The New "Normal" Health System

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The Bottom Line: Boards and Adapting to Changing Environment

- Integrating systems of care in the marketplace, driven by financial pressure and changes in care delivery
- Aligning public and private policies with what is now state of the art in care to improve sustainability of high quality services in rural places

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The Bottom Line: Boards and Adapting to Changing Environment

- Emphasizing value instead of service volume: translation is population health, which means need to think of the total community being served in the places they live, work, and play
- Blending health and human services
- Maintaining the appropriate, sustainable service mix locally

Importance of Transitions to Optimize Opportunities

- Changes are coming, under auspices of reform or otherwise
- Implement the changes in the context of what is desirable for rural communities
- How do we pull that off?

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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

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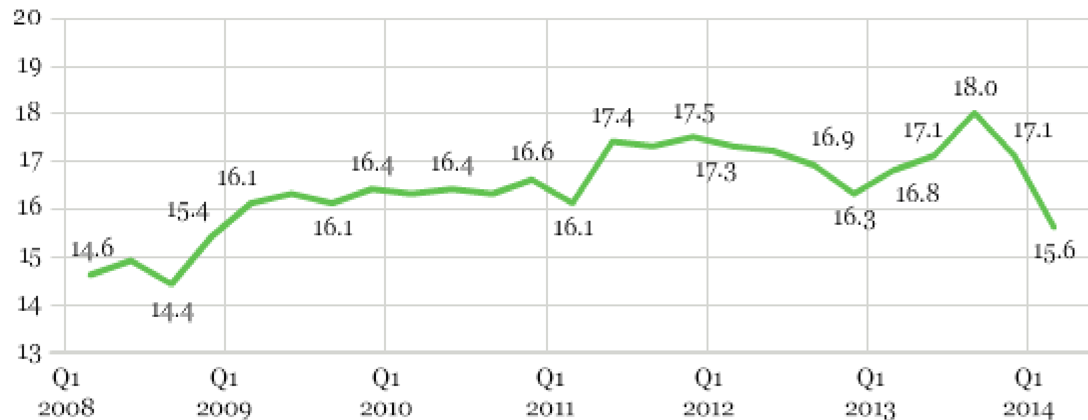
Changes In Insurance Status



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Data from April 14 Gallup Poll

- 4% of US population newly insured as of April; 2.1% through exchanges, 1.9% not
- Among newly insured, 30% aged 18-29 (constitute 21% of population)
- Among newly insured, 75% with household incomes below $60,000

Gallup Daily tracking poll of more than 20,000 adults, aged 18 and older

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Data from RAND Study

- Representative sampling design; 2,641 individuals aged 18 to 64, weighted to provide national estimates, changes September 2013 – March 2014
- Net gain of 9.3 million insured; gain in employer-sponsored insurance of 8.2 million and net loss in individual market of 1.6 million
- Marketplace enrollment of 3.9 million

Changes to Medicaid

- Eligibility changed to 138% of federal poverty guideline
- No categorical eligibility
- Moves closer to insurance model
- Increased population covered, brings increased focus on cost and value

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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)
- New channels of access for those with insurance: implications for academic health science centers, use of emergency rooms, choice (or not) among providers

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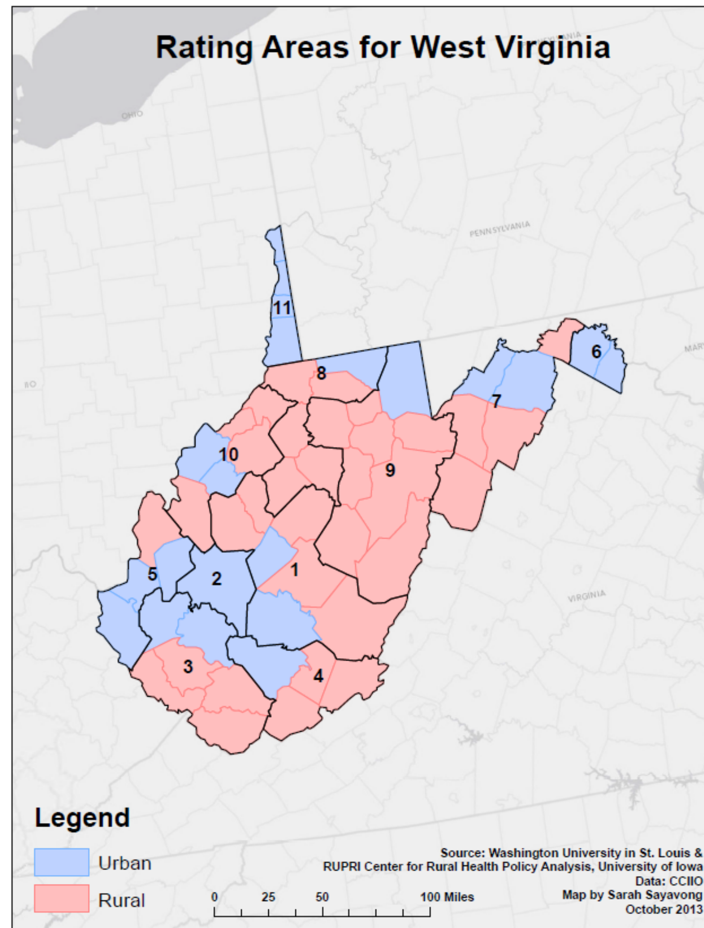
What the Changes May Mean

- 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

And Variation Within the State



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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

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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

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Medicare Payment Changes

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

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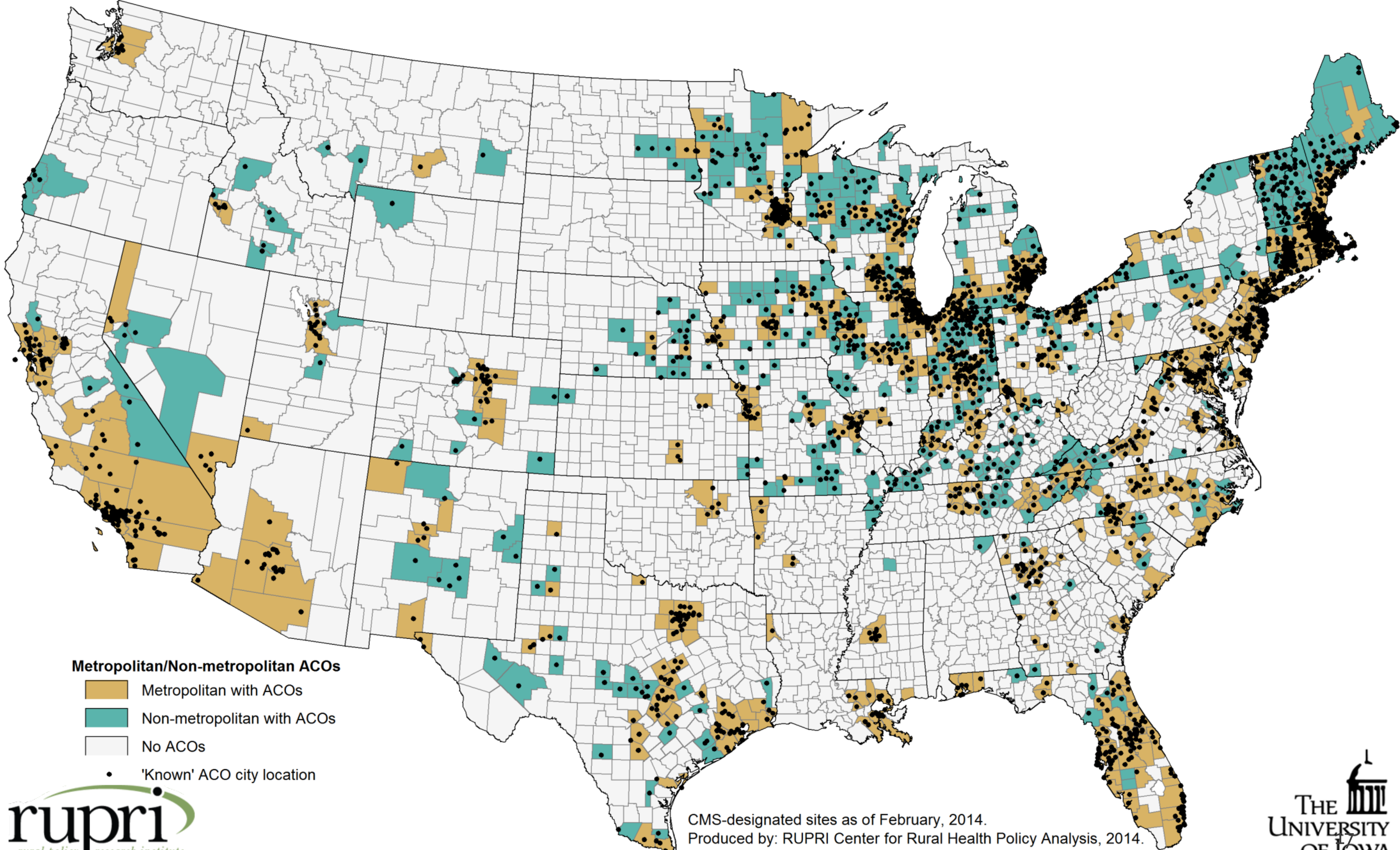
Tally Sheet

- 66 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)

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

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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

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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 <u>and</u> changing financial and policy context

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Changes in Delivery Modalities Create Opportunities

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

Lessons from Tele-Emergency

Authors:

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Examination of hospital-based application of telehealth, specifically tele-emergency (local ED linked to "hub" that provides real-time on call board-certified emergency physician and staff)

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We confirmed these roles

- Clinical resources, including board-certified emergency doctor (deal with unusual cases)
- Care coordination
- Value to patient and community of local care
- Value to providers to have coverage and consultation

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Implications

- Policies that recognize what is now possible: conditions of participation and payment
- Expectations related to new delivery system, connected health
- Appropriate use of clinical personnel (local non-physicians with support from board-certified doctor)
- Increase value of local services, implications for sustainable services, patient satisfaction and loyalty to care givers (implications for shared savings models)

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Conclusion: Part of evolving healthcare system

- Patient care where patients need, want the services; patient-focused care
- Integrated care utilizing care teams, linking facilities
- Role of local primary care re-enforced supported
- Increasing value and lowering costs

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Future Should be: RUPRI Health Panel Vision

The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance rural health care system informed by the needs of each unique rural community will lead to greater community health and well-being.

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Should be: Foundations for Rural Health

- **Better Care**: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

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Source: "Pursuing High Performance in Rural Health Care." RUPRI Rural Futures Lab Foundation Paper No. 4. http://ruralfutureslab.org/docs/Pursuing_High_Performance_in_Rural_Health_Care_010212.pdf

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Central points from RUPRI Health Panel regarding change

- Preserve rural health system design flexibility: local access to public health, emergency medical, and primary care services
- Expand and transform primary care: PCMH as organizing framework, use of all primary care professionals in most efficient manner possible

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Continued

- Use health information to manage and coordinate care: records, registries
- Deliver value in measurable way that can be basis for payment
- Collaborate to integrate services
- Strive for healthy communities

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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

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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

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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.

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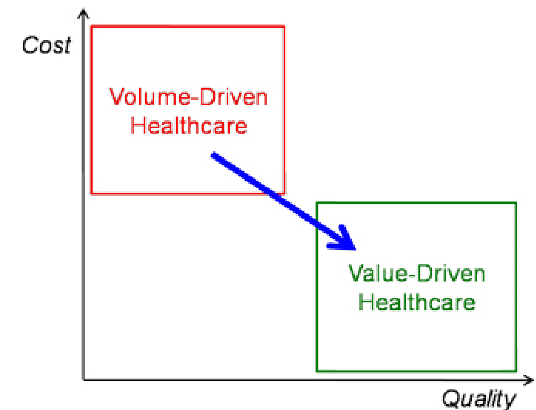
Transition Thinking

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



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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

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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

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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Being an Effective Leader or Partner

- Focus on center of excellence or pillar of excellence
- Proving cost effectiveness, including ability to reduce costs
- Engaging board of trustees and stakeholders

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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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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

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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

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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)

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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.

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Opportunities for Boards

- Setting the tone: all about culture of the organization
- Guiding community assessments
- Leading community-based efforts
- Working through networks (policy and practice) to align incentives
- Local investments in appropriate, sustainable services consistent with shifts in health care organization, delivery and finance

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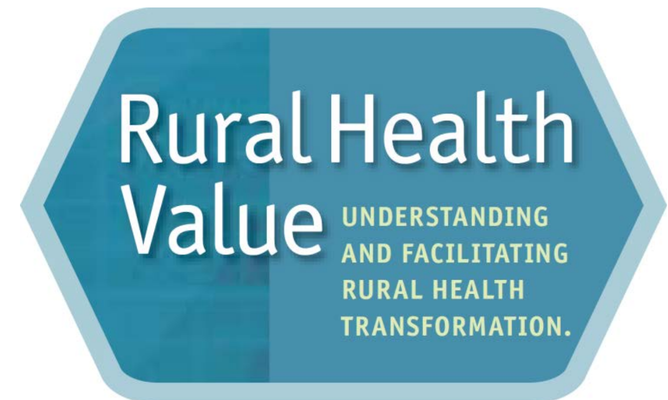
RuralHealthValue.org

- Rural Health System Analysis and Technical Assistance
  - Assess the rural implications of policies and demonstrations
  - Develop tools and resources to assist rural providers and communities
  - Inform and disseminate rural health care innovations



www.RuralHealthValue.org

- Share an innovation with RHSATA that has moved your organization (or another) toward delivering value.
- Continue to be a leadership voice for rural health care value.
  - Our glass is at least half full. A positive attitude is infectious!

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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

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Appendix slides describing West Virginia

- Primary care service areas on a scale
- Medicare Advantage plan activity
- Health Professions Shortage Areas
- Location of hospitals

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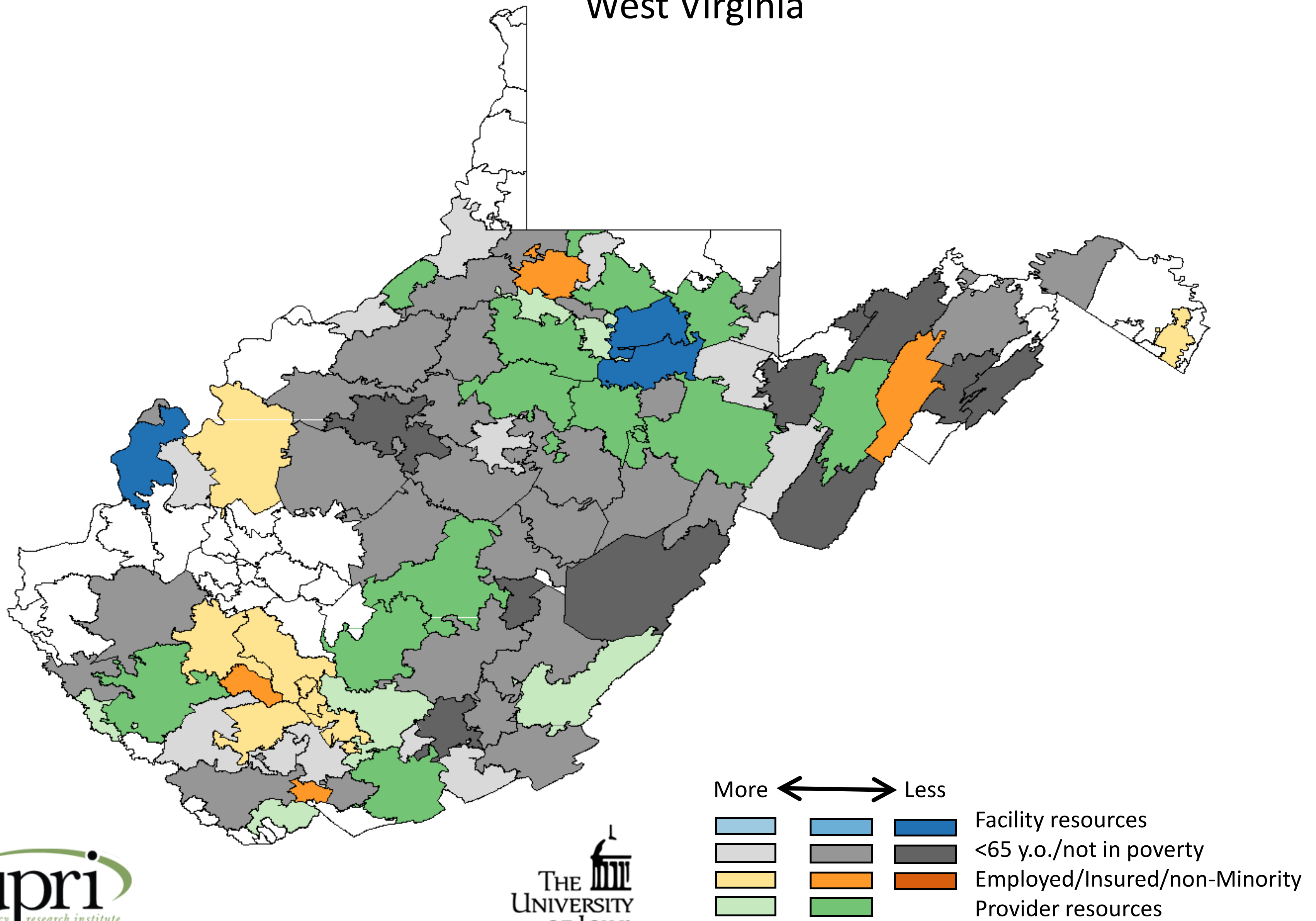
Primary Care Service Areas
West Virginia



Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage in West Virginia, March 2013

Legend

113th Congressional Districts

Metropolitan counties

Percent Enrolled by County

0% - 7%

8% - 15%

16% - 25%

26% - 37%

38% - 65%

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Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2013.

Produced by: RUPRI Center for Rural Health Policy Analysis, 2013

Health Profession Shortage Areas

West Virginia, Primary Care, 2012

HPSA
Entire County
Partial County
non-HPSA

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Produced by: RUPRI Center for Rural Health Policy Analysis, 2014

West Virginia

General Medical and Surgical Hospitals

Legend

- PPS Hospital
- CAH Hospital

Produced by: RUPRI Center for Rural Health Policy Analysis, 2014
Data Source: American Hospital Annual Survey 2012

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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