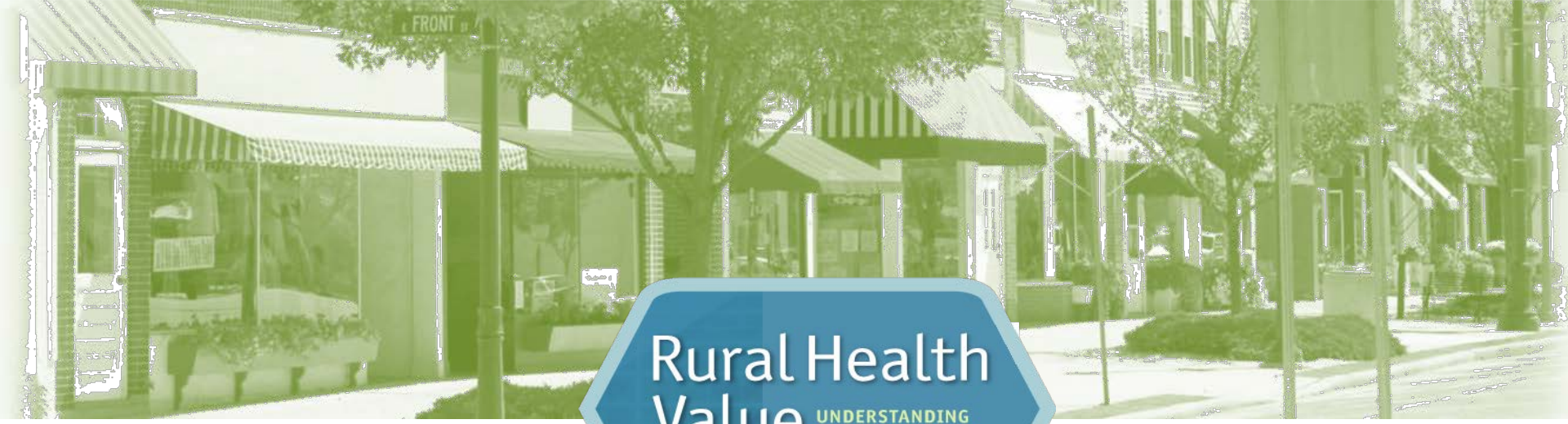

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Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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The Pathway to Health Value

October 29, 2014
Spectrum Health Kelsey Hospital
Lakeview, Michigan

Outline

- Evolution of Health Care
- External Drivers of Change
- Adapting for the Future
- Rural Health Value TA project

Revisiting where we're coming from

HOW HAS MEDICAL CARE EVOLVED?

Once upon a time, medicine was personal…

- Marcus Welby, M.D.
- Physician at the bedside
- Lower mobility
  - We knew our patients and they knew us
- Technology expectations were not as high

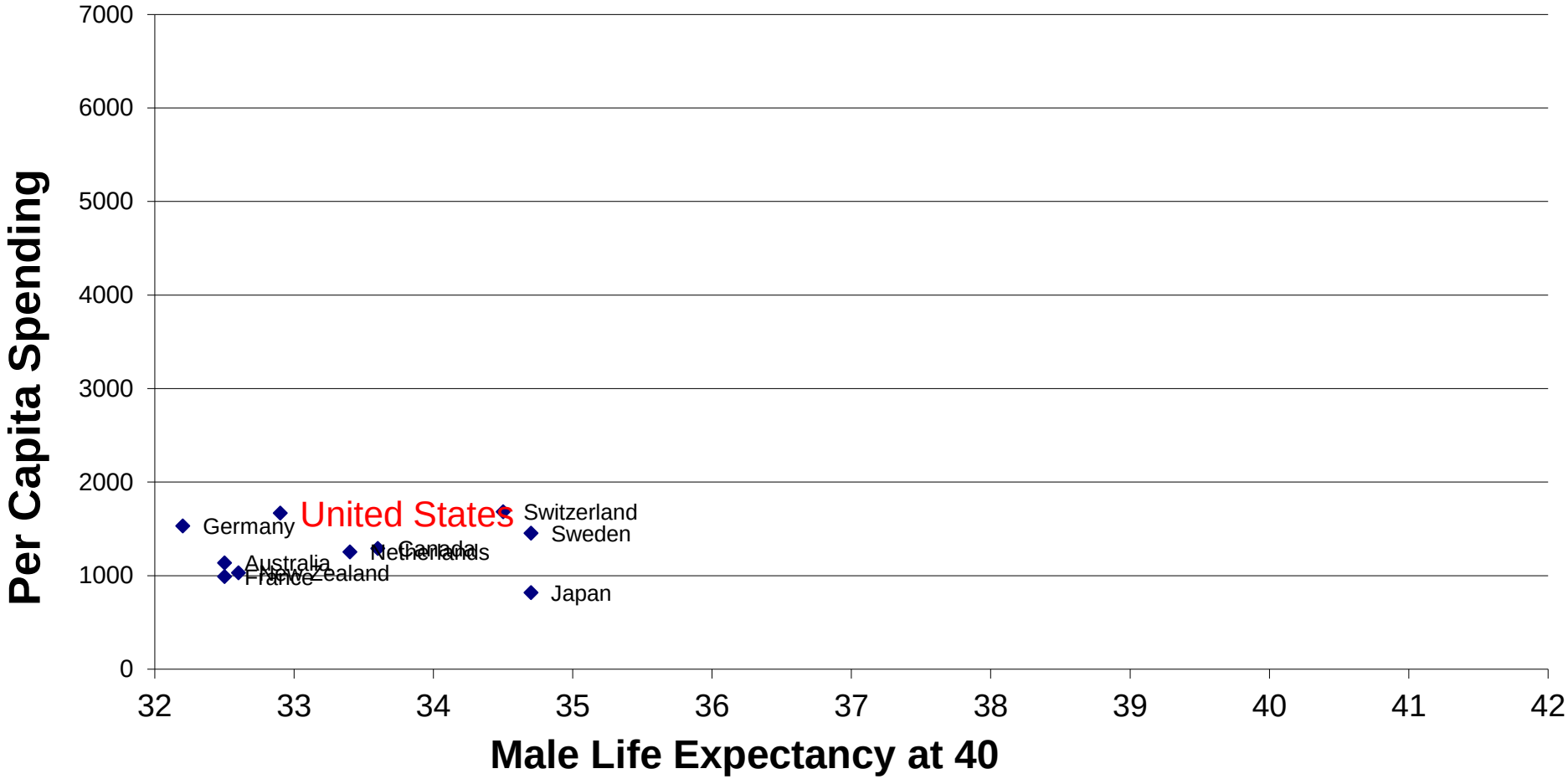
But then we evolved

- Specialties
- Reimbursement
  - Volume over Value
- Technologies
- Specialized skills

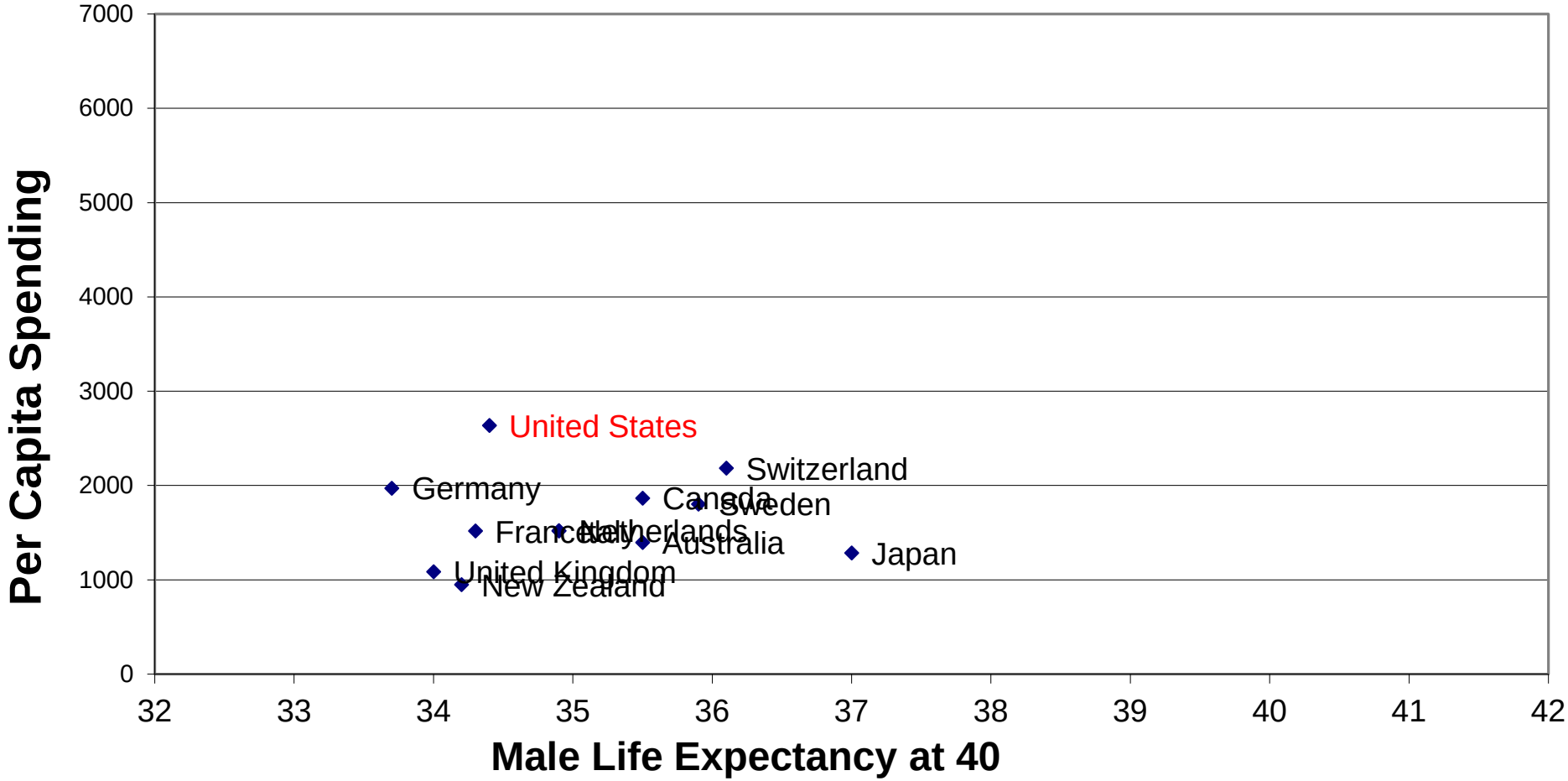
Tyranny of Fee-for-Service

- Current measure of "success" is to maximize:
  - Office visits per day
  - Average daily inpatient census
  - Admissions from the ER
- Is this how you would identify a great physician or a world-class hospital?

Spending and Life Expectancy 1976

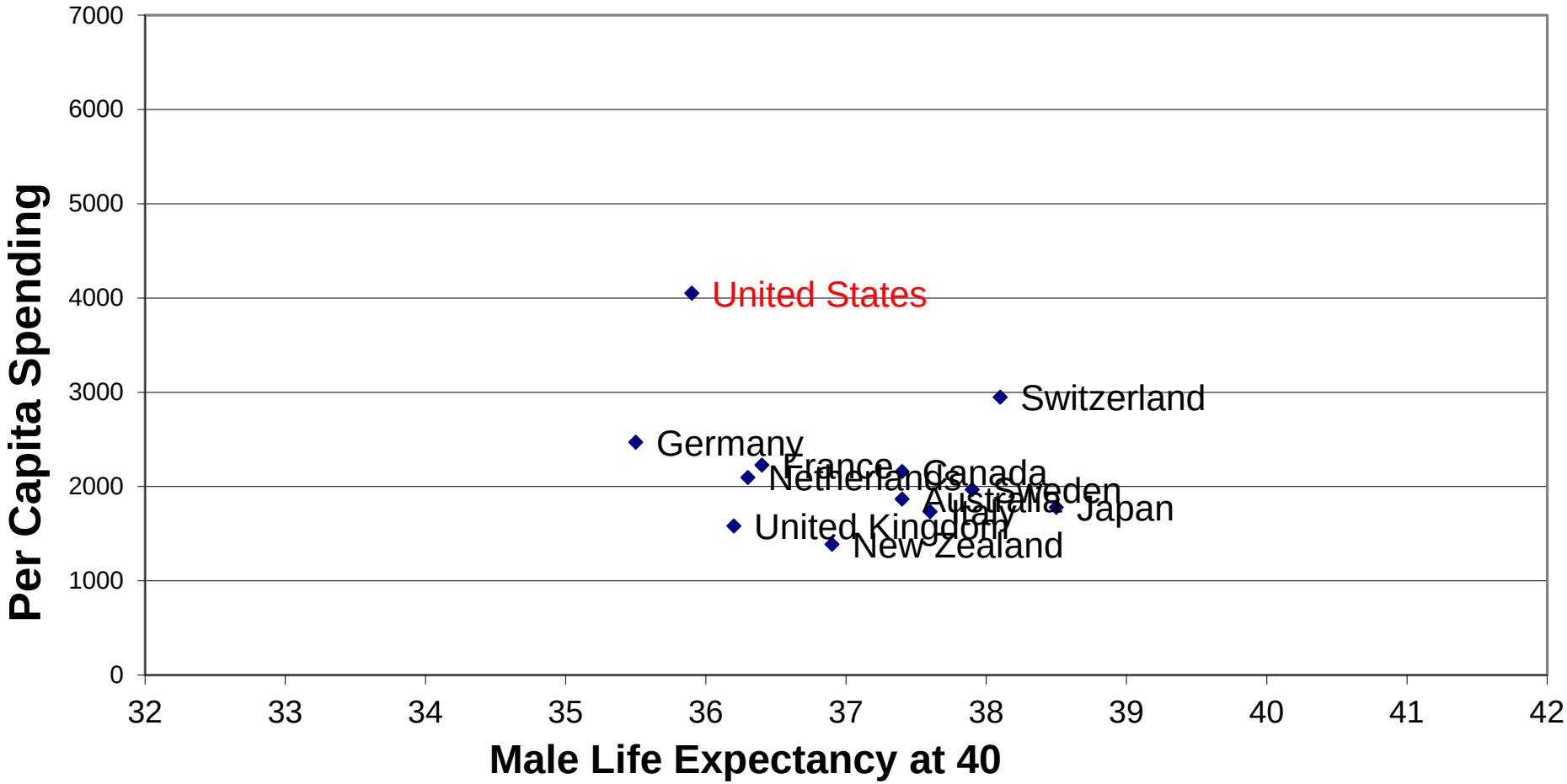


Spending and Life Expectancy 1986



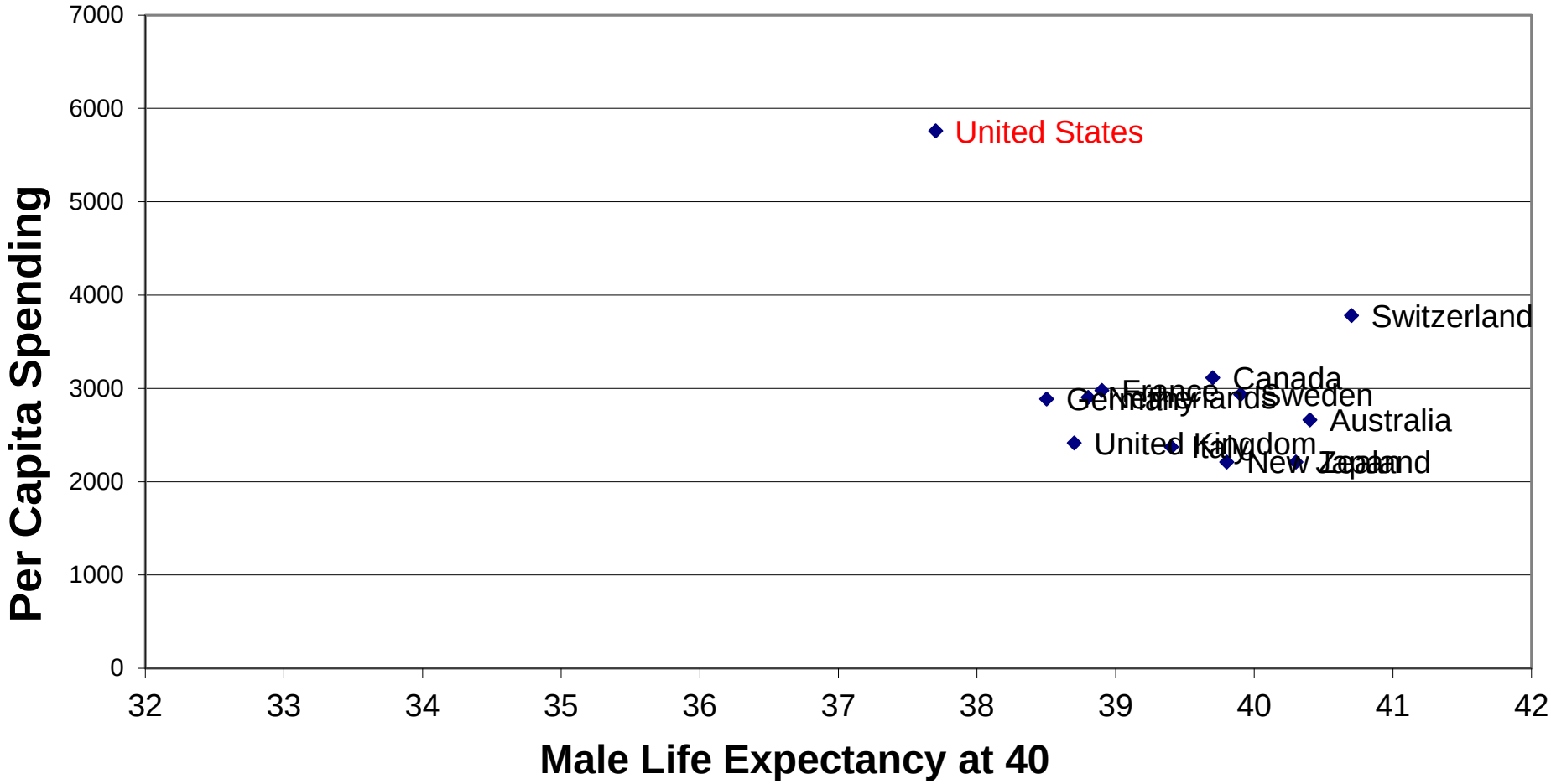
Adapted from a slide by Sherry Glied, Wagner School, NYU

Spending and Life Expectancy 1996



Adapted from a slide by Sherry Glied, Wagner School, NYU

Spending and Life Expectancy 2006



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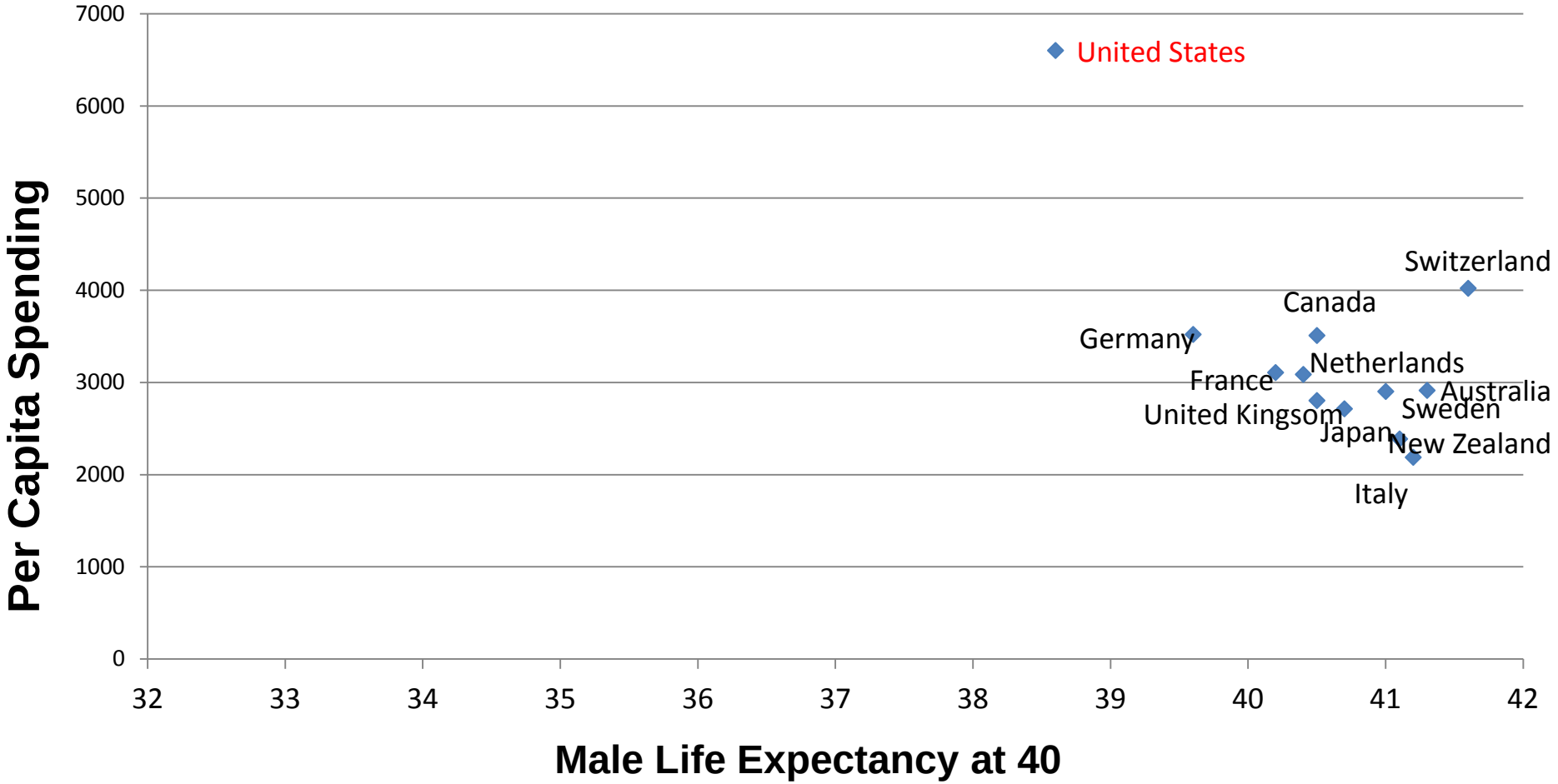
Spending and Life Expectancy 2011



Modeled after slides by Sherry Glied, Wagner School, NYU

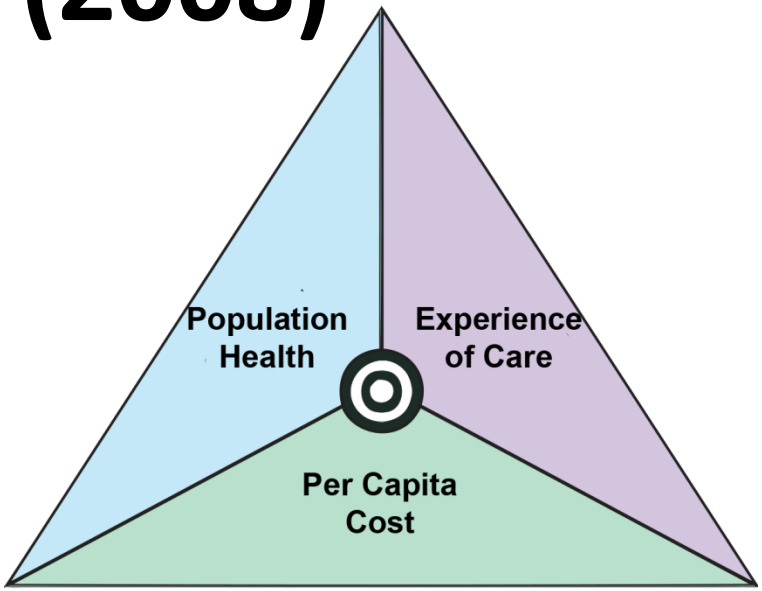
Value Equation

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

But does our current volume-based payment system impede delivering health care of value?

The Triple Aim (2008)

- A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to health system performance
- The three dimensions are:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care



IHI Triple Aim

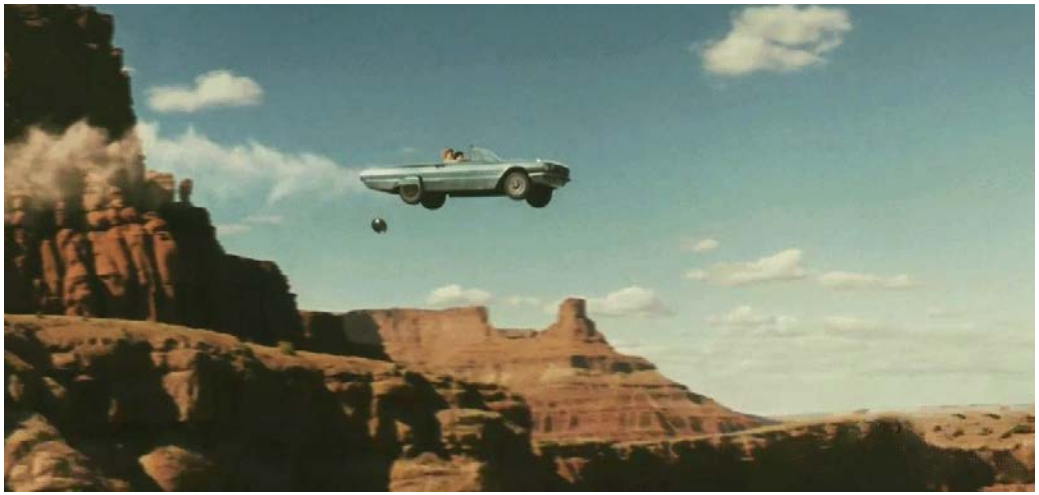
Unacceptable Healthcare Value

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation
- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Highest cost in the world
- **Experience:**
  - Difficult to get appointments
  - Feeling rushed
  - Lack of coordination
- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.

*Source: Berwick and Hackbarth. Eliminating Waste in US Health Care. *JAMA*, April 11, 2012. Vol. 307, No. 14

We are Headed off of a Cliff

- Expenditures for health care are spiraling beyond any single fix
- Complexity of health care problems present more opportunities for medical error
- Millions with limited access because of cost, availability, cultural misfit



- Health care professionals with declining morale
- Breakthrough policies that contribute to problems: Medicare Part D

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
- Self-police

What about paying for health care value?

- **Pay-for-Performance (P4P)?**
- **Accountable Care Organizations (ACOs)?**
- **Patient-Centered Medical Homes?**

THE EXTERNAL DRIVERS OF CHANGE

The Winds of Change

- Health care reform
- Safety and quality
- Aging
- Consumerism
- Technology
- New care delivery models
- Information technology
- Community accountability
- Workforce shortages
- Declining revenue

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A sample of policy and structural changes

- Affordable Care Act
- CMS Value-Based Purchasing & other payment changes
- Accountable Care Organizations
- Patient-Centered Medical Homes
- State Innovation Model Grants
- Innovations in delivery

Affordable Care Act

- Health care reform predicated on a robust primary care foundation
  - Workforce provisions
  - Preventive services focus
  - Accountable care organizations
  - Value-based purchasing
  - Care coordination
  - Medical homes

Value-Based Purchasing & payment changes

- 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

Accountable Care Organizations

- Estimated 14% of U.S. population now being served by an ACO
- 5.3 million in Medicare ACOs
- More than 6.5% of the Medicare population
- ACOs in rural places
  - 109 ACOs operate in a combination of metro and non-metro counties
  - 8 ACOs operate exclusively in rural areas, including 1 such ACO in each of the 4 census regions
  - 24.4% of non-metropolitan counties include a primary care provider being assigned Medicare patients

Sources:

- "The ACO Surprise" by Niyum Gandhi and Richard Weil. Oliver Wyman, Marsh & McLennan Companies. 2012. http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf.
- Centers for Medicare and Medicaid Services *Fast Facts* as of May, 2013
- RUPRI analysis of data obtained from public sources and ACOs

Accountable Community Organizations

- Paradigm shift continues to all payers
- Paradigm shift continues to population health
- Being discussed now at CMS

Patient-Centered Medical Home

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

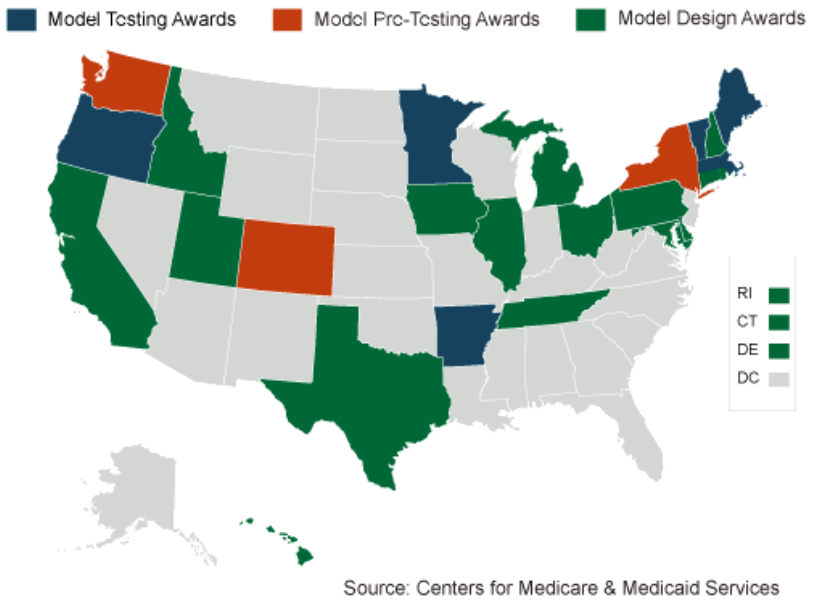
Source: Commonwealth Fund. http://www.commonwealthfund.org

Person-Centered Health Home

- Another paradigm shift
- Focus becomes home based, not clinic based
- Incorporates consideration of social determinants

State Innovation Models

- Providing support to states for the development and testing of state-based models for multi-payer payment and health care delivery system transformation
- Massachusetts supporting:
  - Practice transformation to medical homes
  - Shared risk/savings
  - Statewide quality metrics



Source: http://innovation.cms.gov/initiatives/state-innovations/

Innovations in delivery

- **In health care workforce**: community paramedics, community health workers, optimal use of all professionals (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, and providing services directly to patients where they live

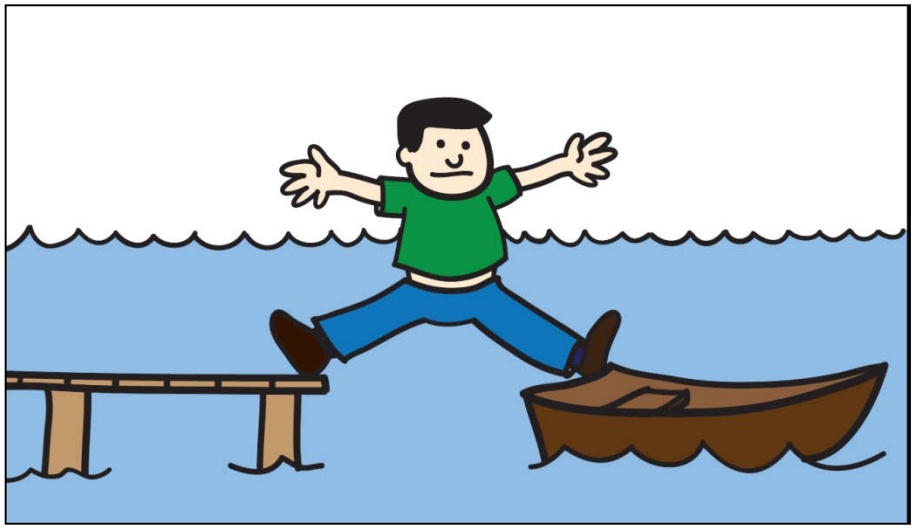
Moving Along the Path

- CMS: Medicare payment, now 20% through alternative payment methodologies, and rising fast; only 10% with no value component
- Physicians – 9% linked to quality and new $800 million initiative to transform practices
- Next generation of ACOs
- State Medicaid programs using new payment methodologies
- Private health plans continue evolving

ADAPTING FOR THE FUTURE

Health Care Transformation

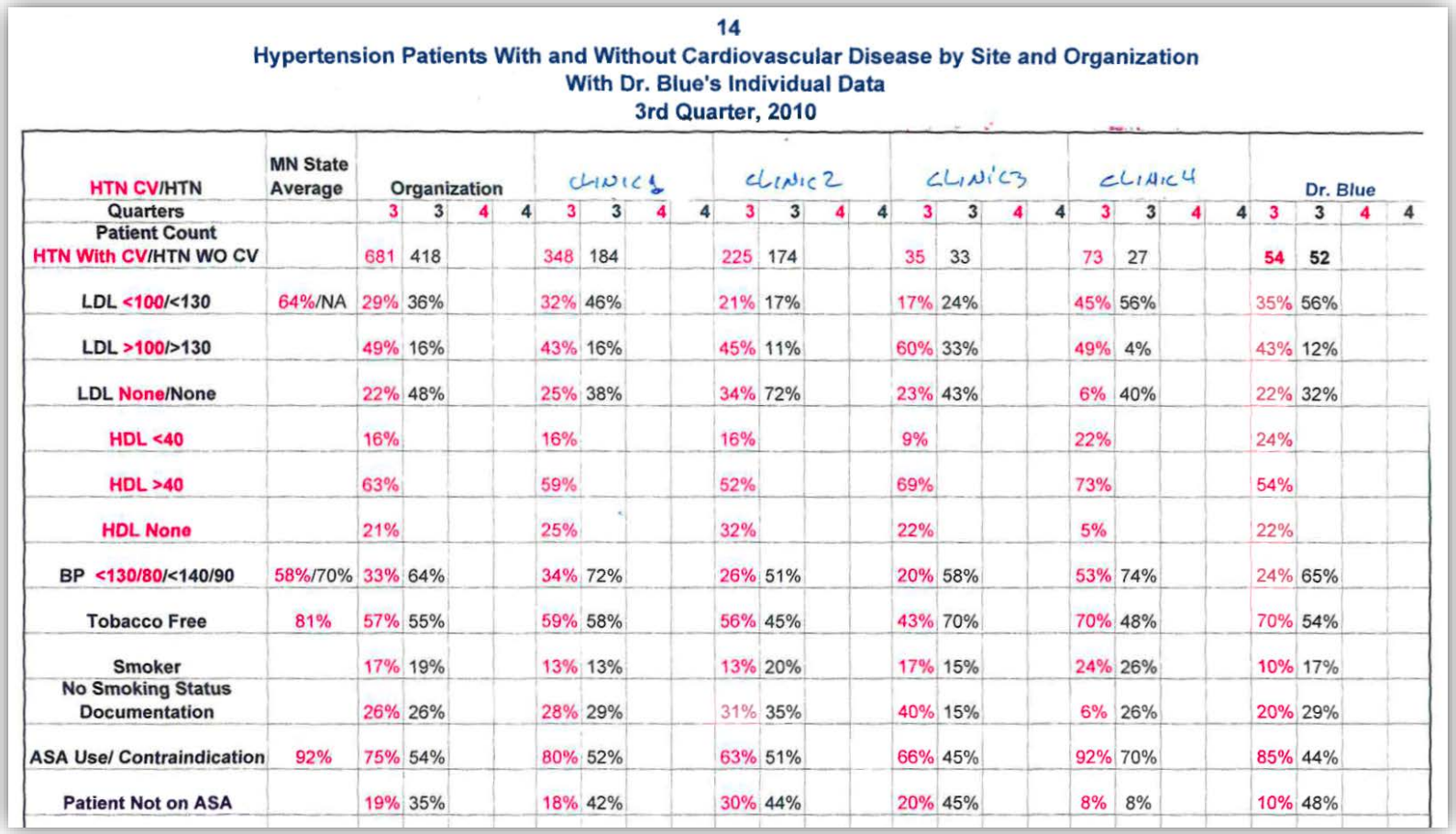
- How do we move toward delivering value when our revenue is primarily volume-driven?
- How do we not get "soaked" during the transition?
- We can "test the waters" with a new set of tools



Transforming Care in the Facility

Today's Care	Transformed Practice
Patient's chief complaint or reasons for visit determines care.	We systematically assess all our patients health needs to plan care.
Care is determined by today's problem in time available today	Care is determined by a proactive plan to meet patient needs.
Care varies by scheduled time and memory/skill of doctor.	Care is standardized according to evidence-based guidelines.
Patients are responsible for coordinating their own care.	A prepared team of professionals coordinates a patient's care.
Clinicians know they deliver high quality care because they're well-trained	Clinicians know they deliver high-quality care because they measure it and make rapid changes to improve.
It is up to the patient tell us what happened to them.	You can track tests consults and follow-up after the ED in hospital.

Tracking Populations



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Hypertension Patients With and Without Cardiovascular Disease by Site and Organization
With Dr. Blue's Individual Data
3rd Quarter, 2010

HTN CV/HTN	MN State Average	Organization				Clinic 1				Clinic 2				Clinic 3				Clinic 4				Dr. Blue			
Quarters		3	3	4	4	3	3	4	4	3	3	4	4	3	3	4	4	3	3	4	4	3	3	4	4
Patient Count HTN With CV/HTN WO CV		681	418			348	184			225	174			35	33			73	27			54	52		
LDL <100/<130	64%/NA	29%	36%			32%	46%			21%	17%			17%	24%			45%	56%			35%	56%		
LDL >100/>130		49%	16%			43%	16%			45%	11%			60%	33%			49%	4%			43%	12%		
LDL None/None		22%	48%			25%	38%			34%	72%			23%	43%			6%	40%			22%	32%		
HDL <40		16%				16%				16%				9%				22%				24%			
HDL >40		63%				59%				52%				69%				73%				54%			
HDL None		21%				25%				32%				22%				5%				22%			
BP <130/80/<140/90	58%/70%	33%	64%			34%	72%			26%	51%			20%	58%			53%	74%			24%	65%		
Tobacco Free	81%	57%	55%			59%	58%			56%	45%			43%	70%			70%	48%			70%	54%		
Smoker		17%	19%			13%	13%			13%	20%			17%	15%			24%	26%			10%	17%		
No Smoking Status Documentation		26%	26%			28%	29%			31%	35%			40%	15%			6%	26%			20%	29%		
ASA Use/ Contraindication	92%	75%	54%			80%	52%			63%	51%			66%	45%			92%	70%			85%	44%		
Patient Not on ASA		19%	35%			18%	42%			30%	44%			20%	45%			8%	8%			10%	48%		

Tracks all the quality measures of interest to them for their hypertensive patients comparing the organization, 3 clinics and one provider to the state statistics

Transforming Care More Broadly

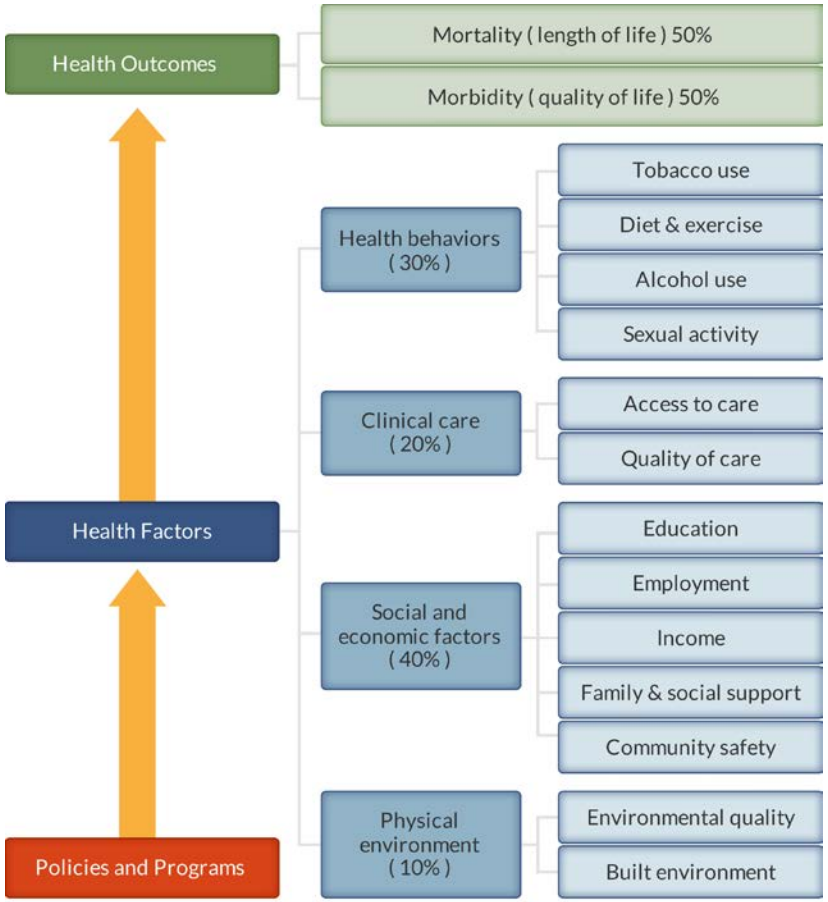
- Inpatient Beds → Community care
  - Expanded/robust primary care
  - Workplace nursing and SNF/ALF clinics
  - Mobile clinics and telehealth
- Illness → Wellness
  - Health Risk Assessments
  - Community Health Assessments
  - Health coaching and care coordination
- Charges → Costs
  - Revenue becomes covered lives
  - Charge master becomes cost master
  - Re-purpose inpatient space

Improving Health

- To improve health, we must move beyond the walls of our health care facilities
- We must collaborate

What are the Determinants of Health?

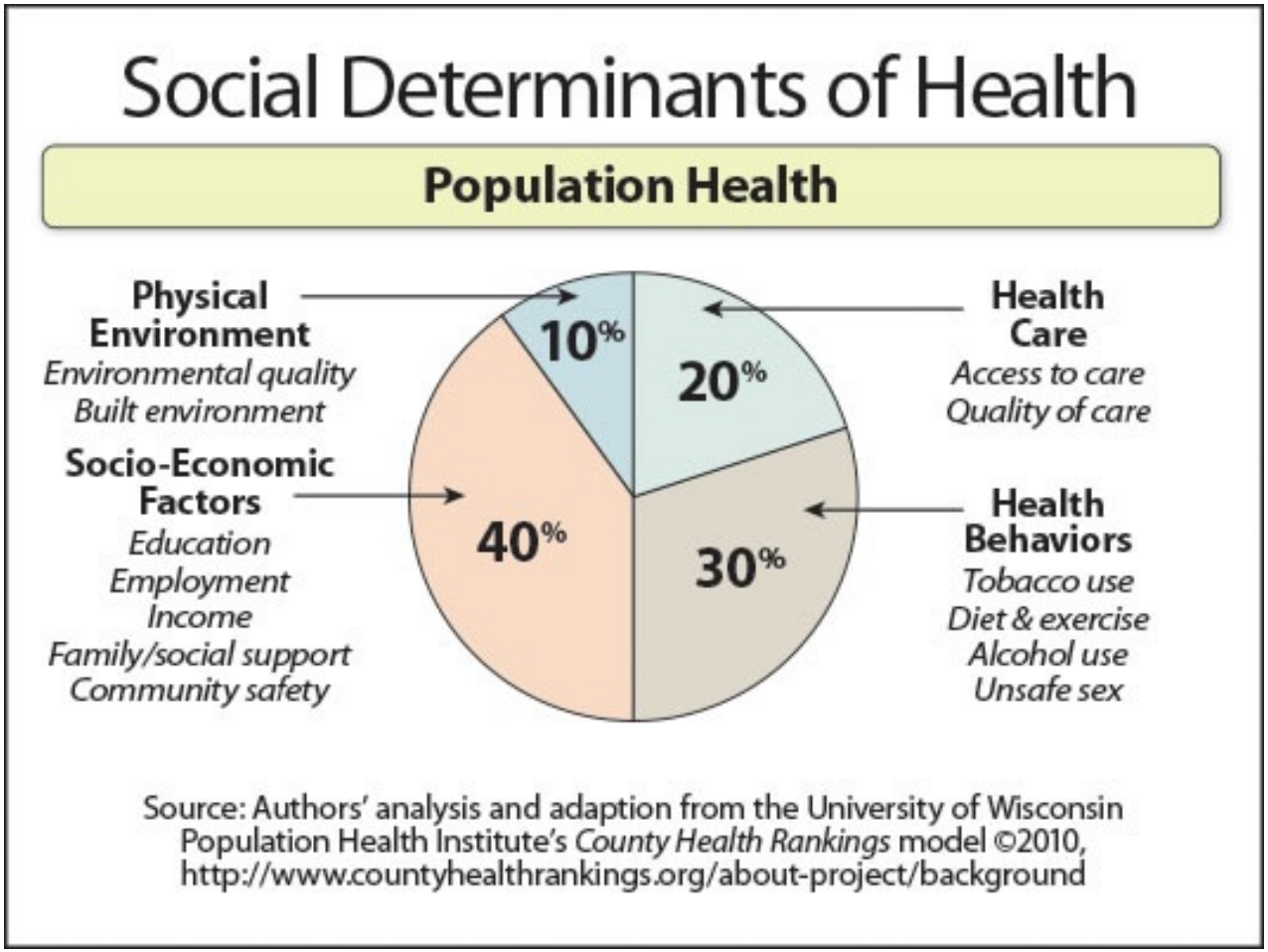
- County Health Rankings & Roadmaps program
  - a collaboration between the Robert Wood Johnson Foundation
  - the University of Wisconsin Population Health Institute.
- Much of what influences our health happens outside of the provider's office



County Health Rankings model ©2012 UWPHI

http://www.countyhealthrankings.org/about-project/rankings-background

Another way to look at it



Lessons from the Field

- Address social issues with prescriptions and follow up
- Take holistic approach to population health
  - Affiliate with organizations who are not healthcare providers
  - Truman Medical Center in Kansas City partnered to open grocery store, bank
- Promote price transparency
- Include physicians in administrative decision-making
- Serious about hospitality
  - Patient experience as area of expertise in upper management

Lessons from "Progressive Hospitals"

- Partner with employers
  - Working with local employers on wellness initiatives, primary and preventive care
- Let patients access personal health information
  - "Open notes"

Taken from "10 Things the Most Progress Hospitals Do." Molly Gamble, *Beckers Hospital Review*. July 8, 2013

Elements of a Successful System Redesign

Elements

- Clear Vision
- 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

Specific Hospital Activities for CAHs

- Hospital leadership fully understand and begin to build case for population health management
- Hospitals put population health on meeting agendas, including board, management, quality improvement
- Hospitals look within own walls and initiate employee wellness programs
- Hospitals reach out to communities to discover health program wants and needs

Source: National Rural Health Resource Center (2014) Critical Access Hospital Population Health Summit: Improving Population Health: A Guide for Critical Access Hospitals

Lessons from Hospitals in Healthiest Counties

- Dansville, NY: “change from thinking about the care that is given while the patient is within our walls to thinking about the care of the patient outside our walls”
- Dansville: “We no longer see ourselves as a standalone organization, but rather as part of the region’s broader healthcare ecosystem”

Lessons from Hospitals in Healthiest Counties

- Oakland CA: “just as our focus on total health–integration, prevention, and empowerment–drives internal planning for our members, it also drives planning for improving the health of our community”
- Oakland CA: “we work closely with the county and state public health departments, reviewing various sets of data, including mortality and morbidity data, as well as substance abuse, drinking, and tobacco consumption figures”

Lessons from Hospitals in Healthiest Counties

- Raleigh, NC: “a physician-led effort in partnership with the hospital to provide integrated, patient-centered care. This means coordination of care, more involvement in prevention as well as a more active role in helping people manager their overall health outside of the healthcare setting.”

Source: Rizzo E (2014) Population Health Lessons From Hospitals in the U.S.’ Healthiest Counties: 3 CEOs Share Successes [illegible]ital Review. June 2.

Examples From Rural Institutions

- Available from the Rural Health Value project: http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/
- Community Outreach in Delhi, LA
- System Transformation in the Mercy Health Network, IA
- Service Delivery Integration& Patient Engagement in Humboldt County, CA

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The University of Iowa

Other Innovations

- Chief Medical Financial Officer in Banner General Hospital in Sandpoint, Idaho (CAH)
- Chief Patient Experience Officer named at Johns Hopkins Medicine
- All about value for the patient/customer

Technical Assistance Project

RURAL HEALTH VALUE

Rural Health Value: Facilitating Rural Health Transformation

- Three-year HRSA Cooperative agreement: Rural Health System Analysis and Technical Assistance (RHSATA)
- Partners: RUPRI Center for Rural Health Policy Analysis and Stratis Health, with support from Stroudwater Associates and Washington University in St. Louis
- Vision: To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems

Rural Health Value Project Aims

1. Analyze rural implications of health care delivery, organization, and finance changes fostered by public policy and private sector actions

2. Develop and test technical assistance tools and resources to enable rural providers and communities to take full advantage of public policy changes and private sector initiatives

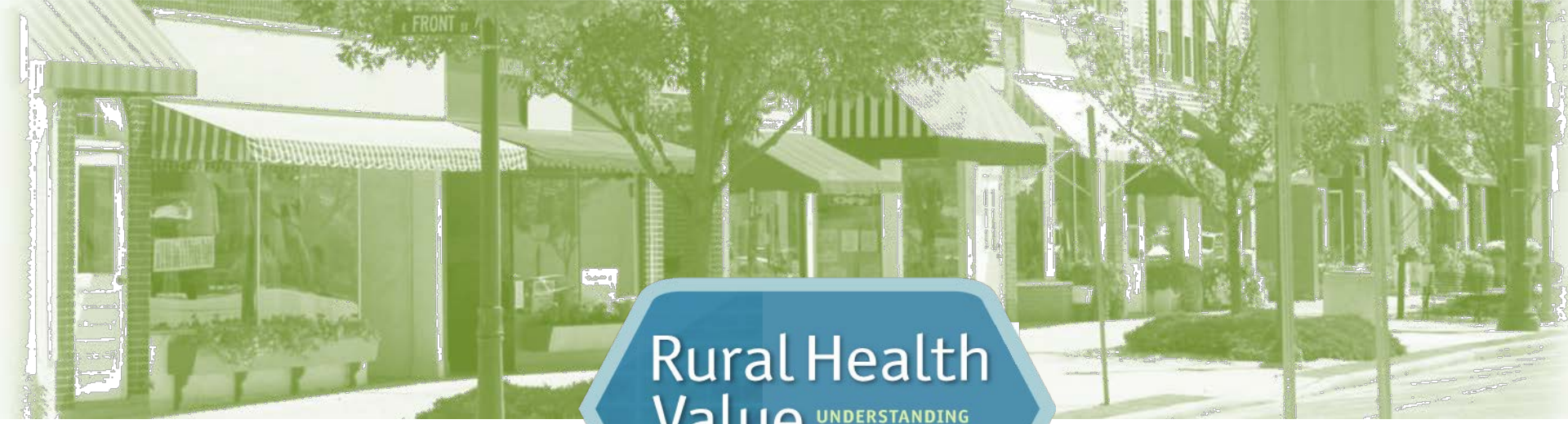
3. Inform further developments in public policy and private action through dissemination of findings

Reflection and Insight

- There is no off-the-shelf solution
- It's about long term capacity, not program of the day
- Small numbers can be challenging, so get creative in measurement
- Find and create a peer network
- Lessons learned from rural innovators:
  - Create a climate of necessity
  - Identify resources and funds to support and sustain change
  - Find the innovators in the community – people "that make things happen"

In Conclusion

- Change is coming, do not get left behind
- Work within your walls to improve care
- Work with your community to improve health
- We are here to help you get started



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Questions?

For more information about Rural Health Value, contact:

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