How to Succeed by Trying: Adapting to Change

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Health Care Organizations of the Future

- Accepting insurance risk
- Focus on population health
- Trimming organization costs
- Using the data being captured (e.g., electronic health records)
- Health care as retail business
Considerations

- Using population data
- Evolving service system (e.g., telehealth)
- Workforce: challenges to fill vacancies, and shifts to new uses of new categories
- Best use of local assets; including physical plant (the hospital)
Roll out Minnesota Institute for Clinical Systems Improvement

Recognize role of social determinants of health: socio-economic factors contribute 40% of different to population health, health behaviors 30% (calculations for MN)

Importance of community collaborations
How to Succeed with Collaboratives

- Use population data (County Health Rankings)
- Shared governance of resource use
- Methodology for sharing savings and re-investing
- Understand linkages between health outcomes and determinants – “patient responsibility”
Focus on center of excellence or pillar of excellence

Proving cost effectiveness, including ability to reduce costs

Engaging board of trustees and stakeholders
PCMH: Attributes to Achieve

- Improve access and communications using advanced access scheduling and e-mail communications
- Streamlining care coordination through integrated data systems
- Promoting active patient and family involvement
PCMH: Attributes to Achieve

- Adopt advanced clinical information systems to reduce errors and expand physicians’ access to critical information and guidelines
- Participate in revised payments systems for care coordination

Challenges Facing ACOs

- Inability to exchange information available in electronic health records
- Insufficient infrastructure, population dispersion
- Patient outmigration to other providers
- Difficulty establishing PCMHs
Challenges Facing ACOs

- Time lag between change in delivery and changes in payment
- Limited resources for care management
- Cultural changes among providers and administrators
Core components for effectiveness

- Commitment to providing care that places people at center of clinical decision making
  - This is a shift EVERYWHERE in the delivery of care, INCLUDING RURAL places/providers
  - Requires transparency, use of tools for shared decision making
  - Works only if everyone is confident it will work
Core components for effectiveness

- Patient-Centered Medical Homes
  - More than “usual source of care”
  - Is primary care, in all of its meaning
  - Probably not NCQA accredited in the beginning
- Population health and data management capabilities
  - Understand what population health is
  - Understand how to use the data
Core components for effectiveness

- Provider network that delivers high quality and reduced cost
  - Importance of primary care providers in the network
  - Other local collaborators
  - Regional care modeling
  - Continuous performance improvement
Core components for effectiveness

- An established ACO governance structure
  - Shared governance across the care continuum
  - Rules for acquiring and distributing resources, including shared savings

- Payer partnerships
  - Commercial payers
  - Self-insured plans
  - Medicare
  - Medicaid
Process for Change

- **Used by the Rural Health Systems Analysis and Technical Assistance project**
- **Inform**: create awareness of need for change
- **Assess**: strengths, needs, and capacity to build value
- **Prepare**: identify action based on organizational and community needs
- **Action**: change that creates value
And ...

- There are sources of help
- Glass is at least half full
- Positive attitude can be infectious
- And there is always retreating to the mountains
For Further Information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org