Transferring Risk – the Road to Health Care Value

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A. Clinton MacKinney, MD, MS
Deputy Director and Assistant Professor
RUPRI Center for Rural Health Policy Analysis
University of Iowa | College of Public Health
clint-mackinney@uiowa.edu
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
Health care should be:

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

The Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost

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Value Equation

Value = Quality + Experience

Cost

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

“Triple Aim”
- Better care
- Better health
- Lower cost

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Mortality Amenable to Health Care by State
Deaths* per 100,000 Population

2004–05

Quartile (range)
- Top (63.9–76.8) Best: MN
- Second (77.2–89.9)
- Third (90.7–107.5)
- Bottom (108.0–158.3) Worst: DC

* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease.
** Excludes District of Columbia.

DATA: Analysis of 2001–02 and 2004–05 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, BMJ 2003
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

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Patient Experience

Patients who reported YES, they would definitely recommend the hospital.

Why is this important?

Medicare Spending Per Enrollee

Source: Kaiser Family Foundation. 2009 Data

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Quality/Cost

Overall quality ranking

Annual Medicare spending per beneficiary (dollars)

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

- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse

- Our volume-based payment system is a significant problem

“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?
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

- Regardless of what we try, we tend to “follow the money”
Form Follows Finance

- 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

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

- Insurance risks
  - Demographic change
  - Technological innovations
  - Prior health status
  - Cost inflation

- Cost is the actuarial metric

- Minimal control, but predictable
Political Risk

- 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

- 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
The Risk of Inertia

Because we’ve ALWAYS done it that way!
The Risk of Doing Nothing

"We've considered every potential risk except the risks of avoiding all risks."

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Payment Risk Continuum

High Payer Risk
- Cost-Based
  - Charge-Based
    - Per Diem
    - Case Rate

High Provider Risk
- Capitation
  - Shared Risk
    - Bundled
    - ACOs
Accountable Care Organizations

- 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

ACO Explosion

- 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.
New World Realities

- 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
Tool Box for Delivering Value

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

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
Shifting Health Care Payments

The Cost of Healthcare

We’ve compiled internal data from 2010 and 2011 to produce an estimate of where your Blue Shield of California health plan dollar goes.

- 40¢: Hospital
- 28¢: Physicians
- 12¢: Pharmaceutical
- 5¢: Other Medical Services
- 2¢: Blue Shield Income
- 13¢: Admin Costs
- 15¢: Other

85¢: Cost of Health Care

Here’s how your health plan dollar is spent

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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
Variation suggests a risk for underperformance, but also an opportunity to excel
Drive Out (Most) Variation

- Best evidence is only the way we practice medicine
- 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
Medical Home Definition

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/
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 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)

Crete Physicians Clinic
Crete, Nebraska
The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA

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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

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
What To Do Now

- 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
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

- 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?
ACOs and other “programs” less important

Collaboration that fosters health care value is key

Future paradigm for success

**Good medicine and good business**
The Risk of Something New
Healthy People and Places