Rural Perspectives on Reform – From Volume to Value

Giving Back
ASHNHA Conference
Anchorage, Alaska
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ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

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Agenda

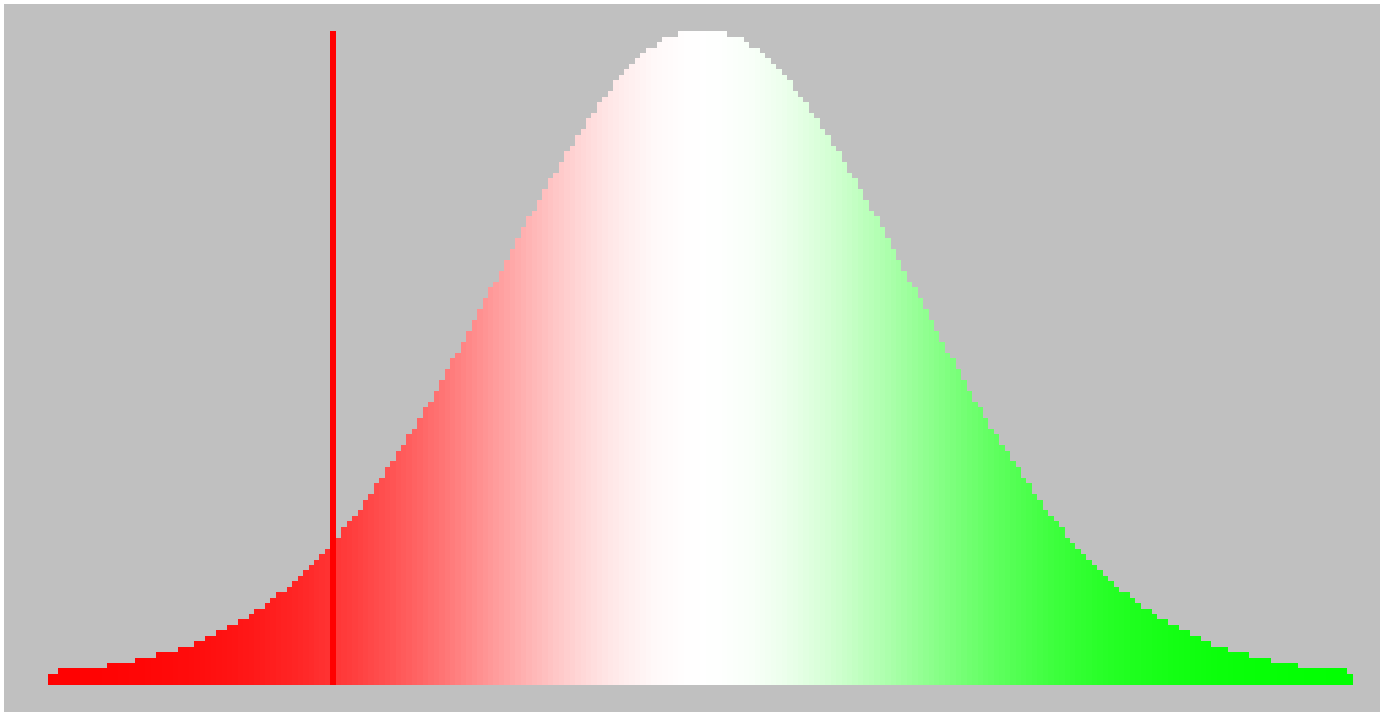
- Why the changes
- Health care "risk"
- Health care "value"
- Risk transfer from payers to providers (eg, ACOs)
- Optimizing opportunities for reward

Health Care Risk

- Insurance risk, eg.
  - Demographics
  - Technology change
  - Prior health status

- Clinical risk, eg.
  - Care plans
  - Drug choices
  - Procedures

Variation = Risk = Opportunity



Variation suggests a risk for underperformance, but also an opportunity to excel

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Calculated Risk

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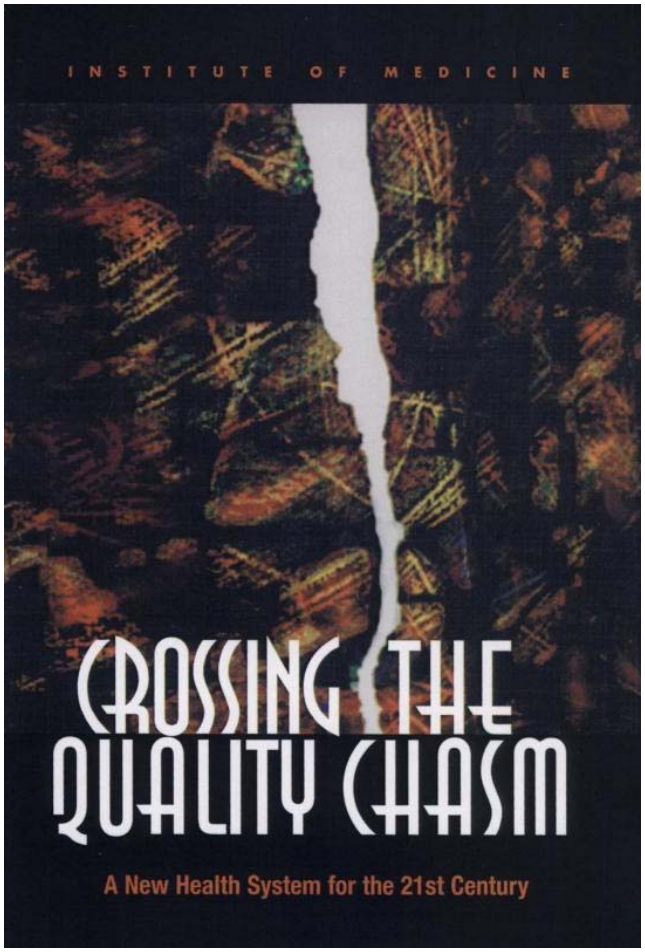
Value – IOM Six Aims

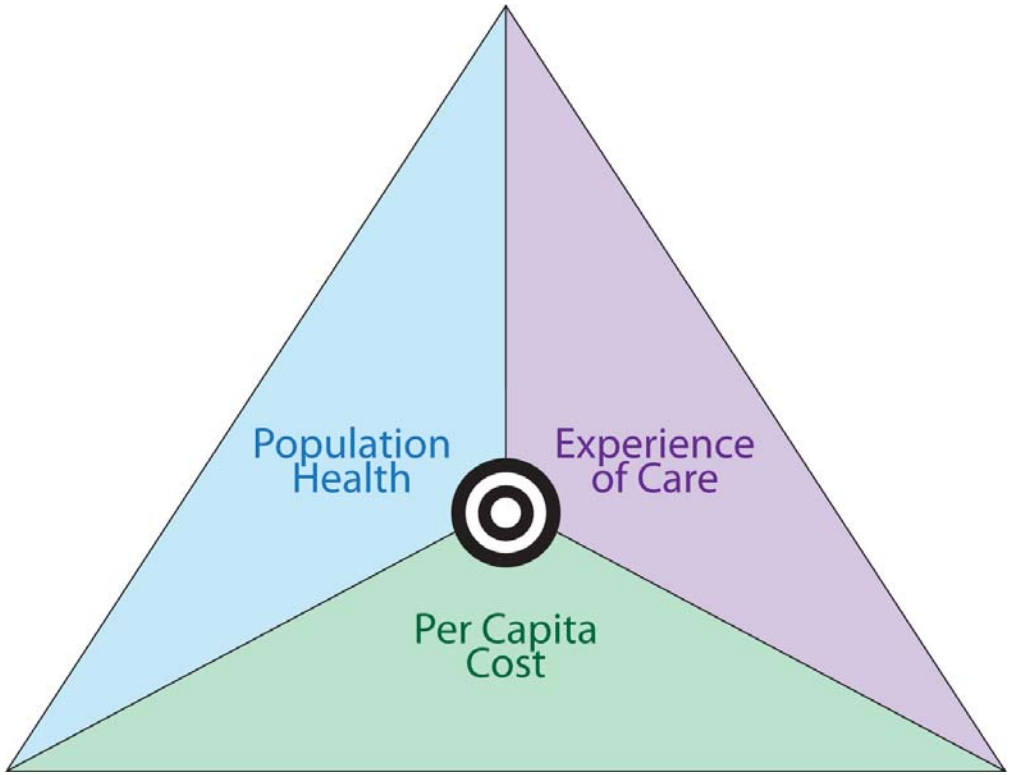
Health care should be:

- **Safe**
- **Effective**
- **Patient-Centered**
- **Timely**
- **Efficient**
- **Equitable**



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm.* Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.

The Triple Aim



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Value Equation

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

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

"Triple Aim"

- Better care
- Better health
- Lower cost

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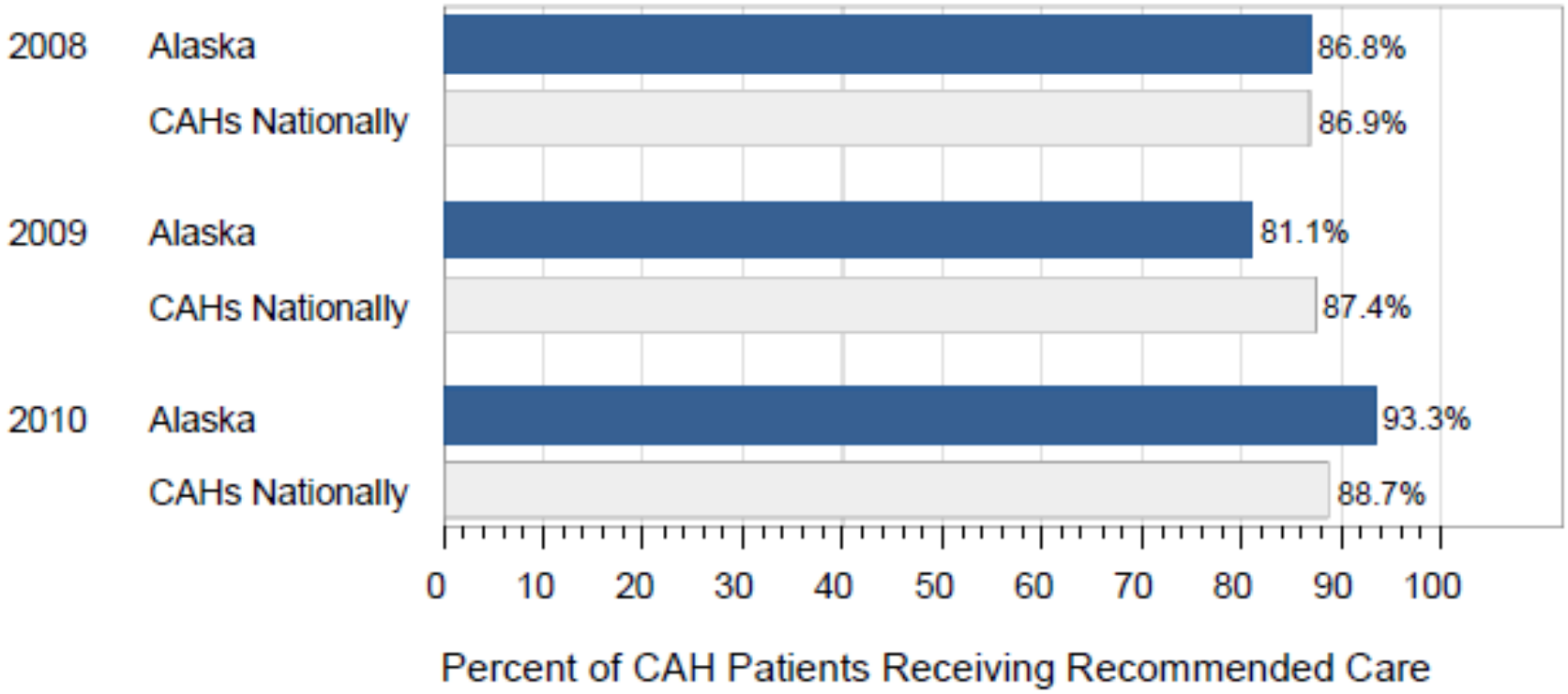
Alaska CAH Quality Reporting

	Alaska				National			
	Number of CAHs	Inpatient data	Outpatient data	HCAHPS data	Number of CAHs	Inpatient data	Outpatient data	HCAHPS data
2006	11	2 (18.2%)	N/A	N/A	1287	811 (63.0%)	N/A	N/A
2007	12	2 (16.7%)	N/A	N/A	1293	891 (68.9%)	N/A	N/A
2008	13	3 (23.1%)	N/A	1 (7.7%)	1301	914 (70.3%)	N/A	442 (34.0%)
2009	13	6 (46.2%)	1 (7.7%)	2 (15.4%)	1312	943 (71.9%)	209 (15.9%)	465 (35.4%)
2010	13	7 (53.8%)	1 (7.7%)	2 (15.4%)	1329	977 (73.5%)	282 (21.2%)	505 (38.0%)

Source: Flex Monitoring Team. Hospital Compare Quality Measures: 2010 National and Alaska Results for Critical Access Hospitals. 2012

Alaska CAH Clinical Quality

Figure 7. Pneumonia: Most Appropriate Initial Antibiotic(s)



Source: Flex Monitoring Team. Hospital Compare Quality Measures: 2010 National and Alaska Results for Critical Access Hospitals. 2012

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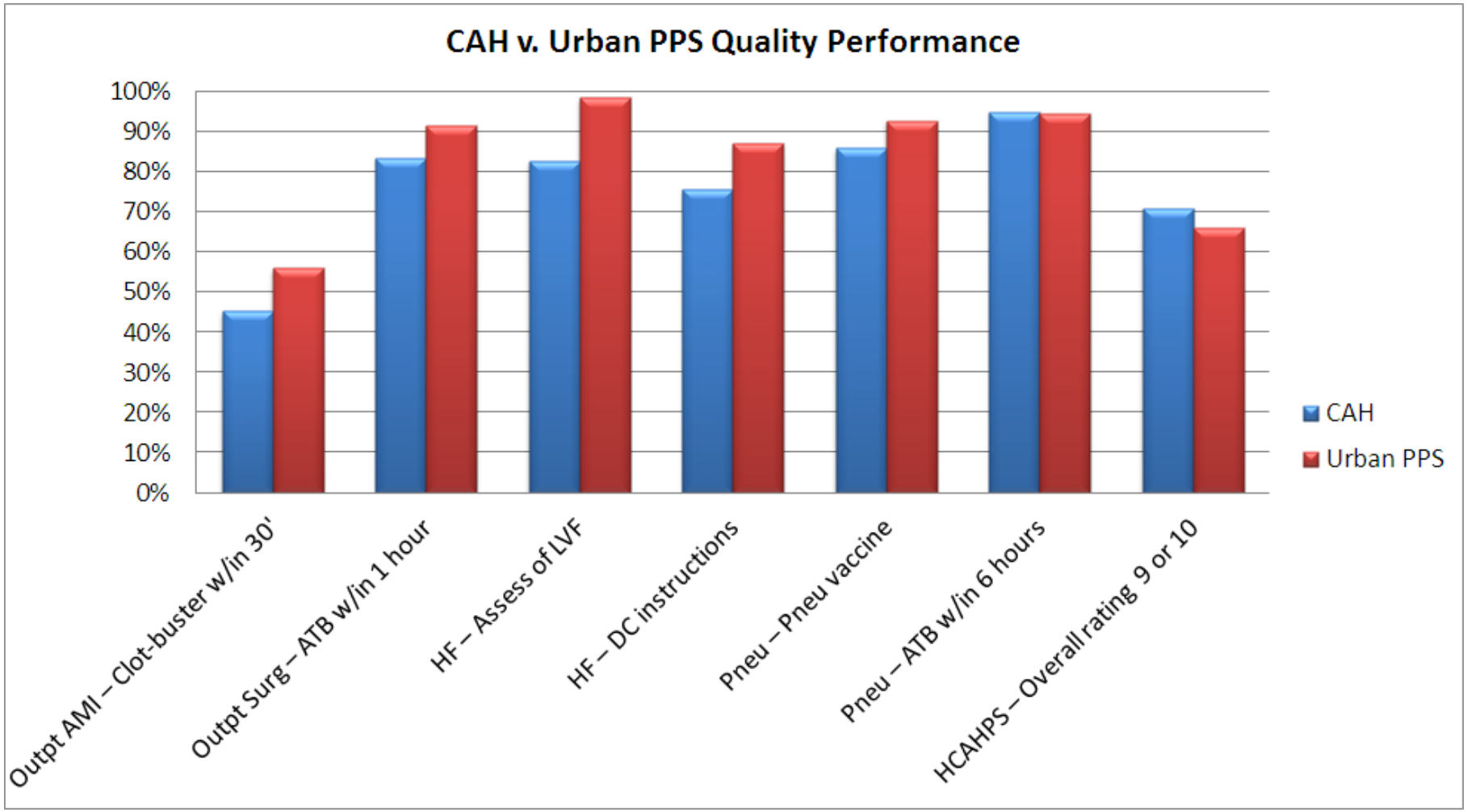
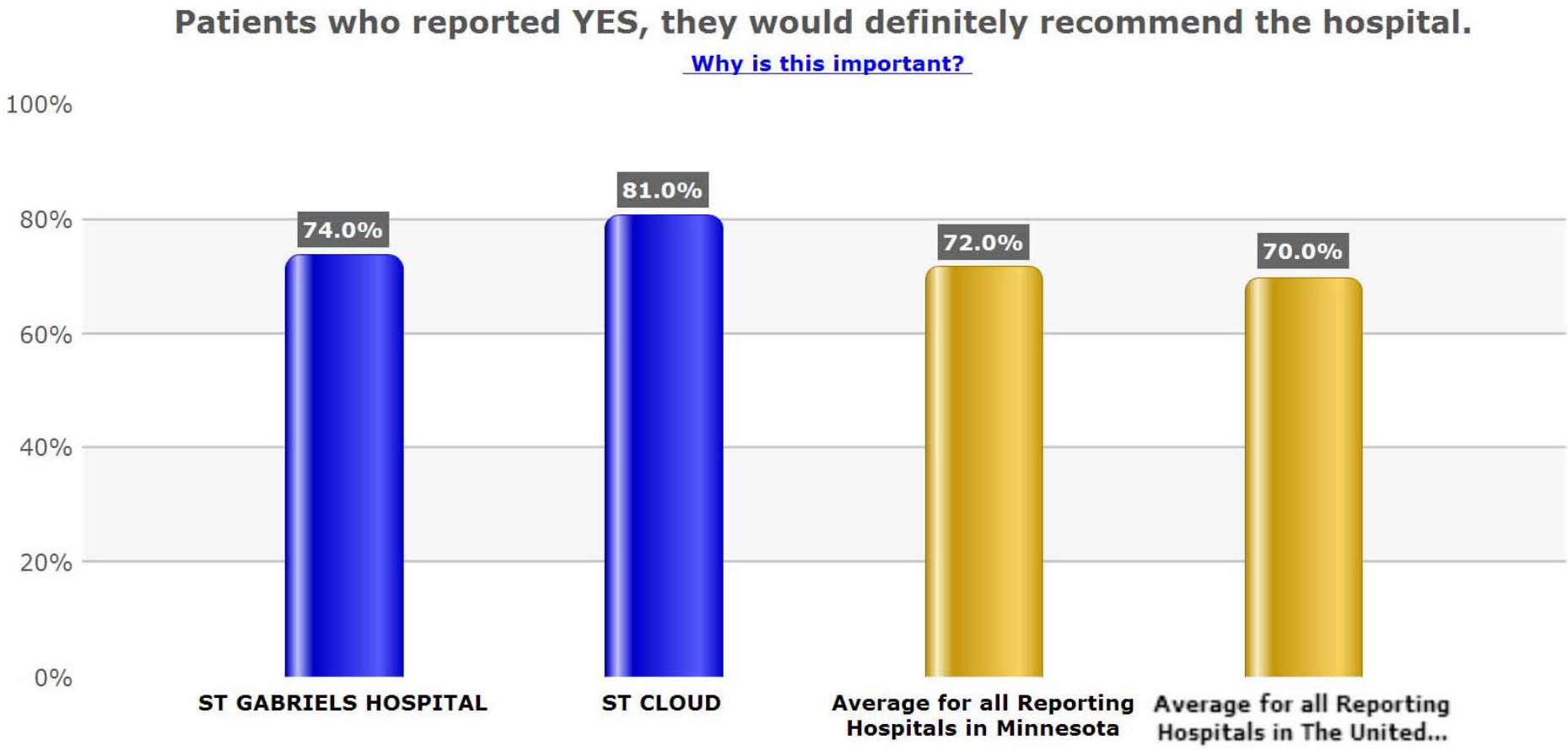
Rural Quality



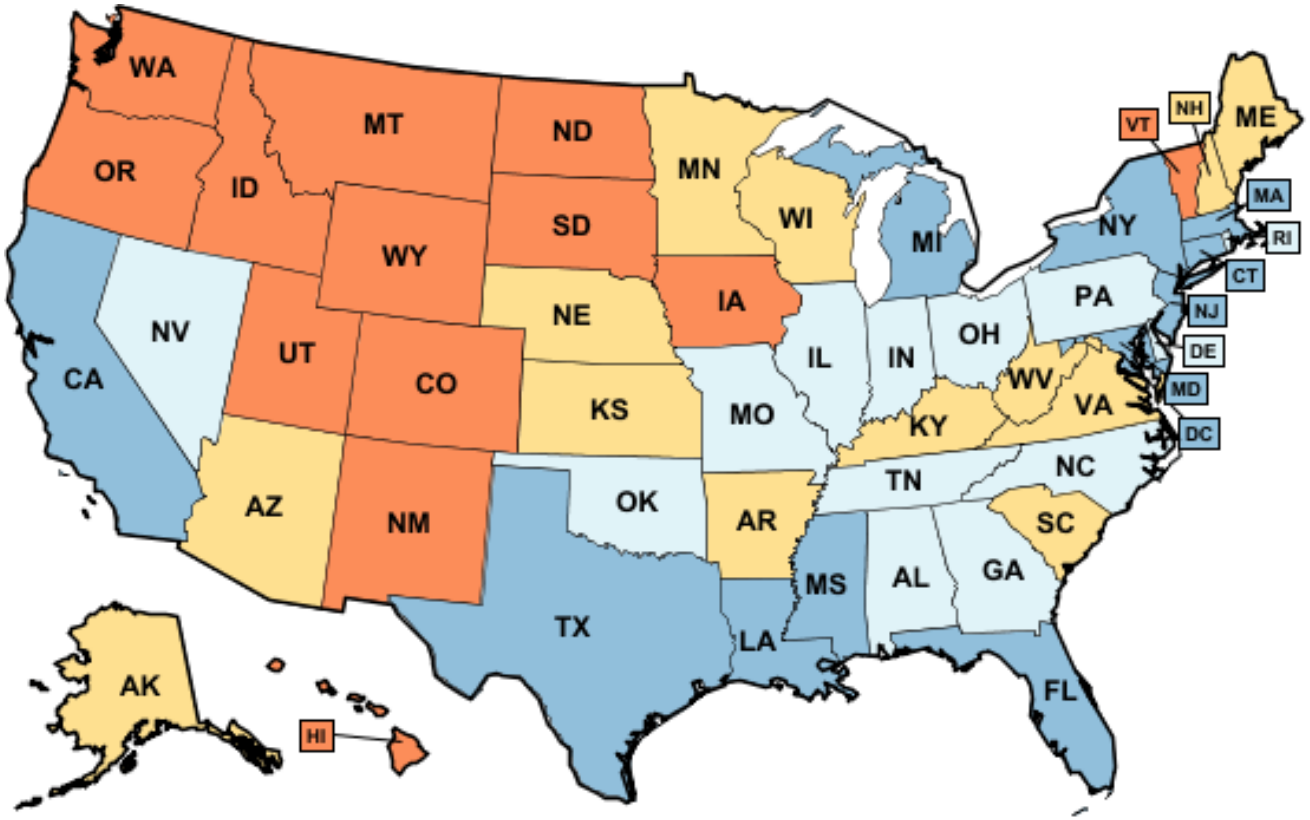
Source: Flex Monitoring Team. Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results. April 2011

Patient Experience



Source: www.hospitalcompare.hhs.gov. Accessed August 8, 2012.

Medicare Spending Per Enrollee



Source: Kaiser Family Foundation. 2009 Data

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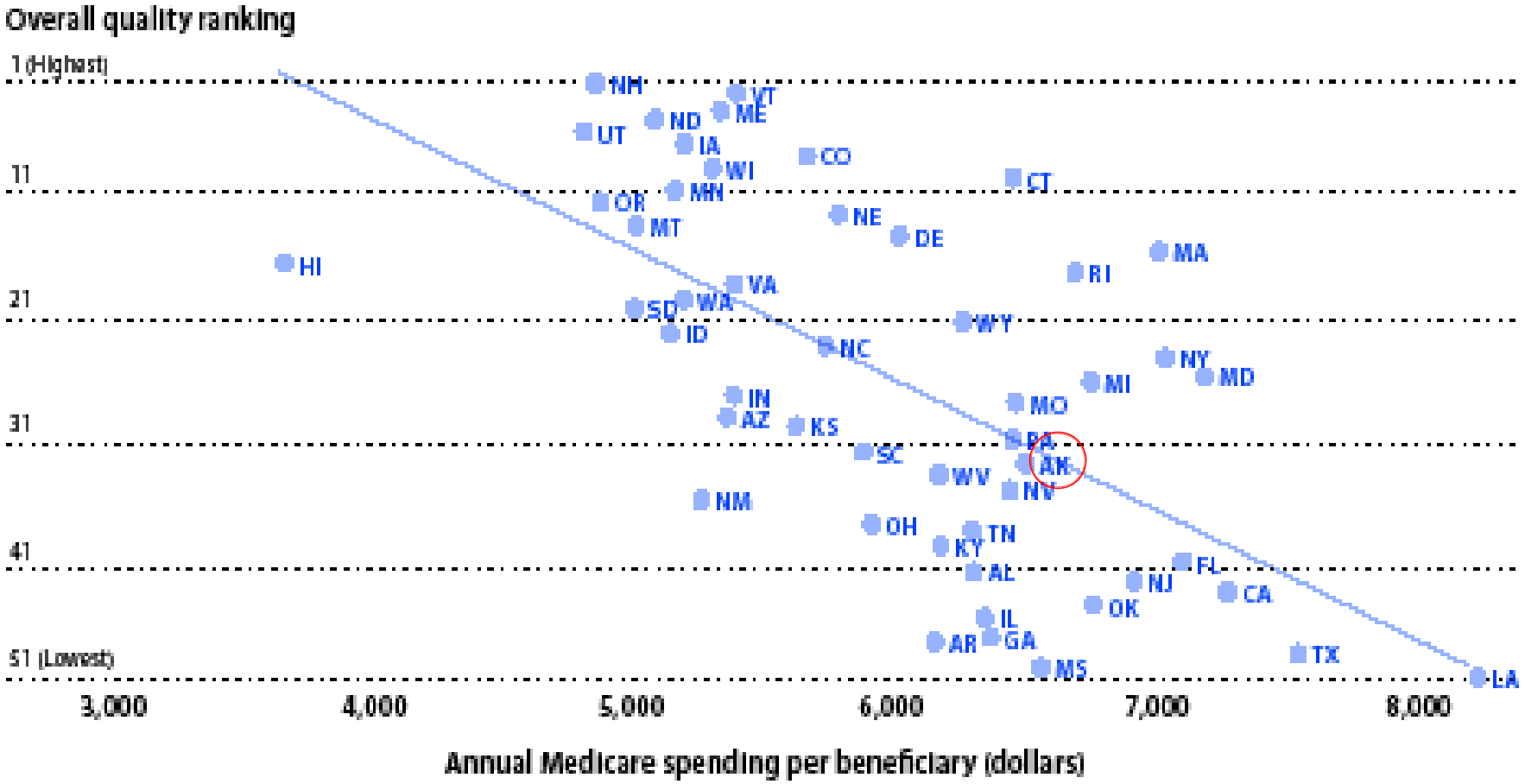
Quality/Cost



Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* Web Exclusive (April 7, 2004).

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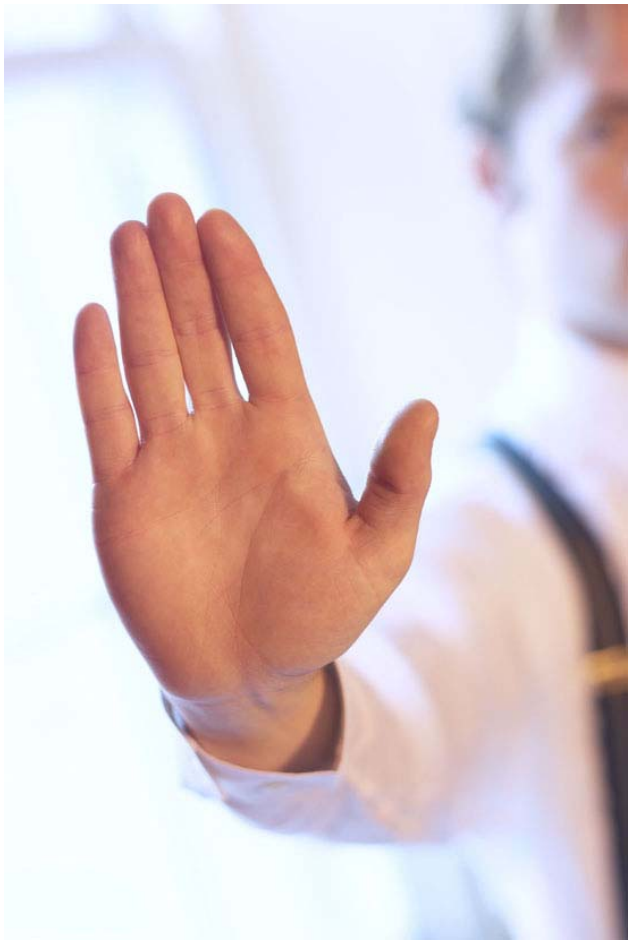
Unacceptable Healthcare Value

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation
- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Highest cost in the world
- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.
- **Nobody agrees about what to do!**



*Source: Berwick and Hackbarth. Eliminating Waste in US Health Care. *JAMA* , April 11, 2012. Vol. 307, No. 14.

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
- Self-police

- **Value-based purchasing?**
- **Accountable Care Organizations?**

Form Follows Finance

- How we deliver care is predicated on how we get paid for care
- Health care reform is changing both
- Fundamentally, a transfer of risk from payers to providers
- Supreme Court ruling has accelerated change

Accountable Care Organizations

- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Accepts *performance risk* for quality and cost

*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.

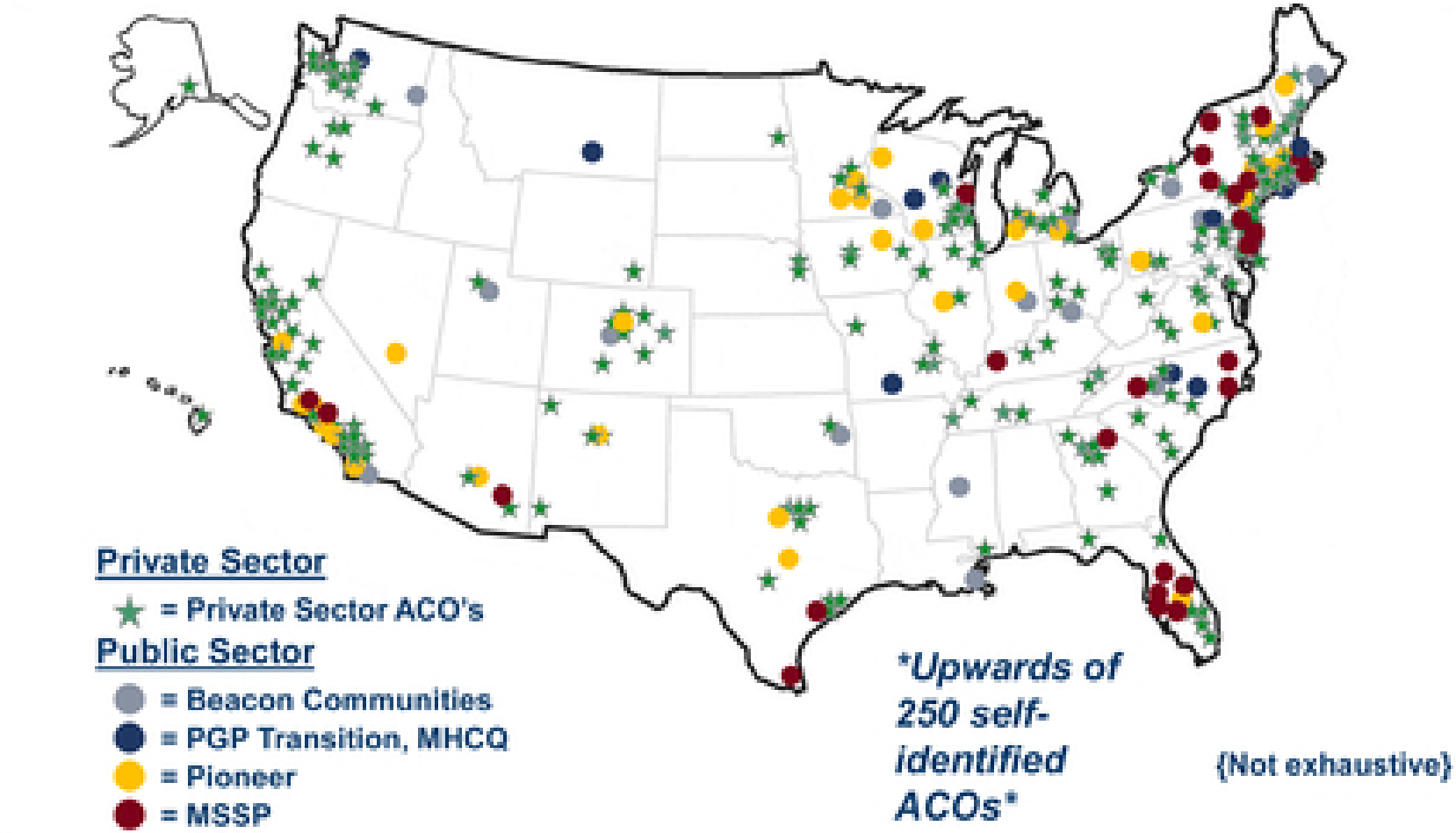
Shared Savings Program

- Medicare pays fee-for-service, then shares any gains at end of 3 years
- Percent of gains shared will be less if suboptimal quality
- Success requires excellent care and low cost – **value!**

ACOs' Rapid Expansion

- 164 private insurer ACOs nationwide (Nov 2011)
  - 60% hospital, 23% physician, 17% health plan
- 174 Medicare ACO Programs (August 2012)
  - Medicare Shared Savings Program (116 ACOs)
  - Physician Group Practice Transition (6 ACOs)
  - Pioneer ACO demonstration (32 ACOs)
  - Advanced Payment ACO demonstration (20 ACOs)
  - **~ 2.5 million (>5%)** of Medicare beneficiaries

ACOs Nationwide



The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute

Advanced Payment Demo

- To support rural and physician-owned organizations
- CMMI has budgeted $170 million
- Only two types of organizations are eligible
  - No inpatient facilities and less than $50 million annual revenue
  - CAH(s) and less than $80 million annual revenue
- Co-ownership with health plan <u>not</u> allowed

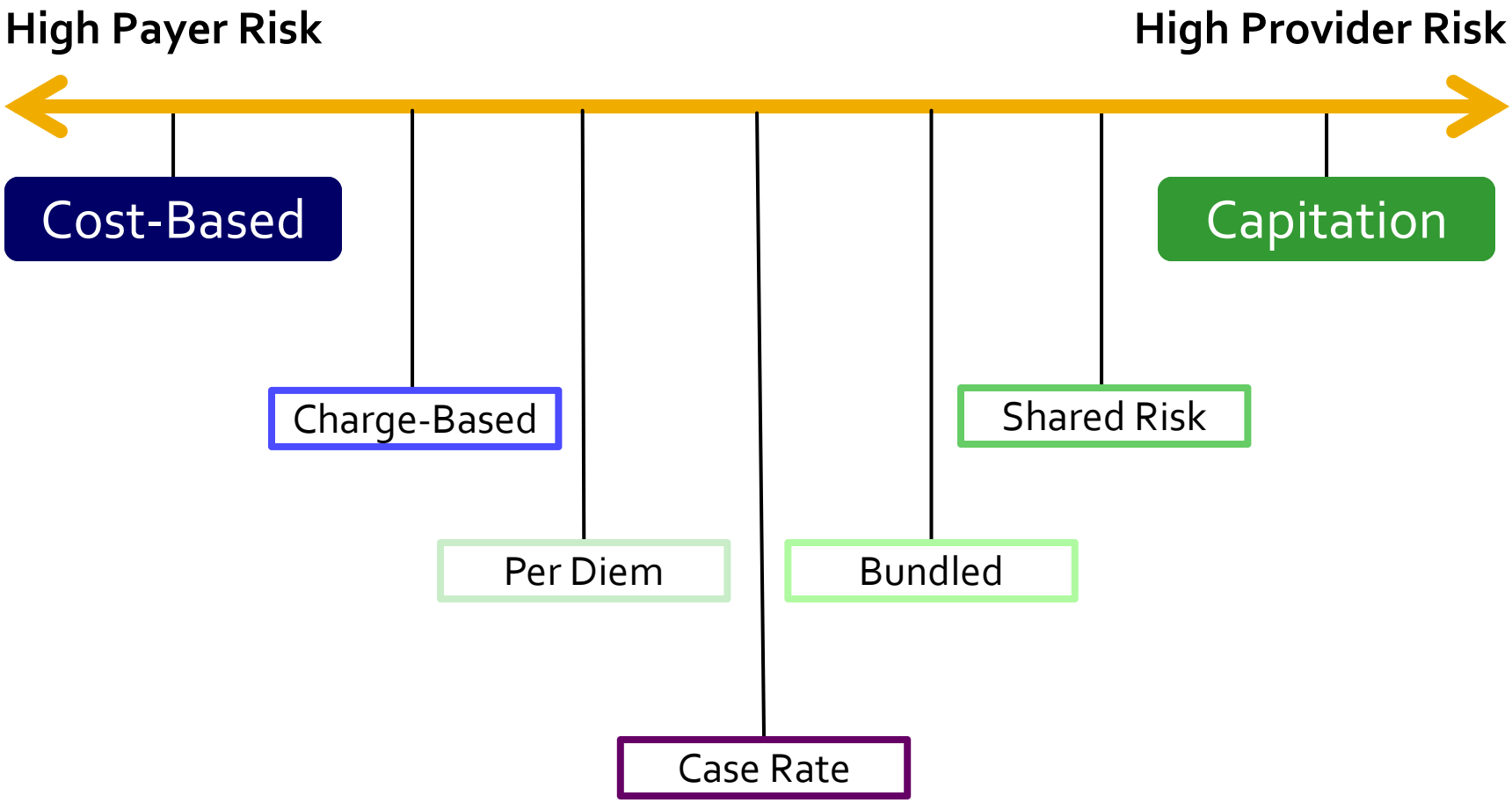
Advanced Payments

- Upfront fixed payment
  - $250,000 for ACO start-up
- Upfront variable payment
  - $36 per beneficiary
- Variable monthly payment
  - $8/month per beneficiary
- $1.87 million in <u>new</u> money
  - Payment in addition to FFS for 5,000 beneficiaries over 3 years
- Payments recouped
  - From savings in three years, but "loan" forgiven if not enough savings

Managed Care Redux?

- Better data regarding cost and quality
- New care management strategies
- Physician-hospital alignments
- Gain-sharing, thus less risk
- More physician (less insurance) control
- Yet Medicare a leader
- Insurer investment in "value" programs
- Private equity/capital market investment
- Public financial pressures

Payment Risk Continuum



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The Risk of Doing Nothing

"We've considered every potential risk except the risks of avoiding all risks."

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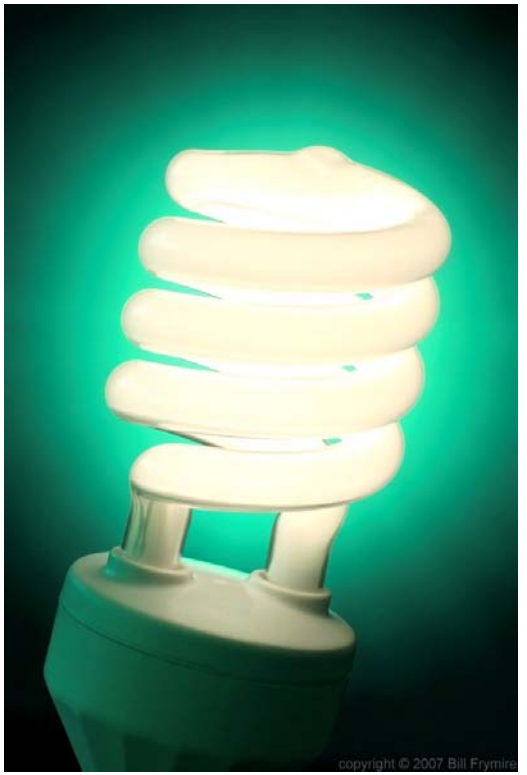
New Thinking

- As risk shifts, old business models are turned upside down
  - Where are our costs?
  - Where is our revenue?
- New world demands
  - Transferring risk to providers
  - Higher quality at lower cost
  - Doing what's needed, not more
  - Dealing with "stranded capital"
- The devil is in the transition
  - One foot on the dock and one in the boat
  - It'll be competitive – winners and losers



Tool Box for Delivering Value

- System thinking
- Balanced approach
- Medical homes
- Health coaches
- Performance improvement
- Medical staff relationships
- Collaboration
- **What we can do now**

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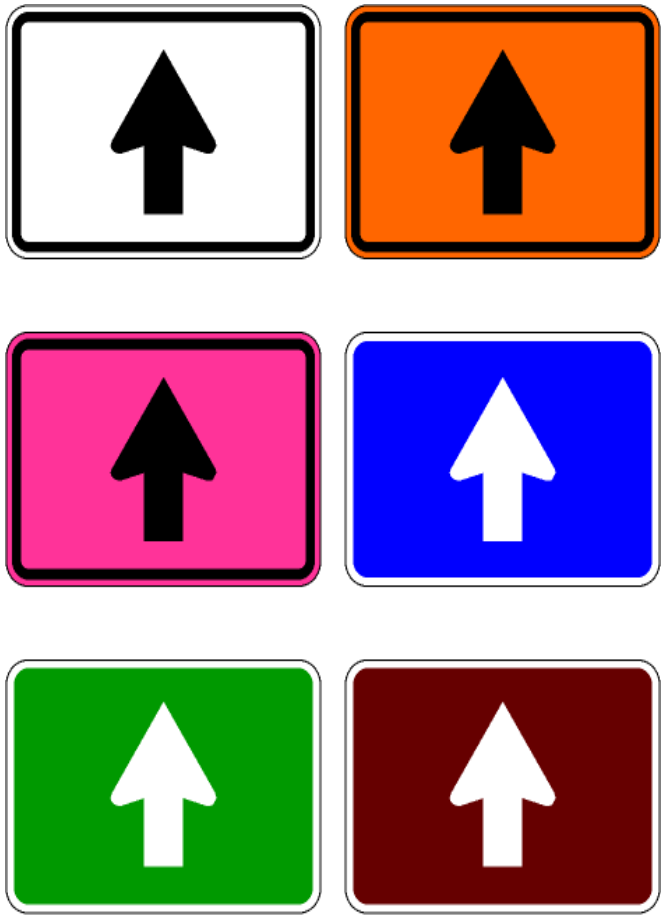
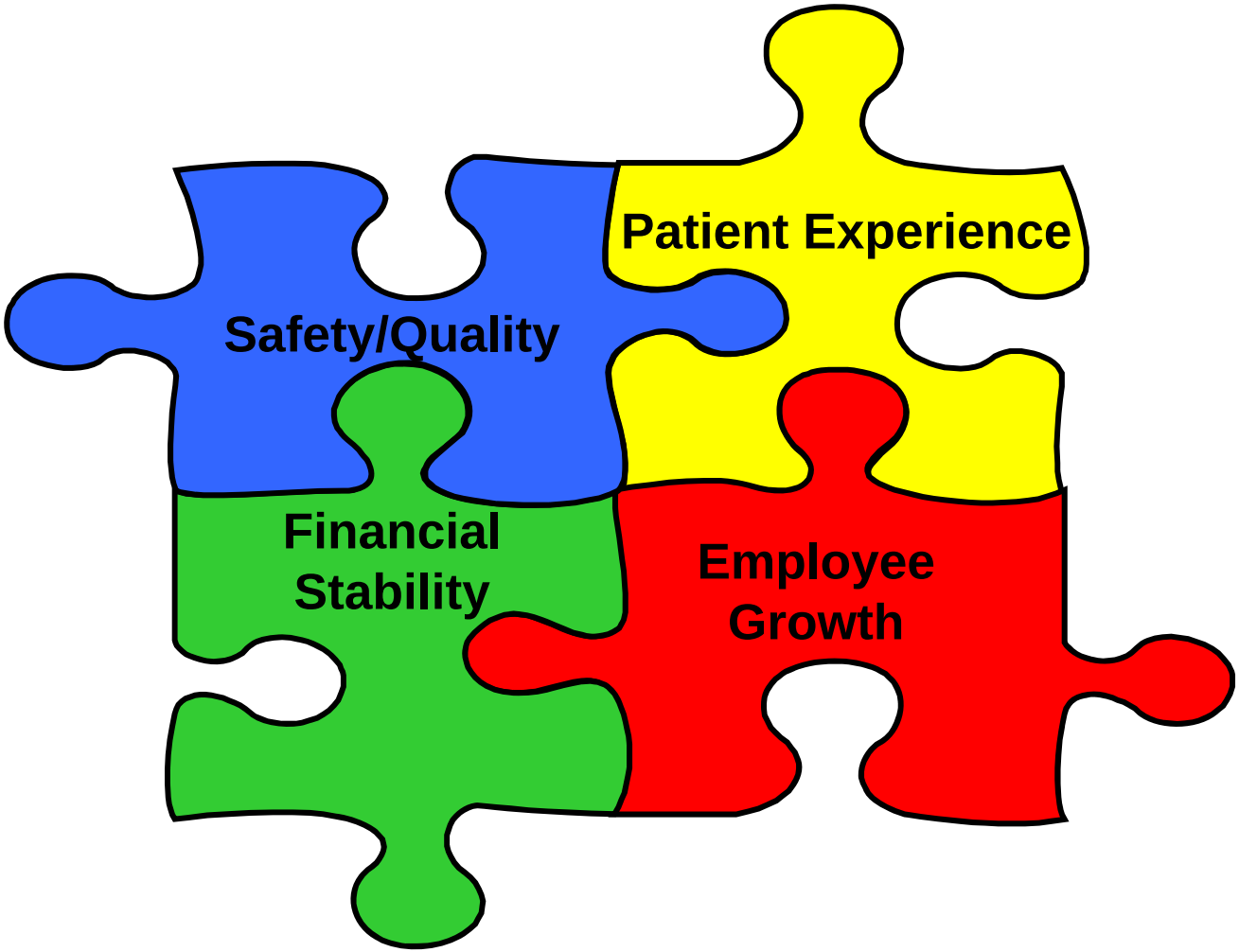
System Thinking

- Currently a *non*-system
  - Fragmented, poorly coordinated, and excessively costly
- Integrated Delivery Systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.
  - Moves from hospital-centric to physician- and patient-focused
- Care continuum
  - Personal health to palliative care
  - Health and human services



Balanced Approach



New Perspective

Source: Roland A. Grieb, MD, MHSA - Health Care Excel and Premier, Inc.

Non-Linearity

- ~~"No margin, No mission"~~
- **Balance** will be the success strategy
  - Health care safety/quality
  - Financial stability
  - Patient experience
  - Employee growth
- It's never about either/or; it's always about **and/both**

Medical Home Definition

The people, processes, and resources that deliver 24/7 accessible, patient-centered, and community-oriented primary care.

- Not a nursing home
- Not home health
- Not a "facility"
- A care team is essential
- Synonyms?
  - Patient-centered medical home
  - Health care home
  - Medical neighborhood

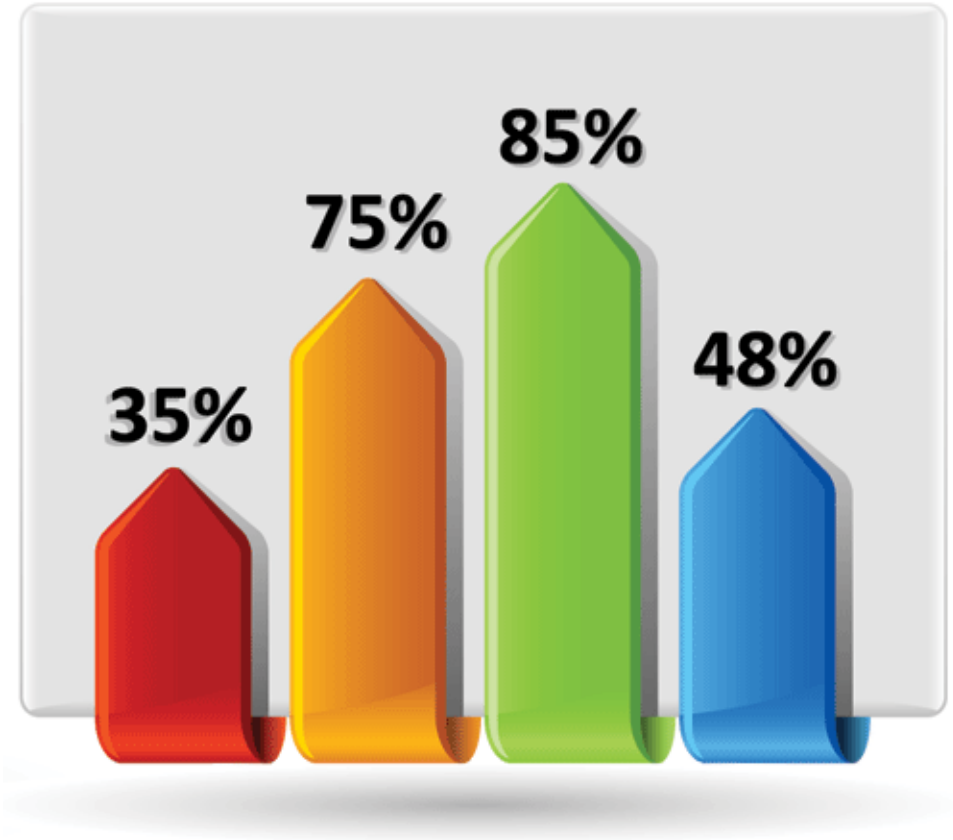
Health Coaches

- Identifies high-risk patients
- Proactively manages care
- Prepares for visits
- Develops disease registries
- Monitors reminder systems
- Provides patient education
- Coordinates care and transitions
- Works proximate to the team

Performance Improvement

The Value Equation

- Quality
  - ACO, VBP, HEDIS, etc.
  - Common diagnoses
  - Many – so "harmonize"
- Experience
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Cost
  - To the payer



Medical Staff Relationships

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

Source: Personal conversation with John Sheehan, CPA, MBA

Medical Staff Development

- Physicians see themselves as independent autonomous, and in control!
- Yet, hospital-physician alignment is essential to deliver value

Some ideas

- Develop and engage physician leaders
- Provide data transparency, but do not overstate discrete measure importance
- Offer rewarding, yet reasonable salary, rather than paying piecework

Source: Adapted from Cassel CK, Sachin HJ. Assessing individual physician performance. *JAMA*. Vol. 307, No. 24. June 27, 2012.

Medical Staff Development

Some Ideas (continued)

- Offer physicians direct ability to influence outcomes
- Provide a continual sense of accomplishment and recognition

Action Plans

- Recruitment and retention
- Governance and engagement
- Leadership development
- Relationship development

Collaboration Questions

- How do we develop a common vision and "culture?"
- How do we respect physician identity and independence, yet promote collaboration?
- How do we define success by *mission*, not hospital growth?
- How do we accept that *increased collaboration will require some loss of control*?

What We Can Do Now

- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership
- Educate Board, providers, and staff regarding performance
  - We are all "above average," right?
- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas that provide equal (or better) quality
  - Reduces Medicare cost dilution

What We Can Do Now

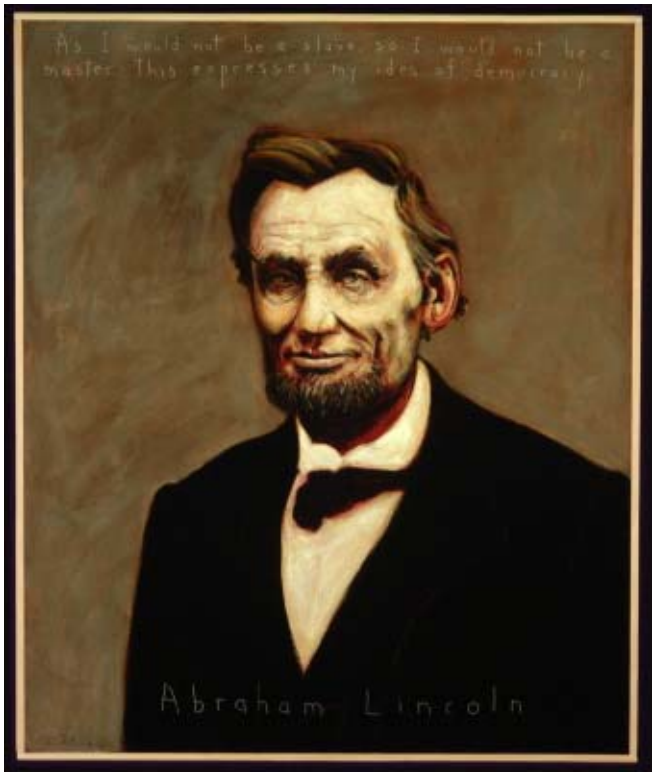
- Negotiate with third party insurers to pay for quality (funds ACO infrastructure)
- Aggressively apply for value-based demonstrations and grants
- Begin implementing processes designed to improve value
- Move organizational structure from hospital-centric to patient/community-centric
- Assess potential affiliations

Collaboration and Value

- ACOs and other "programs" less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**

Leadership

- Great leaders look into the future and see the organization not as it is… but as it can become.
- Reform will require:
  - Paradox
  - Vision
  - Savvy
  - Perseverance
  - Courage



The Risk of Something New

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Healthy People and Places

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