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

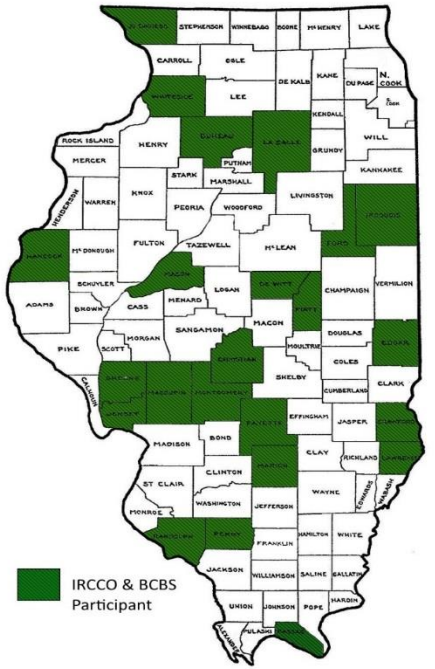
>280 Medical providers providing care for > 28,000 Medicare Beneficiaries

Medicare Shared Savings Program Year 5

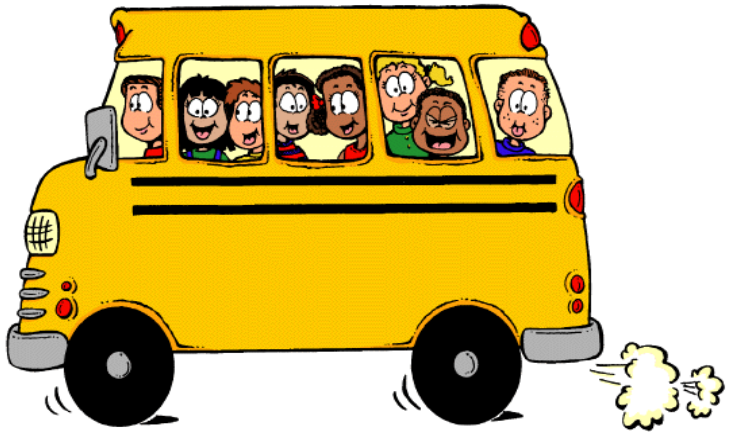
BCBSIL ACO Year 2

www.iruralhealth.org

Illinois Rural Community Care Organization®



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

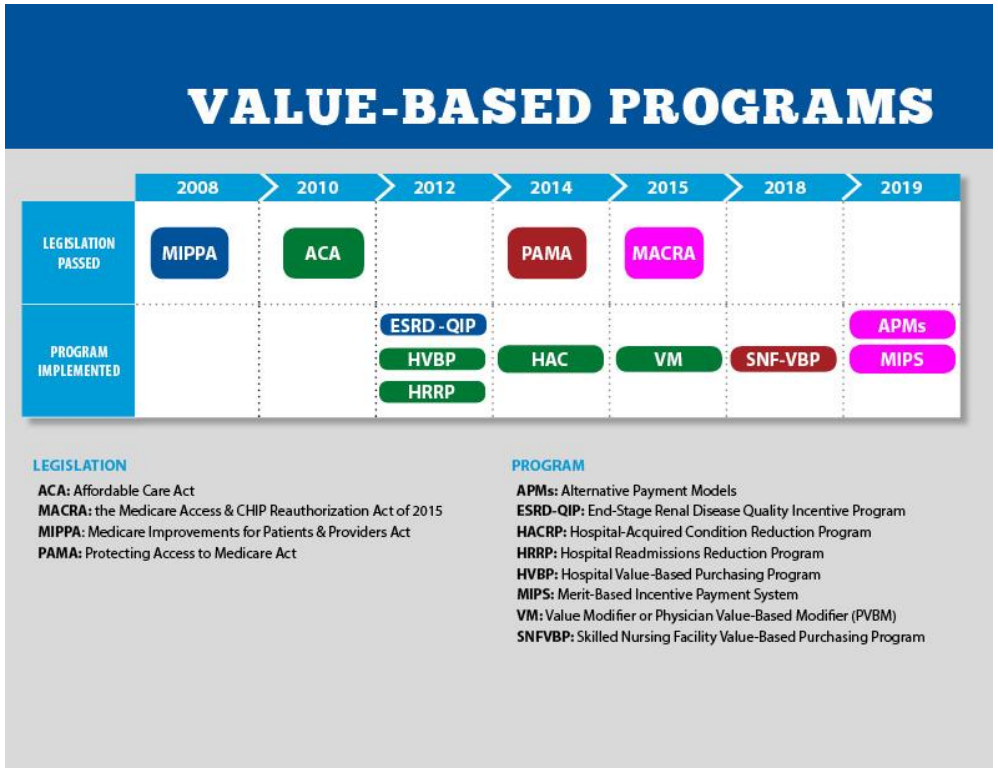
2019 – Drilling Down to Change – pushing to the top! Data Mania and Results!! Either in or out!!

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

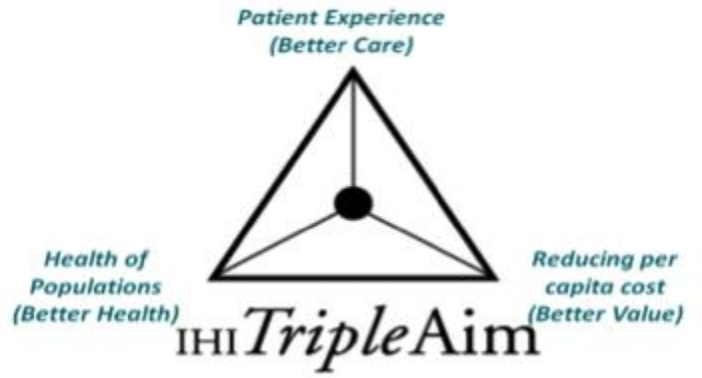
ARE RURAL HOSPITALS READY FOR CHANGE?

- 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 health care 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

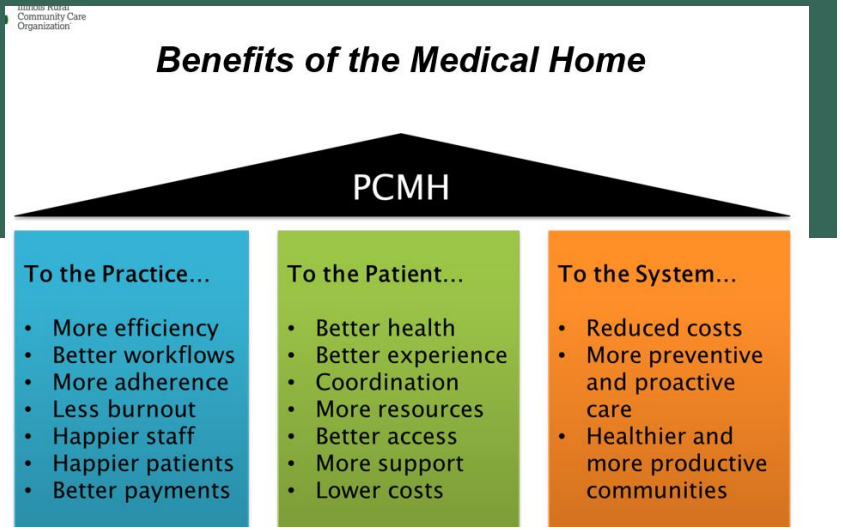
ACCOUNTABLE CARE ORGANIZATION

- 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

PATIENT CENTERED MEDICAL HOMES



- 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 +

- **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.

CLINICALLY INTEGRATED NETWORK

- 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.**

MEDICARE ACOS SAVE MEDICARE $1.84 BILLION/3 YEARS

Modern Healthcare
The leader in healthcare business news, research & data

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.

Recommended for You


What we have here is a failure to communicate: CMS looks for a contractor to explain MACRA models to physicians.


Home healthcare is getting a boost from insurers and the Medicare program.

Medicare ACOs
Traditional Medicare Beneficiaries

A HOSPITAL… WHY? RURAL HOSPITAL MISSIONS FIT VBC

- 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

STRATEGIES – VALUE BASED CARE…*HOW DO WE BEGIN?*

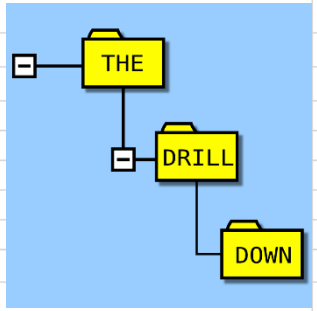
- Focus is on the patient – care through the continuum
- Medicare Well Visits – Wellness and Gaps in Care
- Care Coordination – Hospital Setting to LTC to Home Health to Primary Care
  - New Billing Codes for chronic care management
  - Transitional Care Management
- Specialty Referral…return to primary 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

		ACO X	Other ACOs	FFS
28	**Component Expenditures per Assigned Beneficiary[8]**			
29	Hospital Inpatient Facility, Total	3,894	3,392	3,726
30	Short-Term Stay Hospital	3,616	2,977	3,264
31	Long-Term Stay Hospital	54	71	111
32	Rehabilitation Hospital or Unit	127	235	270
33	Psychiatric Hospital or Unit	116	69	113
34	Skilled Nursing Facility or Unit	1,891	689	899
35	Outpatient Facility	3,819	2,216	2,539
36	Hospital Outpatient Department (including CAH)	2,744	1,799	2,052
37	Outpatient Dialysis Facility	165	193	294
38	Part B Physician/Supplier (Carrier)	2,299	3,405	3,572
39	Evaluation and Management	720	1,138	1,234
40	Procedures	636	910	959
41	Imaging	175	254	285
42	Laboratory and Other Tests	143	329	347
43	Part B Drugs	330	458	490
44	Ambulance	223	128	160
45	Home Health Agency	352	525	652
46	Durable Medical Equipment	291	252	263
47	Hospice	218	193	262
48	Substance Abuse Treatment Services	162	194	276
49	**Transition of Care/Care Coordination Utilization[9]**			
50	30-Day Post-Discharge Provider Visits Per 1,000 Discharges	798	800	789
51	Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries			
52	Chronic Obstructive Pulmonary Disease or Asthma	13.39	9.43	9.92
53	Congestive Heart Failure	16.91	16.12	16.81
54	**Additional Utilization Rates (Per 1,000 Person-Years)[10]**			
55	Hospital Discharges, Total	368	307	327
56	Short-Term Stay Hospital	350	283	300



CMS SKILLED NURSING FACILITY COSTS TO OTHER ACOS

Table 2
Medicare Shared Savings Program
Skilled Nursing Facility (SNF) Report

Year 2018, Quarter 2

Table of Contents

	ACO-Specific [1]	All MSSP ACOs [2]
Number of SNF Stays		
Admissions[3]	2,906	673
Discharges[4]	2,811	648
Admission and Discharge[5]	2,603	603
Total Stays[6]	3,123	715
Rate per 1,000 Person-Years		
Discharges[4]	114	54
Utilization Days, Total Stays[7]	3,358	1,314
Assigned Beneficiaries with a SNF Stay, Total Stays		
Number[8]	2,181	530
Percentage[9]	8.53	4.32
Number of Facilities or Units[10]	285	84
Stays with Discharge during Report Period		
Length of Stay[11]	29	25
Payment Per Stay[12]	14,355	11,105
Payment Per Day[13]	494	447
30-Day Admission Rate After SNF Discharge		
To a Hospital[14]	31.18	28.61
To a SNF[15]	23.55	17.33

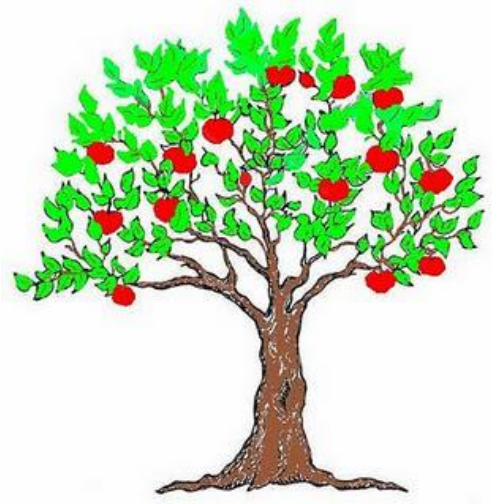
NOTES:

CMS: MOST COMMON CONDITIONS AND DISEASES

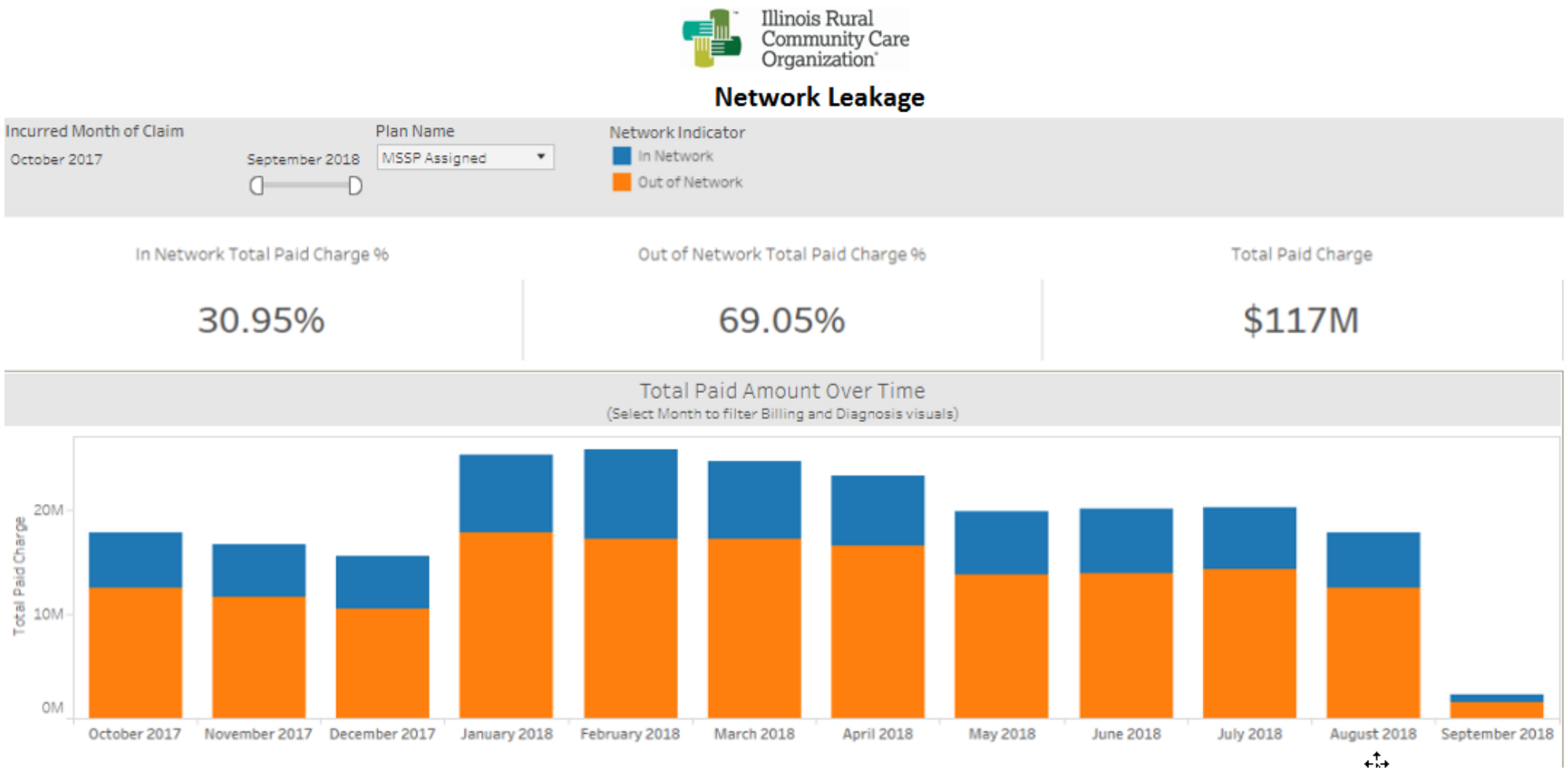
		Currently Assigned Beneficiaries, Total	25,576		
		Currently Assigned Beneficiaries without HCC Data[1]	2,537		
		Currently Assigned Beneficiaries with HCC Data (sample for this table)[2]	23,039		
			ACO-Specific Assigned Beneficiaries		**All MSSP ACOs[3]**
CMS-HCC[4]	**CMS-HCC Label**		**Beneficiaries[5]**	**Rate per 10,000**	**Rate per 10,000**
--	No HCCs[6]		6,320	2,743	2,768
HCC1	HIV/AIDS		10	4	14
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock		564	245	220
HCC6	Opportunistic Infections		55	24	35
HCC8	Metastatic Cancer and Acute Leukemia		218	95	98
HCC9	Lung and Other Severe Cancers		243	105	116
HCC10	Lymphoma and Other Cancers		286	124	152
HCC11	Colorectal, Bladder, and Other Cancers		496	215	228
HCC12	Breast, Prostate, and Other Cancers and Tumors		1,219	529	689
HCC17	Diabetes with Acute Complications		92	40	30
HCC18	Diabetes with Chronic Complications		3,827	1,661	1,670
HCC19	Diabetes without Complication		3,000	1,302	1,172
HCC21	Protein-Calorie Malnutrition		332	144	116
HCC22	Morbid Obesity		1,187	515	544
HCC23	Other Significant Endocrine and Metabolic Disorders		632	274	359
HCC27	End-Stage Liver Disease		77	33	35
HCC28	Cirrhosis of Liver		102	44	47
HCC29	Chronic Hepatitis		62	27	45
HCC33	Intestinal Obstruction/Perforation		363	158	137
HCC34	Chronic Pancreatitis		57	25	24
HCC35	Inflammatory Bowel Disease		208	90	107
HCC39	Bone, Joint, and Muscle Infections/Necrosis		240	104	91
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease		1,412	613	716
HCC46	Severe Hematological Disorders		74	32	43
HCC47	Disorders of Immunity		255	111	141
HCC48	Coagulation Defects and Other Specified Hematological Disorders		777	337	445
HCC54	Drug/Alcohol Psychosis		24	10	11
HCC55	Drug/Alcohol Dependence		395	171	232

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



DISEASE REGISTRIES

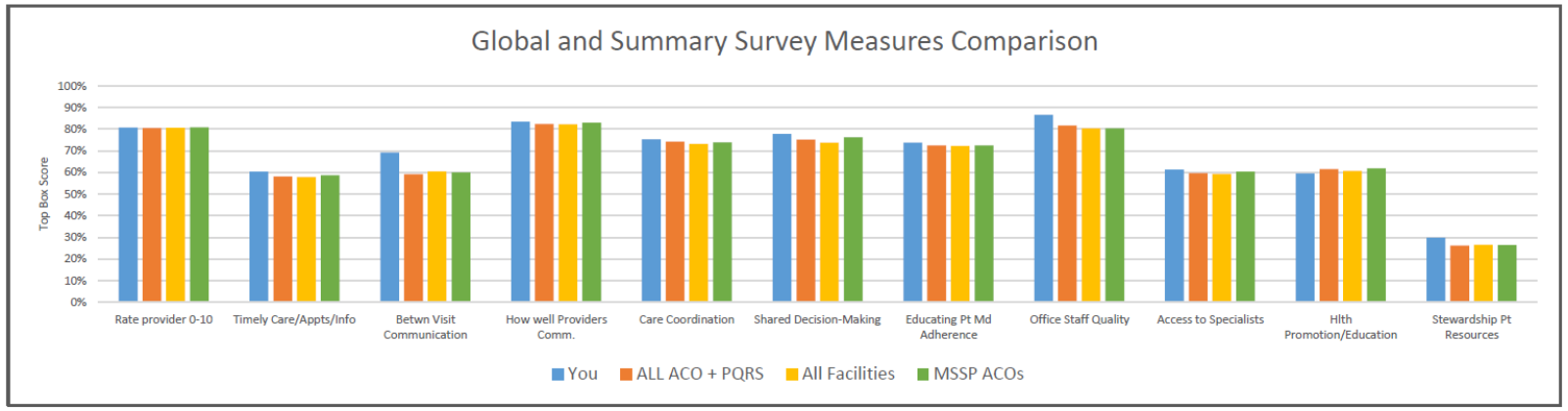
- A **disease registry** is a tool for tracking the clinical care and outcomes of a **defined** patient population. Most **disease registries** are used to support care management for groups of patients with one or more chronic **diseases**, such as diabetes, coronary artery **disease**, or asthma
-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

PATIENT ENGAGEMENT SURVEY

ACO CAHPS Summary Report

Illinois Rural Community Care Org (Site ID: 1)

Surveys Received: November 2016 - February 2017



Illinois Rural Community Care Org (Site ID: 1)		Your Top Box Score			ALL ACO + PQRS N=571	All Facilities N=239	MSSP ACOs N=176
Summary Survey Measures Question	Current n	Previous % Nov15-Feb16	Current % Nov16-Feb17		Percentile Rank	Percentile Rank	Percentile Rank
Rate provider 0-10	283	75.7%	80.6%	▲	45	43	43
Timely Care/Appts/Info	301	55.2%	60.3%	▲	61	62	58
How often get urgent appt as needed	134	55.7%	71.6%	▲	75	71	70
How often get appt soon as needed	233	71.8%	76.8%	▲	69	65	67
How often get answer same day	124	60.7%	59.7%	▼	53	51	53
How often get answer soon as needed	N<11	57.1%	N/A		N/A	N/A	N/A
How often see provider w/in 15 min	296	30.5%	33.4%	▲	37	51	50
Betwn Visit Communication	181	67.1%	69.1%	▲	92	93	95

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!

TO CHANGE THE CULTURE/VALUE

- 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

BIGGEST CHALLENGE – DOWNSTREAM SPEND

- 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

TOOLS TO MANAGE PROCESS AND CHANGE - PLAYBOOK

IRCCO CARE COORDINATION MANAGEMENT

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
Metric Measured	October	November	December	January	February	March	April	May	June	July	August	September
MWV												
Post DC Calls												
TOC Follow Up												
ER PCP Alignment												
ER Telephone Follow Up												
Referral Tracking												
Referral Completion Process												
At end if we want to add one more	#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

- 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

IRCCO POPULATION HEALTH STRATEGIES

Healthy Patients	Early Onset Chronic Disease	Full Onset Chronic Disease	Complex Care
Medicare Well Visits Screenings Immunizations Healthy Eating Exercise Programs Newsletter Patient Education Building relationship with patients	Provider Benchmarks • Diabetes • Hypertension • Cholesterol • Mental Health positive screen • Medication abuse • Traumatic injury • Arthritis Cardiac Rehab Physical Therapy Group counseling Support Groups Primary care monitoring	• Chronic Care Management Program • Health Coach • Community Care Worker Program • Self-management skill-building • Specialty care referral monitoring • Admission, Discharge, Transfer Notification Beneficiaries with multiple conditions .should be in a care coordination program	Specialty care vetting • Outcomes • Cost • Relationship primary care • Support for family Care coordination tracking Admission, Discharge, Transfer Notification

COMMUNITY SYSTEMS OF CARE – IMPACT ON HEALTH CARE COSTS

Figure 1

Social Determinants of Health

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

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

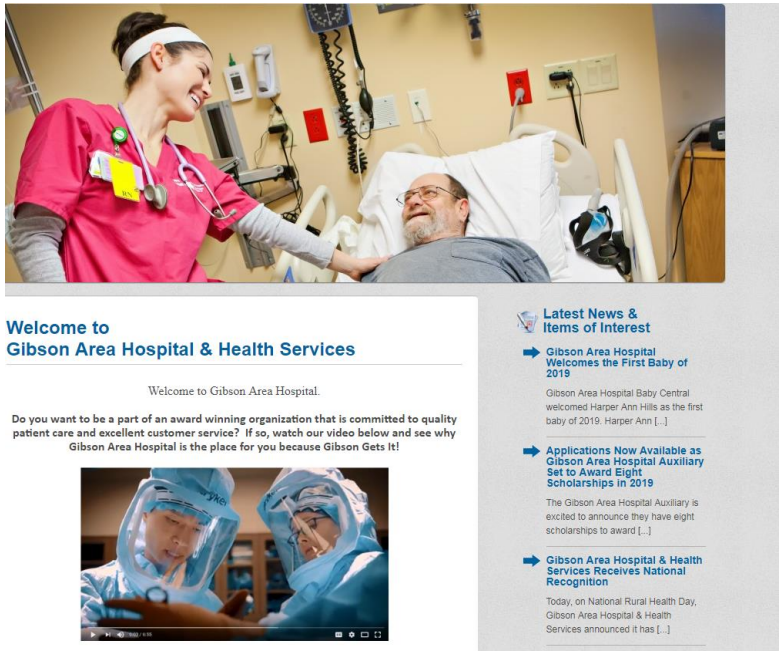
KFF
HENRY J KAISER FAMILY FOUNDATION

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

RURAL HOSPITAL COMMUNITY

Gateway SERVICES, Inc.

Empowering People ~ Enriching Community

AFTER ALL IS SAID AND DONE…
OUR BUSINESS IS STILL ABOUT THE PATIENT

QUESTIONS – THANK YOU!

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