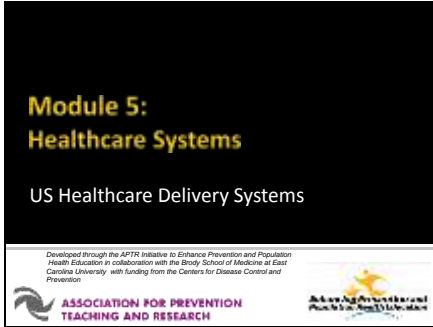
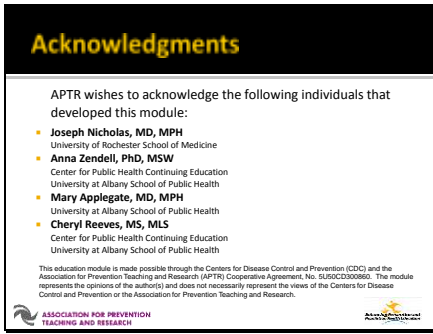


Module 5: Healthcare Delivery Systems

TRANSCRIPT



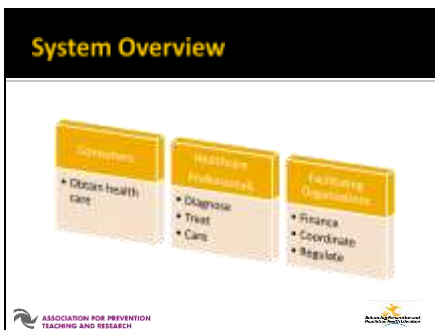
The Healthcare Systems module is one of a series created through funding from the Centers for Disease Control and Prevention and the Association for Prevention, Teaching and Research.



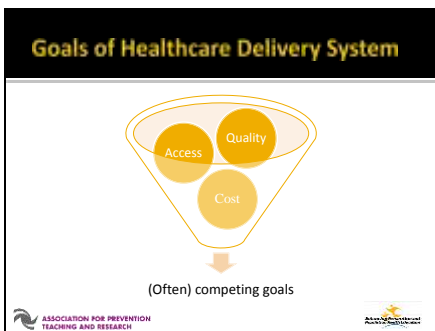
The objectives of this presentation are as follows:

1. List the major sectors of the US healthcare system
2. Describe the interactions among elements of the healthcare system, with attention to the relationships between clinical practice and public health
3. Describe the organization of the public health system at the federal, state, and local levels
4. Describe the interaction of the healthcare system with special populations
5. Describe the impact of various regulatory bodies on US health system policy

TRANSCRIPT



We will begin with a conceptual overview of what we mean by a "healthcare system." Modern health care systems have many interrelated components, so it can be useful to try to reduce the complexity for a moment and recognize the fundamental human and institutional participants in health care. Most healthcare interactions involve consumers, professionals and facilitating organizations. In this scheme, consumers seek healthcare, professionals provide the care, and the facilitating organizations perform a myriad of supporting administrative, regulatory and financing functions to support or control these healthcare encounters. Most components of the US health care system fall primarily into one of these categories.



All sustainable and effective healthcare systems work to balance these 3 goals: 1) appropriate access to necessary healthcare services; 2) assurance of quality workforce, services and institutions; and 3) acceptable cost to society. As you will see, these three goals can be difficult to achieve in concert, and may often compete with each other.

-
- Questions to Consider**
- Who currently utilizes health care in the US?
 - Where do most healthcare encounters occur?
 - What is the reason for most encounters?
 - What are the different models for organizing, funding and regulating these encounters?
 - How do public health and clinical practice influence one another?
- ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH

We will be addressing the following questions in this module. Who currently utilizes health care in the US? What are the reasons for most encounters? Where do most encounters occur? What are the different domestic and international models for organizing, funding and regulating these encounters? How do public health practice and clinical practice influence and interact with one another?

TRANSCRIPT

System Demands

- 1.2 billion ambulatory visits per year (2008)
 - Children - routine health check and respiratory infections
 - Young women - pregnancy, gynecologic care
 - Adults (both sexes) - hypertension, ischemic heart disease, and diabetes mellitus
- 35 million hospital discharges (2006)
 - Average length of stay - 4.8 days
 - 46 million procedures performed

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH National Center for Health Statistics 2008

The demands on our current healthcare system are quite staggering, as the sheer number of interactions can illustrate. Americans had 1.2 billion ambulatory visits in 2008. Ambulatory visits refer to nonhospital based encounters and include office, emergency room, and hospital outpatient services. The purpose of these visits can be analyzed by age and sex: children predominantly seek care for well visits and minor respiratory illnesses, young women often seek pregnancy and gynecologic care, and older adults of both sexes are obtaining chronic disease care around common diseases like hypertension, heart disease and diabetes. Hospital care is also in great demand, with over 35 million patient discharges and 46 million procedures were performed in the hospital setting. These include major surgeries, minor procedures, and advanced diagnostic testing like medical imaging, cardiac testing and endoscopy. This quantity of health care represents countless interactions between providers, consumers and administrative organizations.

Overview of Public Health System

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH

Next we will provide an overview of the public health system. The public health system is focused on the health of the US population as a whole; it interacts but is quite distinct from the clinical healthcare system describes above.

Role of Public Health
Federal

- Regulation of commerce
 - Control entry of persons to US
 - Control inspection/entry of products to US and across state lines
- Funding of public health programs
- Provision of care for special populations
- Coordination of federal agencies

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There is not constitutionally explicit role for the federal government in the maintenance of public health in the US. Most healthcare and public health responsibilities are delegated to the states. Some federal power is derived from the interstate commerce in Article I, and allows public health authorities to monitor and restrict the entry of persons and products into the US. Examples of these include the restriction of people with high risk infectious conditions like active tuberculosis, and the restriction of food and other products contaminated with pathogenic organisms. Toxins and pollutants can also be banned from the US under federal jurisdiction. The federal government has assumed responsibility for funding some public health programs and agencies. These include federal agencies such as the CDC, OSHA, and NIH, and public insurances like Medicare, Medicaid, SCHIP and the VA. The federal government assists with the provision of healthcare for special groups including military personnel, veterans and Native Americans. In the US the primary federal department responsible for health and public health is the Dept of Health and Human Services, or DHHS. Some of the federal agencies under DHHS include the Centers for Disease Control and Prevention, The Food and Drug Administration, and the National Institutes of Health. Most of these agencies under the DHHS are umbrella agencies to their own sets of health and public health organizations. For example, the NIH houses the National Cancer Institute, the National Institute on Aging, National Institute on Mental Health, and the National Center of Minority Health and Health Disparities, just to name a few. The federal public health system is charged with coordinating most if not all of these agencies, as well as working closely with newer agencies like Homeland Security.

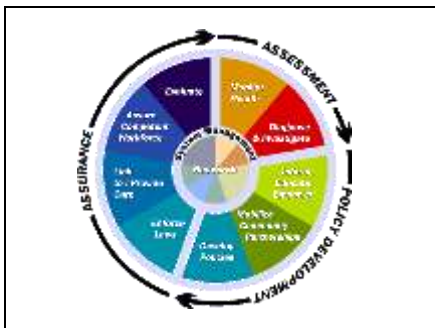
Role of Public Health
State

- Community health assessment
- Public health policy development
- Assurance of public health service provision to communities
- Continuity between federal public and local public health
 - Conduit for funding
 - Linkage of resources to needs

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In the US, states are charged with regulating the public health for many of the healthcare and public health issues affecting US citizens. All 50 states have individual health departments. State public health departments have 3 core functions: assessment of priority health problems, policy development to protect public health, and assurance of public health services to all communities within the state. The state also provides a level of continuity between federal public health and local public health and can act as a conduit for funding to match resources to needs.

TRANSCRIPT



The way in which state health departments carry out the public health purposes are driven by the core functions of assessment, assurance and policy development, as described by the Office of Disease Prevention and Health Promotion. This diagram describes the essential services provided by state public health departments to meet these core functions. These include monitoring the general health of the community, diagnosing and investigating disease outbreaks, educating the public, mobilizing community and government partnerships, developing policies to support health, and services to guarantee access to a quality workforce.

Role of Public Health

Local

- May be city and/or county-based
- Provide mandated public health services
- Enact and enforce public health codes as mandated by state and federal officials
 - Must meet minimum threshold of state standards
 - May be more rigorous than state standards

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Local public health is generally county-based, though many cities, due to their sheer size, have their own city health departments. The local departments are responsible for the enactment and enforcement of state and federal public health regulations. Examples of local health activities include restaurant inspections, disease detection and reporting (such as flu updates or tuberculosis), and the reporting of births and deaths. While local health departments must meet the minimum standards set by the state, their regulations may be more rigorous to meet particular local needs and preferences.

Local Public Health Functions

- Vital statistics
- Communicable disease control
- Maternal and child health
- Environmental health
- Health education
- Public health laboratories


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Specifically, there are six basic minimum functions of local public health departments. Commonly called the “Basic 6” these functions drive the operations of local departments and include: 1.) Vital statistics (otherwise known as births, deaths, and marriage reporting); 2.) Communicable Disease Control; 3.) Maternal and Child Health; 4.) Environmental Health; 5.) Health education; and 6.) Public health laboratory

TRANSCRIPT

Clinical Medicine and Public Health

- Clinical Medicine
 - Patient-focused
 - Diagnosis and treatment
 - Medical care paradigm
- Public Health
 - Population-focused
 - Disease prevention and health promotion
 - Spectrum of interventions



While some goals of clinical medicine and public health can appear generally similar, these two approaches to health differ in many important ways. Clinical medicine is focused on the evaluation and management of the individual patient, providing diagnosis and treatment. Public health is focused on the health of a population, primary through strategies of disease prevention and health promotion. Clinical medicine operates in what we call a medical care paradigm of disease specific treatment, while public health has a wide spectrum of interventions including education, policy, regulation and enforcement.

Healthcare System Sectors



Now that we have completed a review of public health systems in the US, let's look at the healthcare service system in more detail.

Types and Settings of Services

Types of Healthcare Services	Delivery Settings
Preventive Care	Public Health Programs Community Programs Personal Lifestyles
Primary Care	Physician Office/Clinic Self-Care Alternative Medicine
Specialized Care	Specialist Clinics
Chronic Care	Primary Care Settings Specialist Provider Clinics Home Health Long-term Care Facilities Self-Care Alternative Medicine

Shi & Singh 2008

Health care services are often categorized into preventive, primary, secondary and tertiary care. Preventive care is focused on disease prevention, and is conducted mainly in public health and community-based programs. Both public health and clinical medicine strive to have people integrate preventive care behaviors into personal lifestyles. Primary care is clinical care that generally takes place in physicians' offices, at home by patients employing self-care strategies, and through alternative medicine providers. Specialized care takes place in specialist clinics. These might include oncology centers, dialysis clinics, and neonatal facilities. Chronic care takes place in almost any setting. Primary care and specialty settings provide extensive chronic care. Additionally, home health care, alternative medicine providers, and home health care providers do chronic care. LTC facilities also provide chronic care to people who can no longer live on their own. Chronic illnesses can often be managed to some extent at home using self-care principles.

Types and Settings of Services (2)	
Types of Healthcare Services	Delivery Settings
Long-term Care	Long-term Care Facilities Home Health
Sub-Acute Care	Special Sub-Acute Units (<i>Hospital, Long-term Care Facilities</i>) Home Health Outpatient Surgical Centers
Acute Care	Hospitals
Rehabilitative Care	Rehabilitation Departments (<i>Hospital, Long-term Care Facilities</i>) Home Health Outpatient Rehabilitation Centers
End-of-Life Care	Hospice Services

Shi & Singh 2008

Long-term care services may be provided at long term care facilities. Many people can be diverted from long term care through use of home health care services. Sub-Acute care is provided in sub-acute units of hospitals or long-term care facilities. It is also often provided at home using home health services or at outpatient surgical centers. Acute care is provided in a hospital setting. This may be medical or psychiatric acute care. Rehabilitative care is provided through rehabilitation departments within hospitals or LTC's, or it may be provided through outpatient rehab or through home health care. End of life care is provided through hospice services. Much of hospice is provided at home; however, there are a number of residential hospice settings.

Primary Care

- Typically address acute, chronic, preventive/wellness issues
 - Coordinate specialty care when needed
- Providers are typically generalists (MD/DO/NP/PA)
 - Primary care specialties : Family Medicine, General Internal Medicine, Pediatrics, Obstetrics-Gynecology
- Develop ongoing patient-provider relationship
- Multiple settings: provider offices, clinics, schools, colleges, prisons, worksites, home, mobile vans

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Primary care is usually the first contact with the healthcare system. Primary care typically addresses acute, chronic, and preventive or wellness issues. Specialty care can be coordinated when necessary. Primary care providers, often called PCP's, are typically generalists, with specialties like family medicine, general internal medicine, pediatrics, and obstetrics/gynecology. PCP's develop and maintain an ongoing patient-provider relationship. As we have seen in the recent graphics, primary care is provided in many settings: offices, clinics, schools, college, prison, worksites, mobile vans, and even at home.

Secondary Care

- Typically subspecialty care focused on a particular organ system or disease process
- Available in most communities
- Includes common inpatient and outpatient services
 - Subspecialty office care
 - Inpatient care including emergency care, labor and delivery, intensive care, diagnostic imaging


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Secondary care is typically focused on a particular organ system or disease process, such as diabetes, cardiology, or oncology. Secondary care is available in most communities, though there may be some gaps in certain remote rural areas or inner city neighborhoods. Common inpatient and outpatient services fall under secondary care. Examples include subspecialty care offices, emergency room care, labor and delivery, ICU's, and diagnostic imaging, to name a few.

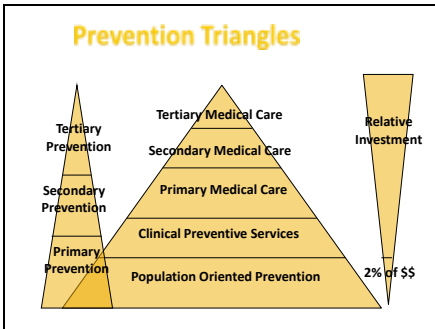
TRANSCRIPT

Tertiary Care

- Consultative subspecialty care
- Typically provided at large regional medical centers
- Characterized by advanced technology and high volume of procedures
- Tertiary care sites usually serve as major education sites for students in a variety of health professions




Tertiary care can be thought of as consultative subspecialty care. Typically provided at large regional medical centers, tertiary care is characterized by use of advanced technology and a high volume of procedures. Tertiary care sites provide a vital resource for education, serving as sites for students in a variety of health professions.



This diagram illustrates that preventive services in general are more cost-effective than provision of secondary and tertiary medical care. The sicker a person or group becomes, the more money resources must be invested.

Current System Components

- Personnel
- Healthcare institutions
- US Public Health Service Commissioned Corps
- Drug and device manufacturers
- Education and research



The healthcare system is quite complicated. The current healthcare systems are not coordinated. We will discuss the major system components in the next few slides.

TRANSCRIPT

Personnel

- Nurses
- Physicians (MD/DO)
- NP,PA, midwives
- Pharmacists
- Dentists
- Several million ancillary personnel
 - 80% involved in direct healthcare provision
 - Therapists, social workers, lab technicians

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH National Center for Health Statistics 2004

Here we have the core personnel that make up the healthcare system. Nurses, physicians, nurse practitioners, physician's assistants, midwives, pharmacists and dentists are some of the core providers. In addition, there are several million ancillary healthcare providers. Over 80% of these are direct providers. Examples of what we mean by ancillary personnel would be physical therapist, occupational therapists, speech therapists, social workers, EMT's, and laboratory technicians.

Personnel
Provider Practice Organizations

- Traditional solo practitioner model is fading
- Most providers join larger groups
 - Private, physician-owned groups
 - Health system owned groups (networks)
 - Health maintenance organizations
 - Preferred provider organizations

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH

The traditional single practitioner model is fading. Most providers are joining large groups. Groups include private physician-owned groups, healthcare networks, HMO's and PPO's.

Healthcare Institutions
Hospitals

- Private, community hospitals
 - Not for profits are most common
 - Many are religiously affiliated
- Private, for profit
- Public (state or local government)
- Psychiatric hospitals
- Academic medical centers
- VA and military centers



ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH

There are many types of hospitals in the US. Private hospitals remain the most common. Religiously affiliated hospitals are growing in prevalence. Private for profit hospitals are also fairly common in the US. Government-run hospitals are slowly declining. Many are being closed down or merged to cut costs. Other types of hospitals include psychiatric hospitals, academic medical centers (teaching hospitals), VA hospitals, and military hospitals. A current trend in hospitals as organizations is the merger. Hospitals that have traditionally competed may choose to merge into one healthcare facility, in order to remain viable as institutions and continue to provide healthcare to their communities.

Other Major Healthcare Institutions

- Long term care facilities
 - Nursing homes/skilled nursing facilities
 - Assisted living facilities*
 - Enhanced care facilities*
 - Adult homes*
- Rehabilitation facilities
 - Physical rehabilitation
 - Substance abuse facilities



*These residential long-term care facilities are not really healthcare institutions but commonly referred to as such.



Other major players in the healthcare field are long term care facilities and rehab facilities. Long term care facilities are those that allow people with chronic illnesses, disabilities and other conditions that limit their functioning physically or mentally. Nursing homes and skilled nursing facilities provide the highest level of medical care in a residential setting. These facilities serve the most medically frail. Assisted living facilities provide housing and personalized supportive care services for people who have difficulties with activities of daily living. Some medical services, such as medication oversight, and nursing services are often included at additional cost. Assisted living programs combine residential and home health care type services. Enhanced care facilities, also commonly called enriched housing, are a type of assisted living that provides residential in community-integrated settings similar to independent housing, such as apartments. ECF's provide room, housekeeping, personal care and some supervision. Adult homes are typically the least structured settings. This type of assisted living provides long-term residential care, housekeeping, personal care and supervision for people unable to live independently. Assisted living facilities are generally included as healthcare institutions. It is debatable whether they actually are healthcare facilities. Residents of assisted living facilities generally need some sort of personal care, but should not require continual medical or nursing care services, as they are not licensed to provide nursing or medical care. Rehab facilities provide restorative care following an illness, injury, disease, or surgery. Physical rehabilitation may be needed subsequent to a wartime injury, auto accident, or a fall. Rehabilitation is also provided for substance abuse treatment.

US Public Health Service Commissioned Corps

- 6,600 full time clinical and public health professionals
- Provide primary care in underserved areas
- Staff domestic and international public health emergencies
- Work in research, administrative and public health capacities in a number of federal agencies



The US Public Health Service Commissioned Corp is charged with providing primary care to underserved populations. They are also at the lead in providing public health promotion and disease prevention. Over 6,600 full time clinical and public health professionals serve with the Corps. The Corps members cover domestic and international public health emergencies, as well. They work in research, administrative and public health capacities in a number of federal agencies, including the Department of Health and Human Services, CDC, and NIH, to name just a few. More information about the USPHSCC can be found in the Resources Section.

TRANSCRIPT

Pharmaceuticals and Devices

- Large industry with major impact on cost and policy
- \$234 billion in 2008
- Growing rapidly with the passage of Medicare D (prescription benefit)
- Regulated by Food and Drug Administration

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH Hartman et al 2010

The pharmaceutical and assistive device industries are quite large, with a major impact on healthcare costs and policies. Prescription drug use in particular is growing rapidly with the recent passage of the Medicare D drug benefit. More and more durable medical and assistive devices, such as sleep apnea machines and portable oxygen, are being covered at least partially through insurance plans. Both pharmaceuticals and these devices are regulated by the FDA for safety.

Education and Research

- Public/Private funding mix supports undergraduate nursing, medical and physician assistant programs
- Public funding of Graduate Medical Education
- US does not actively manage specialty choice or distribution of its physician workforce
- Government is major funder for basic medical research
- Industry is major funder for clinical trials of drugs, and devices and continuing medical education

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH

Education is heavily subsidized through a mix of private and public funding. Undergraduate nursing, medical and PA programs are funded through a mixture of direct funding and enhanced patient care reimbursement to training institutions. Graduate medical education is funded publicly through Medicare. Medicaid funding is available in most states, as are HRSA grants. The US does not actively manage providers' specialty choices or the distribution of the physician workforce. The government is the major funder for basic medical research, particularly the National Institutes of Health. Private foundations are also key funders. For example, the American Cancer Society, Alzheimer's Association and Autism Speaks are major funders of research projects. Industry is the major funder for clinical trials of drugs, medical devices and continuing medical education.


Healthcare Oversight

ASSOCIATION FOR PREVENTION TEACHING AND RESEARCH

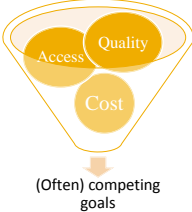
Next, we will discuss healthcare oversight.

Healthcare Regulation Web


- Diverse set of regulators
 - Government (state, federal, local)
 - Insurers
 - Hospitals
 - Private accrediting bodies
 - Professional societies



Goals of Healthcare Delivery System



(Often) competing goals




We are reintroducing this graphic to remind you of the major goals of the healthcare system. Let's now discuss how our regulatory systems attempt to address these goals. All current healthcare delivery models attempt to address these 3 goals. These goals are often competing. It is difficult to increase access without increasing cost. Quality and cost are related in many ways as well. In socialized healthcare systems, cost is often controlled by limitations on services and payments to providers and hospitals. These are known as price controls. US systems have tried increasing consumer contributions to healthcare costs through increased co-payments and premiums and other market mechanisms like managed care. The lack of universal access can also be seen as a form of cost containment. Quality has a variable relationship to cost; for some issues higher quality is associated with higher cost, for other, the opposite appears to be true.

State Regulation

Most healthcare regulation comes from states

- Licensure and oversight of medical facilities and providers
- Control distribution of services through certificate of need process
- Regulate insurance coverage
 - Mandate minimum standards
 - Regulate cost, scope of coverage and exclusion criteria



Most healthcare regulations come from the individual states. Licensure and oversight of facilities and providers is state-driven. States control the distribution of services through the certificate of need process, which we will discuss in a moment. States also regulate insurance coverage in many ways. For example, states mandate minimum standards and regulate the cost, scope of coverage and exclusion criteria to ensure a minimum standard of coverage.

TRANSCRIPT

Certificate of Need (CON)


- Purpose
 - Cost containment
 - Prevent unnecessary duplication of health care
 - Ensure high quality health services
- Accomplishes this through many roles
- Extensive review process



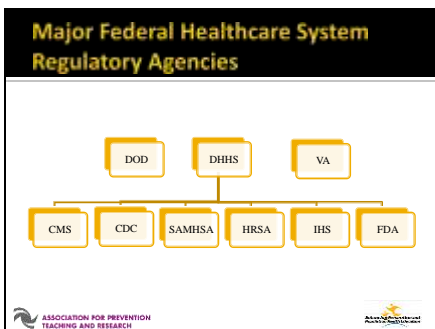
The CON process serves several important functions. It promotes cost containment and prevents unnecessary duplication of health care facilities and services. This process also guides the establishment of health facilities and services to ensure high quality health services. CON accomplishes this through a series of mandates. CON is required for construction or establishment of new healthcare facilities, changes to licensure of beds, capital expenditures, provision of certain health services, and procurement of medical equipment, to name just a few. The review process is quite extensive. CON applications are reviewed by a state hospital review council and a public health council. Visit your state Department of Health website for more information.

Federal Regulation

- Regulatory power derived from federal status as the major payor in most systems (Medicare, Medicaid)
- Reimbursement is increasingly tied to compliance with federal standards
- Department of Health and Human Services (DHHS) is the major federal actor in healthcare regulation





Regulatory power comes from the federal government as the main payer in most healthcare systems, most notably through Medicare and Medicaid reimbursements. Reimbursement is increasingly tied to compliance with federal standards. If standards are not adhered to, reimbursements may be denied, in other words. The DHHS has the biggest role in federal healthcare regulation. Most state and local regulations are derived from DHHS. You can find more information about regulations in the Resource Section.



This organizational chart illustrates the major federal regulators. You will notice that the DHHS has many regulatory bodies under its auspices. There are other regulators, as well. For example, the Dept of Defense and Veterans Affairs have extensive regulatory authority.

Regulators
Insurers

- Contract with physicians/hospitals to encourage
 - Quality
 - Cost control
 - Market share
- Set standards
- Audit providers and institutions
 - Adjust payments accordingly



Insurers play a pivotal role in healthcare oversight. They are in contact with providers and institutions to encourage high quality care with cost controls built in and to ensure their market share. Insurers play roles in setting standards of care and cost. They audit providers and institutions. These audits are negotiated with physicians, and payments are set based on audit outcomes.

Regulators
Hospitals

- Credential physicians, physician assistants, midwives, nurses, other healthcare staff
- Hospital credentialing often necessary for malpractice insurance eligibility
- Regular review of medical staff for quality, professional conduct and practice standards



Here is where much of your professional regulation may come from. Though you may never work in a hospital setting, hospital credentialing may play a large role in your profession. For example, to obtain malpractice insurance for some institutions, providers need to hold hospital privileges, whether they intend to use them or not. Hospitals conduct regular reviews of their medical staff to assess quality of care, professional conduct, and adherence to practice standards.

Regulators
Private Accrediting Organizations

- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
 - Accredits hospitals
 - Private organization of member hospitals
- NCQA (National Committee for Quality Assurance)
 - Accredits managed care plans
 - Private organization representing employers/purchasers
- Specialty Organizations
 - Specific certifications (bariatric surgery centers, Baby Friendly USA)




JCAHO is the most commonly known accrediting body. JCAHO is a private membership organization of hospitals and accredits hospitals. The National Committee for Quality Assurance accredits managed care plans. This is a private organization representing the employers purchasing the plans. There are also specialty accrediting organizations, such as those covering bariatric surgery centers and Baby Friendly USA.

TRANSCRIPT

Professional Societies

- Historically the major regulator of healthcare delivery until increasing influence of government and insurance industries
- Still influential in determining acceptable professional practice standards, and contributing to regulatory policy



Professional societies were historically the major regulator of healthcare until the regulatory influence of the government and insurance industry took hold in the US. Many societies remain influential today in determining acceptable professional standards and contributing to regulatory policies.

Professional Impairment

Regulatory System Response

- Most common impairments
 - Substance abuse/dependency
 - Mental illness
 - Aging-related impairments a growing problem
- Trend toward treatment vs. sanction



The healthcare oversight system is facing a significant challenge – professional impairment. Healthcare professionals can, and do, struggle with issues of substance abuse and mental illness. Aging related impairments, including slowed processes and cognitive impairments are growing. Historically, sanctions were levied against professionals found to be practicing while impaired. Now, treatment is emphasized.

Special Populations



Next we will provide a brief overview of considerations for a few special populations.

TRANSCRIPT

Veterans


- Unique health care infrastructure
- Inter-generational health care needs
- Health/public health considerations
 - War-related injuries
 - Chemical exposure
 - Homelessness
 - Post traumatic stress disorder
 - Prisoners of war



Veterans are eligible to receive care from a unique healthcare infrastructure. Veterans Affairs Centers provide a wide range of intergenerational health care. Public health considerations for veterans are addressed within the VA. Veterans need systems of care for war-related injuries, including traumatic brain injuries and effects of chemical exposure. Homelessness among veterans is a major issue. Veterans may suffer from PTSD and other psychiatric disorders stemming from their experience in combat. Prisoners of war in particular may struggle with long term illnesses and difficulty adjusting to being back in the US. When caring for patients who are veterans, it is important to remember that benefits are not automatic; veterans must proactively apply to receive veteran's benefits.

Indian Health Service


- Created through treaties between US government and Indian tribes
 - Eligibility for US benefits and programs
 - Contract Health Services (CHS) to supplement
- Considerations for American Indians
 - Safe water and sewage
 - Injury mortality rate 2-4x other Americans



A common myth is that American Indians are US citizens. The American Indian population is a sovereign nation. The Indian Health Service was created through a series of treaties between the US Government and Indian tribes. The IHS provides eligibility for US benefits and programs, with supplemental coverage through Contract Health Services. Some unique public health considerations for American Indians include the need for universal access to safe water and sewage treatment systems. Not all have these very basic needs met. American Indians are also very vulnerable to dying as a result of injuries. The injury mortality rate is 2-4x that of other Americans.

Students


- K-12 Student Health Centers
 - Medical, psychosocial, preventive care for all
 - Age appropriate health education
- College Student Health Center
 - Medical and preventive care for all
 - Campus health emergencies



Students from kindergarten through college may have access to health care through their schools. K-12 Student Health Centers provide medical, psychosocial and preventive care for all children. Age appropriate health education is also provided. College student health centers also provide medical and preventive health care for all students. These health centers also respond to campus health emergencies, such as flu outbreaks. These health centers provide needed health care to uninsured and underserved children. Availability of health centers varies across communities. These variations are largely based on community need and available funding.

Correctional Facilities

- Privatization and telemedicine are growing trends to meet prisoner healthcare needs
- Unique considerations
 - Injuries, infectious diseases, and substance abuse very prevalent
 - > 50% of inmates suspected to have mental illness
 - Aging in prisons
 - Must address barriers to health care – secure escort



Inmates have unique needs for health care and may have difficulty accessing it. Correctional facilities are looking to privatized provider care and tele-medicine to meet prisoner healthcare needs. Telemedicine allows inmates to go to a prison nurse or clinic and link to a doctor through telephone or Internet to receive a health consult. Prison populations face some unique health and public health challenges. The rates of injury and infectious disease are quite high in the prison system. Substance abuse is also prevalent. Over half of all inmates are believed to have a mental illness. The numbers of older and chronically ill inmates are growing, increasing the need for access. Prisons are often located at some distance from hospitals. Guards must escort inmates to healthcare appointments. Some high security prisoners need multiple guards.

Intellectual/Developmental Disabilities

Considerations

- Intellectual/Developmental Disabilities (I/DD)-specific clinic or integrated health care
- Consent capacity
 - Surrogate Decision Making Committees
 - Guardianship
- Diagnostic, treatment challenges
- Caregiver perspectives on health concerns



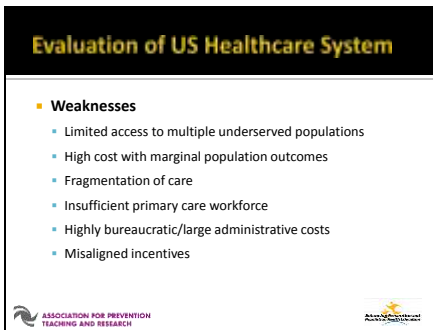
Adults and children with intellectual and/or developmental disabilities have unique healthcare needs that can be challenging to meet in the health and public health systems. Decisions must be made on whether to use an I/DD specific clinic or to use the community's integrated healthcare system. I/DD specific clinics provide care exclusively to persons with I/DD across the lifespan. Dental care is a particular concern for people with I/DD. Adults with I/DD are presumed able to consent for treatment unless they have been legally deemed unable to do so. However, the majority of healthcare providers rely heavily on caregivers for informed consent to provide treatment. Where this is not possible or feasible, states provide two mechanisms to consent for healthcare and other decisions. Surrogate Decision-Making Committees may be contacted to review all the facets of a particular healthcare decision and will be charged to make that decision for a person with I/DD. An example may be consent for a surgery. A person with I/DD may also have a legally appointed guardian to make healthcare decisions. While many people with I/DD are able to communicate symptoms, many are not. This creates diagnostic and treatment challenges. Many diagnostic procedures are predicated at least in part on patient feedback on symptoms. The caregiver perspective becomes critically important, as they are much more familiar the person's communication style and subtle changes in behavior that may indicate illness.



The next few slides provide a global perspective on healthcare systems.



The US system does have a number of strengths. Most notably, an advanced diagnostic and therapeutic technology. Highly available access to subspecialty care and medical procedures.



Despite these strengths, there are many weaknesses. Large portions of the US population remain without access to immediate healthcare and our current costs morph that of any other society. Despite these dramatically higher expenditures on health, US does not have superior health outcomes. In many basic health measures like life expectancy, infant mortality, quality of care. The US healthcare is overwhelmingly fragmented, expensive and in many cases of marginal benefit. Current projections suggest a health care worker shortage and it is expected to intensify over the next decade. Relative to many other systems, the US healthcare system is highly bureaucratic with large administrative costs and misaligned incentives that promote resource utilization, but not necessarily quality.

TRANSCRIPT

Healthcare System Models

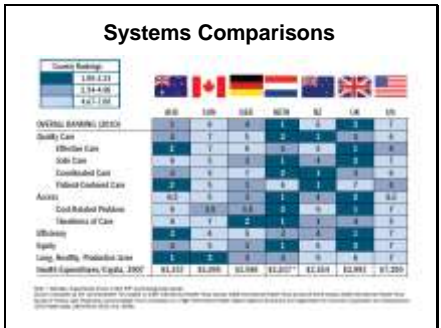
Socialized Medicine (United Kingdom Model)	Socialized Insurance (Bismarck Model)
<ul style="list-style-type: none"> Government is dominant service payor <u>and</u> provider Fund through taxes Universal access In US, this is model for Veterans Affairs (VA) 	<ul style="list-style-type: none"> Private insurance is dominant payor Fund via employers and/or employees Need additional mechanisms for universal access In US, this is primary model for citizens <65 years

For a sense of perspective, let's briefly compare a couple of socialized healthcare system models. The UK model of socialized medicine features government as the primary service payer, as well as the dominant service provider. We see that under the Bismarck model, private insurance is the dominant payer. The UK model is funded through taxes, while Bismarck is funded through employers and/or employees. The UK model provides universal access, which we see here in the US under the VA healthcare model. The Bismarck model, on the other hand, is not universal. Medicare is based on the Bismarck model

Healthcare System Models

National Health Insurance (Canadian Model)	Out of Pocket Model
<ul style="list-style-type: none"> Government is dominant payor Providers, hospitals are a mix of public/private Funded through taxes Universal access In US, this is the model for Medicare and Medicaid 	<ul style="list-style-type: none"> No organized system for payment No pooling of risk Access limited In US, this is the model faced by large numbers of uninsured

In Canada, general tax revenue is used to fund most care and to achieve universal access. The government is the dominant payer. But the government does not typically run the hospitals or employ the healthcare providers. In the US this system is similar to our financing of Medicare and Medicaid; the government is the payer to private physicians and hospitals. In addition to the three models described previously, US is the only one of these societies that does not guarantee universal access to healthcare financing and consequently has large numbers of uninsured and private paid patients who either fail to access care or who incur tremendous major out-of-pocket healthcare costs.



This graphic illustrates the overall ranking of the healthcare systems in seven developed countries, including the US. As you can see, the US spends the most money of all countries. Yet we come in last in healthcare.

TRANSCRIPT



This graph shows the life expectancy outcomes in ten countries. The US has the lowest life expectancy of these countries.

Current Trends

- Medical Tourism
- Concierge Medicine
 - Physician retainer fee
 - Executive healthcare

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There are a number of emerging trends in the US.

Current Trends - Attempts to Expand Access

- Insurance/Payment reforms
 - Less exclusion, access to larger pools
 - Offering less comprehensive benefits/limiting choice
- Shifting more costs to consumers
 - High deductible plans
 - Health savings accounts
- Subsidize private insurance
- Medicaid eligibility expansion
- Funding of community health centers


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Many present trends involve attempts to expand access to more people. Insurance reform is a major aim. Insurance reforms seek less exclusion of people due to pre-existing conditions and larger pools. Insurance companies are looking to offer less choice and fewer comprehensive benefits for cost savings. More of the burden of cost is being shifted to the consumers through higher deductibles and use of health savings accounts to help offset costs. These cost saving measures are intended to expand insurance coverage to more people. Insurance plans are being subsidized and Medicaid eligibility criteria are being expanded. Additionally more community centers are being funded to provide care to those who would otherwise be unable to access healthcare.

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Federally Qualified Health Centers


- Provide primary health care access to persons regardless of ability to pay
 - Includes mental health, dental, transportation, translation, education
 - Accept insurance
- Grant funded by HRSA, enhanced payments from Medicare/Medicaid
- Types
 - Community health centers
 - Migrant health centers
 - Healthcare for the Homeless Programs
 - Public Housing Primary Care Programs



Federally qualified health centers provide primary healthcare access to patients regardless of ability to pay. Services offered include mental health, dental, transportation, health education and translators when needed. FQHC's also accept insurance. These centers are funded through HRSA grants and enhanced payments from Medicare and Medicaid. There are a number of types of FQHC's. Community centers, migrant health centers, Healthcare for the Homeless Programs, and Public Housing Primary Care Programs open up access to some of our most vulnerable groups.

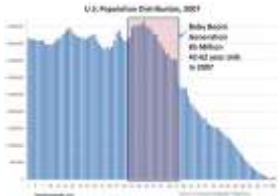
System at the Brink?

- Accelerating healthcare costs promise to swamp access/quality issues
- Workforce and hospitals are geared to provide expensive, high-tech, tertiary care for the foreseeable future
- Aging population living longer with more co-morbidities




Even as we seek to expand access to more people, the US healthcare system is facing serious challenges. Accelerating healthcare costs could subsume access and quality of care. Our workforce and hospitals are geared to provide expensive, advanced technology tertiary care. Add our aging population living longer and with more co-morbid conditions and we can well see out-of-control healthcare costs.

Impending Demographic Tsunami



U.S. Population Distribution, 2007

Baby Boomer Generation: 85 Million, 40-42 year olds in 2007



This graphic shows the US population distribution as of 2007. As you can see, the baby boomers represent a very large subset of the population, and they are now approaching older adulthood.


TRANSCRIPT

Paradigm Shift in Healthcare Delivery

Trends and Directions in Healthcare Delivery

Illness	→	Wellness
Acute Care	→	Primary Care
Inpatient	→	Outpatient
Individual Health	→	Community Well-Being
Fragmented Care	→	Managed Care
Independent Institutions	→	Integrated Settings
Service Duplication	→	Continuum of Services

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Here we see that the overall trend in healthcare delivery is toward prevention and wellness. Primary care settings are taking more of a lead in patient education. Community well-being is receiving more attention. The fragmentation of our healthcare system is being addressed through managed care strategies and a continuum of services.

Summary

- US healthcare system is a large patchwork of public and private programs
- Public funds account for nearly 50% of healthcare spending
- Cost is rapidly becoming dominant policy issue
- Quality and access remain significant policy issues

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The US healthcare system is a large patchwork of public and private programs. Nearly 50% of healthcare funding is in the public sector. The cost of healthcare is rapidly becoming a dominant healthcare issue, particularly with healthcare reform being implemented. Provision of quality care and expansion of access remain significant policy issues. At the moment, the tension between these three overarching goals remains a factor in attempts to reform the healthcare system and meet the needs of our society.

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