Rural Health Strategies for a Value-Based Future

14th Annual Hawai‘i Medicare Rural Hospital Flex Program Conference
Sheraton Kauai Resort
October 22, 2014
The counter-culture poet/musician from the Iron Range of Minnesota

50 years ago – still true today

Especially in health care!

Remember the old days?
The Times They Are A-Changin’

“The future ain’t what it used to be.”

Yogi Berra
The Winds of Change

- Healthcare reform
- Safety and quality
- Aging
- Consumerism
- Technology
- New care delivery models
- Information technology
- Accountable to community
- Workforce shortages
- Declining revenue
Which Way?

- In whirlwind, easy to get disoriented, lose our way
- Healthcare providers can lose our *purpose*
- Rural hospitals can lose their *mission*
- Let me reorient you...
The Triple Aim

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

Clint MacKinney, MD, MS
The healthcare value equation (2007)

Value = Quality + Experience

But we have a problem...
We like getting our paychecks!

Predominantly paid based on fee-for-service, not paid to deliver the Triple Aim©.

Our current volume-based payment system impedes delivering health care of value.

Hence, a SNAFU!

- Situation normal, all fouled up
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 healthcare value?
How we deliver care depends on how we are paid for care.

Healthcare 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 healthcare risk
  - Random
  - Insurance
  - Political
  - Medical care

- Where and how can we:
  - Influence or control risk
  - Reduce risk of harm
  - Optimize risk of benefit
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
Rural Risk?
Risk transfer strategies
- VBP, VBM, SGR (fix), ACOs, readmission policy, hospital acquired conditions policy, bundled payment, reference pricing, narrow networks, and more

Moves payment from FFS toward the Triple Aim©
- Volume → Value

Recall, *form follows finance*
- What form do we need and how should we change to be successful?
Three Big Trends (with examples)

1. Primary Care Ascending
   - Medical Homes

2. New Affiliations
   - Accountable Care Organizations

3. Paying for Quality
   - Sustainable Growth Rate Fix
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.

- Robust primary care
- 24/7 access to care
- Coordinated and team-based
- Patient- and family-centered
- Information technology support
- New 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)
2. New Affiliations

- Accountable Care Organizations
  - A coordinated network of providers (generally hospitals and/or physicians) who share responsibility to provide high quality and low cost care to their patients.*

- Requires excellent clinical quality and patient satisfaction
  - CMS uses 33 **outpatient** measures

- Payer “shares” savings with ACO if costs are less than predicted

Dramatic ACO Expansion

- Rapid expansion in about 2 years
  - 626 ACOs across the country (May 2014)
  - Over half are Medicare ACOs
  - 20.5 million ACO-covered lives
- 123 new Medicare ACOs announced in 2014 – more coming in 2015
- A rural phenomenon too
  - Medicare ACOs operate in 16.7% of all rural counties (December 2013)
- Future of ACO programs uncertain, but competing on value will endure

Source: The Lewin Group 2014 and RUPRI Center 2013
3. Paying for Quality

Sustainable Growth Rate Fix (proposed)

- Minimal fee-for-service payment increase next 10 years (0.5%, then 0%)
  - Actually payment decrease (inflation)

- Merit-Based Incentive Payment System (-9% to +27%)
  - Likely to include quality, satisfaction, and efficiency measures
  - Eventually replaces PQRS, Meaningful Use, and Value-Based Modifier

- Alternative Payment Models (+5%)
Shifting Health Care Payments

The Cost of Healthcare
We've compiled internal data from 2010 and 2011 to produce an estimate of where your Blue Shield of California health plan dollar goes.

40¢: Hospital
28¢: Physicians
12¢: Pharmaceutical

Here's how your health plan dollar is spent

85¢: Cost of Health Care
15¢: Other

2¢: Blue Shield Income
13¢: Admin Costs
5¢: Other Medical Services
Volume → 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?
Strategic Emphases for Success

**More** (not all)
- Primary care and coordination
- Clinical quality and patient experience
- Partnerships
- Employee training

**Less** (not none)
- Inpatient
- Facilities and equipment
- Specialty services
- Top down management
Holy Family Hosp. Transformed

<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.
Volume → Value... Specifically

- 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.
What to Do... Now

- New Skill Development
- Fee-for-Service Attention
- Operations Efficiency
- Performance Improvement
- Physician Engagement
- Care Coordination
- Regionalization
Develop New Skills

- New skills required
  - Data analysis
  - Quality improvement
  - Cost management
  - Team-based care
  - Collaboration

- “But I don’t want to change!”
  - Flat FFS prices – working harder for less
  - No bonuses – less pay for subpar quality
  - Volume at risk – from poor economy, high deductibles, and skilled competitors
Get Your FFS House in Order

Attention to

- Market share
- Expense management
- Revenue cycle
- PQRS/meaningful Use
- Payer and purchasing contracts
- Inventory management
- Appropriate volumes
✓ 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

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
PI: Leadership Priority

- Clinical quality, patient safety, and the patient experience
  - Expectation: “Always above the mean. Always improving.”

- Quality/safety performance
  - Outpatient – 33 ACO measures
  - Inpatient – Hospital Compare

- Communicate to improve
  - Every meeting
  - Charts, not spreadsheets
  - Un-blind the data!
Get Paid for Performance

- **Apply** aggressively for value-based demonstrations and grants
- **Negotiate** with commercial insurers to pay for quality
- **Care management** for self-pay and organization employees first
  - Direct care to lower cost areas with equal (or better!) quality
  - Reduces Medicare cost dilution
The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA
Engage Medical Staff *Deeply*

**Physician* Engagement:**

Active physician involvement and meaningful physician influence that move the organization toward a shared vision and a successful future.

- Governance
- Compensation
- Education
- Data

* or provider

Clint MacKinney, MD, MS
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
Engage Your Community

- What is available locally to improve health care value?
  - Public Health
  - Social Service
  - Area 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
Who provides the best care and value for your patients?
  - How do you know?
  - Use data to make wise decisions

Hospitals and distant specialists should earn our referrals

Collaborate with payers to reward the Triple Aim©
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

Integrate Clinically

- 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
Rural Health Value Project

- **Vision**
  - To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems

- **3-year HRSA Cooperative agreement**
  - Rural Health System Analysis and Technical Assistance (RHSATA)

- **Partners**
  - RUPRI Center for Rural Health Policy Analysis
  - Stratis Health
  - Support from Stroudwater Associates and Washington University

- Check out tools/resources at [www.RuralHealthValue.org](http://www.RuralHealthValue.org)
“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”
“... behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time.”
Yet, “there has never been a better time to be an innovator in health care.”
The Risk of Something New
Healthy People and Places