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Crossing the Uncharted Seas of Transformation

How Innovative Rural Hospitals Will Survive & Thrive in the New World of Healthcare

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caravanhealth

2014

2015

2016

www.NationalRuralConsortium.org

30 Hospital CFO's In Charge

Stop = 0
Slow Down = 0
Keep Going = 30
Best Year Ever = 6

They also:

- **Reduced spending by 3%**
- **Improved access to care**
- **Increased local utilization**
- **Improved quality scores**
- **Decreased Outmigration**

WHAT, ME WORRY?

MAD

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The Shift to Value

Volume	Value
Pay Per Unit	Outcomes/Quality
Reactive	Proactive
Full Hospitals, Lots of Patients, Focus on Illness	Prevention, Wellness, Manage Health
Provider/Facility Focused	Patient Focused
Little Coordination	Clinical Integration
Payors Take All Risk	Providers Take Some Risk
Variance in Practices	Evidence Based Practices

New Payment Models – Provider Choices

OR

CPC+

MSSP Tracks 2&3

Next Gen ACO

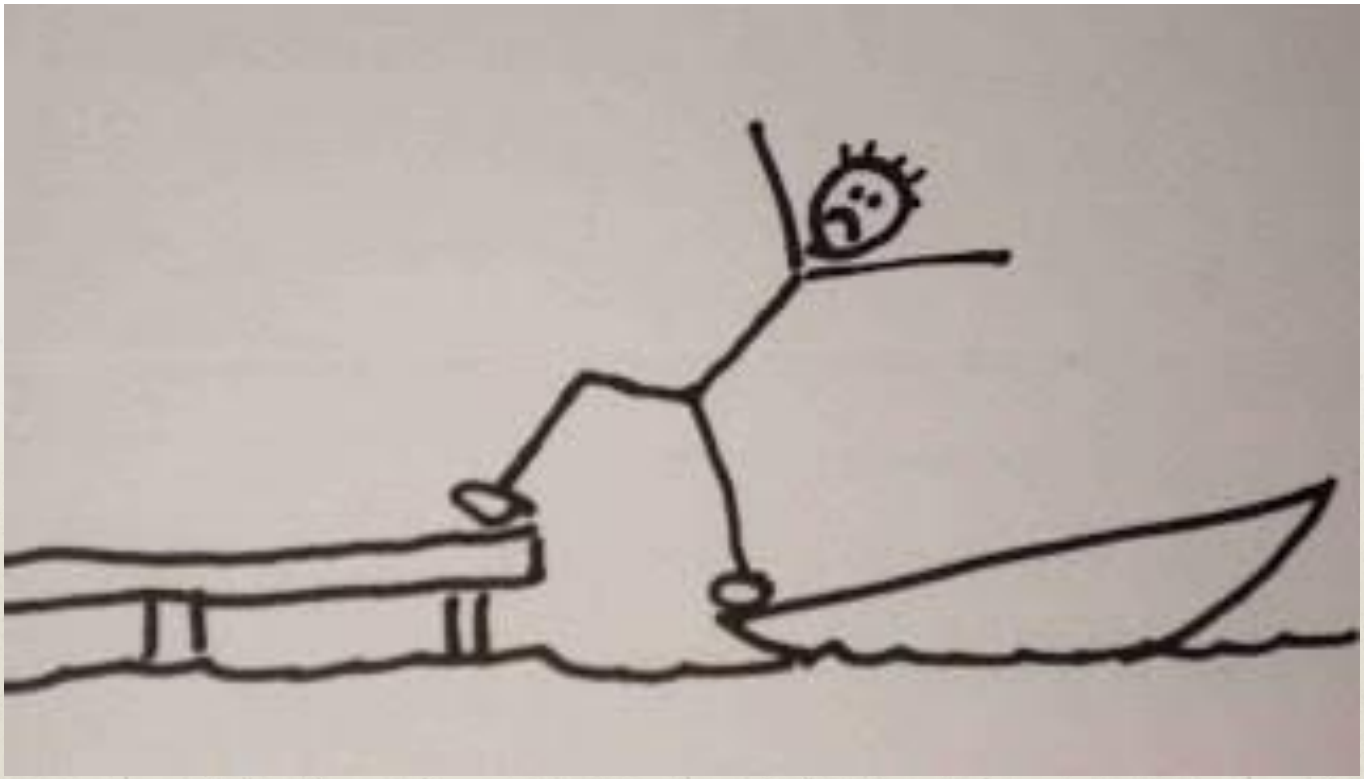
Oncology Care Model

Comprehensive ESRD

Merit-Based Incentive Payment System

Qualifying Advanced Payment Models (APMs)

Rural Providers & Value: One foot on the dock and one on the Boat



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The Speed of Change is Increasing

In January of 2015, Secretary Burwell Announced goals for:

- 30% of all Medicare provider payments to be in **alternative payment tied to value** by 2016.
- 50% by 2018
- Virtually all Medicare fee-for-service **payments to be tied to quality and value;** at least 85% in 2016 and 90% in 2018."

Challenges for Rural Hospitals

- 76 Rural Hospital Closures since 2010
- Many rural states did not expand Medicaid
- Stand alone health systems
- Serve declining populations
- Limited managed care and IT expertise
- Independent provider mentality (change resistant)
- "Sick" care not "health" care orientation
- Difficult to recruit and retain physicians
- Community boards - dedicated but may not know healthcare
- **High turnover; CEO tenure averages less than 3 years**
- **Limited Financial & Human Resources**

The sign placed outside Pungo Hospital when it closed on July 1. Eric Byler/StoryofAmerica.org

Source: America.Aljazeera

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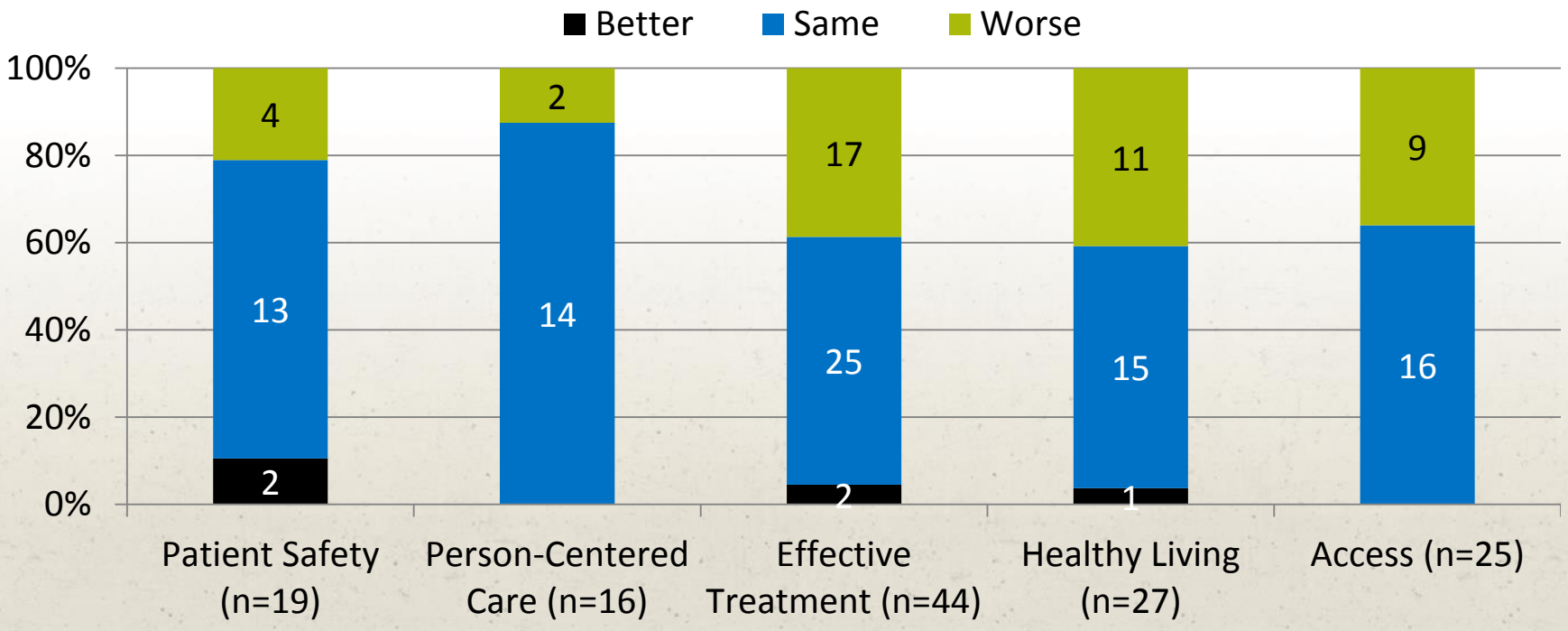
Current State in Rural: Disparities in Quality of Care Measures for Noncore Areas by 4 NQS Priorities and Access



Key: n = number of measures.
Better = Population received better quality of care than reference group
Same = Population and reference group received about the same quality of care
Worse = Population received worse quality of care than reference group

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Disparities in Life Expectancy Between Rural and Urban are Increasing Rapidly

- Due primarily to disparities for **heart disease, diabetes, COPD, lung cancer, stroke, suicide and accidents.**
- Rural providers are about **20% less likely to provide the standard of care for preventive care, diabetes, CHF, COPD.**
- Less than ½ routinely perform Annual Wellness Visits, obesity counseling, smoking cessation, advanced care planning, etc.

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How Does This Affect Rural?

- Objective data suggests we are not high value providers.
- Unless we change, market forces will **drive** patients to other providers.
- We have to find a way to participate in ambulatory quality programs, even though we don't have to yet.

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Rural Strengths

- Passionate about serving their community
- Fixed population served “cradle to grave”
- Increased local volume reduces per capita costs
- Local brand is typically strong
- Major economic driver
- Nimble

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Changing the Delivery System

The movement from Volume to Value requires a **change in the delivery system** as well as in the payment model.

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5 Actions Rural Providers Should be Taking Today

Prevention:

1. **Set up a Care Coordination Programs**
2. **Perform Annual Wellness Visits on 50% of Patients** (AWV)
   - Advanced Care Planning
   - Behavioral Counseling
   - Depression Screening
3. **Provide Integrated Behavioral Health**

Coding:

4. **Improve Hierarchical condition coding** (HCC)

Quality:

5. **Improve Process & Pre-visit Planning**

1. Set Up a Care Coordination Program

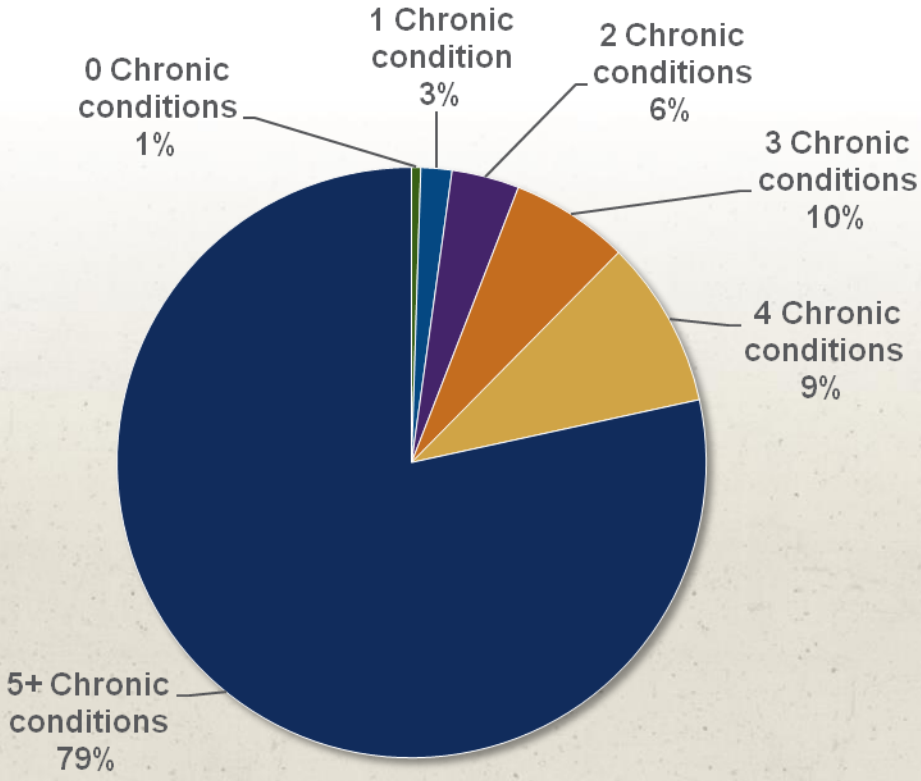
The Core of Transformation

- At risk patients with 2+ chronic conditions expecting to last for the following 12 months or until death of the patient
  - Nurse-driven model
  - 20 minutes per month
  - 24/7 access to care team with access to electronic care plan
- Bill approx. $42 per enrolled patient per month
- **Full case load + ~200 patients = ~$100,000 revenue**
- **Shown to reduce costs by 20-60%** (Commonwealth Fund)

Two-Thirds of Medicare Spending Is for People With Five or More Chronic Conditions

- Ninety-eight percent of Medicare expenditures involve individuals with multiple chronic conditions.

Percentage of Medicare Expenditures



Source: Medicare Standard Analytic File, 2007

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2. Perform Annual Wellness Visits (AWV)

Comprehensive review of patient's medical history & Creates a plan for their health & wellness

- Establishes relationship with primary care provider (PCP) or team
- Improves scores on CMS quality measures (11 measures)
- Health Risk Assessment

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2. Perform Annual Wellness Visits (AWV)

- PHQ-9 Depression Screening
- Mini Cog Exam (tests for Alzheimers)
- Fall Risk Screening
- Advanced Care Planning
- Public health screenings
- Identifies at-risk patients for referral to care coordination

AWV – Optional Services

HCPCS Code	Description
G0447	Behavioral Therapy, Obesity
G0437 G0436	Tobacco-Use Cessation Counseling Services
G0444 3725F	Screening for Depression in Adults
G0328	Colorectal Screening
G0108	Diabetes Self-Management Training
1100F	Fall Risk Screening
4037F	Influenza Immunization
4040F	Pneumococcal Immunization
4050F	Hypertension
99498	Advanced Care Planning

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Check with your MAC re: payments

2. For Patients, the AWV

- One hour per year **extends life and reduces disabilities**.
  - Increases compliance with preventive care
  - Detects emerging chronic conditions
  - Detects functional decline
  - Detects changes in family/social support
  - Detects depression and substance abuse
  - Detects vision and hearing loss
- Appropriate referrals and follow up **reduces progression of diseases** and improves outcomes

Case Study: Hattiesburg Clinic

- Started Slowly in 2012
- Nurse-Driven Model for AWV's
- Supports 22+ Nurses in Multi-Site Clinic (8 AWVs + CCM)
- Physician Engagement – Steering Committee
- Patient Engagement & Education
- Improved Quality Scores & Patient Compliance
- Wellness & Prevention Focus

Case Study: Hattiesburg Clinic

Pro Forma

- RN Average Salary ($25/hr + benefits @ 25%): $65,000
- Nurse sees average 6 patients/245 working days
- Total visits/year potential: 1470
- Average AWV Reimbursement Per Visit $137.51

- **$202,700 Potential Revenue/RN**

AMGA 2014

Appropriate Revenue & Effective Outcomes for Patients

Wellness Visits Drive Quality Up

		2014			2015			
Domain	Metric Name	Eligible	Measure Met	Performance	Eligible	Measure Met	Performance	Change
At-Risk Population Coronary Artery Disease	CAD-2 Lipid Control**	11	9	81.82%				
At-Risk Population Coronary Artery Disease	CAD-7 ACE or ARB with Diabetes or LVSD	7	5	71.43%	7	3	42.86%	-28.57%
At-Risk Population Coronary Artery Disease	CAD-Composite	11	7	63.64%				
Care Coordination/Patient Safety	CARE-1 Medication Reconciliation**1	2	2	100.00%	7	5	71.43%	-28.57%
Care Coordination/Patient Safety	CARE-2 Fall Screening	5	1	20.00%	11	10	90.91%	70.91%
At-Risk Population Depression	Depression remission 12 months				4	0	0.00%	
At-Risk Population Diabetes	DM-7 Eye Exam				3	1	33.33%	
At-Risk Population Diabetes	DM-13 High Blood Pressure Control**2	4	2	50.00%				
At-Risk Population Diabetes	DM-14 LDL-C Control in Diabetes	4	2	50.00%				
At-Risk Population Diabetes	DM-15 Hemoglobin A1c Control	4	0	0.00%				
At-Risk Population Diabetes	DM-16 Daily Aspirin or Antiplatelet with IVD	1	1	100.00%	10	7	70.00%	-30.00%
At-Risk Population Diabetes	DM-17 Tobacco Non-Use**2	4	3	75.00%	12	10	83.33%	8.33%
At-Risk Population Diabetes	DM-2 HA1c Poor Control**3 (lower score)	4	1	25.00%	4	2	50.00%	25.00%
At-Risk Population Diabetes	DM-Composite	4	0	0.00%				
At-Risk Population Heart Failure	HF-6 Beta-Blocker Therapy for LVSD	5	4	80.00%	7	7	100.00%	20.00%
At-Risk Population Hypertension	HTN-2 Controlling High Blood Pressure	15	9	60.00%	9	9	100.00%	40.00%
At-Risk Population Ischemic Vascular Disease	IVD-1 LDL-C Control**	9	4	44.44%				
At-Risk Population Ischemic Vascular Disease	IVD-2 Use of Antithrombotic	9	9	100.00%				
Preventative Health	PREV-05 Breast Screening	32	20	62.50%	40	40	100.00%	37.50%
Preventative Health	PREV-06 Colorectal Cancer Screening	36	18	50.00%	23	19	82.61%	32.61%
Preventative Health	PREV-07 Influenza Immunization	16	3	18.75%	11	7	63.64%	44.89%
Preventative Health	PREV-08 Pneumonia Vaccination	25	9	36.00%	17	10	58.82%	22.82%
Preventative Health	PREV-09 Body Mass Index Screening	21	17	80.95%	23	17	73.91%	-7.04%
Preventative Health	PREV-10 Tobacco Use Screening	20	20	100.00%				
Preventative Health	PREV-11 High Blood Pressure Screening	36	26	72.22%	39	29	74.36%	2.14%
Preventative Health	PREV-12 Clinical Depression Screening	19	3	15.79%	16	12	75.00%	59.21%
Grand Total		**304**	**175**	**57.57%**	**243**	**188**	**77.37%**	**19.80%**

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3. Establish Integrated Behavioral Health

- Nearly half of all Americans will experience a mental health issue in their lifetime (AHA)
- Training Care Coordinators in a Behavioral Health Treatment Modality or Having Social Workers or Counselors on site
- American Psychiatric Association – Training for Psychiatrists
- **Psychiatric Collaborative Care Model** (2017 Fee Schedule)

4. Improve Diagnosis Coding to Provide Acccurate HCC Risk Scores

- Value-based payments are based on expected cost multiplied by Hierarchical Condition Codes (HCC) risk scores.
- HCC risk scores are calculated from all diagnoses listed on bills sent to CMS in the *prior* calendar year – no institutional memory.
- **Providers will be penalized for falsely low scores.**
- **DOCUMENT ALL SIGNIFICANT CHRONIC CONDITIONS ON THE BILL FOR THIS VISIT. ASK PATIENT ABOUT EACH ONE AND DOCUMENT IN SOAP NOTE. PRIORITIZE IF NECESSARY.**

5. Improve Internal Processes & Previsit Planning

- **Process & Pre-Visit Planning**
  - Workflow Redesign for Population Health
  - Access to Care
  - Same Day Appointments
  - Patient Satisfaction

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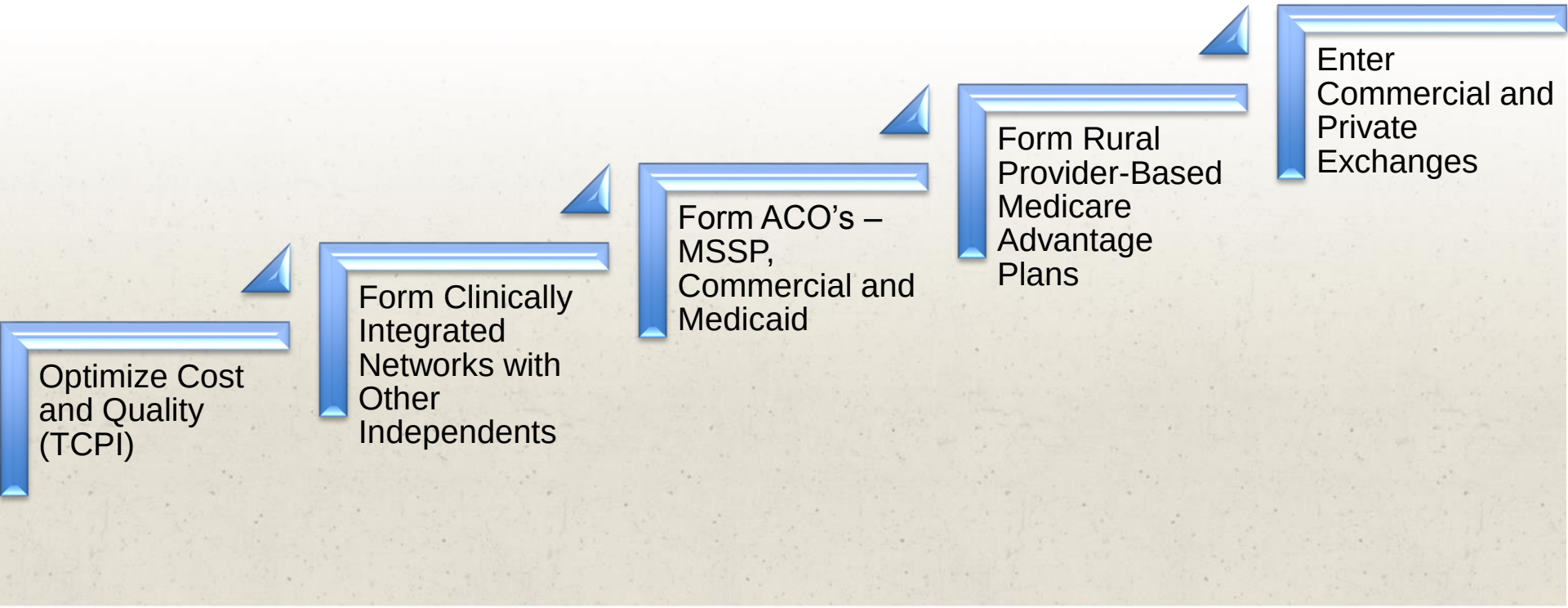
Future of Rural Healthcare Transformation



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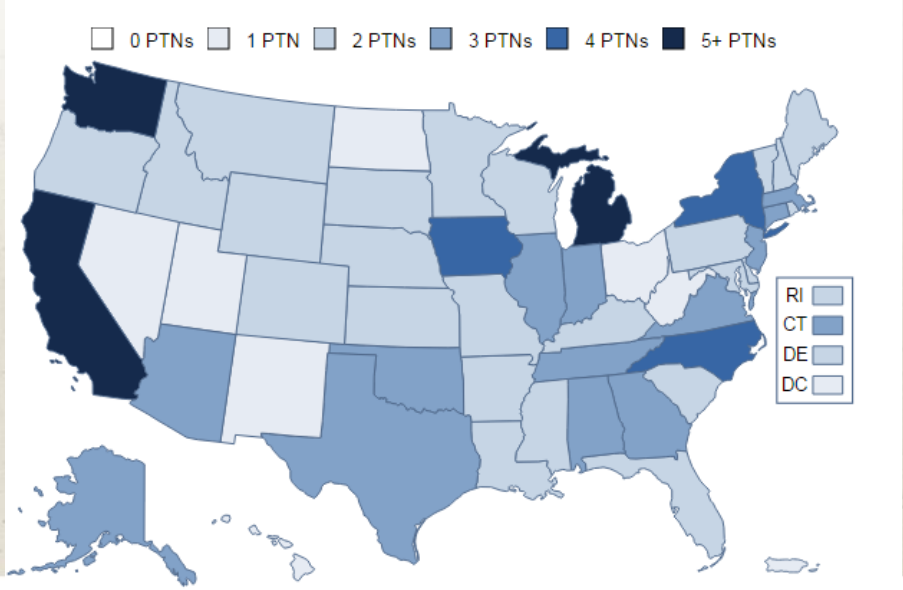
Transforming Clinical Practices Initiative (TCPI) – Resources & Technical Assistance

- **140,000 Clinicians** will Participate in 29 Practice Transformation Networks (PTNs)
- Designed to help clinicians achieve large-scale health transformation over the next 4 years

TCPi | Transforming Clinical Practices Initiative



Source: Centers for Medicare & Medicaid Services

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The NRACC
Practice Transformation Network

Establish Your Value-Based Infrastructure at No Cost.

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Questions?

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Billing for Population Health

Fee-for-Service (+$225-$300)

- Wellness Visit
- Depression Screen
- Advanced Care Plan
- Smoking Cessation
- Obesity Counseling
- Substance Abuse Intervention
- Immunizations
- + E&M visit if needed

RHC

- Can only bill All Inclusive Rate (AIR), but can add cost of staff to do work to cost report for reimbursement.
- Cannot bill for more than one visit.

FQHC (~+$60)

- Can bill for the Wellness Visit (but not for the follow up or add-ons) for 1.3416 times FQHC PPS rate (including regular visit).
- Cannot bill for separate visit

Psychiatric Collaborative Care Model

- Overcomes the lack of psychiatrists, particularly in rural areas.
- Doctors or care coordinators are trained to implement all programs with monthly consultation and review with a psychiatrist.
- More than 80 peer reviewed publications supporting effectiveness.
- New payment model will enable practices to set up program and be successful.