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Rural Health Strategies for a Value-Based Future

ASHNHA Conference
Anchorage, Alaska
April 22, 2014

ASHNHA
ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

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Agenda

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

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Converging Forces

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- Price reduction threats and volume reduction pressures
- Expanding insurance coverage and changing products
- Continually evolving quality measures and expectations
- Alternative models of care (e.g., telehealth, new providers)
- Local health care collaborations and regional affiliations

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Affordable Care Act (and More)

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- 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

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Quality Linked to Payment

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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%)

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Value Equation

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

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

Tyranny of Fee-for-Service

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- "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?**

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The Value Conundrum

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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

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- How we deliver care is predicated on how we are paid for care
- Health care reform is changing <u>both</u>
- Fundamentally, reform involves a **transfer of financial risk** from payers to providers

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Risk Assessment is Ubiquitous

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- 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**

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The Risk of Inertia

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Source: Institute for HealthCare Improvement and Sharon Vitousek, MD

Random

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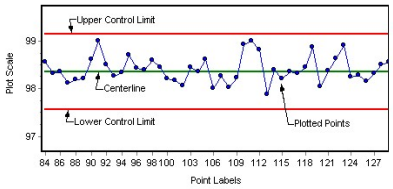
- Normal variation
- Rolling the dice
- Roulette v. poker
- No significant control, but important to recognize



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Insurance Risk

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- Insurance risks
  - Demographic change
  - Technological innovations
  - Prior health status
  - Cost inflation
- Cost is the actuarial metric
- Minimal control, but predictable

Anthem · Aetna · UniCare · Humana · Cigna · PacifiCare · UnitedHealthcare · HealthNet

Political Risk

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- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues

American Hospital Association

NRHA National Rural Health Association

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Medical Care Risk

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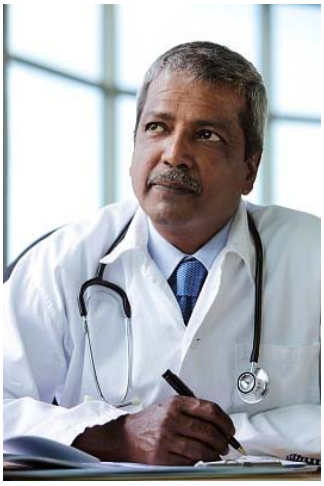
- Medical care *variation*
  - Diagnostic accuracy
  - Care plan implementation
  - Guideline use compliance
  - Pharmaceutical choice
  - Procedural skill
  - Efficient resource use
- Our clinical choices influence health care ***value***
- Greatest control, how we deliver care



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Rural Risk?

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- Toolbox for Value

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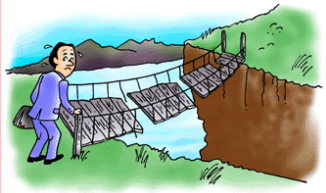
The Volume to Value Gap

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

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Volume to Value Transition

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- 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

22

- Understand the current rural health care milieu
- Acknowledge the paradox of quality, experience, and cost
- Envision and articulate a **value-based future**
- Lead with focus and clarity, but be willing to listen and learn
- Plan for transition challenges

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Redesign our Operations

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- Organization chart
- Capital budgets
- Job descriptions
- Compensation
- Clinical care sites/modes
- Care coordination
- Provide or partner

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Transition Requires New Foci

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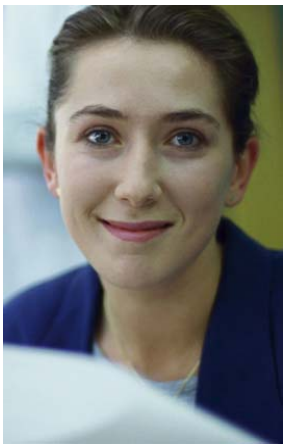
- Inpatient Beds → Clinics (and more)
  - Expanded/robust primary care
  - Workplace nursing and SNF/ALF clinics
  - Mobile clinics and telehealth
- Illness → Wellness
  - Health Risk Assessments
  - Community Health Assessments
  - Health coaching and care coordination
- Charges → Costs
  - Revenue becomes covered lives
  - Charge master becomes cost master
  - Re-purpose inpatient space



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Holy Family Hosp. Transformation

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Hospital	Physicians & NP/PA	Senior Leaders	Mission Focus	Recognition
2001: 90-bed hospital	2001: 35 employed providers	2001: 10 senior leaders	2001: Focus on the sick population	2001: Locally recognized
2012: 35-bed hospital	2012: 90 employed providers	2012: 5 senior leaders	2012: Focus on wellness & prevention	2012: Nationally recognized for safety, innovation and thought leadership

Source: Graphic provided by Mark Herzog, CEO. Holy Family Memorial Hospital. Manitowoc, Wisconsin. 2013.

Health Care Transformation

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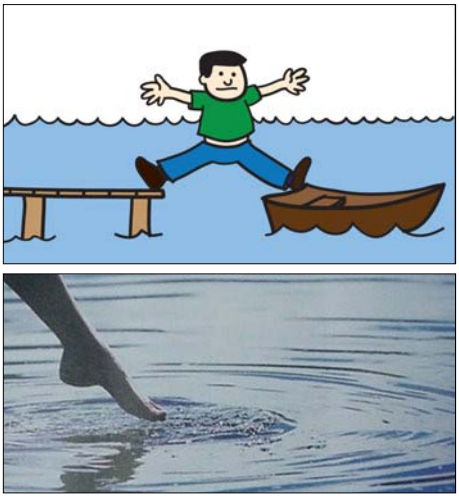
- How do we move toward delivering value when our revenue is primarily volume-driven?
- How do we not get "soaked" during the transition?
- We can "test the waters" with a new set of tools.



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- **Toolbox for Value**

Provider Toolbox

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1. Fee-for-Service Attention
2. Operations Efficiency
3. Physician Engagement

- ✓ Patient-Centered Medical Homes
- ✓ New Skill Development
- ✓ Measure, Report, and Act
- ✓ Performance Improvement
- ✓ Payment for Quality
- ✓ Care Coordination
- ✓ Referral Patterns
- ✓ Regionalization
- ✓ Community Engagement

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1. Get Your FFS House in Order

29

Attention to

- Market share
- Expense management
- Revenue cycle
- PQRS/Meaningful Use
- Payer/Purchasing contracts
- *Appropriate* volumes

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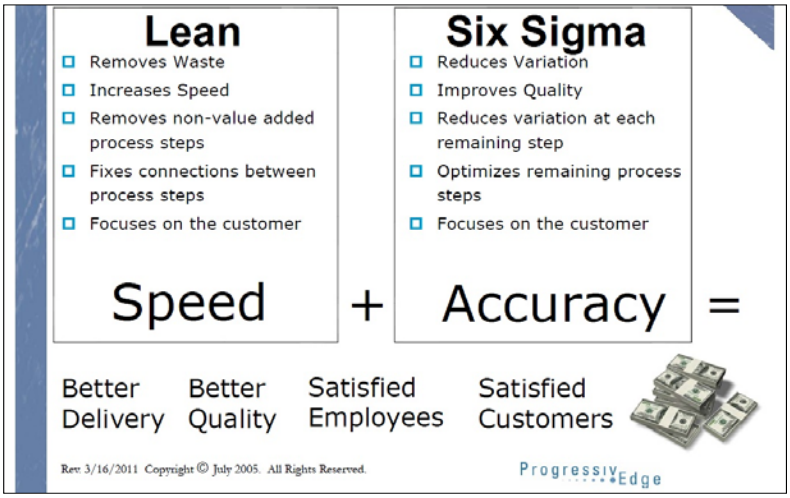
2. Improve Operations Efficiency

30



Resource: Jay Arthur. *Lean Six Sigma for Hospitals: Simple Steps to Fast, Affordable, and Flawless Healthcare.* 2011

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Medical Staff Relationships

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

BKD LLP

Source: Personal conversation with John Sheehan, CPA, MBA

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Physicians

32

- 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 10 phys = **$100 million/yr**)

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3. Engage Medical Staff *Deeply*

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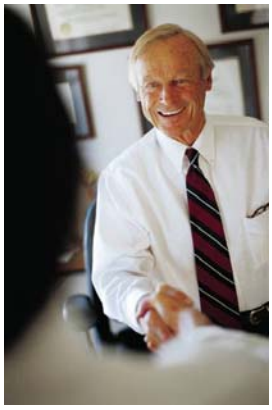
Physician Engagement* means

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

- Governance
- Compensation
- Education
- Data



* or Provider

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Shifting Health Care Payments

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√ Develop Medical Homes

35

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

36

- 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

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√ Cultivate New Skills

37

- 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

√ Measure, Report, and Act

38

- 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

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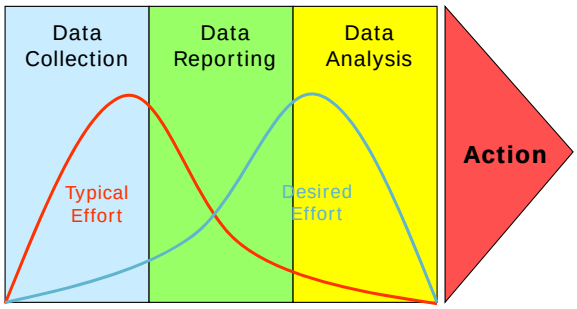
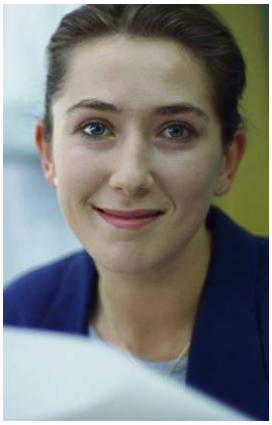
Performance Measurement ROI





The goal is move the curve to the right

Source: Greg Wolf, Stroudwater Associates

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√ Prioritize Improvement

40

- 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

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√ Get Paid for Quality

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- 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

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Cost by Patient

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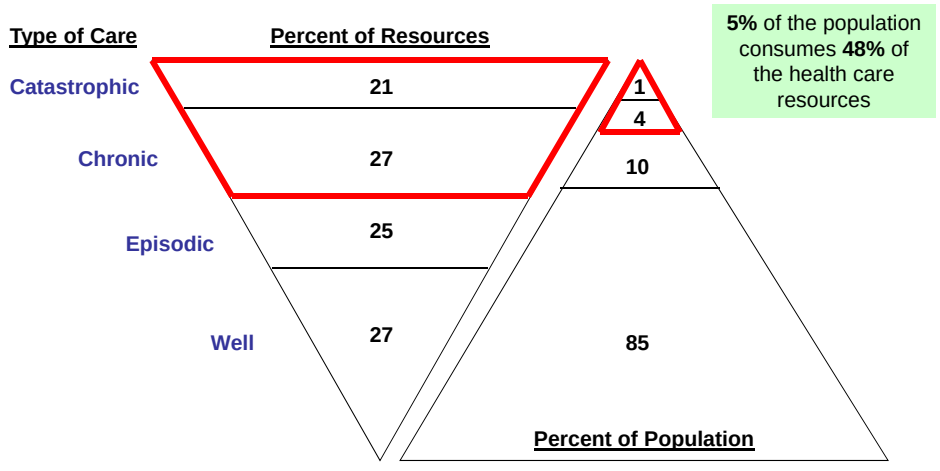

5% of the population consumes **48%** of the health care resources

Source: Rural Wisconsin Health Cooperative, 2003. Updated with Kaiser Family Foundation. *Health Care Costs: A Primer*. March 2009.

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√ Coordinate Care

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- 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

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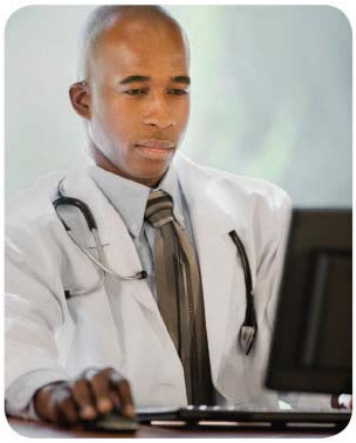
√ Think About Your Referrals

44

- Develop a *Value* Referral Network
  - Who provides the best care for your patients?
  - Who provides the best value for your patients?
  - What quality of care do you want your mom to have?
- Tertiary care facilities and specialists should earn our trust and referrals
  - Our community and patients deserve it



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√ Consider Regionalization

45

- 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
  - Independence is not a mission statement
  - Affiliation is not an end in itself
  - But… options are optional!
  - Success measured by *clinical integration*

Resource: Lupica and Geffner. Enlightened Interdependence. *Trustee*. November/December 2012.

Clinical Integration

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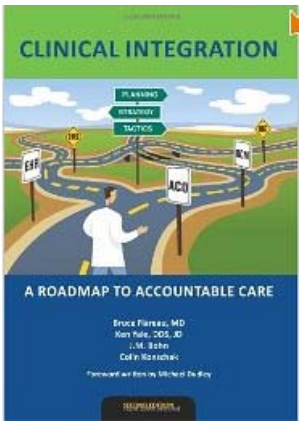
- Clinical data sharing in real-time
- Standardized clinical care protocols
- Consistent clinical performance measures and reporting
- Clear team member responsibilities across multiple facilities
- Sense of professional camaraderie among disparate organizations
- Aligned incentives for regional ***population health*** improvement



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√ Engage Your Community

47

- 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*

RuralHealthValue.org

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- Rural Health Value Project
  - 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

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

www.RuralHealthValue.org

- Share an innovation with us 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!

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The Risk of Something New

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Healthy People and Places

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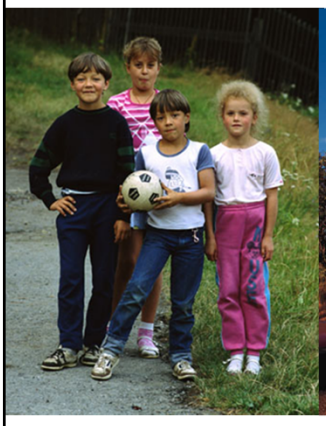

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