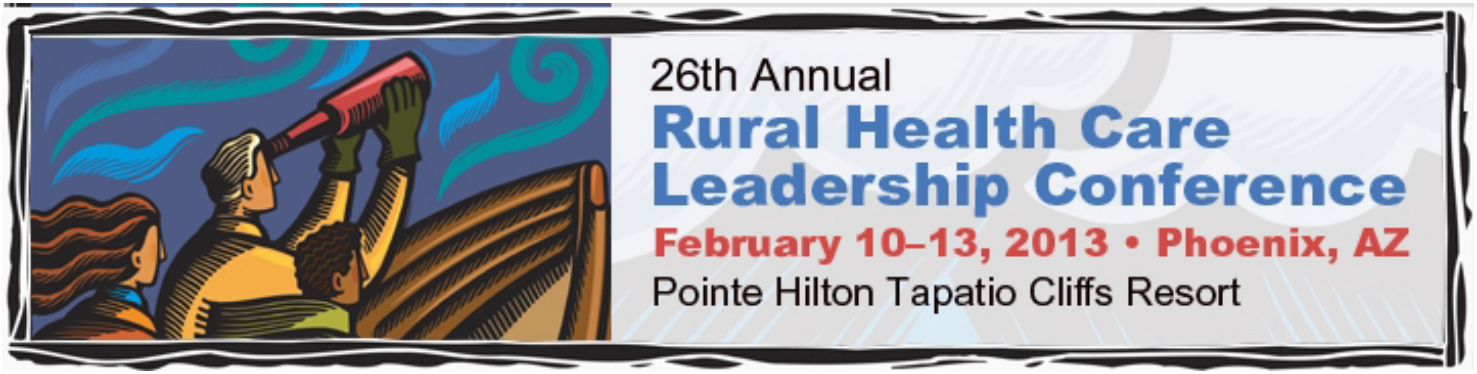
Transferring Risk – the Road to Health Care Value



A. Clinton MacKinney, MD, MS
Deputy Director and Assistant Professor
RUPRI Center for Rural Health Policy Analysis
University of Iowa | College of Public Health
clint-mackinney@uiowa.edu

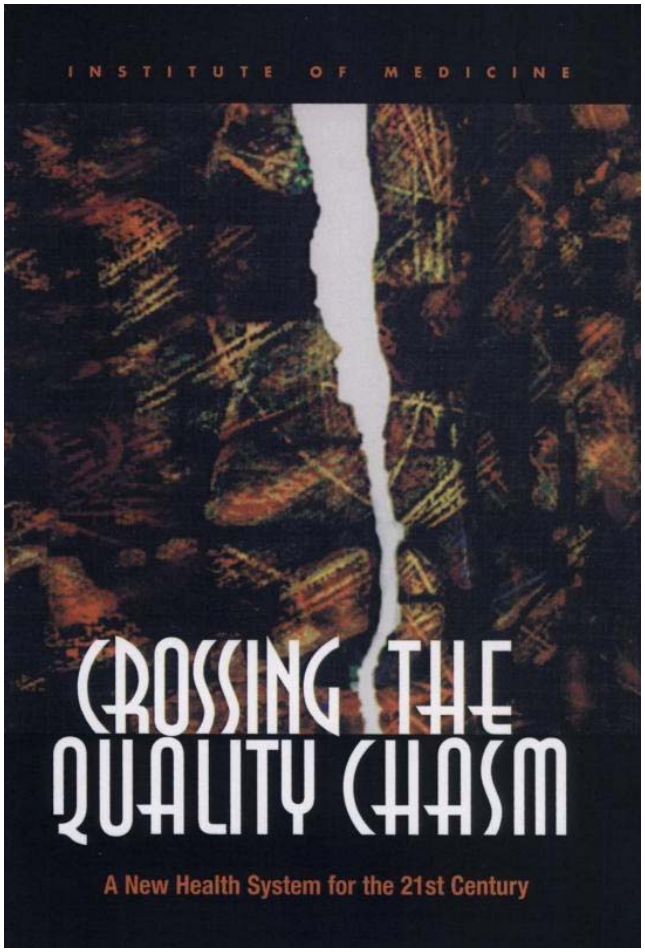
Agenda

- Health care ***value***
- Health care ***risk***
- Transferring risk from payers to hospitals and physicians
  - Fundamental to health care reform
  - Accountable care organizations (for example)
- Strategies for success
  - Ideas for innovative rural hospital leaders

Value – IOM Six Aims

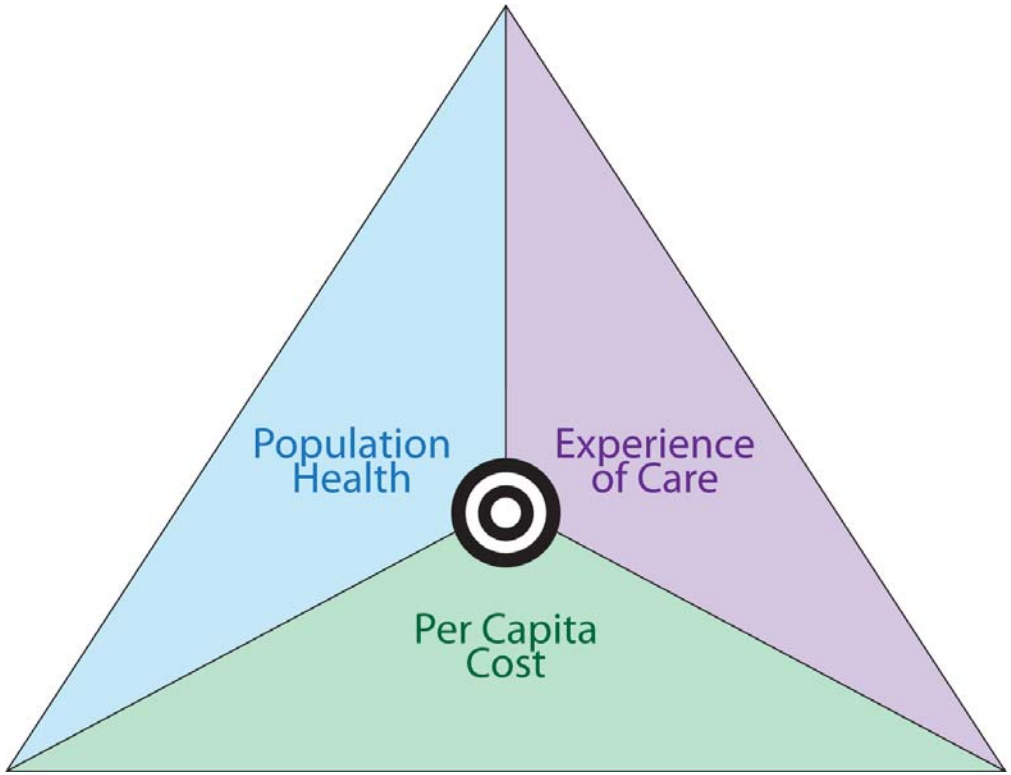
Health care should be:

- **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

rupri
rural policy research institute

Clint MacKinney, MD, MS

The University of Iowa

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

rupri rural policy research institute

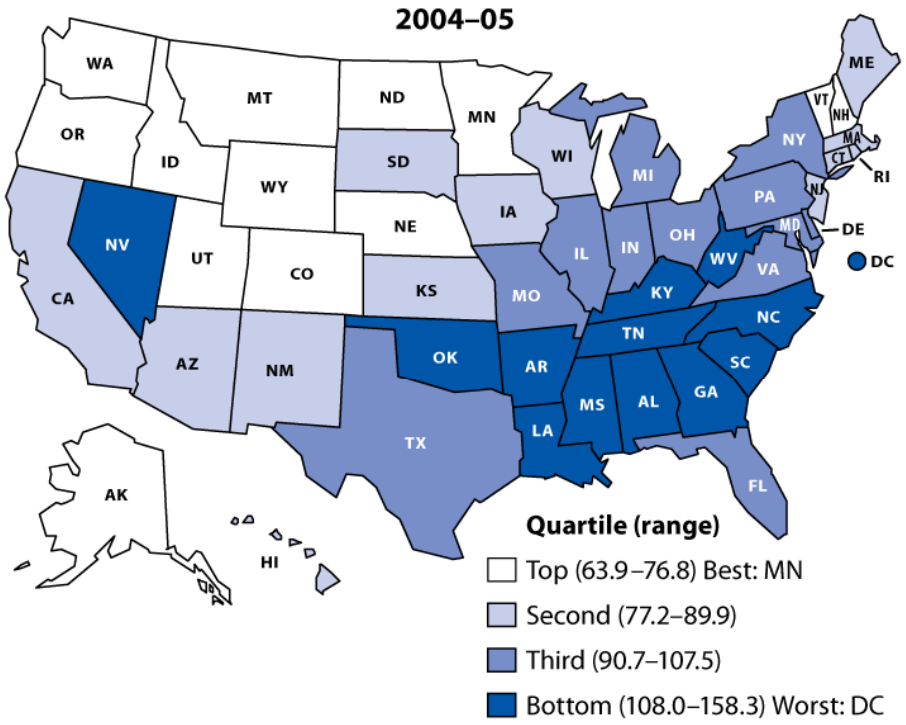
Clint MacKinney, MD, MS

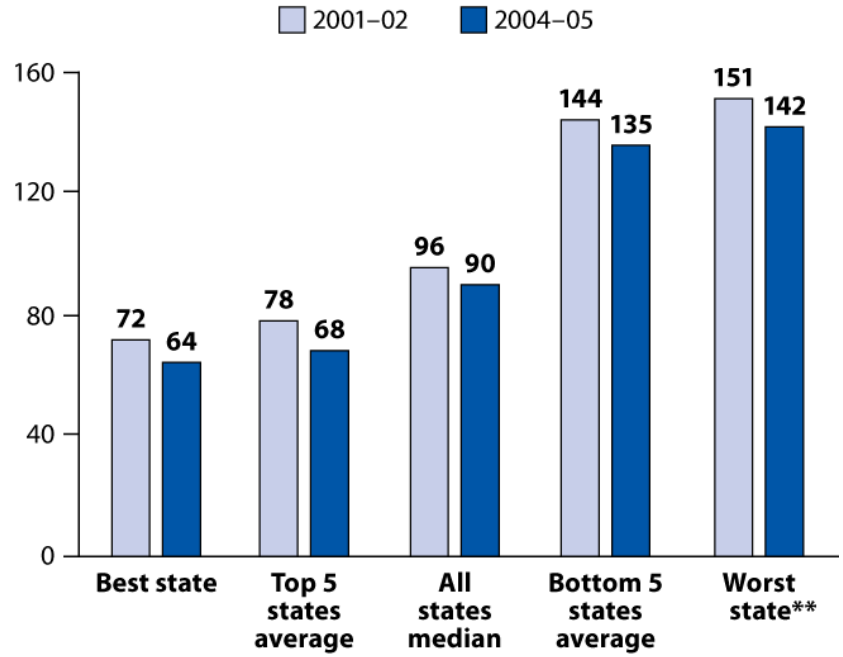
The University of Iowa

Quality

Mortality Amenable to Health Care by State

Deaths* per 100,000 Population





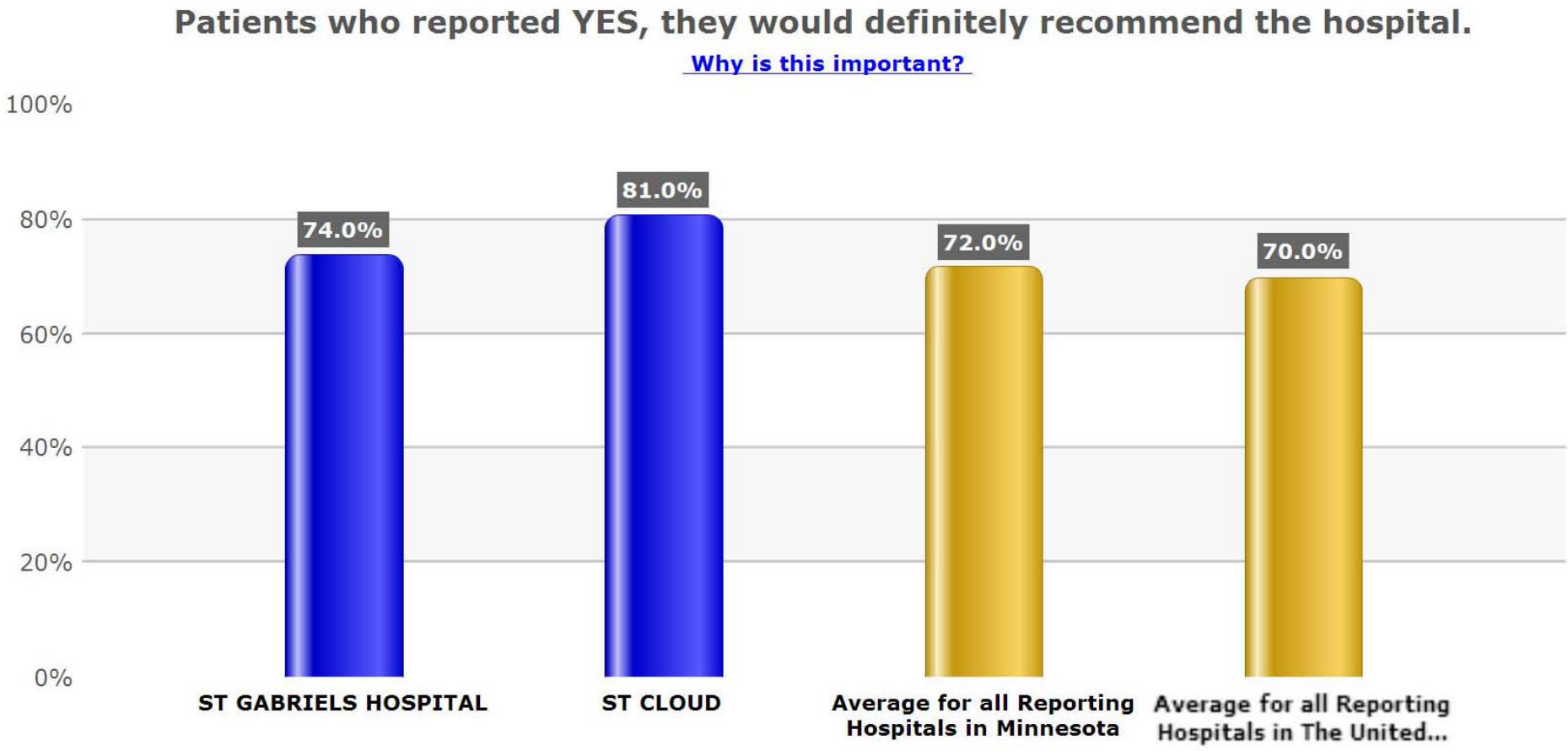
* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease.
** Excludes District of Columbia.
DATA: Analysis of 2001–02 and 2004–05 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, *BMJ* 2003
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

rupri rural policy research institute

Clint MacKinney, MD, MS

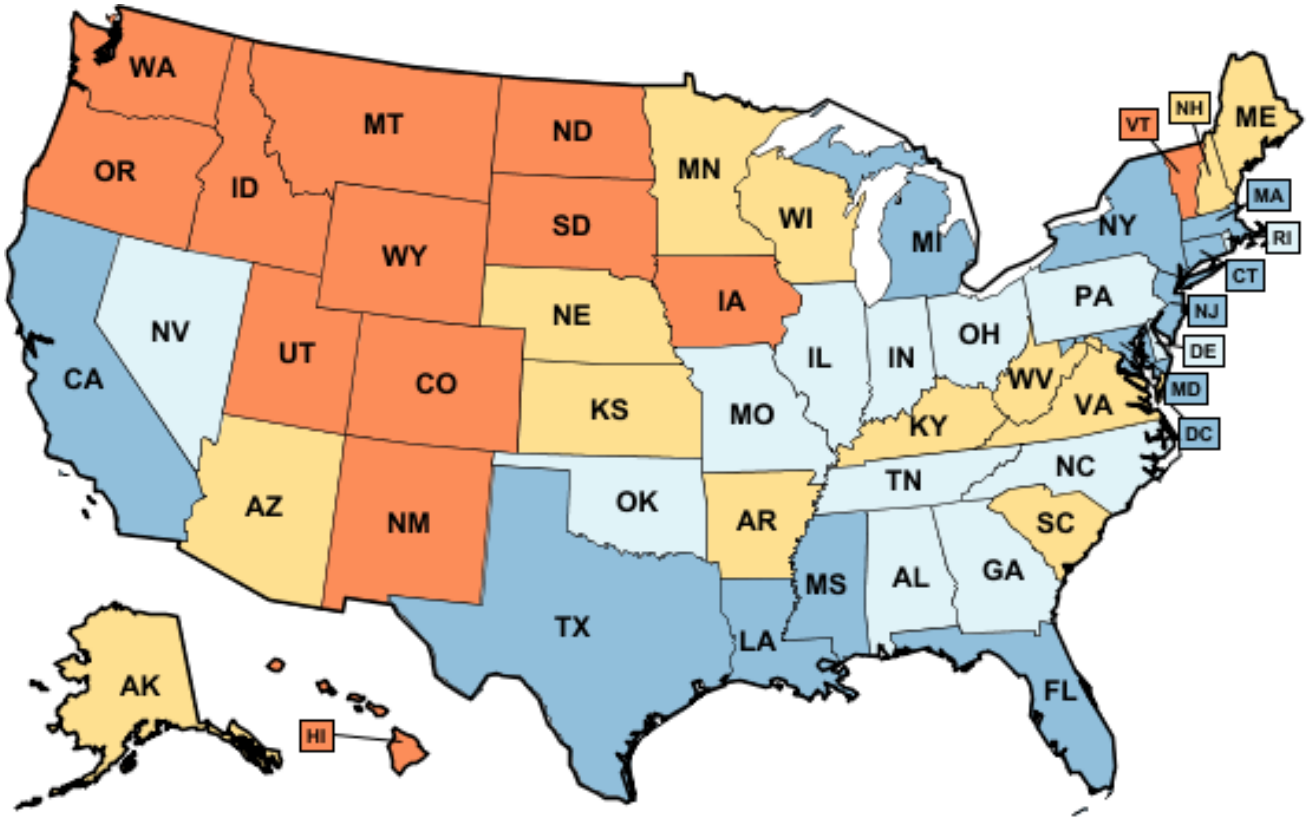
The University of Iowa

Patient Experience



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

Medicare Spending Per Enrollee



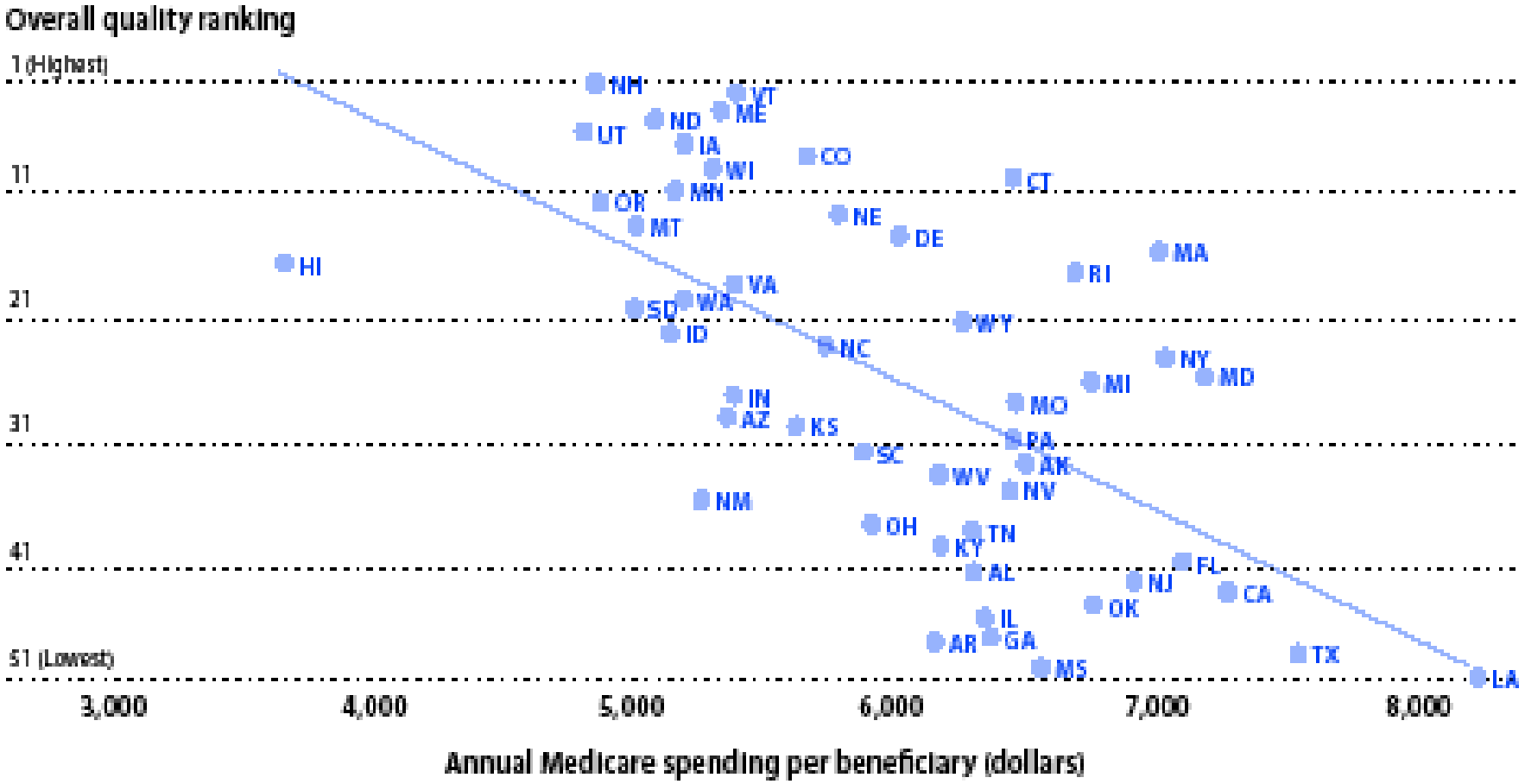
Source: Kaiser Family Foundation. 2009 Data

rupri rural policy research institute

Clint MacKinney, MD, MS

The University of Iowa

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).

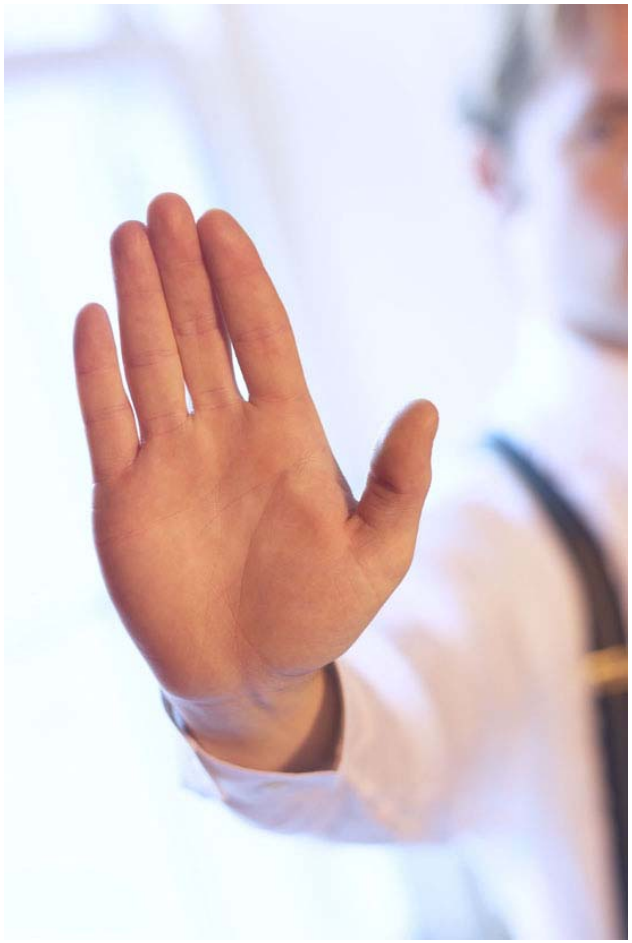
rupri rural policy research institute

Clint MacKinney, MD, MS

The University of Iowa

Unacceptable Healthcare Value

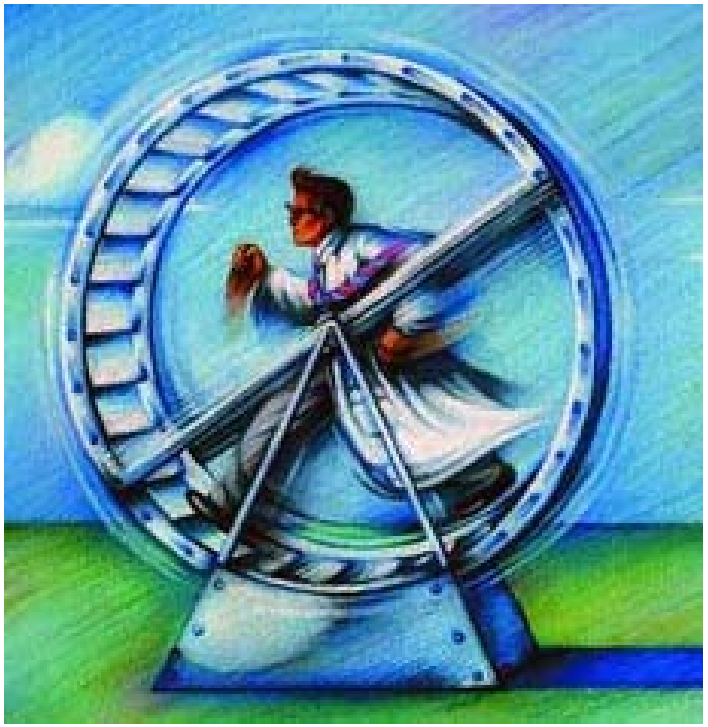
- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation
- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Highest cost in the world
- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse
- Our volume-based payment system is a significant problem



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

Tyranny of Fee-for-Service

- "Successful" physicians and hospitals seek to maximize:
  - Office visits per day
  - Average daily inpatient census
  - Admission percent from the ER
  - Profitability
- Is this how you would identify and reward a great physician or a world-class hospital?
- **No, but what to do?**



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

- **Regardless of what we try, we tend to "follow the money"**

Form Follows Finance

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

Risk Assessment is Ubiquitous

- Risk is present when an outcome is uncertain or unpredictable
- Types of health care risk
  - Random
  - Insurance
  - Political
  - Medical Care
- Where/how can hospitals
  - **Influence or control risk**
  - **Reduce risk of harm**
  - **Optimize risk of benefit**

Rural Risk?

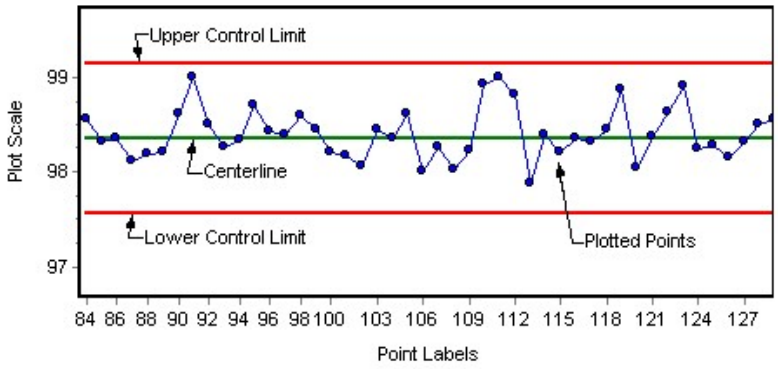
rupri
rural policy research institute

Clint MacKinney, MD, MS

The University of Iowa

Random

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



Insurance Risk

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

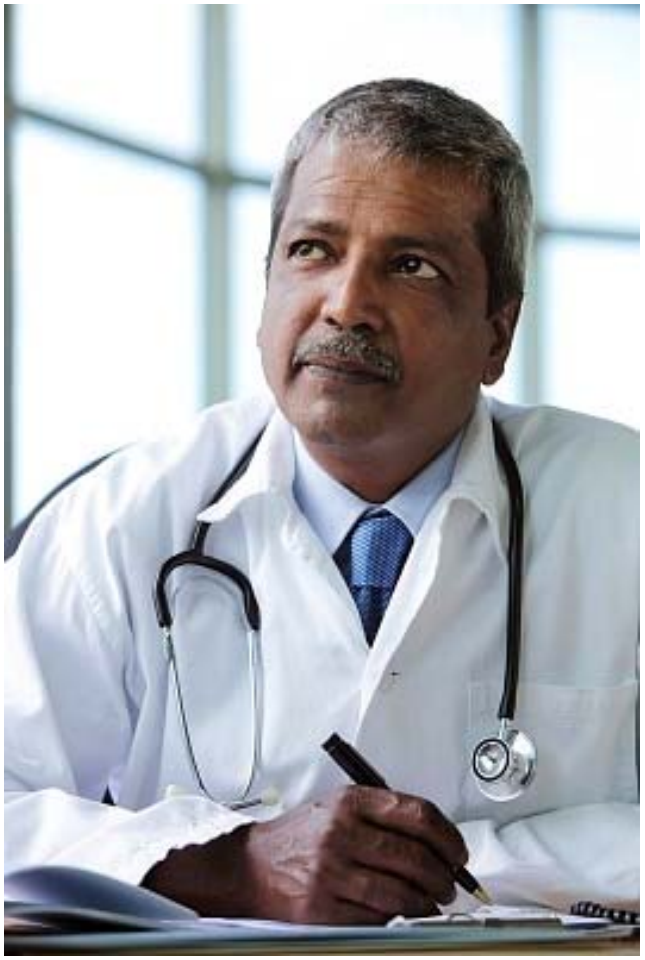
Political Risk

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

American Hospital Association

Medical Care Risk

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



The Risk of Inertia

The Risk of Doing Nothing

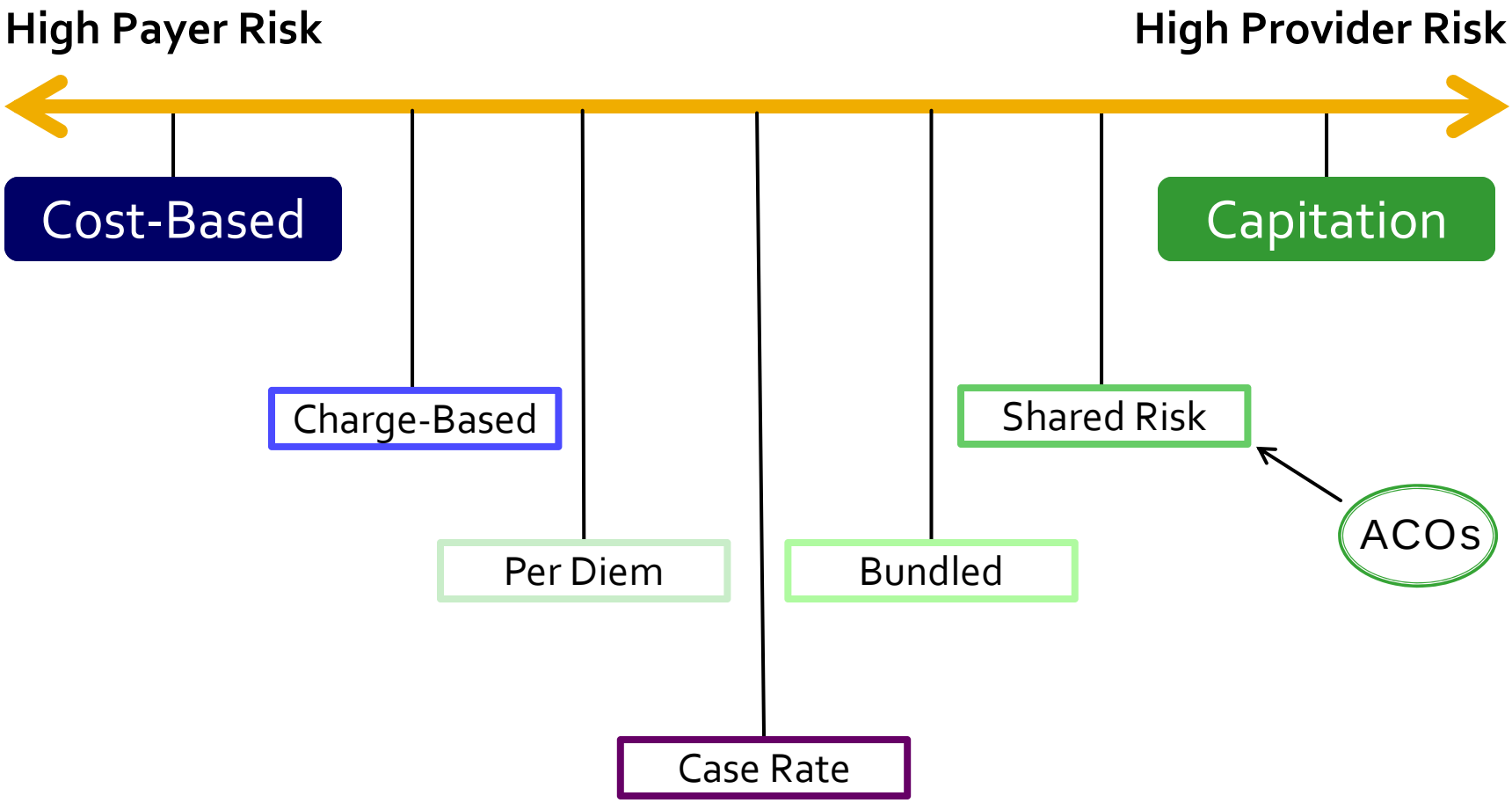
"We've considered every potential risk except the risks of avoiding all risks."

Clint MacKinney, MD, MS

rupri rural policy research institute

The University of Iowa

Payment Risk Continuum



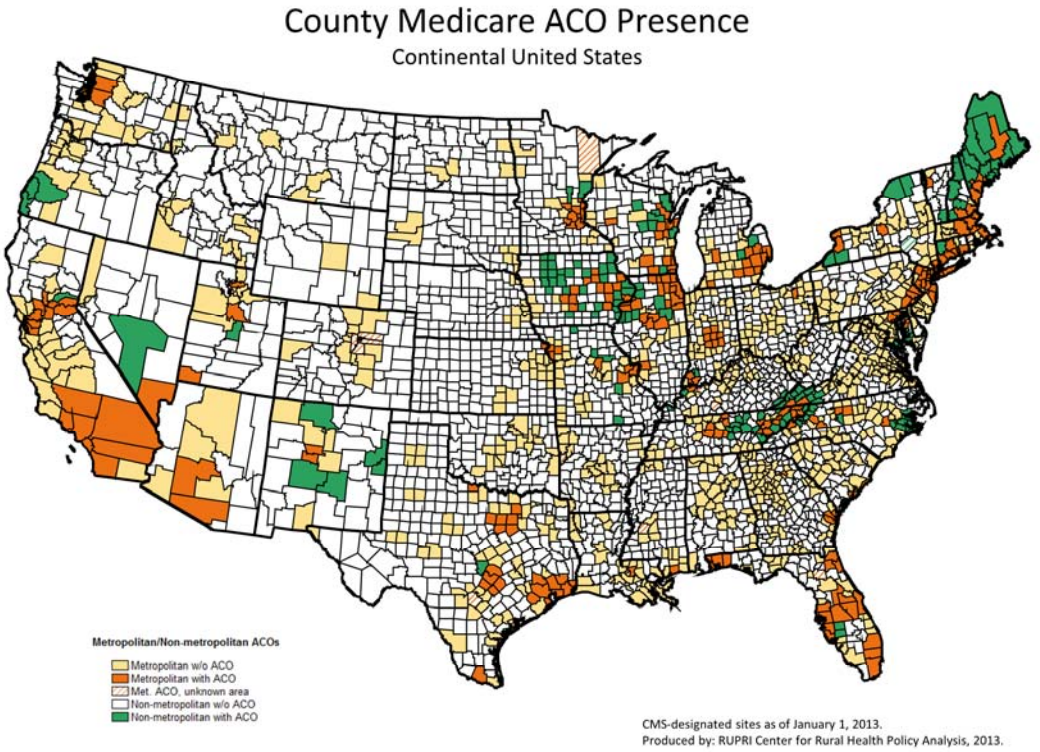
Accountable Care Organizations

- 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.

ACO Explosion

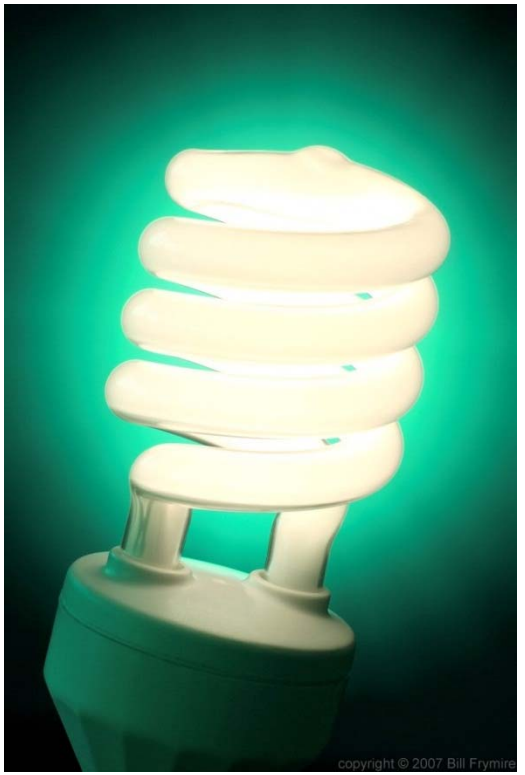
- Rural ACOs in 23 states
- 45 ACOs in rural counties
- 25-31 million patients receive care through an ACO
- ~**10%** of the population
- Remarkably quick growth for a new and complex form of payment and care delivery



Source: RUPRI Center for Rural Health Policy Analysis, 2013.
Niyum Gandhi and Richard Weil, The ACO Surprise, 2012.

New World Realities

- Risk transfer to providers
  - Higher quality at lower cost
  - Doing what's needed, not more
- New business models
  - More primary care, less inpatient
  - Rewarding value, not just volume
- 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

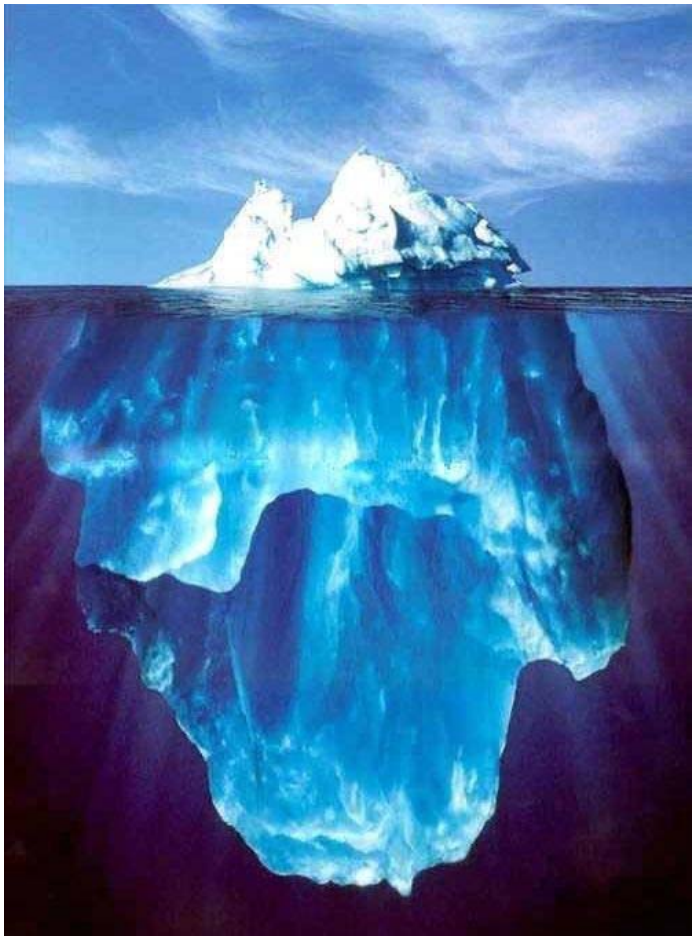
Strategies

- Cultural considerations
- System thinking
- Performance improvement
- Variation reduction
- Medical homes
- Medical staff development
- Collaborations

- **What we can do now**

Culture

- Culture is the residue of success.*
- An environment of behaviors and beliefs
- **What we do becomes what we believe.**



* Source: Edgar Schein, 1999

Our Own Demons

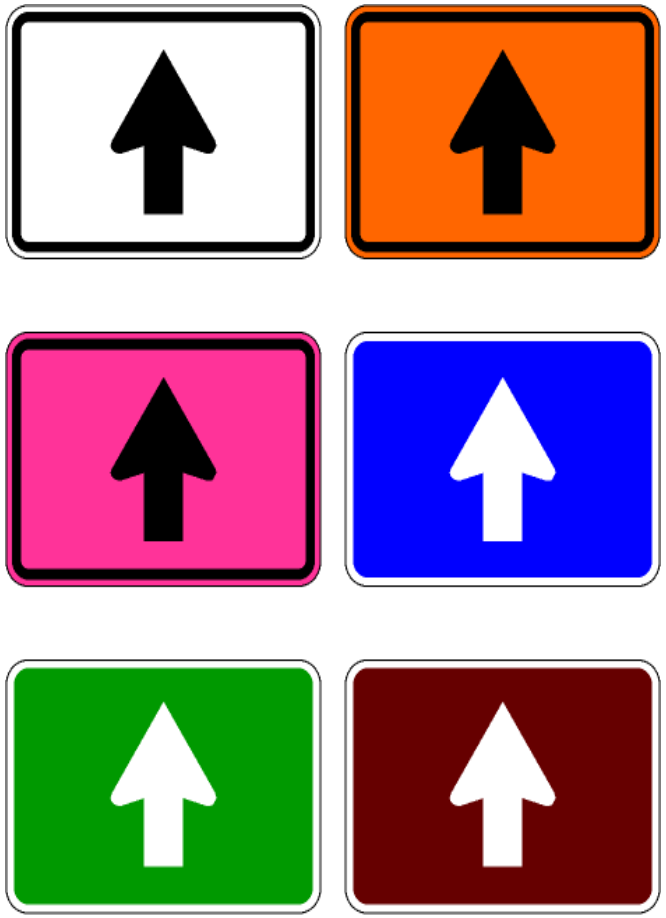
- Nutting et al – small primary care practices are:
  - Physician-centric
  - A hindrance to meaningful communication between physicians
  - Dominated by authoritarian leadership behavior
  - Underserved by PAs/NPs cast into unimaginative roles

"Characteristics so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications.

Source: Nutting, PA, Crabtree, BF, McDaniel, RR. Small primary care practices face four hurdles – including a physician-centric mindset – in becoming medical homes. Health Affairs. 31:11. November 2012.

System Thinking

- Currently a *non*-system
  - Fragmented, poorly coordinated, and excessively costly
- Collaborative delivery systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.
- Care continuum
  - Personal health to palliative care
  - "Cradle to grave"
  - Health and human services



Shifting Health Care Payments

Clint MacKinney, MD, MS

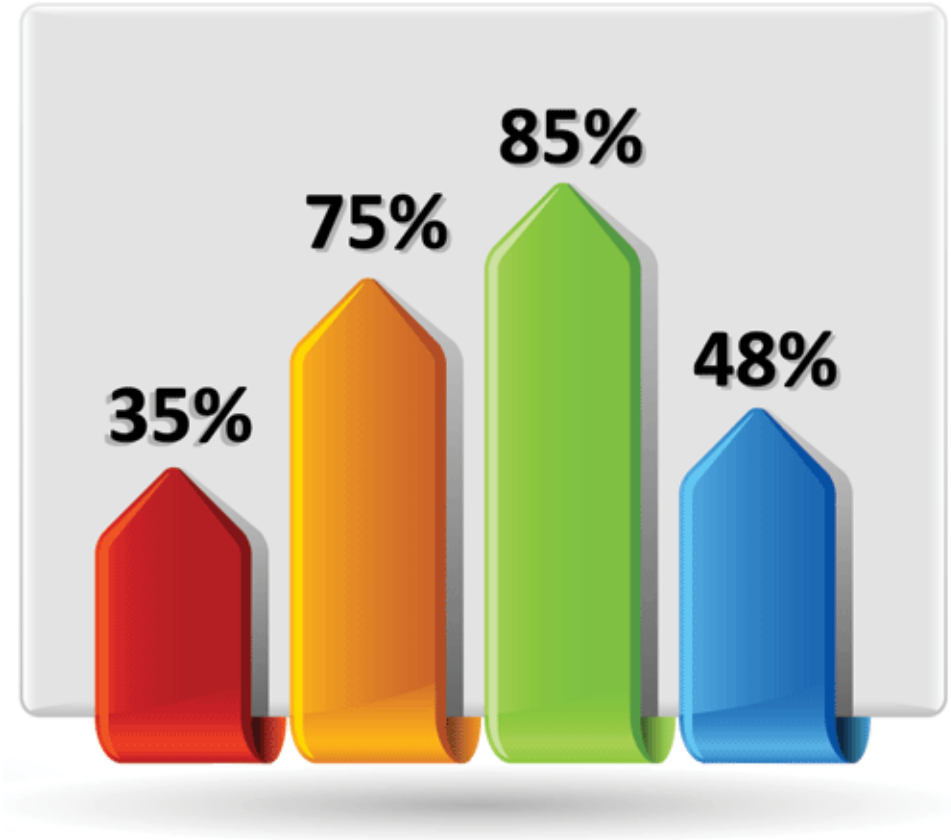
rupri rural policy research institute

The University of Iowa

Performance Improvement

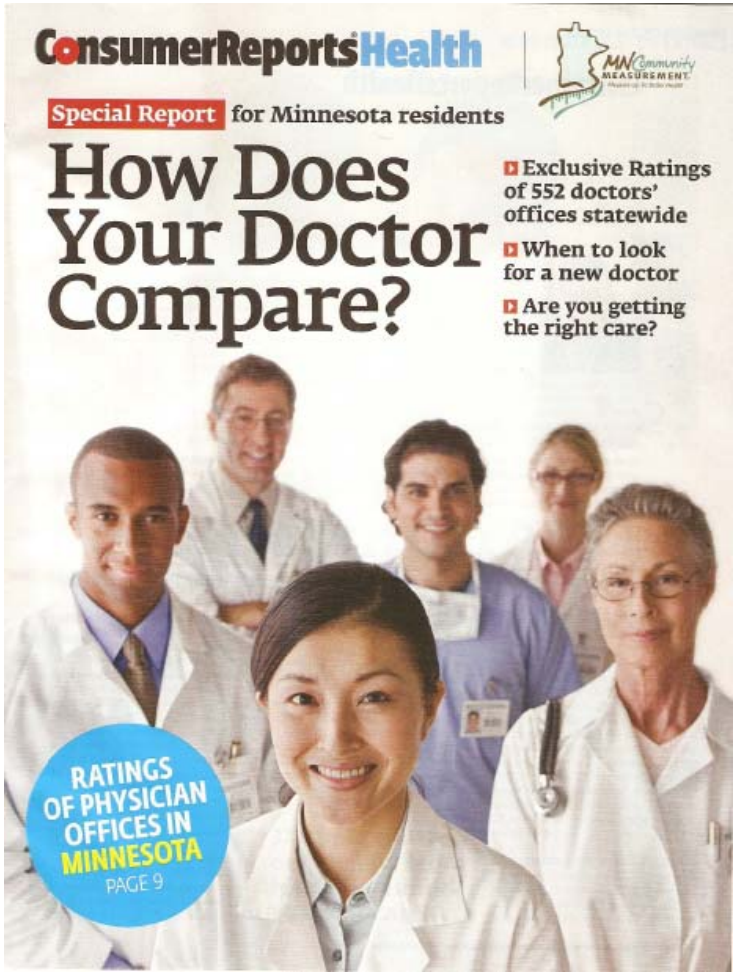
The Value Equation

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

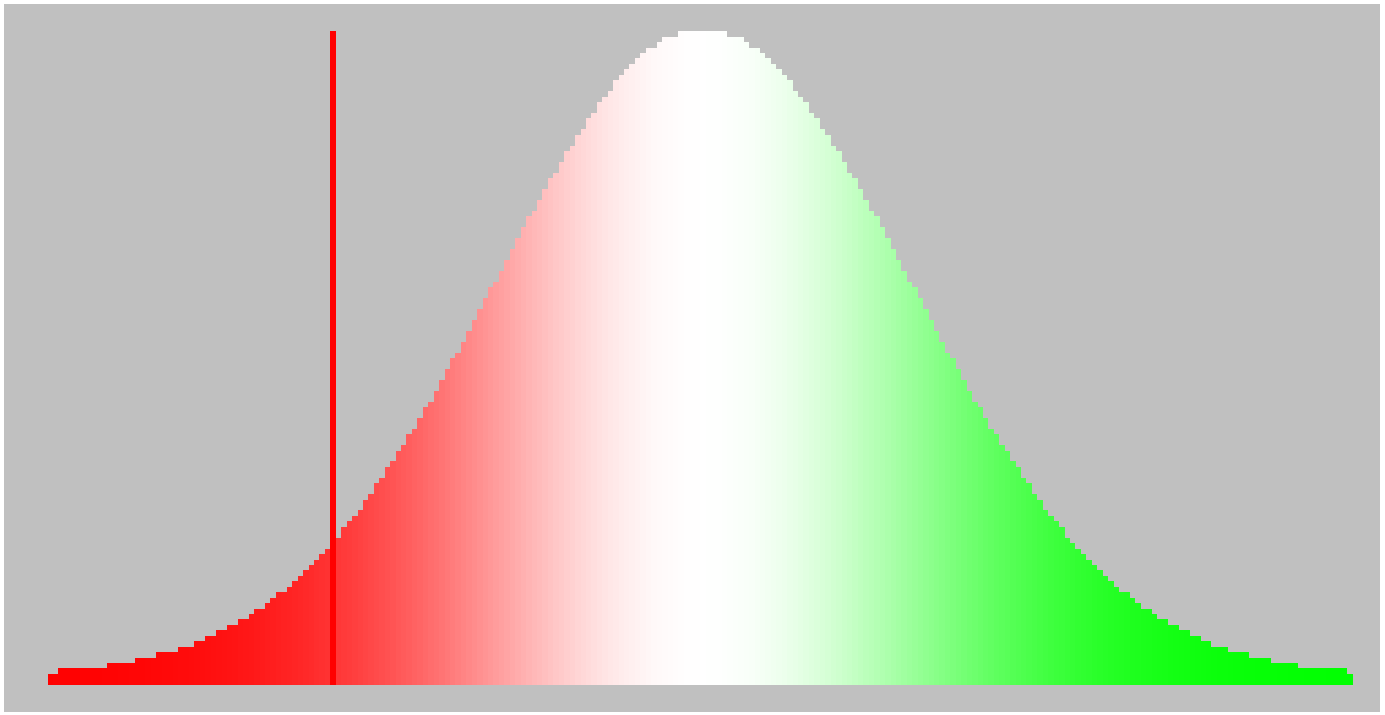


Performance Reporting

- Hospital Compare
  - http://www.hospitalcompare.hhs.gov/
- Healthgrades
  - http://www.healthgrades.com
- CARECHEX
  - http://www.carechex.com/
- Consumer Reports
  - Not just hospital ratings anymore!
- Angie's List and social media



Variation = Risk = Opportunity



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

rupri rural policy research institute

Clint MacKinney, MD, MS

The University of Iowa

Drive Out (Most) Variation

- Best evidence is only the way we practice medicine
- Care should vary by unique *patient* needs, not by
  - Doctor or nurse
  - Day of week, or time of day
- Not cookbook medicine, many opportunities for
  - Clinical judgment
  - Thoughtful interactions
  - The "art" of medicine

Medical Home Definition

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**

Sources: Commonwealth Fund. http://www.commonwealthfund.org/
Joint Principles of Patient-Centered Medical Homes – 2007. http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Documents/Joint-Principles-Patient-Centered-Medical-Home.pdf

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 EHR is critical to proactively managing patient/population health
- Let care protocols do (at least some of) the work (eg, lab orders, med refills, vaccines)

Crete Physicians Clinic
Crete, Nebraska

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

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

Hospital Transformation

- How do we move toward value when our revenue is primarily volume-driven?
- We can test the waters
- The Process
  - Awareness – the value equation
  - Assessment – where we are right now, and where we need to go
  - Experimentation – small scale innovations
  - Implementation – new programs that drive value
- What to do right now

What To Do Now

- Control the data
  - EHR and sophisticated data analytics
- 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?
- Aggressively apply for value-based demonstrations and grants
- Negotiate with third party insurers to pay for quality

More What To Do Now

- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas with equal (or better) quality
  - Reduces Medicare cost dilution
- Manage care beyond the hospital
- Move organizational structure from hospital-centric to patient/community-centric
- Explore potential collaborations with physicians and others

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*?

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**

The Risk of Something New

Clint MacKinney, MD, MS

Healthy People and Places

Clint MacKinney, MD, MS

rupri rural policy research institute

The University of Iowa