Volume to Value: Finding a Glide Path for Rural Hospitals

CAH CEO Meeting
Montana Hospital Association and
Frontier Medicine Better Health Partnership
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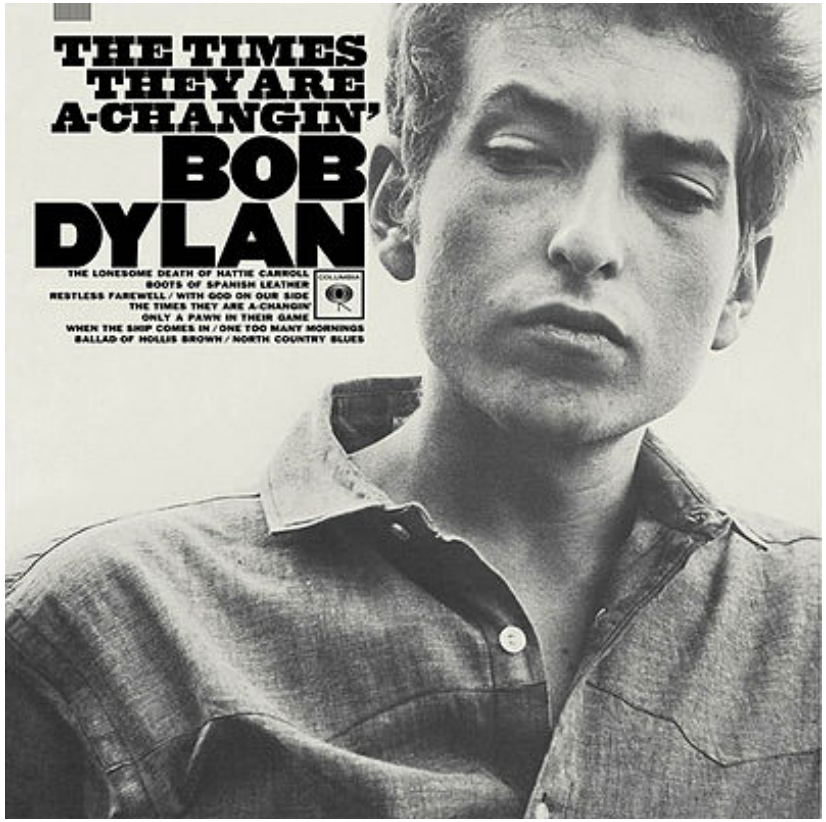
The Times They Are A-Changin'

- 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?



Four Converging Forces

- Price reduction threats and volume reduction pressures
- Expanding insurance coverage, but narrower networks
- Increasing quality of care measures and accountabilities
- Massive healthcare provider consolidations

Which Way?

- In the frenzy of change, it's easy to lose our way
- Healthcare providers can lose their ***purpose***
- Rural hospitals can lose their ***mission***
- Let's reorient…

The Triple Aim©

Improved community health

Better patient care

Lower per capita cost

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

New Champions for Value

- Jim Skogsbergh
  - American Hospital Association Chair-Elect (Iowa HMP grad!)
- Not just the Berwickians or Kais-inger-fields anymore!
- Plus a whole slew of <u>for-profit</u> firms and investors
  - $3 trillion (with a “T”) enterprise
  - Larger than all but four national economies (including the US!)
- Today’s discussion – ***finance***
  - But with only a few numbers

Triple Aim© Equals Value

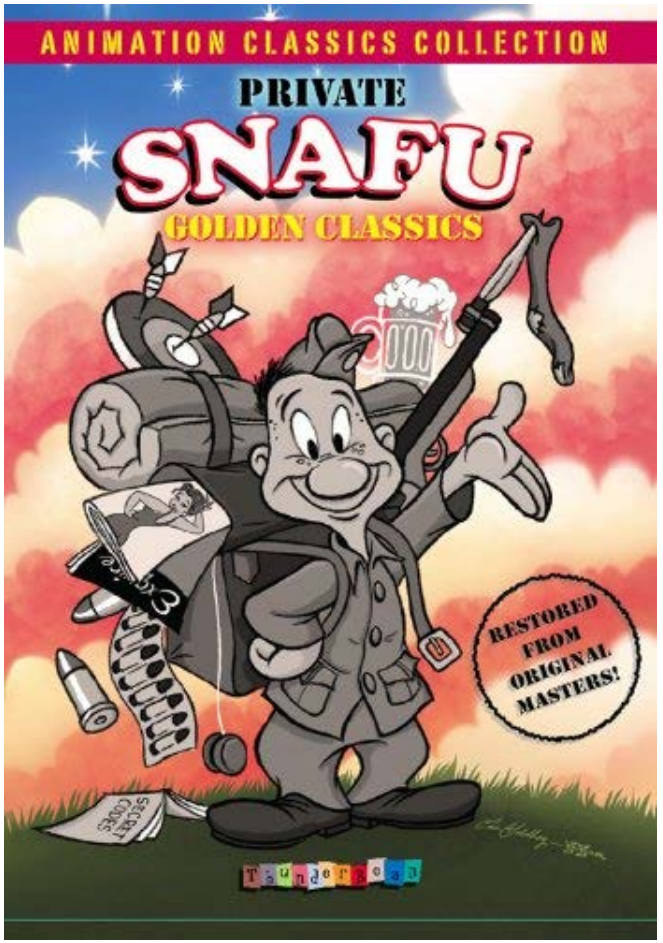
The healthcare value equation (2006)

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

But we have a problem…

Not Getting Paid 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?**

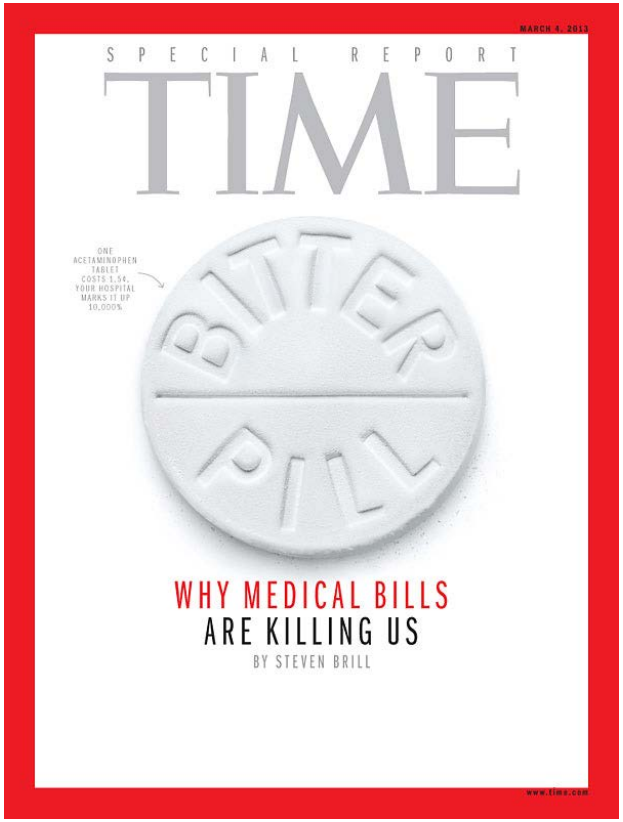
Value-Based Payment Landscape

- 40% private plan payments linked to **value** (11% in 2013)
- 700+ public/private shared savings plans (ACOs)
  - 20+ million patients
- 400+ Medicare ACOs
  - 6+ million beneficiaries
  - Operating in 48 states
- Accountable care has legs!
  - But maybe not ACOs…
  - Community-accountable health systems?

Sources: www.catalyzepaymentreform.org, www.hhs.gov, and RUPRI Center for Rural Health Policy Analysis

Why Is This Important to Us?

- FFS/CBR payment → value payment
  - Primary care physicians become ***revenue centers***
  - High cost procedures, specialists, and *hospitals* become ***cost centers***
- Insurance strategies
  - Reference pricing and narrow networks
- Consumer driven health care
  - High deductibles and price transparency
- Might Medicare Advantage for all be the end game?
  - Population-based payment (capitation)



Form Follows Finance

- How we deliver care depends on how we are paid for care
- Healthcare reform is changing <u>both</u> payment and delivery
  - Large system CEOs are embracing significant care delivery change
  - Venture capitalists are investing in new care models (not FFS!)
- Fundamentally, reform involves **transfer of financial risk** from payers to providers

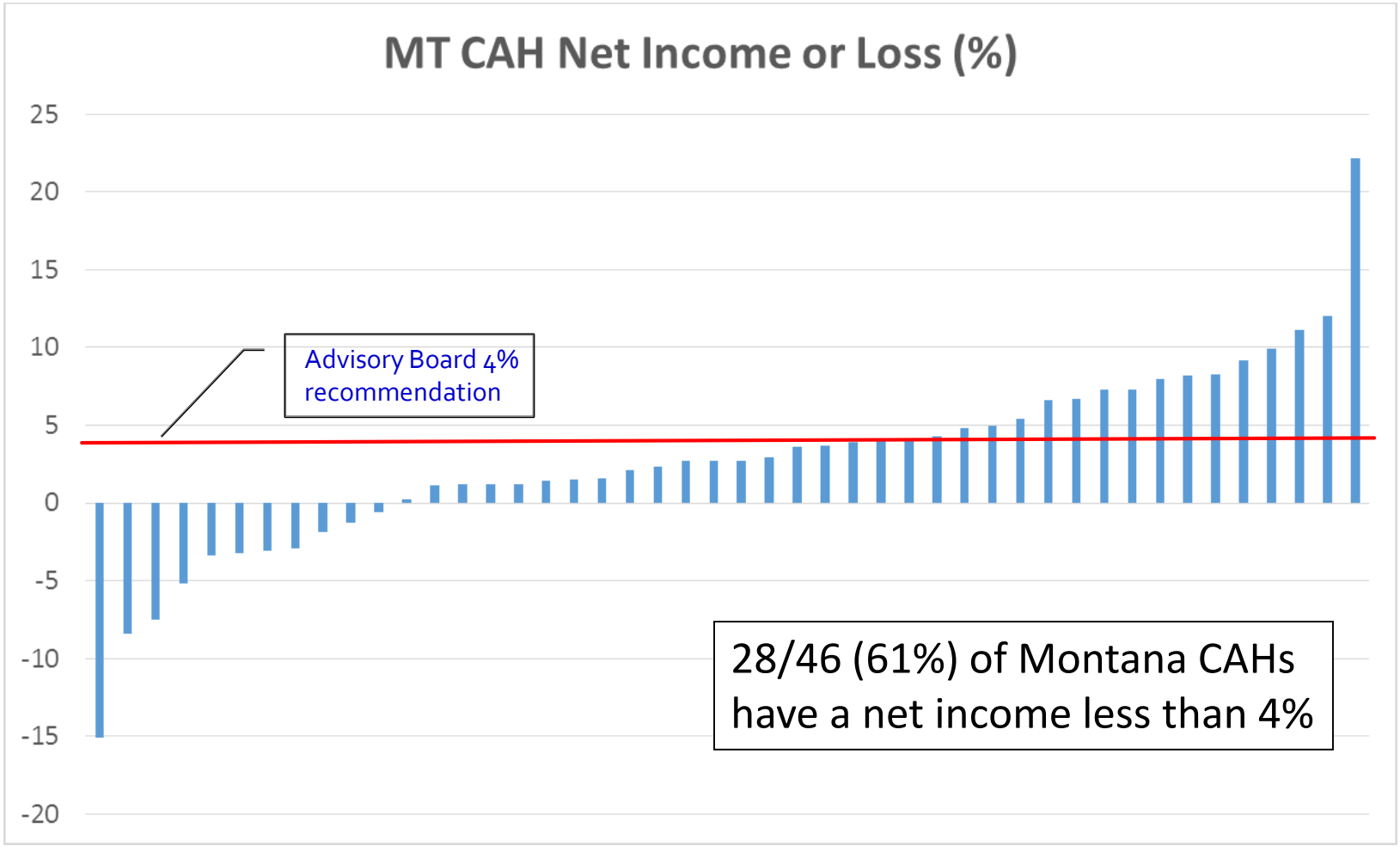
The Risk of Inertia

Source: Institute for HealthCare Improvement and Sharon Vitousek, MD

Rural Risk?

Clint MacKinney, MD, MS

MT CAH Financial Performance



Source: American Hospital Directory. www.ahd.com. Accessed January 7, 2015. (Data for 46 Montana CAHs available.)

FFS/CBR – A False Hope?

- Develop a 5-year pro forma
- Enter conservative assumptions
  - ↓ population (most rural places)
  - ↓ inpatient volume (all hospitals)
  - ↓ commercial insurance rates
  - ↑ employee compensation
  - ↑ employee healthcare costs
  - ↑ information technology costs
  - ↑ medical technology costs
  - ↑ competition
- But wait! At best, only 20% of health care is delivered locally

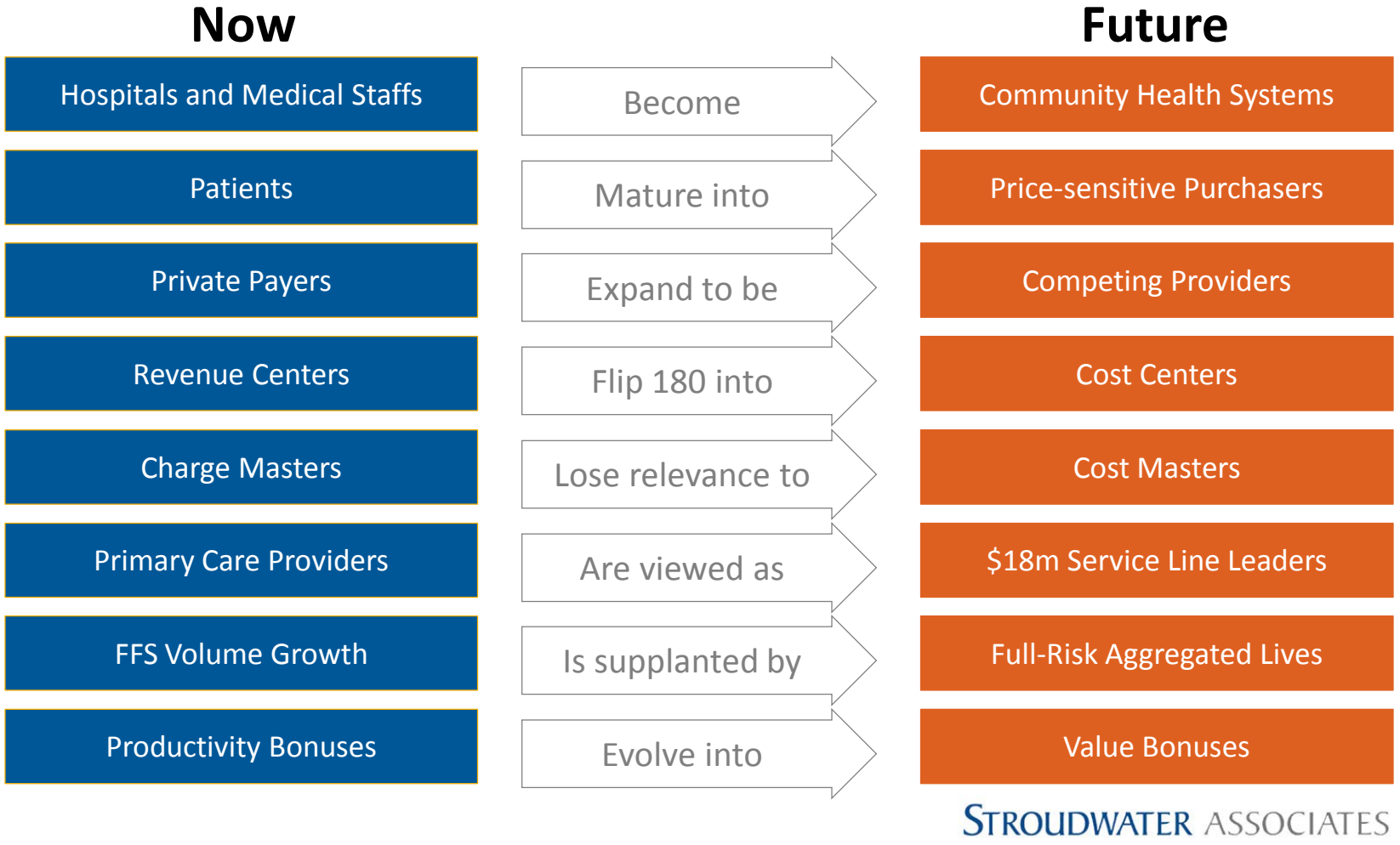
Leveraging the Other 80%

- Some reasonable assumptions
  - 80% of care provided elsewhere
  - One family physician with 2,000 patients could control **$18 million**
  - Do we want part of that action?
- If we cannot *leverage* the 80%, what do we become?
  - Vendor and cost center
  - How do you a manage cost center?
- So, how can a $20 million CAH *leverage* the other $80 million?
  - Actively participate in the shift from volume to value

Group Discussion 1

- List <u>three</u> strategic priorities for your CAH in 2015.
- How do your priorities compare to those of your small group colleagues?
- If they are different, what is unique about your CAH or its environment?

Transformation



Source: Greg Wolf, Stroudwater Associates

Build Your Case for Value

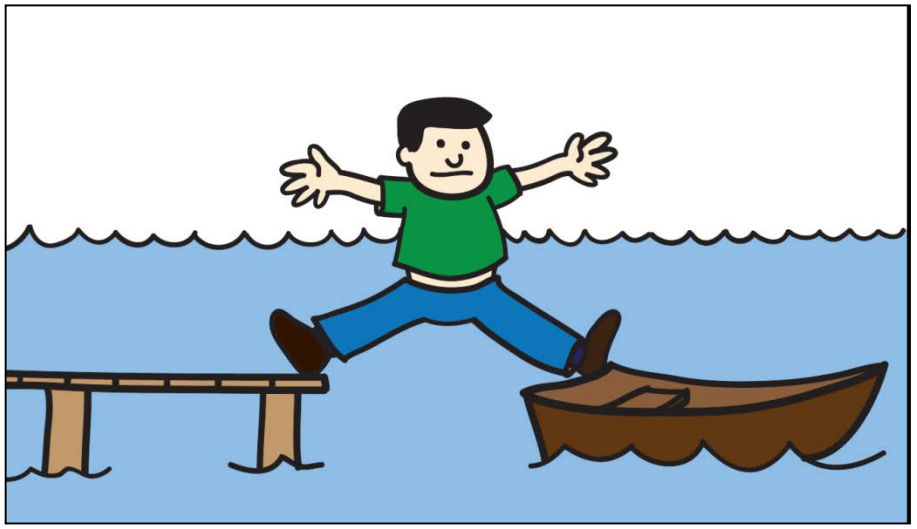
- *Demonstrate* that the care at your CAH is **better** and **cheaper** than your competitors
  - Be brutally honest. Others will.
  - Understand your contribution to a system of health care
    - This is how you'll add *value* to an integrated network
    - This is how you'll earn a "seat of influence"
- Align with the revenue source
  - Primary care physicians
  - Patients (people)

Evolve through Managing Risk

- All about **risk management**
- Career-limiting approaches
  - *Blind innovation* – results in burning through reserves
  - *Navel gazing* – results in market share destruction
- Training wheels concept
- *Discriminating* approaches
  - Environmental insights
  - Sophisticated projections
  - Thoughtful experiments
  - Learning continuously

Volume → Value… *Specifically*

- How do we move toward delivering value when our revenue is primarily volume-driven?
- What changes should we implement *now* to be successful in the future?
- We can "test the waters" with a new set of tools.



CAH Value Evolution Toolbox

1. Optimize Fee-for-Service
2. Enhance Efficiency
3. Improve Patient Care
4. Engage Physicians

- ✓ Develop Medical Homes
- ✓ Measure, Report, and Act
- ✓ Get Paid for Quality
- ✓ Coordinate Care
- ✓ Establish a Referral Network
- ✓ Consider Regionalization
- ✓ Engage Your Community

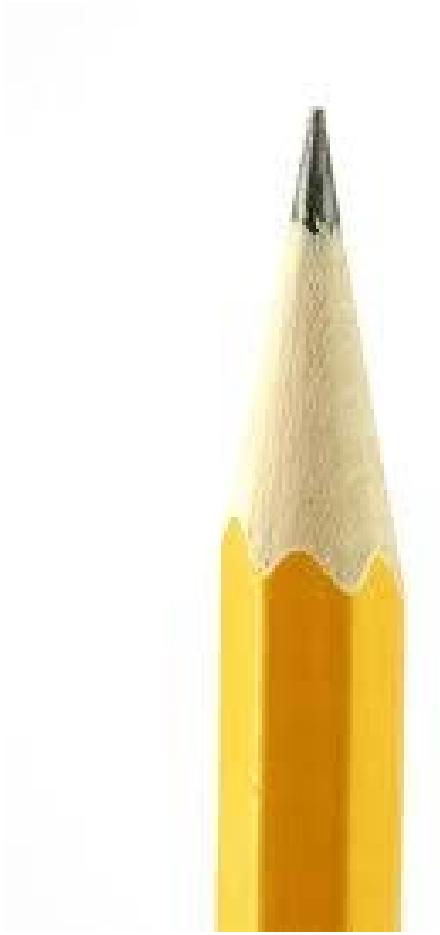
Prerequisite: Develop New Skills

- New skills required
  - Sophisticated data analysis
  - Continuous quality improvement
  - Cost accounting/management
  - Team-based health care
  - Expanded collaborations
- "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

1. Optimize FFS Revenue

Attention to

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



2. Enhance 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

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Progressive Edge

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

3. Improve Patient Care

- Clinical **quality**, patient **safety**, and the patient **experience**
  - "Always > the mean. Always improving."
  - *Leadership* priority
- Quality/safety performance
  - Outpatient – 33 ACO measures
  - Inpatient – Hospital Compare
- Communicate to improve
  - Public reporting (CAH website)
  - Every meeting
  - Charts, not spreadsheets
  - Un-blind the data!

4. Engage Physicians

The hospital CEO's most important job is developing and nurturing good medical staff relationships.

BKD LLP

Source: Personal conversation with John Sheehan, CPA, MBA

Shifting Health Care Payments

Physician Negotiations?

Inspiration: Ian Morrison's presentation "Moving Forward or Turning Back?"

Engage *Meaningfully*

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

✓ 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**

See www.TransforMed.com

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

Medical Home Quotes

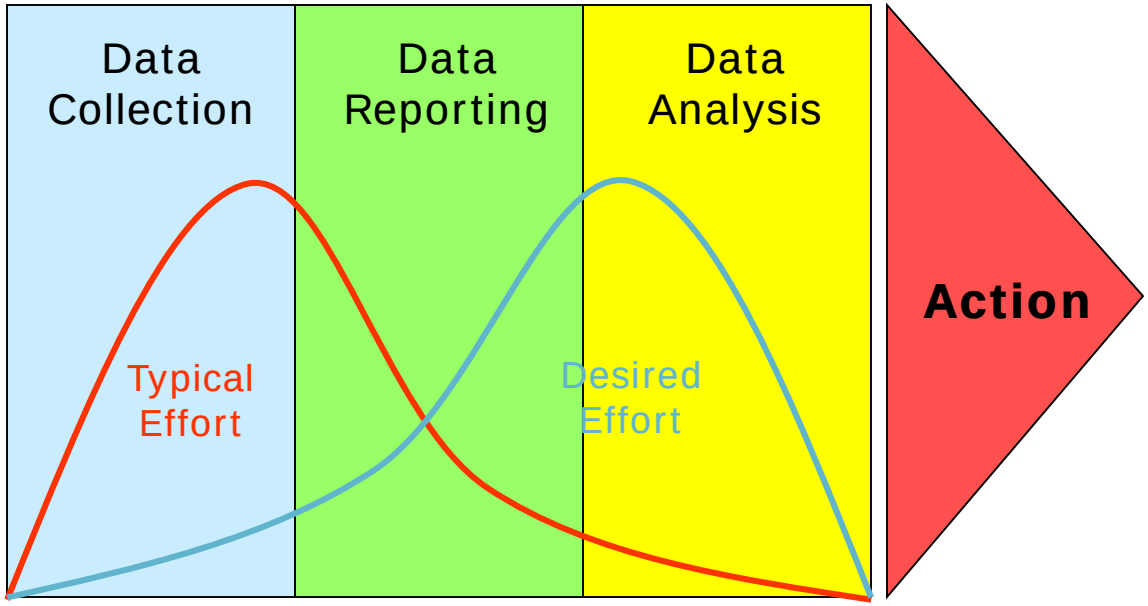
- All team members practice at the top (optimum) of their license and experience
- Best evidence is the best and only way we deliver care
- Care is the same, regardless of the provider
- Continuous performance improvement of our care is rigorously driven by data
- There are no non-compliant patients, 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)

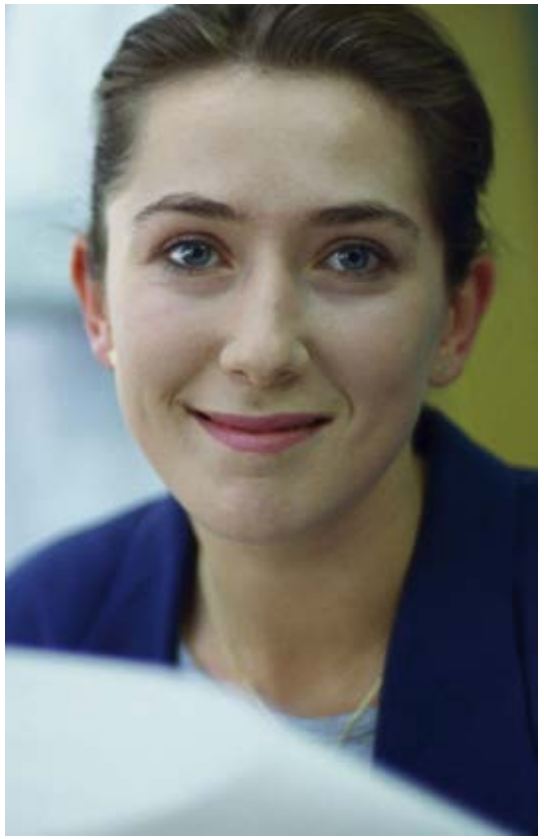
Crete Physicians Clinic
Crete, Nebraska

✓ 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
  - Communicate widely and frequently
- When possible, control the data
  - Market share – who's leaving and why
  - Our costs to payers, and our competitor's costs

Performance Measurement ROI





The goal is move the curve to the right

Source: Greg Wolf, Stroudwater Associates

✓ Get Paid for Quality

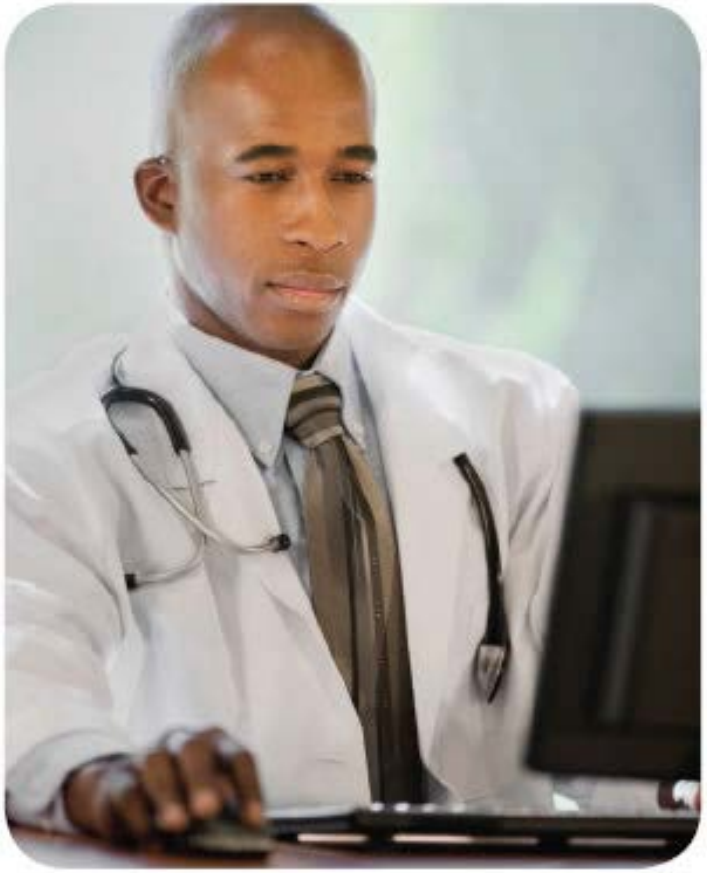
- **Apply** aggressively for value-based demonstrations and grants
- **Negotiate** with commercial insurers to pay for quality
- **Care management** for self-pay and organization employees first
  - Directs care to lower cost areas with equal (or better!) quality
  - May allow employee health insurance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

✓ Coordinate Care

- Identify high-risk patients
- Develop disease registries
- Monitor patient/provider reminder systems
- Support provider care plans
- Support patients with frequent contacts
- Help patients prepare for office visits
- Educate patients about healthcare concerns
- Coordinate care transitions
- Link patients, providers, and community resources
- Locate onsite: health coach and behavioral health

✓ Establish a Referral Network

- Who provides the best care and value for your patients?
  - How do you know?
  - Use data to design <u>your</u> network of distant colleagues and facilities
- Distant hospitals and specialists should <u>earn</u> our referrals
  - High quality
  - Low cost
  - Reasonable access
  - Consistent communication
  - Unfailing respect



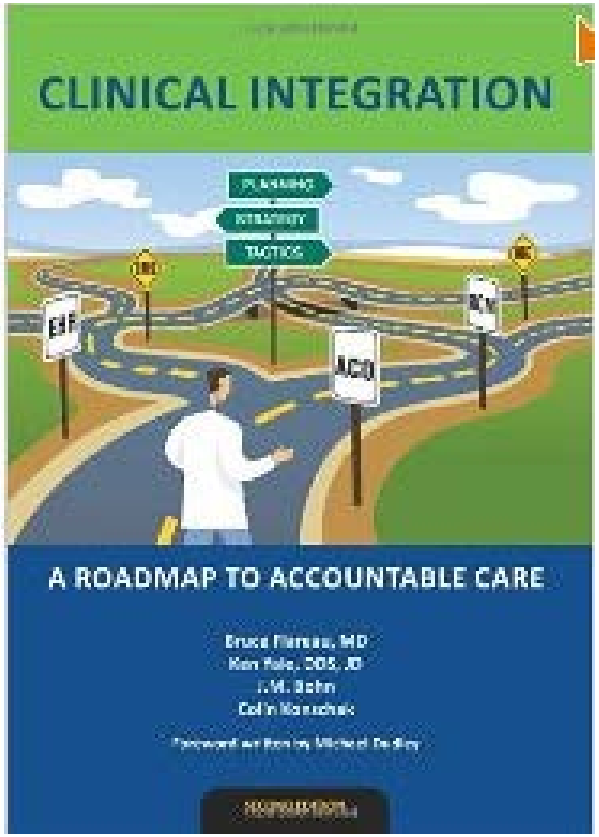
✓ Consider Regionalization

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

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

Clinical Integration

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



✓ Engage Your Community

- The CAH is likely to be the community's best ***convener***
- What is available locally to improve health care **value**?
  - Public Health
  - Social Service
  - Area Agency on Aging
  - Community health workers
  - Schools, churches, and foundations
- Do not duplicate!
  - Collaborations are less expensive than new clinic/hospital services – and build good will

Financing Community Health

- Community engagement
  - ↑ awareness of CAH services
  - ↑ customer trust/loyalty
  - ↓ patient outmigration
- Employee good health
  - ↑ attendance and productivity
  - ↓ insurance costs
- Employee well-being
  - ↑ retention and recruitment
- Community health
  - Meets CHNA requirement
  - Prepares for community-accountable health systems

When to Pull the Trigger…

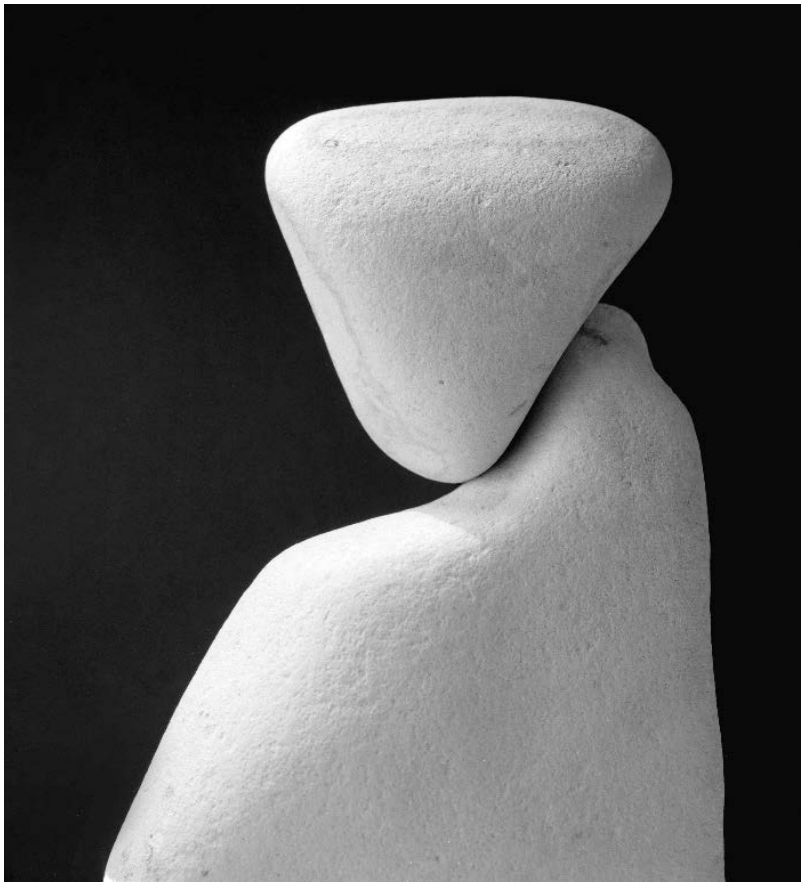
	Late Starters	Sequential	First Movers
Risks	Competitors and potential collaborators have already made transitions and view your organization as a liability	Modifying the wrong strike points in the wrong order creates organizational tension and disruption	Implementing changes to delivery system without harmonizing with payment system results in financial losses
Rewards	Learn from other organizations that have made modifications and use that knowledge to foster success	Deliberate, scheduled process for transitioning at the most *ready* strike points at the best time	Difficult decisions and changes are implemented upfront creating time for well-informed strategic decisions and adjustments

STROUDWATER ASSOCIATES

Source: Greg Wolf, Stroudwater Associates

Group Discussion 2

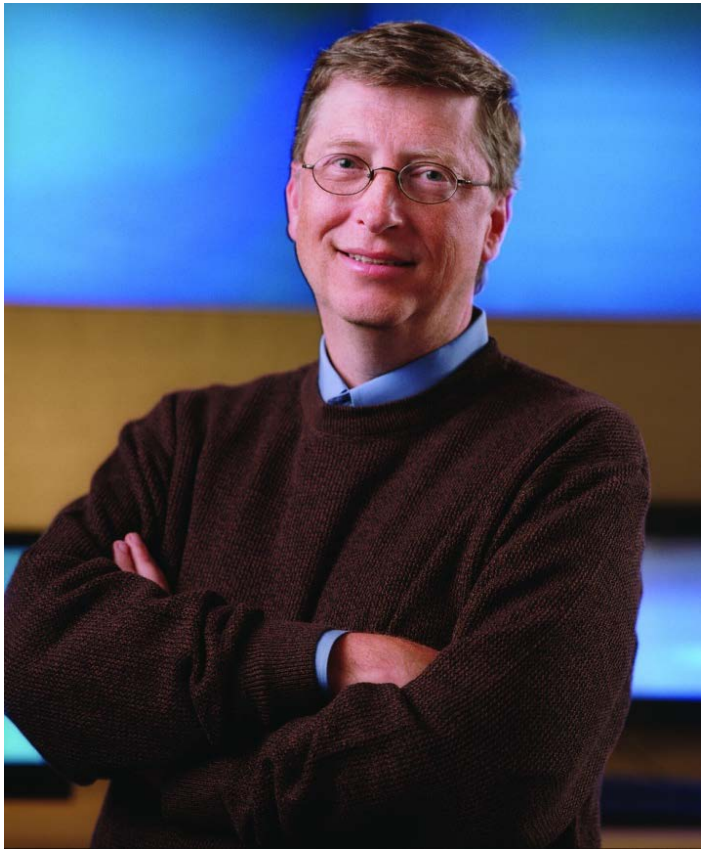
- How will you meaningfully engage your local physicians and outside community organizations?
- How will you ensure that your CAH is included in narrow insurance networks based on high quality and low cost?



Next

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."



Healthcare "Curves"

- 1st curve – **Increase volume**
  - Optimizing FFS/CBR payment
- 2nd curve – **Manage risk**
  - Financial consequence for delivering inferior value
- 3rd curve – **Connect persons**
  - Holistic yet individualized care, shared "big data" information, empowered persons, and community integration

New Policy Opportunities?

- **Alternatives** for low volumes CAHs – legislators interested
- **Conditions of Participation** – CMS open to discussion
- **RUPRI Health Panel** – demonstration recommendations
  - **Primary care redesign** – Combine local primary care and other providers focused on individual and community health improvement.
  - **Integrated governance** – Align various health-related organizations in new governance models.
  - **Frontier health systems** – Apply models that sustain essential local services while integrating distant services.
  - **Asset repurposing** – Leverage existing assets to finance and develop rural health hubs.

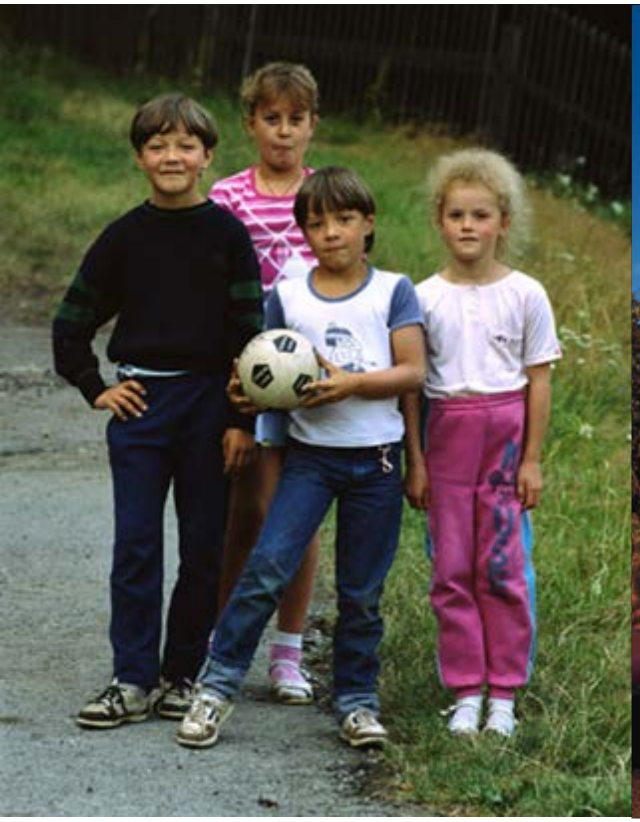
Source: RUPRI Health Panel. Advancing the Transition to a High Performance Rural Health System. 2014.

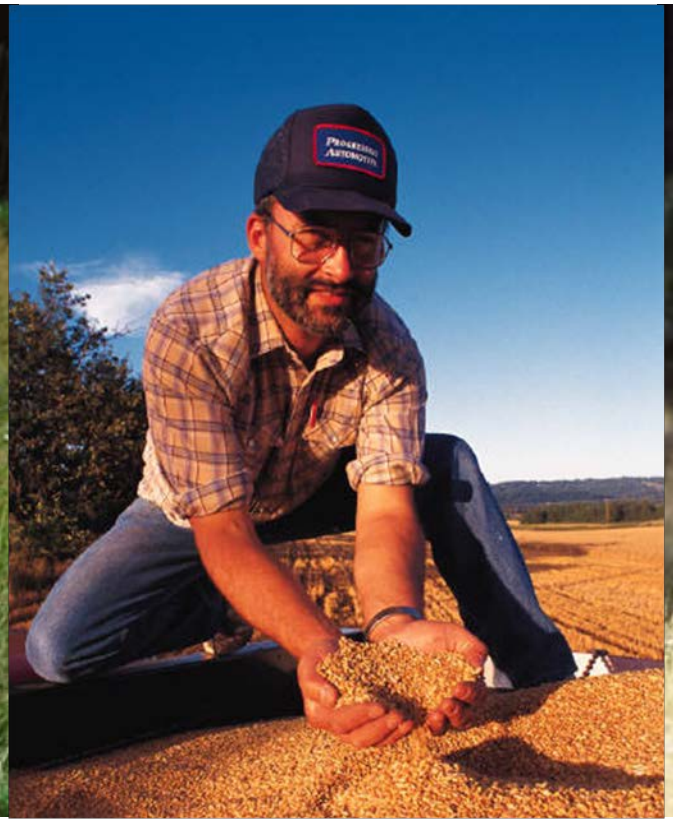
Rural Health Value Project

- **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**

The Risk of Something New

Healthy People and Places





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