finally reduced their hours because the marginal benefit of working long hours is so small. Access to advanced practice clinicians might help

sustain their practice, but with so much financial uncertainty, many physicians are reluctant to take on the salary of another professional in the office. Meanwhile, the cost of complying with fragmented and inconsistent reporting requirements goes up, and the potential penalties for failure to comply instill fear in the providers.

5) The population we serve has become older and poorer, with more uninsured, and those who are insured increasingly recipients of government insurance. It is the failure of the government at all levels to adequately fund health care and to define and fund the safety net for the population that makes physicians wary of a single payor system, which they otherwise might embrace for its simplicity and administrative cost savings of up to 30% which could be redirected to patient care. An adequately funded integrated health care system could incentivize savings for efficiency that could then be returned to the system as a whole, rather than to the bloated expenses and profits of the major for-profit payors. Meanwhile, our ability to offer effective care has increased markedly in the past 50 years. In the first half of the 20th century, medical care often could offer no more than comfort measures and the documentation of the natural course of disease. Now we can often intervene in meaningful ways to change the course of disease, raising the expectations of society, but at a tremendous increase in the cost of care. The gap between the insured and the uninsured has widened. Health insurance plans have tended to cost more and to cover less each year, stretching employers' ability to provide insurance at all, and frustrating patients who may find themselves unable to pay their share of costs for needed care despite their insurance. In the past, medical care providers gave 20% of their services for free to cover the uninsured and under-insured, and some still do, but with economic peril to themselves as their profit margin has disappeared.
6) Our medical providers are aging themselves. The median age of a physician in Humboldt County is over 55 years of age. Many have deferred retirement and stayed in practice in the area because of concern for the community. This is tenuous, however, as an episode of illness or a financial reverse could finally force any of them into retirement.
7) We have lost several physicians to other areas in recent years, leading to further overload of those remaining, and further doubts about the sustainability of their practices here. Older physicians, in particular, are less able to tolerate the increase in administrative work resulting from the loss of their colleagues to retirement. With restriction on the usual market forces due to stringent price controls applied disproportionately to the providers, the only options open to providers as practice expenses rise and reimbursements fall are the options of trying to find a work situation in another area that might be more viable, such as an administrative job which removes them from direct patient care, or to quit altogether. Some physicians have made complete career changes, with the resultant loss to the community of their years of experience.

8) In light of all of the above factors, it should come as no surprise that recruitment to replace us has become increasingly difficult. Current trainees still have to pay for at least 8 years of education beyond high school, and typically leave residency with $100,000-$200,000 in debt. Even though they are paid a stipend during their residency, interest continues to accumulate on their educational loans during the additional 3-7 years of specialty training. Currently tuition is rising faster than the rate of inflation. It is very hard to convince graduates to come to an area where the reimbursement is up to 30% less than suburban areas. There are a few opportunities for loan repayment or forgiveness because we are officially designated a HPSA (Health Professional Shortage Area), but demand far exceeds available funds. Additionally, new graduates have been raised in an environment that limits the hours of work they can do each week, which values a team approach to care, and which has good information technology supporting their work. It is hard, therefore, to attract them to a solo or small group practice in an underserved area. In the past, real estate prices were low enough to interest them in this region, but prices have risen markedly in recent years. In addition, primary care providers so valuable to an area like this are not encouraged in the academic medical centers. The idea of needing to be responsible for the breadth and depth of knowledge required of a family practitioner or a general internist is daunting, so specialization may seem more attractive. Our business leaders predict a slow growth in the population, and hope for retirees from urban and suburban areas moving to this area. Unless we change our method of delivering care, and unless we develop a system that attracts new trainees, we will not be able to keep up with the demand for medical services. Specialists trained in the latest technology will not be attracted to an area that cannot afford to buy the equipment they have learned to use. It is true that life in beautiful Humboldt County is attractive in many ways, but the sheer number of offsetting factors is discouraging.

<u>Twenty-First Century Challenges in Medicine</u>

In addition to challenges unique to rural medicine in California, there are challenges to 21st century medicine in general. In “From Chaos to Care: The Promise of Team-Based Medicine”, David Lawrence MD lists these challenges as follows:

1) Changing Expectations of Patients

    The traditional physician-patient relationship was paternalistic. Patients now expect their medical providers to help them understand their situation and their choices, but our input is only one of many sources of information of widely varying quality, from the Internet, drug company ads, books, magazines and complementary and alternative practitioners. Increasingly, patients expect their care to be accessible in some form anywhere and at

any time, with seamless integration such as the care provided by the banking industry and telecommunications, especially electronically. Patients still want an honest, trusting personal relationship with their physicians, but they view it more as a partnership, and building this relationship takes time and information support. Neither the time needed to establish this relationship nor information technology is supported by current payment systems.

2) Expanding Pace and Scope of Discovery in Medical Science and Technology

   Advances in medical science are occurring exponentially, expanding our knowledge of molecular mechanisms, challenging us to understand new complex statistical methods and measurements, and giving us ready access to an avalanche of publications from a variety of sources, many of which are also available to patients. Add to that the challenge of the overselling of new medications and devices to doctors and patients, and the increased complexity in care for specific diseases. There is need for capital investment to provide care for the increasing number of people living with chronic diseases and to provide adequate local access to new methods of care. It is easy to see why the cost of providing care has been rising so rapidly, and why there is inefficiency in the transition to new care. Physicians must evaluate these new advances, and if they do bring a new care program to the area they must find the resources for the training of staff to help them provide the care. Rural providers need to be make complex decisions regarding which services should be offered here, and which should be available only outside the area. Individual practitioners, competing with each other, risk an “arms race”, further and often unnecessarily increasing costs of providing the care. Competition in medicine tends to increase, rather than to lower, costs.

3) Increasing Number of Patients with Chronic Diseases

   More people are living with chronic disease. The increase in the rate of obesity in particular has led to more diabetes, more cardiovascular disease, and mobility problems. There is a greater proportion of older patients, most of whom have at least one serious chronic condition. Our ability to intervene to make their quality of life better and their lives longer has led to acceleration in expenditures for sophisticated and expensive care. As a society we have not dealt well with the challenges of fruitless end-of-life care.

4) The Growing Complexity of Medical Care

   In addition to the 3 challenges listed above, fragmentation, regulatory environment, legal environment, archaic information and delivery systems, competing incentives, payment systems, and rising expectations make needed change extremely difficult. The sheer size of the medical care system makes any change difficult.

5) The Increasing Need for Transparency

Institutional and health plan accreditation, quality and oversight safety reporting requirements, and data on physician and hospital performance, done right, can lead to more accountability and better consumer information. Without a system of care, many of these efforts only lead to increased paperwork. Our responsibility is to make them truly useful somehow. This responsibility is impossible to carry out in the individual practice and challenging in larger practices or clinics.

6) The Nation's Growing Diversity

This area has experienced perhaps somewhat less pressure than other areas of California when it comes to ethnic, religious, language and cultural diversity, but arguably more pressure with socioeconomic status, ability to pay, access to insurance, strain on social services, and availability of needed care. More primary care service is needed, and certain specialties are in very short supply, some at all hours, some especially after-hours, and some by payor sources accepted.

7) External Threats

There is need to plan for disasters and to provide to care for infectious disease, and to monitor environmental threats, just as in the big city, but often without proportional funding. The Public Health Department has responsibility for these matters, and many more. Any health care system reorganization must support its efforts.

Brainstorming Descriptions

Given all of the adverse factors described above, it was surprising to all who participated in the Physician/APC discussions that there was energy and resolve to tackle these problems. Some expressed relief that they were not the only ones whose financial situation had deteriorated, who had had difficulty recruiting, or who had felt overwhelmed by patient needs and paperwork. Looking at the consistent annual rise in practice expenses and the continued steady reductions in fees paid for their services, they differed only in their estimate of the number of years remaining before the lines on the graph crossed. Some are there already.

It quickly became clear that the present system is not a sustainable option, and that no one was coming to rescue us unless we took the initiative first. While the hospitals have problems, in many ways, the problems of the medical providers themselves loom larger, or at least equal, as hospitals are unable to survive without physicians to care for the patients. Providers have suffered from denial, fatigue, and fear of anti-trust. Now we have to overcome these fears to do something to stabilize our local medical system.

Eight meetings of medical providers took place at the offices of the Medical Society in Eureka. Ideas were recorded on giant Post-Its, which ultimately covered all of the walls of the conference room. Enthusiasm and participation increased over the eight weeks of meetings, and by the end of this period, as one previously demoralized and fatigued participant said, the walls were “dripping with idealism and energy”.

These ideas and more are included in this report.

Resources Available

We looked at the health care system as a whole, with the motto “We have seen evolution. We need intelligent design”.

Among our assets is the quality of the providers in the County, providing the core for a system of regional excellence. This critical mass of well-trained physicians and advanced practice clinicians are ready to provide leadership in a new system of care.

The Community Clinics, Mobile Medical Clinic, and United Indian Health are important forces in the provision of medical care to the underserved in the area, and any new system has to support them. We depend on, and benefit from, a strong Public Health Department, which needs resources to become stronger. In addition, our community is known for innovations such as the Diabetes Project and the Humboldt Community Breast Health Project, among others, which have successfully attracted grant support for original ideas in improving care. The Foundation for Medical Care/IPA has expertise in contract negotiation and grant application, and it is hoped that their expertise can be used to further this large project.

The scope of the entire review of the health care system benefits from the presence of many organizations, including the Community Health Alliance, the California Center for Rural Policy at Humboldt State, and many others. The entire community will be involved in assessment of the workforce, infrastructure and financing, and while the Medical Society has focused on workforce, we will certainly benefit from the conclusions of the whole process of evaluation now underway.

The Rosenberg Report and the New Vision

A 1994 report on health care in Humboldt County, prepared by Rosenberg & Associates, recommended, as Phase I, two group practices without walls, one for primary care and one for specialists, linked by a Medical Services Organization for administrative and purchasing support. In Phase II these would have merged with the hospitals and the Clinics to form a Physician/Hospital/Clinic Organization. The plan worked out by medical providers this summer differs in

that it envisions a group practice led by and involving physicians of all specialties adopting a consistent set of operating principles, forming first a group practice without walls, but ultimately one with walls, which would work closely on an equal footing with the hospitals, perhaps even supplying specialists integrated into the physician group who primarily work in the hospitals. This new group would always be separate from the hospitals, in a rough parallel to the overall relationship between Kaiser Hospitals and the Permanente Medical Group as equal partners. There would be many opportunities to work with the hospitals in information systems, care pathways, purchasing, and packages of services, to name a few. The physicians and advanced practice clinicians would continue to run their own affairs however, and have their own management and policies. It is envisioned that most of the important committees would include community representation.

<u>The Mission</u>

We defined the essential purposes of a health care service:

1) Prevent or delay onset of illness
    a. Protect against disease
    b. Detect and treat disease as soon as possible
    c. Help to prevent decline in health and functioning

2) Enable or restore capabilities of individuals
    a. Maintain individual capacity for activities of daily living
    b. Maintain individual capacity for independent living
    c. Maintain the individual as a constructive member of society

3) Respond to life-threatening illness
    a. Curative intent for the otherwise healthy struck unexpectedly
    b. Palliative intent for others, with a transition of care from home care to assisted living to total care.

4) Chronic disease management
    a. Patient education and motivation
    b. Support tools for medical practitioners
    c. Coordination of the care team

5) Maintain the workforce
    a. Training
    b. Retention
    c. Recruitment

6) Build and maintain the infrastructure
    a. Offices

b. Information systems
c. Organization of care
d. Insurance and self-insurance

The Medical Society is committed to the development and support of a system of care that will ultimately provide improved medical care and improved access to all area residents with the goal of improving the health of the community we serve.

The Medical Society Meetings

It was decided at the first meeting that we were looking at the formation of a system of care, distinguished by quality, access and affordability, with the extent of linkage between existing practices to be determined. It would be multi-specialty and multi-professional, centered on primary care, and principle-driven. Our mission would be to care for our community and each other in a cooperative and respectful system, driven by quality. It would be not-for-profit and reasonably, honestly and fairly priced, and offer services to all residents. If we could not offer recruits the same financial incentives they might receive elsewhere, we could offer a fair compensation in an innovative and energized system of patient-centered care. Since we have limited influence on increasing payments, we could at least devise a system that cut unnecessary and duplicative costs while delivering better care. We set out to decide the form such an institution would take, the benefits, and the obstacles. The only option not considered viable was inaction. If we do nothing, the status quo can only lead to collapse of the health care system in the region.

By the end of the discussions, the new organization was visualized as cooperating fully with and linking to other health care organizations serving our community so that the best care is provided to all, and so that every resident would have a health care home. It would focus on prevention of illness and complications of illness. It would provide access to health care information for shared decision making, and would seek to use resources wisely, reducing waste of resources, both material and time, both ours and our patients'. Wise use of technology and clinical resources would be at its core. The organization would be transparent as to prices, costs and quality measures. The work of the care team would include the patients, the family and the community, and case discussions and case management would be the basis of the team care approach. The medical care team, including the patient and the family, would be evidence-based, but with flexibility for the values of individual patients. The doctors and advanced practice clinicians would be in charge of the care delivery, and the administrative staff would work for them. With our resources pooled, we will be able to make best use of clinicians, freeing them from routine record keeping by providing assistants to be scribes, and from the day-to-day chores of

running a business, though they would be expected to serve on administrative committees. Specialists would be supported in routine tasks like admission and discharge paperwork, and help with hospital rounds, allowing them to spend maximal time performing the work they are trained to do. Mutual education of all personnel and of the community would be a duty, so that the level of overall knowledge in the medical community would be raised, and the inevitable choices and trade-offs which will have to be made regarding new technology and new programs would be shared between all clinicians, the hospitals and the public. Practitioners who now cannot afford to work with an advanced practice clinician would be teamed with one if this arrangement added value to their endeavors. The organization is envisioned as a pleasant place to come to work, physically and emotionally, minimizing isolation. As a resource for the region, it could help to staff the Telemedicine Center, and could be a destination for rural patients from throughout the region seeking to obtain excellent specialty care. This critical mass of respected clinicians with a reputation for quality and affordability could be an influence on and a resource for government, industry, clinical trials and research, and hospitals. They would be able to make joint decisions with the hospitals regarding appropriate technologic acquisitions to improve the health of the community, reducing the risk the hospitals would otherwise face in capital expenditure. Advice for appropriate technology would also be available to specialty services which chose not the be a part of the organization, but which provide services to it.

Physicians who are completely or largely hospital-based, such as hospitalists, anesthesiologists, emergency room physicians, pathologists and radiologists, could continue to have their own groups, could be become hospital employees or could be members of this new organization. If the latter, their services would be sold to the hospitals to cover their compensation and the costs to the new organization for the recruitment and provision of these specialists. They would be an integral part of the health care team regardless of their primary affiliation or employer, and would provide patient care information to the integrated system.

We could provide specialist care to the Community Clinics, the Mobile Medical Clinic, United Indian Health, and other endeavors on a similar basis, taking care of MediCal patients where they are used to receiving care, and where there are pre-existing social services, other support and enhanced reimbursement from their designation as federally qualified health centers.

Some practices, especially groups, will want to maintain their autonomy, and there is no need to disturb that which is working well. Some of these practices will just use the information system, and others will have other negotiated relationships with the new organization as suits the purposes of both sides. More information is available in the section below on transitional issues.

We recognize that this new organization is only one aspect of the system we need and that it does not answer all of the needs for the reform of our local

system. We must work with the hospitals to support their needs, with existing clinics which remain separate, and we need to look again at insurance options for the county. We need to work with elected officials and business groups and we need the good will of the community to help us set up the foundation which will own the enterprise. At the same time, we hope that a local fully integrated system can introduce economies of scale in operations and purchasing, improved quality in patient care, a feeling of community ownership, improved recruitment and retention of providers, return of operational savings to the local economy, and will prepare the way for integration into whatever improvements may come from the state or national levels.

As David Lawrence MD says in From Chaos to Care, speaking of similar efforts in other areas of the country, “Fortunately, we find examples scattered throughout the country where up-to-date science, not shopworn habit, is the basis for clinical decisions, where learning is constant and purposeful, and where errors are discovered early and prevented. Patients are the center of care rather than bystanders on whom medicine is practiced. Professionals and patients work together to decide on a treatment plan, and medical care is coordinated and integrated for the benefit of each patient…These islands are our beacons, our hope”.

It is our mission to construct another one of these beacons of hope, a national model for local care.

Arguments for a Multispecialty Integrated System

Private practice in isolation is dysfunctional, and professional connections and support are key to satisfaction.

A centralized call schedule would be fair, protect personal time, and probably result in fewer clinicians needing to be on call at any given time. Hours would be regular, to the extent possible in an enterprise where emergencies occur.

An information system is desirable, but outside the reach of most individual practices, and even where present, the systems here now are not linked to each other. As long as use of such a system saves time and improves care, clinicians are interested in using it. Patient care aids such as handouts, preps, indications for procedures, and clinical pathways would explain care and identify other community resources available for particular health concerns.

A Permanente (Kaiser physician) model would lead to more integration of care, clinical updates on best practices, stabilization of income, and reduction in hours spent on running a practice and more efficient paperwork. It would be patient-centered, and hopefully could eventually cover all patients not covered by other programs. We could request that the Community Health Alliance look again at opportunities for self-insurance. Our relationships with the hospitals and other

aspects of the system would be based on shared values and negotiation as equal partners. We hope that our collegial value-driven relationship would serve as a model for other groups who negotiate with the hospitals, and would help to create stability among all who work in healthcare. We could help serve to provide feedback up the regulatory channels to regulators of all components of the total system.

Hospitals must recognize the benefits of a strong self-governed provider community, and the value to the hospital of an integrated system of care that reduces the use of the emergency department for primary care.

Group purchasing of supplies and services would result in opportunities for saving money and researching best deals, as well as volume discounts. The business arm of a large group could better negotiate rates, advocate for payment reform, and advise on coding tips to maximize reimbursement.

Transparent pricing may encourage the uninsured and underinsured to purchase packages of preventive care, and more employers to at least offer high deductible policies. Standards would be set by teams for disease screening according to demographics and other conditions, and sold at cost. Chronically ill patients who do not qualify for MediCare would benefit from case management, and transparent pricing of maximally efficient services.

Recruitment and retention could be enhanced. New physicians would be attracted to a collegial group driven by idealism, and we may even attract residents and/or medical students on clinical rotations who would then return here to practice. Children growing up in the community would see a group dedicated to community care that is respected by others, and be inspired to research a career in health care.

There would be opportunities for clinical research.

There would be collaborative standards for specialty referrals, and IPA projects such as the Diabetes Project, the Humboldt Breast Medicine Project and the Specialty Referral Project would be expanded and rolled into the IT support. Self-management classes, decision support and care redesign would be expanded into other chronic conditions, including but not limited to pain, cardiac disease, COPD, asthma, attention deficit disorder, arthritis, kidney disease, hypertension, headache, obesity and mental health. Health educators and advanced practice clinicians could be central in educational efforts, giving information on individuals back into the care teams for appropriate referrals.

Team care and information support would lead to the most effective use of knowledge, and social support for all.

The new organization could band together to recruit types of specialists that individual practices cannot support either financially or in patient volume, but whose services are considered desirable by local experts. When we combine practices, the volume for such specialists may be able to justify hiring and attract candidates. An example given was one or two retinal specialists, who may be especially important for an aging population. Also, when the hospitals or other components of the system are considering capital expenditures, we can collaborate with them in the evaluation of the value of the new technology.

Information System Design and Infrastructure Needs

Central to the development and operation of the new system is information technology linking all practices, the hospitals, and all ancillary services. A comprehensive IT system could keep records and track the patient for smooth hand-offs between EMS, the emergency departments, the hospital and hospitalists, all practitioners (including mental health), assisted living, skilled nursing facilities, physical therapy, hospice, public health, and social services. A participating patient could chose to have one or more sections of his medical records protected by one or two PIN numbers. Patients would be cared for by teams or pods of health care practitioners devoted to a certain number of the healthy population, or a certain number of patients with a particular chronic disease. The physician team leader could track the care of the team's patients who are in contact with any part of the system each day. In this way, the primary care providers who know the patient best would be aware of their status if they are in the hospital, and they would continue to provide care and input as the patient is handed off smoothly from the hospital to Home Health or assisted living in planned transitions of care.

Initially the new organization would exist without walls, but would be linked by the information system. Clearly, to operate optimally, this system would have to be agreed upon and used by everyone who provides health care in the community, including the hospitals, individual groups and clinics.

Patients would be asked to review their charts periodically to update their information. They would have online access to their charts at all times, with a PIN number, similar to online banking. Individual Advance Directives would be available on-line to all members of the system in case of emergency, and there would be an opportunity for patients to make statements in their records regarding their care, and a general statement regarding their wishes and preferences for the whole team to view as they access the record.

There would be information regarding practice policies, best practices, clinical pathways, decision algorithms, information about the rationale for various procedures, and detailed descriptions of those procedures. Any information regarding medications, preps and post-procedure care and more could be downloaded.

The cost of prescriptions, services and tests from various sources around town would be available in real time, in the exam room as well as at other terminals to facilitate decisions by clinicians and patients as to the value of a test result for the patient, and if they have a share of the cost, the best place to get the test done or the medication purchased.
There would be prompts for needed periodic care, both for screening and for health maintenance in chronic disease, with tracking of the patients consistent with the ideals of the chronic care model.
There would be links to community support services.
It is predicted that more of the population will have internet access in the future, but even now an impressive number of the elderly and even the homeless have email addresses. To facilitate care, patients could access terminals in physician offices, and once an actual building and satellites are available, a health library with computers and technical assistance would be available.

Initially the new organization will be a multispecialty group without walls, but it is recognized that walls will make the whole work together better, and fundraising to build a physical plant and satellites would start early, and would require community support.

Operating Principles

Formal operating principles will have to be agreed upon by those actually forming the group. Some suggested operating principles generated by our group are included here. Not all will rise to the level of the core principles, but they are ideas deserving of consideration.

1) Aspects of the system that are working well now should not be changed, except perhaps to be linked.
2) The new system must be primary care-centered and patient-centered. Specialists would be used with maximum efficiency so that they spend most of their time doing things which others cannot do for them. Preventive care, for both primary prevention and prevention of complications of disease in affected persons, is a core value. Physical and mental health issues have parity.
3) Care design is based on evidence which is honest, legitimate, peer-reviewed, and which takes patient values into account. Communication is key, and all aspects are team-based. Teaching and learning for continuous education among and by all participants involved is key, and self-care is a core value.
4) Compensation, to be fair, should be modeled after Kaiser-Permanente, the Palo Alto Medical Foundation or other national organizations which have standards for types of practitioners and years of experience. Compensation may not be as high in absolute terms, especially initially, but it has to be high enough to recruit practitioners, and it has to be internally fair.

5) We will make use of good quality materials and tools already developed, once approved and modified by our group as necessary. We will contribute to and use new programs such as Telemedicine to fill in gaps in care, or to provide specialized care not otherwise available here.
6) The group is inclusive at its founding, but all who join must subscribe to the founding principles and ideals, and adhere to them throughout their tenure. New arrivals will be mentored in these ideals. Self-interest is subordinate to the goal of care of the community. The organization is ethics and values-based, with mutual understanding of rights and responsibilities of staff and the community, and with collegiality and mutual respect between staff members at all levels, and between staff and the community. Patients are true participants in the organization, including governance, as are staff of the organization, so that the goals of the clinicians and the community are aligned at all levels.
7) The new organization will be efficient, reducing wasted time and resources, resulting in better care at lower cost. It will be sophisticated enough to keep most health care dollars in Humboldt County. Every resident of the County will have a "medical home".
8) The new organization will foster collaboration with all aspects of the health care system in the County. (See "Background Work and Resources Available" above). Interdisciplinary teamwork can assist decision-making in the broader health care system, such as establishment of clinical programs or help in evaluating costly new equipment by others. Investments by everyone in the system should be judged according to their value to the community and the needs of the patient. All parts of the total system must be aligned so that the patient receives the appropriate level of care in a timely manner.
9) The new organization is based on transparency with respect to quality and cost. Prices for services will be posted and can be defended based on the costs of delivering the specific care. Cost containment decisions will be evidence-based, attained by group consensus, and be patient-centered, with transparency in any trade-offs made with respect to recommended treatment. Cost information on drugs, tests and imaging by sources selling these products will be available to the patient to aid in decision-making.
10) The new organization is self-governed, with democratic group leadership and decision-making, and self-managed with respect to individual clinical decisions and the operation of the group. There will be continuous quality assessments from patients and staff to elicit problems and to improve existing programs.
11) There will all be a place for individual professional judgment and style as long as it is open and congruent with the values of the organization.
12) The government at all levels must define and adequately fund the safety net, including emergency and trauma care.
13) Industry can help with program support through the foundation associated with the new organization, but individual gifts and samples will not be

accepted, except as needed for decisions on group acquisition of the product.

After the group listed these principles, Dr. Lindsay brought in “Simple Rules for the 21st Century Health Care System” from Crossing the Quality Chasm by the Institute of Medicine. There was clear congruence, though less detail.

1) Care is based on continuous healing relationships.
2) Care is customized according to patient needs and values.
3) Knowledge is shared and information flows freely.
4) Decision-making is evidence-based.
5) Safety is a system priority.
6) Needs are anticipated.
7) Waste is continuously decreased.
8) Cooperation among clinicians is a priority.
9) The patient is the source of control.
10) Transparency is necessary.

Transition Issues

There was preliminary discussion about the mechanics of bringing the group together, once a critical mass of committed clinicians willing to adopt the principles of the group is identified. These concerns are outside the scope of this paper, and will require community support in all respects. In general, physicians no longer have the deep pockets to fund the whole system as it transitions from individual payments to salaried positions. Committees would be formed to establish the principles and policies assess the information technology needs, work with the other components of the total system to coordinate care, set up the legal structure and the offices, among other activities. It should be emphasized that there are opportunities for help from existing community and professional organizations. Furthermore, each practicing clinician already in the County brings with him or her a dowry of patients, cash flow, equipment, and experienced help, all of which can be woven into the new structure of care. The organizational problems should not be minimized, but may be less daunting than they appear initially.

We would try to make best use of resources already here that could be expanded. For instance, the IPA/Foundation might provide business functions and grant writing expertise. The Medical Society could do credentialing, recruitment and retention, and peer review, as well as serving as a focus for the recruitment and care of medical students and residents coming here on clinical rotations.

The Patient Experience

Several patients who have been recent heavy users of the medical system were interviewed regarding their experiences with the current system and their reactions to the potential for the information system described above to impact care. Their comments revealed their concern for the sustainability of medical practices. Several had inspected their Explanation of Benefit forms in detail, and were surprised and concerned by the level of reimbursement for their care.

The discussion yielded the following possible scenario for the patient experience in this new system. The paperwork that they currently fill out every time they make contact with a new individual practice could be exchanged for a single session with an advanced practice clinician to fill out demographic information, review of systems, medication use, allergies and adverse reactions, past medical history, family history and social history. This service would be available free of charge to facilitate the patient or family giving us this information to facilitate care and to trigger preventive care prompts. They would provide any insurance information and would be issued a photo ID similar to a Costco card. This card would have a PIN number allowing access to their profile and their basic information, as well as current care. In the case of emergency, the clinicians on call would be able to access the chart from the emergency department. This access would also be available to patients as they travel. They could download records to take with them as they leave the area, in paper form or on a flash drive. At the patient's choice, additional security would be instituted for information of a sensitive nature, which might include mental health, genetic, infectious disease and pain management information. The patient could choose a primary care team from those available. Some teams might have special expertise in specific chronic diseases, but even then the team would be responsible for all aspects of the patient's primary care. The initial teams could be formed from teams in current practices, but would probably be expanded in terms of professionals available, depending on the team's volume and need for certain specialists. This would be a multi-disciplinary physician-led team. It is important to note that even though the physician now known to the patient might be the patient's chosen physician in the new system, it would not be care-as-usual, as everyone in the system practices according to the policies and principles of the new organization. Each new patient would have an intake physical exam. Advanced practice clinicians would be the focal points of the care team, providing the initial evaluation, managing routine care, and responding first to new clinical problems. Physicians would be free to manage more complex situations collegially with the advanced practice clinician and other team members, to be a resource for specialized information. They would have the responsibility of staying current in their field and sharing the knowledge within the team and with the organization as a whole. The physician would also be responsible for monitoring the care of team patients who are in hospitals, nursing homes, etc. Teams that encourage emails from patients would be responsible for answering and directing responses daily.

Patients would be able to go online to make routine appointments with their health care teams, though special appointments would still need scheduling help. They would also be able to access information about common symptoms, and when to see a clinician for a symptom. The fact that they access the information sheet would be noted in case follow-up is considered desirable by the team. Classes and group medical appointments would be available to supplement individual care, led by health educators and other team members, to cover a variety of topics more comprehensively and at lower cost than individual appointments. Waiting times for appointments would be kept to a minimum, and a continuous quality improvement program would spotlight opportunities for service improvement.

When the patient is seen, the clinician would be free to make clinical assessments and to maintain eye contact while an assistant records the appointment electronically. At the end of the appointment the clinician approves the record, offering a copy to the patient in paper form or to be sent by email. Educational handouts referred to during the office visit can be printed out on a local printer and handed to the patient for further review. If tests are needed and provided on site, every effort would be made to have results available during the appointment. Comparative cost information for off-site tests and procedures would be available for patients. Results would be posted to the chart after review by a clinician. That clinician can annotate the result in order to send a message to the patient about the results. Prescriptions would be sent electronically to the pharmacy of the patient's choice.

Patients who have high deductibles or who are uninsured will know in advance the cost of the service to be delivered, as is done now in the "retail medicine" model. The difference between "doc in the box" care and this proposal is that the care they receive would be part of a true system of care, and not a one-time visit. Packages of preventive care services appropriate for age and condition could be available for a flat annual fee. Common procedures which require hospitalization would be priced as a flat fee for the physician component, and the hospitals would be asked to provide a package rate for their portion of the services also. Prices for all services would be justifiable as reflective of the actual cost of providing the service, and they would be transparent.

As part of the care provided, patients who have hardships and do not qualify for other coverage could have their care provided by donated funds. A committee would be in place to evaluate such requests.

Income Stream

The group would benefit from professional management to negotiate contracts and to obtain grants not available to individual practices. We would like to look to the IPA for advice and perhaps a formal arrangement for help in this aspect. Some income would come from provision of the services of the group to other

entities such as the hospitals, though some of this compensation may come in the form of in-kind services such as purchasing of supplies and insurance. The whole system might reorganize to save costs on a particular service. For instance, with support, the Medical Society might assist recruitment for the area, or do credentialing for all health care entities in the County. All organizations present now would be asked to consider contributions they might make, and how. Another income stream might develop when underinsured or uninsured members of the public seek medical help after learning about actual cost. With reasonable and transparent pricing of routine services, more employers may become interested in providing at least high deductible health insurance plans, improving coverage in the community. Some might become self-insured for routine care. If there is a health care district, or if there is ever universal coverage, we would be in an excellent position to provide care within that system in an efficient and comprehensive manner. Philanthropic and community support, including volunteers, would be critical to the success of this new venture. It is our job to educate the public regarding the threats to sustainable health care and the impact on the local economy should the health care system collapse. In return for their support, we would promise to work hard to care for the public, to trade team care for individual practice, and to be motivated by quality and community service rather than competition between ourselves or the expectation of maximizing personal income.

As part of the larger Community Health Alliance assessment, we expect that the issue of self-insurance will be raised again in discussion, and we would benefit from that development. There is a tremendous need for such a program, particularly for the adult working poor.

There has been much talk about a health care district, but at this point we hope to be able to develop this idea without tax support. If our own efforts at quality, efficiency, negotiation and fundraising should ever fail us, then we would hope to be worthy of taxpayer support, if needed for survival, on the basis of our efficiency and value to the community.

Compensation

Staff in all positions would be paid according to a proportion of a mutually agreed-upon outside scale (e.g. the Permanente Group or the Palo Alto Medical Foundation) which would be internally fair so that no one group of clinicians has the power to hold the others hostage for disproportionately higher compensation. In order to be competitive in recruiting, the salaries have to be attractive enough to retain personnel. National and local salary surveys each year would be reviewed to be sure that we are competitive in recruitment and retention. As in the Permanente system, there would be a base salary, prorated if the clinician is not full time. One benefit of this system is the protection of those who for reasons of child-rearing, illness, age or other reason, wish to practice part-time. At present, they often find that they cannot cover their overhead, and have to stop practice, or face hostility in a practice where they are perceived as not

carrying their fair share of work. In this system we will be able to make use of their available hours and preserve their experience to the benefit of all. One idea has been to have a care team comprised of part-time practitioners who will be supportive of each other as they care for a segment of the population, perhaps practicing at a site with on-site day care, as many of them are young parents.

In addition to the base salary, again analogous to the Permanente model, there would be an opportunity to practice additional time, such as call, or weekend or evening hours. The time spent in additional hours of work could be paid, or taken as time off, and call responsibilities could be traded or sold to others in the group.

An additional opportunity to earn would be based on periodic quality measures. In the Permanente system this is known as a Sustained Performance Award. There would also be Leadership Pay for administrative and supervisory work done in addition to clinical work, and for service on committees related to the practice. They may also be pay differentials based on patient load and level of care needed.

While we will probably never be able to take on educational loan repayment in a lump sum, we might recruits by adding monthly loan payments on consolidated loans to the compensation package, as well as assisting those eligible for Federal and State programs of loan forgiveness applicable to physician shortage areas. Other benefits would be determined later.
This pay structure is envisioned as giving some stability to clinician pay. Compensation would be tied to training and experience according to a national scale. Most people entering medical school did not do so to become wealthy, but they did expect to be paid fairly. The type of idealist drawn to this practice will not have wealth accumulation as a core value, and would likely trade the collegiality and information support for extra income. But the truth is that medical practice in solo and small group form is becoming increasingly difficult for most practitioners to sustain at all, and a group such as this may be the only hope for their continued practice, particularly in an economically challenged area such as ours. Some practitioners have dipped into savings or taken loans to keep their practices open. The relief provided from that drain on personal finances is envisioned as part of the financial reward.

The legal structure is yet to be determined, and we did not feel sufficiently informed to know whether we should be a cooperative, a partnership or a non-profit corporation, or even have some other structure.

<u>Recruitment and Retention</u>
Ideas on recruitment and retention which surfaced, in addition to those mentioned earlier in this paper, include outreach to the training programs,

perhaps with a DVD about the group and the area sent to trainees. We would also try to interest trainees in our community by arranging rotations here during their training, in hopes that when they finish they would seek a job in the area. Involving the community in the welcoming would be important, with help with temporary housing, career help for the dual-career partners of the new recruits, information about community qualities and services that might be valuable to specific individuals (e.g. special education, local sports opportunities, performance opportunities in the arts, and connection to social and cultural activities). A major element in recruiting would be remedies for the rural reimbursement disparity and help with loans.

We could also target clinicians who have visited the area as tourists, and those who are considering the area as a place to retire, and who may want to relocate a few years early.

In this new organization, part-time clinicians would be an asset to the system rather than a burden. Preservation of careers during illness, child-rearing, or as retirement nears benefit the area as a whole, and the experience gained during these times would be available to inform the rest of the group about the system and the community.

Obstacles

There are clearly obstacles other than logistic ones, but none were seen as impossible to overcome. Some physicians own or have long-term leases that will have to be dealt with. It is possible that not all valued staff members can be absorbed. There will certainly be a need for experienced support staff in a variety of positions, given that the staff members can embrace the changes in work patterns inherent in this system. Prior patterns of physician culture and behavior were cited as an obstacle, but it is expected that physicians who cannot adhere to the operating principles and participate in team building, team functions and team support will not be joining. Physicians who feel that they are doing well now may not be motivated to join. At the time most of us entered the profession there were better, safer, and quicker training programs in other fields if wealth were our objective. To the extent that there are still physicians who are motivated by income opportunities, they may not sign up for this endeavor, nor will those who cannot deal with perceived loss of control. Compensation is planned to be adequate, but not lavish, although improved working conditions and the desire to live up to the ideals expressed in our medical school admission essay will motivate many.

There is an inherent tension between the prevention-oriented goals of primary care and the interests of hospitals since hospitals' income depend on sicker patients and more expensive care. Countering that concern is the goal of an integrated system to reduce the amount of uncompensated care the hospitals have to give, guide them in the need for expensive technology so that it goes to improving the health of the community, and provide them categories of service at

a reasonable charge. This structure would also tend to reduce the inherent conflict between fee-for-service procedure-driven care and the goals of preventive care in reducing the number of procedures needed by placing the clinicians on salary and by formulating evidence-based group decision for case management. Professional liability issues will surface, but there are other team-based systems in the USA that we can learn from. Parochialism, with physicians allowing allegiance to certain hospitals or certain areas to divide them, will have to become a thing of the past to make this system work, to the great relief of many and the benefit of the community as a whole.

Planning and Legislation Needed

The planning for this change will have to be community-wide, and it can happen only with community support at several levels. Task forces on financial aspects, infrastructure and workforce planning will include professionals and community members alike. If there is widespread clinician interest, a steering committee for the specific planning process of care delivery can begin work soon. Time is short, as many practices are in jeopardy to various degrees under the present system. If this is a system of care that the community as a whole wants to see, we will rely on them to help us make it happen.

We will need legal help, and political help with antitrust issues.

As mentioned above, the safety net for the uninsured or underinsured with catastrophic or chronic illness has to be defined and funded adequately.

We need to investigate which services should be retained or brought here, and which should be provided outside the area. These hard choices should be revisited every few years by an on-going planning and assessment committee.

We need help in remedying the government payor inequities (MediCare and MediCal) in rural areas. We should support legislative efforts to force the private insurance companies to operate efficiently and limit the amount of profit they can make from premium dollars.

We need to continue to keep the discussion about an adequately funded single payor system going. We are all already paying for the uninsured in one way or another, and these hidden costs need to be brought out into the open.

We need to ask the government to look at incentives for medical schools to train primary care specialists, and incentives to support those who choose primary care as a specialty.

We need to have more help reducing the debt incurred by medical students, especially for those training in primary care.

We need to look at ways to increase the number of insured residents. We need expanded managed care options in the community.

We should look into current similar systems, like Kaiser, to see if there is a way to enter a partnership with them which would give us access to their successful support tools and policies.

We need information on economic development issues and the benefit of excellence in health care here. We need more information on the expected growth in the area and changes in the communities in the future. We need information on the impact on business and property values if the health care system here fails. We need to know if there is potential for bringing in others from surrounding regions for specialty care here.

The seismic retrofit issue is still unresolved, and should be visited again. It does not make much sense to single out the hospitals when there is no similar requirement for the roads bringing staff and patients to the hospital, no for the ambulance and fire facilities, or other critical elements. Legislative leadership will be required.

Comments

Please send comments and statements of interest to emahoney@humboldt1.com, fax 825-6571, or to Ellen Mahoney, P.O.Box 490, Bayside CA 95524.

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