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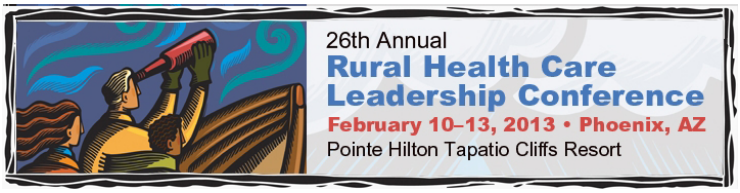
Transferring Risk – the Road to Health Care Value



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Agenda

- Health care ***value***
- Health care ***risk***
- Transferring risk from payers to hospitals and physicians
  - Fundamental to health care reform
  - Accountable care organizations (for example)
- Strategies for success
  - Ideas for innovative rural hospital leaders

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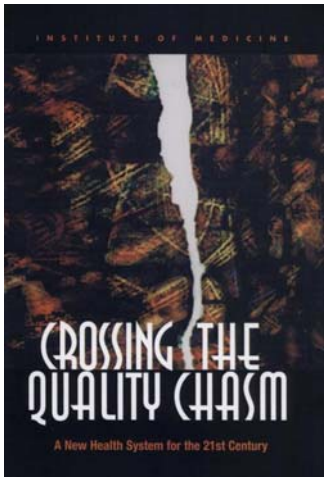
Value – IOM Six Aims

3

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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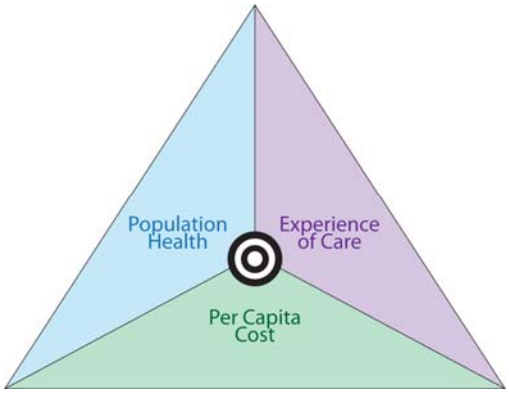
The Triple Aim

4



CMS CENTERS for MEDICARE & MEDICAID SERVICES

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Value Equation

5

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

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

"Triple Aim"
- Better care
- Better health
- Lower cost

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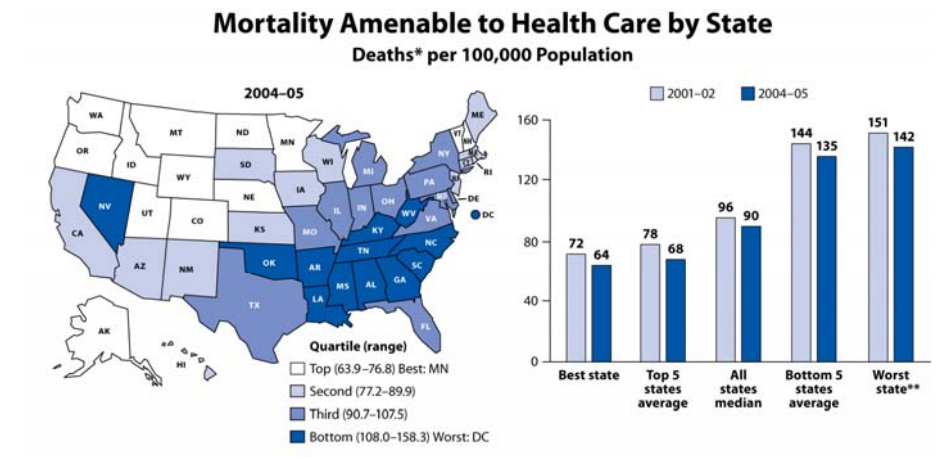
Quality

6



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Patient Experience

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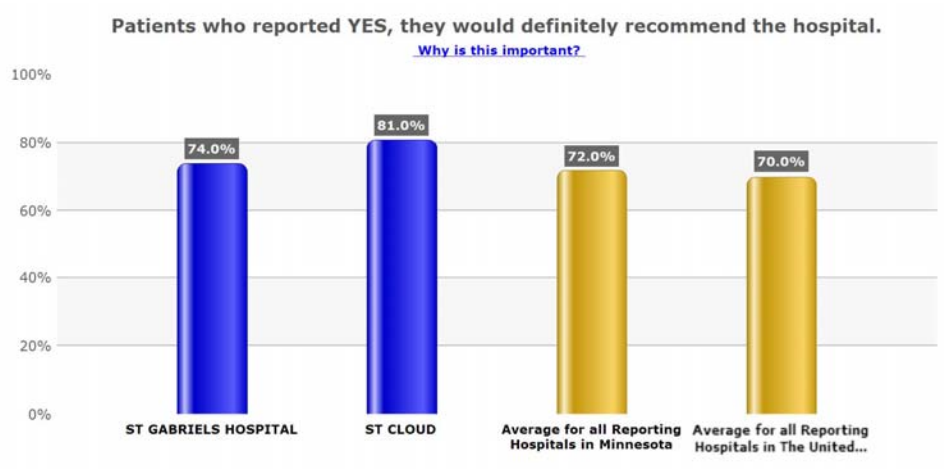

Source: www.hospitalcompare.hhs.gov. Accessed August 8, 2012.

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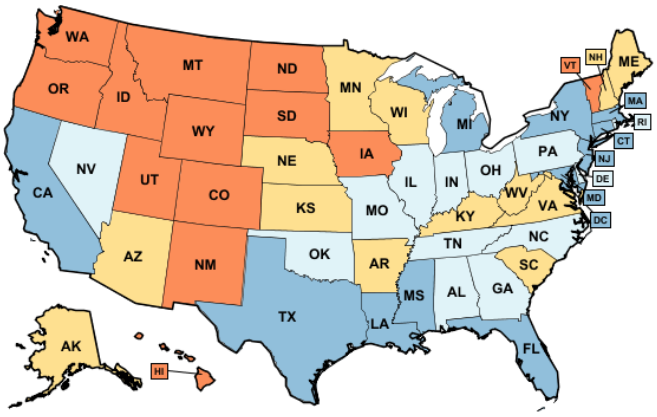
Medicare Spending Per Enrollee

8



$7,576 - $8,727
$8,763 - $9,634
$9,692 - $10,615
$10,667 - $11,903

Source: Kaiser Family Foundation. 2009 Data

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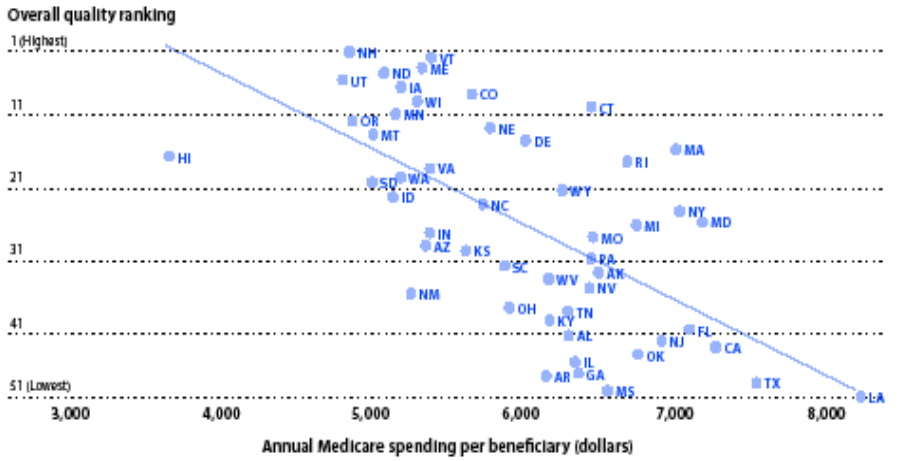
Quality/Cost

9



Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* Web Exclusive (April 7, 2004).

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Unacceptable Healthcare Value

10

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation
- **Cost** unsustainable
  - Growth in excess of GDP growth
  - 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

11

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

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The Value Conundrum

12

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

13

- How we deliver care is predicated on how we get paid for care
- Health care reform is changing both
- Fundamentally, reform involves a **transfer of risk** from payers to providers

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**

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Rural Risk?

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Random

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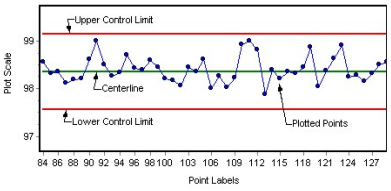
- Normal variation
- Rolling the dice
- Roulette v. poker
- No control, but important to recognize



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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 · Health Net

Political Risk

18

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

American Hospital Association

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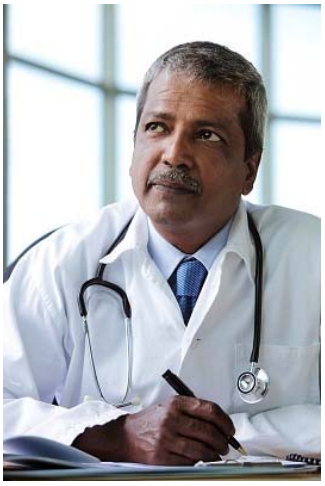
Medical Care Risk

19

- 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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The Risk of Inertia

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The Risk of Doing Nothing

21

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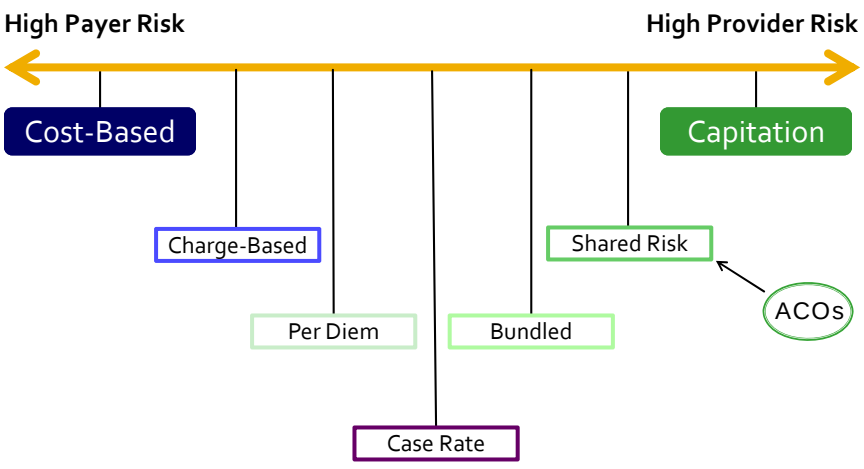
Payment Risk Continuum

22



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Accountable Care Organizations

23

- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Accepts *performance risk* for quality and cost

*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.

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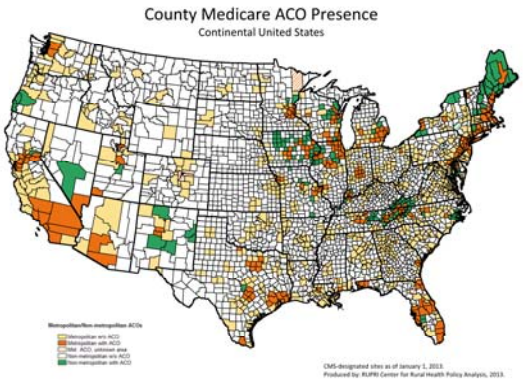
ACO Explosion

24

- Rural ACOs in 23 states
- 45 ACOs in rural counties
- 25-31 million patients receive care through an ACO
- ~**10%** of the population
- Remarkably quick growth for a new and complex form of payment and care delivery



Source: RUPRI Center for Rural Health Policy Analysis, 2013.
Niyum Gandhi and Richard Weil, The ACO Surprise, 2012.

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New World Realities

25

- Risk transfer to providers
  - Higher quality at lower cost
  - Doing what's needed, not more
- New business models
  - More primary care, less inpatient
  - Rewarding value, not just volume
- The devil is in the transition
  - One foot on the dock and one in the boat
  - It'll be competitive – winners and losers

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Tool Box for Delivering Value

26

Strategies

- Cultural considerations
- System thinking
- Performance improvement
- Variation reduction
- Medical homes
- Medical staff development
- Collaborations
- **What we can do now**

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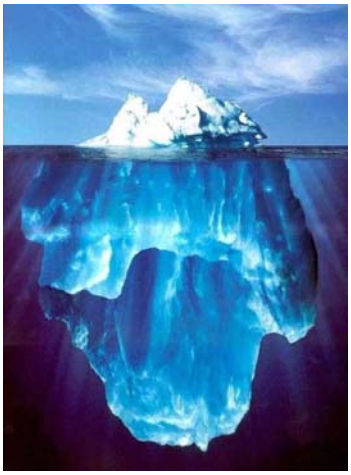
Culture

- Culture is the residue of success.*
- An environment of behaviors and beliefs
- **What we do becomes what we believe.**



* Source: Edgar Schein, 1999

Our Own Demons

- Nutting et al – small primary care practices are:
  - Physician-centric
  - A hindrance to meaningful communication between physicians
  - Dominated by authoritarian leadership behavior
  - Underserved by PAs/NPs cast into unimaginative roles

"Characteristics so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications.

Source: Nutting, PA, Crabtree, BF, McDaniel, RR. Small primary care practices face four hurdles – including a physician-centric mindset – in becoming medical homes. Health Affairs. 31:11. November 2012.

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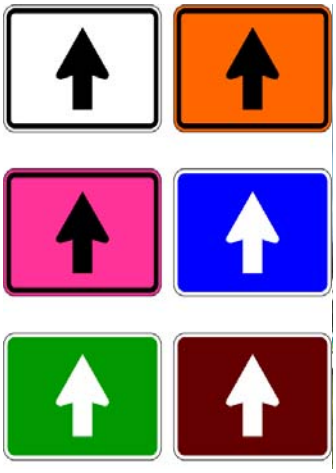
System Thinking

29

- Currently a *non*-system
  - Fragmented, poorly coordinated, and excessively costly
- Collaborative delivery systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.
- Care continuum
  - Personal health to palliative care
  - "Cradle to grave"
  - Health and human services



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Shifting Health Care Payments

30

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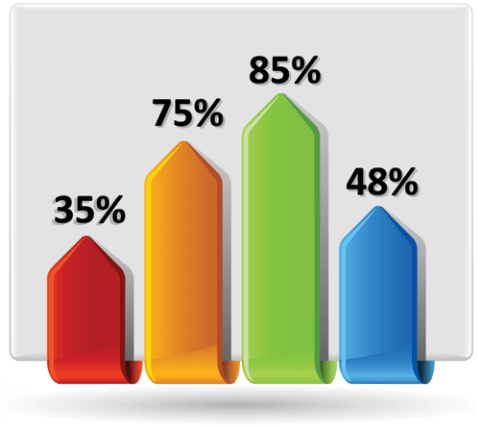
Performance Improvement

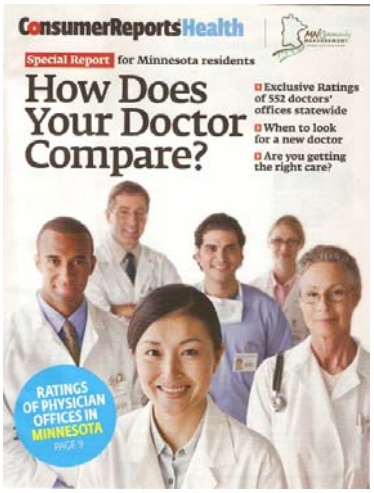
The Value Equation

- Quality
  - ACO, VBP, HEDIS, etc.
  - Common diagnoses
  - Many – so "harmonize"
- Experience
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Cost
  - To the **payer**



Performance Reporting

- Hospital Compare
  - http://www.hospitalcompare.hhs.gov/
- Healthgrades
  - http://www.healthgrades.com
- CARECHEX
  - http://www.carechex.com/
- Consumer Reports
  - Not just hospital ratings anymore!
- Angie's List and social media



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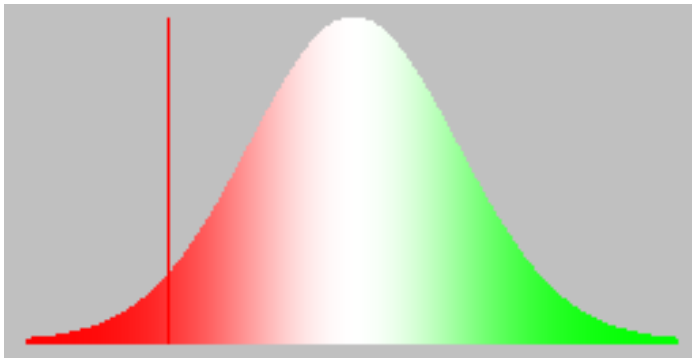
Variation = Risk = Opportunity

33



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

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Drive Out (Most) Variation

34

- Best evidence is only the way we practice medicine
- Care <u>should</u> 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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Medical Home Definition

35

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. http://www.commonwealthfund.org/
Joint Principles of Patient-Centered Medical Homes – 2007. http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Documents/Joint-Principles-Patient-Centered-Medical-Home.pdf

Medical Home Quotes

36

- 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 (eg, lab orders, med refills, vaccines)

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Medical Staff Relationships

37

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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Medical Staff Development

38

- Physicians see themselves as independent autonomous, and in control!
- Yet, hospital-physician alignment is essential to delivering value

Some ideas

- Develop and engage physician leaders
- Provide data transparency, but do not overstate discrete measure importance
- Offer rewarding, yet reasonable salary, rather than paying piecework
- Offer direct ability to influence outcomes
- Provide a continual sense of accomplishment and recognition

Source: Adapted from Cassel CK, Sachin HJ. Assessing individual physician performance. *JAMA*. Vol. 307, No. 24. June 27, 2012.

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Hospital Transformation

39

- How do we move toward value when our revenue is primarily volume-driven?
- We can test the waters
- The Process
  - Awareness – the value equation
  - Assessment – where we are right now, and where we need to go
  - Experimentation – small scale innovations
  - Implementation – new programs that drive value
- What to do right now

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What To Do Now

40

- Control the data
  - EHR and sophisticated data analytics
- 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?
- Aggressively apply for value-based demonstrations and grants
- Negotiate with third party insurers to pay for quality

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More What To Do Now

41

- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas with equal (or better) quality
  - Reduces Medicare cost dilution
- Manage care beyond the hospital
- Move organizational structure from hospital-centric to patient/community-centric
- Explore potential collaborations with physicians and others

Collaboration Questions

42

- How do we develop a common vision and "culture?"
- How do we respect physician identity and independence, yet promote collaboration?
- How do we define success by *mission*, not hospital growth?
- How do we accept that *increased collaboration will require some loss of control*?

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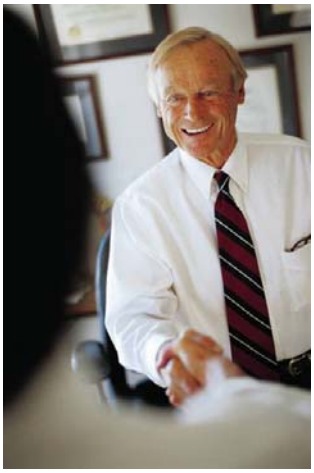
Collaboration and Value

43

- ACOs and other "programs" less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**



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The Risk of Something New

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Healthy People and Places

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