Volume to Value: Finding a Glide Path for Rural Hospitals

CAH CEO Meeting
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The Times They Are A-Changin’

- 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?
Four Converging Forces

- Price reduction threats and volume reduction pressures
- Expanding insurance coverage, but narrower networks
- Increasing quality of care measures and accountabilities
- Massive healthcare provider consolidations
In the frenzy of change, it’s easy to lose our way

Healthcare providers can lose their *purpose*

Rural hospitals can lose their *mission*

Let’s reorient...
The Triple Aim©

Improved community health
Better patient care
Lower per capita cost

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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New Champions for Value

- Jim Skogsbergh
  - American Hospital Association Chair-Elect (Iowa HMP grad!) 🐼

- Not just the Berwickians or Kais-inger-fields anymore!

- Plus a whole slew of for-profit firms and investors
  - $3 trillion (with a “T”) enterprise
  - Larger than all but four national economies (including the US!)

- Today’s discussion – finance
  - But with only a few numbers
The healthcare value equation (2006)

Value = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}

But we have a problem...
Not Getting Paid For Value

- 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
The Value Conundrum

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?
Value-Based Payment Landscape

- 40% private plan payments linked to **value** (11% in 2013)
- 700+ public/private shared savings plans (ACOs)
  - 20+ million patients
- 400+ Medicare ACOs
  - 6+ million beneficiaries
  - Operating in 48 states
- Accountable care has legs!
  - But maybe not ACOs...
  - Community-accountable health systems?

Sources: [www.catalyzepaymentreform.org](http://www.catalyzepaymentreform.org), [www.hhs.gov](http://www.hhs.gov), and RUPRI Center for Rural Health Policy Analysis
Why Is This Important to Us?

- FFS/CBR payment → value payment
  - Primary care physicians become *revenue centers*
  - High cost procedures, specialists, and *hospitals* become *cost centers*

- Insurance strategies
  - Reference pricing and narrow networks

- Consumer driven health care
  - High deductibles and price transparency

- Might Medicare Advantage for all be the end game?
  - Population-based payment (capitation)
How we deliver care depends on how we are paid for care

Healthcare reform is changing both payment and delivery
- Large system CEOs are embracing significant care delivery change
- Venture capitalists are investing in new care models (not FFS!)

Fundamentally, reform involves transfer of financial risk from payers to providers
The Risk of Inertia

Because we’ve ALWAYS done it that way!

Source: Institute for HealthCare Improvement and Sharon Vitousek, MD
Rural Risk?

Branxton Lions Club

Drive Carefully 60

We have L

Two Cemeteries

No Hospital

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28/46 (61%) of Montana CAHs have a net income less than 4%

Develop a 5-year pro forma

Enter conservative assumptions
- ↓ population (most rural places)
- ↓ inpatient volume (all hospitals)
- ↓ commercial insurance rates
- ↑ employee compensation
- ↑ employee healthcare costs
- ↑ information technology costs
- ↑ medical technology costs
- ↑ competition

But wait! At best, only 20% of health care is delivered locally
Some reasonable assumptions
- 80% of care provided elsewhere
- One family physician with 2,000 patients could control $18 million
- Do we want part of that action?

If we cannot leverage the 80%, what do we become?
- Vendor and cost center
- How do you manage a cost center?

So, how can a $20 million CAH leverage the other $80 million?
- Actively participate in the shift from volume to value
List three strategic priorities for your CAH in 2015.

How do your priorities compare to those of your small group colleagues?

If they are different, what is unique about your CAH or its environment?
Transformation

**Now**
- Hospitals and Medical Staffs
- Patients
- Private Payers
- Revenue Centers
- Charge Masters
- Primary Care Providers
- FFS Volume Growth
- Productivity Bonuses

**Future**
- Become Community Health Systems
- Mature into Price-sensitive Purchasers
- Expand to be Competing Providers
- Flip 180 into Cost Centers
- Lose relevance to Cost Masters
- Are viewed as $18m Service Line Leaders
- Is supplanted by Full-Risk Aggregated Lives
- Evolve into Value Bonuses

Source: Greg Wolf, Stroudwater Associates
Demonstrate that the care at your CAH is **better** and **cheaper** than your competitors

- Be brutally honest. Others will.
- Understand your contribution to a **system** of health care
  - This is how you’ll add **value** to an integrated network
  - This is how you’ll earn a “seat of influence”

Align with the revenue source

- Primary care physicians
- Patients (people)
Evolve through Managing Risk

- All about **risk management**
- Career-limiting approaches
  - *Blind innovation* – results in burning through reserves
  - *Navel gazing* – results in market share destruction
- Training wheels concept
- **Discriminating** approaches
  - Environmental insights
  - Sophisticated projections
  - Thoughtful experiments
  - Learning continuously
How do we move toward delivering value when our revenue is primarily volume-driven?

What changes should we implement now to be successful in the future?

We can “test the waters” with a new set of tools.
CAH Value Evolution Toolbox

1. Optimize Fee-for-Service
2. Enhance Efficiency
3. Improve Patient Care
4. Engage Physicians

- Develop Medical Homes
- Measure, Report, and Act
- Get Paid for Quality
- Coordinate Care
- Establish a Referral Network
- Consider Regionalization
- Engage Your Community
New skills required
- Sophisticated data analysis
- Continuous quality improvement
- Cost accounting/management
- Team-based health care
- Expanded collaborations

“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
1. Optimize FFS Revenue

Attention to

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

\[
\text{Speed} + \text{Accuracy} = \text{Better Delivery} \quad \text{Better Quality} \quad \text{Satisfied Employees} \quad \text{Satisfied Customers}
\]

3. Improve Patient Care

- Clinical quality, patient safety, and the patient experience
  - “Always > the mean. Always improving.”
  - Leadership priority

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

- Communicate to improve
  - Public reporting (CAH website)
  - Every meeting
  - Charts, not spreadsheets
  - Un-blind the data!
4. Engage Physicians

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

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

- 85¢: Cost of Health Care
- 15¢: Other

40¢: Hospital

28¢: Physicians

12¢: Pharmaceutical

5¢: Other Medical Services

13¢: Admin Costs

2¢: Blue Shield Income

Here's how your health plan dollar is spent.

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Inspiration: Ian Morrison’s presentation “Moving Forward or Turning Back?”
Engage Meaningfully

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
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](http://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)
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
  - Communicate widely and frequently

- When possible, control the data
  - Market share – who’s leaving and why
  - Our costs to payers, and our competitor’s costs
The goal is move the curve to the right

Source: Greg Wolf, Stroudwater Associates
Get Paid for Quality

- **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
  - Directs care to lower cost areas with equal (or better!) quality
  - May allow employee health insurance premium reduction
  - Reduces Medicare cost dilution
Coordinate Care

- Identify high-risk patients
- Develop disease registries
- Monitor patient/provider reminder systems
- Support provider care plans
- Support patients with frequent contacts
- Help patients prepare for office visits
- Educate patients about healthcare concerns
- Coordinate care transitions
- Link patients, providers, and community resources
- Locate onsite: health coach and behavioral health
Establish a Referral Network

- Who provides the best care and value for your patients?
  - How do you know?
  - Use data to design your network of distant colleagues and facilities

- Distant hospitals and specialists should earn our referrals
  - High quality
  - Low cost
  - Reasonable access
  - Consistent communication
  - Unfailing respect
Consider Regionalization

- Act locally; think regionally
- Economies of scale will demand a contracted cottage industry
  - Yet, future payment linked to local covered lives
- Goal: To care for populations expertly, efficiently, equitably
  - Options are optional!
  - But, independence is not a mission
  - Affiliation is not an end in itself
  - Seek financial leverage
  - Success is 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 sites of care
- Sense of professional camaraderie among disparate organizations
- Aligned incentives for regional *population health* improvement
Engage Your Community

- The CAH is likely to be the community’s best **convener**

- What is available locally to improve health care **value**?
  - Public Health
  - Social Service
  - Area Agency on Aging
  - Community health workers
  - Schools, churches, and foundations

- Do not duplicate!
  - Collaborations are less expensive than new clinic/hospital services – and build good will
Financing Community Health

- Community engagement
  - ↑ awareness of CAH services
  - ↑ customer trust/loyalty
  - ↓ patient outmigration

- Employee good health
  - ↑ attendance and productivity
  - ↓ insurance costs

- Employee well-being
  - ↑ retention and recruitment

- Community health
  - Meets CHNA requirement
  - Prepares for community-accountable health systems
### When to Pull the Trigger...

<table>
<thead>
<tr>
<th>Late Starters</th>
<th>Sequential</th>
<th>First Movers</th>
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<tbody>
<tr>
<td><strong>Risks</strong></td>
<td></td>
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<tr>
<td>Competitors and potential collaborators have already made transitions and view your organization as a liability</td>
<td>Modifying the wrong strike points in the wrong order creates organizational tension and disruption</td>
<td>Implementing changes to delivery system without harmonizing with payment system results in financial losses</td>
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<td><strong>Rewards</strong></td>
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<tr>
<td>Learn from other organizations that have made modifications and use that knowledge to foster success</td>
<td>Deliberate, scheduled process for transitioning at the most <em>ready</em> strike points at the best time</td>
<td>Difficult decisions and changes are implemented upfront creating time for well-informed strategic decisions and adjustments</td>
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Source: Greg Wolf, Stroudwater Associates
How will you meaningfully engage your local physicians and outside community organizations?

How will you ensure that your CAH is included in narrow insurance networks based on high quality and low cost?
Next
“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”
Healthcare “Curves”

- **1\textsuperscript{st} curve – Increase volume**
  - Optimizing FFS/CBR payment

- **2\textsuperscript{nd} curve – Manage risk**
  - Financial consequence for delivering inferior value

- **3\textsuperscript{rd} curve – Connect persons**
  - Holistic yet individualized care, shared “big data” information, empowered persons, and community integration
New Policy Opportunities?

- **Alternatives** for low volumes CAHs – legislators interested
- **Conditions of Participation** – CMS open to discussion
- **RUPRI Health Panel** – demonstration recommendations
  - **Primary care redesign** – Combine local primary care and other providers focused on individual and community health improvement.
  - **Integrated governance** – Align various health-related organizations in new governance models.
  - **Frontier health systems** – Apply models that sustain essential local services while integrating distant services.
  - **Asset repurposing** – Leverage existing assets to finance and develop rural health hubs.

Source: RUPRI Health Panel. Advancing the Transition to a High Performance Rural Health System. 2014.
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)
The Risk of Something New
Healthy People and Places