Critical Access Hospitals, The focal Point For Change and How to React

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by

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Getting There From Here

- Setting the stage: current state of affairs for Critical Access Hospitals
- A new platform created by the Patient Protection and Affordable Care Act and market changes?
- Toward a new world of value-driven principles in health care delivery and finance
- Ultimately to performance measured as population health

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Present Challenges for Critical Access Hospitals and Rural Systems

- Cost-based reimbursement under duress
- Political future of Medicare Rural Hospital Flexibility Program (CAHs and grant program) less certain
- Diffusion of new models of care may question place of CAHs and inpatient services
- New models of care may connect rural services to systems providing care across the continuum

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Cost-based Reimbursement Under Duress

- Discomfort a constant in the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC)
- Understanding of special rural circumstances minimal in CMS and MedPAC: analytical approach is one payment formula at a time
- Driver is cost containment, getting the price "right"

Cost-based Reimbursement Under Duress

- "Explosion" of CAHs to 1,332
- Many designated as necessary providers by states
- Exceeded expectations created by legislative requirements of distance (35 miles or 15 given terrain)

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Cost-based Reimbursement Under Duress

- Result: proposals to enforce federal mileage requirement, or at least some distance (10 or 15 miles)
- Fire stoked by Office of Inspector General report recommending decertifying 849 CAHs
- Debate likely to rage on until alternatives are created and implemented for many CAHs

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Escape to the Future

- Retain cost-based long enough to complete a transition
- But be about the transition to value
- Policy environment includes medical homes, bundled payment, accountable care
- Ultimately need integrated care/service models for communities

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All About Value

- Value will determine payment, initially partial eventually all
- Responding to those changes
- Value will take on a new meaning beyond the hospital/clinic walls
- Responding to those changes; the sandbox of population health

Value Equation

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

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

"Triple Aim"

- Better patient care
- Better community health
- Lower per capita cost

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Payers Are Getting Smarter

Total Cost = Price x Quantity

Current Way

- Negotiate *unit price*
  - Discount on charges
  - CPT codes
  - Per diems
  - Case rates (DRGs)
- Hospital success strategy
  - Negotiate for high unit prices, then optimize volumes

Future Way

- Negotiate *total cost of care*
  - Bundled payment
  - Shared risk (ACOs)
  - Capitation (beyond medical care)
- Hospital success strategy
  - Negotiate high per capita rate, favorable base period, and accurate risk adjustment, then optimize community health

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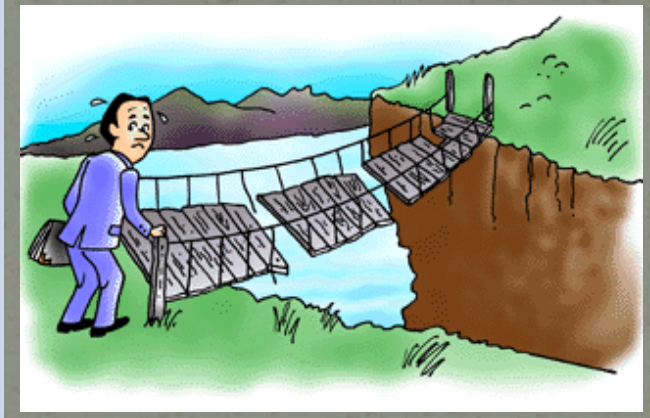
The Volume to Value Gap

Volume-based success strategies

- Pay-for-service
- Cost-based reimbursement
- Inpatient focus
- Hospital/physician independence
- Stand alone care systems
- Illness care



Value-based success strategies

- Pay-for-results (quality/efficiency)
- Shared risk
- Partnerships and collaborations
- Continuum of care consideration
- Community health improvement

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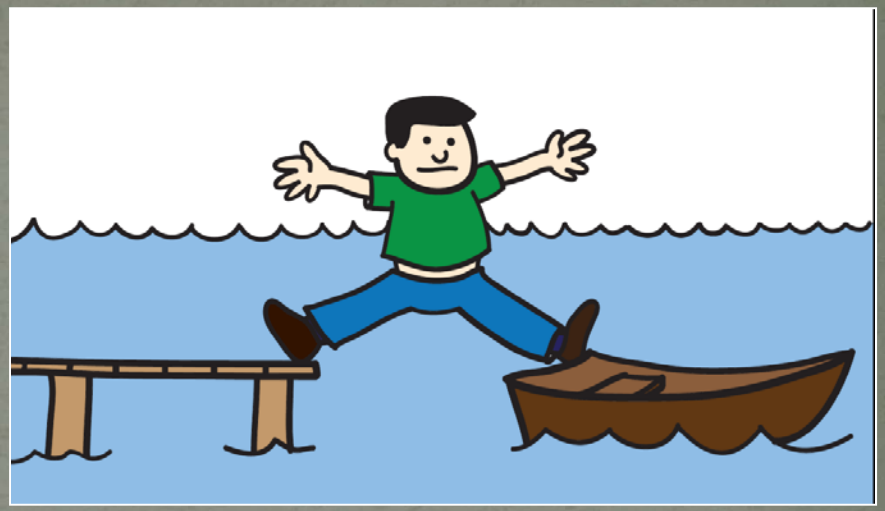
Hospital Transformation

- 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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Tool Box for Delivering Value

Strategies

- Optimize fee-for-service (transition)
- Attend to performance and innovation
- Drive in efficiency
- Drive out variation
- Develop medical homes
- Engage the medical staff
- **Potpourri – What we can do now**

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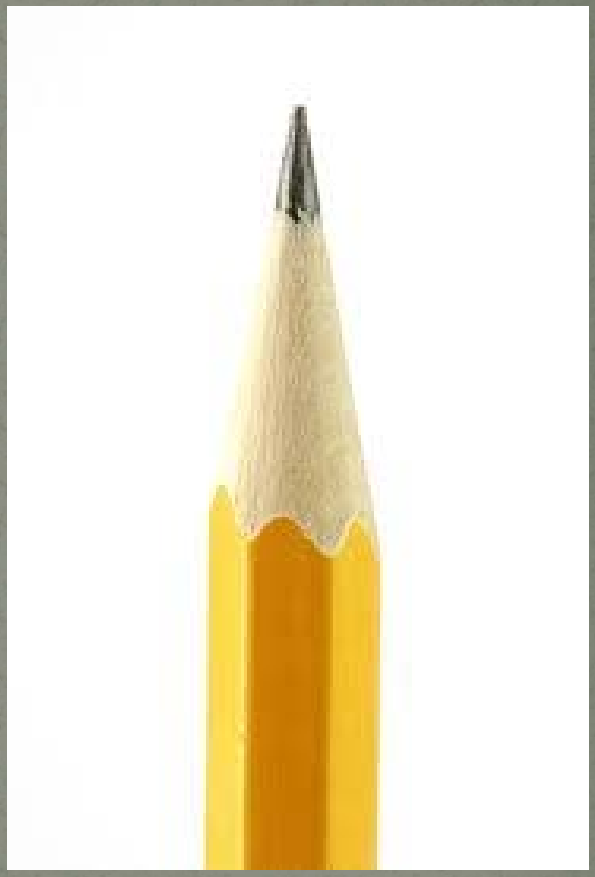
Get Your FFS House in Order

Attention to

- Market share
- Revenue cycle
- Payer contracts
- Purchasing contracts
- Inventory management
- *Appropriate* volumes



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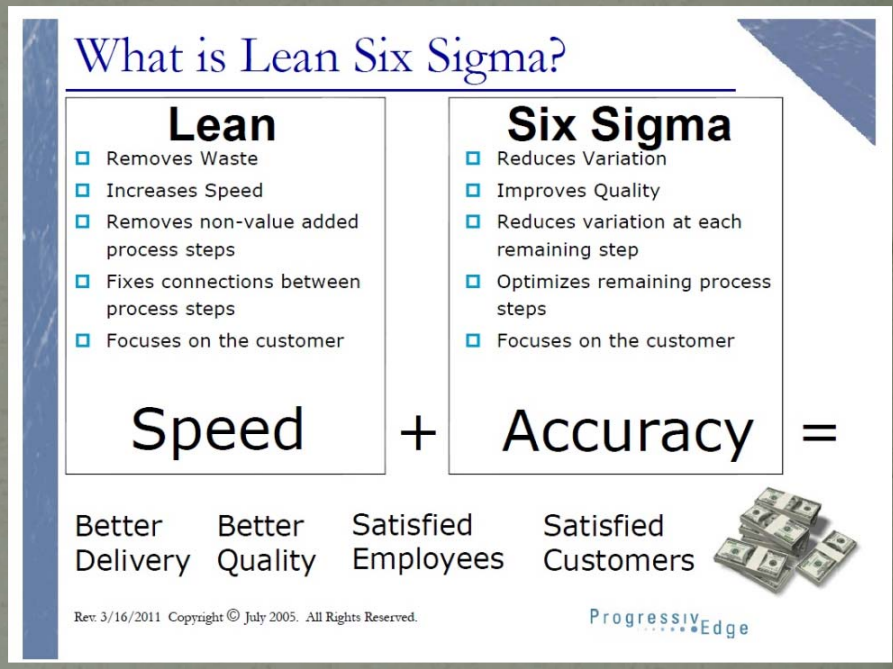
Efficiency

- Eradicate waste (Lean)
- Reduce variation (6 Sigma)
- Flatten the organization
  - Fewer senior leaders
  - Drive decision-making down
- Aggressively review "bricks and mortar" budgets
  - Do planned expenditures support the new reality?
  - Avoid trapped equity!



Innovation Requires New Foci

- Inpatient Beds → Clinics (and more)
  - Expanded and robust primary care
  - Workplace nursing
  - Mobile clinics
  - Telehealth
- Illness → Wellness
  - Health Risk Assessments
  - Community Health Assessments
  - Health coaching
  - Care coordination

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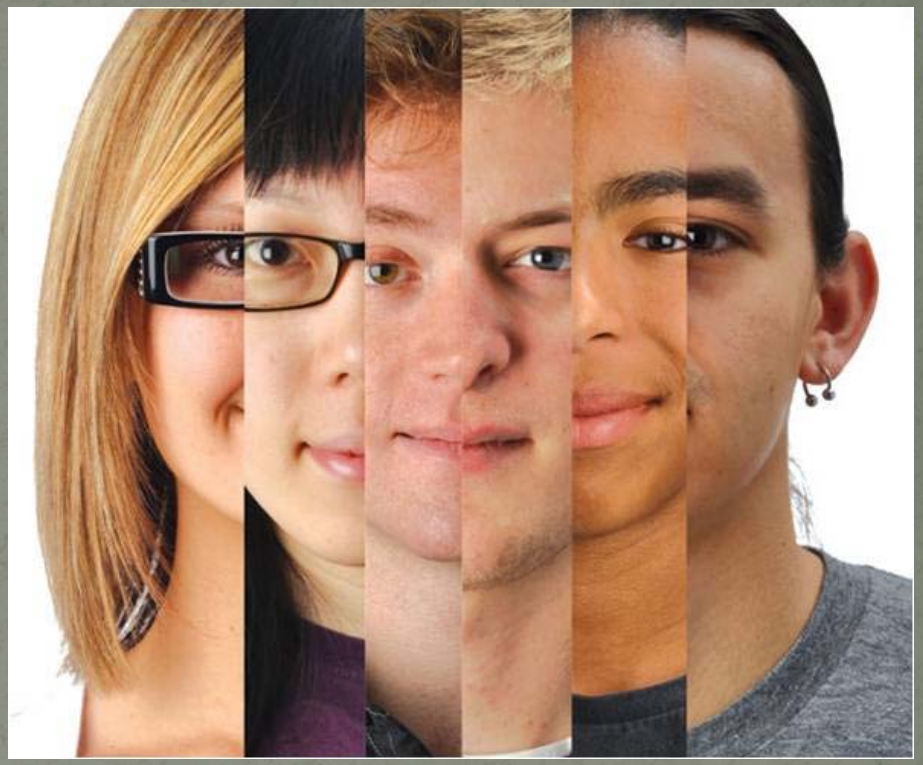
Drive Out (Most) Variation

- Best evidence is only the way we practice medicine
- Care <u>should</u> 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



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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

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Robust Physician Engagement

- *Engage* members of the medical staff in key governance decisions and clinical operations
  - Beyond the normal clinical, credentialing, and quality matters on which hospital boards typically consult their physicians
- Deep involvement at every organizational level and function
  - Strategic planning
  - Governance
  - Operations
  - Evaluation
- CEO cannot abdicate this job!

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Medical Staff Development

Some ideas

- Invest in physician leaders
- Offer direct ability to influence outcomes
- Provide data transparency, but do not overstate discrete measure importance
- Develop salary system based on "How would peers identify a great physician?"
- 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.

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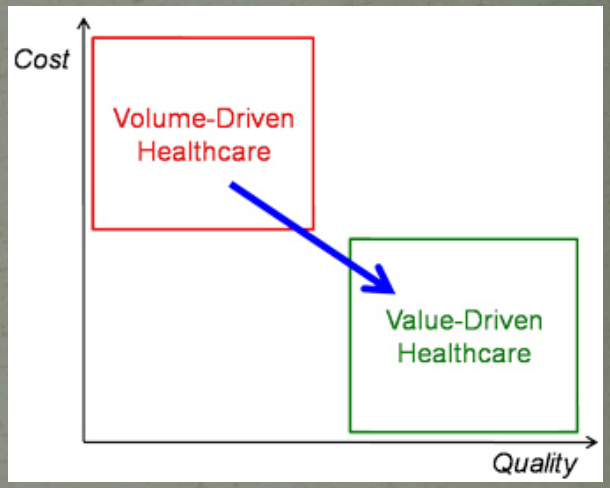
Getting to the End Point of Population Health

- Completing the transition to value measured as health
- Moving out the boundaries of health systems
- New data and analysis
- Collaborations and community leadership

Transition Thinking

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



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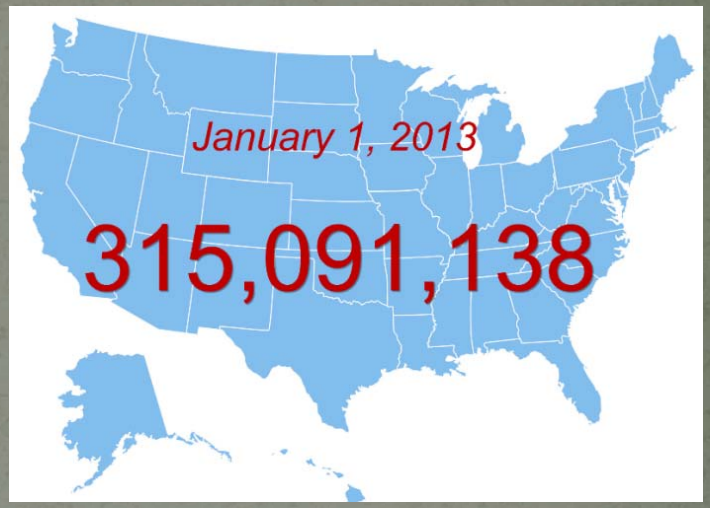
Transition Thinking

- 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
- From exclusively local to inclusive within region

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)



Source: The U.S. Census Bureau

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Financial Risk and Total Cost of Care

- Recognize role of social determinants of health: socio-economic factors contribute 40% of different to population health, health behaviors 30% (calculations for MN)
- Importance of community collaborations

How to Succeed with Collaboratives

- Use population data (County Health Rankings)
- Shared governance of resource use
- Methodology for sharing savings and re-investing
- Understand linkages between health outcomes and determinants – "patient responsibility"

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Concluding with reminders of reality

- Payment per event will moderate
- Tolerance for services of questionable use will diminish
- Systems will form and spread
- Multiple payers moving in similar directions, opportunities to influence should be captured and exploited
- Future is in *health improvement* for population served (community)

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Pursuing the possible

- When community objectives and payment and other policy align
- Community action is where policy and program streams can merge
- Community leadership a critical linchpin
- Pursuing a vision

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What CAHs and Small Rural Hospitals Must Consider

- Future for any hospital-based care in their communities: *if the apparent becomes necessity, transition with foresight, not hindsight*
- Best financial models for sustaining *essential hospital-based services* (could include other services)
- How to get to those models
- Role of the hospital in community-based care; *the business model indicates this is financially wise in addition to being mission driven*
- *From "hospital" to "health hub"*

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Conversation About Getting There

- Starts (or continues) in this forum
- With the ideas generated by learning and participating
- Continues among hospitals in similar circumstances
- Broadened to the communities
- Spread across geography (state, region, nationally)
- With help

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Collaborations to Share and Spread Innovation

- The National Rural Health Resource Center
- The Rural Assistance Center
- The National Rural Health Association
- The National Organization of State Offices of Rural Health
- The American Hospital Association

For Further Information

Rural Health Value

http://ruralhealthvalue.org

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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