Encounter-Based Strategies to Population-Based Strategies

Keith J. Mueller, Ph.D.
Director, RUPRI Center for Rural Health Policy Analysis
University of Iowa College of Public Health

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Importance of Transitions to Optimize Opportunities

- Changes are underway: reform is private and public policy
- Adapt to changes through innovations of best fit for rural communities
- How do we pull that off?
Forces Motivating Change

- “Form follows finance”
- Commercial insurance changing, and employer plans changing
- Medicare changes are dramatic and could be more so
- Medicaid changes spreading
Commercial Insurance and Employers

- Value-based insurance design to steer utilization: wellness, disease management, medication management
- Payment methodologies shifting to value-driven, at least in part
- Employers seeking deals, including national employers such as Walmart and Lowes
Medicare Payment Changes

- Uncertain future (at best) for cost-based reimbursement
- Demonstrations of new methods, including bundled payment, shared savings
- Value-based purchasing across provider types
- Includes non-payment for certain situations
Bundled Payment Models

- **Model 1**: Discount on Part A payment for inpatient hospitalization
- **Model 2**: Inpatient and all related services plus 30, 60, or 90 days after discharge
- **Model 3**: Retrospective Post-Acute Care Only; begin within 30 days and end up to 90 days; 48 clinical condition episodes
- **Model 4**: Prospective bundle for inpatient only to include Part B
Model 2 Participants Include

- Catholic Health Initiatives in CO, KY, NE, TN, AR
- Health Choice Utah Accountable Care LLC
- Maine Heart Center in Portland, ME
- WY Medical Center in Casper
- Geisinger Clinic in Danville, PA
Model 3 Participants Include

- Remedy Partners, Inc with facilities in 11 states
- Amedisys Holdings with facilities in 7 states
- Evangelical Lutheran Good Samaritan Society in Sioux Falls, SD with facilities in SD and MN
Model 4 Sites Include

- St Rose Dominican Hospitals in Henderson, NV
- Health Quest Systems, Inc. in LeGrangeville, NY
- Sisters of Charity of Leavenworth Health System/Exempla, Inc in Denver with facilities in CO, KS, MT
Medicaid

- ACO development being seen as an answer to cost of current and expanded program
- Reduced payments in systems based on pay for service
- Other innovations to reduce cost such as primary care case management, divert from emergency rooms
Concluding discussion of payment change 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
- Future is in *health improvement* for population served (community)
Convincing Evidence

- Change is underway (not just “coming”)
- Driven largely by needs to refinance
- But also involving reorganizing to meet quality objectives
- Respond to change or lead change but CHANGE
Escape to the Future

- Retain cost-based long enough to complete a transition
- But be about the transition to value
- Policy environment includes medical homes, bundled payment, accountable care
- Ultimately need integrated care/service models for communities
All About Value

- Value will determine payment, initially partial eventually all
- Responding to those changes
- Value will take on a new meaning beyond the hospital/clinic walls
- Responding to those changes; the sandbox of population health
Constant Improvement of Value

- Old phrase was continuous quality improvement
- Now more than quality in a narrow sense
- Value a broader term that incorporates cost and patient satisfaction
- There are specific pathways, a toolbox for value
A Continuum of Value Strategies

- 12 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
1. Get Your FFS House in Order

Attention to
- Market share
- Expense management
- Revenue cycle
- PQRS/Meaningful Use
- Payer contracts
- Purchasing contracts
- Inventory management
- Appropriate volumes
2. Measure, Report, and Act

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

• Tell the performance story
  ▫ Data → information → insight
  ▫ We are all “above average,” right?
  ▫ Let the data set you free

• When possible, control the data
  ▫ Market share – who’s leaving and why
  ▫ Our costs to payers, and our competitor’s costs
3. Prioritize Improvement

- Clinical quality, patient safety, and the patient experience
  - Expectation: “Always above the mean. Always improving.”
- Leadership priority
  - Every meeting
  - Charts, not spreadsheets
  - Un-blind the data!
- Quality/safety performance
  - ACOs – 33 outpatient measures
  - Hospitals – Hospital Compare
4. Improve Operations Efficiency

<table>
<thead>
<tr>
<th>Lean</th>
<th>Six Sigma</th>
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<tbody>
<tr>
<td>Removes Waste</td>
<td>Reduces Variation</td>
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<tr>
<td>Increases Speed</td>
<td>Improves Quality</td>
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<tr>
<td>Removes non-value added</td>
<td>Reduces variation at each</td>
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<tr>
<td>process steps</td>
<td>remaining step</td>
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<td>Fixes connections between</td>
<td>Optimizes remaining process</td>
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<td>process steps</td>
<td>steps</td>
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<tr>
<td>Focuses on the customer</td>
<td>Focuses on the customer</td>
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Speed + Accuracy =

Better Delivery Better Quality Satisfied Employees Satisfied Customers

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5. 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 employees first for care management
  - Direct care to lower cost areas with equal (or better) quality
  - Reduces Medicare cost dilution
6. Engage Medical Staff *Deeply*

- Educate, mentor, and engage physician leaders
  - Clinical co-management expected to grow
- Include physicians in key governance decision-making
  - Beyond traditional clinical, credentialing, and quality committee work
  - Offer direct ability to influence outcomes
- Offer rewarding, yet reasonable salary
  - Based on what physicians identify as desirable characteristics and behaviors
7. Develop Medical Homes

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.
8. Cultivate New Skills

• New skills required
  ▫ We are comprehensivists
  ▫ Data analytics
  ▫ Quality improvement
  ▫ Cost management
  ▫ Team management – “leader” need not be a physician

• But I don’t want to change!
  ▫ Static fee-for-service prices – working harder for less
  ▫ No bonuses – less pay for subpar quality
  ▫ Volume at risk – from poor economy, high deductibles, and skilled competitors
9. Coordinate Care

• Supports provider care plans
• Supports patients with frequent contact
• Helps patients prepare for office visits
• Identifies high-risk patients
• Develops disease registries
• Monitors reminder systems
• Provides patient education
• Coordinates care and transitions
• The go-to person to connect the dots
10. Refer Based On Value

- Who provides the best care to your patients?
  - How do you know?
- Who provides the best value to your patients?
  - How do you know?
- What kind of care do you want your mom to have?
- Referral hospitals and specialists should earn our referrals
11. Consider Regionalization

- Act locally; think regionally
- Economies of scale may 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*

12. Engage Your Community

• 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 clinic/hospital services – and build good will

• Do what’s right
Specific Hospital Activities for CAHs

- Hospital leadership fully understand and begin to build case for population health management
- Hospitals put population health on meeting agendas, including board, management, quality improvement
- Hospitals look within own walls and initiate employee wellness programs
- Hospitals reach out to communities to discover health program wants and needs

Lessons from Hospitals in Healthiest Counties

- Dansville, NY: “change from thinking about the care that is given while the patient is within our walls to thinking about the care of the patient outside our walls”
- Dansville: “We no longer see ourselves as a standalone organization, but rather as part of the region’s broader healthcare ecosystem”
Lessons from Hospitals in Healthiest Counties

- Oakland CA: “just as our focus on total health—integration, prevention, and empowerment—drives internal planning for our members, it also drives planning for improving the health of our community”

- Oakland CA: “we work closely with the county and state public health departments, reviewing various sets of data, including mortality and morbidity data, as well as substance abuse, drinking, and tobacco consumption figures”
Raleigh, NC: “a physician-led effort in partnership with the hospital to provide integrated, patient-centered care. This means coordination of care, more involvement in prevention as well as a more active role in helping people manager their overall health outside of the healthcare setting.”

Examples From Rural Institutions

- Available from the Rural Health Value project: [http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/](http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/)
- Community Outreach in Delhi, LA
- System Transformation in the Mercy Health Network, IA
- Service Delivery Integration & Patient Engagement in Humboldt County, CA
Other Innovations

- Chief Medical Financial Officer in Banner General Hospital in Sandpoint, Idaho (CAH)
- Chief Patient Experience Officer named at Johns Hopkins Medicine
- All about value for the patient/customer
So What Should Iowa Hospitals Be Doing?

- Fill in the slide 😊
For Further Information

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

The RUPRI Health Panel
http://www.rupri.org
Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health
145 Riverside Drive, N232A - CPHB
Iowa City, IA  52242
319-384-3832
keith-mueller@uiowa.edu