Evolving Rural Healthcare Environment Strategies for Success

Kenai Peninsula Borough Assembly Meeting

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STROUDWATER

About Stroudwater

Who we are	National healthcare consulting firm founded in 1985 by people with a passion for making a positive difference in healthcare. Our multi-disciplinary team offers deep expertise and perspective across a range of areas including finance, hospital operations, nursing, performance improvement, informatics and business development.
How we add value	• Affiliations and partnership planning • Capital planning and access • Physician-Hospital alignment • Strategic Master Facility Planning • Population Health • Revenue Cycle Management • Strategic Planning and Operational Improvement • Rural Practice
Where we serve	Active projects in all regions of the country serving major academic and tertiary centers, rural providers, physician groups, and government / quasi-government agencies

Goals for Today

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- To broaden awareness of market drivers that are redefining how healthcare is organized and delivered.
    - *Hospitals and providers will need to reimagine how to best partner in an effort to serve their communities*
- To share a macro, high level strategic perspective on three main imperatives that hospitals must focus on to successfully navigate to the new future state
    - *Blocking / Tackling is important → must be balanced with planning for the future*
- To reinforce the need to challenge the status quo
    - *Today's revenue generation playbook will be not be enough to ensure viability → new playbooks will need to be imagined to position rural hospitals for success in the future*

"In times of change, the learners will inherit the Earth while the knowers will find themselves beautifully equipped to deal with a world that no longer exists."
- Eric Hoffer

"If you don't know where you are
going any road will get you there"
- Lewis Carroll

The Healthcare Environment Has Changed!

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- Healthcare field has experienced considerable changes in the past 24 months
  - increased number of rural-urban affiliations, physicians transitioning to hospital employment models, flattening volumes, CEO turnover, etc.
  - Federal healthcare reform passed in March 2010 with sweeping changes to healthcare systems, payment models, and insurance benefits/programs
  - State Medicaid programs are moving toward managed care models or reduced fee for service payments to balance State budgets
  - Commercial insurers are steering patients to lower cost options

- Providers will be required to adapt to the changing market given these challenges and financial uncertainty

Summary of Major Market Drivers

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Federal / State	Private
1. Lower payment rates and lower adjustments (e.g., DSH / provider fees)	1. Decline in the uninsured
2. Pay for quality results in "winners" and "losers"	2. Increases in high deductible health plans
3. Incentives for reducing costs through ACOs and other alternative payment models	3. Narrow networks defined by price and quality
4. Medicaid expansion • 23 states opting out, waivers for their own approaches • Medicaid managed care for transitioning to global payments to reduce state budget expenses	4. Lower utilization 5. More involvement by employers – e.g., direct contracting

Challenges Affecting Rural and Community Hospitals

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- **Difficulty recruiting providers** and succession planning for aging of current medical staff
  - Struggle to pay market rates
- **Increasing competition** from other hospitals and physician providers for limited revenue opportunities
- Small **hospital governance members without sophisticated understanding** of small hospital strategies, finances, and operations
- Consumer **perception that "bigger is better"**
- Severe **limitations on access to capital** for necessary investments in infrastructure and provider recruitment
  - Facilities historically built around IP model of care
- Increased burden of **remaining current on onslaught of regulatory changes**
  - Regulatory Friction / Overload
- Payment systems transitioning from **volume-based to value-based**
- Increased emphasis of **quality** as payment and market differentiator
- **Reduced payments** that are "Real this time"
  - 3rd party steerage (surgery, lab, and Imaging), RAC audits

Closed Rural Hospitals Since the Beginning of 2010

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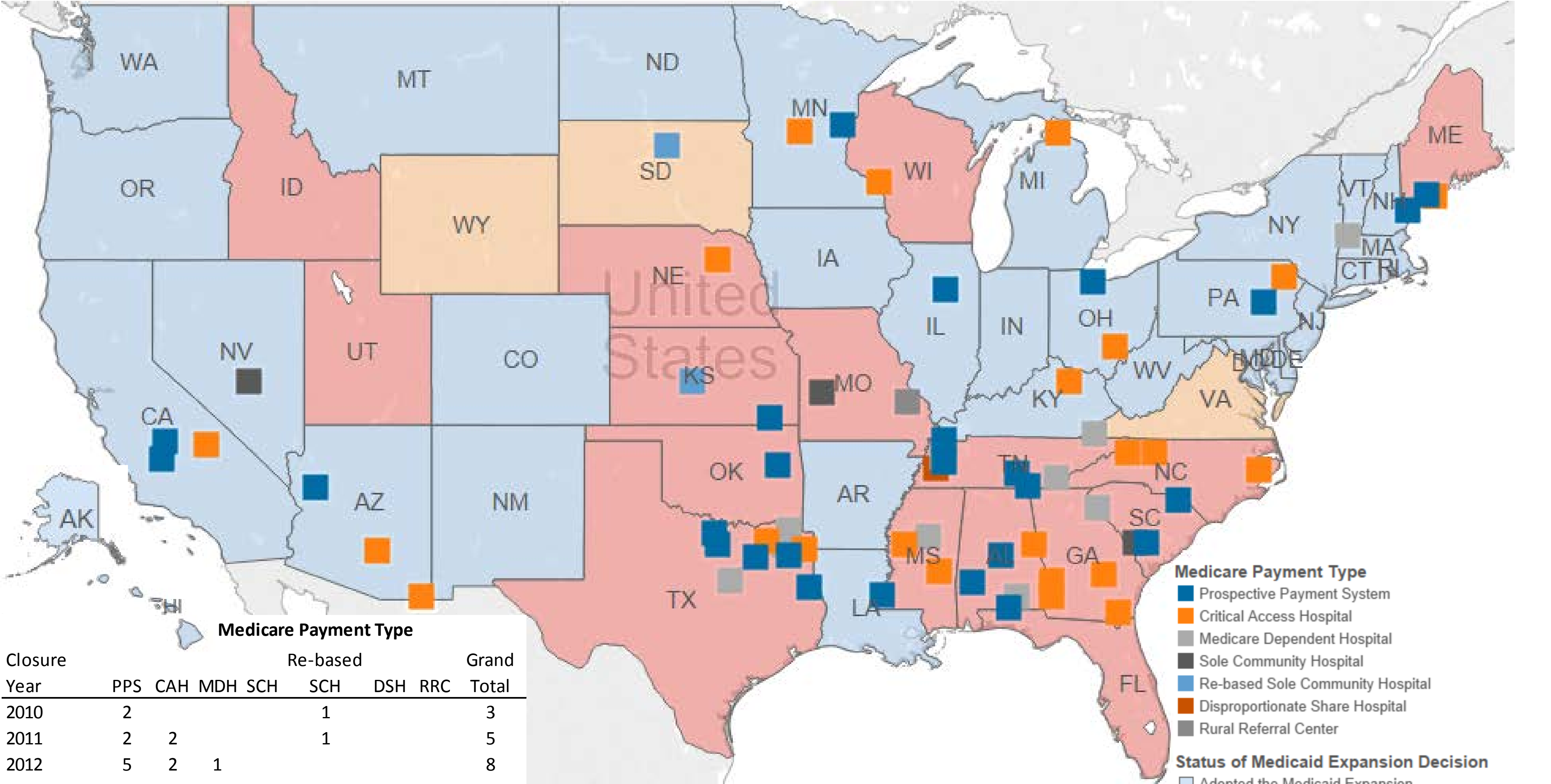


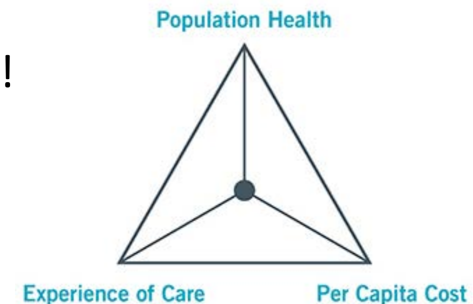
Medicare Payment Type

Closure Year	PPS	CAH	MDH	SCH	Re-based SCH	DSH	RRC	Grand Total
2010	2				1			3
2011	2	2			1			5
2012	5	2	1					8
2013	5	6	3					14
2014	2	7	5	1		1		16
2015	9	6	1	1			1	18
2016	1			1				2
Grand Total	26	23	10	3	2	1	1	66

Sources:
Kaiser Commission on Medicaid and the Uninsured (Medicaid Expansion)
The North Carolina Rural Health Research Program (Closures)

We Have Moved into a New Environment!

- Subset of most recent challenges
  - Payment systems transitioning from volume based to value based
  - Increased emphasis as quality as payment and market differentiator
  - Reduced payments that are “Real this time”
- New environmental challenges are the TRIPLE AIM!!



- Market Competition on economic driver of healthcare: PATIENT VALUE

The wrong kinds of competition have made a mess of the American health care system. The right kinds of competition can straighten it out.

Redefining Competition in Health Care

by Michael E. Porter and Elizabeth Olmsted Teisberg

Future Hospital Financial Value Equation

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- Definitions
  - Patient Value

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}$$

  - Accountable Care:
    - A mechanism for ***providers to monetize the value derived from increasing quality and reducing costs***
      - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.
    - Different "this time"
      - Providers monetize value
      - New information systems to manage costs and quality
      - Agreed upon evidence-based protocols
      - Going back is not an option

Future Hospital Financial Value Equation

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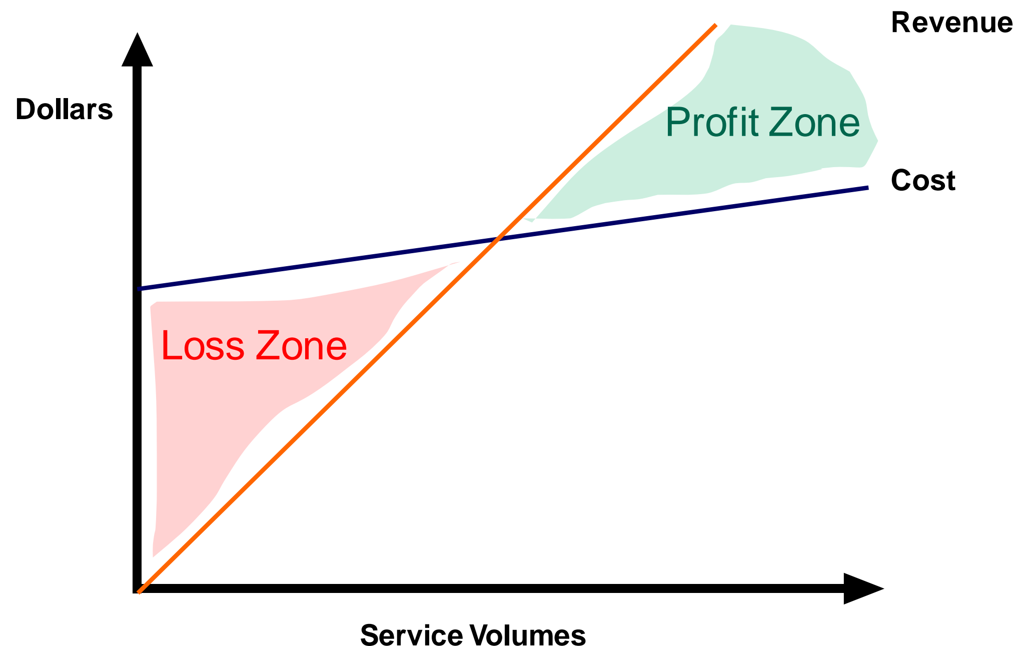
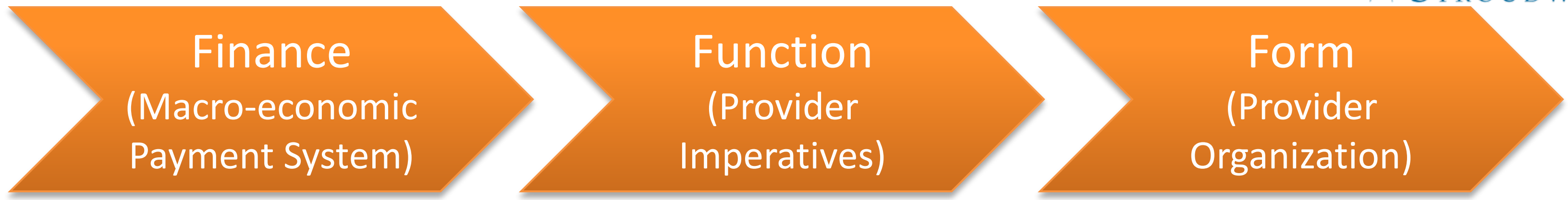
- ACO Relationship to Small and Rural Hospitals
    - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
    - Small and rural hospitals bring value / negotiating power to affiliation relationships as generally PCP based
        - Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
            - Alignment with PCPs in local service area
            - Develop a position of strength by becoming highly efficient
            - Demonstrate high quality through monitoring and actively pursuing quality goals

Future Hospital Financial Value Equation

- Economics
  - As payment systems transition away from volume based payment, the current economic model of **increasing volume to reduce unit costs and generate profit is no longer relevant**
    - New economic models based on patient value must be developed by hospitals but not before the payment systems have converted
  - Economic Model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp



The Premise – Finance System will drive Transition to PBPS



Today (FFS)	• Government Payers
	  • Changing from F-F-S to PBPS
	• Private Payers
	  • Follow Government payers
		• Management of costs	• Independent organizations competing with each other for market share based on volume

Population Health Transition Framework

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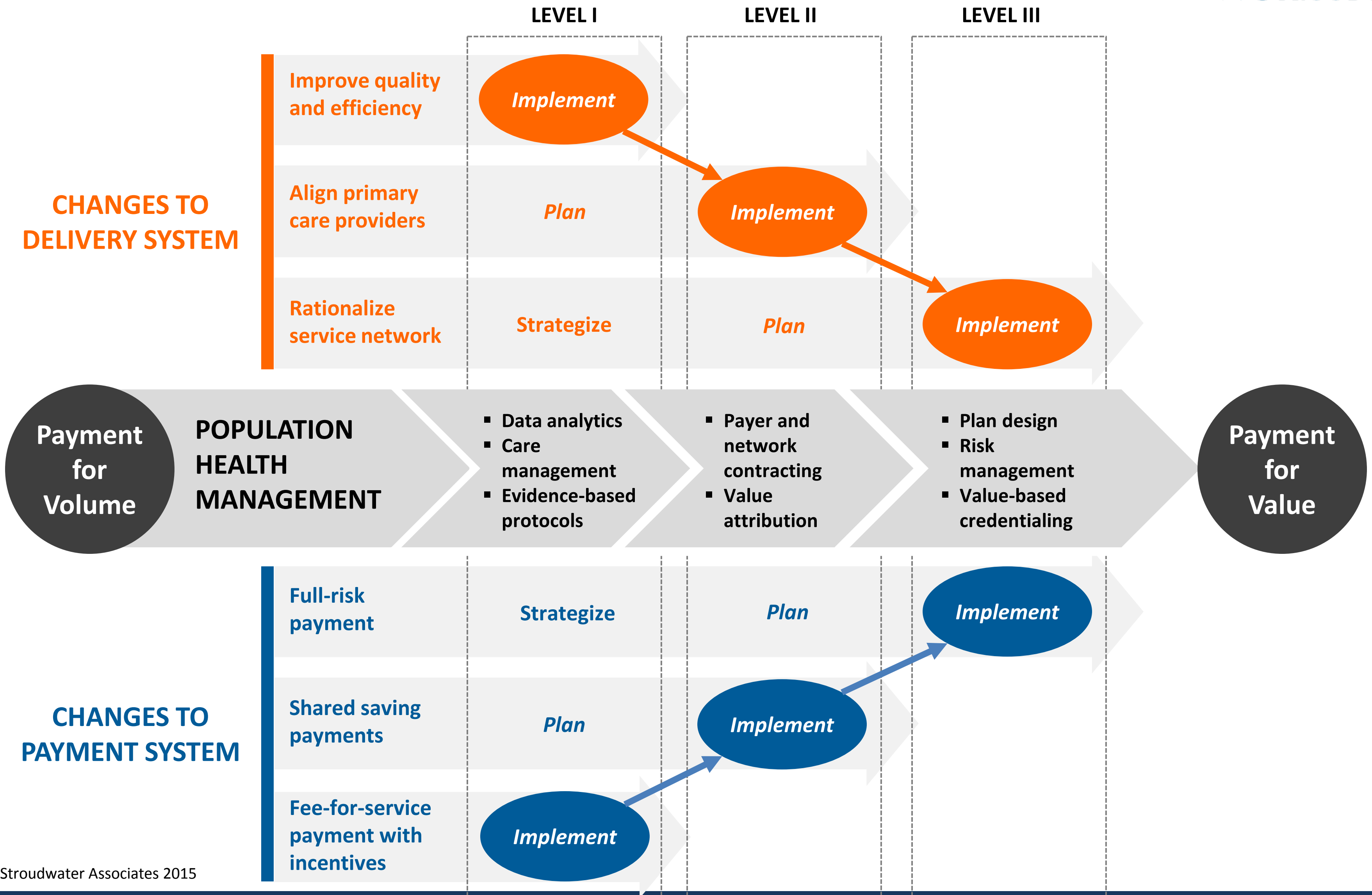

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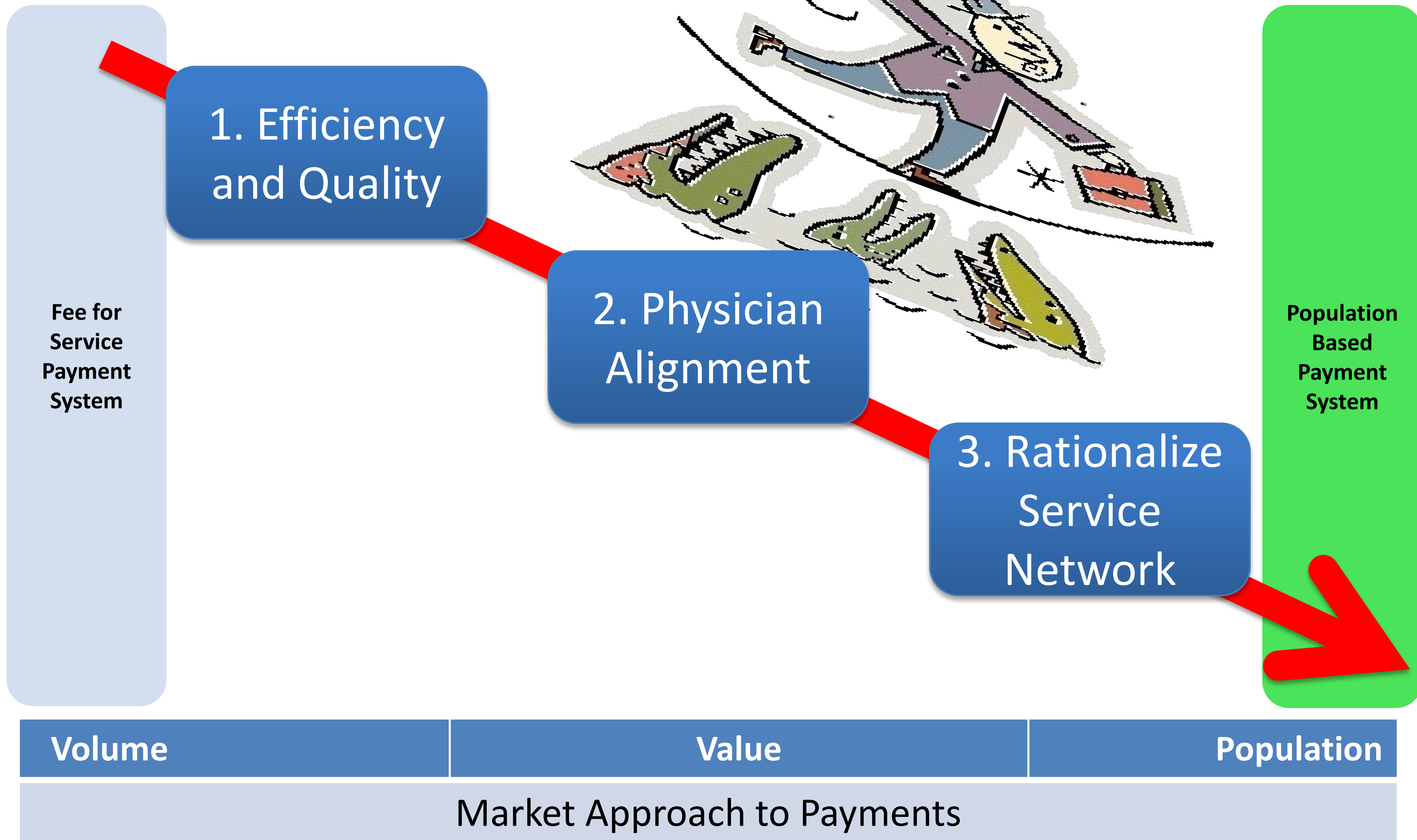
Navigating the Shaky Bridge – 3 Critical Steps



Volume	Value	Population
Market Approach to Payments		

Initiative I – Efficiency and Quality

"Efficient" can be defined as: appropriate patient volumes meeting needs of your service area, Expenses managed aggressively, Revenue cycle practices operating with best practice processes, Physician practices managed effectively, Effective organizational design

- Providers need to define core competencies and excel at delivery of value
  - Review profitable / non-profitable service lines to determine fit with mission and financial contribution to viability of organization
- Explore and adopt LEAN as a business model that can shift the culture towards a relentless focus on delivering customer value
- Quality is now a financial issue (MBQIP, Readmission reduction, etc.) → Transparency of pricing and outcomes will influence consumer choice
  - Providers will need to embrace performance transparency by reporting to Medicare Beneficiary Quality Improvement Program (MBQIP), HCAHPS, etc.
- Partner with Medical Staff to improve quality → restructure compensation agreements to build quality measures into incentive based contracts, as well as modify Bylaws

Initiative II – Primary Care Alignment

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- Today's "Volume drivers" will be tomorrow's "Value / Care coordinators"
  - Primary Care Physicians (PCPs) drive volume today → admissions, ancillary services, specialist referrals
  - Revenue stream of future will be tied to PCP's population of patients whose care they coordinate and direct within the delivery system
- Pursue alignment strategies with employed and independent primary care providers to enable interdependence with medical staff and support clinical integration efforts
  - Contract (e.g., employ, management agreements)
  - Functional (share medical records, joint development of evidence based protocols)
  - Governance (Board, executive leadership, planning committees, etc.)
- Rural hospital alignment with PCPs will yield extraordinary value relative to costs
  - Do the math on the projected healthcare spending that is directed / coordinated by your community's primary care network
    - Avg. PCP panel of 2,300 people X $8,400 per capita spending = $19.3M (4 PCPs = $77.3M)
  - Medical management of chronic conditions, Patient Centered Medical Homes, Direct Primary Care, etc.

Initiative III – Rationalize Service Network

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- Develop system integration strategies that seek to answer *Where* and *How* care is best delivered
  - Preserve primary care base, emergency services and other support services to include wellness, and chronic disease management
  - Evaluate wide range of affiliation options ranging from network relationships, to interdependence models, to full asset ownership models
    - Interdependence models through alignment on contractual, functional, and governance levels, may be option for rural hospitals that want to remain "independent"
- The revenue centers of *today* will be the cost centers of *tomorrow*
  - Today's FFS world → high acuity drives greater intensity of diagnosis and utilization of technology and resources = high cost specialized services which often pay more
  - Tomorrow's fixed budget, population based world→ high cost, resource / technology intensive diagnostic and procedure based services = cost drivers
- Understand that Rural hospitals play critical role in new delivery system
  - Rural hospitals attribute value to system through directing / coordinating care within its primary care network

Initiative III – Rationalize Service Network

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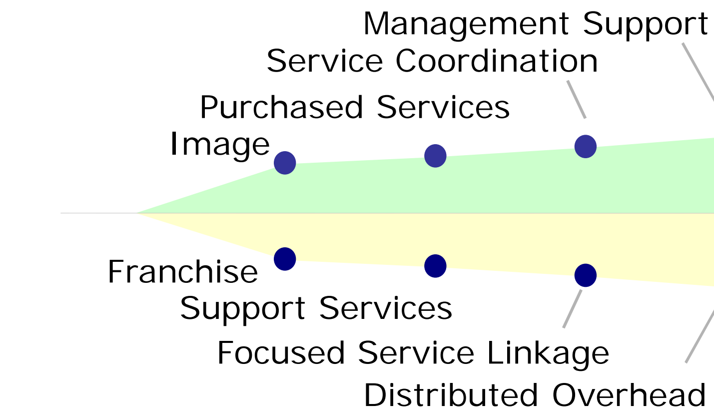
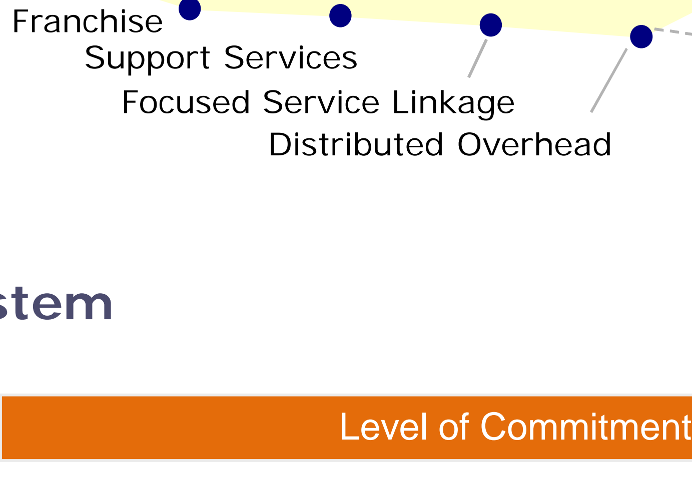
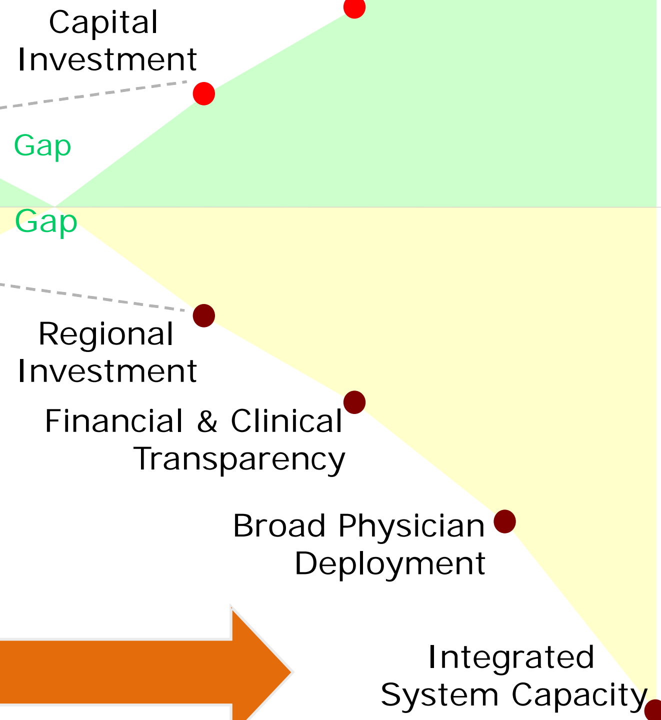
Affiliation Value Curve (AVC)

The level of commitment by both partners must be equivalent to have a sustainable affiliation







Conclusions / Recommendations

- The current environment driven by healthcare reform and market realities now offers a new set of challenges and opportunities
  - Many healthcare providers have not yet considered either the magnitude of the changes or the required strategies to navigate the transition
- Locally delivered healthcare (including rural and small community hospitals) has high value in the emerging delivery system
- "Shaky Bridge" crossing will require a planned, flexible and proactive approach
  - Recognize that finance will lead function and form
  - Increase leadership awareness of new environment realities
- 3 Critical Steps for a successful crossing
  - Drive operational efficiency and adopt effective quality measurement / improvement systems as a strategic priority
  - Align/ partner with medical staff members contractually, functionally, and through governance where appropriate
  - Seek interdependent relationships in efforts to develop regional system