Encounter-Based Strategies to Population-Based Strategies

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Presented During
Iowa Hospital Association Annual Meeting
October 9, 2014
Des Moines, Iowa

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Importance of Transitions to Optimize Opportunities

- Changes are underway: reform is private and public policy
- Adapt to changes through innovations of best fit for rural communities
- How do we pull that off?

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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
- Demonstrations of new methods, including bundled payment, shared savings
- Value-based purchasing across provider types
- Includes non-payment for certain situations

Bundled Payment Models

- Model 1: Discount on Part A payment for inpatient hospitalization
- Model 2: Inpatient and all related services plus 30, 60, or 90 days after discharge
- Model 3: Retrospective Post-Acute Care Only; begin within 30 days and end up to 90 days; 48 clinical condition episodes
- Model 4: Prospective bundle for inpatient only to include Part B

Model 2 Participants Include

- Catholic Health Initiatives in CO, KY, NE, TN, AR
- Health Choice Utah Accountable Care LLC
- Maine Heart Center in Portland, ME
- WY Medical Center in Casper
- Geisinger Clinic in Danville, PA

Model 3 Participants Include

- Remedy Partners, Inc with facilities in 11 states
- Amedisys Holdings with facilities in 7 states
- Evangelical Lutheran Good Samaritan Society in Sioux Falls, SD with facilities in SD and MN

Model 4 Sites Include

- St Rose Dominican Hospitals in Henderson, NV
- Health Que3st Systems, Inc. in LeGrangeville, NY
- Sisters of Charity of Leavenworth Health System/Exempla, Inc in Denver with facilities in CO, KS, MT

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

Concluding discussion of payment change 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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Convincing Evidence

- Change is underway (not just “coming”)
- Driven largely by needs to refinance
- But also involving reorganizing to meet quality objectives
- Respond to change or lead change but CHANGE

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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

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Constant Improvement of Value

- Old phrase was continuous quality improvement
- Now more than quality in a narrow sense
- Value a broader term that incorporates cost and patient satisfaction
- There are specific pathways, a toolbox for value

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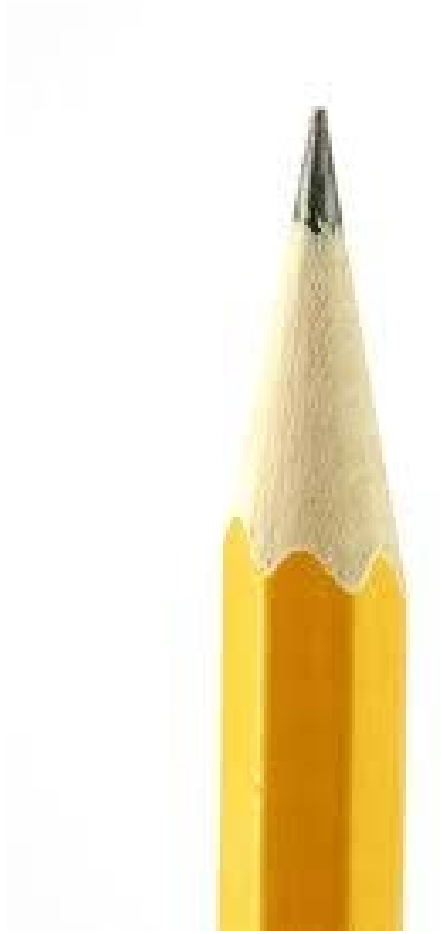
A Continuum of Value Strategies

- 12 strategies, but order and timelines will vary
- A *continuous* transformation
- Broad organizational impact, longitudinal over time, intense leadership attention
- Actionable plans
  - Objectives
  - Timelines
  - Accountabilities
  - Resources

1. Get Your FFS House in Order

Attention to

- Market share
- Expense management
- Revenue cycle
- PQRS/Meaningful Use
- Payer contracts
- Purchasing contracts
- Inventory management
- A*ppropriate* volumes

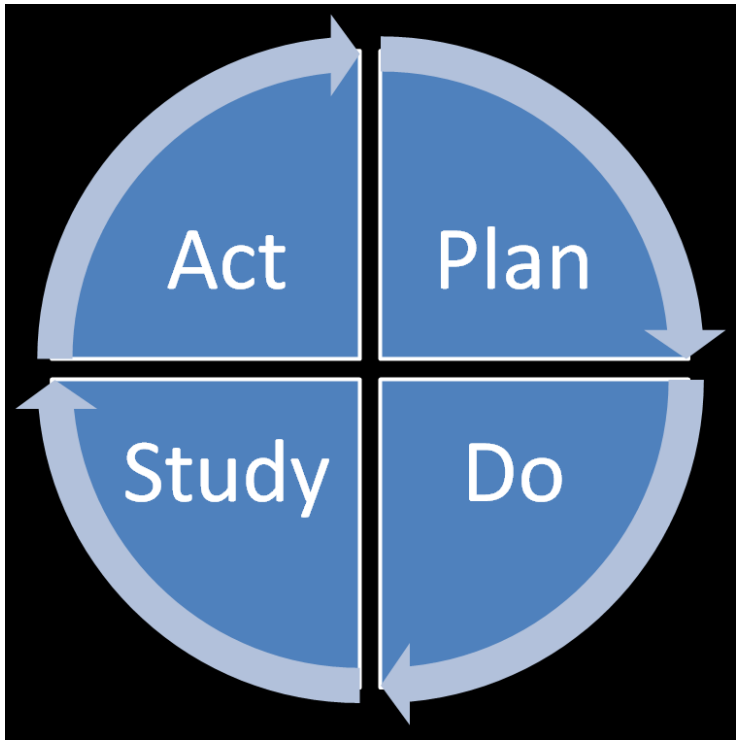


2. Measure, Report, and Act

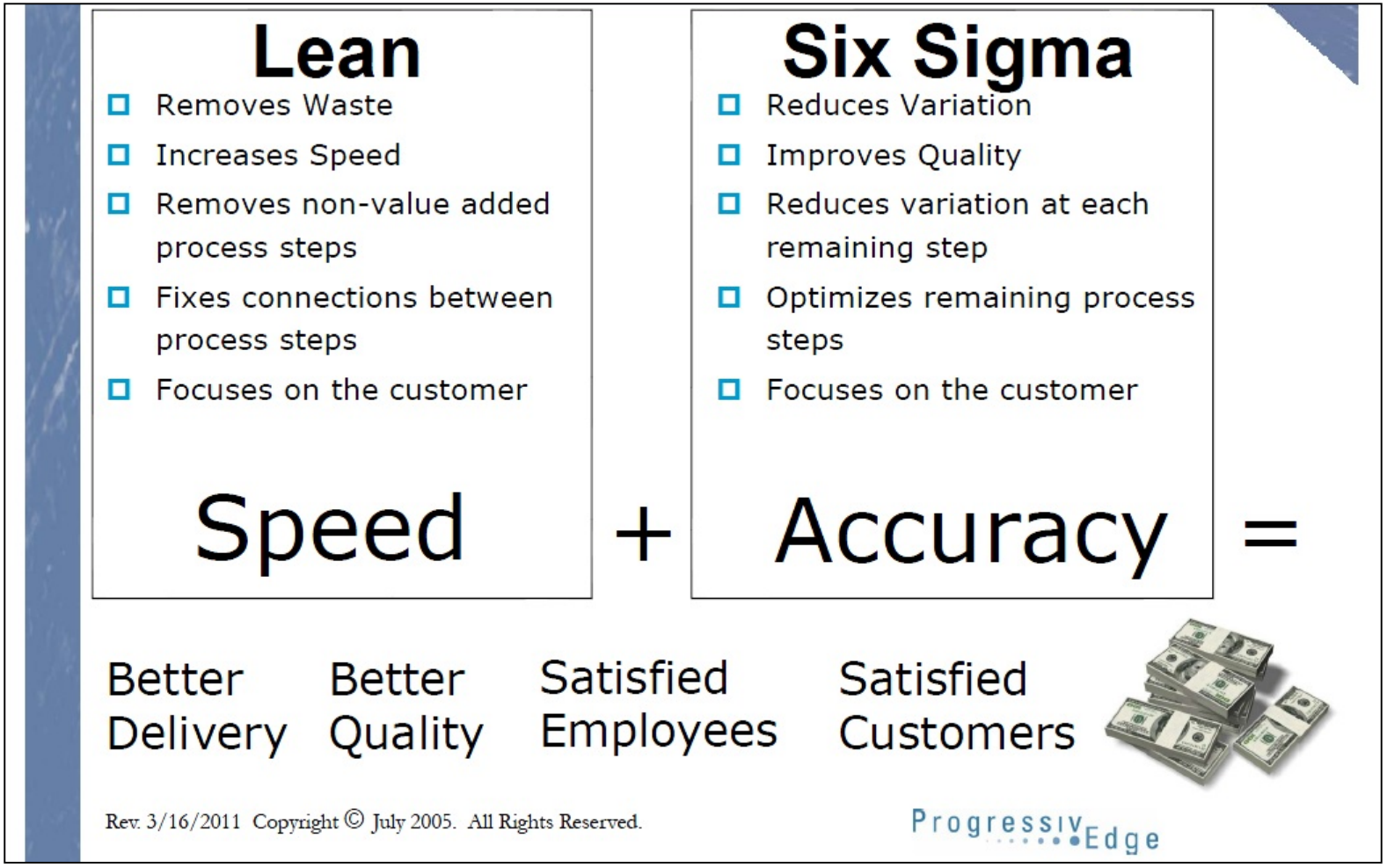
- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership
- Tell the performance story
  - Data → information → insight
  - We are all "above average," right?
  - Let the data set you free
- When possible, control the data
  - Market share – who's leaving and why
  - Our costs to payers, and our competitor's costs

3. Prioritize Improvement

- Clinical quality, patient safety, and the patient experience
  - Expectation: “Always above the mean. Always improving.”
- Leadership priority
  - Every meeting
  - Charts, not spreadsheets
  - Un-blind the data!
- Quality/safety performance
  - ACOs – 33 outpatient measures
  - Hospitals – Hospital Compare



4. Improve Operations Efficiency



Resource: Jay Arthur. *Lean Six Sigma for Hospitals: Simple Steps to Fast, Affordable, and Flawless Healthcare.* 2011

5. Get Paid for Quality

- Aggressively apply for value-based demonstrations and grants
- Negotiate with third party insurers to pay for quality
- Consider self-pay and employees first for care management
  - Direct care to lower cost areas with equal (or better) quality
  - Reduces Medicare cost dilution

6. Engage Medical Staff *Deeply*

- Educate, mentor, and engage physician leaders
  - Clinical co-management expected to grow
- Include physicians in key governance decision-making
  - Beyond traditional clinical, credentialing, and quality committee work
  - Offer direct ability to influence outcomes
- Offer rewarding, yet reasonable salary
  - Based on what physicians identify as desirable characteristics and behaviors

7. Develop Medical Homes

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**
- www.TransforMed.com

Sources: Commonwealth Fund and 2007 Joint Principles of Patient-Centered Medical Homes.

8. Cultivate New Skills

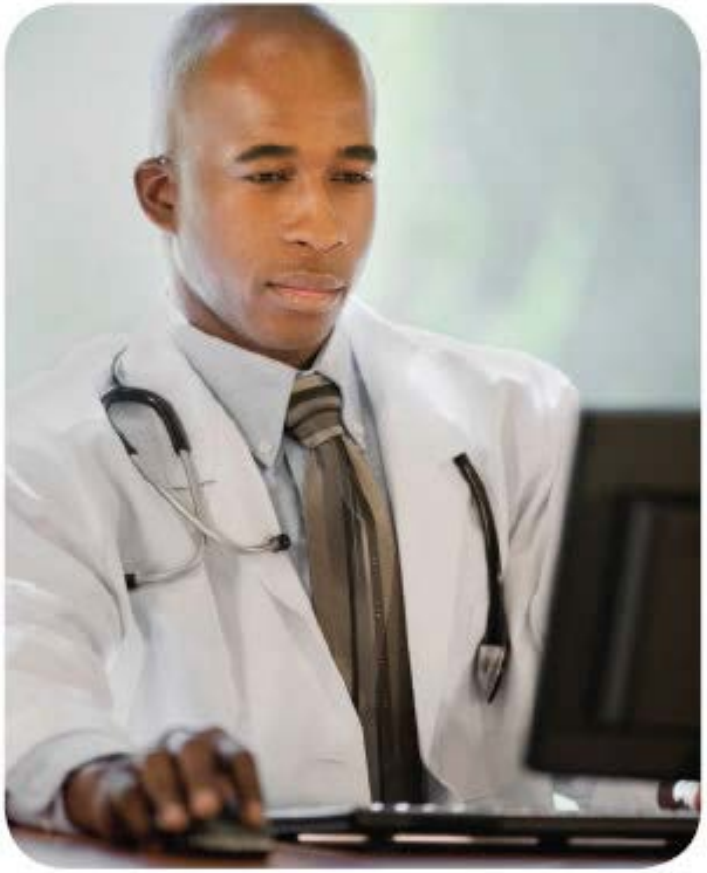
- New skills required
  - We are *comprehensivists*
  - Data analytics
  - Quality improvement
  - Cost management
  - Team management – "leader" need not be a physician
- But I don't want to change!
  - Static fee-for-service prices – working harder for less
  - No bonuses – less pay for subpar quality
  - Volume at risk – from poor economy, high deductibles, and skilled competitors

9. Coordinate Care

- Supports provider care plans
- Supports patients with frequent contact
- Helps patients prepare for office visits
- Identifies high-risk patients
- Develops disease registries
- Monitors reminder systems
- Provides patient education
- Coordinates care and transitions
- The go-to person to connect the dots

10. Refer Based On Value

- Who provides the best care to your patients?
  - How do you know?
- Who provides the best value to your patients?
  - How do you know?
- What kind of care do you want your mom to have?
- Referral hospitals and specialists should earn our referrals



11. Consider Regionalization

- Act locally; think regionally
- Economies of scale may demand a contracted cottage industry
  - Yet, future payment linked to *local* covered lives
- Goal: To care for populations expertly, efficiently, equitably
  - Options are optional
  - Affiliation is not an end in itself
  - Independence is not a mission
  - Success measured by *clinical integration*

Resource: Lupica and Geffner. Enlightened Interdependence. *Trustee*. November/December 2012.

12. Engage Your Community

- What is available locally to improve health care **value**?
  - Public Health
  - Social Service
  - Agency on Aging
  - Community health workers
  - Care transition programs
  - Churches and foundations
- Do not duplicate!
  - Collaborations are less expensive than new clinic/hospital services – and build good will
- Do what's *right*

Specific Hospital Activities for CAHs

- Hospital leadership fully understand and begin to build case for population health management
- Hospitals put population health on meeting agendas, including board, management, quality improvement
- Hospitals look within own walls and initiate employee wellness programs
- Hospitals reach out to communities to discover health program wants and needs

Source: National Rural Health Resource Center (2014) Critical Access Hospital Population Health Summit: Improving Population Health: A Guide for Critical Access Hospitals

Lessons from Hospitals in Healthiest Counties

- Dansville, NY: “change from thinking about the care that is given while the patient is within our walls to thinking about the care of the patient outside our walls”
- Dansville: “We no longer see ourselves as a standalone organization, but rather as part of the region’s broader healthcare ecosystem”

Lessons from Hospitals in Healthiest Counties

- Oakland CA: “just as our focus on total health–integration, prevention, and empowerment–drives internal planning for our members, it also drives planning for improving the health of our community”
- Oakland CA: “we work closely with the county and state public health departments, reviewing various sets of data, including mortality and morbidity data, as well as substance abuse, drinking, and tobacco consumption figures”

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Lessons from Hospitals in Healthiest Counties

- Raleigh, NC: “a physician-led effort in partnership with the hospital to provide integrated, patient-centered care. This means coordination of care, more involvement in prevention as well as a more active role in helping people manager their overall health outside of the healthcare setting.”

Source: Rizzo E (2014) Population Health Lessons From Hospitals in the U.S.’ Healthiest Counties: 3 CEOs Share Successes. Becker’s Hospital Review. June 2.

Examples From Rural Institutions

- Available from the Rural Health Value project: http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/
- Community Outreach in Delhi, LA
- System Transformation in the Mercy Health Network, IA
- Service Delivery Integration& Patient Engagement in Humboldt County, CA

Other Innovations

- Chief Medical Financial Officer in Banner General Hospital in Sandpoint, Idaho (CAH)
- Chief Patient Experience Officer named at Johns Hopkins Medicine
- All about value for the patient/customer

So What Should Iowa Hospitals Be Doing?

- Fill in the slide ☺

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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