



NATIONAL  
RURAL HEALTH  
RESOURCE CENTER

Delta Region Community Health Systems Development (DRCHSD)  
2019 Program Summit

# Taking Value Based Care from Discussing to Doing

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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



# Agenda

1. What's your value story?
2. How do you make that meaningful?



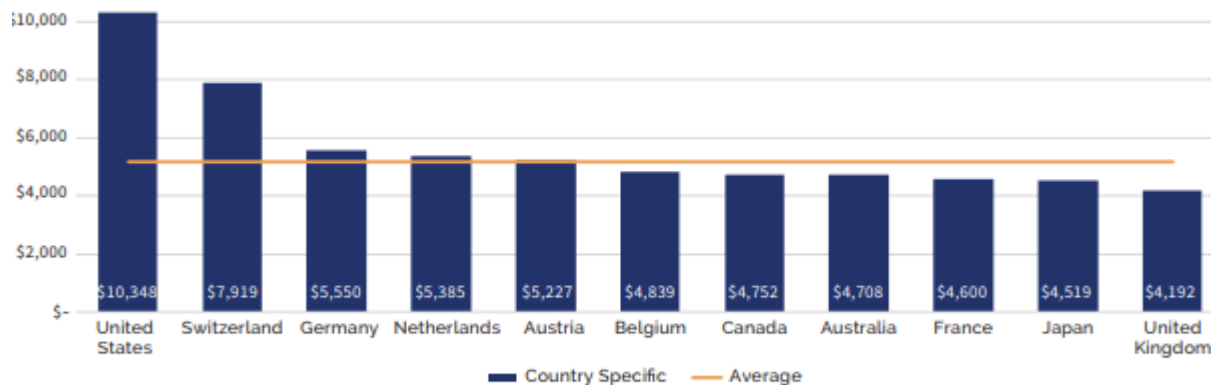
# Healthcare Transformation



# Initiative 18|11

Health care in the United States represents 18 percent of the gross domestic products compared with 11 percent in comparable countries such as the United Kingdom.

Figure 1  
2016 Per Capita Expenditures



Source: Sawyer, Bradley, and Cynthia Cox, How does health spending in the U.S. compare to other countries? Health System Tracker, Feb. 23, 2018, [https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/?\\_sf\\_s=compare#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends](https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/?_sf_s=compare#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends). Accessed Aug. 2, 2018.



# 2017 Commonwealth Study

The study, the only to include survey data to measure and compare patient and physician experiences across wealthy nations, ranks the U.S. last overall, and on providing equally accessible and high-quality health care, regardless of a person's income.

## Health Care System Performance Rankings

	UK	AUS	NETH	NZ	NOR	SWE	SWIZ	GER	CAN	FRA	US
OVERALL RANKING	1	2	3	4	4	6	6	8	9	10	11
Care Process	1	2	4	3	10	11	7	8	6	9	5
Access	3	4	1	7	5	6	8	2	10	9	11
Administrative Efficiency	3	1	9	2	4	5	8	6	6	11	10
Equity	1	7	2	8	5	3	4	6	9	10	11
Health Care Outcomes	10	1	6	7	3	2	4	8	9	5	11



# The 5/50 Population

According to a 2016 Agency for Healthcare Research and Quality (AHRQ) study, more than half of the cost of health care can be attributed to 5 percent of the population.

This is referred to as the Chronic Disease Burden...



# Demographic Changes

## Influencing the framework:

- Baby Boomers entering retirement age,
- Millennials seeking healthcare through technology

## A growing divide in consumer demand for delivery:

- Aging with complex chronic conditions require long term management of diseases
- Young measuring value through convenient access to primary care and wellness



# Current State of Healthcare

Fragmentation of care leads to additional costs and duplication of effort. This applies to both providers and payors!

The current state is not sustainable;  
**There is no option but change in your  
payment and delivery.**



# The Bird's Eye View

To maintain payor sustainability, Medicare **has the intention to bend the cost curve and purchase high quality services.** High quality is the same measurement regardless of your size, volume or location.

To achieve this goal, Medicare **seeks to change the system** in both delivery and payment.

Inherent in these efforts is a requirement for providers to **engage in transformation and ultimately in risk.**

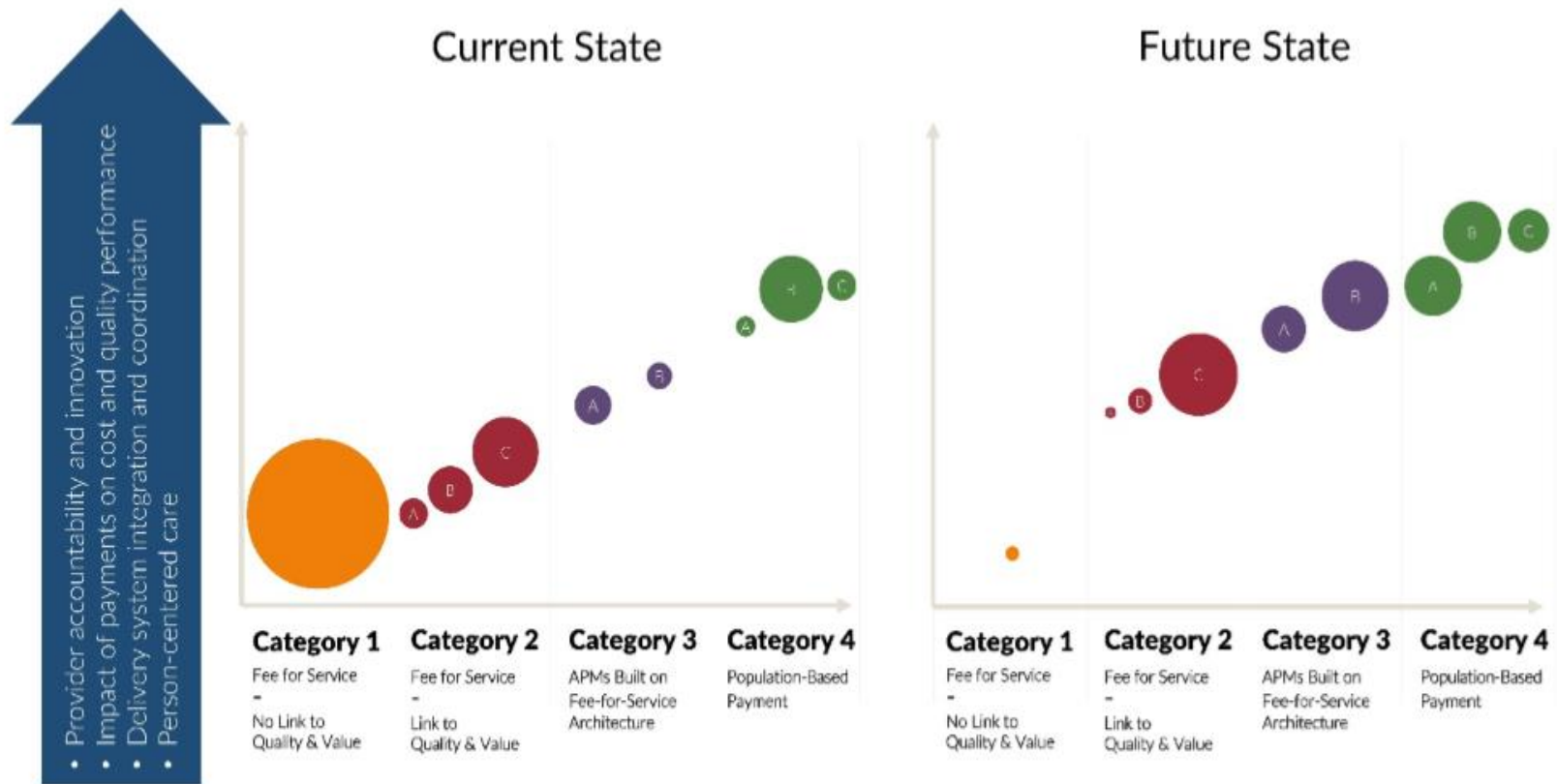
The system is built to award providers taking risk and the result is that those not taking risk are **significantly disadvantaged** in succeeding in transformation.

There is **currently no way to increase current reimbursement** unless you engage in transformation.

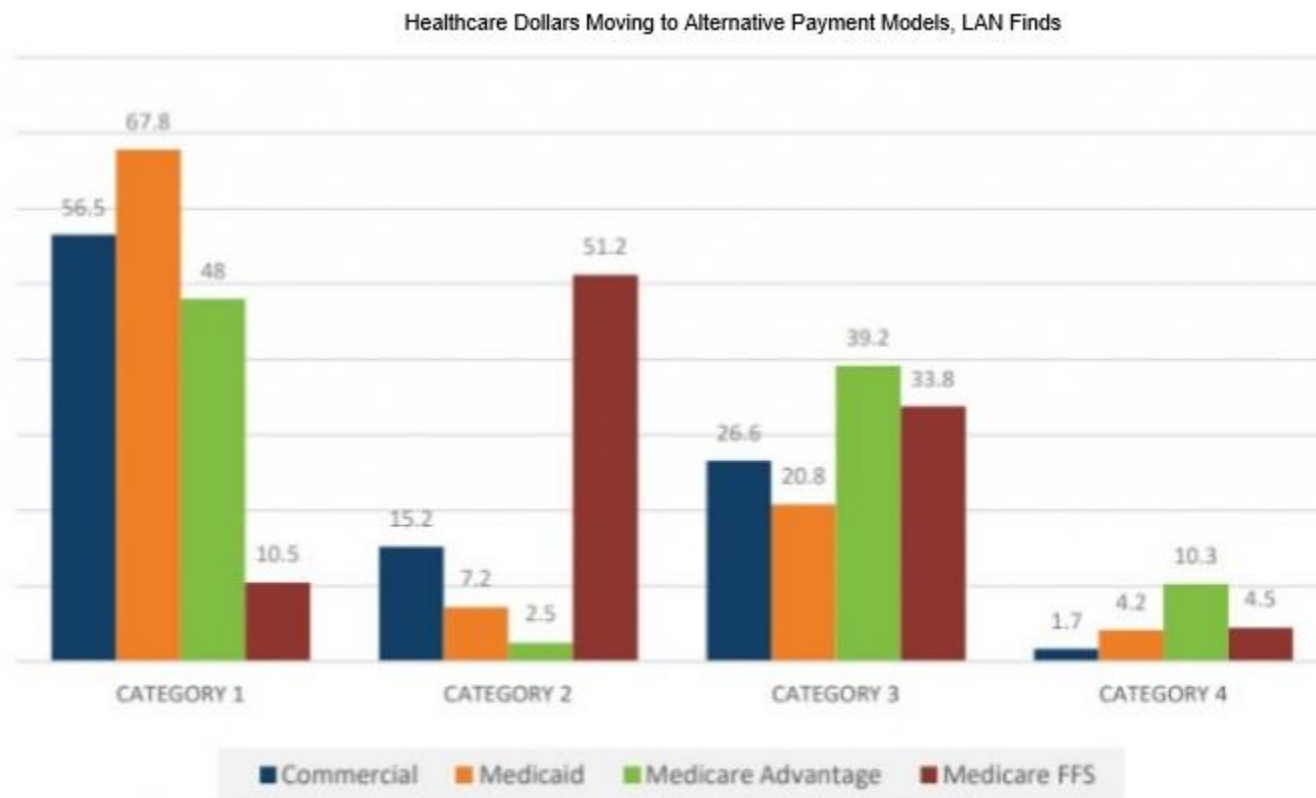


# Payment Reform Goals

Figure 3: Payment Reform Goals



# Participation in Payment Reform Categories



*Figure 4 shows each APM category by line of business. Note: total covered lives <sup>12</sup> and total healthcare spending in each line of business varies.*

([https://revcycleintelligence.com/images/site/articles/\\_large/LAN\\_Chart\\_1%2C\\_Healthcare\\_Payments\\_by\\_Category.jpg](https://revcycleintelligence.com/images/site/articles/_large/LAN_Chart_1%2C_Healthcare_Payments_by_Category.jpg))

Source: Health Care Payment Learning & Action Network (LAN)

# Payment Reform Categories

**Figure 2: LAN APM Measurement Effort Results:  
Comparison between 2015, 2016, and 2017 Payments**



*Figure 2 compares data from CY 2015, CY 2016, and CY 2017. In 2015, data was collected from 70 plans and 2 managed FFS Medicaid states, which represented 198.9 million lives or 67% of the U.S. covered population. In 2016, the data was collected from 78 plans, 3 managed FFS Medicaid states, and Medicare FFS. This represented 245.4 million lives or 84% of the U.S. covered population. In 2017, the data was collected from 61 plans, 3 states, and Medicare FFS, representing 226.3 million lives or 77% of the U.S. covered population.<sup>4</sup>*

([https://revcycleintelligence.com/images/site/articles/\\_large/LAN\\_Chart\\_1%2C\\_Healthcare\\_Payments\\_by\\_Category.jpg](https://revcycleintelligence.com/images/site/articles/_large/LAN_Chart_1%2C_Healthcare_Payments_by_Category.jpg))

Source: Health Care Payment Learning & Action Network (LAN)



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# Paradigm Shift

Merriam Webster's definition of a paradigm shift is:

***“an important change that happens when the usual way of thinking about or doing something is replaced by a new and different way.”***



# THE Paradigm Shift

We are in a discovery phase of THE Paradigm Shift in healthcare.

It is currently referred to as Transformation...to address both payment and delivery reform.

The shift is from reactive care to proactive care, from provider siloed to patient centered, and from transactional payments to outcome-based payments.

**And there is opportunity to be successful!**



# They Tyranny of Small Numbers

Rural providers' delivery and payment models are defined and are limited by the relatively small number of the patients they serve. The effect of low volume, narrow margins, few options results in being ruled by the "tyranny of small numbers".

***The unintended consequence is that in statistical terms rural providers are "outliers".***





# Statistics

In **statistics**, an **outlier** is a data point that differs significantly from other observations. An **outlier** may be **due** to variability in the measurement or it may indicate experimental error; the latter are sometimes excluded from the data set. An **outlier** can cause serious problems in **statistical** analyses.



# Outlier

**Outlier.** more ... A value that "lies outside" (is much smaller or larger than) most of the other values in a set of data. For example in the scores 25,29,3,32,85,33,27,28 both 3 and 85 are "**outliers**".



# How can outliers become an important part of a data set?

Outliers can range from being unimportant to being really important.

- **Outliers are unimportant** if they capture inaccurate information, and/or if they carry little weight in the analysis.
- **Outliers are really important** if they carry a lot of weight, and/or if they give you important information that the more “normal” data don’t.



# So why does this matter?

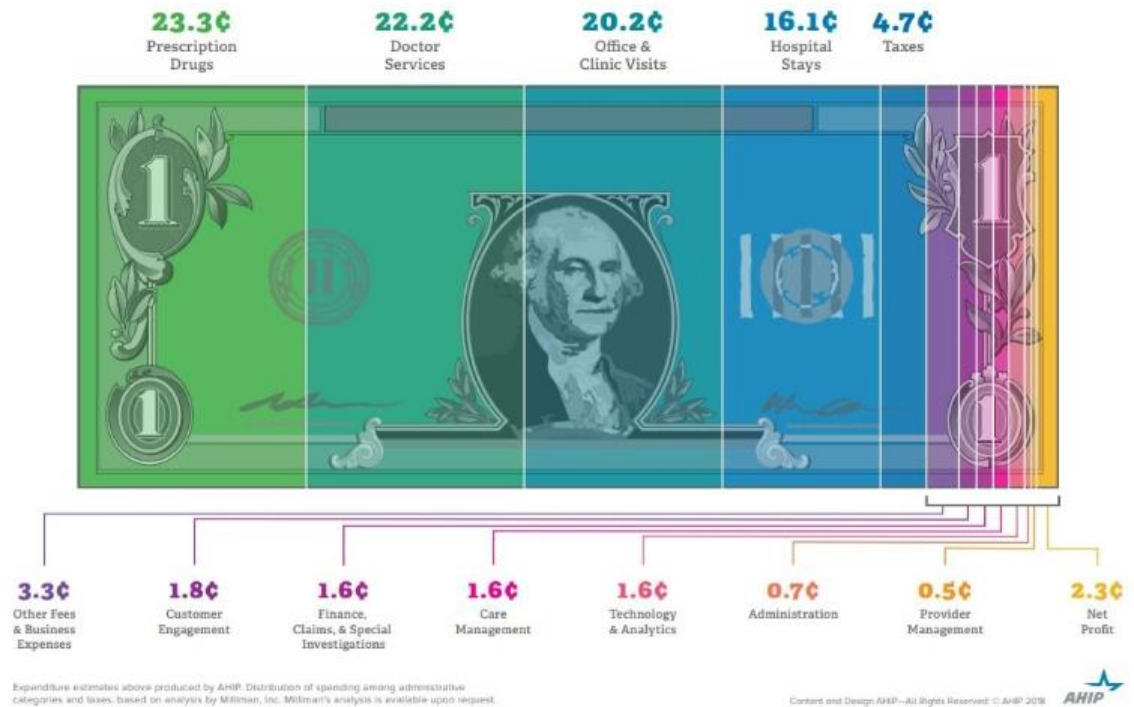
In the current state of health care reform-both payment and delivery reform-due to the spiraling increase in cost of care-- the entities that pay provider's bills, or payors, are seeking to control cost. In doing so, they use data to determine their risks and ***the result is identifying and ultimately excluding outliers.***

The US Census Bureau reports that there are approximately 60 million people in rural American, and yet rural health is considered an outlier.



# Thinking from a Payor perspective

81.8 cents for  
the medical  
Budget!



# Thinking from a Payor Perspective

Managing the medical budget involves risk and risk analysis.

Risk analysis requires statistics.

And in statistics there are outliers.

Because of the tyranny of small numbers, **rural providers are outliers.**

**Outliers are unimportant** if they capture inaccurate information, and/or if they carry little weight in the analysis.

**Outliers are really important** if they carry a lot of weight, and/or if they give you important information that the more “normal” data don’t.



# Measurement of Cost and Quality resides in the Data

data

MUST

reflect your story

in order to demonstrate

value



# Value is measured in Cost and Quality

## **Components of an Alternative Payment Model**

1. **Payments for Services**. The APM needs to pay healthcare providers in a way that reduces or eliminates any barriers in the current payment system that impede delivering high-value services to the eligible patients;
2. **Accountability for Spending**. The APM needs a mechanism for assuring patients and payers that avoidable spending will decrease (if the goal of the APM is to achieve savings), or that spending will not increase (if the goal of the APM is to improve quality);
3. **Accountability for Quality**. The APM also needs a mechanism for assuring that patients will receive equal or better quality of care and outcomes as they would with the kind of care they receive under the current payment system; and
4. **Patient Eligibility**. The APM needs a mechanism for determining which patients will be eligible for the services supported by the APM



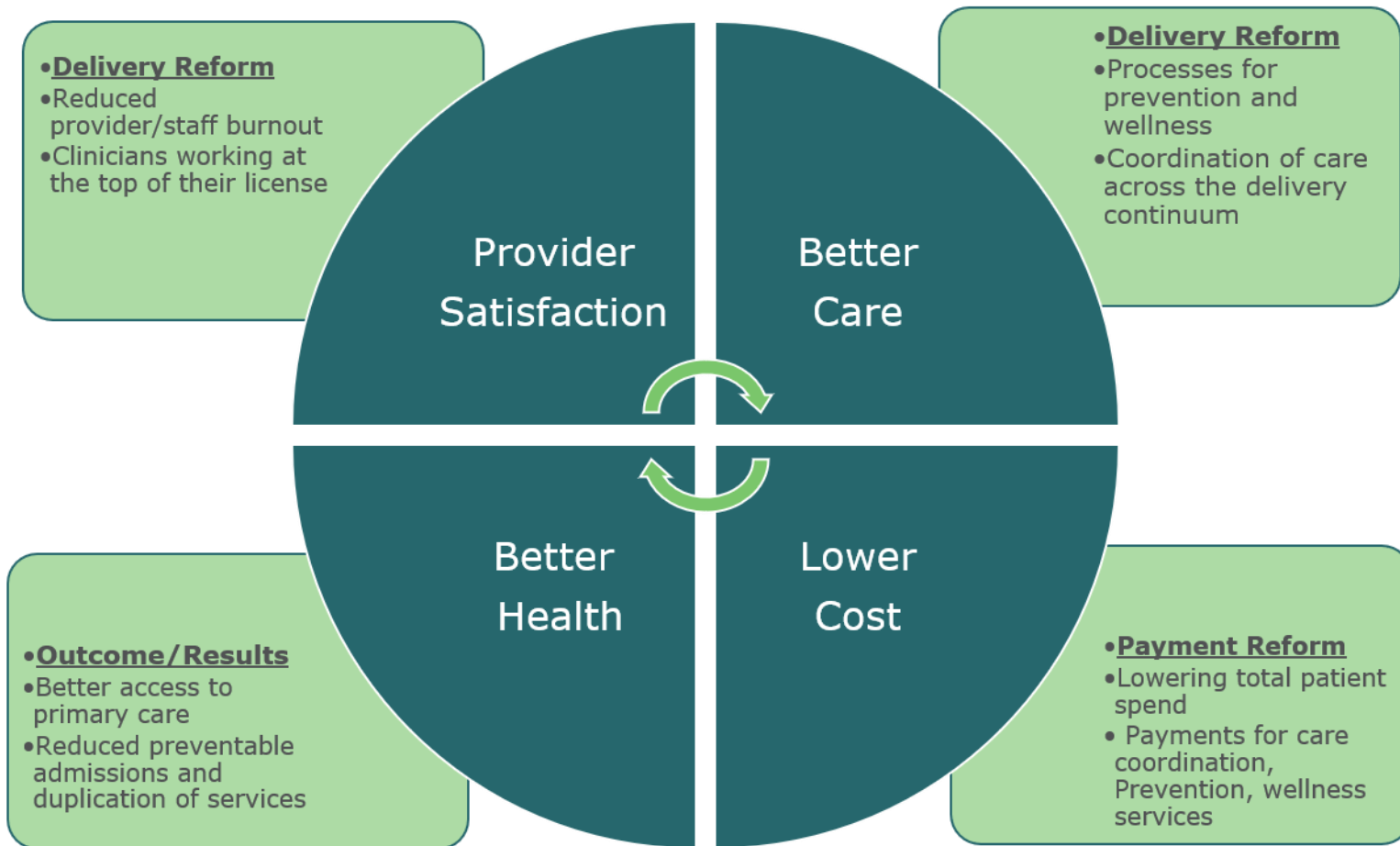


# Alternative Payment Models

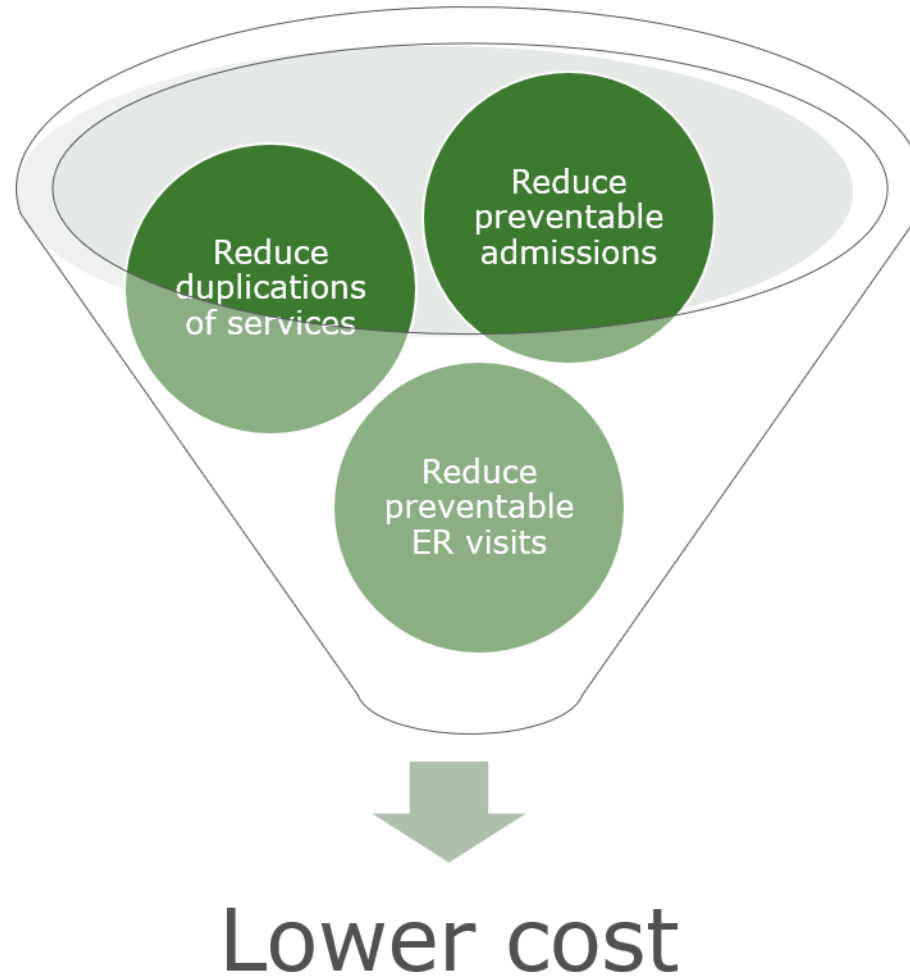
An ***Alternative Payment Model*** (APM) is a payment approach that gives *added incentive payments* to provide ***high-quality*** and ***cost-efficient*** care. APMs can apply to a specific clinical condition, a care episode, or a population.



# Quadruple AIM



# How can providers help lower cost or *“reduce total patient spend?”*



# How do practices provide better care or more *“efficient care delivery”*?

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

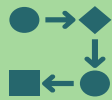


# How can practices create better health or *“better health outcomes”*?

- ✓ Fill care gaps and create more access for chronically ill
- ✓ Manage the patient and disease through consistent evidence-based processes
- ✓ Encourage patients to participate in prevention and wellness services



# Population Health Program Strategies



Workflow and Process

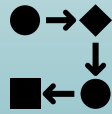


Prevention and Wellness



Coding, Documentation  
and Reporting





## Workflow and Process

### **Change practice workflow to support the quadruple aim**

- ✓ Modify workflow to address care gaps
- ✓ Use data to inform the process and continuously improve
- ✓ Implement necessary IT infrastructure
- ✓ Identify patients who are at risk
- ✓ Pre-visit planning
- ✓ Build a primary care relationship with patients



## Workflow Changes

- Use to data to manage patients
- Pre-visit outreach
- Patients seeing the nurse only
- Rooming a patient that is seeing only the nurse
- Hand off from nurse to doctor
- Role of care coordinator? Also AWWs?
- New type of work for nurse
- Physician nurse huddles
- Care plans—documentation and sharing







### **Provide prevention and wellness services**

- Annual Wellness Visits
  - ✓ Gather as much information as you can
  - ✓ Include other billable services such as advance care planning,
  - ✓ Refer appropriate follow up services, including care coordination
- Care Coordination
  - ✓ Set up the billable care coordination service
  - ✓ Train, mentor, and deploy Care Coordination Nurses
- Use Nurses to extend the services and care



# Population Health Revenue Opportunities

- Initial Preventative Physical Exam
- Annual Wellness Visit, Initial
- Annual Wellness Visit, Subsequent
- Advanced Care Planning
- Chronic Care Management
- Transitions of Care Management
- Integrated Behavioral Health
- Remote Patient Monitoring
- Diabetes Self Management Education
- Telehealth Originating Site Facility
- Preventive Health Screening
  - Depression Screening
  - Alcohol and Drug Screening
  - Alcohol/Substance abuse Assessment and Intervention
  - BMI above Normal
  - Behavioral Therapy for Obesity
  - Tobacco Use Counseling
  - Diabetes Self Management Training





# Coding, Documentation and Reporting

- Code claims properly
  - Any condition is not carried forward from year to year by a payor so each must be documented at least once annually
  - Code with Hierarchal Condition Category Code to demonstrate the severity of the disease state
- Document in the right place
  - Documentation in custom forms in EMRs don't always translate to custom reports
- Be prepared to report quality information
  - Quality payments are tied to identified actions connected to quality measures. If the actions don't show up in the reports you may have to report manually until you can coordinate your documentation with your reporting



# ***Collaborations, Coalitions and Networks***

## ***How we solve the volume problem***



# Coalitions

**Temporary grouping** of rival entities (such as buyer and sellers, sellers and sellers, or different political parties) **formed for a short-term and narrow aim** (such as countering a common enemy). Unlike an alliance, a coalition does not usually involve meeting of minds and pooling of resources.

Read more:

<http://www.businessdictionary.com/definition/coalition.html>



# Collaborations

1. General: Cooperative arrangement in which ***two or more parties*** (which may or may not have any previous relationship) ***work jointly towards a common goal.***
2.
  2. Knowledge management (KM): Effective ***method of transferring 'know how' among individuals,*** therefore critical to creating and sustaining a competitive advantage. Collaboration is a key tenet of KM.
3.
  3. Negotiations: Conflict resolution strategy that uses both assertiveness and cooperation to ***seek solutions advantageous to all parties.*** It succeeds usually where the participants' goals are compatible, and the interaction among them is important in attaining those goals.

Read more: <http://www.businessdictionary.com/definition/collaboration.html>



A **business network** is a **complex network of companies, working together to accomplish certain objectives**. These objectives, which are strategic and operational, are adopted by business networks based on their role in the market. There are two categories of business networks — business associations and company aggregations — that help small and medium-sized enterprises (SME) to become more competitive and innovative. Wikipedia



# Opportunity

Volume	Infrastructure	Vehicle	Platform	Foundation
<ul style="list-style-type: none"><li>• Patients</li><li>• Data</li><li>• Empirical Evidence of Value</li></ul>	<ul style="list-style-type: none"><li>• Shared services</li><li>• Shared Governance</li><li>• Shared Cost</li></ul>	<ul style="list-style-type: none"><li>• Participate in payment models</li></ul>	<ul style="list-style-type: none"><li>• Virtual integration</li><li>• Collaboration</li></ul>	<ul style="list-style-type: none"><li>• Act as an enterprise</li><li>• Maintain financial autonomy</li></ul>





# What is the *Rural Option?*



# Value

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# Contact Information

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