

Transforming Health Care in Rural America: Turning Change into Improvement for Rural Residents

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Overview

- Changes are underway that will change health care and health care systems that provide rural services
- Build on what we have
- Transitioning to an optimal system
- Help to get there

Note: The views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum

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



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)

Local Assets to Consider

- Raw material
- Data and information
- Connectivity
- Core capabilities, e.g., primary care
- Leadership



Recommendations for Hospitals

- Align with primary care doctors
- Ratchet all costs out
- Measure and improve quality
- Know your value proposition



Elements of a Successful System Redesign ⁷

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

Source: *Pursuing the Triple Aim*, Bisognano and Kenney. Jossey-Bass. 2012.

Changes in delivery system: Patient-Centered Medical Homes (PCMH)

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- Not your father's "medical home"
- Potential future of primary care
- Emphasis on integrated services, management of chronic conditions, team-based, patient-centered care



Changes in the delivery system: Accountable Care Organizations (ACO)

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- Including Medicare Shared Savings Program (MSSP)
- Including Pioneer Demonstration from Centers for Medicare and Medicaid Innovation (CMMI)
- CMMI anticipates doubling in 2013
- And much more.....

Tally Sheet

- 32 Pioneer ACOs
- 222 MSSP ACOs
- 35 116 are Advanced Payment
- 424 total ACOs; in 48 states



Serving Millions

- 21-31 million Americans receive care through ACOs
- 2.4 million in Medicare ACOs
- 15 million non-Medicare patients of Medicare ACOs
- 8 to 14 million patients of non-Medicare ACOs

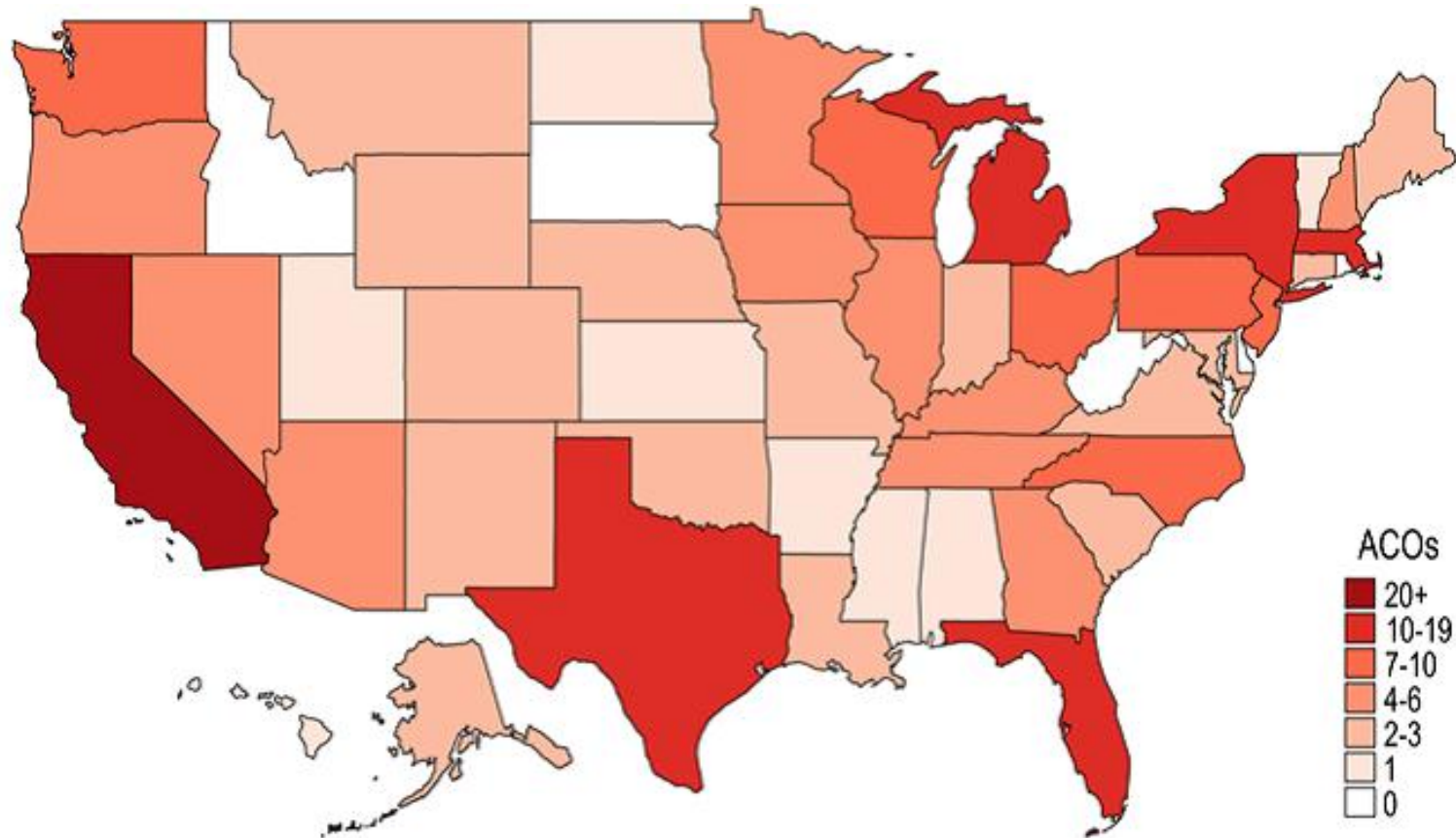
Source: "The ACO Surprise" by Niyum Gandhi and Richard Weil. Oliver Wyman, Marsh & McLennan Companies. 2012. http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf

People Live in Areas with ACOs Available

- In 19 states more than 50% of residents have access to ACOs
- In 12 states between 25% and 50% have access to ACOs (includes Montana)

Source: http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf

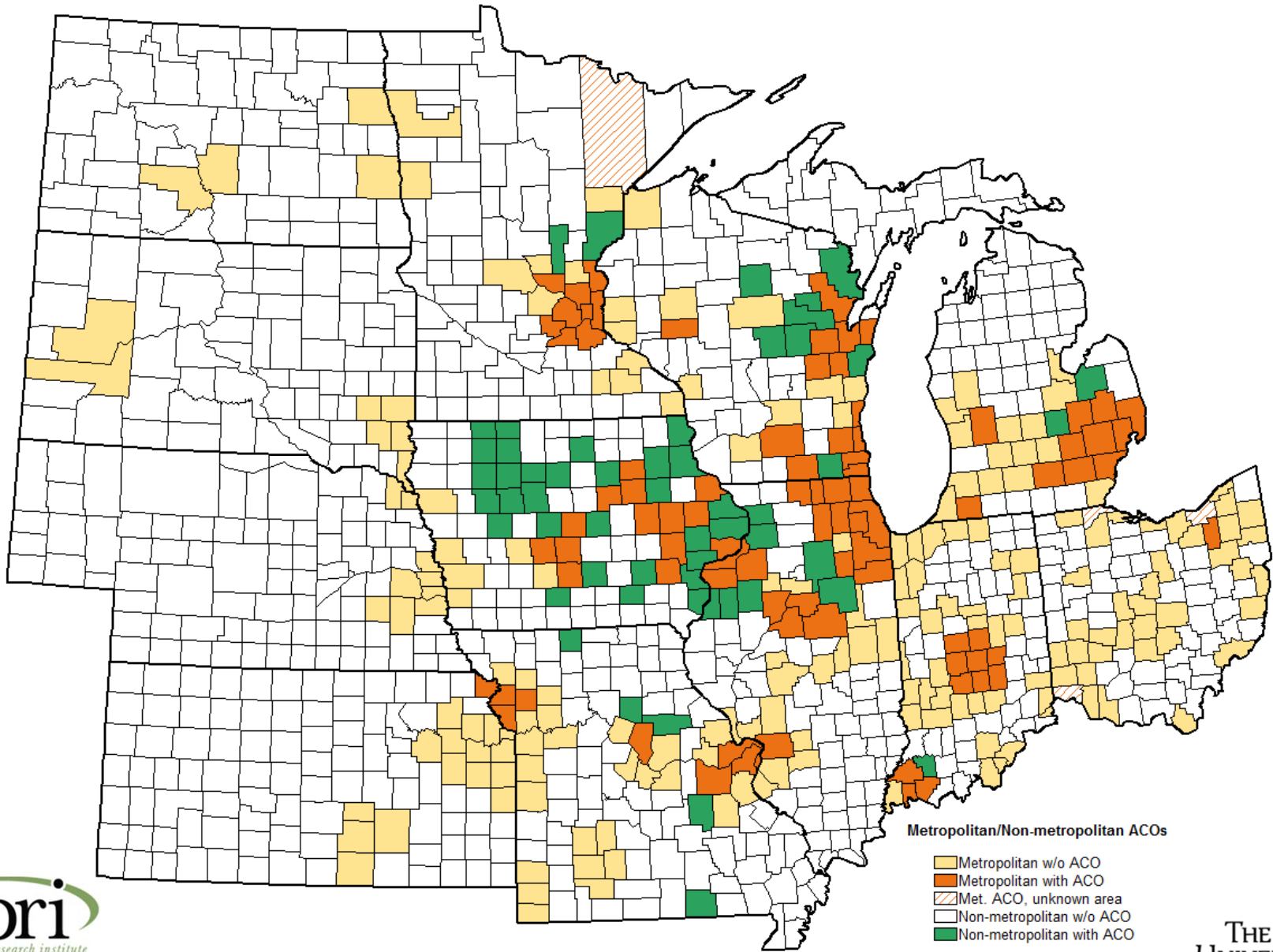
ACO DISTRIBUTION BY STATE



Source: David Muhlestein, Andrew Croshaw, Tom Merrill, Cristian Pena. "Growth and Dispersion of Accountable Care Organizations: June 2012 Update." Leavitt Partners. Accessed August 20, 2012 from LeavittPartners.com

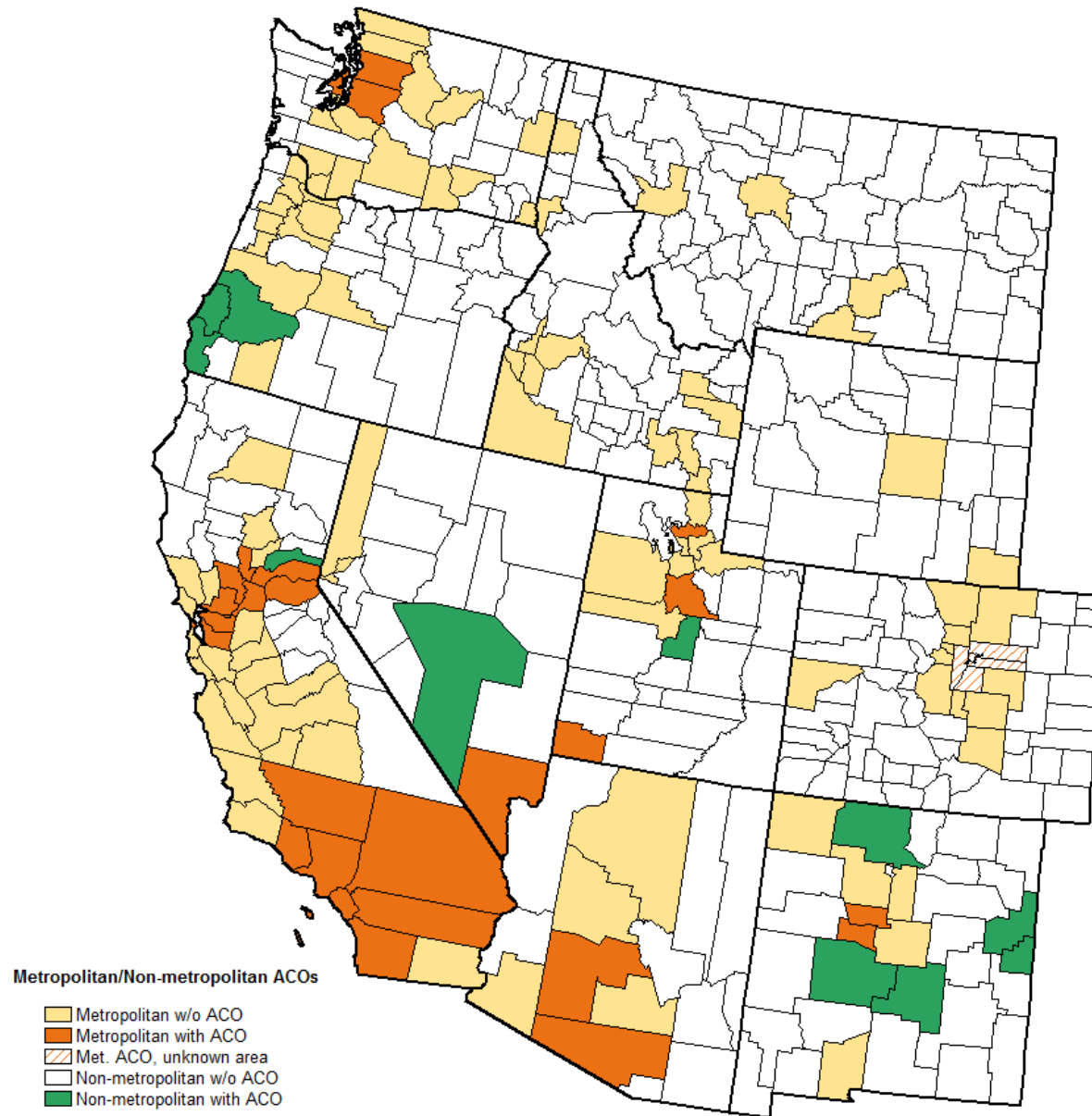
County Medicare ACO Presence

Midwest Census Region



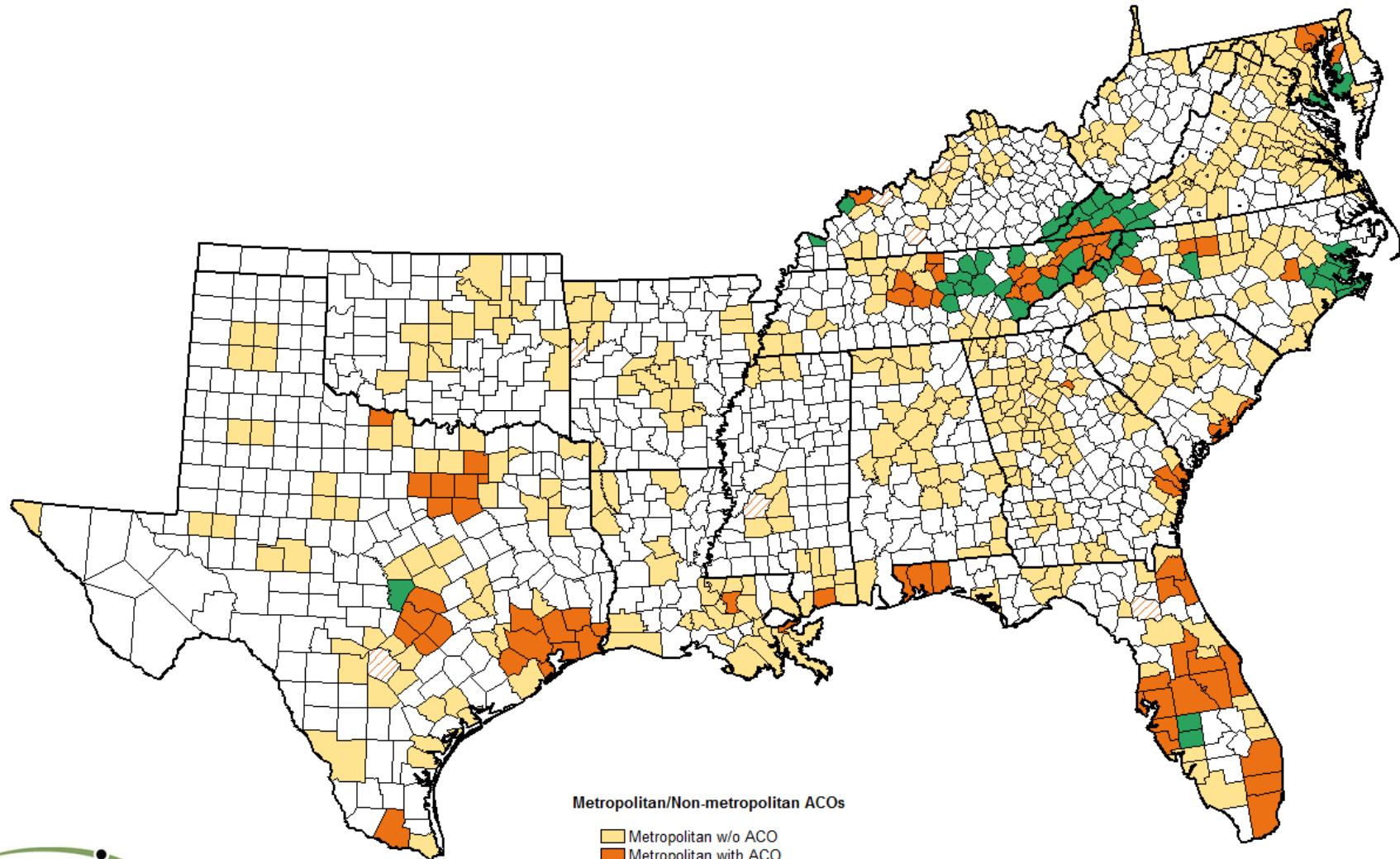
County Medicare ACO Presence

West Census Region



County Medicare ACO Presence

South Census Region

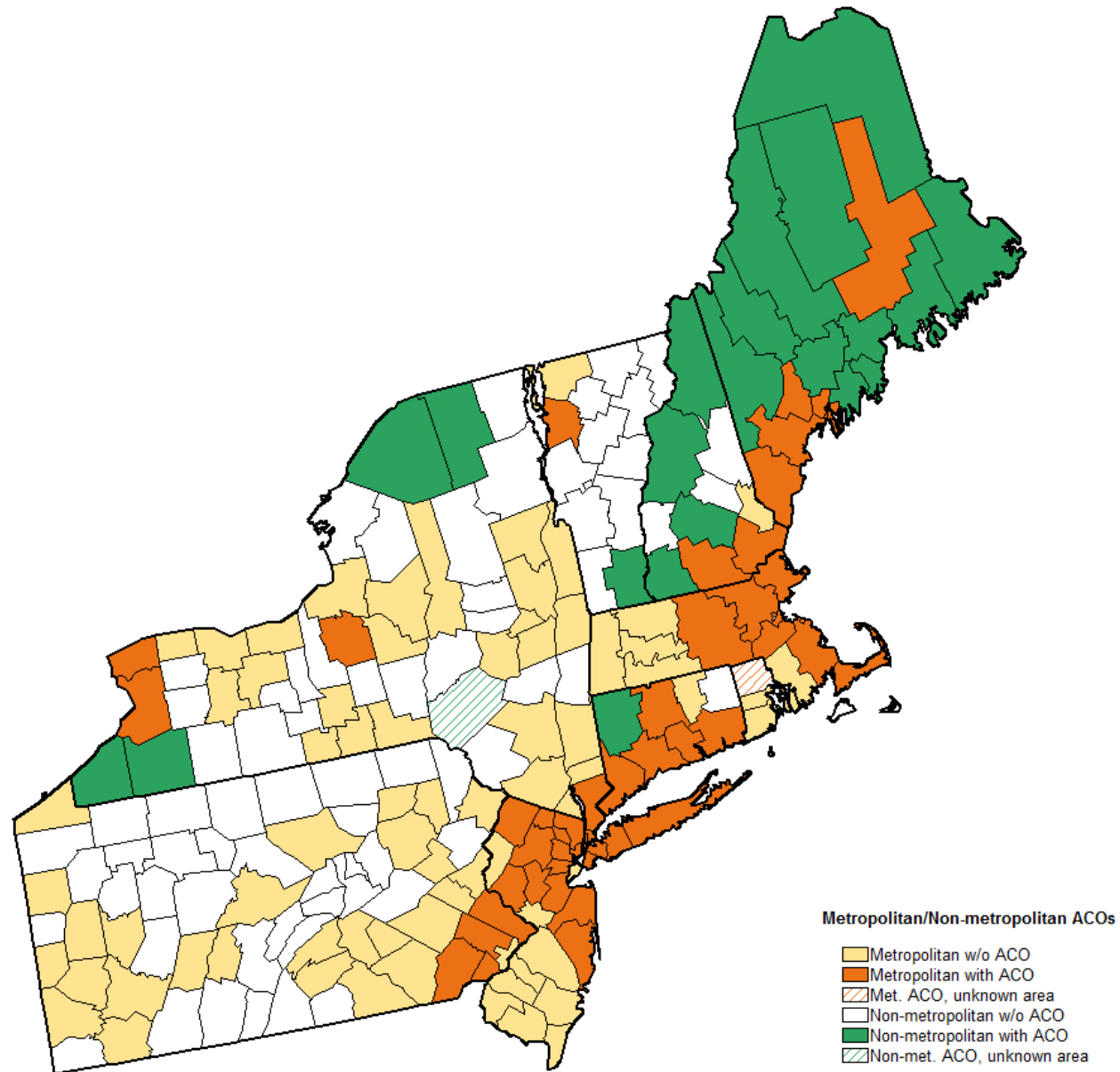


Metropolitan/Non-metropolitan ACOs

- Metropolitan w/o ACO
- Metropolitan with ACO
- Met. ACO, unknown area
- Non-metropolitan w/o ACO
- Non-metropolitan with ACO

County Medicare ACO Presence

Northeast Census Region



Core Components of an ACO

- People-centered foundation
- Health home
- High-value provider network
- Population health and data management
- ACO leadership
- Payer partnership

Source: AJ Forster, BG Childs, JF Damore, SD DeVore, EA Kroch, and DA Lloyd "Accountable Care Strategies." Commonwealth Fund. August, 2012.

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_acountable_care_strategies_premier.pdf

The World According to Payers, 2014 and Beyond

- Revenue reduced for readmissions
- Must prove quality and cost to be part of network
- More patient shopping, even across rural hospitals
- By 2020 6% of Medicare payment tied to risk incentives: VBP, readmissions, hospital-acquired conditions

Transition Thinking

- Volume to value
- Group contract to patient service
- Care coordination across the continuum
- Patient centered care
- Lower costs



Transition Thinking

- 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

Where do we want to be?

- Whom do we serve?
- How do we provide best possible service?
- How do we get strategy and money to match mission?



Understanding and Facilitating Rural Health Transformation

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- New cooperative agreement: Rural Health system Analysis and Technical Assistance
- Partners: RUPRI Center for Rural Health Policy Analysis and StratisHealth
- Vision: to build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems

Project's Triple Aim

1. Analyze rural implications of health care delivery, organization, and finance changes fostered by public policy and private sector actions.
2. Develop and test technical assistance tools and resources to enable rural providers and communities to take full advantage of public policy changes and private sector initiatives
3. Inform further developments in public policy and private action through dissemination of findings.

Analysis and Assessment

- Typologies of places and systems
- Activities that do and could occur, given types of places and health systems
- Assess implications for rural people, places, and providers



Technical Assistance Framework

- **Inform:** to help leaders create awareness of the need to change care delivery to deliver value to all stakeholders, and make that case locally
- **Assess:** to understand strengths, needs, and capacity to build value in local health care environment



Technical Assistance Framework

- **Prepare:** to identify action steps based on organizational and community needs and capacity
- **Act:** to select activities based on synthesis of assessments and discussion and then implement organizational and community change that creates value



Actions

- **Improve:** changes to current activities that optimize effectiveness
- **Enhance:** modest changes to broaden and improve care delivery (one foot still on the dock) characterized by focused, limited, tactical, and low risk activities
- **Innovate:** transformational changes with new structures and models characterized by broad, enterprise-wide, bold, and experimental activities

Reality meets creativity

- Payment per event will moderate
- Tolerance for services of questionable merit will diminish
- Opportunities to generate payment for population health management
- Best care, best health, optimum benefits for the community

For Further Information

The RUPRI Center for Rural Health Policy Analysis

<http://cph.uiowa.edu/rupri>

The RUPRI Health Panel

<http://www.rupri.org>

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