1 The March to Accountable Care Organizations: How Will Rural Fare?
   • MN Rural Health Conference
   • Duluth, MN
   • June 28, 2011

2 Agenda
   • National Context
     – Value + Collaboration
   • What are ACOs
   • Why, Who, When
   • How (Rural Preparation)

3 Affordable Care Act Themes
   • Major titles
     – Insurance coverage and reform
     – Public programs and public health
     – Quality and efficiency
     – Workforce
     – Transparency
     – CLASS
   • A provider’s perspective – key themes
     – Value-based purchasing
     – Health care provider collaboration

4 Value Equation
   • Value = (quality + service) / cost
   • Value incorporates IOM’s six Aims
   • Also the “Triple Aim”
     – Better care
     – Better health
     – Lower cost

5 Solutions to the Value Conundrum
   • We’ve tried (unsuccessfully?):
     – Fee-for-service
     – Capitation
     – Market
     – Single payer
     – Self-police
   • What about Accountable Care Organizations?

6 Collaboration (Integration)
   • Current non-system: fragmented, uncoordinated, and costly
   • Integrated Delivery Systems
     – An organized and collaborative provider network designed to provide coordinated and
       comprehensive health care services.
     – Is the urban integrated delivery system the genesis of, and template for, ACOs?
   • The rural question:
     – How do we do get these ACO things to work with autonomous and independent hospitals and
       physicians?

7 Accountable Care Organizations
   • A health care delivery system organized to improve health care quality and control costs through
     care coordination and provider collaboration, and then is held accountable for its performance
   • Couples provider payment and delivery system reforms
   • Accepts performance risk (quality and cost)

8 The Clueless CEO (ACO video)

9 Medicare Shared Savings Program
   • A fundamental transition from volume-based FFS to value-based payments
   • Usually includes hospitals/physicians
   • Provides all health care for a Medicare beneficiary (Parts A + B)
• 5,000 beneficiary minimum
• Medicare pays fee-for-service, plus shares ~ 50%-60% of savings (if any) at end of 3 years
• No downside risk until third year – maximum 5%-10%
• Savings to share will require excellent care and low cost – AKA value!

Managed Care Redux? Probably Not!
• Provider led, not insurance (75% of governing board must be ACO professionals)
• Medicare as leader (although BCBS and others have been paying for quality and establishing tiers based on cost)
• New care management strategies
• Increased physician-hospital alignments
• Information technology (EHR) improvement
• Much less risk than capitation, yet significant start-up costs
• Public financial pressures mandate Medicare cost control

Why Should Rural Consider ACOs
• SWOT – weaknesses
  – Band-Aid station image
  – Operational inefficiency
  – Professional recruitment
  – Minimal health management
  – Underdeveloped care processes
  – Inadequate HIT
  – Financial instability
• SWOT – threats
  – Eroding market share
  – Inability to access capital
  – Clinical excellence demand
  – Information technology demand
  – Performance reporting
  – Demographic changes
• Medicare dominates rural payer mix
• Value will become a competitive market advantage
  – Payers and consumers will increasingly demand value

Who Should We Consider for Collaboration
• Urban motivations
  – Primary care base expansion, preparation for capitation?
  – Health (care) management resource investment
  – Significant fixed costs (including specialists)
  – Post-acute care management to reduce readmissions
  – Scope of influence
• Favorable characteristics of a collaborator
  – Staying power/market power
  – Respectful negotiator
  – Appreciation of the rural experience
  – Knowledge of rural reimbursement systems
  – Clinical excellence and transferable care policies
  – Commitment to community with defined services
  – Commitment to capital and infrastructure investment
  – Professional recruitment
• ACO competencies for success
  – Leadership (culture change)
  – Teamwork in action
  – Coordination and communication
  – Quality management and reporting
  – Financial risk management
  – Gains distribution capacity
When Should Rural Consider an ACO

- Rural obstacles
  - Provider autonomy
  - Cottage industry
  - Volume maximization and fee-for-service focus
  - Local control mandate
  - Cost-based reimbursement
- Obstacles must become opportunities for improvement
- When will a rural provider be ready for ACO participation:
  - Primary care (quality improvement here)
    - True team-based care
    - Chronic disease and preventive health management
    - Evidence-based care
    - Quality improvement processes
    - Care coordination
  - Specialty and hospital care (cost control here)
    - Patients directed to low cost, high quality care
    - Reduced hospitalizations are a specific goal and process focus
    - Evidence-based care and care protocols
  - Information technology
    - 50% of primary care must be meaningful use providers by year 2
    - Disease mgmt and care coordination likely demands HIT
  - Health management
    - Health coaches and care coordination are supported and engaged
  - Governance
    - Structure that actively leads to performance improvement
    - Active physician engagement at all levels of enterprise

How to Prepare for ACOs

1. Cultural fundamentals
2. Clinical + finance
3. Care continuum
4. Health management
5. Medical staff
6. Leadership

Integrative Thinking Fundamental

- Integrate the priorities of:
  - Safety/quality
  - Patient experience
  - Employee growth
  - Financial stability

New Perspective Fundamental

- Efficiency without quality is unthinkable
- Quality without efficiency is unsustainable

Non-Linearity Fundamental

- "No margin, No mission" is too simplistic
- Balance will be the success strategy
  - Health care safety/quality
  - Financial stability
  - Patient experience
  - Employee growth
- It's never about either/or; it's always about and/both

Care Continuum
• Synchronization along the continuum requires:
  – Process management
  – Primary care emphasis
  – Care coordination
  – Communication strategies
  – Consistent care policies
  – Information technology

 19 Health Management
• Proactive care management
  – Visit preparation
  – Disease registries
  – Reminder systems
  – Preventive health, as well as disease management
• Team-based care
  – Health coaches
  – PAs and NPs
  • As true team members
  • Clinically appropriate patients and visits
  • Not simply filling in for absent physicians
• Patient centeredness
  – Cultural sensitivity
  – Communicating as patient desires
  – “Nothing about me without me”
• Care Coordination
  – Up and down the care continuum
    • Mental health, nursing home, home health, etc.
  – Synchronize and optimize
  – Medical home tenets

20 Medical Staff Relationships
• The hospital CEO’s most important job is developing and nurturing good medical staff relationships (John Sheehan, BKD).

21 Medical Staff Development
• ACOs demand hospital-physician alignment, especially primary care
• Yet, provider autonomy and cottage industry practices are barriers
• Strategic plan required
  – Goals
  – Objectives for each goal
  – Specific actions
  – Due dates
  – Resource allocations
  – Responsible individual
• Suggested goals for a medical staff development plan
  – Recruitment and retention
  – Governance and engagement
  – Leadership development
  – Relationship development

22 Leadership Foci
• Attention is the currency of leadership
  – If leaders wish to get something done, they attend to it
• Success will be intentional, not accidental
• Foci to be considered
  – New paradigms of value-based health care
  – Paradox of multiple competing priorities
  – Negotiation skills required – read Getting to Yes
  – Perseverance
Collaboration and Value
- ACOs and MSSP less important
- Collaboration leading to value is the key mission
- Future paradigm for success
- Fundamentals of value and collaboration are good medicine and good business, regardless of the reimbursement system

Healthy People and Places