The Rural Bridge to Value and Population Health

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The National Rural Health Resource Center (The Center) is a non-profit organization dedicated to improving health care in rural communities. As the nation’s leading technical assistance and knowledge center in rural health, we focus on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce
It’s Changing!

Institute for Healthcare Improvement (IHI) Triple Aim
- Better health
- Better care
- Lower cost

CMS Health Care Transformation Vision
- Better Care
- Smarter Spending
- Healthier People
Alternative Payment Model Targets

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

2011
- 0%
- ~70%

2014
- ~20%
- >80%

2016
- 30%
- 85%

2018
- 50%
- 90%

Historical Performance Goals
HHS/CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality.

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<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tr>
<td>Accountable Care Organizations</td>
<td>Medicare Shared Savings Program ACO*</td>
<td>Pioneer ACO*</td>
<td>Comprehensive ESRD Care Model</td>
<td>Next Generation ACO</td>
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<td>Bundled Payments</td>
<td>Bundled Payment for Care Improvement*</td>
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<td>Advanced Primary Care</td>
<td>Comprehensive Primary Care*</td>
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<td>Multi-payer Advanced Primary Care Practice*</td>
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<td>Other Models</td>
<td>Maryland All-Payer Hospital Payments*</td>
<td>ESRD Prospective Payment System*</td>
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CMS will continue to test new models and will identify opportunities to expand existing models.

* MSSP started in 2012, Pioneer started in 2012, BFCI started in 2013, CPC started in 2012, MAIPC started in 2011, Maryland All-Payer started in 2014 ESRD PPS started in 2011.

Source: Alternative Payment Models and Sustainability, Advance Interoperable HIE Program Senior Leader Call, February 24, 2016, John Rancourt, Deputy Director, Office of Care Transformation
Accountable Care Organizations (ACOs):

- A mechanism to monetize value by increasing quality and reducing cost
- A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals
Accountable Care Organizations (ACOs)

• Rapid growth
  ◦ August 2012: 154
  ◦ January 2015: 747
  ◦ January 2016: 1,000+ (41 new in rural)
  ◦ July 2016: 1,000+ in Transforming Clinical Practice Initiative (TCPI)

• Both hospital and physician led

• Medicare and private insurance models
According to a 2014 Leavitt Partners survey for Modern Healthcare magazine:

- $417 million in savings
- 19% improvement in quality
- 2013 growth in health spending lowest since 1960
Population Health has Many Determinants

Health Behaviors (30%)
- Tobacco Use
- Diet & Exercise
- Alcohol & Drug Use
- Sexual Activity

Clinical Care (20%)
- Access to Care
- Quality of Care

Social & Economic Factors (40%)
- Education
- Employment
- Income
- Family & Social Support
- Community Safety

Physical Environment (10%)
- Air & Water Quality
- Housing & Transit

Rural Health Value, *Understanding the Social Determinants of Health: A Self-Guided Learning Module for Rural Health Care Teams*
Population Health has Many Partners

- Hospitals
- Clinics
- Mental Health
- Schools
- Government
- Businesses
- Long-Term Care
- Faith-based Organizations
- Housing
- Public Health
- Social Services
• Revenue stream of the future tied to primary care providers
• Lower beneficiary costs in rural
• Critical access hospitals (CAHs), rural health clinics (RHCs), and federally qualified health centers (FQHCs) have reimbursement advantages in the old payment system
• Rural can change more quickly
• Rural is more community-based
The Challenge: Crossing the Shaky Bridge
Leadership

• Educate & align key leaders:
  ◦ Boards
  ◦ Providers
  ◦ CEO/CFO/CNO/Managers

• Develop a compelling strategic plan to achieve value
Collaboration/Partnerships

• Partner with:
  ◦ Primary care providers
  ◦ Other/community services
  ◦ Businesses
  ◦ Payers?
• Join Networks/Systems
• Engage Community and Patients
Maximize Finances/Quality

- Maximize financial and quality performance
- Optimize revenue cycle management, coding and cost accounting
- Improve customer satisfaction and quality
- Develop Lean processes
Care Management

- Develop care coordination capabilities
- Redesign care processes
- Focus on high cost patients
- Focus on chronic illness management
Information Management

- Develop access to shared patient databases
- Gain access to in-depth data analysis
- Use information to improve value of services
- Use information to improve patient outcomes
Technology

• Develop effective:
  ◦ Telehealth applications
  ◦ Websites and social media
  ◦ Handheld technology applications
  ◦ Educational technology
Workforce Preparation

- Help staff understand the “why” of change
- Develop a culture of continuous improvement
- Teach staff new value-based and population health skills and knowledge
- Maximize teamwork and customer focused services
Population Health Management

- Develop new wellness and disease prevention services – start with hospital staff
- Engage and enlist partnerships with patients and their families
- Lead/join initiatives to address community health needs and issues
A health system that links health care with community stakeholders, to create a network of organizations working together to improve population health.
What Rural Providers can do Now

• Determine the most important things to do now to prepare for ACOs and other value models
• Determine where providers are now in preparation for value – readiness
• Develop strategies to bridge the gap between current and future payment systems
• Work together to maximize efficiency and shared volume
• Participate in value-based models
“Even if you’re on the right track, you’ll get run over if you just sit there.”
-Will Rogers
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