Setting Yourself Up for Success in Neuropsychology

Business Strategies for Neuropsychology in the Context of a Changing Healthcare Market

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Learning Objectives

As a result of attending this presentation, participants will be able to:

- Discuss implications of changes in health reform legislation on maintaining a high-quality professional neuropsychology practice.

- Evaluate the strengths and weaknesses of neuropsychology business models and develop a strategies for change/improvement.

- Identify strategies to improve chances of success in the practice of neuropsychology.

- Use the information to thrive in the field of neuropsychology by taking a proactive role in promoting individual careers and the field of neuropsychology.
Here is the conversation with a former student that led to this presentation...
HEALTHCARE IN THE U.S.

A Brief Look at Where We Have Been, Where We Are, and Where We Are Going
“Demography, Economy, Technology”

- First Curve
  - Established way
  - Current $$
  - Slowing in long run
  - *Fee for Service*

- Second Curve
  - Radically new way
  - Source of future $$
  - Explosive in long run with long tail
  - *Fee for Health*

*Ian Morrison, Healthcare Economist/Futurist (1996)*
Private vs. Government Share of Health Expenditures

- Private: Businesses and Households
- Government

1987:
- 68%
- 32%

2010:
- 55%
- 45%

Figure V

U.S. Health Care Spending

- Government: 45%
- Private Insurers/Employers: 42%
- Out-of-Pocket: 13%

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

(1) Includes Medicaid Disproportionate Share payments.
International Comparison of Spending on Health, 1980–2008

Average spending on health per capita ($US PPP)

- United States
- Norway
- Switzerland
- Canada
- Netherlands
- Germany
- France
- Denmark
- Australia
- Sweden
- United Kingdom
- New Zealand

Total expenditures on health as percent of GDP

- United States
- France
- Switzerland
- Germany
- Canada
- Netherlands
- New Zealand
- Denmark
- Sweden
- United Kingdom
- Norway
- Australia

Source: OECD Health Data 2010 (June 2010).
### Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>1.00-2.33</th>
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<th>OVERALL RANKING (2010)</th>
<th>AUS</th>
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<td>Safe Care</td>
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<tr>
<td>Health Expenditures/Capita, 2007</td>
<td>$3,357</td>
<td>$3,895</td>
<td>$3,588</td>
<td>$3,837$*</td>
<td>$2,454</td>
<td>$2,992</td>
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Note: * Estimate. Expenditures shown in US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).


Number of Medicare Beneficiaries Soars Beginning in 2010

Source: HCFA, 2000; Census Bureau 2001
Federal Spending Under CBO’s Alternative Fiscal Scenario
(assumes likely changes in legislation)
Sources of Growth in Projected Spending on Medicare and Medicaid

Percentage of GDP

- Effect of Excess Cost Growth
- Interaction of Aging and Excess Cost Growth
- Effect of Aging of Population
How the current/prior system “works”...

- Providers are paid for procedures that are completed not the outcome
- Poorer outcomes and high risk patients can in essence improve profits (additional follow up care)
- In some cases, providers with less experience often get paid more per case
Pay by Procedure Vs. Pay By Hour
Is the current system sustainable?

- Inflation rate in healthcare is tremendous
- Despite the fact that U.S. has the highest per capita healthcare expenditures in the world, it was estimated that there are 50 million uninsured Americans (somewhat inflated number to be discussed later)
- 53% of all bankruptcies reportedly due to medical expenditures
- Uninsured cannot be turned away from ER resulting in a cost $62 billion in 2009
- This lost revenue along with lower reimbursements results in a “cost shift”, raising fees for others to cover the costs of the uninsured
Is the current system sustainable?

- Obvious gaps in quality and desired outcome
- Soaring costs with decreasing efficiency, quality, and outcome highlighted the need for change
- Multiple attempts for change over the years, with little success – largely due to political factors (on both sides)
- “Transformation” was suggested, and ultimately passed...
  - Patient Protection and Affordable Care Act was signed into law in 2010 after a very long political battle
    - Do the ends justify the means?
    - Is the new system sustainable?
    - Can it actually be implemented?
    - Lots of expert opinions, but ultimately time will tell.....
■ Purported to extend coverage to 32 million individuals
■ Expanded Medicaid eligibility, insurance reforms, and an individual insurance mandate
■ Key cost savings provisions implemented 2012, 2013, 2014, 2015, and beyond
■ Streamline Bureaucracy (?!?!)

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
1,968 New and Expanded HHS Secretarial Powers In the Health Reform Law

- Title I: Health Insurance Coverage
- Title II: Government Programs
- Title III: Health Care Delivery
- Title IV: Chronic Disease and Public Health
- Title V: Health Care Workforce
- Title VI: Transparency and Program Integrity
- Title VII: Access to Medical Therapies
- Title VIII: Long-Term Care CLASS Act
- Title IX: Revenue Provisions
- Title X: Medicaid, CHIP, Women’s Health, Indian Health Care and Education Affordability Reconciliation Act
Implementation Time Line

- Changes are gradual and extend beyond 2017...
Implementation – the best laid plans…

- Health reform is a dynamic process

- Continual changes scheduled on the basis of the law – Be prepared!

- Continual changes to the changes

- Be Knowledgeable and Be Prepared!!!!!!

- Look for facts - not just what you agree with.
Implementation – the best laid plans…

- Continual changes to the changes
  - PPACA has already been amended on several occasions
  - Past and current and future litigation
    - SCOTUS rulings have not settled the issues and may actually have complicated them further
  - Exclusions and rule changes as it has been implemented
  - Ongoing government shutdown/debt ceiling battles
  - Societal changes
  - Economic realities
  - Political changes (November(s); HHS Sec’y Power)
  - States and Medicaid Expansion
  - Others
Proposed Implications of Health Reform

ACCESS and QUALITY while COST

1. Negative sum outcomes-focused reimbursement (Darwinian Economics)
2. Decreased inpatient revenue will drive operational efficiency redesign
3. Bundled payments across extended (acute to post-acute and outpatient) care episodes
4. Rewards primary care focus on population health and chronic disease management
Proposed Implications of Health Reform

5. Total cost management supplants fee for service incentives (“fee for health”)

6. Providers will maintain tighter and fewer affiliations across delivery system

7. Focus on functional vertical integration between systems and physicians

8. Information technology-driven care as a competitive differentiator

*Health Care Advisory Board (www.advisory.com)*
Further Implications

9. Principle of Insurance
   - Wealthy Pay for the Poor
   - Young Pay for the Old
   - Healthy Pay for the Sick
   - Non-Utilizers Pay for the Utilizers
   - Low Performers Pay for High Performers (VBP)

10. Technology, evidence, incentives, and transparency will wring out waste

11. Personal responsibility for health behaviors?
    - More changes on the political horizon (e.g., state and federal laws regarding sodas, trans fats, smoking, etc)?
PPACA Spring Loads Broad Implementation of New Payment Models

Episodic Costs

- Prospective Payment System
- Pay-for-Performance
- Hospital-Physician Bundling
- Episodic Bundling
- Shared Savings Model/ACO
- Capitation

Total costs

Provider Cost Accountability
Payment Models

- Shared Cost Savings
  - Budget provided for the year based on the number of patients seen

- Bundled Payments
  - Fixed payment amount per episode of care
    - Can be across the continuum of care for the event
  - ACO’s can bill for multiple episodes

- Global Payment/Capitation
  - Payment is per patient per month to cover all care regardless of the number of episodes/events
Global Payment Systems and Capitation

- Initially implemented in the 1990’s (HMO’s) but fell out of favor due to the lack of choice and access associated with such payment arrangements, difficulties with risk management, and limited infrastructure to handle this system.

- The idea is that doctors and hospitals would no longer be paid for each individual service they provide (Fee for Service).

- Instead, they would have a yearly budget for the care of their patients (Fee for Health).

- Hence, it will be in the organization’s best interest to keep patients healthy and out of the hospital.

- The danger is that responsibility for deciding level of care and necessary diagnostics are in the hands of the provider organizations (rather than the doctors) hands.
Global Payment Systems and Capitation

Results in:
- Increased opportunity to control spending
- Shared savings if spending is below the pre-specified budget
- Shared accountability for deficits if spending exceeds the budget
  - This downside risk helps control spending by providers
- Two-sided system in terms of risk rather than one
Hospital Value Based Purchasing

- 1% of Medicare payment withheld (grows to 2% by FY2017)
- Hospitals may earn back all or part of “withhold”
  - If performance percentile ranks are high
  - If performance improves
- Two performance areas:
  - Clinical outcomes (Medicare core measures)
  - Medicare IP satisfaction (HCHAPS scores)
- Low performers pay for high performers
- Timeline:
  - 7/2011 – 3/2012 = Performance period
  - 7/2013 - Beyond = VBP Payment period
VBP: Proposed Quality Measures

- 17 Process of care measures (70% weight)
  - 3 Heart Attack (AMI)
  - 3 Heart Failure (CHF)
  - 4 Pneumonia (PN)
  - 7 Surgical Care (SCIP)

- 8 Customer Satisfaction Domains (HCAHPS) (30% weight)
P4P/Value Based Purchasing

CM/S/Premier HQID Project Participants Composite Quality Score: Trend of Quarterly Median (5th Decile) by Clinical Focus Area. October 1, 2003 - June 30, 2007 (Year 1 and 2 Final Data; Year 3 and 4 Preliminary Data).
Hospital Level Mortality Trend Emerges Over 3 Years

Median Severity Adjusted Mortality from October 2003 – September 2006

AMI Patients
(10,000 cases per qtr +/- 2,600)

N of hospitals = 260 +/- 12

Pneumonia Patients
(84,000 cases per qtr +/- 18,000)

N of hospitals = 260 +/- 10

Heart Failure Patients
(27,600 cases per qtr +/- 6,000)

N of hospitals = 260 +/- 10

CABG Patients
(8,200 cases per qtr +/- 1,760)

N of hospitals = 180 +/- 6

Statistical Significance: Mortality - AMI (p<0.001), HF (p<0.001), PN (p<0.001), CABG (p<0.01).

HQI based on 3M APR-DRG severity adjustment.

Hip and knee replacements had insufficient mortalities for analysis.

Transforming Healthcare Together
Hospital Level Cost Trend Emerges Over 3 Years

Median Severity Adjusted Cost per Case from October 2003 – September 2006

- **AMI Patients**
  - 18,000 cases per qtr +/- 2,800
  - No of hospitals = 222 +/- 4

- **Knee Replacement Patients**
  - 7,000 cases per qtr +/- 860
  - No of hospitals = 191 +/- 7

- **Pneumonia Patients**
  - 84,000 cases per qtr +/- 13,000
  - No of hospitals = 268 +/- 10

- **Heart Failure Patients**
  - 27,600 cases per qtr +/- 6,000
  - No of hospitals = 268 +/- 10

- **Hip Replacement Patients**
  - 8,150 cases per qtr +/- 860
  - No of hospitals = 146 +/- 8

- **CABG Patients**
  - 3,800 cases per qtr +/- 1,760
  - No of hospitals = 130 +/- 6

Statistical Significance: Cost – AMI (p<0.01), HF (p<0.001), FN (p<0.05).

PREMIER
Transforming Healthcare Together

13
CHANGES IN CLINICAL AND RESEARCH ACTIVITIES UNDER THE PPACA
Important ACA Changes with Implications for Research & Clinical Practice

- ACA will fund comparative effectiveness research that compares different interventions and strategies to prevent, diagnose, treat, and monitor health conditions through the Patient-Centered Outcomes Research Institute (PCORI) – www.pcori.org

- Who is interested in this information?

- How does affect clinical practice and reimbursement?
Independent Payment Advisory Board (IPAB)

- 15 member government agency that was supposed to be created in 2010

- Members appointed by the president, confirmed by the senate, and serve six year terms (staggered)

- Charged with achieving savings *without* affecting coverage or quality

- New power relative to old system
Independent Payment Advisory Board (IPAB)

- Previously, MEDPAC made recommendations regarding payment rates and program rules that required ratification by an act of Congress
  - Congress regularly overruled MEDPAC recs

- IPAB “proposals” about changes to Medicare payments are automatically implemented without congressional approval
  - Congress is able to overrule the changes only through a supermajority vote

- Think about issues like the SGR…
- Think about the current battles over the budget and debt ceiling…
Independent Payment Advisory Board (IPAB)

- Hence, IPAB is much smaller, but much more powerful than MEDPAC
  - IPAB shall not make any recommendations to ration health care, raise revenues or Medicare premiums, increase Medicare cost sharing, or otherwise restrict benefits or modify eligibility criteria
  - IPAB shall to the extent feasible... protect and improve Medicare beneficiaries’ access to necessary and evidence-based services.
  - It is not clear how this will affect the determinants of necessary versus unnecessary services and what defines evidence-based
  - This highlights the need for high quality outcomes based research to support clinical activities and to identify best practice evidence based clinical practice
THE NEW MODELS OF HEALTHCARE DELIVERY
THE NEW MODELS OF HEALTHCARE DELIVERY

Fee For Health Vs Fee For Service

- Patient-Centered Medical Home

- Accountable Care Organization (ACO)

- Alternative Quality Contract (ACQ)

- Global Payment Systems
A Thought Experiment Proposed
By Karen Postal, Ph.D., ABPP
Why do private insurers love ACO/Global Payment Model?

- Authorization
- Gate keeping
- Financial risk

Providers
Current common referral patterns

Private practice

Institutional setting

- Neurology
- Primary care
- Word of mouth

- Neurology
- Primary care
- Other specialists
PCP refers to neurologist

$ of You + neurologist + PCP

ACO

Neurologist refers to:

You.
PCP refers to another neurologist.

Neurologist refers to:

neurologist

PCP

ACO

Neurologist refers to:
PCP refers to:

Only $ of PCP

ACO
Your contribution

Reducing Costs

Improving quality measures
Fundamental shift in our professional identity

What is the diagnosis?

How can cognitive & psych data be used to improve health and reduce cost?
How many neuropsychologists…. 

- Treat medication non-compliance as a crisis?
- Utilize psychological and cognitive data to develop an action plan to address their major health issues?
  - Diabetes action plan: blood monitoring and diet
  - Heart disease action plan: exercise
  - Asthma management (often family systems intervention)
- Focus on recommendations and interventions as much as assessment
PCP refers to:

- PCP+
  Neuropsych
  Cost saving

- Neuro-psychology
Where Does Neuropsychology Need To Go From Here?
Solutions for Neuropsychology

- Expand service offerings outside of traditional neuropsychology roles
  - Intervention focus
  - 1 stop shop
  - Consider medico-legal aspects

- Identify new referral streams in a rational/strategic manner
  - Strategic Planning
  - SWOT Analysis
  - Marketing and Business Development
Determine your “theory of your business” and market yourself appropriately

- Low Cost Leader
- High Quality Differentiation
- Niche/Focus
- Morton’s vs McDonald’s
“Non-Traditional” Neuropsychology Opportunities?

- Pain Management
- Preparation for Invasive Procedures
- Pervasive Fatigue/Chronic Sleep Impairment
- Frustration With Pace of Rehabilitation/Recovery
- Factors Affecting Adherence/Medication Adherence
- Long-Term Acceptance of Residual Limitations
- Body Weight Management
- Activity Re-Integration/Fear Avoidance of Activity
- Anticipatory Anxiety/Post-Traumatic Stress
- Anger/Guilt/Survivor Remorse
- Vocational Rehabilitation
- Forensic/Legal Applications

Adapted from Van Dorsten, 2009
Some Rapidly Growing Areas of Outpatient Medicine

- Pain Medicine
- Primary Care
- Spinal Surgery
- Bariatric/Obesity
- Orthopedics/Surgery/Neurosurgery/Recovery
- Cancer
- Metabolic Disease (e.g. Diabetes, Arthritis)
- Cardiovascular Medicine

***Clear and Present Need for Neuropsychological and Psychological “Intervention” as well as Assessment

Adapted from Van Dorsten, 2009
Valuable Neuropsychology Contributions

- Individual and Group – Evidence Based Therapies
- Multi-Disciplinary Consultation/Collaboration
- Pre-Surgical Assessments
- Outcome Measure Development and Evaluation
- Psych/NPsych Testing with Medical Patient Norms
- “Normative Course” Prognostic Statements
- Defining Impact of Cognitive-Mood-Behavioral-Coping Factors on Treatment and Outcome Prognosis

Adapted from Van Dorsten, 2009
Some Questions to Answer

- What new referral sources could benefit from current clinical activities?
- What additional services would benefit our current referral sources?
- What are the plans for growth or decline in service areas within my institution?
- What new services might be needed in the geographic area in the future?
- What new professionals or specialty clinics are moving to the area and how can we best serve them?
- What “non-neuropsychology” clinical activities might enhance our overall clinical offerings?
- What political/social changes are on the horizon that may influence healthcare needs?
Solutions for Neuropsychology

- Identify and Develop a relationship with local ACO(s)
  - Better understand our *new* customer (MDs/systems)
- Learn how to effectively communicate how neuropsychological assessments will help lower costs and improve quality
- Move into administrative/leadership roles to maximize your impact in your setting
- Support APA Practice organization/advocacy groups for more favorable rules
- Remain active in local, state, regional, and national organizations to increase the volume of our voice
Solutions for Neuropsychology

- Reduce “total cost” of production
  - Live on Medicare rates (or less) by 2014 (too late?)
- Match supply with demand
- Cost Containment in Clinical Activities
  - Batteries, reports, testing practices, etc.
  - Consider integrating doctoral and mid-level providers onto care teams with differentiated roles and accountabilities
  - Consider care extenders - don’t compete to do same things that they can do cheaper
  - Use of psychometrists where applicable
    - More important under bundled payment systems
    - For current system – techs reduce payments so there needs to be additional volume to financially justify use
Solutions for Neuropsychology

- Use of office staff for high time/low professional requirement activities (e.g., billing, coding, pre-cert)
- EBM interventions for highest cost/poorer outcome diagnoses with highest rates of hospital readmission
- Doctoral psychologists as systems-level measurement scientists and performance improvement specialists
- Engage in EMR and technology initiatives (Outcomes Based Research & Office Processes)
  - Clinical data sharing, self-scheduling, productive use of wait time, behavioral self-monitoring
Outcomes Based Research

- Increased need for accountability
- Market-driven

Has resulted in need for:
  - Evidence for effectiveness
  - Consistency in outcomes
  - Need to meaningfully compare “outcomes” across services, conditions, literatures

There is increased need for consensus about outcomes: Across professions, services, and conditions
Advocacy Efforts

- Organizations
  - APA Practice Directorate
  - DIV 40 (e.g., PAIC, research grants pgm)
  - APA Division Federal Advocacy Coordinators
  - National Academy of Neuropsychology (e.g., LAAC/PAIC)
  - AACN (e.g., Outcomes research grants pgm)
  - ABN
  - State and Local Organizations
  - IOPC – all organizations participate
  - Others
Advocacy Efforts

■ Activities

- HONE In (Health Outcomes and Neuropsychology Efficacy INitiative)
- IOPC collaborative efforts to challenge Medicare LCD Transmittals in various regions
- Local and national advocacy efforts through the APA, Divisions, and State organizations
- Position papers on various topics
- Letters, calls, faxes, in-person meetings, and other activities
- Grant programs through NAN, AACN Foundation, Division 40, Division 22, etc funding outcomes based research
INTER ORGANIZATIONAL PRACTICE COMMITTEE
INTER ORGANIZATIONAL PRACTICE COMMITTEE

Neuropsychoogytoolkit.com
Advocacy Efforts

Learn More – Thanks to Laura Howe


- G. Goldstein, Advocacy for Neuropsychology in the Public Sector.

- G. Chelune, Evidence-Based Research and Practice in Clinical Neuropsychology.

- G.P. Prigatano, J. Morrone-Strupinsky, Advancing the Profession of Clinical Neuropsychology with Appropriate Outcome Studies and Demonstrated Clinical Skills.

- D. Cox, Board Certification in Professional Psychology: Promoting Competency and Consumer Protection.


- L.L.S. Howe, N. Pliskin, Advocacy Issue Conclusion.
Advocacy Efforts – Take Part!!!

- “A primary motivation to engage in advocacy should be found in the stark realization that most critical decisions that affect neuropsychological practice are made by non-neuropsychologists.” (Howe, et al., 2010)

- “It is not fair to ask of others what you are not willing to do yourself.” - Eleanor Roosevelt
Strategies For Success…
As a Student and ECNP

- Strong Education and Training
- Diversification of Experiences
- Full Service Provider
  - Not Test & Release or Diagnose & Adios
- Secure Stable Network Connections
  - Get Involved and Get To Know People
  - Find Mentors
- Research – Outcomes and Quality Based
Strategies For Success…
As a Student and ECNP

- Partnerships (in NP and outside of NP)
- Check Your Ego At The Door!
- Do what you love – Love what you do
- Understand Goodness of Fit
- Be Engaged and Satisfied
- Have Fun!!!!!!
Some Final Thoughts on the Future of Neuropsychology

It’s hard to make predictions, especially about the future.

-Yogi Berra
The future is here…
How prepared are you?
If you prepare well....