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StratisHealth

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Rural Innovation Profile

Proactively Pursuing Value-Based Payment

What: A Critical Access Hospital (CAH) in western Washington that is proactively advancing value-based care and approaching payers for value-based payment contracts.

Why: Without new health care payment mechanisms, the provision of value-based care may be financially unfeasible.

Who: Summit Pacific Medical Center, Elma, Washington. Renee Jensen, CEO.

How: Focused leadership attention to identify core service lines, develop value-based care capacity, and pursue value-based payment contracts.

Key Points

- Identify the core service lines in which your organization provides better patient care than your competitors.
- Rigorously drive operational efficiency, regardless of the health care payment mechanism.
- After developing the capacity to deliver value-based care, proactively approach payers for value-based payment contracts.
- Begin to quantitatively demonstrate the value of the health care you deliver.

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SUMMIT PACIFIC MEDICAL CENTER

Summit Pacific Medical Center (SPMC) is an independent CAH in western Washington, approximately equidistant from larger hospitals in Aberdeen (21 miles to the west) and Olympia (30 miles to the east). The SPMC service area population is about 25,000 people. SPMC includes three Rural Health Clinics, an Urgent Care Clinic, and a 12,000-visits-per-year Emergency Department. SPMC's name is purposeful; it de-emphasizes the traditional concept of an inpatient hospital and instead focuses on primary care, emergency care, and other outpatient services. SPMC employs 225 individuals and realizes $57 million in yearly revenue. Of that revenue, 90 percent is attributable to outpatient services. Unlike a traditional inpatient hospital, SPMC specializes in primary and emergency care.

LEADERSHIP FOCUS

Renee Jensen is the CEO of SPMC. Ms. Jensen brings to her position a clear focus, a driven attitude, and an articulate and persuasive plan for SMPC's future. Ms. Jensen has identified SPMC's strengths and opportunities, is committed to delivering high-quality and coordinated primary care, and wants SPMC to get paid appropriately for the value-based care it provides. SPMC value-based care is grounded in primary care, integrated with mental wellness, centered on patient and community, and delivered efficiently. Under Ms. Jensen's leadership, SPMC aims to accomplish its organizational goals by developing value-based care capacity and by getting paid for delivering value-based care.

VALUE-BASED CARE CAPACITY

Volume-to-value is not simply a "program de jour" at SPMC. **Volume→Value = >Care Transformation** is a high-level SPMC strategic priority involving multiple individuals, foci, and programs. Areas of SPMC's care transformation focus include patient-centered medical homes, accountable care, value-based purchasing, and mental wellness integration. To support these priorities, SPMC is investing in care coordination and care transition infrastructure. Furthermore, Ms. Jensen has identified and compensates clinical champions to help build the clinical processes to support value-based care. Importantly, building the capacity to deliver value-based care at SPMC is a leadership priority, Ms. Jensen's priority. She *attends* to value-based care capacity at SPMC. When leaders such as Ms. Jensen want something done, they attend to it. Attention is the currency of leadership.

GETTING PAID FOR VALUE

Investing in the infrastructure to deliver value-based care is expensive. And the current payment system (fee-for-service and cost-based reimbursement) rewards health care service volume, not value (defined by Medicare and others as better patient care, improved community health, and lower per capita cost). So the question becomes, "How does a CAH pay for the volume-to-value transformation when the bulk of payment remains (for now) based on fee-for-service and cost-based reimbursement?" Ms. Jensen and the SPMC team's approach is five-pronged.

Optimize Efficiency

No matter what payment system a hospital operates within, it will be financially advantageous to function efficiently. Strategies such as Lean reduce waste. Strategies such as Six Sigma reduce variation. In addition, revenue cycle management, inventory control, and informed contracting all help secure the financial reserves necessary to fund the volume-to-value transformation.

Direct Patients to Core Services

Ms. Jensen identifies primary care clinics (Rural Health Clinics and Urgent Care) and the SPMC Emergency Department as SPMC's core services. Consequently, SPMC will develop and implement processes and policies that drive patient care toward those core services. Ms. Jensen is enthusiastic about additional SPMC strategies, such as care coordination and care transition services, designed to reduce unnecessary or excessive tertiary hospital care and subspecialty physician services at distant sites.

Join the Medicare Shared Savings Program

SPMC has joined a Medicare accountable care organization (ACO) to learn new clinical care processes required to deliver value-based care. Furthermore, the Medicare Shared Savings Program allows participants access to Medicare claims data that facilitate informed clinical and financial decision making. Although the Medicare ACO program is a "shared savings program," meaning that Medicare shares any savings that the ACO realizes, Ms. Jensen does not expect an immediate shared savings or investment payback. Instead, she sees the Medicare ACO is a relatively low-risk strategy to learn population health management and financial risk management (i.e., value-based care).

Pursue Value-Based Payment Contracts

Elma, Washington, is served by four Medicaid managed care organizations. Ms. Jensen and the SPMC team proactively approached the payers requesting a value-based payment contract, noting that SPMC

was investing in value-based care that will eventually lead to lower payer costs. In the interim, however, SPMC has requested payer contracts that would reward SPMC for lower per capita costs and help fund the development of value-based care infrastructure. The payer responses have been varied thus far:

- The SPMC service area population is too small for the payer to accept additional risk;
- The SPMC service area population is too small to justify additional payer management and data analysis resources;
- Accept this boilerplate value-based care contract that is inappropriate for rural providers; or
- Let's work together to design a contract that is mutually beneficial.

Not surprisingly, the latter response from one payer is exactly what the SPMC team was looking for. Currently SPMC is developing a value-based care council that will include the selected insurer to design a workable value-based payment contract. By offering enhanced health promotion and care coordination services that will eventually lower per capita costs, the selected insurer's market share is expected to increase.

Quantitatively Demonstrate Value-Based Care

Ms. Jensen understands that not all insurers will automatically offer contract flexibility to comparatively low-volume rural providers. Therefore, she plans to develop a rural hospital-appropriate value-based payment model that can be exported to other Washington CAHs. To ensure continued applicability, the model will require that CAHs *quantitatively demonstrate* the health care value that they provide; that is, better patient care (clinical quality and patient satisfaction), improved community health, and (importantly) lower cost to the payer. (Value-based care will allow the payer to establish competitive rates and increase market share. A greater number of enrolled lives moderates insurer risk.) Only then will CAHs be in a strong position at the contract negotiating table. The process by which SPMC will demonstrate health care value, not only to payers, but to providers and community members, is a work in progress. Ms. Jensen's tenacious and attentive leadership will ensure that SPMC's path to value will remain on track.

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