Rural Health Strategies for a Value-Based Future

CAH and RHC Conference
Bloomington, Minnesota
February 5, 2014

Agenda

- Rural Health Context
- Transfer of Financial Risk
- Redefine and Redesign
- Toolbox for Value
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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

The Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost

Clint MacKinney, MD, MS
Value Equation

Value = **Quality + Experience**

Cost

*But does our current volume-based payment system impede delivering health care of value?*

Tyranny of Fee-for-Service

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

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

What about paying for health care value?

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
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/clinics:
  - 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 significant 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
- Our clinical choices influence health care value
- Greatest control, how we deliver care

Drive Out (Most) Variation

- 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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Volume to Value Transition

- Bath water
  - Fee-for-service and CBR
  - 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 value-based future that serves patients and communities
- Lead with focus and clarity, but be willing to listen and learn
- Plan for transition challenges
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
  - Re-purpose inpatient space
Redesign our Operations

- Organization chart
- Capital budgets
- Job descriptions
- Compensation
- Accounting
- Clinical care sites/modes
- Care coordination
- 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.
**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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Provider Toolbox

1. Fee-for-Service Attention
2. Measure, Report, and Act
3. Performance Improvement
4. Operations Efficiency
5. Payment for Quality
6. Physician Engagement
7. Patient-Centered Medical Homes
8. New Skill Development
9. Care Coordination
10. Referral Patterns
11. ACOs and Regionalization
12. Community Engagement

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
Performance Measurement ROI

Data Collection | Data Reporting | Data Analysis

Typical Effort | Desired Effort | Action

The goal is move the curve to the right

Source: Greg Wolf, Stroudwater Associates

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

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 Delivery + Better Quality + Satisfied Employees + Satisfied Customers


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

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 physician leaders to devise new care models and create sustainability
- Primary care could potentially control large amounts of dollars, so...
  - ($5,000/pt/yr x 2,000 pts/phys x 20 phys = $200 million/yr)
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

Shifting Health Care Payments

Here’s how your health plan dollar is spent.
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

See www.TransforMed.com

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 electronic health record is critical to managing patient and population health
- Let care protocols do (at least some of) the work (e.g., lab orders, med refills, vaccines)

Crete Physicians Clinic
Crete, Nebraska
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

Cost by Patient

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Percent of Resources</th>
<th>Percent of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophic</td>
<td>21</td>
<td>1%</td>
</tr>
<tr>
<td>Chronic</td>
<td>27</td>
<td>4%</td>
</tr>
<tr>
<td>Episodic</td>
<td>25</td>
<td>10%</td>
</tr>
<tr>
<td>Well</td>
<td>27</td>
<td>85%</td>
</tr>
</tbody>
</table>

5% of the population consumes 48% of the health care resources

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
Rural Regionalization – ACOs

- As of December 2013
  - 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
- But, 50% growth as of January 2014!
- 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.

Rural (Teal) Counties with ACOs

Coverage increased 50% on 1/2/14

Source: CMS data as of January 2013.
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


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
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

County Health Rankings

Excellent data and resources

- Morbidity
- Mortality
- Health Behaviors
- Clinical Care
- Social & Economic Factors
- Physical Environment
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!

The Risk of Something New
Healthy People and Places