Reinventing Rural Healthcare

Ian Morrison PhD

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Outline

• The Second Curve
• The Quest for Value in Canadian and US Healthcare
• Delivery System Transformation
• What this all means for Rural Healthcare
The Second Curve

First Curve

Second Curve
Hospitals and Care Systems of the Future

Engage senior leadership in planning for the hospital of the future

- Must-do strategies to be adopted by all hospitals
- Second curve metrics measure success of the implemented strategies
- Organizational core competencies that should be mastered
  - Self-assessment questions to understand how well the competencies have been achieved
Key Environmental Drivers

• **Health Reform**
  – Health reform (particularly ACOs and exchanges) creates increased demands on care delivery and changes in economics of all actors
  – Mandated coverage expansion under PPACA and the primary care surge in demand

• **Reimbursement Pressures and Reimbursement Reform**
  – Federal and state budgets (particularly Medicaid) under huge pressure politically and economically
  – Private payers resisting cost shifting through skinny networks and costs sharing
  – From payment for volume to payment for value, quality needs to be measured along the way
  – Rise of new payment models to promote coordinated, integrated care
  – All payers seeing payment tied to quality

• **Provider Consolidation**
  – Doctors and Hospitals are coming together in anticipation of coordinated accountable care across the country
  – Larger regionalized systems of care

• **High change environment involving multiple stakeholders**
First-Curve to Second-Curve Markets

How will hospitals successfully navigate the shift from first-curve to second-curve economics?

**Volume-Based First Curve**
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute Inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

**Value-Based Second Curve**
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

THE GAP
Strategy Implementation Leads to Core Competency Development

Adoption of Must-Do Strategies

1. Clinician-hospital alignment
2. Quality and patient safety
3. Efficiency through productivity and financial management
4. Integrated information systems
5. Integrated provider networks
6. Engaged employees & physicians
7. Strengthening finances
8. Payer-provider partnerships
9. Scenario-based planning
10. Population health improvement

Organizational culture enables strategy

Development of Core Competencies

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance & leadership
3. Strategic planning in an unstable environment
4. Internal & external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees’ full potential
7. Utilization of electronic data for performance improvement

Metrics to Evaluate Progress

Self-Assessment Questions
Defining Value of Health Services

Value = \frac{(Access + Quality + Security)}{Cost}
Health Care Spending per Capita by Source of Funding, 2011
Adjusted for Differences in Cost of Living

Dollars ($US)

<table>
<thead>
<tr>
<th>Country</th>
<th>Out-of-pocket spending</th>
<th>Private spending</th>
<th>Public spending</th>
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<tbody>
<tr>
<td>US</td>
<td>987</td>
<td>3,454</td>
<td>4,066</td>
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<tr>
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<td>1,455</td>
<td>527</td>
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<td>CAN</td>
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<td>DEN*</td>
<td>4,495</td>
<td>75</td>
<td>3,827</td>
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<td>593</td>
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<tr>
<td>FR</td>
<td>4,118</td>
<td>650</td>
<td>3,161</td>
</tr>
<tr>
<td>SWE</td>
<td>3,925</td>
<td>635</td>
<td>3,204</td>
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<tr>
<td>AUS*</td>
<td>3,800</td>
<td>733</td>
<td>3,405</td>
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<tr>
<td>UK</td>
<td>3,405</td>
<td>338</td>
<td>2,638</td>
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<td>JPN*</td>
<td>3,213</td>
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<td>2,631</td>
</tr>
<tr>
<td>NZ</td>
<td>3,182</td>
<td>348</td>
<td>2,631</td>
</tr>
</tbody>
</table>

* 2010.
Source: OECD Health Data 2013.
US Last in Overall Ranking of 11 Countries

![Overall Ranking Table]

**Notes:** * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

**Source:** Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).
U.S. Lags Other Countries: Mortality Amenable to Health Care

Deaths per 100,000 population*

* Countries’ age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Exhibit 10. Mortality Amenable to Health Care

Deaths per 100,000 population

- 57–67 (12 states)
- 71–81 (13 states)
- 82–95 (14 states)
- 97–136 (11 states + D.C.)

Why the Big Difference?

• The Fallacy of Excellence
• The 6 Point Spread
  – Everyone makes more money: Not just doctors, higher prices and incomes for everyone
  – Administrative Waste Motion: 25%-30% Price of Pluralism
  – Intensive and Expensive Use of Technology
    • End of Life Care: 30% of Medicare
    • Intensive use of Diagnostics, procedures, and high-tech interventions
    • Primary versus Specialty Care Balance
• Is it fixable?
  – Some is culture: Values, expectations, and attitudes
  – Some is population differences: Way too much is made of this e.g. The Natural Experiment Paper
  – Most is policy, management and payment system
Canadians are Different from Americans
The U.S. is an anomaly in health and social spending patterns

Source: OECD
Figure 1. Obesity among adults, 2012 or nearest year
Figure 2. Obesity rates
Hospital Spending per Discharge, 2010
Adjusted for Differences in Cost of Living

Dollars

<table>
<thead>
<tr>
<th>Country</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
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<td>US*</td>
<td>19,319</td>
</tr>
<tr>
<td>CAN*</td>
<td>14,896</td>
</tr>
<tr>
<td>NETH*</td>
<td>13,134</td>
</tr>
<tr>
<td>JPN**</td>
<td>12,650</td>
</tr>
<tr>
<td>DEN</td>
<td>11,295</td>
</tr>
<tr>
<td>SWIZ</td>
<td>11,219</td>
</tr>
<tr>
<td>NOR*</td>
<td>11,021</td>
</tr>
<tr>
<td>SWE</td>
<td>9,990</td>
</tr>
<tr>
<td>AUS*</td>
<td>9,531</td>
</tr>
<tr>
<td>FR</td>
<td>8,049</td>
</tr>
<tr>
<td>NZ</td>
<td>7,856</td>
</tr>
<tr>
<td>OECD Median</td>
<td>7,180</td>
</tr>
<tr>
<td>GER</td>
<td>5,192</td>
</tr>
</tbody>
</table>

* 2009.
** 2008.
Source: OECD Health Data 2012.
Physician Incomes, 2008
Adjusted for Differences in Cost of Living

Dollars

Orthopedic surgeons

<table>
<thead>
<tr>
<th>Country</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
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<td>442,450</td>
</tr>
<tr>
<td>UK</td>
<td>324,138</td>
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<tr>
<td>CAN</td>
<td>208,634</td>
</tr>
<tr>
<td>GER</td>
<td>202,771</td>
</tr>
<tr>
<td>AUS</td>
<td>187,609</td>
</tr>
<tr>
<td>FR</td>
<td>154,380</td>
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Primary care doctors

<table>
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<tr>
<th>Country</th>
<th>Dollars</th>
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</thead>
<tbody>
<tr>
<td>US</td>
<td>186,582</td>
</tr>
<tr>
<td>UK</td>
<td>159,532</td>
</tr>
<tr>
<td>CAN</td>
<td>131,809</td>
</tr>
<tr>
<td>GER</td>
<td>125,104</td>
</tr>
<tr>
<td>FR</td>
<td>95,585</td>
</tr>
<tr>
<td>AUS</td>
<td>92,844</td>
</tr>
</tbody>
</table>

Physician Satisfaction with Practicing Medicine

Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Cost-Related Access Barriers and Out-of-Pocket Costs in the Past Year

**Experienced cost-related access problem***

- **UK**: 4
- **SWE**: 6
- **NOR**: 10
- **CAN**: 13
- **SWIZ**: 13
- **GER**: 15
- **AUS**: 16
- **FR**: 18
- **NZ**: 21
- **NETH**: 22
- **US**: 37

**Spent US$1,000 or more out-of-pocket**

- **SWE**: 2
- **UK**: 3
- **FR**: 7
- **NETH**: 7
- **NZ**: 9
- **GER**: 11
- **CAN**: 14
- **NOR**: 17
- **SWIZ**: 24
- **AUS**: 25
- **US**: 41

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* Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

Source: 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries.
Access to Doctor or Nurse When Sick or Needed Care

<table>
<thead>
<tr>
<th>Country</th>
<th>Same-day or next-day appointment</th>
<th>Waited six days or more for appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>GER</td>
<td>76</td>
<td>5</td>
</tr>
<tr>
<td>NZ</td>
<td>72</td>
<td>14</td>
</tr>
<tr>
<td>NETH</td>
<td>63</td>
<td>14</td>
</tr>
<tr>
<td>AUS</td>
<td>58</td>
<td>15</td>
</tr>
<tr>
<td>SWE</td>
<td>58</td>
<td>16</td>
</tr>
<tr>
<td>FR</td>
<td>57</td>
<td>16</td>
</tr>
<tr>
<td>NOR</td>
<td>52</td>
<td>22</td>
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<tr>
<td>UK</td>
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<td>26</td>
</tr>
<tr>
<td>US</td>
<td>48</td>
<td>28</td>
</tr>
<tr>
<td>CAN</td>
<td>41</td>
<td>33</td>
</tr>
</tbody>
</table>

Note: Question asked differently in Switzerland.

Source: 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries.
Wait Times for Specialist Appointment

Less than four weeks

<table>
<thead>
<tr>
<th>Country</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland (SWIZ)</td>
<td>80</td>
</tr>
<tr>
<td>United Kingdom (UK)</td>
<td>80</td>
</tr>
<tr>
<td>United States (US)</td>
<td>76</td>
</tr>
<tr>
<td>Netherlands (NETH)</td>
<td>75</td>
</tr>
<tr>
<td>Germany (GER)</td>
<td>72</td>
</tr>
<tr>
<td>New Zealand (NZ)</td>
<td>59</td>
</tr>
<tr>
<td>Sweden (SWE)</td>
<td>54</td>
</tr>
<tr>
<td>Australia (AUS)</td>
<td>51</td>
</tr>
<tr>
<td>France (FR)</td>
<td>51</td>
</tr>
<tr>
<td>Norway (NOR)</td>
<td>46</td>
</tr>
<tr>
<td>Canada (CAN)</td>
<td>39</td>
</tr>
</tbody>
</table>

Two months or more

<table>
<thead>
<tr>
<th>Country</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands (NETH)</td>
<td>3</td>
</tr>
<tr>
<td>Switzerland (SWIZ)</td>
<td>3</td>
</tr>
<tr>
<td>United States (US)</td>
<td>6</td>
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<tr>
<td>United Kingdom (UK)</td>
<td>7</td>
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<tr>
<td>Germany (GER)</td>
<td>10</td>
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<td>Sweden (SWE)</td>
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<td>Australia (AUS)</td>
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<td>France (FR)</td>
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<td>New Zealand (NZ)</td>
<td>19</td>
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<tr>
<td>Norway (NOR)</td>
<td>26</td>
</tr>
<tr>
<td>Canada (CAN)</td>
<td>29</td>
</tr>
</tbody>
</table>

Base: Needed to see specialist in the past two years.
Source: 2013 Commonwealth Fund International Health Policy Survey in Eleven Countries.
Access to After-Hours Care

**Adults, 2013**
Easy getting after-hours care without going to the ER

**Primary care physicians, 2012**
Practice has arrangement for patients’ after-hours care to see doctor or nurse

<table>
<thead>
<tr>
<th>Country</th>
<th>Access After-Hours Care</th>
<th>Arrangement for After-Hours Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>69</td>
<td>95</td>
</tr>
<tr>
<td>NOR</td>
<td>58</td>
<td>95</td>
</tr>
<tr>
<td>GER</td>
<td>56</td>
<td>90</td>
</tr>
<tr>
<td>NETH</td>
<td>56</td>
<td>90</td>
</tr>
<tr>
<td>NZ</td>
<td>54</td>
<td>81</td>
</tr>
<tr>
<td>SWIZ</td>
<td>49</td>
<td>80</td>
</tr>
<tr>
<td>AUS</td>
<td>46</td>
<td>78</td>
</tr>
<tr>
<td>US</td>
<td>39</td>
<td>76</td>
</tr>
<tr>
<td>CAN</td>
<td>38</td>
<td>68</td>
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<tr>
<td>FR</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>SWE</td>
<td>35</td>
<td>35</td>
</tr>
</tbody>
</table>

Base: Needed care after hours.

* In Norway, doctors asked whether their practice had arrangements or there were regional arrangements.

Source: 2012 and 2013 Commonwealth Fund International Health Policy Surveys.
Doctors’ Use of Electronic Medical Records in Their Practice, 2009 and 2012

Source: 2009 and 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Average Annual Premiums for Single and Family Coverage, 1999-2014

- Single Coverage
- Family Coverage

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Red Counties, Blue Counties
Obama Care: The Original Simple Version

• Coverage Expansion to 30 million people by 2015 on
  – 15 million through Medicaid Expansion
  – 15 million through subsidized health insurance exchanges

• Regulation of health insurance practices
  – Guaranteed issuance
  – Individual Mandate

• Paid for by supplementary Medicare Tax on $250K+ earners and “voluntary” taxes on healthcare stakeholders

• Promising pilots and processes for reimbursement reform
  – Patient Centered Medical Homes
  – Accountable Care Organizations
  – Innovation Center at CMS

• The Cadillac Tax
NOTES: *AR and IA have approved waivers for Medicaid expansion; MI has an approved waiver for expansion and plans to implement in Apr. 2014. NH passed legislation approving the Medicaid expansion in March 2014; the expansion will start July 1, 2014. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. IN and PA have pending waivers for alternative Medicaid expansions. These states along with MO, VA, UT have been classified as Open Debate on the Medicaid expansion decision.

The Not-So-United States Of Obamacare

Polls show the Affordable Care Act is covering previously uninsured people across the country. But the effect varies widely from state to state. According to a new Gallup survey, states that embraced Obamacare have seen bigger decreases in their uninsured rates than those that resisted the law.

Change in uninsured, 2013 to midyear 2014 (percentage points)

Source: Gallup

THE HUFFINGTON POST
The Work

• Centrality of Clinical Integration
• Health IT as platform not panacea
• Learning to live on Medicare
• Managing Business Model Migration
• Building a culture of Quality and Accountability
  – “We have the anatomy of an Accountable Care Organization but none of the physiology”
US Rural Populations have Lower Income

Figure 1: Rural and metropolitan families have differences in family income

<table>
<thead>
<tr>
<th>Family Income as % of FPL for Nonelderly Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>400%+ FPL</td>
</tr>
<tr>
<td>25%</td>
</tr>
<tr>
<td>100-400% FPL</td>
</tr>
<tr>
<td>50%</td>
</tr>
<tr>
<td>&lt;100% FPL</td>
</tr>
<tr>
<td>25%</td>
</tr>
<tr>
<td>Metropolitan</td>
</tr>
<tr>
<td>400%+ FPL</td>
</tr>
<tr>
<td>36%</td>
</tr>
<tr>
<td>100-400% FPL</td>
</tr>
<tr>
<td>43%</td>
</tr>
<tr>
<td>&lt;100% FPL</td>
</tr>
<tr>
<td>21%</td>
</tr>
</tbody>
</table>

NOTE: Undocumented immigrants are excluded from income analysis. In 2012 the federal poverty level was $19,790 for a family of three.
US Rural Non-Elderly more Dependent on Public Coverage

Figure 2

Rural residents were more likely to have public coverage and less likely to have ESI than metropolitan residents


* - the difference between rural and metropolitan groups is significant at the 0.05 level for this coverage category.
US Rural Population are Disproportionately in Non-Expansion States

Figure 3
Uninsured individuals in rural areas are disproportionately likely to live in states that are not expanding Medicaid

- Total: 47.3 Million Uninsured
- Rural: 7.3 Million Uninsured
- Metro: 40.0 Million Uninsured

% living in Non-Expansion States:
- Total: 48%
- Rural: 35%
- Metro: 50%

% living in States that are Expanding Medicaid:
- Total: 52%
- Rural: 65%
- Metro: 50%


NOTE: “States expanding Medicaid” includes the 25 states and the District of Columbia expanding Medicaid as of March 1. “States not Expanding” includes 25 states that are not expanding as of March 1, some of which may be considering expansion in the future.
US Rural Population more Likely to be in the Coverage Gap

Figure 4
Uninsured rural residents are more likely than metropolitan residents to fall into the “coverage gap”
Coverage eligibility levels among nonelderly uninsured residents

- Rural:
  - Eligible for Tax Credits: 37%
  - Eligible for Subsidy-level Income: 13%
  - Eligible for Medicaid: 11%
  - Ineligible Immigrant: 6%
  - In The Coverage Gap: 15%
  - Medicaid-Eligible Adult: 18%

- Metropolitan:
  - Eligible for Tax Credits: 32%
  - Eligible for Subsidy-level Income: 15%
  - Eligible for Medicaid: 11%
  - Ineligible Immigrant: 14%
  - In The Coverage Gap: 9%
  - Medicaid-Eligible Adult: 19%

7.4 million uninsured Non-MSA residents
40.2 million uninsured MSA residents

SOURCE: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey. See Methods for more details. Tax credit eligibility does not account for offers of ESI.
Low Income Residents in Non-Expansion States strongly favor Medicaid Expansion

<table>
<thead>
<tr>
<th>Survey Respondents’ Awareness Of And Attitudes Toward Affordable Care Act (ACA) Coverage Expansion, November And December 2013</th>
<th>Arkansas</th>
<th>Kentucky</th>
<th>Texas</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favor Medicaid expansion</td>
<td>83%</td>
<td>83%</td>
<td>79%</td>
<td>0.21</td>
</tr>
<tr>
<td>Heard or read that state will offer new Medicaid expansion in 2014</td>
<td>35</td>
<td>33</td>
<td>31</td>
<td>0.49</td>
</tr>
<tr>
<td>Heard or read that state will offer new financial assistance to purchase private health insurance in 2014</td>
<td>25</td>
<td>33</td>
<td>31</td>
<td>0.03</td>
</tr>
<tr>
<td>Believe that you’d be subject to a fine if you do not have health insurance in 2014</td>
<td>62</td>
<td>61</td>
<td>49</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**Source:** Authors’ analysis of survey data of 2,864 low-income adults (ages 19–64) in Texas, Arkansas, and Kentucky. **Note:** p values are for significance in differences across states.
Payment to Cost Ratio (Illustrative)

Source: Morrison Estimates, in other words a good guess
Payment to Cost Ratio (Illustrative)

Source: Morrison Estimates, in other words a good guess
# US Critical Access Hospitals
## Financial Indicators Report, 2011

### Selected Financial Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin</td>
<td>0.68%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>69.15</td>
</tr>
<tr>
<td>Outpatient Revenues/ Total Revenues</td>
<td>73.09%</td>
</tr>
<tr>
<td>Medicare Inpatient Payer Mix</td>
<td>73.25%</td>
</tr>
<tr>
<td>Medicare Outpatient Payer Mix</td>
<td>37.40%</td>
</tr>
<tr>
<td>Average Age of Plant (Years)</td>
<td>10.00</td>
</tr>
<tr>
<td>FTEs per Adjusted Occupied Bed</td>
<td>5.78</td>
</tr>
<tr>
<td>Average Daily Census Swing-SNF Beds</td>
<td>1.60</td>
</tr>
<tr>
<td>Average Daily Census Acute Care Beds</td>
<td>3.74</td>
</tr>
</tbody>
</table>
Rural Health Landscape

• Rural population is 20% (but 12% is adjacent to urban areas and only 2% of population in remote rural areas)
• Rural hospitals are one third of total but only 12 % of national hospital spending
• Critical Access Hospitals key policy
  – Less than 96 hour stay
  – 25 Beds or less
  – 35 miles from another hospital (15 miles in some cases)
Rural Health Challenges

• Rural economy has few large employers
• Dominated by public coverage
• Higher health needs: sicker, older and more chronic conditions
• Difficulty attracting providers especially specialists, mental health providers and emergency responders
• Sub-optimal in scale both clinically and financially
• Quality of care differentials
• Aging plant and equipment
• Access to Capital
• Implementing Health Information Technology
• Measuring Quality with small numbers
• A cost based system in a value based world
• Can’t be: “Send Checks and leave us alone”
Reinventing Rural Health

• Regional Integrated Systems
  – Avera, Mayo, Trinity
• High-Tech Rural Ambulatory Centers
  – Kaiser Hub as example
• Rural community-based continuum of care centers for the chronically ill
• Referral Platforms
Rural Reinvention: Some US Examples

• Regional Quality Improvement Initiatives: e.g. Michigan, Iowa, Mississippi
• Coordinated Care Organizations (CCOs): e.g. Oregon
• Rural IT Initiatives: e.g. Othello Community Hospital in Washington State
• Workforce Training: e.g. WWAMI in Pacific Northwest based out of University of Washington, or University of Kansas establishing rural branch
• Community Health Integration: e.g. Frontier Health in Montana or Rural Health Integration Project in Wisconsin

Source: AHA Trendwatch 2011
Reinvention Principles

• Imaginative use of contemporary information and communications technology
• Regionalized quality improvement initiatives
• Payment Reform (toward fixed global budgets/capitation with performance indicators and away from cost plus or FFS)
• Rationalized deployment of clinical technology and human resources
• New Partners
• New Thinking
Figure 1 - Core Health Hub Services with Contracted Health Services and Community Partnerships

**Primary Care**
- Multi-disciplinary Care Team
- Chronic Disease Management
- Health Promotion and Preservation

**Emergency, Inpatient and Ambulatory Care Including**
- Complex Continuing Care beds
- Rehabilitation services
- Outpatient Clinics
- 24/7 Emergency Room or Urgent Care

**Mental Health and Addictions**
- Access Specialty Beds
- Community Support Services

**Home and Community Long-Term Care (LTC)**
- LTC Facility Beds
- Assisted Living
- Community Support Services
- Professional Homecare Services

**Contracted Health Services**
- Public Health
- Ambulance Service

**Community Partnerships**
- Social Services
- Recreation
- Education
Ontario Examples on the Right Path

• **Governance**
  – Steering Committees e.g. Dryden Regional Health Center
  – Collaboratives e.g. Winchester Health

• **Partnerships**
  – Community e.g. Deep River
  – Care Partners e.g. Arnprior Regional Health, St Francis

• **Integration**
  – Continuum of Care e.g. Hopital de Mattawa
  – Focus on Palliative Care and Chronic disease management e.g. Campbellford
  – Integration under one administration e.g. Espanola

• **Leverage Technology and Telehealth**
  – e.g. Weeneebayko Area Health, Wilson Memorial and Marathon
Triple Aim

- Better Health
- Better Health Care
- Lower Per Capita Costs
Triple Aim

- Better Health
  - Big Data
    - Data Analytics and Predictive Modeling
    - Social/Community Support
    - Transportation/Housing
    - Priority Setting
    - “The Mediterranean Diet”
  - Delivery Redesign
  - Scope of Practice
  - Lowest Cost Site of Care
  - Telehealth
  - Digital Substitution
  - Self-Care
  - Palliative Care

- Triple Aim
  - Information
  - Incentives
  - Integration
  - Integrity

- Better Health Care
  - Transparency
  - CQI/Lean
  - Shared Decision-Making
  - Standardization
  - Clinical Guidelines and CarePaths
  - Patient Experience

- Lower Per Capita Costs
Massively Coordinated Care

• The 5/50 Problem
  – 5% account for 50% of spending
  – 1% account for 20%
  – Bottom 50% account for about 2%

• Big Data meets Mobile Apps

• New Thinking
  – Care More
  – Hot Spots
  – The Assistant City Manager

• Meet patients and populations in their lives
  – More like social work than medicine
The Truck and the Refrigerator
Key Issues to Resolve in Rural Ontario

• Hubs have real promise so go for it
• Experimentation is fine but standardization on best practice would be even better
• Identify the value of relationships with the bigger institutions: Independence is overrated
• Decide on how much financial risk you can take
  – Supplementary P4P or PCMH additional funding
  – Regional Capitation
• Don’t forget quality measurement and transparency
• Pursue the Triple Aim
Summary

• Health Reform will expand coverage but payment rates and coverage levels won’t be rich on a per case or per capita basis
• No matter what there will be huge pressure on the rural health delivery system to improve value performance
• Health system leaders can make a difference and meet any future by improving performance and developing a new math for the delivery system
• The Delivery System must be transformed or it will be done for you by larger outside forces
• Rural healthcare has a unique opportunity to reinvent itself for the benefit of the community