Rural Hospital Strategies for a Value Based Future

2013 Annual Rural Health Conference
CSRHA
Sacramento, California
November 7, 2013

Agenda

- Rural Hospital Context
  - Transfer of Financial Risk
  - Redefine and Redesign
  - Toolbox for Value
Converging Forces

- Price reduction threats and volume reduction pressures
- Changes in payment policies and financing sources
- Continually evolving quality measures and expectations
- Alternative models of care (e.g., telehealth, different care sites, new providers types)
- Local health care collaborations and regional affiliations

Affordable Care Act (and More)

- New ACA emphases
  - Insurance coverage
  - Primary care
  - Financing innovation (incremental)
- Major ACA themes
  - Demand for health care value
  - Transfer of financial risk
  - Collaboration and competition
- Not just the ACA!
  - Macro economic forces will continue to drive health care reform
Value – IOM Six Aims

Health care should be:
- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable


The Triple Aim

Source: CMS/Centers for Medicare & Medicaid Services.
Value Equation

Value = Quality + Experience

Cost

Value = Quality + Experience

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

- Better patient care
- Improved community health
- Lower per capita cost

Unacceptable Healthcare Value

- Quality suboptimal
  - Wide geographic variation
- Cost unsustainable
  - Highest cost in the world
- Waste intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse
- Our volume-based payment system is a significant problem

“Successful” physicians and hospitals seek to maximize:
- Office visits per day
- Average daily inpatient census
- Admission percent from the ER
- Profitability

Is this how to identify and reward a great physician or a world-class hospital?

No, but what to do?

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You can always count on Americans to do the right thing – after they’ve tried everything else.

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police

Regardless of what we try, we tend to “follow the money”
Form Follows Finance

- How we deliver care is predicated on how we are paid for care
- Health care reform is changing both
- Fundamentally, reform involves a transfer of financial risk from payers to providers

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Risk Assessment is Ubiquitous

- Risk is present when an outcome is uncertain or unpredictable
- Types of health care risk
  - Random
  - Insurance
  - Political
  - Medical Care
- Where/how can hospitals:
  - Influence or control risk
  - Reduce risk of harm
  - Optimize risk of benefit

The Risk of Inertia

Because we’ve ALWAYS done it that way!

Source: Institute for HealthCare Improvement and Sharon Vitousek, MD
Random

- Normal variation
- Rolling the dice
- Roulette v. poker
- No control, but important to recognize

Insurance Risk

- Insurance risks
  - Demographic change
  - Technological innovations
  - Prior health status
  - Cost inflation
- Cost is the actuarial metric
- Minimal control, but predictable
**Political Risk**

- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues

**Medical Care Risk**

- Medical care variation
  - Diagnostic accuracy
  - Care plan implementation
  - Guideline use compliance
  - Pharmaceutical choice
  - Procedural skill
  - Efficient resource use
- How our choices influence health care **value**
- Greatest control, how we deliver care
Variation suggests a risk for underperformance, but also an opportunity to excel.

- Measure individual provider performance and discuss
  - Learn from one another
- Care should vary by unique patient needs, not by
  - Doctor or nurse
  - Day of week, or time of day
- Not cookbook medicine, many opportunities for
  - Clinical judgment
  - Thoughtful interactions
  - The “art” of medicine
Rural Risk?

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- **Redefine and Redesign**
- Toolbox for Value
Are We Post Turtles?

- The Post Turtle dilemma
  - I don’t know how I got up here.
  - I don’t know how to get down.
  - And I don’t know how to avoid getting put up here again.
- The answer is No!
  - We need not be paralyzed and helpless Post Turtles
- We can redefine our future and redesign our operations

Volume to Value Transition

- Bath water
  - Cost-based reimbursement
  - Necessary providers (OIG)
  - Few quality demands
  - Inefficiency tolerated
- Turning up the heat
  - Decreased per unit price
  - Pressure to reduce volumes
  - Quality demands
  - Competitive market
- How to avoid getting cooked?
Redefine Our Future

- Understand the current rural health care milieu
- Acknowledge the paradox of quality, experience, and cost
- Envision and articulate a different future – across the volume to value gap
- Plan for transition challenges
- Lead with focus and clarity

The Volume to Value Gap

**Volume-based**
- Pay-for-service (volumes)
- Cost-based reimbursement
- Hospital/physician independence
- Inpatient focus
- Stand alone care systems
- Illness care

**Value-based**
- Pay-for-results (quality/efficiency)
- Shared risk
- Partnerships and collaborations
- Continuum of care consideration
- Community health improvement (HIT)
- Wellness care
Transition Requires New Foci

- **Inpatient Beds → Clinics (and more)**
  - Expanded/robust primary care
  - Workplace nursing and SNF/ALF clinics
  - Mobile clinics and telehealth

- **Illness → Wellness**
  - Health Risk Assessments
  - Community Health Assessments
  - Health coaching and care coordination

- **Charges → Costs**
  - Revenue becomes covered lives
  - Charge master becomes cost master
  - “Trapped equity” is a concern

Redesign our Operations

- Organization chart
- Capital budgets
- Job descriptions
- Compensation
- Accounting
- Clinical care sites/modes
- Provide or partner
**Holy Family Hosp. Transformation**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physicians &amp; NP/PA</th>
<th>Senior Leaders</th>
<th>Mission Focus</th>
<th>Recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012: 35-bed hospital</td>
<td>2012: 90 employed providers</td>
<td>2012: 5 senior leaders</td>
<td>2012: Focus on wellness &amp; prevention</td>
<td>2012: Nationally recognized for safety, innovation and thought leadership</td>
</tr>
</tbody>
</table>

Source: Graphic provided by Mark Herzog, CEO. Holy Family Memorial Hospital, Manitowoc, Wisconsin. 2013.

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**Payers Are Getting Smarter**

**Economists:** Total Cost = Price x Quantity  
**Health Care:** Revenue = Unit Price x Volume

**Current Way**
- Negotiate unit price  
  - Discount on charges  
  - CPT codes  
  - Per diems  
  - Case rates (DRGs)
- Hospital success strategy  
  - Negotiate for high unit prices, then optimize volumes

**Future Way**
- Negotiate total cost of care  
  - Bundled payment  
  - Shared risk (ACOs)  
  - Capitation (beyond medical care)
- Hospital success strategy  
  - Negotiate high per capita rate, favorable base period, and accurate risk adjustment, then optimize community health
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Right place, time, provider, price

- Hospital Stay
  - $200
- Office Visit
  - $2,000
- ER Visit
  - $20,000

Better yet, how about care in the home, workplace, or not at all?
Preventive care may reduce the need for acute care!

Hospital Transformation

- How do we move toward delivering value when our revenue is primarily volume-driven?
- How do we not get “soaked” during the transition?
- We can “test the waters” with a new set of tools.
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Tool Box for Delivering Value

- Implement
  - Fee-for-service attention
  - Performance measurement
  - Care quality and patient safety
  - Operational efficiency
- Plan
  - Medical staff development
  - Patient-centered medical home
  - Community engagement
- Prepare
  - Quality rewards
  - Regionalization
  - Clinical integration
A Continuum of Value Strategies

- 10 strategies, but order and timelines will vary
- A continuous transformation
- Broad organizational impact, longitudinal over time, intense leadership attention
- Actionable plans
  - Objectives
  - Timelines
  - Accountabilities
  - Resources

Get Your FFS House in Order

Attention to
- Market share
- Expense management
- Revenue cycle
- Cost report accuracy
- Payer contracts
- Purchasing contracts
- Inventory management
- Appropriate volumes
Measure Performance

- 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?
  - Let the data set you free
- When possible, control the data
  - Market share
  - What you are paid by payers
  - Comparisons to competitors

Care Quality and Patient Safety

- Clinical quality, patient safety, and the patient experience
  - Expectation: "Always above the mean. Always improving."
- Leadership priority
  - Board meetings
  - Quality Improvement Officer (QIO)
- Quality/safety performance
  - Present information, not data
  - Tailor to your audience
  - Benchmarks are only a snapshot
Efficiency

Lean
- Removes Waste
- Increases Speed
- Removes non-value added process steps
- Fixes connections between process steps
- Focuses on the customer

Six Sigma
- Reduces Variation
- Improves Quality
- Reduces variation at each remaining step
- Optimizes remaining process steps
- Focuses on the customer

Speed + Accuracy =

Better Better Satisfied
Delivery Quality Employees Satisfied
Customers


Medical Staff Relationships

The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA
Physicians

- Physicians see themselves as independent autonomous, and in control!
  - The antithesis of team work?
- Yet, hospital-physician alignment is essential to delivering value
- Need accountable physician leaders to devise new care models and create sustainability
- Primary care could potentially control large amounts of dollars, so...
  - Involve physicians early and often
  - Recognize and act upon the cultural and personality differences between physicians and administrators
  - ($5,000/pt/yr × 2,000 pts/phys × 20 phys = $200 million/yr)

Deep Medical Staff Engagement

- Educate, mentor, and engage physician leaders
  - Clinical co-management expected to grow
- Include physicians in key governance decisions (beyond traditional clinical, credentialing, and quality committee work)
  - Offer direct ability to influence outcomes
- Provide data transparency, but do not overstate discrete measurements
- Offer rewarding, yet reasonable salary based on what physicians identify as desirable traits
- Always follow-up as promised (even if an implicit promise!)
Patient-centered medical homes are primary care practices that offer around-the-clock access to coordinated care and a team of providers that values patients' needs.

- Access and communication
- Coordination of care
- Patient and family involvement
- Clinical information systems
- Revised payment systems

Sources: Commonwealth Fund and 2007 Joint Principles of Patient-Centered Medical Homes.
Medical Home Quotes

- All team members practice at the top (optimum) of their license and experience
- Best evidence is the best and only way we deliver care
- Care is the same, regardless of the provider
- Continuous performance improvement of our care is rigorously driven by data
- There are no non-compliant patients, only those we have not reached
- An EHR is critical to proactively managing patient/population health
- Let care protocols do (at least some of) the work (e.g., lab orders, med refills, vaccines)

Connect Community Resources

- What is available locally to improve health care value?
  - Public Health
  - Social Service
  - Agency on Aging
  - Community health workers
  - Care transition programs
  - Churches and foundations
- Do not duplicate!
  - Collaborations are less expensive than new hospital services – and build good will
**Get Paid for Quality**

- Aggressively apply for value-based demonstrations and grants
- Negotiate with third party insurers to pay for quality
- Consider self-pay and hospital employees first for care management
  - Direct care to lower cost areas with equal (or better) quality
  - Reduces Medicare cost dilution

**Regionalization**

- Act locally; think regionally
- Economies of scale demand a contracted cottage industry
  - Yet, future payment linked to local covered lives
- Goal: To care for populations expertly, efficiently, equitably
  - Options are optional
  - Affiliation is not an end in itself
  - Independence is not a mission
  - Success measured by clinical integration

Rural Regionalization – ACOs

- 79 Medicare ACOs operate in both metro and rural counties
- 9 Medicare ACOs operate exclusively in rural counties
- Medicare ACOs operate in 16.7% of all rural counties
- Even if you do not participate as an ACO, you will compete with an ACO
  - Future of ACOs as a program is uncertain
  - But competing on value will endure

Source: RUPRI Center research. 2013.
Clinical Integration

- Clinical data sharing in real-time
- Standardized clinical care protocols
- Consistent clinical performance measures and reporting
- Clear team member responsibilities across multiple facilities
- Sense of professional camaraderie among disparate organizations
- Aligned incentives for regional *population health* improvement

A Resource to Help

- Rural Health System Analysis and Technical Assistance
  - Assess the rural implications of policies and demonstrations
  - Develop tools and resources to assist rural providers and communities
  - Inform and disseminate rural health care innovations

- Share an innovation with RHSATA that has moved your organization (or another) toward delivering value.

- Continue to be a leadership voice for rural health care value.
  - Our glass is at least half full. A positive attitude is infectious!

www.RuralHealthValue.org