Rural Health Strategies for a Value-Based Future

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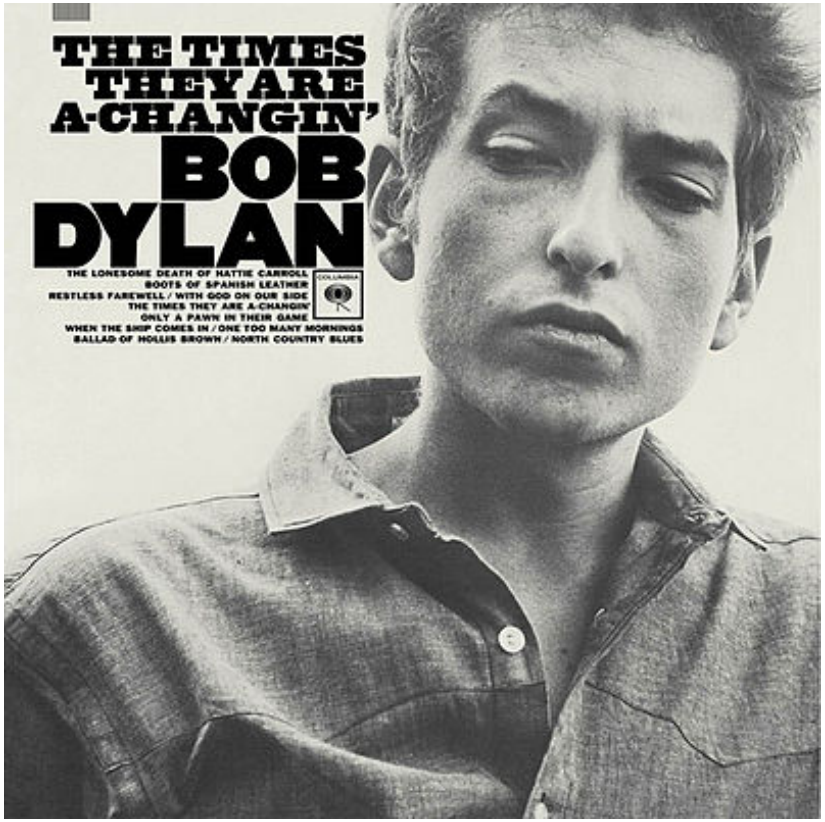
THE UNIVERSITY OF IOWA

The Times They Are A-Changin'

- The counter-culture poet/musician from the Iron Range of Minnesota
- 50 years ago – still true today
- Especially in health care!
- Remember the old days?



The Times They Are A-Changin'

- *"The future ain't what it used to be."*

  Yogi Berra

The Winds of Change

- Healthcare reform
- Safety and quality
- Aging
- Consumerism
- Technology
- New care delivery models
- Information technology
- Accountable to community
- Workforce shortages
- Declining revenue

Which Way?

- In whirlwind, easy to get disoriented, lose our way
- Healthcare providers can lose our ***purpose***
- Rural hospitals can lose their ***mission***
- Let me reorient you…

The Triple Aim©

Improved community health

Better patient care

Lower per capita cost

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Triple Aim© Equals Value

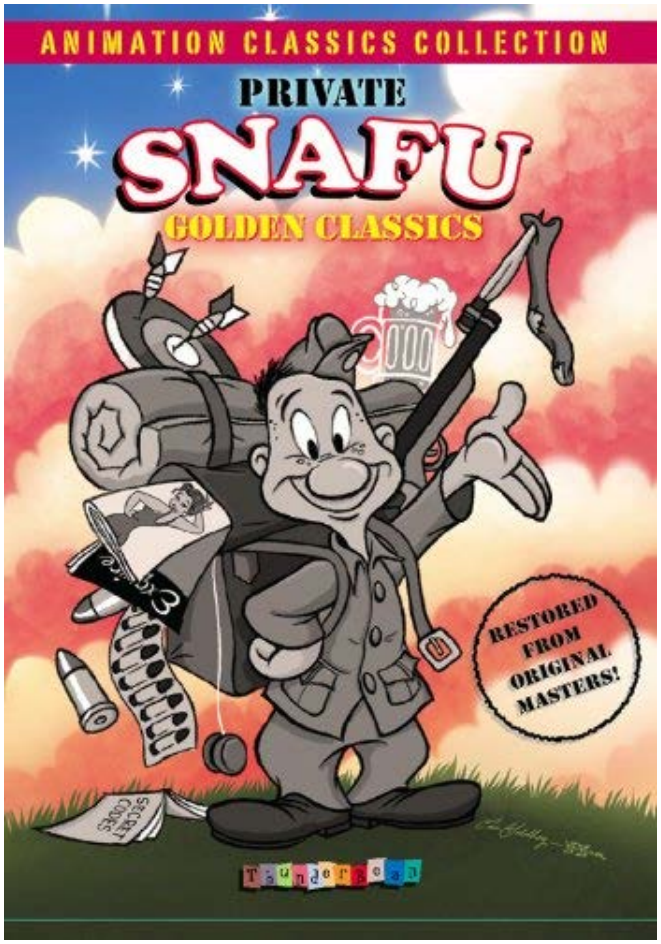
The healthcare value equation (2007)

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

But we have a problem…

We Are Not Pay For Value!

- We like getting our paychecks!
- Predominantly paid based on fee-for-service, not paid to deliver the Triple Aim©.
- Our current volume-based payment system impedes delivering health care of value.
- Hence, a SNAFU!
  - Situation normal, all fouled up



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

- **What about paying for healthcare value?**

Form Follows Finance

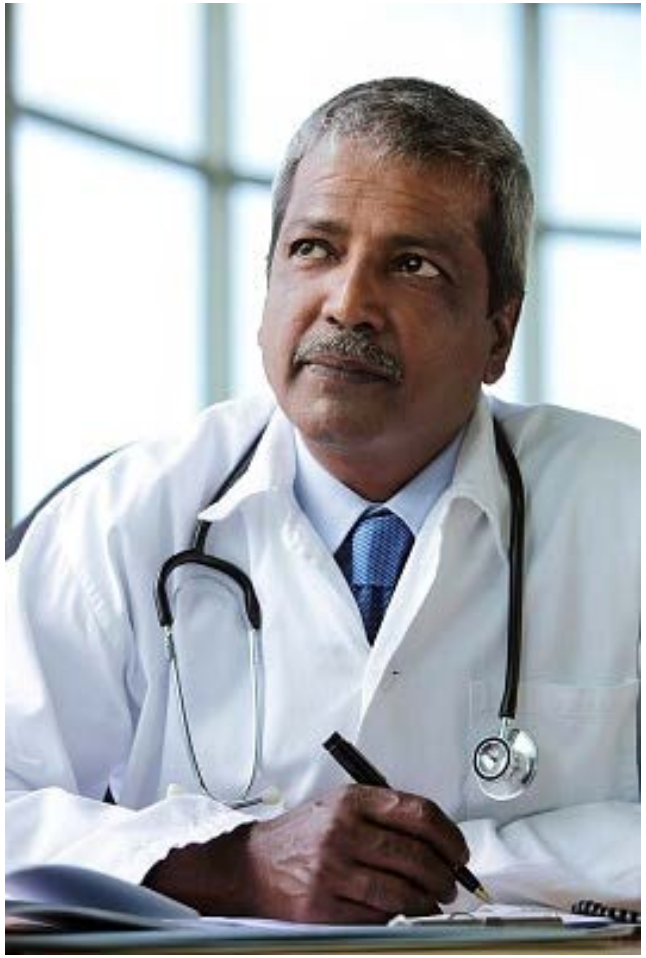
- How we deliver care depends on how we are paid for care
- Healthcare reform is changing <u>both</u>
- Fundamentally, reform involves a **transfer of financial risk** from payers to providers

Risk Assessment Is Ubiquitous

- Risk is present when an outcome is uncertain or unpredictable
- Types of healthcare risk
  - Random
  - Insurance
  - Political
  - Medical care
- Where and how can we:
  - **Influence or control risk**
  - **Reduce risk of harm**
  - **Optimize risk of benefit**

Medical Care Risk

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



Rural Risk?

Clint MacKinney, MD, MS

The Times They Are A-Changin'

- Risk transfer strategies
  - VBP, VBM, SGR (fix), ACOs, readmission policy, hospital acquired conditions policy, bundled payment, reference pricing, narrow networks, and more
- Moves payment from FFS toward the Triple Aim©
  - Volume → Value
- Recall, ***form follows finance***
  - What form do we need and how should we change to be successful?

Three Big Trends (with examples)

1. **Primary Care Ascending**
   - Medical Homes
2. **New Affiliations**
   - Accountable Care Organizations
3. **Paying for Quality**
   - Sustainable Growth Rate Fix

1. Primary Care Ascending

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.*

- **Robust primary care**
- **24/7 access to care**
- **Coordinated and team-based**
- **Patient- and family-centered**
- **Information technology support**
- **New payment systems**

See www.TransforMed.com

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

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 electronic health record is critical to managing patient and population health
- Let care protocols do (at least some of) the work (e.g., lab orders, med refills, vaccines)

Crete Physicians Clinic
Crete, Nebraska

2. New Affiliations

- Accountable Care Organizations
  - A coordinated network of providers (generally hospitals and/or physicians) who share responsibility to provide high quality and low cost care to their patients.*
- Requires excellent clinical quality and patient satisfaction
  - CMS uses 33 outpatient measures
- Payer "shares" savings with ACO if costs are less than predicted

*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.

Dramatic ACO Expansion

- Rapid expansion in about 2 years
  - 626 ACOs across the country (May 2014)
  - Over half are Medicare ACOs
  - 20.5 million ACO-covered lives
- 123 new Medicare ACOs announced in 2014 – more coming in 2015
- A **rural** phenomenon too
  - Medicare ACOs operate in **16.7 %** of all rural counties (December 2013)
- Future of ACO programs uncertain, but competing on ***value*** will endure

Source: The Lewin Group 2014 and RUPRI Center 2013

3. Paying for Quality

Sustainable Growth Rate Fix (proposed)

- Minimal fee-for-service payment increase next 10 years (0.5%, then 0%)
  - Actually payment decrease (inflation)
- Merit-Based Incentive Payment System (-9% to +27%)
  - Likely to include quality, satisfaction, and efficiency measures
  - Eventually replaces PQRS, Meaningful Use, and Value-Based Modifier
- Alternative Payment Models (+5%)

Shifting Health Care Payments

Volume → Value Transition

- Bath water
  - Fee-for-service and CBR
  - Necessary providers (OIG)
  - Few quality demands
  - Inefficiency tolerated
- Turning up the heat
  - Decreased per unit price
  - Pressure to reduce volumes
  - Quality demands
  - Competitive market
- How to avoid getting cooked?

Strategic Emphases for Success

More (not all)

- Primary care and coordination
- Clinical quality and patient experience
- Partnerships
- Employee training

Less (not none)

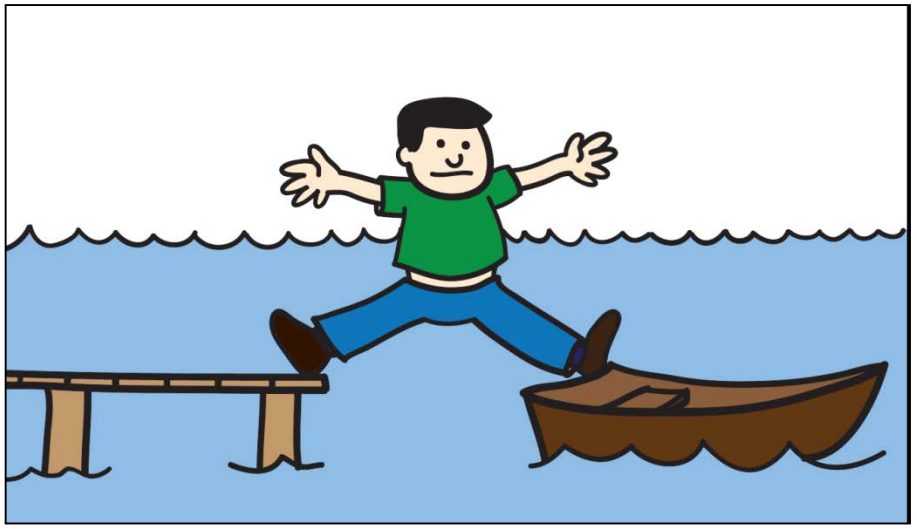
- Inpatient
- Facilities and equipment
- Specialty services
- Top down management

Holy Family Hosp. Transformed

Source: Graphic provided by Mark Herzog, CEO. Holy Family Memorial Hospital. Manitowoc, Wisconsin. 2013.

Volume → Value… *Specifically*

- 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.



What to Do… Now

- ✓ New Skill Development
- ✓ Fee-for-Service Attention
- ✓ Operations Efficiency
- ✓ Performance Improvement
- ✓ Physician Engagement
- ✓ Care Coordination
- ✓ Regionalization

✓ Develop New Skills

- New skills required
  - Data analysis
  - Quality improvement
  - Cost management
  - Team-based care
  - Collaboration
- "But I don't want to change!"
  - **Flat FFS prices** – working harder for less
  - **No bonuses** – less pay for subpar quality
  - **Volume at risk** – from poor economy, high deductibles, and skilled competitors

✓ Get Your FFS House in Order

Attention to

- Market share
- Expense management
- Revenue cycle
- PQRS/Meaningful Use
- Payer and purchasing contracts
- Inventory management
- *Appropriate* volumes

✓ Improve Operations Efficiency

Lean

- Removes Waste
- Increases Speed
- Removes non-value added process steps
- Fixes connections between process steps
- Focuses on the customer

Speed

+

Six Sigma

- Reduces Variation
- Improves Quality
- Reduces variation at each remaining step
- Optimizes remaining process steps
- Focuses on the customer

Accuracy

=

Better Delivery

Better Quality

Satisfied Employees

Satisfied Customers

Progressive Edge

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

✓ Performance Improvement

- 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

PI: *Leadership* Priority

- Clinical quality, patient safety, and the patient experience
  - Expectation: "Always above the mean. Always improving."
- Quality/safety performance
  - Outpatient – 33 ACO measures
  - Inpatient – Hospital Compare
- Communicate to improve
  - Every meeting
  - Charts, not spreadsheets
  - Un-blind the data!

Get Paid for Performance

- **Apply** aggressively for value-based demonstrations and grants
- **Negotiate** with commercial insurers to pay for quality
- **Care management** for self-pay and organization employees first
  - Direct care to lower cost areas with equal (or better!) quality
  - Reduces Medicare cost dilution

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

✓ Engage Medical Staff *Deeply*

Physician Engagement:*

Active physician involvement and meaningful physician influence that move the organization toward a shared vision and a successful future.

- Governance
- Compensation
- Education
- Data

* or provider

✓ 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

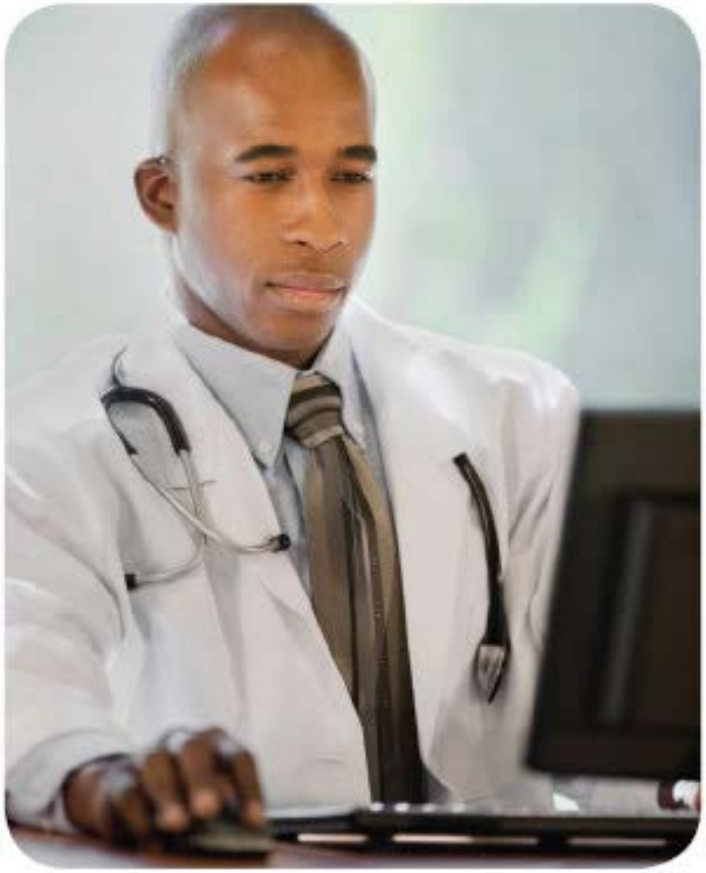
Engage Your Community

- What is available locally to improve health care **value**?
  - Public Health
  - Social Service
  - Area 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*

Coordinate Referral Care

- Who provides the best care and value for your patients?
  - How do you know?
  - Use data to make wise decisions
- Hospitals and distant specialists should earn our referrals
- Collaborate with **payers** to reward the Triple Aim©



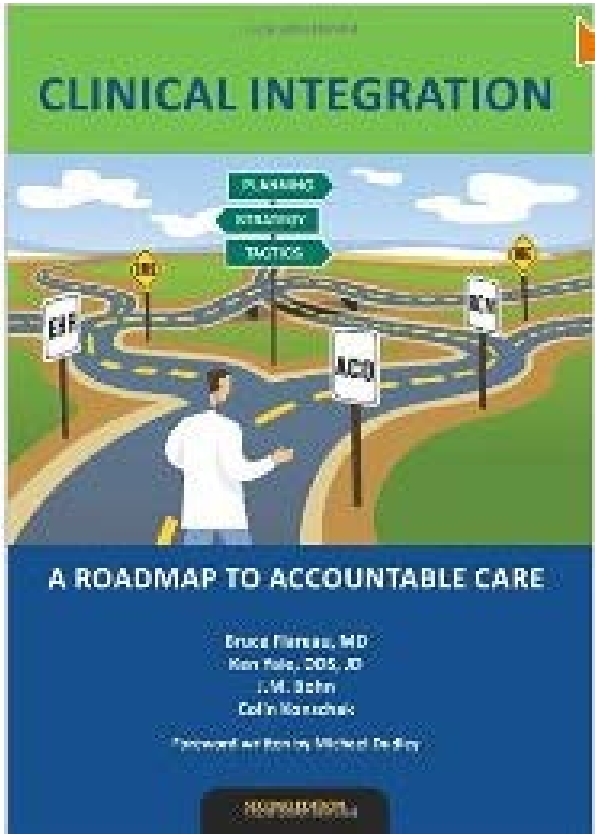
✓ Consider Regionalization

- 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.

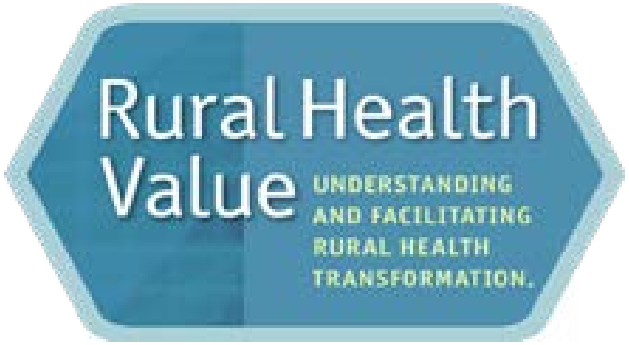
Integrate Clinically

- Clinical data sharing in real-time
- Standardized clinical care protocols
- Consistent clinical performance measures and reporting
- Clear team member responsibilities across multiple facilities
- Sense of professional camaraderie among disparate organizations
- Aligned incentives for regional ***population health*** improvement



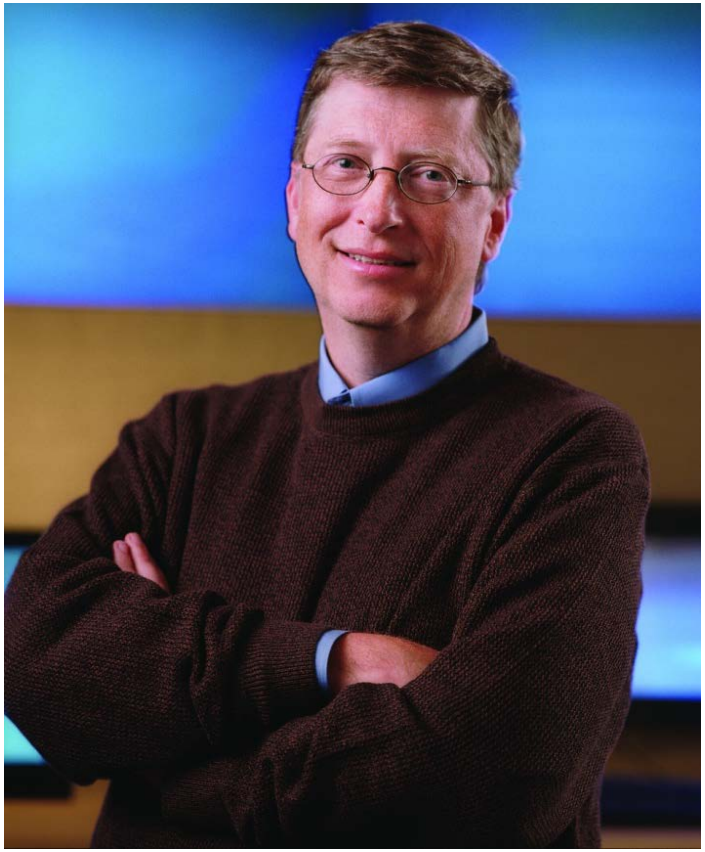
Rural Health Value Project

- **Vision**
  - To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems
- 3-year HRSA Cooperative agreement
  - Rural Health System Analysis and Technical Assistance (RHSATA)
- Partners
  - RUPRI Center for Rural Health Policy Analysis
  - Stratis Health
  - Support from Stroudwater Associates and Washington University
- Check out tools/resources at www.RuralHealthValue.org



Bill Gates, Jr.

- *"We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten."*

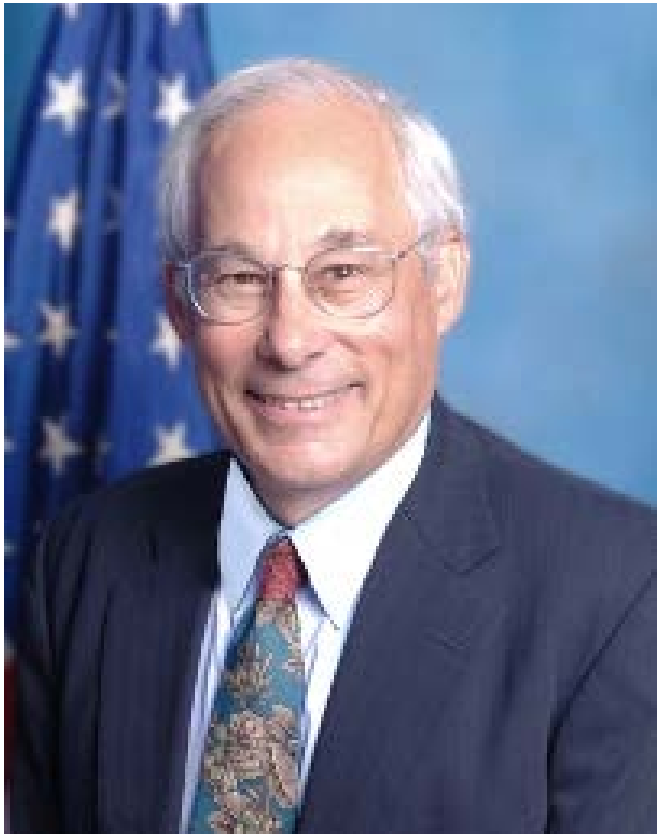


Gail Collins

- *"… behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time."*

Don Berwick

- *Yet, "there has never been a better time to be an innovator in health care."*



The Risk of Something New

Healthy People and Places