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Marshfield, Wisconsin: Better Health Care, U.S.A

By John Reichard, CQ HealthBeat Editor

Imagine having access to a nurse at any time to help you figure out whether that jolt of mysterious pain merits a visit to the doctor or to the emergency room.

Imagine a team of doctors that figures out the best way to manage and control your diabetes, coronary artery disease, or high cholesterol. Imagine nurses calling you just to see how you are, and whether you are keeping up with your check-ups and medication. Imagine a health plan that rates doctors on how faithfully they follow the very best clinical practices, and doctors who believe in those measures because of convincing data that those treatment practices are keeping their patients out of the hospital.

Now imagine that this well-organized system of care, employing some 800 doctors at 33 clinics, saves the federal government money and could lower the federal deficit, even if only modestly.

That's reality, not a day dream, at the Marshfield Clinic in Marshfield, Wis., a community of 19,000 that sits squarely in the center of the state. Or so claim the clinic's executives — and with good reason, apparently, given the clinic's performance in a Medicare test program pitting it against respected group practices around the country.

As economists everywhere warn that health costs will crush the economy with rising debt, Marshfield offers evidence that what politicians say in pitching health overhaul proposals can actually be true — higher quality care saves money.

Medicare officials reported in August that Marshfield was one of just two physician groups to earn bonus payments in all three years of the Medicare test program, which is known as the Physician Group Practice Demonstration (the other was the University of Michigan Faculty Group Practice). Marshfield, which cares for 35,927 Medicare enrollees in the program, calculates that it has saved Medicare about \$48 million over the three-year period.

Marshfield and other participants get to keep about 80 percent of the money they save Medicare, with Medicare trust funds keeping 20 percent of the savings.

But if Marshfield-style care seems like a fantasy come true for a nation in desperate need of retooling its health care system, the notion that health overhaul legislation will push the country hard in that direction is but a pipe dream, said a consultant familiar both with national politics and the health care marketplace.

Asked how well current overhaul proposals push the system toward Marshfield-style care, insurance industry consultant Robert Laszewski said, "On a scale of 1 to 10, it's probably 0.5 percent."

How It's Done

Marshfield CEO Karl J. Ulrich makes the now-familiar observation that electronic medical records are the key to well-organized care, but not necessarily just for the reasons often cited. Health IT offers advantages such as eliminating unnecessary testing, reducing medication errors and issuing reminders to patients to get preventive care.

But Ulrich says “utilization of electronic medical records and the use of data is absolutely critical” to showing doctors the payoff from adhering to the best clinical practices. “You have to have the data to show the doctors,” he said in an interview. “It’s really doctors and other providers like nurse practitioners that drive the change.

“You need to show them to say, ‘This is why we’re doing it, there’s fewer hospitalizations because we’re adhering to these quality measures by doing these tests on patients.’”

Another key element is that Marshfield also has a management team that emphasizes to doctors and nurses the importance of performing well on quality measures. “You have to have administrative support to make sure that the whole organization is thinking along the same lines,” Ulrich says.

Many analysts say that scrapping the current fee-for-service payment system is essential to eliminating unneeded care but Marshfield and other group practices in the Medicare test program are paid using a modified fee-for-service system.

At the end of each year, Medicare calculates outlays for physician and hospital treatment of Marshfield patients. If Medicare’s spending growth for the Marshfield patients is two percentage points lower than that for other Medicare patients in the local area, Marshfield keeps up to 80 percent of Medicare’s savings.

Bonus payments are higher if the clinic rates well both on savings and on 32 measures of quality. “National benchmarks and group-specific quality improvement targets are used to provide incentives for quality improvement,” says an August Centers for Medicare and Medicaid Services report on the Medicare Physician Group Practice Demonstration program.

Ulrich said that Marshfield has used the bonus payments to build up programs to keep patients healthier and to add modestly to its bottom line.

Examples include a specialized clinic to manage cardiovascular patients on the crucial but potentially dangerous blood-thinning drug warfarin, which is sold under the brand name Coumadin.

The drug is used to help prevent and treat blood clots in the legs and lungs as well as clots associated with heart-valve replacement or atrial fibrillation, an irregular, rapid heartbeat. It’s also used in heart attack patients to lower the risk of death, another heart attack, stroke, and blood clots moving to other parts of the body.

The tricky part about using the drug is that too little won’t provide enough protection against clots while too much causes dangerous bleeding.

“Until a couple of years ago, if you and I were on Coumadin our own individual doctors would manage that,” Ulrich said. “If we wanted to get our dosage adjusted based on our bleeding time, the doctor might not get to me that day because he or she is busy.”

In the past, the doctor might have been a little lackadaisical if the blood level of the drug was a little too high but not really so high that the doctor felt it was worth calling the patient and adjusting the dosage right away. But “now we have very firm protocols” with almost immediate test results available to determine whether dosage levels should be changed, Ulrich said. The clinic is staffed by people who only work in warfarin dosages who can call the doctors “if something really strange happens.”

The program frees up doctors while improving management of the drug, Ulrich said. “In an average month we end up changing. . .at least 50 percent of patients’ dosages, that’s how dynamic this is,” Ulrich said. “And so you have to watch this very closely.”

With more patients taking correct dosages, side effects are down – “and the main side effect you worry about. . .is that if your blood levels get too high, then you run into bleeding problems into your colon or elsewhere,” Ulrich said. “People can die from those side effects.”

The result is that there are fewer hospitalizations from inadvertent overdoses of the drug. Marshfield is developing similar clinics to manage congestive heart failure and excessive cholesterol.

“What we’re learning is that the active interaction between visits becomes absolutely critical in detecting potential problems very early. . .and correcting them, even via telephone,” Ulrich said.

“As we needed to hire new folks, train them, and get these programs up and going, there was an immediate cost to us” that didn’t get covered in the first two years of the Medicare test program, he added. But “we’re probably over the hump now.”

Ulrich credited other elements of Marshfield care for strong results in the demo. “We also do telemedicine here. That allows for patients in very rural areas to be seen by specialists,” he explains. “We also developed a 24-hour, seven-day-a-week telephone nurse line, both for triage reasons – i.e., do I need to go to the emergency room, do I not – or just for advice — ‘Gee, I just started taking this pill yesterday and now I’m feeling a little woozy, do you think it’s a side effect?’”

How Hard to Replicate?

“Most of the multi specialty groups would be very interested in doing this,” Ulrich opined. “Anybody can do this, assuming that you have the right attitude to undertake it and you’ve got the right infrastructure set up to take care of patients a bit differently.

“I think, however, if you are a very small group — maybe a two-or-three-man primary care group — it might be difficult. So size is going to matter because we’re large enough, we can invest in information technology and gear it exactly for what we want it to do for us.”

Laszewski, the insurance industry consultant, said of Marshfield, “It’s essential to move the system in that direction.” Central Wisconsin residents used to go to Mayo Clinic in Minnesota and now they go to Marshfield, he said.

What’s different about Marshfield is that even though its physicians are not employees of

the clinic, “it is an institution where care is coordinated very carefully,” Laszewski says. “There is excellent and comprehensive leadership. So you’ve already got these people in a model that they have largely been recruited to and largely bought into the notion that it will be collegial and that there will be leadership that they need to pay attention to.”

As such, he said, its model contrasts with “driving down any other street in middle America and seeing a urologist in this strip mall, and a gynecologist in that strip mall and what they have in common is that they have privileges at the same hospital — and in no way are they integrated. So Marshfield, Cleveland Clinic, Mayo are examples of the best health care in America, but unfortunately that model is a very small percentage of what the American health care system looks like.”

He added, “It would require the vast majority of physicians who are not part of such a model to be willing to become involved. And of course physicians have a long history of liking those strip malls.

“It’s going to require an enormous mind set change among the vast majority of physicians in America. What we have to have are incentives so physicians feel the need to be in these kinds of systems if they are going to do well.”

That would take bundling of payments so doctors have to team up with other doctors to coordinate care to get paid, as well as economies of scale that would allow them to comply with data reporting requirements. “What you say to the primary care physician is, ‘Your pay is going to have a lot to do with what that urologist does. . .you’re going to have to be part of an integrated system if you are going to win.’”

Current overhaul legislation just doesn’t move the system in that direction, Laszewski said. “It just doesn’t. They’re talking about some pilot projects. There’s nothing in the bill that is really going to move this beyond some pilot projects.

“The framers of these health bills don’t want to make doctors and hospitals mad at them by demanding any kind of meaningful change.”

They constitute “two of the biggest lobbies in Washington, D.C.” Employers similarly lack the backbone to force changes in the system, he added.

“I think employers have got to say, ‘We’re not going to pay for this anymore,’” Laszewski said of the fragmented system.

But Chip Kahn, president of the Federation of American Hospitals, said it would be foolish to push a particular model of integration on the health care system without first going through a period of pilot programs and experimentation.

“From my view, the hospital industry has been extremely supportive of reforms,” he said. Kahn noted that there are legislative provisions to move toward quality-based payment and to lower Medicare payments for hospital readmissions stemming from poor care.

“I’m just sort of befuddled by his conclusions” about hospitals standing in the way, Kahn said of Laszewski’s comments. Provisions to create “accountable care organizations” to promote payment based on quality care are in legislation on the Hill, Kahn said.

He noted that there are various approaches to team-based care that “grew up organically” in different health care settings. “Great ideas. . .do not always succeed in the Medicare context.

“We need to test them out,” Kahn said of cutting edge organized systems. “Most of the world’s not organized that way. . .if it were easy to do, it would have been done yesterday.”

Source: **CQ HealthBeat News**

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