

Change is Coming Health Markets and Delivery Systems: Effects on Rural

Presentation to NOSORH Region C

by

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The Past is Prologue, 2006 forward

- ▶ Transformation in Health Care Delivery:
The Future in Rural America
- ▶ Delivered to the 2006 Nebraska Rural
Health Conference

2025 in Sidney, Nebraska: Family with moderate income and high-deductible health insurance

- ▶ 12 year-old Tommy develops cold symptoms and Mom takes him to Wal-Mart for care because the store is now a Super Wal-Mart offering health care services that include:
 - ▶ Routine care
 - ▶ Children and adolescent Health
 - ▶ Diagnostic testing
 - ▶ X-Ray imaging
 - ▶ Vaccinations
 - ▶ Preventative care
- ▶ [taken from www.quickqualitycare.com/services.htm on August 11, 2006; current sites in Tampa, Sturt, Fort Myers FL]
- ▶ Mom pays the bill on site, \$30 in 2006 dollars, and withdraws the money from the family health savings account



2025 in Crawford, Nebraska

Lifelong 85-year-old resident with lifetime of healthy living now covered exclusively by Medicare

- ▶ 85-year-old Elizabeth has recently experienced worsening of the arthritis condition that had been only a minor pain in the She had been taking over-the-counter pain killers purchased at the local convenience store. Now she has multiple choices for upgrading care:
- ▶ Establish a medical home in Chadron, a mere 22 miles away
- ▶ Also purchase her medications in Chadron at Wal-Mart or Safeway
- ▶ Use mail order to purchase 90 day supplies of some medications
- ▶ As she needs help in activities of daily living hope neighbors can help because the home health agency does not serve Crawford (too costly)
- ▶ Give up her lifelong commitment to remain in Crawford and move to a place with full services in the community

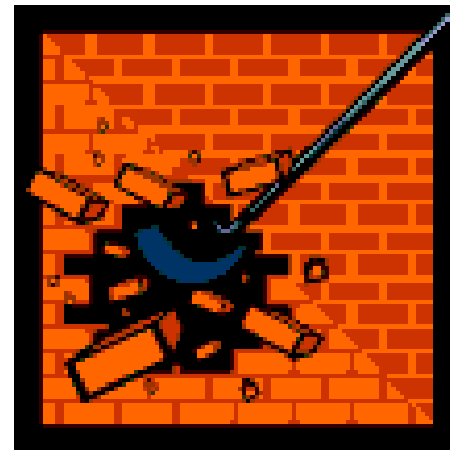
2025 in West Point, Nebraska

The health care system of the future

- ▶ An integrated health care delivery system offers local access to:
- ▶ Same day surgery performed by rotating surgical teams with telehealth back-up
- ▶ 24/7 primary care in the local clinic (not the hospital ER)
- ▶ Local pharmacy which also supports the hospital and skilled nursing facility
- ▶ Behavioral health services through a social worker backed up with telehealth
- ▶ General surgery, delivery services, diagnostic imaging on site at the CAH
- ▶ Assisted living and independent living supported by a regional nursing service
- ▶ And linked to other health care services through a fully automated information system that includes electronic health records and ability to crosswalk to personal health records

We are on the Eve of Destruction

- ▶ Expenditures for health care are spiraling beyond any single fix
- ▶ Complexity of health care problems present more opportunities for medical error
- ▶ Millions with limited access because of cost, availability, cultural misfit
- ▶ Health care professionals with declining morale
- ▶ Breakthrough policies that contribute to problems: Medicare Part D
- ▶ **WILL IT ALL IMplode?**



YES

- ▶ Fast forward to 2014, 2015
- ▶ Delivery system: Health care leads all sectors in mergers and acquisitions, challenging anti-trust experts to balance enhanced service/lower cost with potential for higher prices
- ▶ Delivery system: Hospital closure re-emerging as a rural rallying cry

YES

- ▶ Payment system: Commercial insurance and consumer-driven design, pay for value, use of shared risk models
- ▶ Payment system: Medicare and use of Medicare Advantage, Accountable Care Organizations, Value-Based Purchasing
- ▶ Payment system: Medicaid use of managed care, accountable care organizations

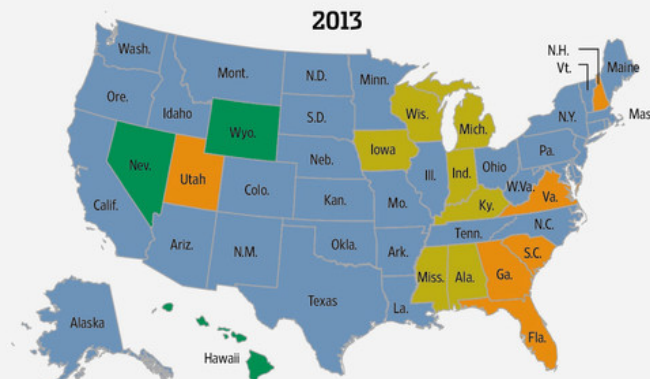
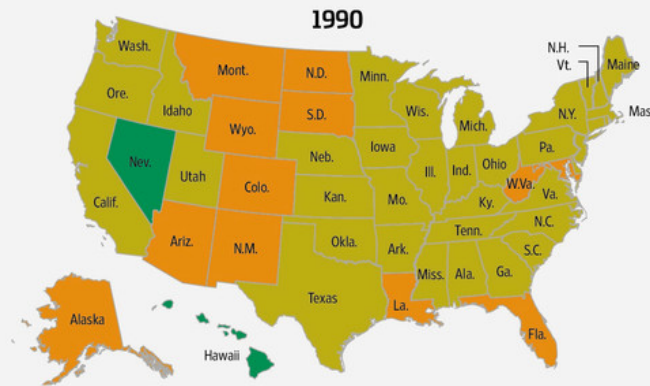
YES

- ▶ Tipping point reached: Why changes at the margin yield organizational responses
- ▶ Leadership commitment within healthcare sector
- ▶ Demands from the consumer
- ▶ Economic driver – the largest sector of economic growth

Jobs a Signal of Investor, Innovator Interest

Work Then and Now | Industry with highest employment by state

Manufacturing Health care Retail trade Accommodation and food services



Source: U.S. Bureau of Labor Statistics

The Wall Street Journal

What Will We Build?

- ▶ Back to 2006 ...

Getting there: Commission on a High Performance System

- ▶ Expand health insurance coverage: CHECK, 4% of US population newly insured as of April (Gallup Poll)
- ▶ Implement major quality and safety improvements: CHECK as work in progress
- ▶ Work toward a more organized delivery system that emphasizes primary and preventive care that is patient-centered: CHECK, spread of patient-centered medical homes, medical homes, preventive benefits as covered without copayment
- ▶ Increase transparency and reporting on quality and costs: CHECK, web sites from Medicare, other sources

Getting there: Commission on a High Performance System (continued)

- ▶ Reward performance for quality and efficiency: PARTIAL CHECK, use of value-based payment systems
- ▶ Expand the use of interoperable information technology: WEAK CHECK, greater trend to systems using one system
- ▶ Encourage collaboration among stakeholders: PARTIAL CHECK
- ▶ *Source:* The Commonwealth Fund Commission on a High Performance Health System. “Framework for a High Performance Health System for the United States.” August 2006. www.cmwf.org

The Rural Way: Illustrated with the Flex program

- ▶ “The goal of the state grant program is to strengthen the rural healthcare infrastructure using Critical Access Hospitals as the hub of organized, local systems of care. The overarching program goal is to foster the growth of collaborative rural delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support.”

(from the Flex Monitoring Team May 2004 synthesis of state flex program plans)

Visions for Health Delivery and Community Health: The Community Foundation

From the IOM Committee on the Future of Rural Health Care report (p 4):

“The committee encourages rural communities to build a population health focus into decision making within the health care sector, as well as other key areas (e.g., education, community and environmental planning) that influence population health.”



Back to 2014: The Changes in Health Insurance Coverage

- ▶ Will influence “patient flow”
- ▶ Will also direct “consumers” to use system differently
- ▶ Will affect revenue
- ▶ Creates backdrop for different investment strategies

What the Change Means

- ▶ New sources of payment
- ▶ New rules associated with the sources of payment
- ▶ Initial federal involvement in raising payment for primary care (2013 and 2014)
- ▶ Rating areas, service areas, and network contracts with commercial insurers

What the Changes May Mean

- ▶ Types of insurance plans may “devolve” when premiums increase
- ▶ Could be more shifting into “consumer driven” health insurance design
- ▶ Increase in deductibles and copayments drives consumer behavior
- ▶ Premium dollar becomes a source of revenue in new risk-sharing arrangements

Basic Forces Motivating Change

- “Form follows finance”
- Commercial insurance changing, and employer plans changing
- Medicare changes are dramatic and could be more so
- Medicaid changes spreading



Commercial Insurance and Employers

- Value-based insurance design to steer utilization: wellness, disease management, medication management
- Payment methodologies shifting to value-driven, at least in part
- Employers seeking deals, including national employers such as Walmart and Lowes



Medicare Payment Changes

- Uncertain future (at best) for cost-based reimbursement, unless through exceptions (F-CHIP)
- Demonstrations of new methods, including bundled payment, value-based for Critical Access Hospitals
- Value-based purchasing across provider types
- ACOs and a harbinger



Tally Sheet

- ✓ 660+ public and private ACOs
- ✓ 366 Medicare ACOs
- ✓ 23 Pioneer ACOs
- ✓ 35 are Advance Payment
- ✓ Medicare ACOs located in 48 states (and DC and Puerto Rico)



Serving Millions

- Estimated 14% of U.S. population now being served by an ACO
- 5.3 million in Medicare ACOs
- More than 6.5% of the Medicare population



Sources: “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

Centers for Medicare and Medicaid Services *Fast Facts* as of May, 2013

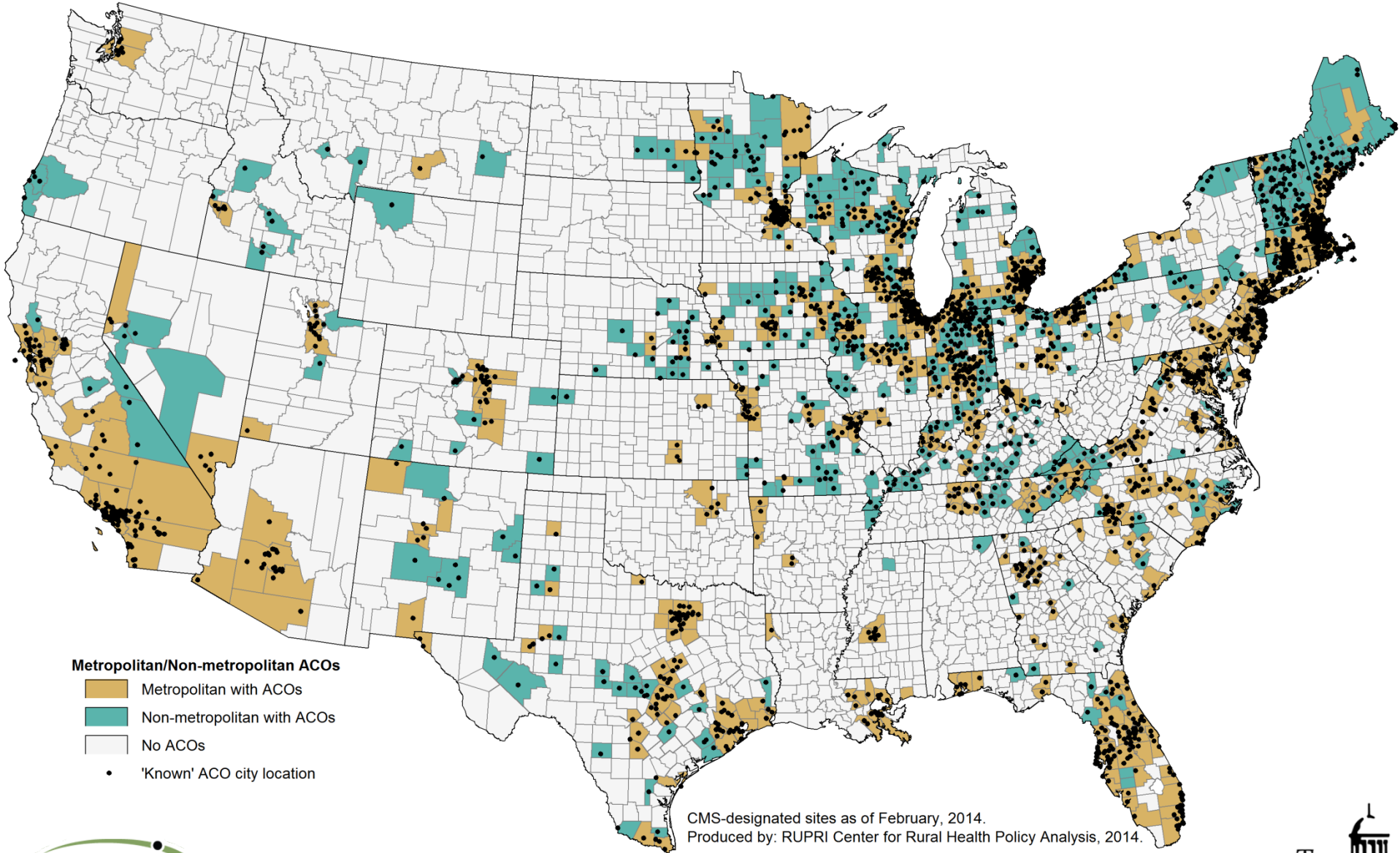


ACO's in Rural Places

- 109 ACOs operate in a combination of metro and non-metro counties
- 8 ACOs operate exclusively in rural areas, including 1 such ACO in each of the 4 census regions
- 24.4% of non-metropolitan counties include a primary care provider being assigned Medicare patients

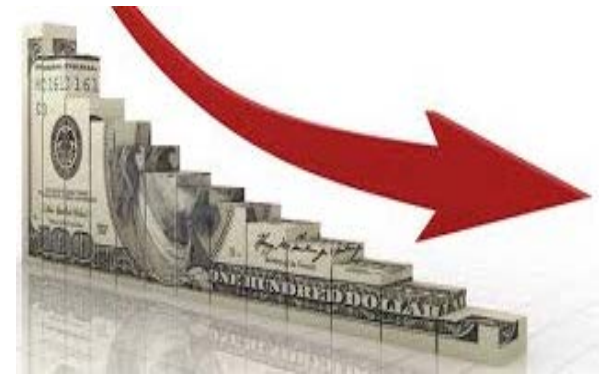
Source: RUPRI analysis of data obtained from public sources and ACOs

County Medicare ACO Presence Continental United States



Medicaid

- ACO development being seen as an answer to cost of current and expanded program
- Reduced payments in systems based on pay for service
- Other innovations to reduce cost such as primary care case management, divert from emergency rooms



Early Results in Medicaid

- ▶ Colorado: \$44 million in gross savings or cost avoidance in FY 2013; reduced hospital readmissions 15–20%
- ▶ Oregon: in place 16 months, 90% of Medicaid beneficiaries

Source: *ACO Business News* January, 2014

Aligning Market Based Changes with Clinical and Delivery Changes

- ▶ Shifts in modality of care
- ▶ Shift in vision/mission to be more encompassing
- ▶ Innovation consistent with vision/mission and changing financial and policy context

Changes in Delivery Modalities Create Opportunities

- Telehealth
- Using professionals to full capacity of licensing
- Care in different settings
- Inter-disciplinary care



Innovate to accelerate pace of change

- In health care work force: community paramedics, community health workers, optimal use of all professionals, which requires rethinking delivery and payment models – implications for regulatory policy including conditions of participation
- In use of technology: providing clinical services through local providers linked by telehealth to providers in other places – E-emergency care, E-pharmacy, E-consult
- In use of technology: providing services directly to patients where they live

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



Elements of a Successful System Redesign

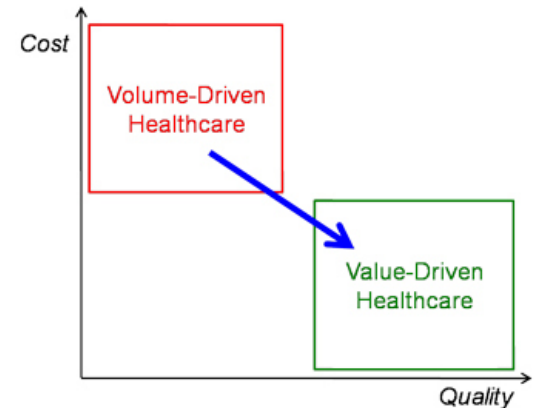
- Clear Vision
- Principles for redesign (reliability, customization, access, coordination)
- Teamwork
- Leadership
- Customer focus
- Data analysis and action plans
- Inclusive beyond health care system



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

Transition Thinking

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



Continued

- 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



Actions to Consider

- Measure organizational performance
- Inform key stakeholders regarding performance
- Consider employees for care management
- Negotiate payment for measurable quality and patient satisfaction
- Collaborate with health care and human services providers
- Strategic focus on patients /community

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”



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 -- population health

Illustration: Chief Medical Financial Officer

- ▶ Bonner General Hospital in Sandpoint, Idaho: CAH conversion in 2011
- ▶ Meld financial and clinical goals – example of opening wound center after physician recognized market potential
- ▶ “Engaging physicians to cut costs while maintaining quality” (from article cited below)

Illustration: Chief Medical Financial Officer

- ▶ Dr. Kenneth Cohn, CEO of Healthcare Collaboration: “It’s about giving doctors a more proactive role in strategy and identifying physician finance champions”
- ▶ CFO conducts rounds with physicians

Source: Bob Herman, “In the Future, Will Hospitals Have a Chief Medical Financial Officer?”
Beckers Hospital Review April 8, 2014.

Lessons from “progressive hospitals”

- ▶ Address social issues related to healthcare: Montefiore focuses on social determinants of health
- ▶ Take holistic approach to population health: affiliate with organizations who are not healthcare providers; Truman Medical Center in Kansas City partnered to open grocery store
- ▶ Promote price transparency: promotes patient trust
- ▶ Include physicians in administrative decision-making: in the C-suite, in all decisions of the hospital
- ▶ Serious about hospitality: patient experience as area of expertise in upper management

Lessons from “progressive hospitals”

- ▶ Partner with employers: big time example is contract between Cleveland Clinic and Lowes for heart procedures, with Wal-Mart and Boing for cardiac care; rural reality is working with local employers on wellness initiatives, primary and preventive care
- ▶ Let patients access personal health information: leader has been Geisinger allowing access to physician notes

Taken from “10 Things the Most Progress Hospitals Do,” Molly Gamble, *Beckers Hospital Review*. July 8, 2013

What if Medicare Were the Only Payer?

- ▶ Can be a target for management
- ▶ Question used by Benefis Health System in Great Falls, Montana – two hospital system with only tertiary hospital for 37,800 square miles, 70% of payment from government
- ▶ Made Medicare break-even a goal in 2009, annual operating margin since has been at least 3.6%, 2.6% on Medicare in 2012

Imperatives Learned by Benefis

- ▶ Entrench cost reduction mindset throughout management supervisory ranks
- ▶ Emphasize why cost reduction is important to all employees
- ▶ Measure results and report often, celebrate success
- ▶ Include physicians, employed and independent, as cost reduction partners
- ▶ Be prepared to look beyond low-hanging fruit
- ▶ Evaluate external partners, their contribution to reducing costs

Taken from “What if Medicare Were the Only Payer,” Bob Herman. *Beckers Hospital Review* May 6, 2014.

For Further Information

<http://ruralhealthvalue.org>

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

<http://www.rupri.org>

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