NATIONAL
RURAL HEALTH
RESOURCE CENTER

Flex Coordinator
Learning Collaborative
Week 2

Success In Healthcare Transformation

How Population Health can grow Primary Care

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The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

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Context

- Building on the first webinar about transformation, goals/intentions, and some mechanics
- Transformation is about Cost, Quality, and Total patient spend. What is the first step in achieving transformation?
- What are the myths about shifting Cost, Quality and Total patient spend?

Webinar Series

1. Healthcare Transformation: Understanding Payment and Delivery Reform

2. Success in Transformation: How Population Health can grow Primary Care (the leader of healthcare transformation).

3. Delivery Reform for Payment Reform: Practice Transformation

4. How to demonstrate Value: Hierarchal Condition Category Coding.

5. Return on Investment to Value Based Care

6. The Big Picture-RESULTS MATTER

Last week's recap and homework

Any thoughts or questions about Week 1 webinar?

How did the calls go with your hospitals? Did you find 5 who will collaborate with you?

What did you learn in the conversations with them about transformation?

What are we trying to accomplish

The "Triple Aim"

Better Health

Better Care

Lower Cost

Measured as the total spend on the Medicare population

How do we lower cost?

- Reduce preventable admissions
- Reduce duplications of services
- Reduce preventable ER visits

How do we increase Quality? Better Health

Fill care gaps and create access for chronically ill in the practice

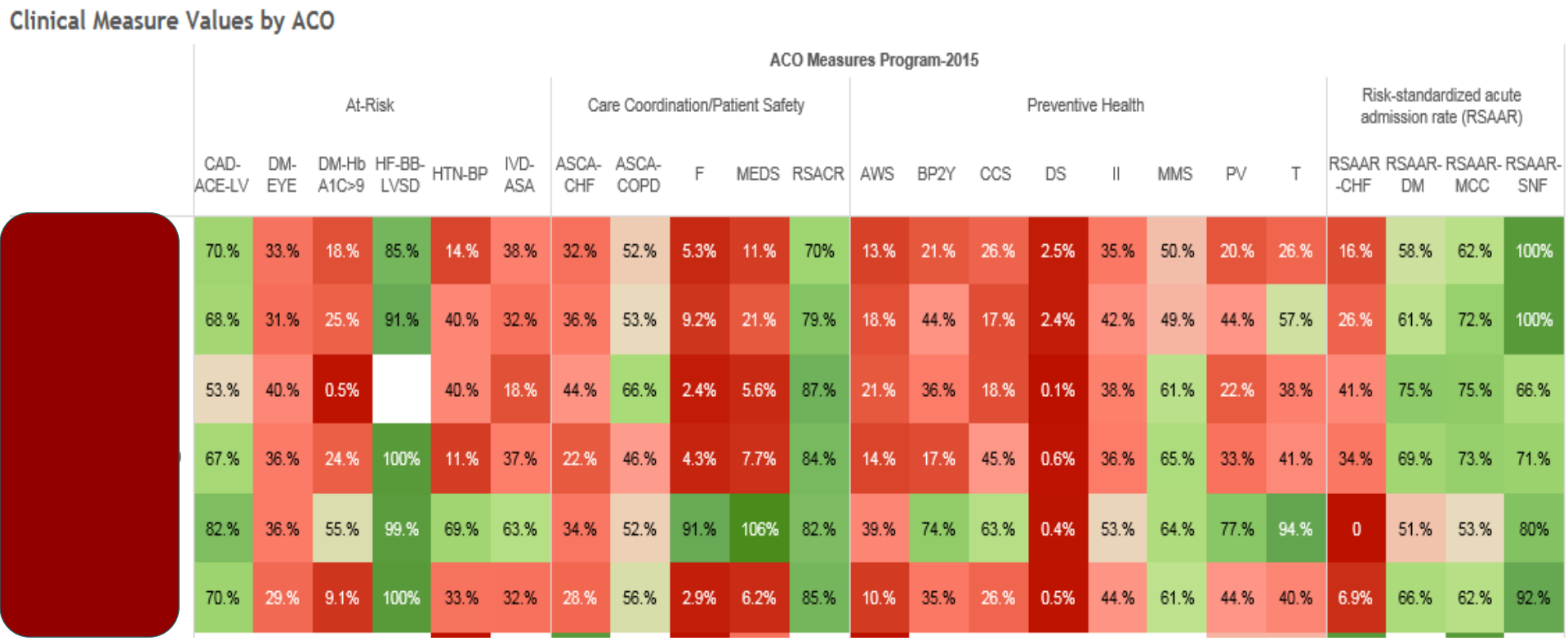
Manage the patient and disease through consistent evidence based processes

Encourage patients to participate in prevention and wellness services

How do we increase Quality? Better Care

- Provide prevention and wellness services
- Utilize new codes/services for care management
- Utilize data to inform you of population and patient needs
- Document thoroughly

Quality Varies but Problem Areas are the Same



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Deploy a Population Health program

- ***Use the prevention and wellness codes available***
  - Annual Wellness Visit
  - Care Coordination
  - Advance Care Planning, Depression Screening, Fall Risk Screening,

- ***Use nurses, (or Medical Assistant) for these services***

25% Wellness Visits=20%Improvement

		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%**

Pre-AWV

Post-AWV

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Trained Nurses Excel at Prevention

	No AWV (n=15,232)	AWV done by MD/NP (n=446)	AWV done by QM nurse (n=2,863)
Men up to date on AAA screen	70.1%	77.7%	83.8%
Women up to date on mammogram	42.2%	61.1%	74.0%
Women up to date on bone density	45.3%	63.5%	75.1%
Up to date on PCV-23 vaccine	33.4%	57.6%	58.4%
Up to date on depression screening	1.9%	3.4%	94.9%
Up to date on Health Risk Assessment	1.9%	2.0%	94.3%
Up to date on Fall Risk Screening	1.9%	2.0%	94.3%
Up to date on ADL Assessment	1.9%	2.0%	94.3%
Up to date on Smoking Cessation screen	1.9%	2.0%	94.3%
Up to date on End of Life Plan screen	1.9%	2.0%	93.8%

Source: Hattiesburg Clinic

Benefits of Population Health Programs

1. ***Build your primary care capacity***
   a. Population Health requires 1 a hour a year more in visits for every Medicare patient
   b. Care management creates the need for right time visits
   c. Wellness and prevention services builds strong relationships with all patients, not just chronically ill
2. ***Nurse led programs support increase in primary care demand***
   a. Utilize nurses and medical assistants to meet patient needs and provide additional support to providers.
   b. Physicians get more time to attend acute patient needs, and patients benefit from more attention overall
3. ***Increases revenue to support more population health staffing***

Sustainability

- It is predicted that a population health program will require an extra hour visit with each patient per year.
- 3 AWV a day will pay for a nurse
  - 200 days X $114 x 3 = $68,400
- 150 CCM patients will pay for a nurse
  - 150 Patients X CCM $61 x12 months = $77,400

Myths

- Deny access?
- Financially harmful to rural hospitals?
- Reduces inpatient admissions?
- Treat only the chronically ill?

Outreach this week

- Ask your five providers how many Medicare beneficiaries/patients they in each practice.
- Find out how many Annual Wellness Visits are performed.

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