The New “Normal” Health System

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The Bottom Line: Boards and Adapting to Changing Environment

- Integrating systems of care in the marketplace, driven by financial pressure and changes in care delivery
- Aligning public and private policies with what is now state of the art in care to improve sustainability of high quality services in rural places
Emphasizing value instead of service volume: translation is population health, which means need to think of the total community being served in the places they live, work, and play
- Blending health and human services
- Maintaining the appropriate, sustainable service mix locally
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 Changes in Health Insurance Coverage

- Will influence “patient flow”
- Will also direct “consumers” to use system differently
- Will affect revenue
- Creates backdrop for different investment strategies
Changes In Insurance Status

Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?
Among adults aged 18 and older

% Uninsured

Quarter 1 2008-Quarter 1 2014
Gallup-Healthways Well-Being Index

GALLUP
Data from April 14 Gallup Poll

- 4% of US population newly insured as of April; 2.1% through exchanges, 1.9% not
- Among newly insured, 30% aged 18-29 (constitute 21% of population)
- Among newly insured, 75% with household incomes below $60,000

Gallup Daily tracking poll of more than 20,000 adults, aged 18 and older
Representative sampling design; 2,641 individuals aged 18 to 64, weighted to provide national estimates, changes September 2013 – March 2014

- Net gain of 9.3 million insured; gain in employer-sponsored insurance of 8.2 million and net loss in individual market of 1.6 million
- Marketplace enrollment of 3.9 million
Changes to Medicaid

- Eligibility changed to 138% of federal poverty guideline
- No categorical eligibility
- Moves closer to insurance model
- Increased population covered, brings increased focus on cost and value
What the Change Means

- New sources of payment
- New rules associated with the sources of payment
- Initial federal involvement in raising payment for primary care (2013 and 2014)
- New channels of access for those with insurance: implications for academic health science centers, use of emergency rooms, choice (or not) among providers
What the Changes May Mean

- Types of insurance plans may “devolve” when premiums increase
- Could be more shifting into “consumer driven” health insurance design
- Increase in deductibles and copayments drives consumer behavior
And Variation Within the State
Basic 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
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, unless through exceptions (FCHIP)
- Demonstrations of new methods, including bundled payment, value-based for Critical Access Hospitals
- Value-based purchasing across provider types
- ACOs as a harbinger
66 public and private ACOs
366 Medicare ACOs
23 Pioneer ACOs
35 are Advance Payment
Medicare ACOs located in 48 states (and DC and Puerto Rico)
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
Early Results in Medicaid

- Colorado: $44 million in gross savings or cost avoidance in FY 2013; reduced hospital readmissions 15-20%
- Oregon: in place 16 months, 90% of Medicaid beneficiaries

Aligning Market Based Changes with Clinical and Delivery Changes

- Shifts in modality of care
- Shift in vision/mission to be more encompassing
- Innovation consistent with vision/mission and changing financial and policy context
Changes in Delivery Modalities Create Opportunities

- Telehealth
- Using professionals to full capacity of licensing
- Care in different settings
- Inter-disciplinary care
Lessons from Tele-Emergency

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Examination of hospital-based application of telehealth, specifically tele-emergency (local ED linked to “hub” that provides real-time on call board-certified emergency physician and staff)
We confirmed these roles

- Clinical resources, including board-certified emergency doctor (deal with unusual cases)
- Care coordination
- Value to patient and community of local care
- Value to providers to have coverage and consultation
Implications

- Policies that recognize what is now possible: conditions of participation and payment
- Expectations related to new delivery system, connected health
- Appropriate use of clinical personnel (local non-physicians with support from board-certified doctor)
- Increase value of local services, implications for sustainable services, patient satisfaction and loyalty to care givers (implications for shared savings models)
Conclusion: Part of evolving healthcare system

- Patient care where patients need, want the services; patient-focused care
- Integrated care utilizing care teams, linking facilities
- Role of local primary care re-enforced supported
- Increasing value and lowering costs
Future Should be: RUPRI Health Panel Vision

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
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
Continued

- 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
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
Elements of a Successful System Redesign

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

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
Actions to Consider

- Measure organizational performance
- Inform key stakeholders regarding performance
- Consider employees for care management
- Negotiate payment for measurable quality and patient satisfaction
- Collaborate with health care and human services providers
- Strategic focus on patients/community
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)

Source: The U.S. Census Bureau
How to Succeed with Collaboratives

- Use population data (County Health Rankings)
- Shared governance of resource use
- Methodology for sharing savings and re-investing
- Understand linkages between health outcomes and determinants – “patient responsibility”
Being an Effective Leader or Partner

- Focus on center of excellence or pillar of excellence
- Proving cost effectiveness, including ability to reduce costs
- Engaging board of trustees and stakeholders
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
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 -- population health
Old phrase was continuous quality improvement
Now more than quality in a narrow sense
Value a broader term that incorporates cost and patient satisfaction
Illustration: Chief Medical Financial Officer

- Bonner General Hospital in Sandpoint, Idaho: CAH conversion in 2011
- Meld financial and clinical goals – example of opening wound center after physician recognized market potential
- “Engaging physicians to cut costs while maintaining quality” (from article cited below)
Illustration: Chief Medical Financial Officer

- Dr. Kenneth Cohn, CEO of Healthcare Collaboration: “It’s about giving doctors a more proactive role in strategy and identifying physician finance champions”
- CFO conducts rounds with physicians

Source: Bob Herman, “In the Future, Will Hospitals Have a Chief Medical Financial Officer?” Beckers Hospital Review April 8, 2014.
Opportunities for Boards

- Setting the tone: all about culture of the organization
- Guiding community assessments
- Leading community-based efforts
- Working through networks (policy and practice) to align incentives
- Local investments in appropriate, sustainable services consistent with shifts in health care organization, delivery and finance
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
Collaborations to Share and Spread Innovation

• The National Rural Health Resource Center

• The Rural Assistance Center

• The National Rural Health Association

• The National Organization of State Offices of Rural Health

• The American Hospital Association
Appendix slides describing West Virginia

- Primary care service areas on a scale
- Medicare Advantage plan activity
- Health Professions Shortage Areas
- Location of hospitals
Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage in West Virginia, March 2013

Legend
- 113th Congressional Districts
- Metropolitan counties
- Percent Enrolled by County
  - 0% - 7%
  - 8% - 15%
  - 16% - 25%
  - 26% - 37%
  - 38% - 65%

Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2013.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013
Health Profession Shortage Areas
West Virginia, Primary Care, 2012
For Further Information

The RUPRI Center for Rural Health Policy Analysis
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