Perspectives in Rural Health Care

John T. Supplitt, Senior Director
AHA Section for Small or Rural Hospitals
Agenda

1. The economic environment for rural hospitals
2. Who gets treatment, how, and where they go.
3. Health reform is here to stay.
4. Planning our future.
5. A place to start.
6. Resources
The economic environment for rural hospitals.
Rural Health Care

Now

Future
Closed hospitals since the beginning of 2013

PEOPLE PER SQ MILE
- 20 or less
- 20 to 40
- 40 to 50
- 60 to 80
- 80 to 100
- 100 or higher

- Closed hospital
- States that opted out of medicaid expansion
- States with continued open debate on medicaid expansion

North Carolina Rural Health Research Program
Reuters Graphics
American Hospital Association
Hospital Credit Ratings

Percentage of Credit Rating by Hospital Status

SOLIC Capital; Standard & Poor’s Ratings Services
The stronger CAHs will be those that are located in Medicaid expansion states with larger underserved populations and have strong affiliations with bigger, financially strong facilities or systems that can help foster regional Accountable Care Organizations and provide merger partners, if necessary. - Shelley Michelson, August 27, 2014
Who gets treatment, how, and where they go.
Population and inpatient care in rural and urban areas: US 2010

NOTE: Urban areas are those defined by the Office of Management and Budget as metropolitan, and rural (non-metropolitan) areas are defined as those outside of metropolitan areas.

Age distribution of hospitalized residents

- **Under 15**: 4% (Rural) vs. 6% (Urban)
- **15-44**: 21% (Rural) vs. 25% (Urban)
- **45-64**: 24% (Rural) vs. 32% (Urban)
- **65 and over**: 51% (Rural) vs. 37% (Urban)

**Rural and Urban Hospitals' Role in Providing Inpatient Care**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

American Hospital Association
How rural hospital and urban hospital inpatients differ
- Significantly older
- Larger percentage are covered by Medicare
- Diagnoses and stays are equal

Table. Characteristics of rural and urban hospital inpatients, 2010

<table>
<thead>
<tr>
<th></th>
<th>Rural hospital inpatients</th>
<th>Urban hospital inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
<td>4.1 million</td>
<td>31.0 million</td>
</tr>
<tr>
<td>Age 65 and over¹ (percent)</td>
<td>51</td>
<td>37</td>
</tr>
<tr>
<td>Medicare¹ (percent)</td>
<td>52</td>
<td>41</td>
</tr>
<tr>
<td>Medicaid (percent)</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Average number of diagnoses</td>
<td>7.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>4.5 days</td>
<td>4.8 days</td>
</tr>
</tbody>
</table>

¹Difference is statistically significant at the 0.05 level.
Patients’ first-listed diagnoses

- Relatively more frequent in urban hospitals:
  - Childbirth
  - Cancer
  - Poisoning

- Relatively more frequent in rural hospitals:
  - Dehydration
  - Bronchitis
  - Pneumonia

- Similar relative frequency in rural and urban hospitals:
  - Septicemia
  - CHF
  - Heart attack

Percent of hospitalizations
Rural and urban inpatient nonsurgical and surgical procedures

- Rural hospital patients
- Urban hospital patients

Number of procedures:
- 0: 64
- 1: 19
- 2: 10
- 3: 5
- 4 or more: 3
- 0: 38
- 1: 28
- 2: 17
- 3: 10
- 4: 8

Percentages:
- 0: 64%
- 1: 19%
- 2: 10%
- 3: 5%
- 4 or more: 3%
- 0: 38%
- 1: 28%
- 2: 17%
- 3: 10%
- 4: 8%
Rural and urban hospital patient discharges

Data from the National Hospital Discharge Survey, 2010
Summary

• In 2010, 12% of the 35 million U.S. hospitalizations were in rural hospitals.
• A higher percentage of inpatients in rural hospitals were aged 65 and over.
• The average number of diagnoses for inpatients was similar, as was the average length of stay.
• First-listed diagnoses including dehydration, bronchitis, and pneumonia, were more frequent among rural hospital inpatients.
• Sixty-four percent of rural hospital inpatients had no procedures performed while in the hospital.
• Following their hospitalization, a higher percentage of rural inpatients were transferred to other short-term hospitals, and a higher percentage of rural inpatients were discharged to long-term care institutions.
Health reform is here to stay.
Health Reform Gaining Traction

Federal Payment and Delivery Reform Programs in the ACA

- Meaningful Use
- VBP: In-Patient critical access hospitals (through 2016)
- Patient Quality Reporting System (PQRS)
- Quality Reporting Program
- HACs
- Bundled Payments for Episodes of Care (through 2018)
- Value-Based Purchasing
- Preventable Readmissions
- CMI Pilot Programs and Pioneer ACOs (through 2019)
- ACO Shared Savings Program
- Community-based Transition Care (through 2016)

2012 2013 2014 2015

Incentives/Bonus Penalties/Risk

Source: Leavitt Partners Center for Accountable Care Intelligence
ACO Defined
A clinically integrated network of physicians, hospitals, and others providers committed to using and advancing the latest thinking in clinical care, quality and efficiency.

Designed to achieve the triple aim:
1. better health
2. better healthcare, and
3. better value
Accountable Care Organizations

Source: Leavitt Partners Center for Accountable Care Intelligence
Accountable Care Organizations

Source: Leavitt Partners Center for Accountable Care Intelligence
Leavitt Partners’ Center for Accountable Care Intelligence

Growth of ACO Covered Lives Over Time

Estimated ACO Penetration by State

% ACO Lives
- >15%
- 10-15%
- 5-10%
- 4-6%
- 2-4%
- 0-2%

American Hospital Association
Accountable Care Organizations

- Trinity Pioneer ACO
- Wheaton Franciscan ACO
- Unity-Point ACO
- Mercy ACO
- MCR/Univ. IA ACO
- Genesis ACO
Accountable Care Organizations

State Medicaid ACO Movement

Source: Leavitt Partners Center for Accountable Care Intelligence – Douglas Hervey
AHRQ defines the PCMH as having five key domains:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Care</strong></td>
<td>The PCMH is designed to meet the majority of a patient’s physical and mental health care needs through a team-based approach.</td>
</tr>
<tr>
<td><strong>Patient-Centered Care</strong></td>
<td>Delivering primary care that is oriented towards the whole person by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.</td>
</tr>
<tr>
<td><strong>Coordinated Care</strong></td>
<td>The PCMH coordinates patient care across all elements of the health care system, such as specialty care, hospitals, home health care, and community services, with an emphasis on efficient care transitions.</td>
</tr>
<tr>
<td><strong>Accessible Services</strong></td>
<td>The PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers.</td>
</tr>
<tr>
<td><strong>Quality &amp; Safety</strong></td>
<td>The PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management.</td>
</tr>
</tbody>
</table>
The PCMH model is built upon three foundational supports:

<table>
<thead>
<tr>
<th>Foundational Support</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Health IT</strong></td>
<td>Health IT can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregate data that can be used to improve processes and outcomes.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>A strong primary care workforce including physicians, physician assistants, nurses, medical assistants, nutritionists, social workers, and care managers is a critical element of the PCMH model.</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>Current fee for service payment policies are inadequate to fully achieve PCMH goals. Payment reform is needed.</td>
</tr>
</tbody>
</table>
Planning our future.
Information Technology Interoperability: Some organizations have begun to derive benefits from coordinated care supported by robust IT infrastructure, such as single-source clinical solutions.

Reimbursement and Cost Management: hospital and health care leaders have no choice but to seek new opportunities for growth while also driving greater affordability for consumers and patients.
Efficiency: Employers will expect to benefit from increased efficiencies in the form of lower total charges and better results.

Provider Affiliations: An honest assessment of how your organization can best serve its mission and the population entrusted to its care.

Physician Alignment: Increasing value means expanded reliance on aligned primary care physicians.
Coordinating Care for Population Health: Hospital and health care system leaders recognize that advancing population health will enable them to thrive in a value-based landscape.

Measuring the Success of Population Health: Parallel strategies for keeping healthy people healthy while managing those who drive the vast majority of total costs in each of our local systems.

Equity of Care: To realize the goal of eliminating health care disparities, hospital leaders must believe that results can be achieved.
10 Trends for 2014

Steven T. Valentine, M.P.A.
President, The Camden Group, Los Angeles
svalentine@the camdengroup.com
1. Exchanges (state or federal marketplaces, CO-OPs or SHOPS) will provide mixed results to providers.

Keep an eye on: payer mix in the organization and growth in exchange-offered health plans and Medicaid. Watch trends in bad debt closely.

Steven T. Valentine, M.P.A.
President, The Camden Group, Los Angeles
2. New care models will continue to develop.

Keep an eye on: utilization reduction in terms of admissions and length of stay. Health systems must adapt their care processes to include coordinated care management by consolidating functions to incorporate inpatient, outpatient, and high-risk case management.

Steven T. Valentine, M.P.A.
President, The Camden Group, Los Angeles
3. Consolidation among providers will continue, and the big will get bigger.

Keep an eye on: branding by academic medical centers. Hospital ownership of a health plan, starting with its own employees and dependents.

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4. Physician shortages begin to take effect, and alignment becomes a top priority.

Keep an eye on: supporting or developing a means to align with physicians.

Steven T. Valentine, M.P.A.  
President, The Camden Group, Los Angeles
## Best Hospitals 2014-15: Honor Roll

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hospital</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Mayo Clinic, Rochester, Minnesota</td>
</tr>
<tr>
<td>2</td>
<td>Massachusetts General Hospital, Boston</td>
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<tr>
<td>3</td>
<td>Johns Hopkins Hospital, Baltimore</td>
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<tr>
<td>4</td>
<td>Cleveland Clinic</td>
</tr>
<tr>
<td>5</td>
<td>UCLA Medical Center, Los Angeles</td>
</tr>
<tr>
<td>6</td>
<td>New York-Presbyterian University Hospital of Columbia and Cornell, New York</td>
</tr>
<tr>
<td>7</td>
<td>Hospitals of the Univ. of Pennsylvania-Penn Presbyterian, Phil.</td>
</tr>
<tr>
<td>8</td>
<td>UCSF Medical Center, San Francisco</td>
</tr>
<tr>
<td>9</td>
<td>Brigham and Women's Hospital, Boston</td>
</tr>
<tr>
<td>10</td>
<td>Northwestern Memorial Hospital, Chicago</td>
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<tr>
<td>11</td>
<td>University of Washington Medical Center, Seattle</td>
</tr>
<tr>
<td>12</td>
<td>Cedars-Sinai Medical Center, Los Angeles</td>
</tr>
<tr>
<td>12</td>
<td>UPMC-University of Pittsburgh Medical Center</td>
</tr>
<tr>
<td>14</td>
<td>Duke University Hospital, Durham, North Carolina</td>
</tr>
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</table>
5. Marketing and creating a strong brand for organizations becomes increasingly important.

Keep an eye on: the marketing plan and brand management. Consider private label health plans.

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President, The Camden Group, Los Angeles
6. The demand for transparency will increase sharply.

Keep an eye on: reports from senior leaders that identify various high-quality sites and how the facility compares with competitors. Revisit price transparency.

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President, The Camden Group, Los Angeles
7. Large employers will look to form partnerships with providers.

Keep an eye on: reports from management about employer activity in the market and participation in large employers' cost-reduction and value-improvement strategies.

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8. The deployment of new technology will continue.

Keep an eye on: IT plans. Strategies for population health analytics with less emphasis on diagnostic and therapeutic equipment and facilities.

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President, The Camden Group, Los Angeles
10 Trends for 2014

9. Hospitals and systems will continue to expand their continuum of care within their market.

Keep an eye on: the volume, cost savings and investment required to move into post-acute care.

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10. Labor relations will continue to be a challenge.

Keep an eye on: monthly reporting on labor costs, staffing and benefits that are benchmarked to industry standards and historical performance.

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## CHECKLIST: CHARACTERISTICS OF SUCCESSFUL INDEPENDENT HOSPITALS

### Strategic Position

- Appropriate continuum of health care services (affiliated or owned/operated)
- Robust primary care network
- Appropriate specialty care and strong referral sources
- Health plans that prefer you as a provider
- A service area population large enough to manage risk in population health

### Clinically Integrated Network Platform and Performance

- Clinically integrated network delivering cost-efficient and clinically effective care
- Integrated and aligned physician network
- High-value services (high-quality outcomes, patient satisfaction and low cost per case)
- Value-based reimbursement models with payers (pay for performance, [P4P], shared savings, global budgets)
- Integrated care delivery model with systems to support care redesign and management across the continuum (efficient throughput, effective care transitions)
- Systems and processes to define preferred care paths and tools to measure and report on performance

### Infrastructure Readiness

- Information technology infrastructure and analytics to support clinical integration and information exchange across the continuum
- Ambulatory footprint with a variety of access points across the service area
- Robust physician enterprise that is efficiently operated and effectively led
- System that is prepared for further care transition from inpatient to ambulatory settings

### Financial Performance

- Operating margins capable of supporting short- and long-term needs and strategic objectives
- Available capital to fund:
  - Facility and equipment needs
  - Physician recruitment and alignment
  - Clinical integration development or expansion
  - Information technology advancement
  - Positive contribution margin for bundled-price, shared savings, P4P or capitated payer arrangements for the clinical service portfolio

### Leadership

- Leadership team capable of successfully managing the organization through future challenges and transition
- Clinical leaders engaged in driving the transformation with and among their peers
- Culture of innovation, adaptability, performance excellence and accountability
A place to start.
Where to begin?

Your Hospital’s Path to the Second Curve

The report provides:
A framework with must-do strategies to implement, deploy, organizational capabilities to master, top strategic questions to answer and five potential paths to identify and consider.
ANSWER Top 10 Strategic Questions

Responses to each question will lead hospitals and care systems to an optimal path or series of paths for transformation.

1. What are the primary community health needs?
2. What are the long-term financial and clinical goals for the organization?
3. Would the organization be included in a narrow/preferred network by a health insurer based on cost and quality outcomes?
4. Is there a healthy physician-hospital organization?
5. How much financial risk is the organization willing or able to take?
6. What sustainable factors differentiate the organization from current and future competitors?
7. Are the organization’s data systems robust enough to provide actionable information for clinical decision making?
8. Does the organization have sufficient capital to test and implement new payment and care delivery models?
9. Does the organization have strong capabilities to deliver team-based, integrated care?
10. Is the organization proficient in program implementation and quality improvement?
Five Potential Paths

- **Redefine** to a different care delivery system (i.e., either more ambulatory or oriented toward long-term care)
- **Partner** with a care delivery system or health plan for greater horizontal or vertical reach, efficiency and resources for at-risk contacting (i.e., through a strategic alliance, merger or acquisition)
- **Integrate** by developing a health insurance function and/or services across the continuum of care (e.g., behavioral health, home health, post-acute care, long-term care, ambulatory care)
- **Experiment** with new payment and care delivery models (e.g. bundled payment, accountable care organization, medical home)
- **Specialize** to become a high-performing and essential provider
Every market is different. Factors will have different weights corresponding to the local market.

- Changing payment system
- Degree of physician alignment
- Health care needs of the community
- Purchasers moving to new models
- Providers in the market moving to new models
Resources.
AHA Resources

- Hospitals in Pursuit of Excellence

AHA Guides

- Hospitals and Care Systems of the Future
- Metrics for the Second Curve of Health Care
- Second Curve Road Map for Health Care
- AHA Research Synthesis Report: Accountable Care Organizations
- AHA Research Synthesis Report: Patient-Centered Medical Home
- AHA Research Synthesis Report: Bundled Payment
- Accountable Care Organizations: An AHA Research Synthesis Report
- A Guide to Strategic Cost Transformation in Hospitals and Health Systems

Other Resources

- H&HN Daily: Making the Leap to Value
Must Reading

- Commins, John; Retail Medicine a Big Shift for 2014, HealthLeaders Media, January 6, 2014.
- Beckham, Dan; Hospitals Choosing to Join Networks Instead of Merging, H&HN Daily, April 14, 2014.
Must Reading

- Muhlestein, David, Accountable Care Growth in 2014: A Look Ahead, Health Affairs Blog, Jan. 29, 2014 david.muhlestein@leavittpartners.com


- Stowell, Susan and Puiia, James; *Rural at a Crossroads*, Trustee, Vol. 64, No. 1, January 2011.


- Cosgrove, Delos et al; A CEO Checklist for High-Value Health Care, Institute of Medicine (National Academies of Science), June 2012.

John Supplitt
Senior Director
AHA Section for Small or Rural Hospitals
Chicago, IL
312-422-3306
jsupplitt@aha.org