The Unintended Effects of Bundled Payments on Health Disparities.

Featuring Mary O'Connor, 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 policy, health policy with Dr. Mary O'Connor from Yale University and is also Chair of the Movement Is Life Caucus. Thanks for being with us today, Dr. O'Connor.

Mary: Thank you, Bill. It's a pleasure to be here.

Bill: Why don't you tell our audience a little bit about yourself, kind of your background, what you're doing, now, and then, we can talk a little bit about how you got into this whole area of health disparities and health policy.

Mary: Well, thank you, Bill. I'm an orthopedic surgeon and I am currently the Director of the Center for Musculoskeletal Care at Yale School of Medicine and Yale New Haven Health System. My focus there is really, taking the team forward with creating multidisciplinary, more integrated, patient-centered care and really, working to get us out of our traditional silos of

academic medicine because patient-centered holistic care is what we all want, and what will help drive improved health for patients of all gender, race and ethnicities, and also, to help us drive value because the money that we spent on healthcare in this country is really not sustainable when we look at the cost of healthcare. It's crazy and we as patients understand that when we get a bill with our out-of-pocket expenses and copays. So, I firmly believe that we have a lot of passion in medicine and we're very motivated to make healthcare better for patients. People became physicians or nurses or physical therapists to serve patients and we need to harness that passion, motivation to solve healthcare. We can do it I think better than having change imposed on us by people that really are not in this space.

Bill: So, you're talking about the policymakers and the people who are making decisions?

Mary: Yes, I'm talking about the policymakers.

Bill: You're talking Medicare, commercial insurance…?

Mary: Well, everybody. I mean the challenge is that the people that pay for healthcare are insurance companies or the government, and individuals don't really, pay for healthcare. So, we have a lot of areas of disconnect

where people are not aligned. It's different when you go and buy something, when you go and buy a new TV or something. You shop for it, you know what the prices are, you know what the features are, and you can make a different kind of decision. In medicine, it's very difficult to understand even price transparency with what a procedure or a doctor's visit or medicine is going to cost you, and where that further impacts outcomes for patients are in those patients that already have challenges accessing the system and challenges with out-of-pocket expenses.

Bill: So, that gets us kind of to this issue of health disparities. What does health disparities mean to you, as a physician, as an orthopedic surgeon, when somebody says, we have to eliminate health disparities, can you kind of translate? How does that translate and what does that mean for me, as a patient?

Mary: I think of health disparities in pretty simple terms. It means that patients are getting different care because of their race, gender or ethnicity or, in some cases, their economic means, and fundamentally, I believe that's wrong. I mean, I believe that's morally wrong. Right? We shouldn't be discriminating against people, in terms of the type of medical care we provide or recommendations that we make as physicians, based on their gender or the color of their skin.

Bill: But if you look at payment policy, as an example, and you go in and you look at a particular surgical procedure and Medicare says, we're going to pay the doctor "X" amount of money. It doesn't say we'll pay you "X" amount of money if the patient is black versus "Y" amount of money if the patient is white. It doesn't say that, we're going to pay "X" amount if it's a male versus "Y" amount if it's a female or if you live in a city. So, payment policy is colorblind, right? It doesn't make that distinction but, yet, what you're suggesting is that somehow that is built into the system.

Mary: So, it would be fabulous if our payment policies towards hospitals and physicians and healthcare providers was like Lady Justice, right; colorblind, genderblind, but the reality is, is that it's not. And the reason, even though, as you stated, the regulations and the policies don't say I'm going to get paid more for operating on this white Caucasian male as opposed to an African American female, there are more nuanced barriers that make me, as a physician based on certain payment policies, less likely to provide care to that woman or that individual of color. So, let me just backup because I think it's important for the listeners to try and understand this. The way that things have evolved from a healthcare, policy, payment standpoint is the following. At a very high level, everyone recognizes we're paying too much for healthcare and we're not getting the clinical outcome and results that we all want. So, we're spending a lot of money, and we're not, necessarily, getting the quality care. So, the efforts

have been focused on, how can we drive value, better outcomes at lower cost? That is absolutely the correct concept. What has happened in the current payment models is that people did not take into account that all patients are not equal, and because the patients aren't equal, the policy ends up creating disparities.

Bill: Why does that matter to you, as a physician? How does it impact you, as a physician? One of the things, for example, I've heard is that some of the new models are going to be outcomes based, and that, how a particular patient does is going to dictate how much or how little you get paid. So, does that affect you as a surgeon and the kinds of patients you're willing to try and provide care to?

Mary: Absolutely. Well, we would hope that it wouldn't, but we know that it does. I'm going to just take you through a little brief example. Medicare, the government has moved towards the concept of what we call bundled payments, which says, the government says to a hospital, I'm going to pay you, hospital, "X" amount of dollars for this patient, this Medicare beneficiary to have knee replacement surgery, and that amount of money is for the time the patient goes into the hospital until 90 days after the surgery. Actually, it's a couple of days before the patient goes into the hospital and for 90 days after. Now, if you spend less money, if the medical resources spent on taking care of that patient, in the hospital, and

for the physical therapy afterwards, and all that care, is less than the target, their savings, and we're willing to share some of the savings with you. If the care cost more, then, you may be paying part of a penalty. So, automatically, that sets up a financial incentive for hospitals to become more efficient in the delivery of healthcare because everyone wants to lower costs, so that they can have some of the savings. Okay, that's conceptually a good idea. The problem is that, then, if there's a patient who you know is going to require more medical resources, which means they're going to generate higher levels of costs in spending, then, there's this perverse incentive to not offer them the care because I know that they're going to cost more. I'm going to put this in very simple terms. Let's say I have two patients. They're both 68 years old. One is a healthy, Caucasian male. He lives in the suburbs. He's got his wife who is home with him. She can help take care of him after surgery. He's got all kinds of support. He's going to be able to come in, maybe even, if he's healthy enough have same day surgery or maybe stay one night in the hospital. He's going to be discharged to home. He doesn't need to go to a skilled nursing facility. I might even be able to sign him up for an innovative tele-rehab program, which is further going to reduce my post-discharge costs. He's going to do great. He's got lots of support. His wife is there to help take care of him at home. Contrast that with a 68-year-old, African American woman who is obese. She doesn't have a spouse. She doesn't have a husband to help take care of her. She may have children

who are around and, of course, they want to help, but they may not be in the same financial position to help. She's diabetic. She's got high blood pressure. She's obese. She's fundamentally, from a medical standpoint, at higher risk of a complication. She's going to stay in the hospital longer because she's sicker. She's going to need, potentially, to go to a skilled nursing facility, after discharge from the hospital because she doesn't have enough support at home to help her. So, the cost for that 90-day episode of care is going to greater for her than it is for the healthy, white male.

Bill: So, there's no way to risk adjust? I think that's the term that we hear this with regard to health plans. Insurance companies have argued that well, if we're going to take on sicker patients, patients with a lot of medical problems or other issues, then, we need to be paid more in the way of insurance premiums, and so, we do a process called risk adjusting to account for that. So, you're saying that there's no similar kind of thing that's occurring when the physicians are put at financial risk and we don't risk adjust for any of those factors for you, as a surgeon.

Mary: That's correct. Currently, we're not risk adjusting and that's the challenge that lays before us, right now, is that if we're going to improve health equity, we have to figure out how to appropriately risk adjust patients and reflect that in the payment models to hospitals and physicians. Otherwise,

we see what currently happens. I know of orthopedic surgeons in our region that are fundamentally good people, but if they have a patient whose BMI is 38 or 40.

Bill: What's a BMI?

Mary: Body Mass Index, so obese. Obese patients, particularly, if they have other risk factors like diabetes and hypertension. Then, they say, "I'm sorry. I can't do your joint replacement surgery. You have to go lose weight and get healthier or go down the road and see Dr. O'Connor in New Haven, at the Tertiary Referral Center." So, we see a lot of cherry-picking and lemon dropping. Those are the terms that we use. Some hospitals and some surgeons and providers are going to cherry-pick and say, "I'm going to take care of that healthy patient. They're easier. There's less risk. My financial risk is significantly less. The more complicated, sicker patient, I'm going to send someplace else." So, that's a challenge for that patient, but the sicker patient, oftentimes, those patients have less income. It's even harder for them to travel to a tertiary referral center. So, it really makes the barrier for those patients getting the care that they need even higher. It's just even harder for them, and we need to help those patients be healthier and improve the quality of their lives and not become more disabled.

Bill: We're familiar and we hear it a lot with regard to medical conditions, risk adjusting, but another term that I hear used in a context are what are called social determinants of health. We all understand diabetes, arthritis, obesity and, even if we're not a doctor or a clinician, we know them, we know somebody who has it. Can you talk a little bit about what are social determinants of health and how they're different from medical determinants of health, so that being obese may complicate things from a medical standpoint because of the obesity, but what are social determinants of health and how might they impact an outcome?

Mary: Several years ago, when I was still working at Mayo Clinic, I had a patient and she was heavy. She had knee pain. She was pretty young. She was only in her mid-30's. Probably that was her age, when I first saw her, and I was worried about her because she wasn't on the right path. Right? She needs to lose weight, to take better care of herself, or her knees were going to get progressively arthritic. And so, one of the early conversations I had with her was could she just increase her activity level by taking a walk in the evening, after dinner, something like that. And she said to me, "You know, Dr. O'Connor, people don't walk in my neighborhood." And I said, "Well, why is that?" And she said, "There are drug dealers. There are shootings." And, I was so taken aback because, of course, that's not the neighborhood where I am. I knew it. I mean, intellectually, I know there are neighborhoods that are unsafe, but, now, I'm sitting across from

a patient of mine and she's telling me that that's the neighborhood where she lives. So, she doesn't have the ability to go out and walk and increase her level of physical activity, as I do. That's a social determinant of health.

Bill: So, they say the first step in trying to solve a problem is recognizing that it's a problem and kind of what we've been talking about is recognizing that we have a problem. So, then, the next step is what do we do to fix it? And, I understand that Movement Is Life has been working with some folks in the Congress to try and fix that. Can you talk a little bit about what Movement Is Life is doing in that area, and what you're hoping to accomplish?

Mary: So, Bill, we've been very engaged in the, I call it the, "Policy Space." As you know, we've been very fortunate, blessed that Congressman John Lewis is very receptive and enthusiastic about our vision of health equity and he's introduced a bill in Congress to help address the gap in the current policies related to exacerbation of health disparities. In other words, he's saying, if Medicare is going to introduce a payment policy, it needs to be crosschecked that it's not going to exacerbate disparities, that the application of that payment model will provide the same opportunities for women, as well as, individuals of color to receive healthcare.

Bill: I'm familiar with that bill. I think it's called the Equality in Medicare and Medicaid Treatment Act. It was really, interesting when I looked at that legislation and some of the underlying changes it wanted to make, and kind of gets to a point you were making earlier that Medicare is doing these alternative, these innovative payment models, and there's only two things that they need to look at, in order to determine whether or not the government wants to move ahead. Does it save money and does it improve quality, which are great things, but I think what you've been touching on is another aspect of that that the bill tries to get at, which is if we're going to evaluate quality, for example, we can look at the patients who get the surgery and say, "Hey, you had a great outcome," but what we don't know is who's not getting the surgery. Who's not getting into the hospital. Who's not getting the treatment who's sitting at home suffering in pain that could be alleviated but maybe they're not a good candidate.

Mary: So, we have data, now, from hospitals in terms of the patients that they're carrying for, when they're in a bundled payment model versus a hospital that's not in a bundle payment model, and how the profile of patients has changed over time.

Bill: And that bundled payment that's what you were talking about earlier?

Mary: For the hip and knee replacement.

Bill: Where from a couple of days before to 90 days after you're getting a bundle. They're bundling all those monies together and they're saying, here's "X" amount of dollars to cover all the care that's going to occur during that time period.

Mary: Correct. And what we see is hospitals that are being paid in this bundled payment model, the complexity of the patients that are getting surgery in that hospital has changed. That they're trending towards healthier patients. So, this, again, the terminology we use is cherry-picking. So, we are seeing changes in the behavior. So, when, exactly to your point, CMS looks and says, how is this bundled payment performing? Oh, great, we're lowering costs. That's great. We're driving quality. That's great. But because the original legislation did not take into account health equity, the blind spot that's occurred is that these bundled payment models are driving increased disparities because the sicker patient, the higher risk patient, which tends to be a woman or an African American or Hispanic/Latina tends to be the higher risk patient. Why? Because obesity is so much more prevalent in those groups, as well as, diabetes, hypertension, heart disease and what's often underappreciated is depression, another very important factor.

Bill: I think a lot of us, and maybe this is just my bias as a white male, but I can get and understand where health disparities can occur based on an individuals race and ethnicity, but there's clearly, the data shows there's this gender distinction between men and women, and I think that always made me find it even more interesting. Can you talk a little bit about the fact that their disparities, as it relates to women regardless of the color and distinctions between men and women when it comes to some of these policy decisions?

Mary: Yes, I'm delighted to speak about a topic near and dear to my heart because, as an orthopedic surgeon, as a woman, and as someone who does a lot of joint replacements, I will see women that come in, and they have seen prior orthopedic surgeons and I think, probably the easiest way to put it is, their symptoms haven't been taken seriously. Now, I have a lot of wonderful male orthopedic surgeons. I practice with male colleagues. They take care of my patients when I'm out of town. They've operated on me and my family members. I trust them. This is not anyone consciously trying to say, "I'm not going to treat the woman equitably compared to the men." There's a lot of unconscious bias that we have as members of our society that result in us treating women differently than men. We don't believe women when they say they're in the level of pain that they are. We are socialized, we're conditioned to think that the woman is exaggerating her level of pain compared to the man. That's one factor.

The second is there's different communication styles. Women tend to be much more narrative. Men are much more factual. If the person that you're seeing, the doctor that you're seeing who's making the decision on whether he or she thinks you should have an operation is a man, and you, the patient, are a woman, you have inherently a difference in communication style. I know, individual, there can be some variation but, nonetheless, when people study this, there's men speak differently than women. There're communication differences. So, that is also a factor that creates disparities in treatment recommendations. There's a fascinating study done by my friend in Canada, a woman named Cory Borkhoff, and she sent to groups of patients out to different physicians in Canada. There was a man and a woman that had severe knee osteoarthritis, and she sent them out to a bunch of physicians to see if the doctors would recommend knee replacement surgery. Everybody was telling those patients, irregardless whether it was the man or the woman, they needed surgery. She sent another team, a man and a woman with moderate knee arthritis and these were what we call standardized patients. In other words, they were trained up to have the same symptoms, the same story, the same kind of x-ray findings. When she sent those patients out, the primary care physician was two times more likely to tell the male patient that he should think about having knee replacement surgery. That the recommendation should be knee replacement surgery compared to the woman patient. When those two patients saw orthopedic surgeons, so,

they saw the same orthopedic surgeons, the orthopedic surgeons were, this is startling, so, get ready, 22 times more likely to tell that man that they recommended knee replacement surgery than that woman. Yes, wow is right. Now, the limitation of that study, it was just one man and one woman. Okay, but, nonetheless, what that tells me, as a physician is that there's a lot of bias that we bring to the table when we're interacting with patients because in that scenario, where the patients had moderate arthritis and the judgment that I, as the surgeon, bring into the conversation with the patient about whether they should have surgery or not, is significant. So, in that scenario, most of the orthopedic surgeons thought, "That man is worse. That man is worse and he's ready for surgery. But that woman, she's just not bad enough for surgery, right now. When, in fact, they gave the same level of pain, the same functional limitations, they were standardized. So, it shows the power of our unconscious mind and how we, as physicians, interact with our patients.

Bill: Those type of Secret Shopper kinds of studies are really fascinating. Do you know did they go back and talk to the surgeons and to the primary care docs to share with them the findings and say, "Hey, were you even aware of this that you were 22 times more likely to recommend surgery?"

Mary: Well, I know the findings were shared. I think it's very difficult, on an individual basis. People don't want to believe.

Bill: They don't want to acknowledge their own.

Mary: Well, it's hard because I really, truly believe that physicians are people that are trained to serve their patients and 99.99% of doctors want to do what's right for their patient and it's hard for us to accept that maybe we're not treating everyone fairly or equally, but, the reality is that we don't. And, we need to learn how to do that better. We need to develop shared decision-making tools, so that some of our bias is removed. For example, in a shared decision-making tool model, there would be more data points. You can think of it, let's just say there's a certain threshold and if the patient scores in this shared decision-making tool, at a certain level, then, I, as the orthopedic surgeon, should know. I should be having a conversation with this patient about whether surgery should be considered. Now, that doesn't mean the patient's going to have an operation, but it means that I'm created that space to say, "Let's at least talk about it."

Bill: So, you mentioned that as a woman, you had some particular interest in this, and looking at the data, as a woman in orthopedic surgery, you're in the minority within your profession. I noticed in looking at your bio, there are a lot of firsts in terms of some of the different organizations and things that you've done. Is that what kind of drove you to get into the health

disparities space? I mean, you know, obviously, you're at Yale. You're very successful. You're well respected in your field. What made you want to kind of get into this health disparities issue?

Mary: My practice, prior to Yale, was at Mayo Clinic – Florida and my population there was primarily Caucasian, but I saw a lot of gender disparities.

Bill: That woman you were talking about.

Mary: The woman that I was talking about, well, she happened to be African American, but I would see a lot of Caucasian women that would come to me having seen other orthopedic surgeons and I would say, "Why have you not already had joint replacement surgery?" When your knee is so bad and you're miserable, why haven't you had, what I would consider, appropriate and timely care? The story, there were various reasons. People would often say, "Well, the woman didn't want to do it. She was putting it off. She was taking care of her family." All these other social issues and sometimes those are valid, but, a lot of the time, it was that the female patient didn't feel that the surgeon wanted to operate on her. So, there's these all kinds of messages that we give with body language. The other thing is obesity. You know, women are more obese than men and I can tell you that orthopedic surgeons prefer to operate on skinny patients, normal weight patients, than, obese patients. It is physically harder. I've

had my rotator cuff repaired. Surgery is a physical, physically demanding profession and it's physically harder, more demanding and the risks are higher. You're more concerned with that obese patient. Are they going to have delayed wound healing? Are they going to rehab well? They're going to be at higher risk of blood clot because they just aren't getting up and moving around as quickly, as well or as well. So, everything ratchets up in the obese patient. And so, part of I think what I worked on, in terms of my own bias, and that of my team was that I wouldn't let anyone say the patient was fat. Like we just didn't do that. Now, having said that there's some patients where they're just so obese, they're superobese and you say, oh, my god, the medical risks of operating on you are just so high, and I know the surgery would benefit you, but I'm just afraid that you're going to have a really, bad complication afterwards and we need to try and get you healthier before we can do your knee replacement surgery. The challenge there is, guess what, that woman knows she's superobese. She's known that for years. She didn't become superobese overnight. So, she's probably struggled with her weight her entire life. She's depressed. She hasn't been able to get into any kind of effective weight management program and, now, she can't walk. She can't walk because her knees are shot. She has horrible arthritis. Now, you're in a jam and that's what orthopedic surgeons face everyday and they face it disproportionately with women and individuals of color. So, we see that that inherently creates conflict in the mind of the orthopedic surgeon. Is the patient so sick that I

shouldn't operate on them or should I operate on them knowing that the surgery is going to help them with their knee pain, but there's this risk to benefit analysis. Now, layer on top of that, the new complexity of bundled payments and this, kind of, disincentive to operate on patients who are medically more complex, and we see an exacerbation of existing disparities.

Bill: So, if you had to look through a crystal ball and kind of say five years out, what would you like to see as a matter of policy where we would have addressed those? Are you optimistic that these issues are going to get addressed? Are you seeing more recognition of the reality of health disparities and more recognition in the policy space or where you're working that people are going, yeah, you're right, we do have to address it, or is there still a lot of education that they're people out there who just don't believe that we have a health disparities problem?

Mary: Well, that was a lot, Bill. I'll try and take it. I'll unpack that. I often speak, as you know, about health disparities across the nation and one of the things I have to say, one of the things I almost always say is health disparities are real. First of all, you have to get people to acknowledge that they're real because we don't want to believe that they're real, but the reality is health disparities are real and they're impacting patients every day and their families and our communities. If we want to look at how

we're going to improve the health of our nation, we have to address disparities. The impact is even more significant, as we recognize the changing demographics of the nation. So, the Caucasian majority will cease in projected around 2044 or so. We are a nation that is becoming increasingly, racially and ethnically diverse. So, what that means is if there are medical conditions that disproportionately impact communities of color, in other words, if they're heavier, if they're sicker because they get more diabetes and more hypertension and more heart disease, that's a concern. That means that the whole nation because sicker. So, we have to start addressing the overall health of the country and we have to focus on how are we going to improve the health of various communities and by the communities I mean women, regardless of your racial and ethnic background, because women have much higher rates of obesity and communities of color where we see higher obesity, hypertension, diabetes. I think we have no alternative. We have to do this. We have to address obesity and fundamentally, we have to address movement and that's why our team, our Caucus is named Movement Is Life because we understand that movement is the key. It is the central element that impacts all these other health issues. If you're moving, you're healthier. If you're moving, you're less likely to be obese. You're going to have lower blood pressure. It's going to help control your blood sugar. It's going to help you not be depressed. So, we have to simply embrace movement, and what I'd like to see is policies on the healthcare side that get

embraced, across all segments of society, where we are enhancing physical activity. You know, we have taken physical activity out of schools, for example. When I was a kid, we had gym every day. It didn't matter that you didn't like it. You had to go to gym. Now, we don't have that in schools and we're seeing this epidemic rise in childhood obesity. It breaks my heart. It's, really, seriously, troublesome for us.

Bill: As the father of an elementary school physical education teacher, I wholeheartedly agree. In his school, the kids get maybe 30 minutes, every other day of activity, and just, at least, it's not eliminated. You're right. I remember, when I was in elementary school, junior high, senior high, it was an integral part of the educational environment. So, I think you're right. It is contributing to some of the things we're seeing today. I want to thank Dr. Mary O'Connor for being with us here, today, on our health disparities podcast for Movement Is Life. Dr. O'Connor, as she said, is at Yale University. She did her undergraduate work at Yale and she got her medical degree at Drexel University and she did her orthopedic residency at the Mayo Clinic. Just for our audience, Dr. O'Connor was the first woman accepted into the Musculoskeletal Tumor Society. She was the first woman elected president of that society, and she was the first woman member of the American Association of Hip and Knee Surgeons, and the first director of the Center for Musculoskeletal Care at Yale University and she also chairs the Women Health Issues

Committee of the American Association of Orthopedic Surgery. So, quite an accomplished career and that's not even going into some of the things you've accomplished in your life outside of medicine. Want to thank you for being with us today and appreciate all of the insight and perspective you've been able to provide us.

Mary: Thank you, Bill.

(End of Podcast)