How risk adjustment payments could help complex conditions in rural areas.

Featuring Tamara Huff, MD.

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Bill: You are listening to the Health Disparities Podcast from Movement Is Life. Conversations about health disparities with people who are working to eliminate them. I'm Bill Finerfrock and today I'm discussing health disparities and health policy with Dr. Tammy Huff. Dr. Huff is on the Executive Committee of Movement Is Life and she's an orthopedic surgeon practicing in Columbus, Georgia at San Francis Orthopedic Institute. Dr. Huff thanks for being here. Tell us a little bit about yourself and how you got into the whole issue of health disparities and what caused you to kind of be interested in that particular topic?

Tammy: Well, thank you so much, Bill, for having me. I've been interested in health disparities for a very, very longtime. I'm originally from Columbus, Georgia and have the opportunity to work all over the state of Georgia, where we have a various amount of healthcare in different parts of the state. After training down in Louisiana, again, in different aspects of the state, you have drastically, different access to care, whether you're in New Orleans proper or all the way down to the Bayou in some of those smaller areas like Homer, Louisiana. The ability to get access to physicians drastically changes and that's what really, opened my eyes. After leaving

down from Louisiana and coming back to Georgia, I started practicing in a tiny, little town in a corner of Georgia and that's when it really, kind of hit me in the face that we do not have access, and our patients need that access to care and also, access to hospitals, in particular. I practiced in Waycross, Georgia and right before I started in that area, one of their hospitals closed. It was 45 miles south, and all of a sudden, patients are coming to see me from 100 to 150 miles away, and that really, started me on that path of being more passionate about care.

Bill: One of the things I was particularly interested in talking to you about is this issue of rural. We often think about health disparities as an issue that is correlated to race, ethnicity, gender, but the geographic disparities is something that is often not as well recognized, and you just talked about the fact. I thought it was interesting, you said one of your local hospitals closed. It was about 45 minutes away. And, I think that's the way a lot of folks in rural areas, 45 miles away is nothing. I live in the Washington DC area and that would be like telling me that every time I needed to go to the hospital I'd have to go to Baltimore. Again, I'd go, you crazy. Why would I have to go all the way to Baltimore. So, talk a little bit about that rural aspect of health disparities.

Tammy: Access is so important in rural areas and it's just a lot of it is just logistical, just to be honest. In my little area that I was practicing in Waycross was

the county seat. So, that entire county was about 50,000 people, but the county seat or the city was only 15,000. When you have a city that small, you have very limited public transportation options. So, it is a herculean activity to try to go to a doctor's visit, especially, in the case that I was mentioning of a hospital that was closed. So, 45 minutes away, again, that's a very far drive. We had people coming from all the way in Kingsland, Georgia, which was close to an hour away, right on the Georgia/Florida border, and they were coming via the Medicaid van. So, that van only travels once a day. So, even if your appointment is at 2:00 o'clock in the afternoon, they pick you up at 8:00 a.m. So, taking the time off of work, if you need to have a caregiver come with you, it's a huge undertaking and that really limits your options. Not to mention having physicians in the area and things like that, but for the patients themselves, just getting to the doctor is hard.

Bill: Yes, we saw that same phenomenon situation or circumstance in Hazard, Kentucky, recently. A group of us went there and it was the same thing. They had a van that would take folks to Louisville for some of the specialized care, but it was once a day, and it left at 8:00 in the morning, and then, it left at 5:00 or 6:00 in the evening. And so, that's was how you got there, and you ended up, you just had to sit there in the waiting room until if you had an appointment at 2:00 in the afternoon. How does that impact you as a surgeon in terms of how you have to think about providing

care, not just the actual surgery, but all the follow-up care and that? Can you talk a little bit about that part of being a healthcare provider and that situation?

Tammy: That's a great question because even with people that have their own vehicle, it's challenging to schedule pre-op appointments and post-op appointments and physical therapy, when you don't have transportation or heaven forbid, you're traveling from a rural area where it's 45 minutes to an hour away. Number one, getting ready for surgery is a challenge. Trying to make sure that you have all those appointments on the same day for patients is very, very important because they only have that one form of transportation. After surgery is a major issue because they have physical therapy. The whole point of doing a knee replacement or doing a hip replacement is to improve your function but, in many of those cases, you need to have some form of therapy. In many of our rural areas, there aren't many physical therapists. There definitely are very, very few occupational therapists. So, finding someone that can provide that service that also takes your insurance is very challenging. In addition, we don't have access to high speed internet in many of those areas. So, a possible solution has been let's do telemedicine, but the internet services, we have a challenging time just even getting cellphone service in some of those areas. So, they don't have access to high speed enough internet, so they

can watch the video. So, that becomes very, very challenging. It seems like a simple solution, but there really isn't a great solution for folks.

Bill: So, we're looking at the government's talked about changing the way that they pay for surgical procedures and particular joint and knee replacement and moving to what is referred to as a bundled payment, as opposed to a fee for service payment. Can you talk a little bit about the bundled payments and what that might mean, for example, some of those were all communities that have the challenges that you talk about, and then, what that means for you as a surgeon and how you may view patients.

Tammy: Again, another great question. So, with the bundle payment model, the idea is that you have one big pot of money that you need to use to take care of the patient from getting him ready for surgery, for the surgery, itself, and then, after the surgery. In rural areas, the proportion of people that have medical comorbidities such as obesity or diabetes or heart disease, tobacco use are much higher than the general population. Those comorbidities make you at a higher risk for surgical complications, specifically, the obesity and diabetes. So, that bundle or that group of people are already higher risk from that. In addition, we just talked about all the access issues of trying to get them to the doctor to make sure that everything is ready to go. So, that's a challenge. As a surgeon, I have to make the decision, okay, Mrs. Jones desperately needs to have this knee

replaced because she can barely get around and her kidney disease is actually getting worse because she's taking so many anti-inflammatories. So, I know she needs to have this done, but she has all these risk factors. She has obesity. She has diabetes. She has kidney disease. I just, finally, got her to stop smoking. So, she has all these problems. Do I go ahead and do that surgery because I know it's the right thing to do? Probably. Is my hospital happy about the fact that I'm going ahead and doing that surgery because she's such a high risk, and if she gets readmitted, we're on the hook for that additional readmission and that's counted against in some of the Medicare metrics because we took the risk on Mrs. Jones. That's a challenge for a surgeon and, currently, the balance for me is to continue to take those patients, but that's a very, very challenging proposition for surgeons moving forward, especially, in the current hospital climate and, especially, if you're an employee/physician where it is disincentivized.

Bill: So, you talked about some of these access issues and what's not available, PT or home health. It seems to me that means that a likely situation might be to say, "Alright, well, we're going to put you in a nursing home post-operatively, but is that nursing home admissions covered for that bundled payment? Are you on the hook for that, as well?

Tammy: It's all supposed to be included in that bundled payment. So, that brings up a couple of issues. One is studies show that people that have to go to a nursing or a skilled nursing facility do rehab quite as fast or don't do quite as well, as people that go home. So, that's just what studies show. In addition, is does cost more to go and get that care. On top of all of that, they're away from their families. So, you're already, many of these communities do not have those kinds of facilities.

Bill: Just like they don't have a PT. There's not a skilled nursing facility. That might be 45 minutes away.

Tammy: Exactly. They have all these medical comorbidities. They're 45 minutes away from their family. Of course, they're going to have more depression. Of course, that's going to slowdown their progress. So, from a financial standpoint it's not the best situation. From an outcome's perspective, it's not, but, actually, from a mental health and patient care perspective, it's not the best situation.

Bill: I mean the payment models themselves can't, necessarily, deal with getting a PT, getting a skilled nursing facility into a community, but are there things that could be done to how we pay the hospital, how we pay the surgeon to kind of mitigate some of those things, so, as you said, the hospital is not happy with you but because of your moral compass you're

like, “No, I’m going to provide care to this patient because it’s the right thing to do,” but are there things that can help the hospital say, “No, that’s fine, Dr. Huff. We’re happy to provide care,” because the way that the hospital is now going to be compensated may take that into account.

Tammy: Absolutely. What we really need is what’s called risk adjustment. So, the ability to know that Mrs. Jones is going to be a more complex patient. We’ve documented all the complex problems that she has, and we’ve also tried to mitigate them. We’ve done everything we can to get her as healthy as possible. With that in mind, we’re still moving forward with her surgery. So, instead of getting just a 1,000-dollar bucket of money for Mrs. Jones’ surgery, we need to have a 3,000-dollar bucket of money because of her higher risk and that risk stratification would give us an opportunity or those of us that are willing to take on those more challenging patients, we’re no longer penalized for that. The system would then take that into account and reimburse accordingly.

Bill: So, the idea of risk adjusting isn’t new. The managed care plans, for example, have been getting risk adjusted payments for a longtime saying if you have a disproportionately high percentage of patients with diabetes, obesity, whatever it may be, they’ll get an adjustment in their payment. I guess you’re kind of just talking about taking that concept and just moving

that down to the physician hospital level, as these models ask you to take on risk to say build those same things into your payment model?

Tammy: Yes, very similarly, and, also, too, when the results are published of how our hospital is doing with readmission rates and things, for there to be some acknowledgement that we are doing more complex patients. So, the length of stay may be longer, that those things are taking into account.

Bill: Yes, we just had a conversation with Dr. Wiznia and got into that. That the hospital that is caring for lower risk patients may get a five-star rating and the hospital that's caring for the higher risk patients may get a three-star rating and the public perception is that the five-star rated hospital is a better hospital than the three-star rated hospital, but, in reality, you may want to go to that three-star hospital because they're actually more experienced dealing with high risk patients. I think that's kind of what you're talking about, right?

Tammy: That's exactly what I'm talking about because there are so many rating agencies and so many ways of getting that information out. We just want to make sure that people understand all the things that come out. So, if you are a patient who is super healthy, super active and your only problem is your knee for a knee replacement, that's one thing. But many of us are very, very complex and have a variety of different things that are medically

with us, and also, access as far as ability to get to our appointments and things like that, we need to look at all those different things.

Bill: Yes, and I think that last piece is something I wanted to explore a little bit more because the concept of risk adjusting for disease is, and disease states is pretty well accepted, but what you're talking about, too, is some form of risk adjusting for the social determinants of health. Could you talk a little bit about that?

Tammy: This is one that I'll be frank, I don't have a great answer for, but in our country, there is definitely a divide between urban and rural and, especially, in our rural areas, the social determinants of health such as where you live, your access to care, transportation and issues like that really are something to think about and with the census coming up, maybe that's an opportunity to look at are there certain zones where there isn't a hospital within a 50-mile radius. There isn't a specialist in a 50-mile radius or there isn't a primary care physician. Is there only one primary care physician for this entire area? If you come from one of these high-risk areas or more challenging areas, when you do seek care is there some benefit for that if you go to a larger center because we know that we can't do follow-up. Your follow-up might not be as great as we would like to. So, those are some things that, as a provider I think about, how can we adjust for that?

Bill: You started out your answer with you don't know what the answer is, but I don't know that anybody knows, right now, but I think one of the things that we've been talking about and we've been working with Congressman John Lewis from Georgia on legislation to say, alright, even if we don't, necessarily, know the answer, we, at least, need to ask the questions. Are you familiar with that initiative and what's going on there and what you think about that?

Tammy: I am familiar with it and having that discussion is so important to just get that out in our political atmosphere or in the air. Whenever there's a problem, there's a challenge. One of the biggest challenges in addressing it is knowing and acknowledging that there's that problem, and that's what I think the key part of this bill is to have that ability to acknowledge that yes, there is a concern. Yes, there is a problem. Now, we can work on trying to find a solution for it.

Bill: So, if you could wave a magic wand and we said, "Dr. Tammy Huff is now in charge of everything," what one or two things would you like to see folks do or come away with from either this conversation of it if is a public policymaker folks, what would you like them to take away from all of this?

Tammy: Magic wands. (Laughter) To understand the importance of access and availability in rural areas. It doesn't matter how great your insurance is or how active and proactive you are as a patient, if you can't get, if there's nobody around you that does this procedure or you don't have a physical therapist or anyone around you in a 100-mile radius, it doesn't matter how much money you have, you can't do anything. So, in my perfect world are political representatives who understand the importance of there being dedicated funding for rural health in every part of the country, especially, in areas such as the South and Appalachia. I've had the chance to be up in Hazard, myself, so I know what they're dealing with because the frustration that they have there is the exact same thing I see in my patients. So, if I had that magic wand, it would be just people that are not in those areas, the technology and understand what they're going through and to know that we need to earmark funding to help the support the hospitals and facilities that are there and to do what's necessary to recruit more people to those areas.

Bill: Yes, I've spent a fair amount of time in rural America and dealing with some rural health issues and I think you're spot on that a lot of times I've told people having an insurance card that's great, but if you don't have a healthcare provider, if you don't have a hospital within reasonable access that card is really meaningless. So, where, in some communities, access to healthcare may have its basis on economics, in other areas of the

country, access to healthcare is a matter of geography. So, we have to look at both. We have to how do we resolve and eliminate barriers to healthcare based on economics, but how do we eliminate those same barriers to healthcare based on geography?

Tammy: Many times, and I think history will prove this out, is the foundation of a community, the foundation of society is the health and wellness of the people in that society. So, one of the big concerns in the political climate in our country, right now, is the decline of rural America, of these areas that were machinery oriented and things like that, part of that is, now, those people are suffering from disease states and there's no access, there's no healthcare in those areas. So, as a country, we really have to take a step back and realize, yes, we can advocate for jobs and things, but if our fellow citizens are not mentally and physically healthy enough to take those jobs, what good is that?

Bill: Yes, I think, it's often, whether it's some political leaders or media that homelessness is an urban phenomena, but it's like, well, you may not see it when you drive down the highway through rural America, but 50 yards back in the woods or off, out of sight, it exists and just because you can't see it doesn't mean that it doesn't exist.

Tammy: Can I share a story about that?

Bill: Yes, absolutely.

Tammy: You just brought up a great point. When I was working in Waycross, Georgia, I had a patient. Out of control Type 2 diabetes. Had knee problems and things like that, but her main concern was her diabetes. And she kept cutting, initially, it was the toe. Then, initially, the toe wouldn't heal. So, we had to take the toe off. And before we knew it, we had to, actually, amputate her foot to save her life. Well, we did that. She actually did great in the hospital. She healed. We sent her out and told her, "Hey, we need you to follow-up in two weeks." Two weeks goes by and we haven't heard anything from her. Another week goes by and we're in a small community. So, we were all looking for her. We actually started looking for her because we had an idea of where she was supposed to be living. Nothing. At about four weeks she comes in, in the ER and she was admitted, and we had to clean her wound up and everything. Then, we noticed that as soon as she got out, her sister was back in the emergency department for just an exacerbation. What was happening is they were using the emergency department and one of them being admitted to the hospital as a housing solution because what later we found out is her and her sister who is blind and has COPD and multiple medical comorbidities and, now, my patient, who was an amputee were living out of a station wagon next to the swamp, and they were living like that for the last three

months. So, while all this was going on and we were like, “Why can’t you control your diabetes? You know you’ve got to keep your wound clean.” They were living out of a car and the only time they had guaranteed access to hot meals was when they came into the hospital.

Bill: Wow, yes, that’s such a poignant example of kind of what we’ve been talking about and working on and I just want to thank you for everything you’re doing in your community by giving voice and talking about these kinds of things. I appreciate you taking the time to spend some time with us today to talk about it and look forward to working with you and moving forward. So, thanks, Dr. Huff.

Tammy: Thank you.

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