PROVIDERS AND PAYERS WORKING TOGETHER:
THE RURAL WAY
SRHT – NATIONAL RURAL RESOURCE CENTER
JANUARY 16 2019
AGENDA

- Share experience managing an ACO – new care delivery model
- Discuss differences of the payment and care delivery models
- Explain why the move to value-based care
- Identify the parts to value-based care framework and strategies for success
- Connect care coordination and prevention activities to population health
- Address the challenge of culture on changing to value based care models
- Discuss the advantages and disadvantages of ACOs and APMs
- Cover how to evaluate the return on investment when considering ACOs and the other care delivery models
ILLINOIS RURAL COMMUNITY CARE ORGANIZATION

Illinois Statewide Rural ACO – established 2014

25 Critical Access and Rural Hospitals; 40 rural health clinics

4 Independent physician practices

>280 Medical providers providing care for > 28,000 Medicare Beneficiaries

Medicare Shared Savings Program Year 5
BCBSIL ACO Year 2
www.iruralhealth.org
OUR JOURNEY – “ON THE BUS”

- **2014 -** ACO Concept/IRCCO established as LLC sole member of ICAHN
- **2015 –** MSSP; ACO Concepts
  - PCMH, Care Coordination, Data Management, Aim Application; 20 Hospitals; 8 Physician Practices
- **2016 –** Processes – IRCCO Management Team
  - Transfer coordination; medication management; readmissions; MWV; primary care post hospitalization; referral management
  - 22 Hospitals
- **2017 –** Outcomes – ACO Participants
  - A1C < 8; hypertension lower; Stroke readiness; ED Utilization; Post Acute care decreased LOS – home management; advanced care/best practices
  - Hospital Playbook – guide for ACO participation
  - 23 Hospitals
- **2018 –** Building towards sustainability
  - Improved Utilization; Cost Savings; Quality, Outcomes
  - Preparation for Risk Sharing
  - Approved 2nd 3-year Medicare Agreement; Approved Blue Cross Blue Shield ACO; 25 Hospitals and 4 Physician Practices
- **2019 –** Drilling Down to Change – pushing to the top! Data Mania and Results!! Either in or out!!
RURAL HOSPITAL CLOSURES 2010 = 90+
CONSUMER HEALTHCARE IMPACT

- Higher Deductibles
- Insurance
- Shopping
- Internet – Mobile Applications
- Premiums based on compliance
- Savvy – yet poor healthcare behaviors
- Generation X,Y and Z
- Real time care – Anytime Care
VALUE BASED CARE – ALL PART OF CMS’S PLAN SINCE 2008

- **ACA** – Primary Care Based
- **CMS Quality Programs in Place**
  - End-Stage Renal Disease Quality Incentive Program (*ESRD QIP*)
  - Hospital Value-Based Purchasing (*HVBP*) Program
  - Hospital Readmission Reduction (*HRR*) Program
  - Value Modifier (*VM*) Program (also called the Physician Value-Based Modifier or PVBM)
  - Hospital Acquired Conditions (*HAC*) Reduction Program
ARE RURAL HOSPITALS READY FOR CHANGE?

- Yes
- No
- Maybe?
- What does it take?

Perry Memorial Hospital
Princeton, IL - hometown
VALUE BASED CARE

- **Moving the dial for healthcare**
- **CMS Definition**
  - *Value-based* programs reward healthcare providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger *quality strategy* to reform how health care is delivered and paid for. Value-based programs also support our *three-part aim*:
  - Better care for individuals
  - Better health for populations
  - Lower cost
VALUE BASED MODELS - TODAY

- Accountable Care Organizations
- Patient Centered Medical Home
- Clinically Integrated Networks
- Comprehensive Primary Care Plus
- Integrated Health Homes
- Medicare Advantage
- Others
Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The focus begins with patients assigned to an ACO based on primary care services rendered.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

- Types of ACOs: Medicare, Medicaid and Commercial – none are the same
- 2018 – 649 ACOs in total = 12.4 million Medicare Beneficiaries
The Patient-Centered Medical Home (PCMH) is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians/medical provider, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Guidelines…almost like Conditions of Participation for Practices and Clinics – huddles, same day appointments, care coordination, follow up, quality and safety

Certification programs….qualifies as advanced payment and insurance carriers will pay more
Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States.

CPC+ seeks to improve quality, access, and efficiency of primary care. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. (CMS Innovation Model)

2,932 primary care practices - selected states: Colorado, Kansas, Missouri, Louisiana, New York, Ohio, Kentucky, Tennessee, Rhode Island, Nebraska, North Dakota, Pennsylvania, Oregon, New Jersey, Ohio, Montana, Michigan, Hawaii, and Oklahoma

Practices are financially incentivized to case manage patients.
A Clinically Integrated Network (CIN) is a collection of healthcare providers, such as doctors and healthcare facilities, who commit to work together on the quality and cost effectiveness of care for a specific patient population. A CIN's goal is to ensure that patients receive the highest quality care while providers minimize duplication of services and prevent medical errors.

Department of Justice allows CINs to function without violation to anti-trust laws. There are three types: 1) Physician – hospital organization; 2) Independent practice association; and a 3) Subsidiary of a health system as the sole member.

CIN can negotiate contracts and participate as a legal entity. Key components

- Physician/provider led
- Data and technology
- Measurable improvements
- Clinical guidelines
**Medicare Advantage Programs**

- **Medicare Advantage plans**, also referred to as Part C plans, are part of the Medicare program for senior citizens and disabled adults who qualify. Private companies provide Medicare Advantage plans instead of the federal government, and these plans typically include the same Part A hospital, Part B medical coverage and Part D drug coverage that Medicare does, with the exception of hospice care. As of 2017, about one third of the 57 million Medicare participants were enrolled in a Medicare Advantage plan.

- Types of Medicare Advantage plans – Health Maintenance Organizations, Preferred Provider Organizations, Private fee for services, and special care organizations.

- Goal – ensure quality but control utilization and keep patients in network

- Growing in rural communities
GLOBAL PAYMENT MODEL

- **A global payment**—a fixed prepayment made to a group of providers or a health care system (as opposed to a health care plan)—covers most or all of a patient’s care during a specified time period. Global payments are usually paid monthly per patient over a year, unlike fee-for-service, which pays separately for each service.

- In most cases, a global payment encompasses physician and hospital services, diagnostic tests, prescription drugs and often other services, such as hospice and home health care. Under a global fee arrangement, a large multispecialty physician practice or hospital-physician system receives a global payment from a payer (e.g., health plan, Medicare or Medicaid) for a group of enrollees. It is then responsible for ensuring that enrollees receive all required health services. Global payments usually are adjusted to reflect the health status of the group on whose behalf the payments are made.

- Pilots in several states….Maryland, Pennsylvania
  - If can’t change healthcare costs through new delivery models, then try changing payment models.
  - Bundled Payment Programs (Comprehensive Joint) — global episode payment/one check
WILL POLITICAL LEADERS TURN VALUE BASED CARE BACK?

- NO…turning back
- Fee for Service - Gone
  - Politicians ran on healthcare – Won!!
  - Healthcare costs still growing….
WANT VALUE FOR OUR DOLLAR – NEW HEALTHCARE ENVIRONMENT

- **Patients** spend less money to achieve better health.
- Providers achieve efficiencies and greater patient satisfaction.
- Payers control costs and reduce risk.
- Suppliers align prices with patient outcomes.
- Society becomes healthier while reducing overall healthcare spending.
CMS underestimated Medicare ACOs' savings

By Maria Castellucci | September 11, 2018

The Medicare Shared Savings Program generated $1.84 billion in savings over three years, which is nearly twice the savings that CMS data show, according to a new study commissioned by the National Association of ACOs.

The study, published Tuesday, also found accountable care organizations reduced Medicare spending by $542 million after accounting for shared savings by the ACOs from 2013 to 2015. This contradicts data from the CMS that ACOs actually increased Medicare spending by $344 million over the time period.

The study is the latest in a series that find Medicare ACOs are saving more money than CMS’ methodology shows. Just last week the New England Journal of Medicine published an analysis with similar results. ACO analysts argue the CMS consistently underestimates savings because it’s using a benchmarking methodology, which only compares ACO performance over the years to calculate savings.
Value Based Care Strategies = Success in Primary Care and Rural Market

- **Focus is on primary care and where RURAL SHINES**
- **Hospitals now own and/or manage vast majority of physician practices and clinics in rural areas**
- **Providers are paid based on services and patient healthcare outcomes**

**Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes.** Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

**Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver.** The “value” in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.
IMPORTANCE OF MOVING INTO ACTION

- Care coordination…patient centered care
- Primary Care focus – keeping your local market
- Learning about how patients use healthcare
Focus is on the patient – care through the continuum
Medicare Well Visits – Wellness and Gaps in Care
Care Coordination – Hospital Setting to LTC to Home Health to Primary Care
  - New Billing Codes for chronic care management
  - Transitional Care Management
Specialty Referral…return to primary care
Improvement in medical care…such as diabetes and hypertension/chronic diseases
Access to claims data for utilization of services - DATA
  - Duplication and appropriate services
  - Reduce unnecessary and avoidable ED visits
Access to information to understand market share – network leakage
  - BOTTOM LINE….better care, more appropriate utilization and saving costs
LEARN ABOUT YOUR DATA

- Claims information
- Quality Data
- Disease registry
- Readmission Rates
- ED utilization
- Hospital Specific/Comparison
## CMS Statistics FY 2018 2Q – Procedures & Services

<table>
<thead>
<tr>
<th>Component Expenditure per Assigned Beneficiary</th>
<th>ACO X</th>
<th>Other ACOs</th>
<th>FFS</th>
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<td>Hospital Inpatient Facility, Total</td>
<td>3,894</td>
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<td>Short-Term Stay Hospital</td>
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<td>Long-Term Stay Hospital</td>
<td>54</td>
<td>71</td>
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<tr>
<td>Rehabilitation Hospital or Unit</td>
<td>127</td>
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<td>Psychiatric Hospital or Unit</td>
<td>116</td>
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<td>Skilled Nursing Facility or Unit</td>
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<tr>
<td>Outpatient Facility</td>
<td>3,819</td>
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<tr>
<td>Hospital Outpatient Department (including CAH)</td>
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<tr>
<td>Outpatient Delivery Facility</td>
<td>165</td>
<td>193</td>
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<tr>
<td>Part B Physician/Supplier (Carrier)</td>
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<td>Evaluation and Management</td>
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<td>Procedures</td>
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<td>Imaging</td>
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<td>Laboratory and Other Tests</td>
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<td>Part B Drugs</td>
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<td>Ambulance</td>
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<td>Home Health Agency</td>
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<td>Durable Medical Equipment</td>
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<td>Hospice</td>
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<td>Substance Abuse Treatment Services</td>
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<td>276</td>
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<td>Transition of Care/Care Coordination Utilization</td>
<td>798</td>
<td>800</td>
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<tr>
<td>30-Day Post-Discharge Provider Visits Per 1,000 Discharges</td>
<td>798</td>
<td>800</td>
<td>789</td>
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<tr>
<td>Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries</td>
<td>13.39</td>
<td>9.43</td>
<td>9.92</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease or Asthma</td>
<td>16.91</td>
<td>16.12</td>
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<td>Congestive Heart Failure</td>
<td>16.91</td>
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<td>Additional Utilization Rates (Per 1,000 Person-Years)</td>
<td>368</td>
<td>307</td>
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<tr>
<td>Hospital Discharges, Total</td>
<td>350</td>
<td>283</td>
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<tr>
<td>Short-Term Stay Hospital</td>
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</table>
### Table 2: Medicare Shared Savings Program Skilled Nursing Facility (SNF) Report

#### Year 2018, Quarter 2

<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>ACO-Specific [1]</th>
<th>All MSSP ACOs [2]</th>
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<tbody>
<tr>
<td><strong>Number of SNF Stays</strong></td>
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<tr>
<td>Admissions[3]</td>
<td>2,006</td>
<td>673</td>
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<tr>
<td>Discharges[4]</td>
<td>2,511</td>
<td>648</td>
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<tr>
<td>Admission and Discharge[5]</td>
<td>2,603</td>
<td>603</td>
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<tr>
<td>Total Stay[6]</td>
<td>3,123</td>
<td>715</td>
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<tr>
<td><strong>Rate per 1,000 Person-Years</strong></td>
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<tr>
<td>Discharges[4]</td>
<td>114</td>
<td>54</td>
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<tr>
<td>Utilization Days, Total Stays[7]</td>
<td>3,358</td>
<td>1,314</td>
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<tr>
<td><strong>Assigned Beneficiaries with a SNF Stay. Total Stays</strong></td>
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<td>Number[8]</td>
<td>2,181</td>
<td>530</td>
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<tr>
<td>Percentage[9]</td>
<td>8.53</td>
<td>4.32</td>
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<tr>
<td>Number of Facilities or Units[10]</td>
<td>285</td>
<td>84</td>
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<tr>
<td><strong>Stays with Discharge during Report Period</strong></td>
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<tr>
<td>Payment Per Stay[12]</td>
<td>14,355</td>
<td>11,105</td>
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<tr>
<td>Payment Per Day[13]</td>
<td>494</td>
<td>447</td>
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<tr>
<td><strong>30-Day Admission Rate After SNF Discharge</strong></td>
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<tr>
<td>To a Hospital[14]</td>
<td>31.18</td>
<td>26.61</td>
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<tr>
<td>To a SNF[15]</td>
<td>22.55</td>
<td>17.33</td>
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</table>

**Note:**
## CMS: Most Common Conditions and Diseases

<table>
<thead>
<tr>
<th>CMS-HCC Label</th>
<th>ACO-Specific Assigned Beneficiaries</th>
<th>All MSSP ACOs[3]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Assigned Beneficiaries, Total</td>
<td>25,576</td>
<td>25,576</td>
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<tr>
<td>Currently Assigned Beneficiaries without HCC Data[1]</td>
<td>2,537</td>
<td>2,537</td>
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<tr>
<td>Currently Assigned Beneficiaries with HCC Data (sample for this table)[2]</td>
<td>23,039</td>
<td>23,039</td>
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</table>

<table>
<thead>
<tr>
<th>CMS-HCC[4]</th>
<th>ACO-Specific Assigned Beneficiaries</th>
<th>All MSSP ACOs[3]</th>
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</thead>
<tbody>
<tr>
<td>No HCCs[5]</td>
<td>6,320</td>
<td>2,743</td>
</tr>
<tr>
<td>HCC1: HIV/AIDS</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>HCC2: Septemia, Septic, Systemic Inflammatory Response Syndrome/Shock</td>
<td>564</td>
<td>245</td>
</tr>
<tr>
<td>HCC6: Opportunistic Infections</td>
<td>55</td>
<td>24</td>
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<tr>
<td>HCC8: Metastatic Cancer and Acute Leukemia</td>
<td>218</td>
<td>95</td>
</tr>
<tr>
<td>HCC9: Lung and Other Severe Cancers</td>
<td>243</td>
<td>105</td>
</tr>
<tr>
<td>HCC10: Lymphoma and Other Cancers</td>
<td>286</td>
<td>124</td>
</tr>
<tr>
<td>HCC11: Colorectal, Bladder, and Other Cancers</td>
<td>496</td>
<td>215</td>
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<tr>
<td>HCC12: Breast, Prostate, and Other Cancers and Tumors</td>
<td>1,219</td>
<td>529</td>
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<tr>
<td>HCC17: Diabetes with Acute Complications</td>
<td>92</td>
<td>40</td>
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<tr>
<td>HCC18: Diabetes with Chronic Complications</td>
<td>3,827</td>
<td>1,661</td>
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<tr>
<td>HCC19: Diabetes without Complication</td>
<td>3,000</td>
<td>1,302</td>
</tr>
<tr>
<td>HCC21: Protein-Calorie Malnutrition</td>
<td>332</td>
<td>144</td>
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<tr>
<td>HCC22: Morbid Obesity</td>
<td>1,187</td>
<td>515</td>
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<tr>
<td>HCC23: Other Significant Endocrine and Metabolic Disorders</td>
<td>632</td>
<td>274</td>
</tr>
<tr>
<td>HCC27: End-Stage Liver Disease</td>
<td>75</td>
<td>33</td>
</tr>
<tr>
<td>HCC32: Carcinoma of Liver</td>
<td>102</td>
<td>44</td>
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<td>HCC39: Chronic Hepatitis</td>
<td>62</td>
<td>27</td>
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<tr>
<td>HCC33: Intestinal Obstruction/Perforation</td>
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<tr>
<td>HCC34: Chronic Pancreatitis</td>
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<td>25</td>
</tr>
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<td>HCC35: Inflammatory Bowel Disease</td>
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<td>HCC9: Bone, Joint, and Muscle Infections/Neurosis</td>
<td>249</td>
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<tr>
<td>HCC40: Rheumatoid Arthritis and Inflammatory Connective Tissue Disease</td>
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<td>613</td>
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<td>HCC46: Severe Hematological Disorders</td>
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<td>HCC47: Disorders of Immunity</td>
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<td>HCC48: Coagulation Defects and Other Specified Hematological Disorders</td>
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<td>335</td>
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<tr>
<td>HCC54: Drug/Alcohol Psychosis</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>HCC55: Drug/Alcohol Dependence</td>
<td>395</td>
<td>171</td>
</tr>
</tbody>
</table>
HOW DO YOU IMPROVE CARE AND REDUCE COST?

- Example: $12,400/Medicare beneficiary/year
  - Reduce SNF days
  - Appropriate use of ED
  - Chronic Care Management
  - MWV - Prevention
  - Specialty Tracking
NETWORK LEAKAGE – AVERAGE 70/30

Network Leakage

<table>
<thead>
<tr>
<th>Incurred Month of Claim</th>
<th>Plan Name</th>
<th>Network Indicator</th>
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<tbody>
<tr>
<td>October 2017</td>
<td>NISP Assigned</td>
<td>In Network, Out of Network</td>
</tr>
<tr>
<td>September 2018</td>
<td></td>
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</tbody>
</table>

- In Network Total Paid Charge %: 30.95%
- Out of Network Total Paid Charge %: 69.05%
- Total Paid Charge: $117M

Total Paid Amount Over Time
(Select Month to filter Billing and Diagnosis visuals)
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 this built in (IRCCO can help you use yours)

What can the disease registry tell me?

- Clinical care parameters....B/P; A1C; medication use; # diagnoses
- Measures clinical compliance/performance
HAVING ACCESS TO DATA IS POWERFUL

- Reflects the care provided
- Provides quality comparison with peers and others
- Insight in to practitioner performance
- Provides opportunity to control costs – best value for $

- Provides strategic information about your market share and a guide to build your base – Be competitive!!
WHAT HAVE WE LEARNED?

- How beneficiaries use healthcare
- **Change is hard and takes time – Culture and Team Work**
  - Must understand value of change and sense of urgency
- Use data to improve hospitals processes
- Use data to evaluate our local market
- Transition of care from one setting to the next
- Must run primary care like division of hospital (quality and performance)
- Rural can be a player and the Best!
Change must come from within the hospital and practice setting
Move from volume to value
Must understand the ROI and why?
Sense of urgency
Administrative support
Provider engagement
IMPORTANCE OF CEO/ADMINISTRATIVE IMPORTANCE OF THE TEAM

- Components to be Successful
  - # 1 Hospital Leaders commitment
  - Vision and expectations
  - Practitioner engagement
  - Quality focus
  - Patient loyalty
  - Clinic/hospital staff
  - ACO management team
  - **Leadership is KEY to success in your organization!**
CARE COORDINATION – MOST IMPORTANT
Today…rural providers manage 20% of the local market
- 20 years ago, rural providers managed 80%
- Rural providers are not the highest cost of care

- Few tracking systems in place for specialty referral
- Push to higher systems of care when can be managed locally
- Lack of communication for post-hospitalization/discharge planning
<table>
<thead>
<tr>
<th>Metric Measured</th>
<th>Quarter 4</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
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<td>MWV</td>
<td>October</td>
<td>November</td>
<td>December</td>
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<td>Post DC Calls</td>
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<td>February</td>
<td>March</td>
<td>July</td>
</tr>
<tr>
<td>TOC Follow Up</td>
<td>April</td>
<td>May</td>
<td>June</td>
<td>August</td>
</tr>
<tr>
<td>ER PCP Alignment</td>
<td>September</td>
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<td>ER Telephone Follow Up</td>
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<td>Referral Tracking</td>
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<td>Referral Completion Process</td>
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At end if we want to add one more | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! |
SUCCESS STORIES – PATIENT IMPROVEMENT

- Better utilization of the emergency department and reducing frequent users
  - 10% reduction of avoidable ED Visits and several hospitals reduced ED readmits to <3 %
- Care coordination and discharge instructions – working with local nursing homes / patient huddles
- Medicare well visits – focus on health
- Chronic Care Management…provider buy in
- Improved satisfaction scores!!!!!!
- Health coaching programs
  - 55 year old diabetic >12 A1C down to 7 A1C
- Patient Centered Medical Homes
Population health “brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population.”

- Centers for Disease Control

Hospital’s perspective – understanding the needs of the local community/keeping people healthy

- Community Health Needs Assessment
- Health Department
- Disease registries – outcomes
- Impact of social issues – charity care/billing
<table>
<thead>
<tr>
<th>Healthy Patients</th>
<th>Early Onset Chronic Disease</th>
<th>Full Onset Chronic Disease</th>
<th>Complex Care</th>
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</thead>
<tbody>
<tr>
<td>Cardiac Rehab Physical Therapy Group counseling Support Groups Primary care monitoring</td>
<td>Beneficiaries with multiple conditions should be in a care coordination program</td>
<td>Care coordination tracking Admission, Discharge, Transfer Notification</td>
<td></td>
</tr>
</tbody>
</table>
# Community Systems of Care – Impact on Health Care Costs

## Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social integration</td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Support systems</td>
<td>Discrimination</td>
<td>Quality of care</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community engagement</td>
<td>Stress</td>
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<td>Support</td>
<td>Walkability</td>
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</tr>
<tr>
<td></td>
<td>Zip code / geography</td>
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</tr>
</tbody>
</table>

## Health Outcomes

- Mortality
- Morbidity
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations
PREVENTION – WELLNESS – GAPS IN CARE

- Commercial Carriers...focus on gaps in care
- Health Coaching Programs
- Screenings
HOSPITAL – HUB OF COMMUNITY - RESOURCES

- One of top 3 employers in rural community/county
- Own 95% of all physician practices
- Average rural hospital has 3 rural health clinics
- Ambulance/EMS support
- KEY: Access to medical providers
- Social support systems
  - Pharmacies, home health, nursing homes
VALUE BASED CARE - ROI

- Increased patient satisfaction scores
- Decrease in appropriate use of services
  - Chronic Care Management in 12 -18 months reduces many frantic calls to providers
  - Decrease denials for ED visits
- Increased local primary care market
- Improved commercial contracts
- Increased preventive care and services
ADVANTAGES AND DISADVANTAGES – VALUE BASED CARE

Disadvantages - Challenges

- Change in culture and work flow is NOT easy.
- Cost – staff resources
- Time Commitment
- Can hospitals take risk with 1-3% margins or less?
- Provider frustration
- Staff not buying in/protecting medical provider

Advantages - Benefits

- Learn best practices
- Keep patients locally – Healthier populations
- Better contracts
- Ready for 2020
- Patient outcomes improvement
- Financially viability long term
YOUR FOCUS: HOW DO I KEEP PATIENTS LOCALLY? VALUE OF PRIMARY CARE

- What do we need to do to keep patients within your practices?
  - Healthcare is local
  - 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

- Working with referral centers and tertiary Care?
  - IRCCO will manage primary care
  - Systems will manage specialty care
    - Both work together
AFTER ALL IS SAID AND DONE…
OUR BUSINESS IS STILL ABOUT THE PATIENT
QUESTIONS – THANK YOU!

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