Rural Hospital Experience: Population Health Journey

PAT SCHOU, FACHE, EXECUTIVE DIRECTOR
ILLINOIS CRITICAL ACCESS HOSPITAL NETWORK
ILLINOIS RURAL COMMUNITY CARE ORGANIZATION

Understanding “Why” Population Health

- Move to value based care as new delivery and payment system
- Accountable Care Organizations as an option
  - Provide tools, resources and support
    - Carves out your local population and the cost to provide that care
  - Principles of value based care same whether in ACO or not
- Population Health – Keeping patients locally
  - Rebuilding and/or expanding primary care and market share
  - Rural facilities = 30% of local market share all payers
  - Viability for the local community
  - Improving care for your patients

Population Health – Where do we begin?

- Sense of Urgency – “Change the Culture”
- Readiness Assessment – Resources and Commitment
  - Leadership
  - Medical Staff
  - Clinical Staff
- Hospital Operations
  - Financial Resources
  - Quality
  - Market Share
  - Data
- Community Health Needs Assessment – *What does my population look like?*
  - Community Resources…what is in place and is needed

“On the Bus”

Sense of Urgency

- Create a sense of urgency for providers and staff
- Appeal – 2020 is around the corner
  - Value based payment
  - Global budgets
  - Physician payment system change
- Rural competition – maintaining local services/market share
- Strategy and action steps to get interest, involvement and then commitment
  - If not, will not move the dial
  - Can't be "*just okay*"

Readiness Assessment – Preparing for Population Health

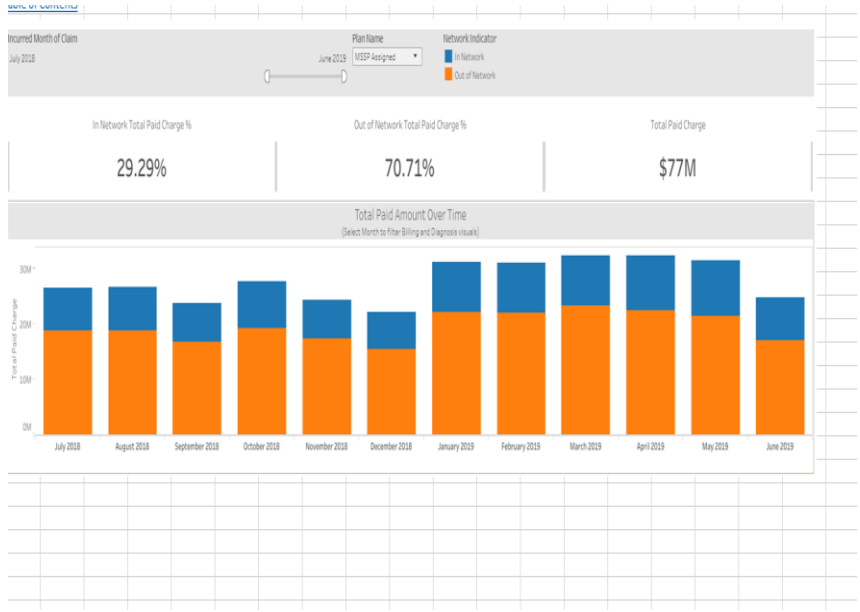
- Leadership
  - Champion to lead the change
  - Understanding your culture
  - Do I have the resources?
- Medical Staff
  - Education
  - Resources
  - Willingness
  - Practice/clinic efficiency – work flow
- Hospital Staff
  - Clinical
  - Informatics/IT system

Medical Staff Engagement - Critical

- Importance of Culture Change
- Consideration work flow/schedule – making changes
- Standards and Data Capture
  - Coding
- Patient Outcomes
- Creating change
- Telemedicine/patient engagement programs

Hospital Operations

- Finances – start simple
  - Budget dollars – staff time to make changes
  - New billing codes for care coordination/gaps in care
  - Coding and work flow analysis
- Quality
  - Inpatient and outpatient
  - Stroke, cardiac and diabetes care
  - Satisfaction surveys
- Market Share
  - In network versus out of network / all payers
- Data Smart
  - Informatics – data registries – claims information



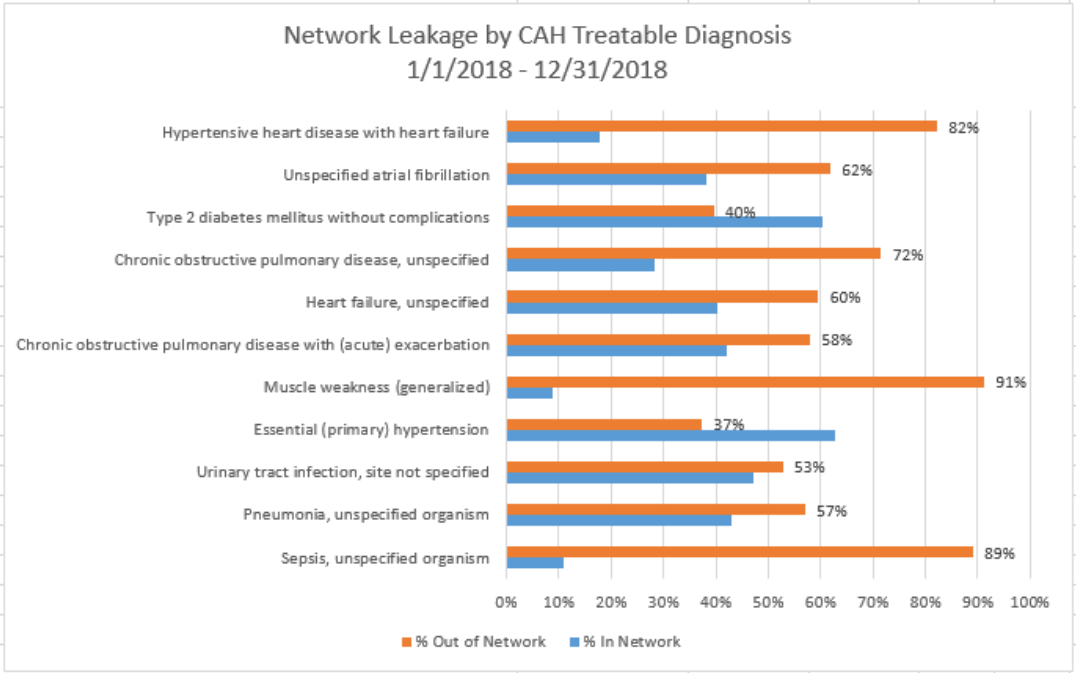
Market Share Comparison In vs Out

Data…what can you learn?

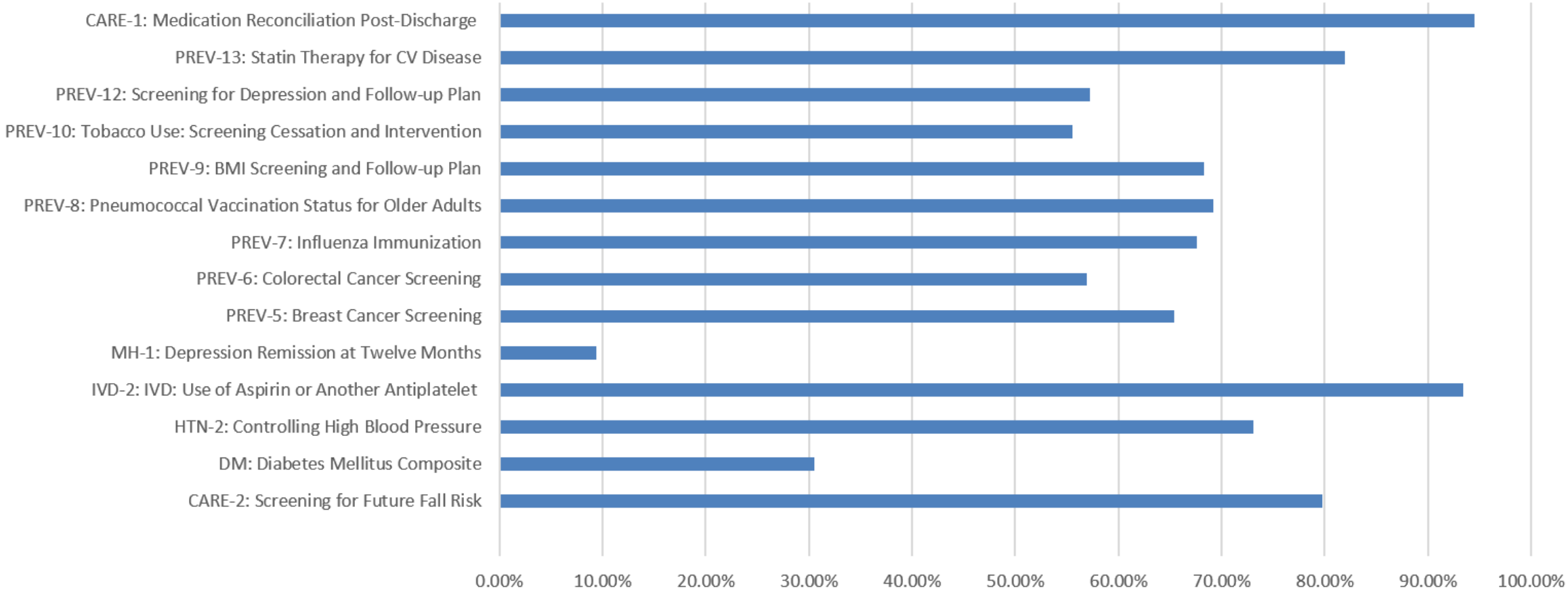
- **Cost and Utilization…access to claims very helpful**
  - Where do patients go?
  - Cost of care each Medicare visit? All settings except pharmacy
  - Comparisons with other ACOs and/or hospitals
  - Cost and frequency per beneficiary - inpatient, outpatient, primary care, ESRD, emergency department, post acute hospitalization, MRI, Cat Scans
- **Provider comparison** (medical practitioner and hospital) per tax ID/NPI
- **Coding accuracy** – diagnosis and care delivered /HCC/improve reimbursement to providers
- **Population** – diagnoses/DRGs per population
- **Preventive Care**
- **Dashboard for comparisons and reports**

Network Leakage – Opportunity "$$ that leave our hospitals"

Principle Diagnosis	In Network	Out of Network	Total Paid	% In Network	% Out of Network
Sepsis, unspecified organism	$2,625,353	$21,298,380	$23,923,733	11%	89%
Pneumonia, unspecified organism	$7,689,566	$10,194,473	$17,884,039	43%	57%
Urinary tract infection, site not specified	$5,932,307	$6,624,205	$12,556,512	47%	53%
Essential (primary) hypertension	$7,600,493	$4,535,413	$12,135,906	63%	37%
Muscle weakness (generalized)	$936,091	$9,721,726	$10,657,817	9%	91%
Chronic obstructive pulmonary disease with (acute) exacerbati	$4,470,329	$6,165,040	$10,635,369	42%	58%
Heart failure, unspecified	$3,890,473	$5,734,016	$9,624,489	40%	60%
Chronic obstructive pulmonary disease, unspecified	$1,748,393	$4,399,633	$6,148,026	28%	72%
Type 2 diabetes mellitus without complications	$3,641,667	$2,383,451	$6,025,118	60%	40%
Unspecified atrial fibrillation	$2,237,076	$3,623,511	$5,860,587	38%	62%
Hypertensive heart disease with heart failure	$685,389	$3,162,379	$3,847,768	18%	82%



Quality Performance…how we are measured?



Disease Registries – Quality Patient Care

A **disease registry** is a tool for tracking the clinical care and outcomes of a **defined** patient population. Most **disease registries** are used to support care management for groups of patients with one or more chronic **diseases**, such as diabetes, coronary artery **disease**, or asthma

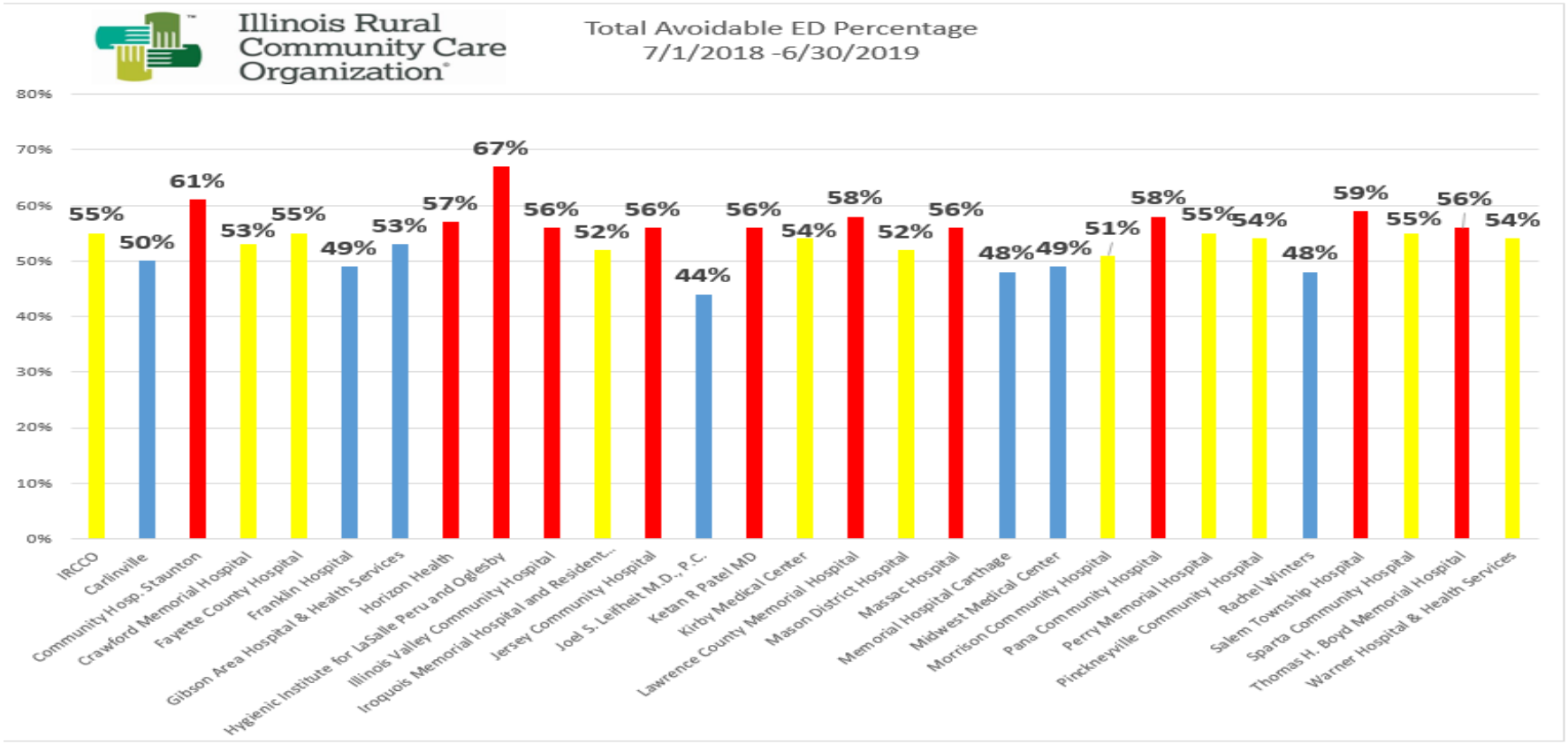
Tremendous Value - underutilized

EMRs - have them

What can the disease registry tell me?

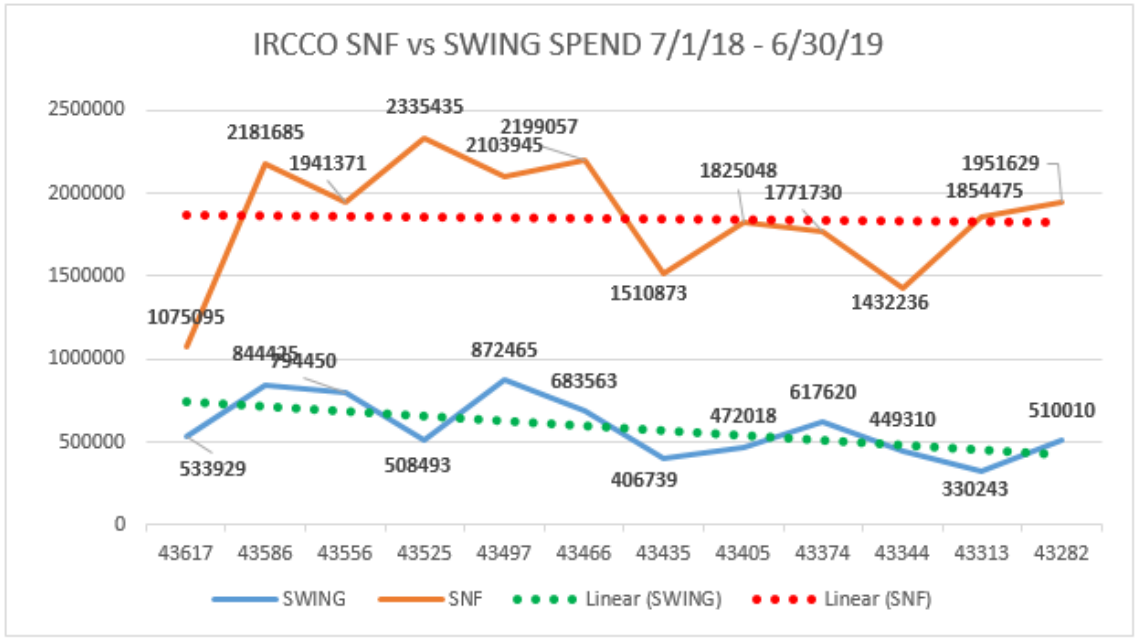
- **Clinical care parameters….B/P; A1C; medication use; # diagnoses**
- **Measures clinical compliance/performance**

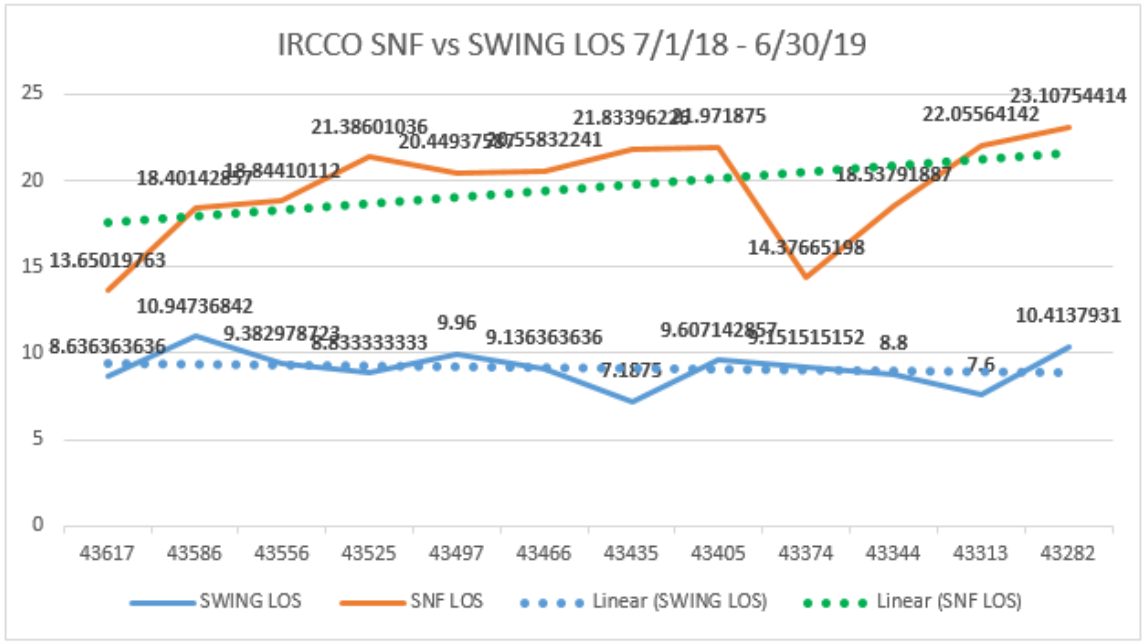
ED Utilization - How do you compare?



Skilled Care Utilization

Table of Contents





SNF spend continues to trend upward while Swing is fairly constant, with a very slight upward trend.

We are seeing a downward trend in SNF LOS with Swing staying constant.

Downstream Spend /Specialty Care

- Rural providers and practitioners have not been tracking patients leaving facility for specialty care
- Cost of complex care and specialty care >60%
- Care coordination
- Caring for the patient through the continuum
- Being the gatekeeper and research for patient and family

Community Resources and Support

- Community Health Needs Assessment…what does my community say?
- Social Services – social determinants
- Community Inventory
- Building relationships
- Emergency Medical Services
- After hours care
- Home Health
- Pharmacy…the list does on

➢ *What does rural do best? Support each other*

Princeton, IL 7800 population
my community

Okay How Do ACOs work?

1. Care Coordination
2. Data Aggregation and Analysis
3. Patient Stratification
4. Performance Measurement/Outcomes
5. Administrative/Business Management
6. Patient Engagement

How do you manage care and cost? Able to take risk?

Illinois Rural Community Care Organization (IRCCO)

- Established in 2014 as a LLC under its parent corporation, Illinois Critical Access Hospital Network
- Approved as MSSP Track 1 in 2015: 20 IL independent CAHs, 35+RHCs and 15 independent practices covering 13,000+ beneficiaries/200 + providers
  - ICAHN staff to manage
  - 9 hospital CEO board of managers
  - Received AIM funding in 2016
  - Joined IL Blue Cross Blue Shield Shared Savings Program in 2017
- Approved for 2nd term MSSP Track 1 in 2018: 25 CAHs and small rural PPS facilities/28,000 beneficiaries
  - In 2019, IRCCO increased Medicare beneficiaries to 44,000; BCBS to 28,000
- For 2020, IRCCO will grow to 28 IL CAHs and rural PPS facilities, 4 practices, 75+ RHCs
- Medicare MSSP program and Blue Cross Blue Shield

Why Participate in ACO? IRCCO?

MEDICARE SHARED SAVINGS/ACOS

Access to payor claims

Protection of anti-trust for sharing information for purposes of contracting and controlling costs and care

Learn about your patients and use of healthcare

Preserving your primary care

Better contracts/relationships with other providers (know information on them)

Access to shared savings

Able to move towards risk and value based care

Quality reporting – Medicare Alternative Payment Models

IRCCO

Share resources and management cost of the program; access to education and support

- Management Strategy and ICAHN Connectivity

Leverage numbers with trusted rural providers

Quality Reporting – 100% /APM

Enough pool to access commercial contracts and/or Medicaid MCOs

Identify best specialty care/better pricing

Access to claims

Population Health – Gap Care

Your Focus: How to keep Patients locally? Value of Primary Care

What do we need to do to keep patients within your practices?

- Your strategies…*patient care through the continuum*
- ACO programs – well visits, care coordination, access to data, CCM, TCM, monitoring A1C, quality reporting for success, SNF, tracking discharges and readmissions, ED utilization – other options
- System bias – growing….care should only be done there

- **In 2018, IRCCO had 28,000 Medicare beneficiaries**
  - **1400 patients consumed 80% of total spend….*where were those dollars spent?***

Working with referral centers and tertiary Care?

- ACO participants manage primary care
- Systems will manage specialty care
  - Both work together

So what have we learned – Population Health

Rural skilled care patients – care is not well coordinated

Importance of wellness – few gap care programs in place

- Rural patients are generally sicker and more chronic diseases

Can lower A1C and BP – learning disease registries

Rural providers have been behind – compete and excel

Patient engagement still difficult/not organized well enough yet

Seeing success with care coordination and improving some outcomes

- Beneficiaries can be reluctant to pay “co-pay”/poorer population

Rural people want to stay locally

Care Coordination – Still Secret Recipe

Evidence of Success…if you do that well!

- Decrease readmissions
- Improved Quality Scores
- Improved Patient Satisfaction Scores/Interviews
- Decreased ED Utilization
- Improved documentation
- Patients staying locally
- Decreasing “big is better” bias

Primary Care Management

- Patient Centered Medical Home – an example
- Evaluating your clinics and practices
- Your “hand off” to primary care practice
  - See you in 7
- Work flow and using your tools and staff
- Patient engagement
  - Mobile apps/chronic care management/disease clinics
- Quality documentation/EMRs

Has IRCCO achieved Shared Savings?

No…but

- We have increased coding scores to better reflect chronic diseases
- We have put systems in place for population health
- We have implemented care coordination in our communities
- We have assisted our hospitals increase patient satisfaction scores and market share
- We have raised awareness on costs and decreased ED utilization

Ended FY 2018 $12,452 as our historic benchmark and IRCCO was over

FY 2019 1Q and 2Q expenditures went down to $12,060 and $12,079 ($400 below and continue will have shared savings.

Finally moving the dial and will be successful 2020!

IRCCO Challenges as a Rural ACO

Disparate electronic medical records

Different hospital engagements - commitment

Limited resources/staff being pulled/change in culture

Staff turnover and medical provider turnover

Having the sense of urgency…once hospital team “gets it”, okay

Medical management of rural patients in skilled care

Time to develop comprehensive care coordination through all settings

Downstream spend and re-alignment of systems of care

Coding accuracy – both hospital and clinic

Nurse practitioners/Physician Assistants not originally assigned

Successful Population Health Strategies for Rural Providers Regardless of ACO

- Prevention – Well Visits
- Skilled Nursing Care – Care Management
- Care Coordination – all settings
- Specialty Referral Tracking
- Emergency Department Utilization – commercial payers
- Quality Measures – Medicare and HEDIS
- Cost comparison
  - Medical management
  - Overhead / general operations
  - Downstream spend

Has it been a challenge? YES!

Learning new terms and programs

Changing culture – proactive and caring for patients through the continuum

Changing workflow

Reporting requirements

Meetings

Expectations

Creating the sense of urgency

Understanding all the data!

After all is said and done…
Our Business is still about the patient