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Rural Hospital Strategies for a Value Based Future

2013 Annual Rural Health Conference
CSRHA
Sacramento, California
November 7, 2013

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Agenda

- **Rural Hospital Context**
- Transfer of Financial Risk
- Redefine and Redesign
- Toolbox for Value

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Converging Forces

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- Price reduction threats and volume reduction pressures
- Changes in payment policies and financing sources
- Continually evolving quality measures and expectations
- Alternative models of care (e.g., telehealth, different care sites, new providers types)
- Local health care collaborations and regional affiliations

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Affordable Care Act (and More)

5

- New ACA emphases
  - Insurance coverage
  - Primary care
  - Financing innovation (incremental)
- Major ACA *themes*
  - Demand for health care *value*
  - Transfer of financial risk
  - Collaboration and competition
- Not just the ACA!
  - Macro economic forces will continue to drive health care reform

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Value – IOM Six Aims

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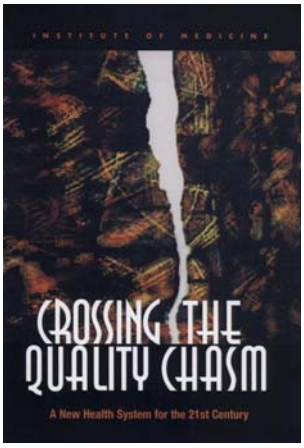
Health care should be:

- **Safe**
- **Effective**
- **Patient-Centered**
- **Timely**
- **Efficient**
- **Equitable**



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm.* Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.

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The Triple Aim

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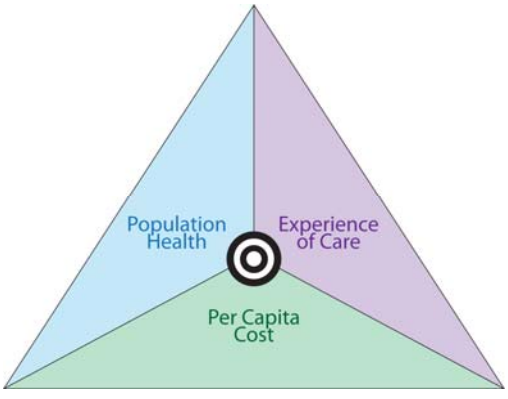

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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Value Equation

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Value = Quality + Experience / Cost

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

- Better patient care
- Improved community health
- Lower per capita cost

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Unacceptable Healthcare Value

9

- **Quality** suboptimal
  - Wide geographic variation
- **Cost** unsustainable
  - Highest cost in the world
- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse
- Our volume-based payment system is a significant problem

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

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Tyranny of Fee-for-Service

10

- "Successful" physicians and hospitals seek to maximize:
  - Office visits per day
  - Average daily inpatient census
  - Admission percent from the ER
  - Profitability
- Is this how to identify and reward a great physician or a world-class hospital?
- **No, but what to do?**

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The Value Conundrum

11

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

- **Regardless of what we try, we tend to "follow the money"**

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Form Follows Finance

- How we deliver care is predicated on how we are paid for care
- Health care reform is changing <u>both</u>
- Fundamentally, reform involves a **transfer of financial risk** from payers to providers

Agenda

- Rural Hospital Context
- **Transfer of Financial Risk**
- Redefine and Redesign
- Toolbox for Value

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Risk Assessment is Ubiquitous

14

- Risk is present when an outcome is uncertain or unpredictable
- Types of health care risk
  - Random
  - Insurance
  - Political
  - Medical Care
- Where/how can hospitals:
  - **Influence or control risk**
  - **Reduce risk of harm**
  - **Optimize risk of benefit**

The Risk of Inertia

15

Source: Institute for HealthCare Improvement and Sharon Vitousek, MD

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Random

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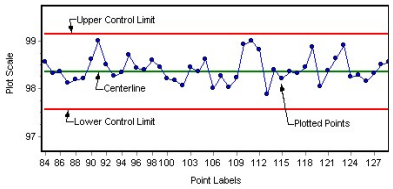
- Normal variation
- Rolling the dice
- Roulette v. poker
- No control, but important to recognize



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Insurance Risk

17

- Insurance risks
  - Demographic change
  - Technological innovations
  - Prior health status
  - Cost inflation
- Cost is the actuarial metric
- Minimal control, but predictable

Anthem Aetna UniCare HUMANA CIGNA PacifiCare UnitedHealthcare HealthNet

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Political Risk

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- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues

American Hospital Association

NRHA
NATIONAL RURAL HEALTH ASSOCIATION

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Medical Care Risk

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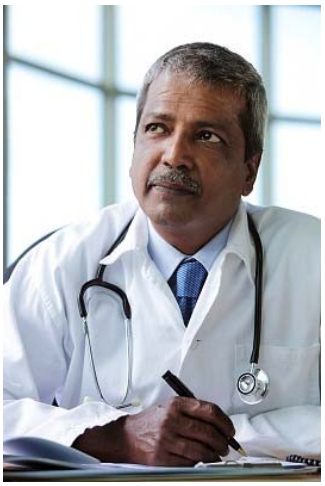
- Medical care *variation*
  - Diagnostic accuracy
  - Care plan implementation
  - Guideline use compliance
  - Pharmaceutical choice
  - Procedural skill
  - Efficient resource use
- How our choices influence health care ***value***
- Greatest control, how we deliver care



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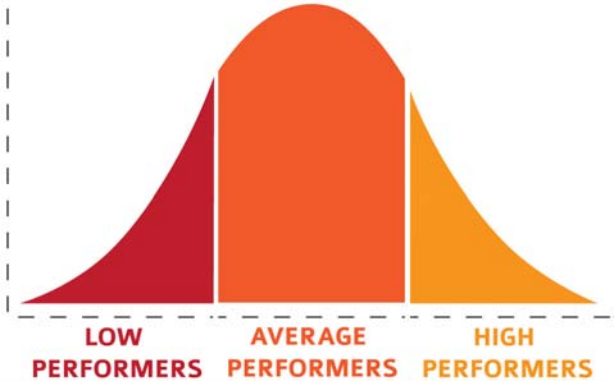
Medical Care Variation = Risk

20



Variation suggests a risk for underperformance, but also an opportunity to excel

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Drive Out (Most) Variation

21

- Measure individual provider performance and discuss
  - Learn from one another
- Care should vary by unique *patient* needs, not by
  - Doctor or nurse
  - Day of week, or time of day
- Not cookbook medicine, many opportunities for
  - Clinical judgment
  - Thoughtful interactions
  - The "art" of medicine

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Rural Risk?

22

Agenda

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- Toolbox for Value

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Are We Post Turtles?

24

- The Post Turtle dilemma
  - I don't know how I got up here.
  - I don't know how to get down.
  - And I don't know how to avoid getting put up here again.
- The answer is No!
  - We need not be paralyzed and helpless Post Turtles
- We can ***redefine*** our future and ***redesign*** our operations

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Volume to Value Transition

25

- Bath water
  - Cost-based reimbursement
  - Necessary providers (OIG)
  - Few quality demands
  - Inefficiency tolerated
- Turning up the heat
  - Decreased per unit price
  - Pressure to reduce volumes
  - Quality demands
  - Competitive market
- How to avoid getting cooked?

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Redefine Our Future

26

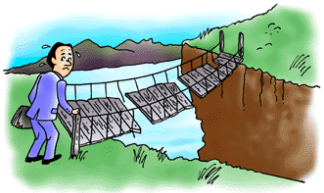
- Understand the current rural health care milieu
- Acknowledge the paradox of quality, experience, and cost
- Envision and articulate a different future – across the volume to value gap
- Plan for transition challenges
- Lead with focus and clarity

The Volume to Value Gap

27

Volume-based

- Pay-for-service (volumes)
- Cost-based reimbursement
- Hospital/physician independence
- Inpatient focus
- Stand alone care systems
- Illness care



Value-based

- Pay-for-results (quality/efficiency)
- Shared risk
- Partnerships and collaborations
- Continuum of care consideration
- Community health improvement (HIT)
- Wellness care

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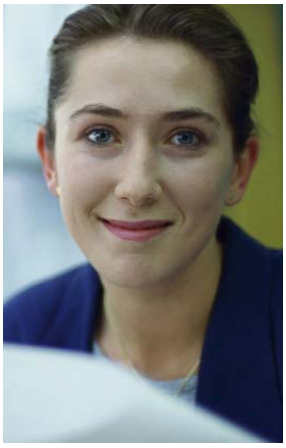
Transition Requires New Foci

28

- Inpatient Beds → Clinics (and more)
  - 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
  - "Trapped equity" is a concern



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Redesign our Operations

29

- Organization chart
- Capital budgets
- Job descriptions
- Compensation
- Accounting
- Clinical care sites/modes
- Provide or partner

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Holy Family Hosp. Transformation

30

Source: Graphic provided by Mark Herzog, CEO. Holy Family Memorial Hospital. Manitowoc, Wisconsin. 2013.

Payers Are Getting Smarter

31

Economists: Total Cost = Price x Quantity
~~Health Care: Revenue = Unit Price x Volume~~

Not forever!

Current Way

- Negotiate *unit price*
  - Discount on charges
  - CPT codes
  - Per diems
  - Case rates (DRGs)
- Hospital success strategy
  - Negotiate for high unit prices, then optimize volumes

Future Way

- Negotiate *total cost of care*
  - Bundled payment
  - Shared risk (ACOs)
  - Capitation (beyond medical care)
- Hospital success strategy
  - Negotiate high per capita rate, favorable base period, and accurate risk adjustment, then optimize community health

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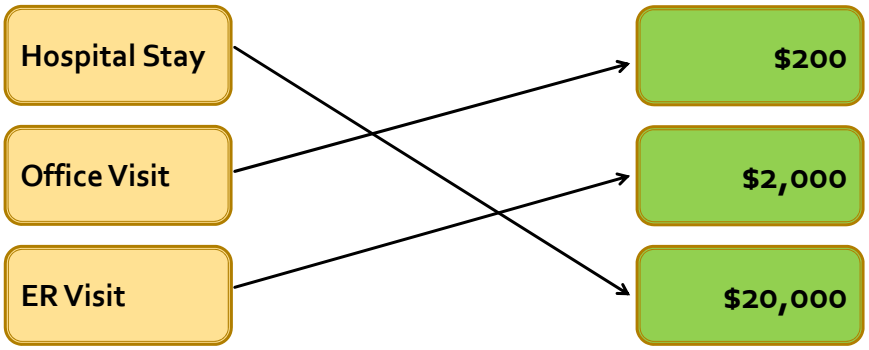
Right place, time, provider, *price*

32

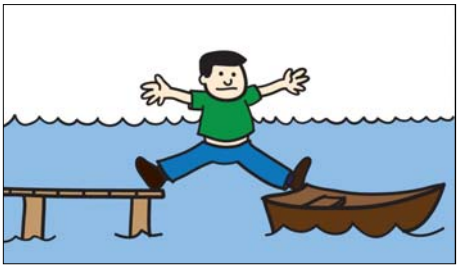


Better yet, how about care in the home, workplace, or not at all?
Preventive care may reduce the need for acute care!

Hospital Transformation

33

- 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.



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- **Toolbox for Value**

Tool Box for Delivering Value

- **Implement**
  - Fee-for-service attention
  - Performance measurement
  - Care quality and patient safety
  - Operational efficiency
- **Plan**
  - Medical staff development
  - Patient-centered medical home
  - Community engagement
- **Prepare**
  - Quality rewards
  - Regionalization
  - Clinical integration

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A Continuum of Value Strategies

36

- 10 strategies, but order and timelines will vary
- A *continuous* transformation
- Broad organizational impact, longitudinal over time, intense leadership attention
- Actionable plans
  - Objectives
  - Timelines
  - Accountabilities
  - Resources

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Get Your FFS House in Order

37

Attention to

- Market share
- Expense management
- Revenue cycle
- Cost report accuracy
- Payer contracts
- Purchasing contracts
- Inventory management
- A*ppropriate* volumes

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Measure Performance

38

- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership
- Educate Board, providers, and staff regarding performance
  - We are all "above average," right?
  - Let the data set you free
- When possible, control the data
  - Market share
  - What you are paid by payers
  - Comparisons to competitors

Care Quality and Patient Safety

39

- Clinical quality, patient safety, and the patient experience
  - Expectation: "Always above the mean. Always improving."
- Leadership priority
  - Board meetings
  - Quality Improvement Officer (QIO)
- Quality/safety performance
  - Present information, not data
  - Tailor to your audience
  - Benchmarks are only a snapshot

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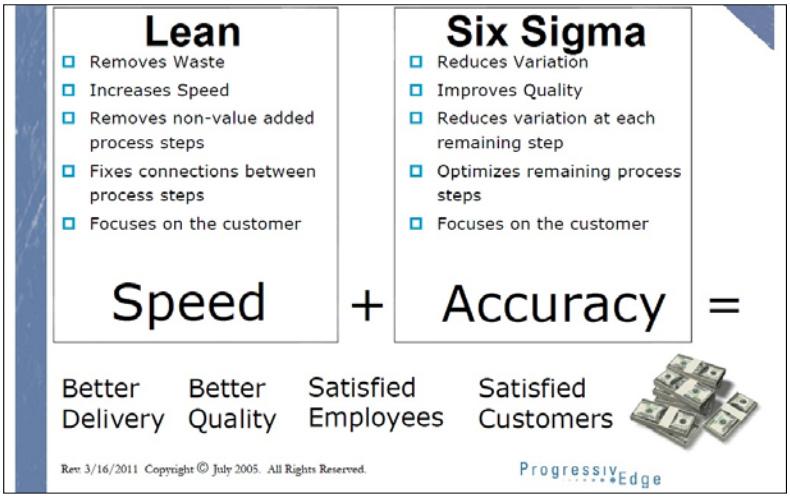
Efficiency

40



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

Medical Staff Relationships

41

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

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Physicians

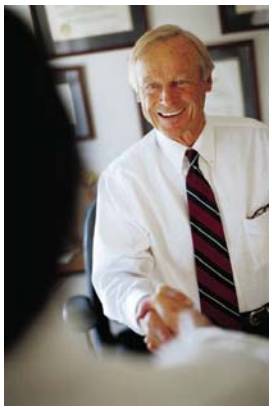
42

- Physicians see themselves as independent autonomous, and in control!
  - The antithesis of team work?
- Yet, hospital-physician alignment is essential to delivering value
- Need accountable physician leaders to devise new care models and create sustainability
- Primary care could potentially control large amounts of dollars, so…
  - Involve physicians early and often
  - Recognize and act upon the cultural and personality differences between physicians and administrators
  - ($5,000/pt/yr x 2,000 pts/phys x 20 phys = **$200 million/yr**)

Deep Medical Staff Engagement

43

- Educate, mentor, and engage physician leaders
  - Clinical co-management expected to grow
- Include physicians in key governance decisions (beyond traditional clinical, credentialing, and quality committee work)
  - Offer direct ability to influence outcomes
- Provide data transparency, but do not overstate discrete measurements
- Offer rewarding, yet reasonable salary based on what physicians identify as desirable traits
- Always follow-up as promised (even if an implicit promise!)



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Shifting Health Care Payments

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Medical Home Definition

45

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**

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

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Medical Home Quotes

46

- 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 EHR is critical to proactively managing patient/population health
- Let care protocols do (at least some of) the work (e.g., lab orders, med refills, vaccines)

Crete Physicians Clinic
Crete, Nebraska

Connect Community Resources

47

- What is available locally to improve health care value?
  - Public Health
  - Social Service
  - Agency on Aging
  - Community health workers
  - Care transition programs
  - Churches and foundations
- Do not duplicate!
  - Collaborations are less expensive than new hospital services – and build good will

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Get Paid for Quality

48

- Aggressively apply for value-based demonstrations and grants
- Negotiate with third party insurers to pay for quality
- Consider self-pay and hospital employees first for care management
  - Direct care to lower cost areas with equal (or better) quality
  - Reduces Medicare cost dilution

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Regionalization

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

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

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Rural Regionalization – ACOs

50

- 79 Medicare ACOs operate in both metro and rural counties
- 9 Medicare ACOs operate exclusively in rural counties
- Medicare ACOs operate in **16.7 %** of all rural counties
- Even if you do not participate as an ACO, you will compete with an ACO
  - Future of ACOs as a program is uncertain
  - But competing on *value* will endure

Source: RUPRI Center research. 2013.

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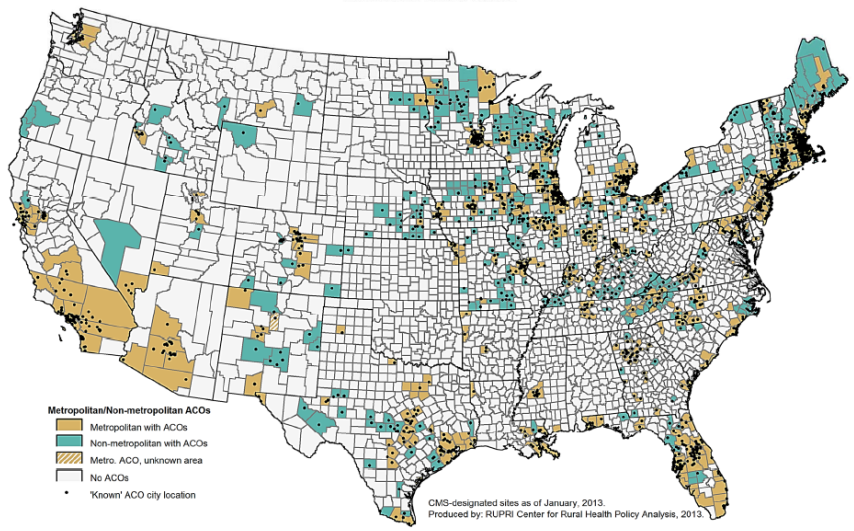
Rural (teal) Counties with ACOs

51



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Clinical Integration

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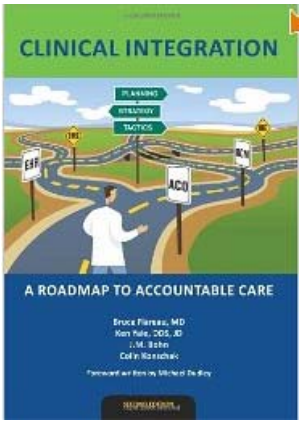
- Clinical data sharing in real-time
- Standardized clinical care protocols
- Consistent clinical performance measures and reporting
- Clear team member responsibilities across multiple facilities
- Sense of professional camaraderie among disparate organizations
- Aligned incentives for regional ***population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



A Resource to Help

53

- 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

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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!