One year later, re-design of health care still needed

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One year ago, President Barack Obama signed the Patient Protection and Affordable Care Act into law. Designed to rein in costs and provide health insurance coverage for millions of currently uninsured Americans, the law has been both praised and criticized. Regardless of where you may be on the political spectrum, one thing we should all be able to agree upon is a common desire to continually improve quality and make health care more affordable.

The current payment system in the American health care encourages higher volume whether it is medically appropriate or not. This leads to unnecessary tests and procedures that often do not benefit patients. Instead, payment to health care providers should reward quality and value. High quality is almost always associated with better outcomes and lower costs, from reduced complications and hospital readmissions to decreased emergency department visits. Changing how we care for patients and what we pay for are the fundamental means to financing further innovation and affordable universal coverage.

Everything that we do as a nation to evolve health care must center on patients. We have to ensure that patients receive the right care at the right time and for the right cost. At the same time, patients must accept personal responsibility for their health and well-being, and actively partner with their providers to ensure they are reaching optimal health.

We must continue to aspire to a health care delivery system that provides affordable coverage for all, payment for value rather than volume, and a commitment to best-practice, coordinated care. It will take an ongoing, concerted effort among physicians, hospitals and insurers to get there. Working together, a healthier America is within reach. We cannot abandon our efforts until we get there.

GHP offers new wellness-based plan

Geisinger Health Plan now offers employers a plan that directly incents employees to improve their health. Called Smart Steps, this wellness-based plan focuses on key measures such as weight, blood pressure, blood sugar and not using tobacco. If employees meet predetermined benchmarks for these measures, or agree to a treatment plan and then meet the criteria, they qualify for a specific incentive.

Employers have two ways to design their plan:

• Vary employee copays and deductibles, based on health measures. This option is available for employers who offer PPO coverage. GHP will work with employers to determine the basic plan design. Employees who meet key criteria for weight, blood pressure, blood sugar and not using tobacco qualify for “Enhanced Benefits.”

Incent employees directly, via the level of incentive. Employers designate the incentive earned by the employee if he or she meets the key criteria. There are several ways employers can provide incentives. Examples include:
Wellness-based plan  (Continued from page 1)

contributions to employee’s premium payment, end-of-year wellness rebate and tangible incentives including electronics, gift cards and paid time off.

Both of these program designs can activate employees to take the “smart steps” they need to improve their health. To simplify the enrollment process, a GHP wellness specialist will visit the worksite to explain how Smart Steps works and to provide customized education and materials for employees. This important step will get employees off on the right foot.

The participant has 90 days to verify he or she is at goal for the qualifying measures. If the participant does not qualify immediately, he or she can commit to following an action plan that could include weight loss or a program to stop tobacco use, for example. Participants will have until the required deadline to take the smart steps that will help them meet the goals and earn the designated incentive. Geisinger Health Plan offers additional resources to help participants stop tobacco use, manage weight, increase physical activity and manage chronic disease. If a participant is unable to reach the goals by the program deadline, he or she will not receive the incentive.

Employers or brokers who are interested in learning more about Smart Steps should contact their Health Plan representative.

Most radiation comes from medical tests

Americans are getting more and more radiation from medical imaging tests. In fact, Americans get the most medical radiation in the world and the average dose has grown sixfold since 1980.

Radiation is measured in millisieverts. Some imaging tests emit more radiation than others. For example, a chest or abdominal CT scan involves 10 to 20 millisieverts compared to 0.01 to 0.1 for an ordinary chest X-ray. The use of CT scans has increased from just 3 million in 1980 to more than 70 million and often replace tests that don’t require radiation such as ultrasounds and magnetic resonance imaging or MRIs. In addition, the amount of money spent on medical imaging doubled between 2000 and 2006 to about $14 billion a year—and that is just Medicare alone, according to a study by the Government Accountability Office.

Too much radiation can cause cancer. While individual tests that use radiation pose little threat, the dose accumulates over time. According to a recent study in the Archives of Internal Medicine, CT scans alone will cause nearly 30,000 unnecessary cancer cases (about 2 percent of cancer cases), which will lead to about 14,500 deaths.

It’s hard to say how much radiation is safe. Chernobyl nuclear power plant survivors and Japanese atomic bomb survivors who had excess cancer risk had exposures of 50 to 150 millisieverts of radiation.

A recent Archives of Pediatrics and Adolescent Medicine published study of 355,088 children found that on average, children receive seven imaging procedures using radiation by age 18. Another study, done in 2009, found an estimated 4 million Americans get more than 20 millisieverts a year from medical imaging.

In all, approximately 30 percent of imaging tests are considered unnecessary. Which tests are overused? A scientific group, the International Commission on Radiological Protection, cites routine chest X-rays when people are admitted to a hospital or before surgery; imaging tests on car crash victims who don’t show signs of head or abdominal injuries; and low-back X-rays in older people with degenerative, but stable, spine conditions.

Even when tests are justified, they often include more views than needed and too much radiation. The top offender is a chest CT scans looking for clogged arteries and heart problems. Cardiologists are increasingly aware of this risk and are seeking solutions.

In 2005, Geisinger Health Plan launched a physician prior-consultation program designed to further enhance the quality and appropriateness of diagnostic imaging. Under the program, providers ordering outpatient, non-emergency advanced imaging tests were asked to work with National Imaging Associates (NIA) to improve member safety and promote efficient use of diagnostic services.

This year, Geisinger Health Plan expanded the relationship. NIA will now assist physicians with the selection of an imaging facility that is both conveniently located and cost-effective for the member. If a member or provider selects a different facility, NIA will notify both parties of any additional costs to the patient or the employer.

Geisinger Health Plan is working to promote the most effective and efficient use of health care dollars and resources. If you have any questions regarding NIA or the coordination of imaging services, contact your Health Plan representative.
ACO regulations released

The Affordable Care Act includes a number of policies to help physicians, hospitals, and other caregivers improve the safety and quality of patient care and make health care more affordable. One of the provisions is Accountable Care Organizations (ACOs). The Department of Health and Human Services (HHS) released ACO regulations on March 31, 2011.

Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve with Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions. The law requires each ACO to include health care providers, suppliers, and Medicare beneficiaries on its governing board. The ACO must take responsibility for at least 5,000 beneficiaries for a period of three years, also suggested in the law.

There are three main goals of ACOs.

- **Sharing savings**—Under the proposed rule, Medicare would continue to pay individual health care providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses. The amount of shared savings depends on whether an ACO meets or exceeds quality performance standards.

- **Measuring quality improvement**—The proposed rule links the amount of shared savings an ACO may receive to its performance on quality standards. The rule proposes quality measures in five key areas. They are patient/caregiver experience of care; care coordination; patient safety; preventive health; and at-risk population/frail elderly health.

- **Improving care for patients**—ACOs are designed to improve the partnership between patients and doctors in making health care decisions. People with Medicare will have better control over their health care, and their doctors can provide better care because they will have better information about their patients’ medical history and can communicate with a patient’s other doctors. Medicare beneficiaries whose doctors participate in an ACO will still have a full choice of providers and can still choose to see doctors outside of the ACO. Patients choosing to receive care from providers participating in ACOs will have access to information about how well their doctors, hospitals, or other caregivers are meeting quality standards.

The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have worked together to facilitate the creation of ACOs by giving providers the guidance they need to form innovative, integrated health care delivery systems without running afoul of antitrust laws.

Integrated health systems like Geisinger are well positioned to assume the mantle of an ACO. Geisinger’s doctors, hospitals, and Geisinger Health Plan plan have partnered to launch innovative initiatives designed to provide a coordinated approach to the continuum of care—preventive, primary, acute, and inpatient care. The continuum of care places an emphasis on value—keeping costs down and quality up, and working with payers to tie payment to outcomes.” In high-performing health systems, affecting population health becomes not just good community benefit but a path to organizational success. That philosophy has played itself out in the way Geisinger has carefully built strong relationships with other providers in its region and in its priorities on research and learning.

Improving coordination and communication among physicians and other providers and suppliers through Accountable Care Organizations will help improve the care Medicare beneficiaries receive, while also helping lower costs. According to the analysis of the proposed regulation for ACOs, Medicare could potentially save as much as $960 million over three years. If ACOs see these savings, the result could be a expansion to commercial populations.

Before the rule is finalized, CMS will review all comments from the public and may make changes to its proposals based on those comments.

Source: U.S. Department of Health and Human Services fact sheet
GHP enhances regional focus

In an effort to better serve members, employers, providers and hospitals in our network, Geisinger Health Plan uses a regional approach to medical management. This allows the Health Plan to better address the unique characteristics of each region in our service area.

“We have seen that various regions of our service area have different needs,” says Geisinger Health Plan Chief Medical Officer, Duane E. Davis, M.D. “By focusing our efforts regionally, we are better able to support the health care needs and referral patterns of these different populations.”

As part of this regional focus, Geisinger Health Plan employs medical directors for each region. Each regional medical director coordinates with other Health Plan departments including sales, provider network management, medical home and wellness to enhance relationships and provide leadership.

Regional medical directors include:

- Q. Thomas Novinger, M.D.-Eastern region
- Ray Roth, D.O.-North Central region
- Beverly Blaisure, M.D.-Western and South Central regions

Wilkes Barre/Scranton sales location change

Our Wilkes Barre and Scranton offices have merged and are now located at:
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