

# 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

# 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?



# 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

# Changes In Insurance Status

## Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?

Among adults aged 18 and older

■ % Uninsured



Quarter 1 2008-Quarter 1 2014

Gallup-Healthways Well-Being Index

GALLUP®

# 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

# 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

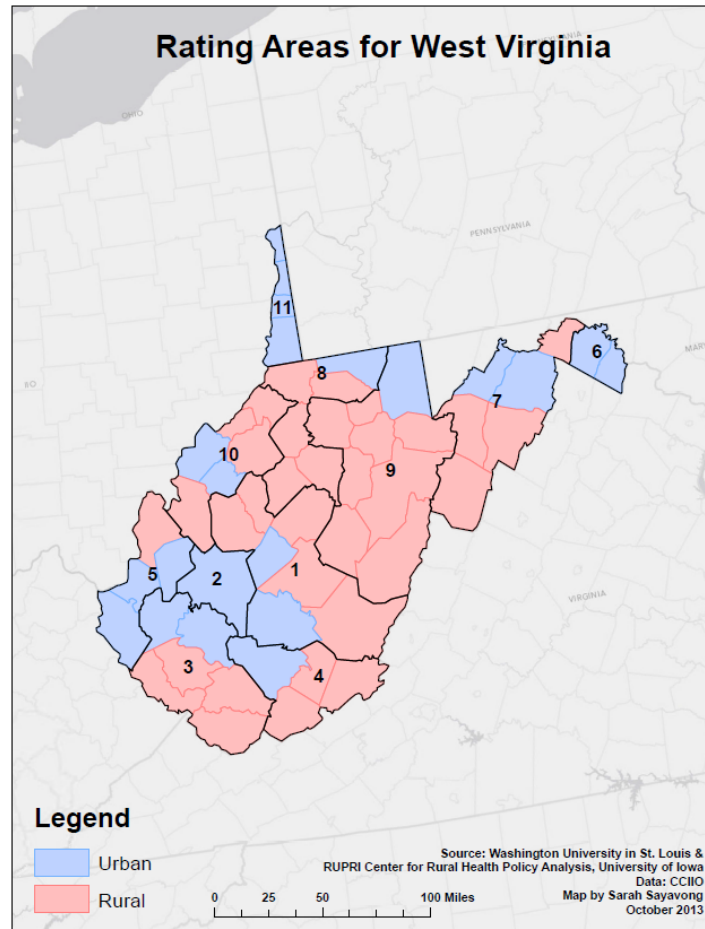
# What the Change Means

- 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

# 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



# 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 (FCHIP)
- Demonstrations of new methods, including bundled payment, value-based for Critical Access Hospitals
- Value-based purchasing across provider types
- ACOs as a harbinger



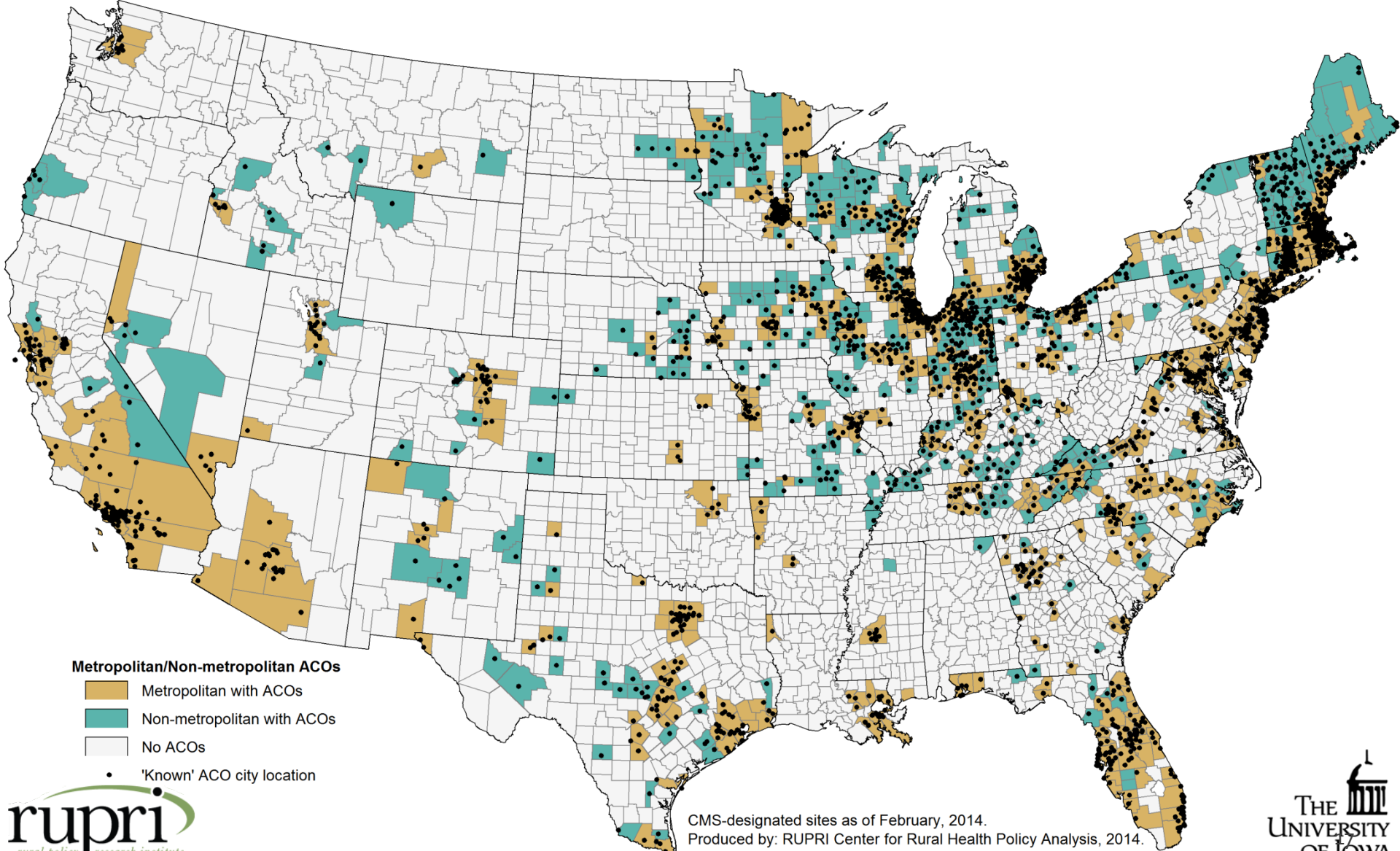
# Tally Sheet

- 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



# 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



# Lessons from Tele-Emergency

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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)

# 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



# 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)



# 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



# 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.

# 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.

# 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

# 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



# 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

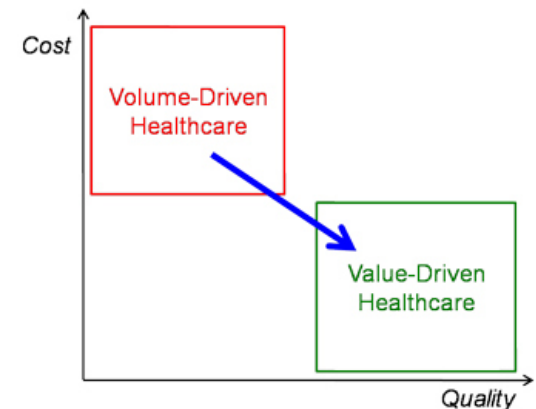


Source: *Pursuing the Triple Aim*, Bisognano and Kenney. Jossey-Bass. 2012.



# 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

# 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”



# 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



# 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



# 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



# 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

# 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.

# 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

# RuralHealthValue.org

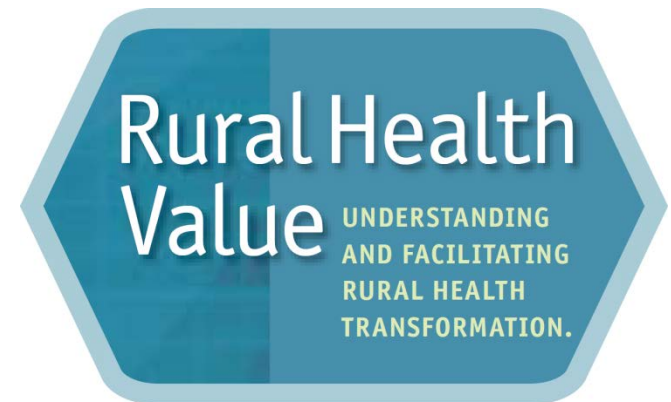
## ■ Rural Health Value

- 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

■ Share an innovation with Rural Health Value 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!



[www.RuralHealthValue.org](http://www.RuralHealthValue.org)

# 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



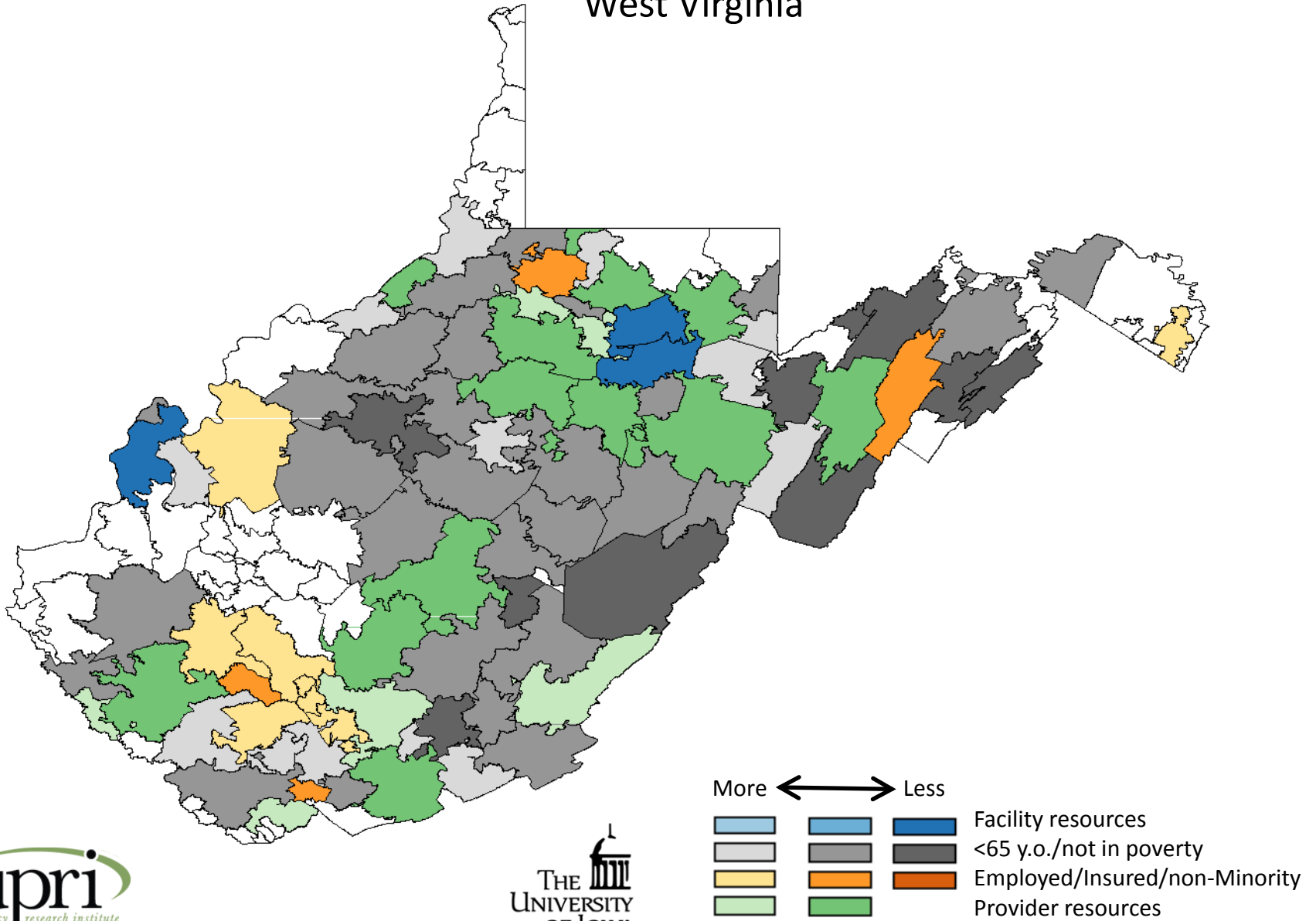
- The American Hospital Association



# Appendix slides describing West Virginia

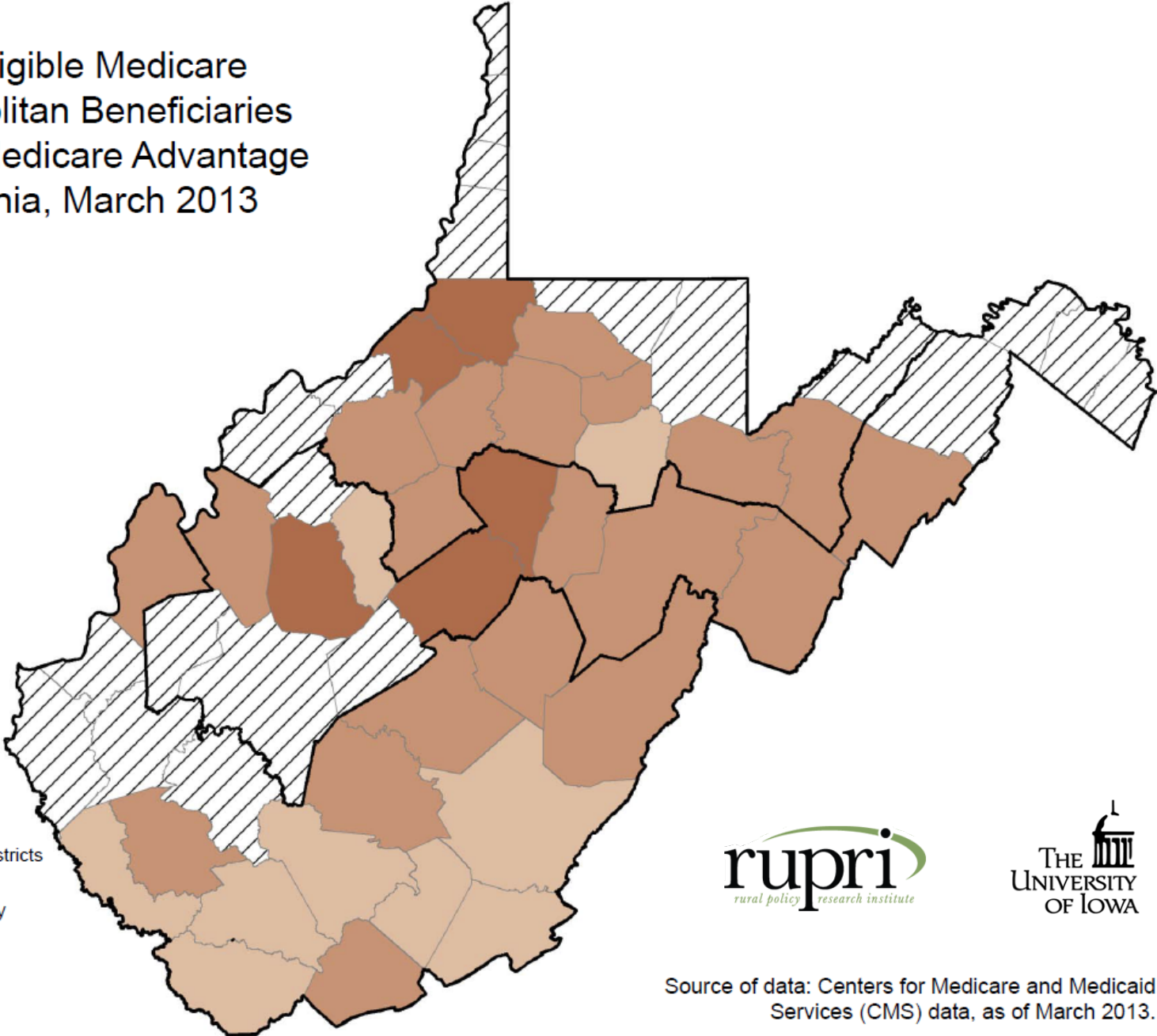
- Primary care service areas on a scale
- Medicare Advantage plan activity
- Health Professions Shortage Areas
- Location of hospitals

# Primary Care Service Areas West Virginia












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



**Legend**

-  113<sup>th</sup> Congressional Districts
-  Metropolitan counties
- Percent Enrolled by County
-  0% - 7%
-  8% - 15%
-  16% - 25%
-  26% - 37%
-  38% - 65%

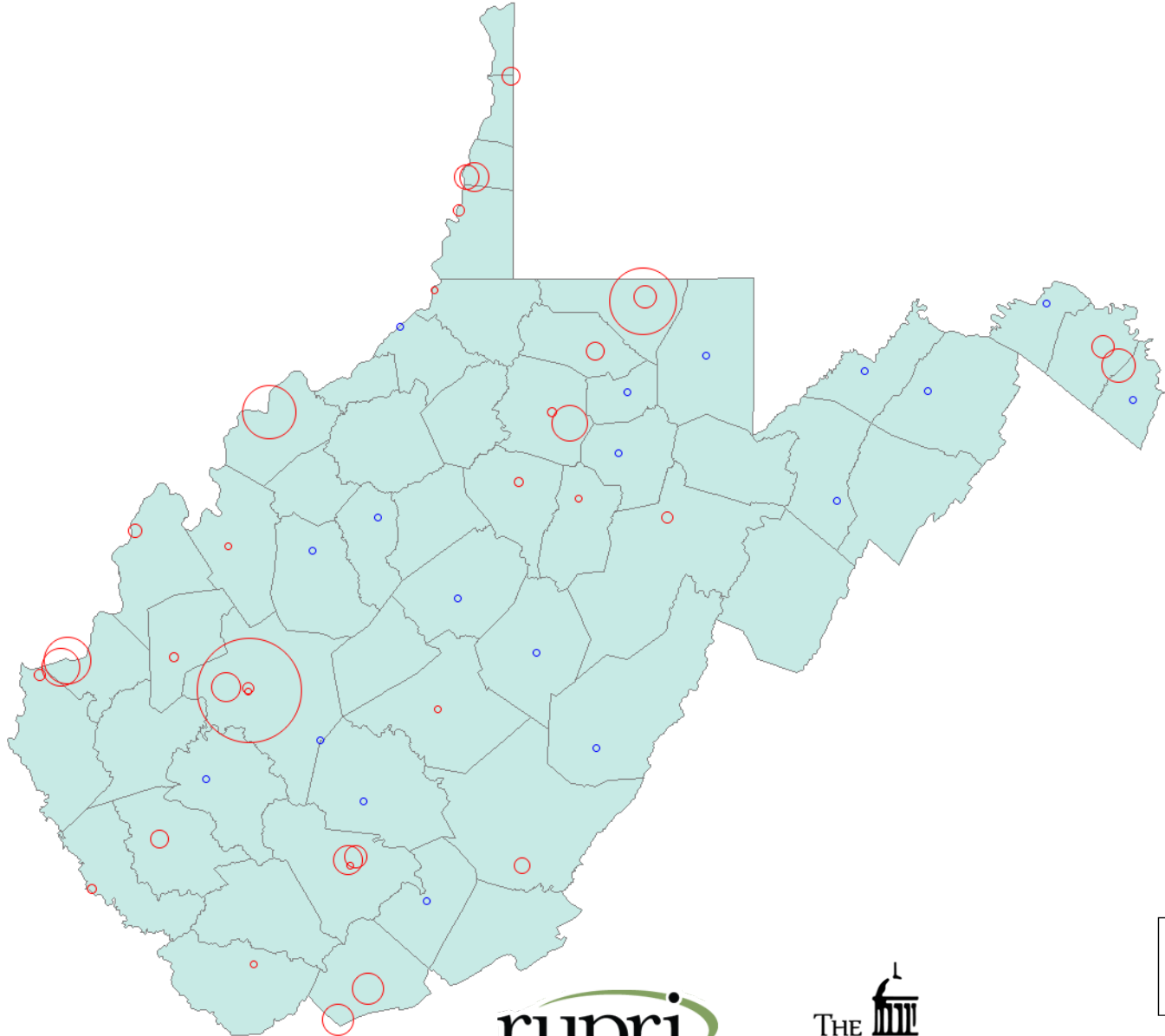


Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2013.

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



West Virginia  
General Medical and Surgical Hospitals



Legend

- PPS Hospital
- CAH Hospital



# 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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