Designing and Implementing the Rural Health System of the Future

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"Advancing the Transition to a High Performance Rural Health System"

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RUPRI Health Panel Paper:
http://cph.uiowa.edu/rupri/publications/policybriefs/2014/Advancing%20the%20Transition%20-%20Health%20Panel%20Paper.pdf
RUPRI Health Panel Brief:
http://cph.uiowa.edu/rupri/publications/policybriefs/2014/Advancing%20the%20Transition%20-%20Health%20Panel%20Brief.pdf

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Rural System Balance

- Need points of access to modern heath care services: Hill/Burton
- Payment system change with advent of PPS: payment designations for rural institutions, culminating in Medicare Rural Hospital Flexibility Program (Critical Access Hospitals)
- Payment and delivery system reform: rural based action to evolve into high performance systems

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Current rural landscape

- Population aging in pace
- Increasing prevalence of chronic disease
- Sources of patient revenue change, including doubt about ability to collect in era of increased use of high deductible plans
- Is small scale independence sustainable?

Tectonic shifts occurring

- Insurance coverage shifts: through health insurance marketplaces; private exchanges; use of narrow networks
- Public programs shifting to private plans
- Volume to value in payment designs
- Evolution of large health care systems

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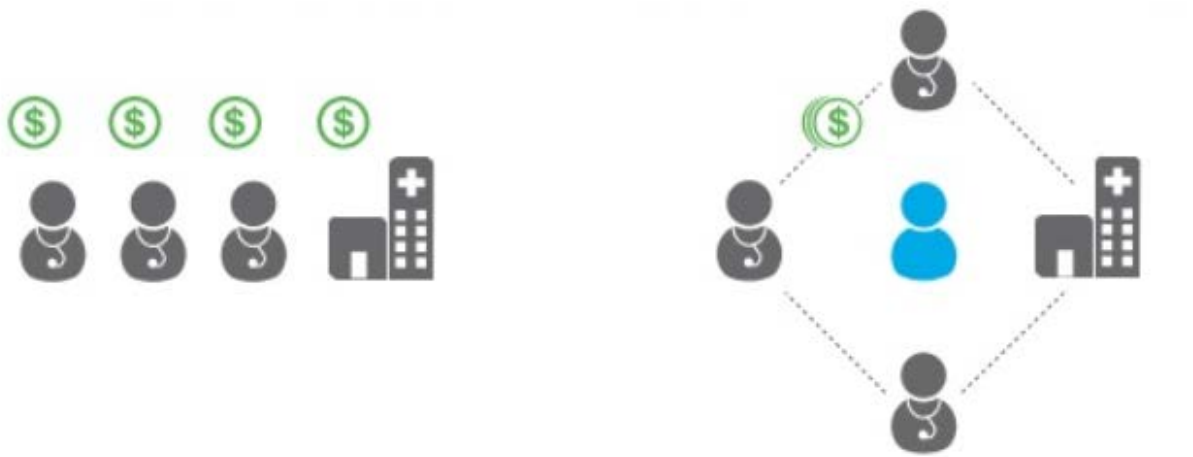
Tectonic shifts occurring

- Volume to value in payment designs



Speed and Magnitude: Goals for Medicare Payment

- 30 percent of Medicare provider payments in alternative payment models by 2016
- 50 percent of Medicare provider payments in alternative payment models by 2018
- 85 percent of Medicare fee-for-service payments to be tied to quality and value by 2016
- 90 percent of Medicare fee-for-service payments to be tied to quality and value by 2018

Parallel in Commercial Insurance

- Coalition of 17 major health systems, including Advocate Health, Ascension, Providence Health & Services, Trinity Health, Premier, Dartmouth-Hitchcock
- Includes Aetna, Blue Cross of California, Blue Cross/Blue Shield of Massachusetts, Health Care Service Corporation
- Includes Caesars Entertainment, Pacific Business Group on Health
- Goal: 75 percent of business into value-based arrangements by 2020

Source: http://www.hcttf.org/

Evolution of Medicare Payment Through Four Categories

- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

Source of this and following slides: CMS Fact Sheets available from cms.gov/newsroom

Illustration of Move to Population-Based Payment

Payment Taxonomy Framework				
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

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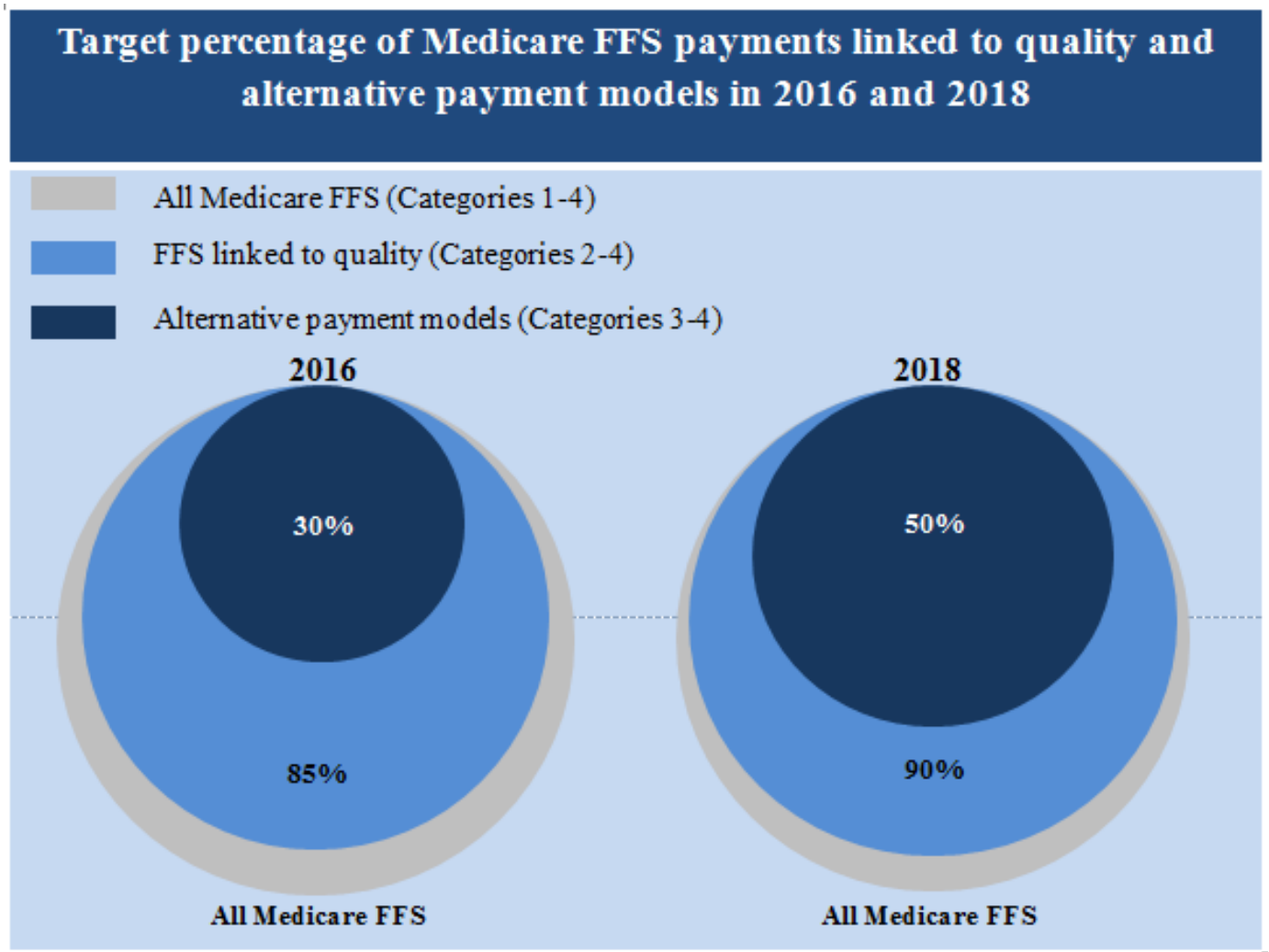
Shrinking Band of Traditional Payment



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CMS Slogan: Better Care, Smarter Spending, Healthier People

- Comprehensive Primary Care Initiative: multi-payer (Medicare, Medicaid, private health care payers) partnership in four states (AR, CO, NJ, OR)
- Multi-payer Advanced Primary Care Initiative: eight advanced primary care initiatives in ME, MI, MN, NY, NC, PA, RI, and VT
- Transforming Clinical Practice Initiative: designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Pay for Value with Incentives: Hospital-based VBP, readmissions reduction, hospital-acquired condition reduction program
- New payment models: Pioneer Accountable Care Organizations, incentive program for ACOs, Bundled Payments for Care Improvement (105 awardees in Phase 2, risk bearing), Health Care Innovation Awards

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Better coordination of care for beneficiaries with multiple chronic conditions
- Partnership for patients focused on averting hospital acquired conditions

Summary: Market Forces Shaping Rural Health

- Hospital closure: 47 since 2010 (*USA Today* story from November 14, 2014)
- Enrollment into insurance plans and function of choice and cost ("Geographic Variation in Plan Uptake in the Federally Facilitated Marketplace" http://www.shepscenter.unc.edu/wp-content/uploads/2014/09/EnrollmentFFMSeptember_rvOct2014.pdf)
- Choices among plans ("Geographic Variation in Premiums in Health Insurance Marketplaces" http://cph.uiowa.edu/rupri/publications/policybriefs/2014/Geographic%20Variation%20in%20Premiums%20in%20Health%20Insurance%20Marketplaces.pdf)
- Development of health systems
- Growth in Accountable Care Organizations (Illinois Rural Community Care Organization)

What is the next move to rural vitality?

- Goals of a high performance system
- Strategies to achieve those goals
- Sustainable rural-centric systems
- Aligning reforms: focus on health (personal and community), payment based on value, regulatory policy facilitating change, new system characteristics

The high performance system

- **Affordable**: to patients, payers, community
- **Accessible**: local access to essential services, connected to all services across the continuum
- **High quality**: do what we do at top of ability to perform, and measure
- **Community based**: focus on needs of the community, which vary based on community characteristics
- **Patient-centered**: meeting needs, and engaging consumers in their care

Strategies

- Begin with what is vital to the community (needs assessment, formal or informal, contributes to gauging)
- Build off the appropriate base: what is in the community connected to what is not
- Integration: merge payment streams, role of non-patient revenue, integrate services, governance structures that bring relevant delivery organizations together

Illustration: CHNA for Percy Memorial

- Indicators from county health rankings:
  - Adults reporting poor or fair health: 14% (IL 16%)
  - Adult obesity: 28% (IL 25%)
- Risk factors
  - High Blood Pressure: 32% (29%)
  - Arthritis: 30% (26%)
  - At Risk Alcohol: 18% (17%)

Illustration: CHNA for Percy Memorial: Priorities

- Substance abuse
- Nutrition, physical activity and obesity
- Access to care
- Mental health

Illustration: Adams County Community Health Assessment

- Partners: Adams County Health Department, Blessing Hospital, United Way of Adams County
- Data from Healthy People 2020, County Health Rankings, Illinois State Improvement Plan survey

Illustration: Adams County Community Health Assessment Priority Areas

- Access to Health Services: increase proportion of people with usual primary care provider
- Oral Health: Reduce proportion of children and adolescents with untreated dental decay
- Substance Abuse: Reduce proportion of adolescents reporting rode with drive who had been drinking

Tools to use

- Team based care
- Use of data as information to manage patient care, integrate efforts focused on patient, community
- Payment reform that shares premium dollar

Approaches to use

- Community-appropriate health system development and workforce design
- Governance and integration approaches
- Flexibility in facility or program designation to care for patients in new ways
- Financing models that promote investment in delivery system reform

Community-appropriate health system development and workforce design

- Local determination based on local need, priorities
- Create use of workforce to meet local needs within the parameters of local resources
- Use grant programs

Governance and integration approaches

- Bring programs together that address community needs through patient-centered health care and other services
- Create mechanism for collective decision making using resources from multiple sources

Flexibility in facility or program designation to care for patients in new ways

- How to sustain emergency care services
- Primary care through medical home, team-based care models
- Evolution to global budgeting

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Financing models that promote investment in delivery system reform

- Shared savings arrangements
- Bundled payment
- Evolution to global budgeting
- New uses of investment capital

Special importance: shared governance

- Regional megaboards
- Aggregate and merge programs and funding streams
- Inter-connectedness of programs that address personal and community health: the culture of health framework
- Strategic planning with implementation of specifics
- Develop and sustain *appropriate* delivery modalities

Special Considerations to Get to Shared Responsibility, Decisions, Resources

- A convener to bring organizations and community leaders together: who and how?
- Critical to success: realizing shared, common vision and mission, instilling culture of collaboration, respected leaders
- Needs an infrastructure: the megaboard concept
- Reaching beyond health care organizations to new partners to achieve community goals

Examples of Governance

- Quad City Health Initiative: 25-member community board
- Heart of New Ulm Project in MN: New Ulm Medical Center in lead role in rural community

Source: "Improving Community Health through Hospital-Public Health Collaboration." November, 2014. Available through the AHA web site

Results

- Linking housing to a community health plan in St. Paul, MN; financing from health foundations and community development financial institutions
- Collaboration of public health, community development corporation, and community development finance improved indoor air quality in NYC

Getting to the new system: demonstrations

- "Local Primary Care Redesign" projects that combine primary care and other health care providers (including the local hospital) in organizational configurations that expand and sustain access to comprehensive primary care focused on individual and community health improvement
- "Integrated Governance" projects align various organizations in a community or region in a new model of governance, using affiliation agreements and memoranda of understanding, requiring new governing entities such as community foundations, or establishing new designs that merge financing and funding streams and direct new programs

Getting to the new system: demonstrations

- "Frontier Health Systems" – innovative models to secure sustainable essential health care services integrated with services across the horizontal and vertical care continua
- "Finance tools to repurpose existing local health care delivery assets;" support projects that leverage existing assets to develop sustainable rural systems meeting needs of local populations

Population health capabilities

- Define the care model to meet population's needs
- Health information: data warehouse and use of the data as information; clinical decision support; care navigation support tools
- Care navigation/management
- Network of partners

Source: Kate Lovrien, "4 population health capabilities health systems need." *Becker's Hospital Review* January 28, 2015.

Aspirational Goal: Accountable Care Community Components

- Collaboration and partnership for effective local governance
- Structure and support including health information technology, a "backbone" organization
- Leadership and support from strong champions
- Defined geography and geographic reach
- Targeted programmatic efforts

Rapid Cycle Learning and Change

- Momentum is toward something very different, more than changing how to pay for specific services
- Need to be strategic, in lock step with or ahead of change in the market
- Change in dependencies from fee-for-service to sharing in total dollars spent on health

Retaining rural values

- Accessible
- Affordable
- High quality
- Community-based
- Patient-centered

For further information

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

The RUPRI Health Panel
http://www.rupri.org

Rural Health Value
http://cph.uiowa.edu/ruralhealthvalue/

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