Importance of Transitions to Optimize Opportunities

- Changes are coming, under auspices of reform or otherwise
- Implement the changes in the context of what is desirable for rural communities
- How do we pull that off?
The Changing Landscape

- $$ must be squeezed out of current health care expenditures: 20+% of GDP by 2020 is not acceptable
- **Both** price and quantity of services must be reduced
- Changes will happen in the delivery system, fundamental not cosmetic
- For health systems, PRESSURE TO GROW AND SUSTAIN PATIENT VOLUME
Coincidental Presence of Models for Change (old and new)

- Prevention and population health
- Community well-being
- Bundled payment
- Value based purchasing
- Managed care organizations
- Accountable care organizations
Demands for service will shift

- Expansion of Medicaid enrollment with some federal help in paying providers, but limited
- Expansion of enrollment in the individual and small group markets
- CAN’T EXPECT CURRENT / HISTORIC APPROACHES TO DELIVERING AND FINANCING CARE TO RESPOND TO THIS SHIFT
Changes in Finance / Payment: Value based purchasing

- Inpatient payment to PPS hospitals effective October 1, 2012
- Will be developed for outpatient payment
- Demonstration project for CAH payment
- Value based modifiers for physician payment
Finance Change: Payer mix

- Decrease in uncompensated care
- Increase in covered lives (commercial health plans) and therefore “negotiated” prices
- Increase in Medicaid coverage and shift of that client base toward different payment schemes
- Non patient revenues subject to turns in the economy
The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance rural health care system informed by the needs of each unique rural community will lead to greater community health and well-being.
Should be: Foundations for Rural Health

- **Better Care**: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

Source: “Pursuing High Performance in Rural Health Care.” RUPRI Rural Futures Lab Foundation Paper No. 4.
http://ruralfutureslab.org/docs/Pursuing_High_Performance_in_Rural_Health_Care_010212.pdf
A High Performance Rural Health Care System Is

- **Affordable**: costs equitably shared
- **Accessible**: primary care readily accessible
- **Community-focused**: priority on wellness, personal responsibility, and public health
- **High-quality**: quality improvement a central focus
- **Patient-centered**: partnership between patient and health team
Central points from RUPRI Health Panel regarding change

- Preserve rural health system design flexibility: local access to public health, emergency medical, and primary care services
- Expand and transform primary care: PCMH as organizing framework, use of all primary care professionals in most efficient manner possible
Use health information to manage and coordinate care: records, registries

Deliver value in measurable way that can be basis for payment

Collaborate to integrate services

Strive for healthy communities
Innovate to accelerate pace of change

- In health care work force: community paramedics, community health workers, optimal use of all professionals, which requires rethinking delivery and payment models – implications for regulatory policy including conditions of participation
- In use of technology: providing clinical services through local providers linked by telehealth to providers in other places – E-emergency care, E-pharmacy, E-consult
- In use of technology: providing services directly to patients where they live
The future can be healthy people in healthy communities

- Through local providers linked to integrated systems of care
- Who, together with their patients, manage health conditions
- Not the same design everywhere, but the high quality, patient-centered everywhere
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)
Local Assets to Consider

- Raw material
- Data and information
- Connectivity
- Core capabilities, e.g., primary care
- Leadership
Recommendations

- Align with primary care doctors
- Ratchet all costs out
- Measure and improve quality
- Know your value proposition
Value = Quality + Experience

Cost

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

“Triple Aim”
- Better care
- Better health
- Lower cost
Unacceptable Healthcare

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation

- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Impact on budgets: public, business, family

- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.

- **Nobody agrees about what to do!**

Clear Vision
Principles for redesign (reliability, customization, access, coordination)
Teamwork
Leadership
Customer focus
Data analysis and action plans
Inclusive beyond health care system

Changes in delivery system: Patient-Centered Medical Homes (PCMH)

- Not your father’s “medical home”
- Potential future of primary care
- Emphasis on integrated services, management of chronic conditions, team-based, patient-centered care
Billings Clinic PCMH Development

- A building block toward accountable care: health home, population health data management
- Began in 2009 in 2 clinics (Western Montana Clinic and Billings Clinic)
- Now 12 physician groups (9 active as of 11/12), 242 MDs, 66 Midlevel
- 2012 BCBSMT program focuses on chronic diseases and preventative care
Billings Clinic PCMH Development

- Provider perspective
- Team model: improve access, re-energize profession
- “rules of the road” help: standards, framework for payment, quality metrics and reporting
- Investment and change: IT, FTEs, financial risk
Billings Clinic PCMH Development

- Payer perspectives
- Financial risk/commitment with need for ROI
- Assurances that practice is transforming: standards, quality reporting
- Patient perspectives: improved access, better outcomes, increased satisfaction

Changes in the delivery system: Accountable Care Organizations (ACO)

- Including Medicare Shared Savings Program (MSSP)
- Including Pioneer Demonstration from Centers for Medicare and Medicaid Innovation (CMMI)
- CMMI anticipates doubling in 2013
- And much more.....
32 Pioneer ACOs
116 MSSP ACOs
20 116 are Advanced Payment
318 total ACOs; in 48 states
21-31 million Americans receive care through ACOs
2.4 million in Medicare ACOs
15 million non-Medicare patients of Medicare ACOs
8 to 14 million patients of non-Medicare ACOs

http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf
People Live in Areas with ACOs Available

- In 19 states more than 50% of residents have access to ACOs
- In 12 states between 25% and 50% have access to ACOs (includes Montana)

Source:
http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf
ACO DISTRIBUTION BY STATE

County Medicare ACO Presence
Midwest Census Region

CMS-designated sites as of August, 2012.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.
County Medicare ACO Presence
Northeast Census Region

CMS-designated sites as of August, 2012.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.

Metropolitan/Non-metropolitan ACOs
- Metropolitan w/o ACO
- Metropolitan with ACO
- Met. ACO, unknown area
- Non-metropolitan w/o ACO
- Non-metropolitan with ACO
- Non-met. ACO, unknown area
Core Components of An ACO

- People-centered foundation
- Health home
- High-value provider network
- Population health and data management
- ACO leadership
- Payer partnership

The World According to Payers, 2016 and Beyond

- Revenue reduced for readmissions
- Must prove quality and cost to be part of network
- More patient shopping, even across rural hospitals
- By 2020 6% of Medicare payment tied to risk incentives: VBP, readmissions, hospital-acquired conditions
Transition Thinking

- Volume to value
- Group contract to patient service
- Care coordination across the continuum
- Patient centered care
- Lower costs
Continued

- From clinical care to health and health promotion
- From discharges to people enrolled in system and interactions with people
- Managing patients according to patient need across illness spectrum and continuum of care
Where do we want to be?

- Who do we serve?
- How do we provide best possible service?
- How do we get strategy and money to match mission?
Elements of excellence

- Patient-centered care
- Use of technology to provide optimal services
- Link to other care providers in continuum, being first source, transition source
- Core services as center of excellence
What We Can Do Now

- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership

- Educate Board, providers, and staff regarding performance
  - We are all “above average,” right?

- Consider self-pay and hospital employees first for care management
  - Direct care to low cost areas that provide equal (or better) quality
  - Reduces Medicare cost dilution
What We Can Do Now

- Negotiate with third party insurers to pay for quality (funds ACO infrastructure)
- Aggressively apply for value-based demonstrations and grants
- Begin implementing processes designed to improve value
- Move organizational structure from hospital-centric to patient/community-centric
- Assess potential affiliations
Collaboration and Value

- ACOs and other “programs” less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- Good medicine and good business
Concluding with reminders of reality

- Payment per event will moderate
- Tolerance for services of questionable use will diminish
- Systems will form and spread
- Multiple payers moving in similar directions, opportunities to influence should be captured and exploited
Pursuing Alternative Futures

- Organizations should pursue “first do no harm” but also alternative visions for the future.
- Health care systems active in reshaping delivery, with Triple Aim in mind.
- Dialogue has to lead to action.
Pursuing the possible

- When community objectives and payment and other policy align
- Community action is where policy and program streams can merge
- Community leadership a critical linchpin
- Pursuing a vision
For Further Information

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

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