

THE FUTURE OF QUALITY HEALTHCARE: ACO'S??????

ARKANSAS LEADERSHIP FORUM



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September 15, 2015

Learning Objectives

- Recognize current changes in rural hospital delivery systems
- Identify new models of care (ACOs and Population Health) in rural healthcare
- Discover ways to positively impact rural healthcare quality and engage the community

Rural Healthcare Environment

- Affordable Care Act in full swing...new delivery models, expansion of health care and change
 - *Push for Collaboration, Coordination and Consolidation*
- Reimbursement challenges – highly regulatory
- Mergence of Population Health Management
- Physician retention – changing model for them
- Transitional Care – a must

Hospital Operations

- Care Coordination – patient and family
 - Care Management
 - Potential for telemedicine (in rural areas)
- Quality and Hospital Performance
- Community Health Needs Assessment –*outreach to community*
- Customer Service – importance of employee

Physician Partnerships

- Inclusion in hospital QI decision-making and part of care management teams; board participation
- Incentive programs includes quality and performance
- Medical staff bylaws that focus on quality outcomes
- Training for advanced practice practitioners
- Understanding the hospitalist role in quality
- Nursing and physicians work together for quality outcomes
- Quality must be a top priority for hospitals

Physician Management Issues

- Requires new hospital and board understanding and management skills
- Expect increase in salaries and decrease work schedule
- Supervision of advance practice providers
- Responsibility for care coordination
- Increased scrutiny/ quality benchmarks
- Changing physician role toward quality
- E-health

On The Radar



- Changing **Environment** and Delivery System – *Healthcare Marketplace...**how are you preparing?***
- **Reimbursement** Impact – Rural Programs
- **Care** Transition and Coordination – *clinical inventory of services and strengths and gaps*
- **Community** Connection
- Role of **Quality** in rural hospitals

Quality is on everyone's radar. So what?



Attending "When Excellent is Required" is a Valuable Investment in Your Time and Organization!

Everyone is talking about **QUALITY!**



This session shifts the Quality Conversation to a Higher Level.

Reserve Your Seat Now!

Discover the Keys to Removing the Roadblocks Stopping You from Achieving and Sustaining Excellent Quality Outcomes!

GOOD

BETTER

BEST



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Good Is Not Good Enough

When Excellent is Required.

A Day Designed to Shift Your Perceptions & Approaches Toward **QUALITY**

Save the date – August 27, 2015 9am - 3:30pm

Crowne Plaza Little Rock 201 South Shackleford, Little Rock, AR 72211

CAH CEOs, CNOs, Quality Directors and Clinical Leaders Invited to Attend

The Arkansas Office of Rural Health and Primary Care will sponsor a one-day call-to-action session entitled: "When Excellent is Required" on Thursday, August 27. The informational and interactive session will feature three leading experts in innovation, quality processes (including HCAHPS and MBOIP), and organizational culture transformation. The session is ideal for Critical Access Hospital administrators and leadership teams, directors of nursing, quality improvement managers, human resources managers, and rural clinic managers.

The free-of-charge work session and collaborative discussion will take a deep and meaningful dive into:

- Obstacles to achieving and sustaining quality and patient-centered satisfaction in our frenetic and fast-changing healthcare environment
- Unraveling MBOIP with an emphasis on evidence-based interventions using the data
- Proven, practical strategies to strengthen leaders and accountability across the organization
- Solutions for setting and achieving high-level expectations from providers and caregivers
- Causes and effects of outmigration and the relationship to quality perceptions



Arkansas Department of Health



Continental breakfast and lunch will be provided.

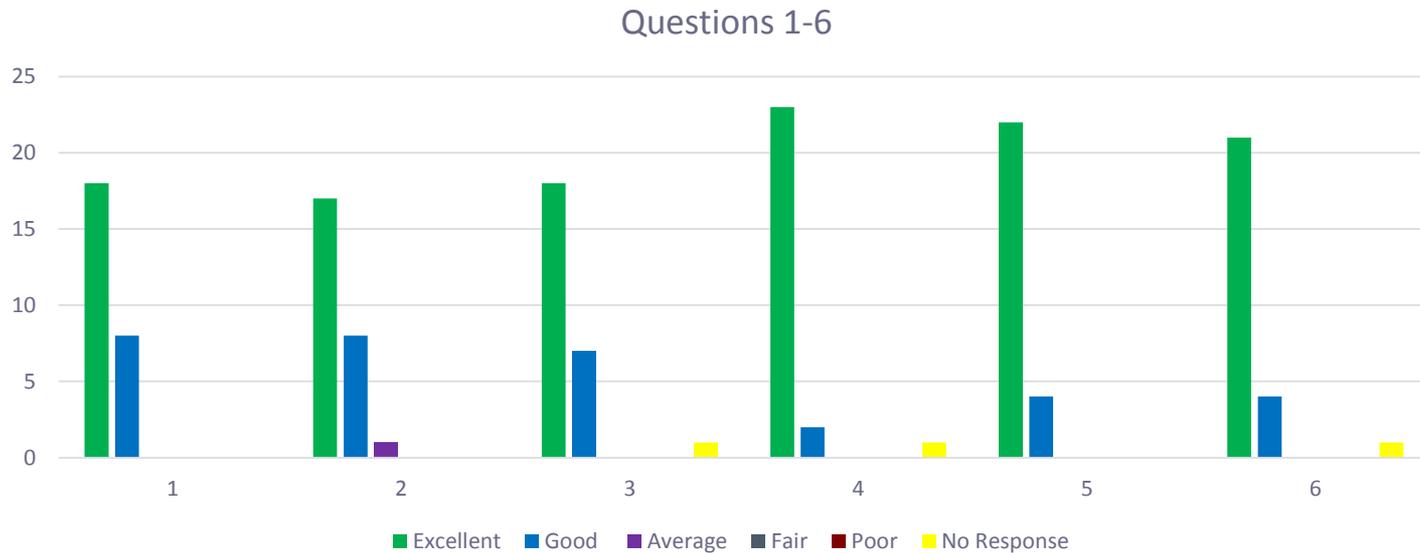
Brought to you by The Arkansas Office of Rural Health & Primary Care



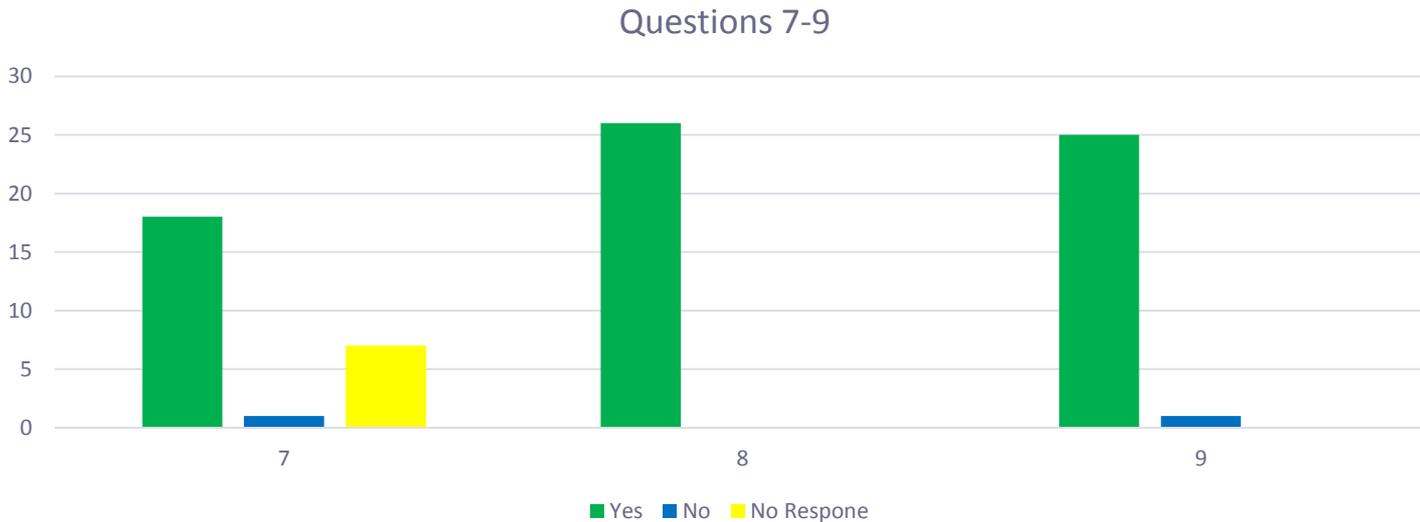
Good is Not Good Enough: When Excellence is Required Evaluation Results

	Excellent	Good	Average	Fair	Poor	No Response
1. I can describe the challenges facing rural health today and in our future	69% (18 responses)	31% (8 responses)				
2. I can understand and speak to MBQIP with a more robust understanding of its purpose	65% (17 responses)	31% (8 responses)	4% (1 response)			
3. I can explain how to achieve higher levels of expectations from providers and caregivers	69% (18 responses)	27% (7 responses)				4% (1 response)
4. I can identify two methods on how to improve culture in my organization	88% (23 responses)	8% (2 responses)				4% (1 response)
5. I can describe the methods to communicate effectively with others in the organization	85% (22 responses)	15% (4 responses)				
6. I can identify at least two areas to improve as it relates to HCAHPS scores	81% (21 responses)	15% (4 responses)				4% (1 response)
	Yes	No	No Response			
7. Were handout materials useful?	69% (18 responses)	4% (1 response)	27% (7 responses)			
8. Did the workshop meet your expectations?	100% (26 responses)					
9. Were the group discussions helpful?	96% (25 responses)	4% (1 response)				

Good is Not Good Enough: When Excellence is Required Evaluation Results



Good is Not Good Enough: When Excellence is Required Evaluation Results



Healthcare is changing!

- ACOs
- Physician/staff shortages
- Swing from inpatient care to outpatient care
- Regulatory burdens
- Reimbursement cuts

Hospital are closing!



2015 Hospital Closures

- Nye Regional Medical Center (SCH/NV)
- Cochise Regional (CAH/AZ)
- Parkview Adventist (PPS/Maine)
- Yadkin Valley (CAH/NC)
- Hunt Regional (CAH/TX)
- Marlboro Park (PPS/SC)
- Parkridge West (PPS/TN)
- Parkway Regional (PPS/ KY)
- Kilmichael Hospital (MDH/MS)

Source:

UNC Sheps Center [hospital closure website:](#)

57 Hospital Closures Since 2010

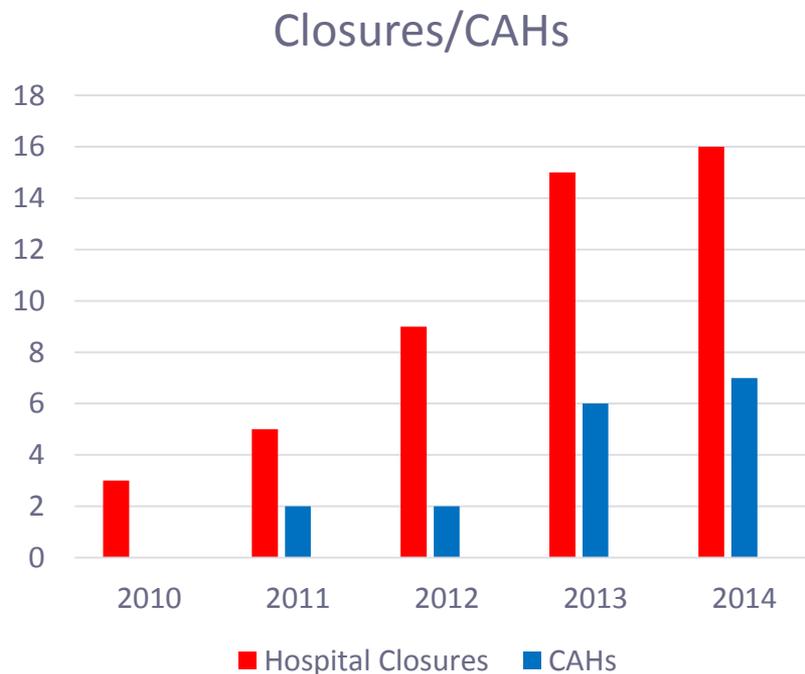
2010 – 3

2011 – 5

2012 – 9

2013 – 15

2014 – 16



Source:

UNC Sheps Center [hospital closure website:](#)

Reasons for Closures

- Medicare/Medicaid reimbursement cuts
- Pending loss of CAH status
- 2% cut in Medicare reimbursements
- Low patient usage
- Cash flow problems
- Uninsured population

Where are we headed?



National ACO's

- On December 23, 2013, the Centers for Medicare and Medicaid Services announced the new “Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).
- This is the 4th round of MSSP participants, which, coupled with the Pioneer ACOs, brings the number of Medicare ACOs to 366.
- The total number of public and private ACOs is 60

ACOs; What Are They?

- An ACO at the most basic level is a group of providers that accept responsibility to care for the health needs of a defined population while meeting predetermined quality benchmarks.
- At the heart of each patient's care is a primary care physician.
- The goal of the ACO is to improve quality outcomes, improve the experience of care and lower cost.

ACOs; What Are They?

- The law take a “carrot-and-stick” approach by encouraging the formation of ACOs in the Medicare program.
- Providers make more if they keep their patients healthy.
- An ACO is a network of doctors and hospitals that share financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending.

ACOs; What Are They?

- ACOs make providers jointly accountable for the health of their patients, giving them financial incentives to cooperate and save money by avoiding unnecessary tests and procedures.
- Sharing of patient information is crucial.
- Providers can choose to be at risk for bigger rewards or they can enter the program with no risk at all.

ACOs; What Are They?

- ACOs are projected to save Medicare \$940 million in the first four years.
- ACOs don't do away with traditional fee-for-service, but they create an incentive to be more efficient by offering bonuses when providers keep costs down.
- Doctors and hospitals have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases.

ACOs Year One

- In year one of the Medicare ACO program, provider groups saved a total of \$380 million according to CMS.
- Of the 114 Shared Savings Program ACOs, only 29 generated enough savings to qualify to keep some of it.

ACOs and the Patient

- Patients would still be free see doctors of their choice outside without paying more but doctors and hospitals will likely refer patients to hospitals and specialists within the ACO network.
- Patients can decline to have their data shared within the ACO.

ACOs; Who's in Charge?

- ACOs can include private companies like Walgreens
- More than half of ACOs are run by physicians
- In some regions, large hospital systems are scrambling to buy up physician practices with the goal of becoming ACOs that directly employ the majority of their providers.
- Some of the largest health insurers; Humana, UHC and Cigna are forming their own ACOs.

ACO Growth

- Since the MSSP round 3 participants began in January 2013, nearly 200 new public and private ACOs have been formed across the country.*
- There are 5.3 million Medicare ACO covered lives.
- The total number of estimated lives in public and private ACOs has risen to 18.2 million lives up from 13.6 million in 2012.
- Following the round 4 announcement, ACOs are now located in all 50 states and the District of Columbia.

ACO Growth

- California leads all states with 50 ACOs followed by Florida with 55 and Texas with 44.
- ACOs are primarily local with 538 (out of 606) having facilities in only one state.
- Oregon, due to the movement of its Medicaid population toward ACO (27%).
- Eight other states have more than 10%.
- Nationally, approximately 6% of the population is estimated to be enrolled in an ACO.

ACO Future

- The ACO movement represents the “volume to value” transition that has been the long term objective by many policy makers.
- Organizations that are considering accountable care will be best helped by seeing similar organizations.

3 year CMS Payment Reform Strategies

1. Establish greater focus on better care, better health, and lower costs for patients
2. Engage in **accountable care** and other alternative contracts based on better outcomes and lower cost
3. Test models to coordinate care for people with **multiple chronic conditions**
4. Pursue **improving health outcomes**

The Rural Perspective

There exists a great opportunity to affect the quality of care in our small, rural hospitals.... and communities



Warning/Reality Check



- ❖ The path will be difficult and not all will want to go
- ❖ There will be frustration and growing pains
- ❖ There will be doubters

A Change in Perspective is Needed; Population Health & Care Coordination

- Focusing on population health requires us to think differently about leadership
- *If you don't help your community to thrive and grow –how will your organization thrive and grow?*

What is Population Health?

Any provider arrangement with a payer in which you agree to provide care to a defined group of people (the population) in which you must do 3 things:

1. **Improve** the group's medical outcomes
2. **Reduce** the group's per-capita costs
3. Contractually capture the savings from the value you've created in 1 & 2

Build The Case for Population Health

- Create alignment towards value-based reimbursement
- Frame the conversation in terms of charity care, bad debt, and community benefit
- Identify the impact on other priorities (recruitment/retention, patient satisfaction, and care transitions)

We must FOCUS on chronic disease management!

Successful Population-Health Business Models

4 REQUIREMENTS

1. Focused commitment on PCP care coordination, improved quality, and reduced per-capita cost—i.e., producing patient value
2. Non-FFS payer reimbursement that incentivizes & rewards patient value
3. PMPM cost measurement and management
4. Actuarially **credible population size:**
(THIS IS THE CENTRAL PROBLEM for rural physicians & CAHs population health revenue models.)

We have to put Population Health on the Agenda

Answer the following questions:

1. How does population health align with **strategic initiatives** and health reform activities?
2. What is your role in addressing the two aspects of population health (cohort/community)?
3. What are next steps to implementing/integrating population health strategies?
4. What community needs are a priority and how do they impact the hospital?

We have to start somewhere!



Look Inside Your Own Walls

Apply employee wellness programs

- Implement case management/care coordination services for employees with chronic conditions



Healthcare is Changing!

Triple Aim

- Better health
- Better care
- Lower cost



We must build trust in our communities to promote quality healthcare and re-engage our neighbors.

Michelle Rathman, Impact! Communications

Reach Out To The Community

Don't wait to be asked.....

- Build on CHNA results and monitor progress
- Support staff involvement in community task forces
- Articulate roles/responsibilities in supporting community efforts
- Think beyond traditional partners
- Be patient; changing culture takes time

Ideal Health Care

The ideal health care scenario is to:

- ✓ Deliver the right care
- ✓ At the right time and
- ✓ To the right person

The rural health care delivery system and the patient MUST interact with each other via; phone visits, team based care, web portals and traditional office visits to be successful.

We have to get in the race!



Arkansas Goals

- 1. Rural hospitals must partner with the community to continue to be successful in the future*
- 2. The hospital must deliver quality, affordable programs that positively impact the local community and their health*

Why Quality?

The answer is obvious; better patient outcomes!

Our future depends on it!



QUESTIONS???

Thank you!

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