American Hospital Association

FROM VOLUME TO VALUE: TOWARD THE SECOND CURVE

A Network Affiliation that Preserves Independence

Grinnell Regional Medical Center, Iowa

As the transformation of the nation's health system begins to take shape, hospitals and health systems will find themselves more accountable for patient outcomes, patient experience, cost of care, and population health. To be successful, organizations will need to transition from volume of services and demonstrate their value to their patients and the communities they serve.

Grinnell Regional Medical Center (GRMC), in Grinnell, Iowa, is a 49-bed private, non-profit hospital, with a medical staff of about 50 physicians and advanced practice professionals. GRMC serves about 40,000 people in three counties with three rural health clinics plus another partnered clinic. In addition, Postels Community Health Park houses GRMC's integrated medicine center, physical therapy, dialysis, and a full service fitness and wellness center. The Light Center for Community Health houses the Community Care Clinic for uninsured and underinsured residents as well as home health, hospice, and public health services.

GRMC has embarked on an affiliation with Mercy Health Network, Des Moines, Iowa, and is part of the University of Iowa Health Alliance in Iowa City. GRMC wants to preserve local control, but acknowledges the need to partner. In addition, GRMC must integrate its physicians and manage its population's health if it hopes to expand on its experience with its 900-member self-funded employee health plan, and extend it to community employers while participating in the Iowa Consumer Operated and Oriented Plans (CO-OP) and state health insurance exchanges.

Mercy HEALTH NETWORK

FINDING A PARTNER

GRMC has a volunteer board of directors. The board spent a year studying networks, and early in this process recognized the importance of partnering to tap into new resources and achieve savings through economies of scale, benchmarking, best practice sharing, and participating in affinity groups. More recently, there has been a focus on preparing for value-based care.

The board published a request for proposal. After a thorough review process, the board opted to affiliate with Mercy Health Network (MHN) in 2009. MHN was founded in 1998 under a joint operating agreement between two of the largest Catholic, not-for-profit health organizations in the United States: Catholic Health Initiatives (CHI), based in Denver, Colorado, and CHE / Trinity Health, based in Novi, Michigan.

As a network affiliate of MHN, GRMC pays an annual fee and is able to access many of the network benefits while still preserving its independence. Its “affiliate” status means that GRMC is neither owned nor managed by the network.

“Given the massive changes that are going on in health care now, I can’t imagine not being part of a network or system,” Linden says. “GRMC’s path to identifying a partner was a complex and thoughtful process.”

The path toward integration and transformation did not end there. In June 2012, four of Iowa’s premier health care organizations announced the creation of the University of Iowa Health Alliance (UIHA), which recently added a fifth member. UIHA comprises more than 58 hospitals, including GRMC, and more than 175 clinics. The UIHA consists of MHN; Genesis Health System, Davenport, Iowa; Mercy Care Service Corporation, Cedar Rapids, Iowa; Wheaton Franciscan Healthcare, Waterloo, Iowa; and the University of Iowa Health Care, Iowa City, Iowa. The alliance creates a platform for sharing expertise, selected support services, and information technologies needed to succeed in the emerging accountable care systems and payment programs.

CLINICAL INTEGRATION

With partnerships in place, GRMC moved toward the next phase of integration. In Grinnell about 50 percent of the providers have employment agreements with GRMC. The other 50 percent are in private practice, mostly small group practices. To move to value-based care, GRMC needed to form a clinically integrated network.

In 2013, GRMC established a clinically integrated network steering committee comprising six board members, six physicians, two advanced practice providers, and several administrators. The committee was charged with recommending a strategy for developing a local network.

With guidance from MHN and the steering committee, GRMC dedicated numerous meetings with its physicians to the process of integration while the board discussed the topic at nearly every meeting. In the end, the committee discovered that there was likely no scenario where all the providers would come together under one balance sheet, given the clear desire for many of the physicians to remain in private practice.

In December 2013, GRMC established a limited liability corporation called The Grinnell Clinically Integrated Network (CIN), LLC. Through the network, physicians can facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused. The

new network's board met for the first time in February 2014 to organize its subcommittees, including governance, clinical standards and protocols, credentialing, and contracting. The local CIN allows for connection to the broader CIN under development by UIHA.

TOWARD THE SECOND CURVE

The next phase of the GRMC integration and transformation strategy meant getting closer to the premium dollar. Using its own self-funded health plan of more than 900 employees and family members, GRMC decided that 2014 would be an experimental year – during which GRMC would endeavor to improve quality and reduce costs for its own health plan. The focus would be identifying at-risk patients and organizing its medical staff to use standards and accepted clinical protocols that include evidence-based best practices, especially for managing chronic disease. Linden believes that after a year of experimentation, "GRMC will be more prepared to take on some risk in statewide initiatives and potentially with some other self-funded plans in the community."

UIHA was selected as the narrow network provider for CoOportunity Health, one of the largest and fastest growing CO-OPs in the nation. CoOportunity Health teamed up with Health Partners of Minneapolis to help establish this start-up insurance company. Together they are collaborating to introduce unique health plan products for Iowans on the new Iowa Health Insurance Marketplace. These open-access, tiered-benefit design plans provide significant consumer savings when UIHA facilities and clinicians are used for services. GRMC, as a partner with UIHA, will serve patients covered under these plans in the future.

GRMC agreed to use CoOportunity Health as its partner for its self-funded plan. During 2014, CoOportunity/Health Partners will embed a health coach for GRMC employees and dependents to help identify patients with chronic disease such as uncontrolled hypertension or diabetes. Health coaches will interact with the member, the primary care provider, and the clinically integrated network to see if it has data and means necessary to improve overall value of health care.

By using its own health plan as a model, GRMC then can share its experience with other self-insured employers in the community and can highlight its partnerships with other organizations that provide services that GRMC does not. "It makes sense for employers and providers to work together," Linden says. "And it makes sense for payers to be at the table if they are willing to be transparent about administrative costs and bring the value they can with data management and claims management expertise. This is exactly what CoOportunity Health is doing with GRMC."

HEALTH INFORMATION AND MINING DATA

Many rural organizations, including GRMC, are looking to system relationships, especially for IT support. Data is critical to the ability of GRMC to manage its self-funded plan and eventually partner with employers and others. “Our community is a mix of partnered providers and those in private practice, and they need the data to manage care,” Linden says.

Achieving quality standards and preferred outcomes requires data mining and the use of analytics. Smaller hospitals lack the expertise, resources, and capacity to enter into contracts with large data mining companies and data warehouses, and rarely have staff available to mine data or analyze it. For GRMC, the relationship with MHN will help.

Data mining is more affordable tapping into the MHN and UIHA, compared with GRMC doing data mining on its own. In addition, the four founding partners of UIHA have agreed to use the same data warehouse for predictive modeling of population and patient health.

UIHA has also chosen a software program that mines social data to evaluate whether patients have the social support necessary. It allows GRMC to tailor services to each patient – pick up prescriptions, coordinate for home health nurses, schedule transportation, etc. “Once again, utilizing the power of skill and scale, we can afford our share of the data capabilities we need locally that we would not afford on our own,” Linden says.

CONCLUSION

With the Grinnell Clinically Integrated Network focused on the care locally and in a structure that will allow connection into the larger statewide MHN and UIHA, the strategy is to ease into value-based care over the next 12-24 months. Managing the health of the population is a key to future success. With a manageable number of clinical professionals in a smaller market area, GRMC can work directly with its providers and ask them what they need to improve outcomes and make more effective decisions about the care being provided to at-risk patients.

However, wringing out costs and deferring admissions place GRMC in the precarious gap between volume- and value-based services. Linden acknowledges that the strategy is going to mean less volume. “But when you lose money on almost every patient now, more volume doesn’t help you much,” Linden says. “Once we have a product where we can deliver value at lower cost and be able to have some margin by getting closer to the premium dollar, we’re going to want all the volume we can get of that. But we have to keep working on getting there.”