

Shifting to a Value-Based Health Care System

A Guide for the Small Rural Hospital Improvement Grant Program

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INTRODUCTION

The American health care system is undergoing profound, perhaps even transformative, change. The change is driven both by the Accountable Care Act of 2010, and by the market itself. For the past several decades, health care in this country has been characterized by major breakdowns in quality, cost, access and population health. Despite the hard work and dedication of health care providers throughout the nation, the American system has fallen farther and farther behind other countries in terms of health care value. The problem has not been the providers, or the other key actors in the system; the real problem has been the design of the system itself.

Peter Senge, the preeminent expert on systems theory, wrote, “Every system is ideally designed to achieve the outcomes it is achieving” (Senge, 1990). Since the passage of the Medicare and Medicaid legislation in 1965, the major U.S. payers have been paying for volume; the more medical procedures performed, the more revenue produced. That business model was ideally designed to produce too much care, of too little quality, at too great a cost. Today, almost 50 million people are without health insurance, quality and patient safety are inconsistent, health care costs are the leading cause of personal bankruptcy, and the growth rate of diabetes and other chronic illnesses is staggering. The health care system that produced these results cannot be adequately tweaked; it requires fundamental redesign.

The health care system that is now emerging in this country is based on value, as defined by quality, satisfaction, cost and population health. It can best be summed up by the Institute for Health Improvement’s Triple Aim: Better care, lower cost and better health (IHI, 2013). The emerging new delivery models are based on maximizing efficiencies, coordinating care, teamwork and partnerships, and more effective transitions of care.

This guide is designed to offer small rural hospitals a basic overview of the key models of value-based purchasing that have been developed, and are in the process of being evaluated, to address this transformation from volume to value-based purchasing of health care services. Recommendations and strategies for managing this shift in payment structure are also included in this guide to aid rural health providers in managing the magnitude of the required changes. An example of a successful patient-centered medical home which demonstrates the challenges, benefits and lessons learned to date is also profiled.

KEY MODELS OF VALUE-BASED PURCHASING

Rural hospitals and providers are not immune to market forces that are moving the health care payment structure from fee-for-service payments based on volume to one that is focused on paying value as defined by better health, better experience and lower cost. This Triple Aim of quality is driving changes in the health care system at all levels.

To address the profound change and complexity of the U.S. health care industry, the Centers for Medicare & Medicaid Services (CMS) have developed new payment and service delivery models termed “Innovation models.” These innovation models include Accountable Care Organizations, bundled payments for care improvement and primary care transformation as well as initiatives focused on Medicare and Medicaid enrollees (CMS, 2013).

The key innovation models of value-based purchasing include:

Accountable Care Organizations

Accountable Care Organizations (ACOs) and similar care models are designed to incentivize health care providers (hospitals, physicians and others) to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality and efficient service delivery. The ACOs are based on three core principles:

1. Provider-led organizations with a strong base of primary care providers that are collectively accountable for quality and total per capita costs across a full continuum of care for a set population of patients (currently a minimum of 5,000 Medicare patients);
2. Payments are linked to quality improvement that also reduce overall costs; and,
3. Reliable and sophisticated performance measurements and technology to support improvement.

CMS is funding three ACO models:

1. Pioneer ACO Model—a program designed for early adopters of coordinated care (initial demonstration program). These organizations across the country have already transformed the way they deliver care, in ways similar to the ACOs that Medicare supports. An ACO manages all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. The ACO is said to be financially at risk, and is incentivized to produce cost savings with high quality outcomes.
2. Medicare Shared Savings Program—a program that helps a Medicare fee-for-service provider become an ACO. It is a three-year, voluntary ACO formed by primary care-led physicians and hospitals that provide care for at least 5,000 assigned Medicare beneficiaries. The ACO receives standard fee-for-service

and shared Medicare savings if they meet cost and quality targets. This model has no capitation risk, but does risk additional cost incurred and the potential for lost hospital revenue.

3. Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program. Targeted for small and rural providers and CAHs.

For small rural hospitals opting to participate in an ACO model, it is beneficial to recognize and build the organization's assets, while acknowledging and addressing weaknesses. ACOs place much greater value on primary care, a rural asset. ACOs also value medical homes (which are found in isolated rural settings) and cost-effective care, which are other rural assets. On the other hand, rural providers lack patient volume, access to needed expertise, access to capital, and, often, technology. These are weaknesses that will have to be addressed. For those opting to participate in an ACO model, it is imperative to begin as soon as possible to forge strategies to prepare for the value-based future and seek interdependent relationship with developing regional systems and ACOs.

Bundled Payments for Care Improvement

Payers' offering health care providers a single, bundled payment for an episode of care makes them jointly accountable for the patient's care. It also allows providers to achieve savings based on effectively managing resources as they provide treatment to the beneficiary throughout the episode. Medicare currently makes separate payments to various providers for the services they furnish to the same beneficiary for a single illness or course of treatment (an episode of care). There are four models:

1. Acute care hospital stay only;
2. Acute care hospital stay plus post-acute care;
3. Post-acute care only; and,
4. Prospective payment of all services during inpatient stay.

It is recommended that small rural hospitals consider maintaining the alignment between delivery system models and payment systems, building flexibility into the delivery system model for the changing payment system.

Primary Care Transformation

One of the largest challenges for hospitals in making the transition from a volume to a value-based purchasing system is transforming the primary care practice. For hospitals it is important to align or partner with medical staff contractually, functionally and/or through governance where appropriate. Under ACOs, primary

care physicians, in particular, have greater influence and value. In the value-based models, as primary care providers are called upon to manage the comprehensive care of a specific group of patients, for a predetermined total amount of payment, sometimes at a financial risk for them. The challenges arise as primary care providers must learn how to transform their systems of care to one that: creates improved quality and cost outcomes; fosters greater accountability; and, takes advantage of innovations in health information technology (HIT). Each of these transitions requires effective hospital leadership, a resilient workforce skilled in change management and team coordination, as well as shared decision-making. The Agency for Healthcare Research and Quality (AHRQ) has awarded cooperative grants to assist with primary care redesign models. Click [here](#) for a list of the various AHRQ sponsored models that improve and build a culture of accountability based on quality and economic efficiency.

Patient-Centered Medical Homes

Revitalizing the nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans, and the patient-centered medical home model is one that holds much promise for how care is organized and delivered. According to AHRQ and the [Patient Centered Medical Home Resource Center](#), the medical home model encompasses six functions and attributes:

1. Comprehensive care: Generating a team of physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators; all practicing at the top of their license to address the physical and mental health acute, chronic and prevention/wellness needs of patients.
2. Patient centered: Establishing partnerships with patients and their families to best meet unique needs, cultures, and preferences; and caring for patients as a whole person.
3. Coordinated care: Creating communication pathways across the health care system during transitions between sites of care (e.g. hospital to a long term care facility).
4. Community oriented: Exploring opportunities and partnerships to improve the overall health of the population.
5. Accessible services: Implementing technology capabilities for enhanced provider-patient-family communication; minimizing waiting times for urgent care, enhanced patient access to a member of the provider care team.

6. Quality and safety: Demonstrating use of evidenced-based medicine and clinical decision-support tools to guide shared decision making with patients and families; and engaging in ongoing performance improvement initiatives.

As with any organizational redesign effort, establishing a patient centered medical home can be challenging. Early adopters of this model report that effective hospital leadership and the use of a framework (such as the Baldrige Performance Excellence framework) to measure and monitor performance have been important.

COMMUNITY ENGAGEMENT

The above value-centered models will not be successful without hospitals effectively engaging their communities as partners in health. In the new models, hospitals will need to be actively engaged in population health management, and must therefore reach out to partner with other health organizations in the community. Hospitals must learn how to listen and respond to the health needs of the community to successfully make the shift to a value-centered health care system. Examples of methods hospitals have used to engage their communities include:

- Administering a community health needs assessment;
- Facilitating focus groups;
- Gathering secondary community health data;
- Hosting educational health forums on prevention/wellness or chronic disease management; and,
- Establishing health priorities from the assessment and leading the development of an implementation plan to improve community health.

When a small rural hospital participates in a community engagement initiative, such as those identified above, the hospital builds customer trust and loyalty within the service area as community members build collective ownership in the local facility when their voice is heard and acted upon. The psychology behind this notion is that when a community member holds a stake in the local facility, they often become actively engaged in promoting the hospital and share stories of their contributions with their family and friends residing within the service area. This community engagement can often result in increasing the hospital's market share within the service area, which is key to the financial success of small rural hospitals.

HIT AND PATIENT DATABASES

Participation in the new value-based models will require sophisticated electronic health records and, at minimum, a regional health information exchange. The population health management and quality improvement activities will also require the development and management of complex data bases. This will enable providers to determine the best treatment protocols as well as determine progress

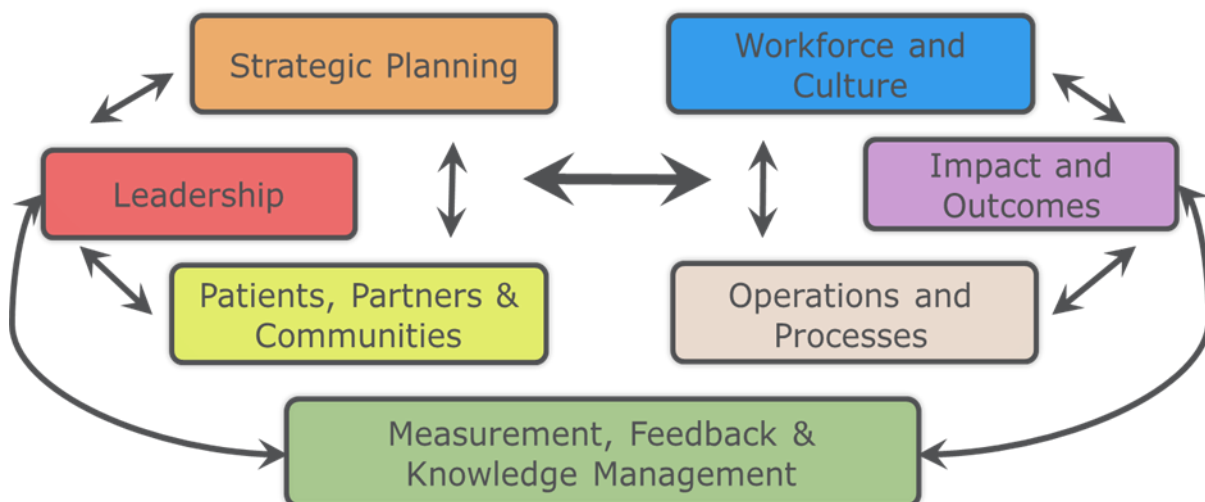
toward wellness, chronic illness management and population health management goals. Rural hospitals have the option of participating in large health system (or ACO) databases, or coming together in networks to pool their data and manage and analyze the data cooperatively. Access to research and analytical expertise will also become important in translating the data to be used as information for quality and population health improvement.

PERFORMANCE EXCELLENCE FRAMEWORK

Rural hospitals need a renewed focus on quality and efficiency to stay relevant in this rapidly changing market place. Rural hospitals, which inherently have a primary care focused delivery model are well positioned to thrive in the changing marketplace, but not without a system level approach to pursue and demonstrate quality and efficiency, align with primary care providers, and develop population health improvement strategies. Use of a systems-based performance excellence framework, such as the Baldrige Performance Excellence framework, provides a proven systems approach to help rural hospitals manage the crucial elements of organizational excellence desperately needed in this rapidly changing environment.

Key inter-linked components of the framework include:

- Leadership
- Vision and Strategy
- Partnerships and a focus on the community
- Use of data and information
- Change ready adaptable workforce
- Efficient and effective operations
- Impact and Outcomes



Each component of the framework is highlighted below, along with critical access hospital (CAH) relevant critical success factors outlining a blueprint for rural hospital leaders. Organizations and individuals won't have to address all of the recommended activities at the same time, but it's important to lay out a play for taking action at the appropriate time. The below are critical success factors for CAHs in each of the components of the Baldrige framework.

Critical Success Factors for CAHs

Leadership

- Educate and engage the board regarding health industry trends and potential impact on the organization.
- Empower and motivate hospital employees to achieve performance excellence focusing on systems based approach to creating value.
- Align with primary care providers to have common values, goals, and strategies focused on creating value.

Vision and Strategy

- Do meaningful strategic planning at least annually
- Use a systems framework for planning to ensure a holistic approach
- Communicate the plan organization-wide in easy to understand language

Partnerships and a Focus on Community

- Excels at customer service
- Explores partnerships with larger systems or rural networks
- Explores partnerships with other types of providers in the service area
- Engages and educates the community to improve health and encourage use of local health services

Measurement, Feedback, & Knowledge Management

- Uses a strategic framework to manage information and knowledge
- Evaluates strategic progress regularly and shares information organization-wide
- Gathers and uses data to improve health and safety of patients in the service area

Workforce and Culture

- Develop a workforce that is change ready and customer/patient focused
- Have an intense focus on staff development and retention

Operations and Efficiency

- Develops efficient business processes and maximizes revenue cycle management
- Continually improves quality and safety processes
- Uses information technology to improve both efficiency and quality

Impact and Outcomes

- Publically report and communicates outcomes internally and externally
- Documents value in terms of cost, efficiency, quality, satisfaction, and population health

Leadership awareness and support is critical in helping rural hospitals stay relevant during the market transformation. This framework is flexible and can be used in multiple ways- a starting point is just reviewing the critical success factors.

CONCLUSION

The transformation of the health care system will not be stopped or significantly altered by political events. We will move from the volume-based system of the past to the value-based system of the future because the old model produced low-value outcomes and is no longer financially sustainable.

Urban and rural health providers have the immediate challenge of preparing for success in the value-based payment system while still being paid in the old volume-based system. This challenge is already clear to those building the new ACOs. They may not have figured out the answers, but they're acutely aware of the problem.

Rural providers should act now to increase their awareness and begin to map out strategies that will make them successful in the future. Becoming part of an ACO or positioning the hospital or clinic to be successful in an ACO-like environment are both viable options that rural providers should consider carefully. Doing nothing or hoping the value-based model will go away, may leave the hospital and the community badly positioned for the future.

As is the case in almost every industry, change is inevitable, and managing change has become the greatest challenge of the 21st century. Will Rogers recognized this even back in the 1930s when the nation faced the immense challenge of the last great depression, in this comment, "Even if you're on the right track, you'll get run over if you just sit there."

CASE STUDY



Your Family Medical Home

HENRY COUNTY FAMILY PHYSICIANS, INC.

Patient Centered Medical Home Transformation Benefits, Lessons Learned, Practical Tips



Your Family Medical Home

Practice Demographics

- 4 full time physicians; 1 part time nurse practitioner
- 3 rural office locations in Henry County, Ohio
- EMR implemented in 2006
- 9565 active patients in the practice
- Applying for NCQA Patient Centered Medical Home designation in January, 2014
- One of 50 practices in Ohio participating in HB 198 Project



Your Family Medical Home

Practice Transformation

Patient Centered Medical Home Model includes:

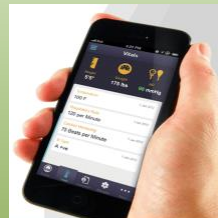
- Access to Care and Information
- Practice-Based Services
- Care Management
- Care Coordination
- Practice-Based Care Teams
- Practice Management
- Health Information Technology
- Quality and Safety



Your Family Medical Home

Benefits

- Providing a Patient Portal and App for Access to Care
- Defined Standing Orders
- Transition of Care Management
- Established Walk In Hours for Acute Visits

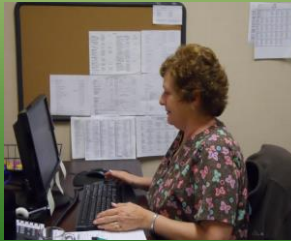




Your Family Medical Home

Benefits

- Implemented Daily Team Huddles
- Implemented “Team Concept”
- Staff are trained to work at the top of their licensure



Your Family Medical Home

Data Monitoring

- Quality Measures monitored monthly
- Reports brought to monthly physician and staff meetings
- Reports posted for staff to see on bulletin board and on shared public drive
- Reported quarterly to TransformMED HB 198 project

Metrics	Measure	June, 2013			Numerator
		Numerator	Denominator	Percent	
*Diabetics-HbA1C Poor Ctrl (> 9%)	Registry	6	125	5%	
*HTN - BP Control (<140/90)	300-CE	180	253	71%	
*I/D - LDL Control (<100)	350-B	90	103	87%	
Colorectal Cancer Screening	701-CM	6	506	1%	
*Mammography Screening	711-CM	224	462	49%	
*Pneumococcal Vaccine > 65 y/o	812-CT	352	679	52%	
*Tobacco Use	201-DT	906	998	91%	
*Tobacco Cessation Intervention	211-CM	42	162	26%	
Patients Web Enabled	Registry	2828	9536	30%	
Patients Seeing Assigned PCP	101-OI	1201	1260	95%	
Would Recommend Our Practice	Manually	197	200	99%	



Your Family Medical Home

Challenges

- Group Visits – Engaging Patients
- Staff Training – Seasoned Employees vs. New Employees
- Pre-Visit Planning
- Risk Stratification



Your Family Medical Home

Questions?

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RESOURCES

[Additional Value-Based Purchasing Resources](#)

National Rural Health Resource Center

[The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships](#) – June 2013

American Hospital Association

[Rural Health Value](#)

Rural Health Systems Analysis and Technical Assistance
RUPRI Center – University of Iowa and Stratis Health

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