



NATIONAL  
RURAL HEALTH  
RESOURCE CENTER

Delta Region Community Health Systems Development (DRCHSD)

# The Big Picture – Results Matter

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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



# Today's Context

What does your data say to purchasers of healthcare?



# Rural State of Affairs



## Rural Hospital Closures



### Rural Hospital Closures since 2010\*

88

### Rural Hospital Vulnerability Heat Map\*\*



### Losing vulnerable rural hospitals would jeopardize...



11.7M

Patient Encounters  
within 1 year\*\*



99,000

Healthcare Jobs Lost  
within 1 year\*\*



137,000

Community Job Lost  
within 1 year\*\*



\$277B

Loss to GDP within 10  
years\*\*



# Today's Agenda

## Background:

- Drivers of change

- Direction of change

- Why is this even a conversation?

- How did we get here?

## Rural Barriers and how to overcome

- Unintended consequences

- How to demonstrate your hospital matters

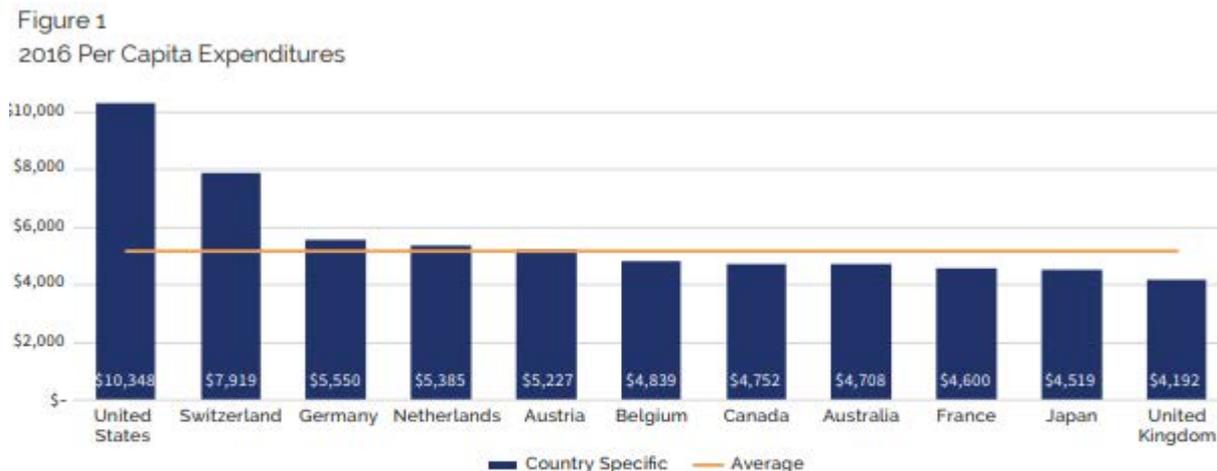
- Impact of Healthcare changes, in general and worldwide



# Healthcare Transformation



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.



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



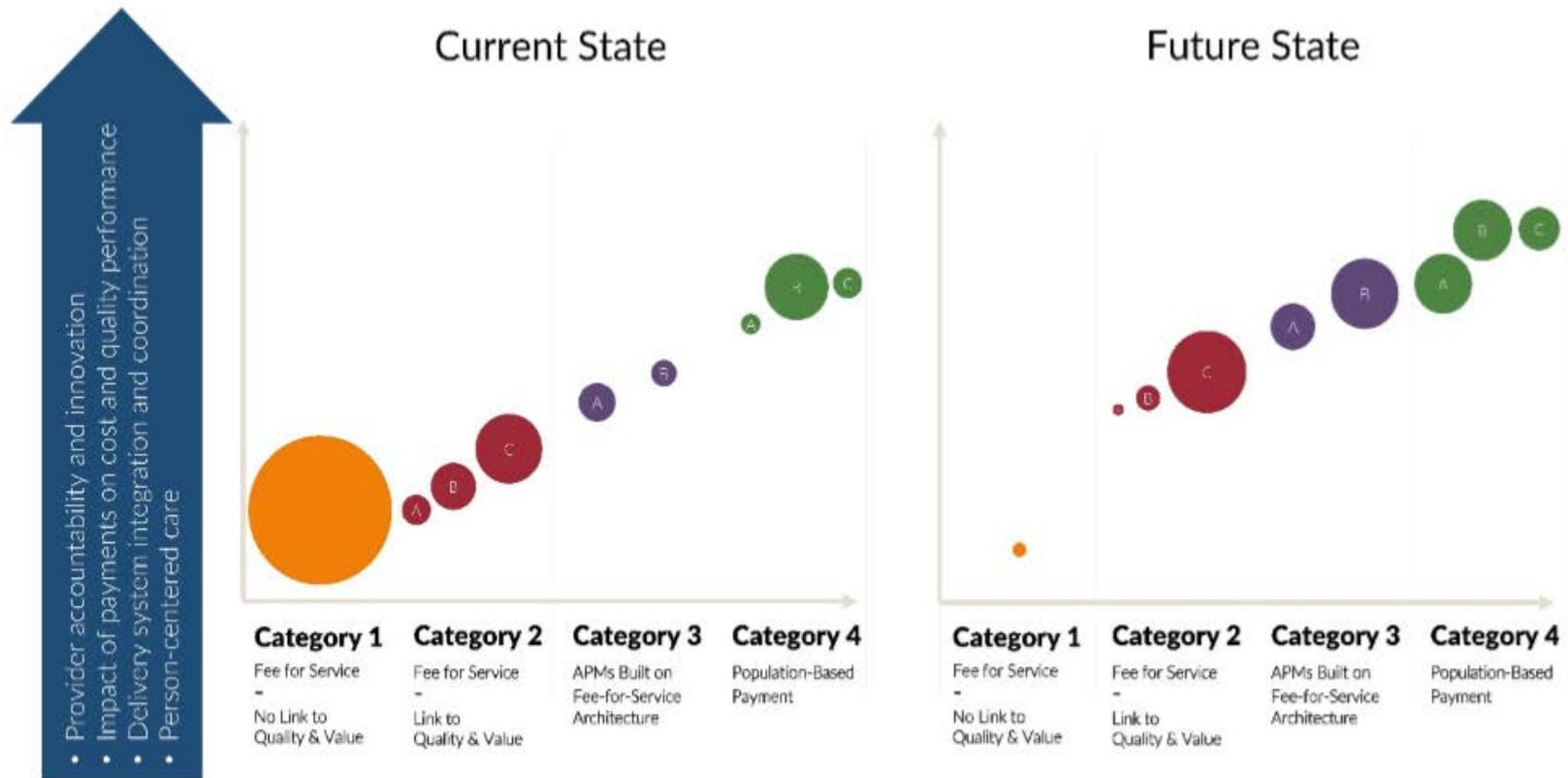
# The 5/50 Population

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...

# Medicare Payment Reform Goals

Figure 3: Payment Reform Goals



# CMS' Seema Verma's Rural Offerings

1. QPP provides support for small, underserved, and rural practices...helping them actively participate in the program.
2. Advancing new telehealth payment policies across the board to cover more services.
3. Working with the FCC to accelerate the expansion of broadband capabilities to support telehealth technology in rural communities.
4. Due to differences in Medicare wage index, issued a proposed rule to increase reimbursement to rural hospitals that would allow them to improve quality, attract more talent, and expand patient access.
5. Expanding value-based payment arrangements that cater to the unique needs of rural communities and recently announced the new CMS Primary Cares Initiative, which offers 2 pathways—Primary Care First and Direct Contracting—and five voluntary model options to test how to pay for primary care.

# What's not included in her offer?

Removing the “value” imperative of measurement and accountability for cost and quality



# 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.

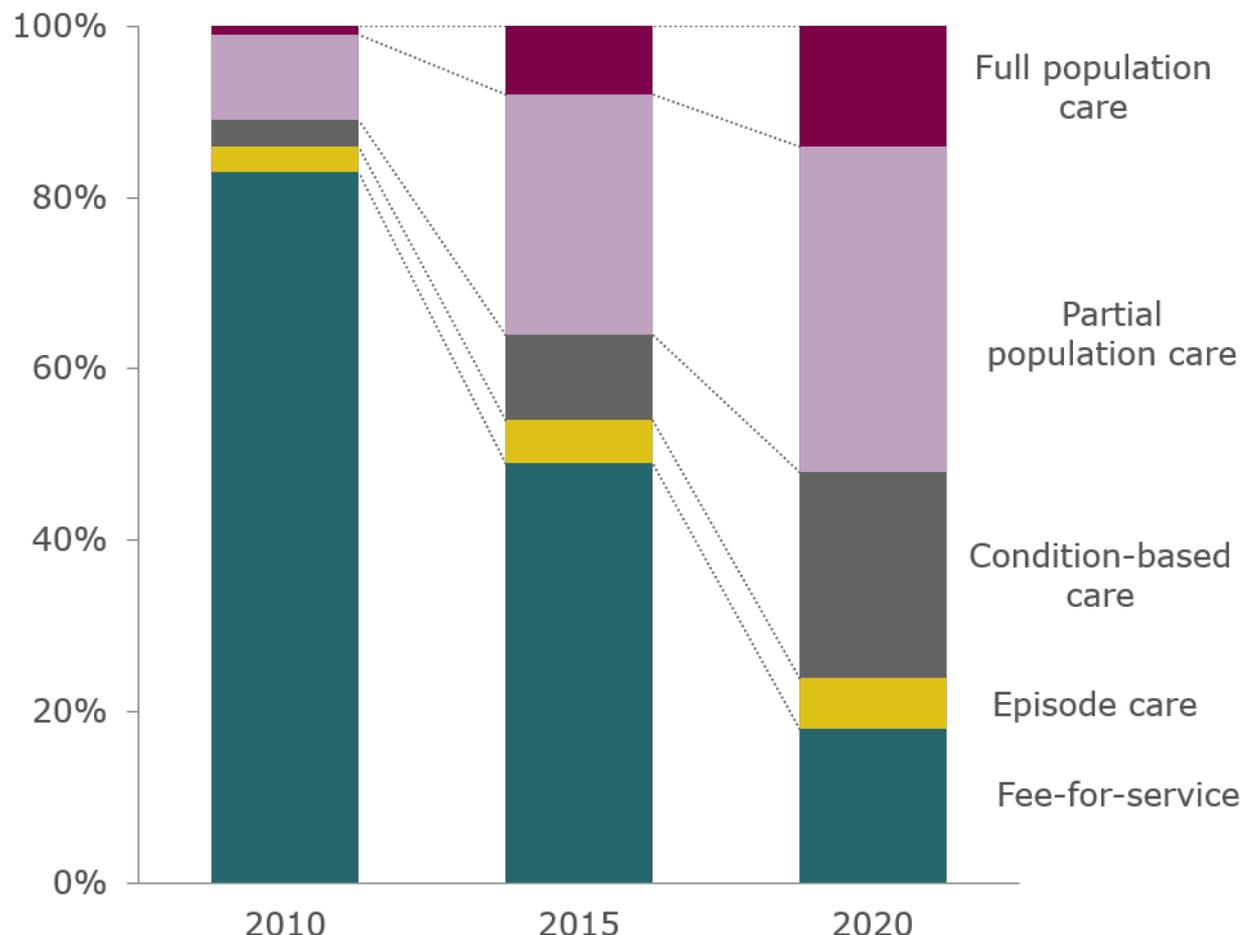
Inherent in these efforts is a requirement for providers to **engage in transformation and ultimately in risk.**

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.



# The Changing Healthcare Market— Payment Methodologies



Source: "The View from Healthcare's Front Lines: An Oliver Wyman CEO Survey"



# The Changing Healthcare Market – Government and Commercial Payors

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



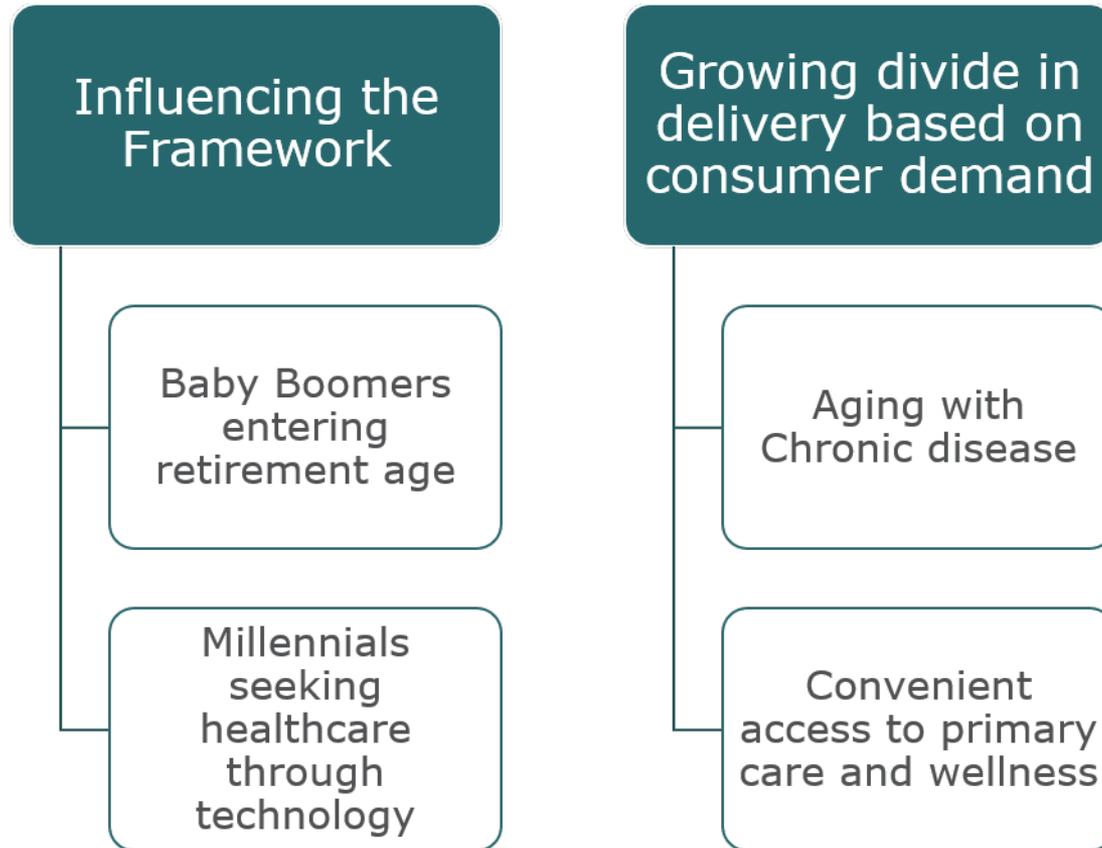
*Figure 2 compares data from CY 2015, CY 2016, and CY 2017. In 2015, data was collected from 70 plans and 2 managed FFS Medicaid states, which represented 198.9 million lives or 67% of the U.S. covered population. In 2016, the data was collected from 78 plans, 3 managed FFS Medicaid states, and Medicare 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)



# The Changing Healthcare Market - Demographic Changes



# Current State of Healthcare

Fragmentation or variation 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 Rural Barriers:

## Small Numbers

### Exceptions to “Norms”



# The 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".***



# Data Driven External Pressures

Competition

Perceived  
Relevance

Demand for  
Quality

Demand for  
Value



# The effect of status quo

- We've never had to market before
  - We were the only game in town
  - There was generally one major payor—the government (Medicaid, Medicare, Self pay, no pay and indigent)
  - So documentation was driven by government programs addressing the Tyranny of Small Numbers
- Today purchasers of health care are large national insurance companies, even for the government populations. Those programs (Medicaid Managed Care, Medicare Advantage, Commercial, exchanges) **DON'T** **ADJUST THEIR analysis for ToSN**

# 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.



# By any other name....

## Winsorizing



Winsorizing or winsorization is the transformation of statistics by limiting extreme values in the statistical data to reduce the effect of possibly spurious outliers. It is named after the engineer-turned-biostatistician Charles P. Winsor. The effect is the same as clipping in signal processing. [Wikipedia](#)



# 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.***



# Blue Cross Blue Shield Example

## The BLUEQ Scorecard

- Used Data for measurement was publicly available data
- 427 hospitals measured

## The BLUEQ Ribbon Network

- Ranked as Exceeds, Meets, Does not Meet, Not Enough Data, or Declined
- Marketed directly to patients as an option for a provider network with a lower co-pay or deductible.
- Most rural hospitals did not have enough data. The results was that patients were ***incentivized to chose a provider in the network instead of close to home.***



# 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.

data

MUST

reflect your story

in order to demonstrate

value



# How do you build your Value Story?



# Benefit of the Tyranny of Small numbers—Experience!

The historical effect of the Tyranny of Small Numbers=  
experience in payment and delivery reform

Payment Model

All Inclusive Rate

Delivery Model

Critical Access Hospital Designation  
(CAH)

Payment Model  
(DSH)

Disproportional Share Payments

Delivery Model

Rural Health Clinics

Payment Model

Cost Based Reimbursements



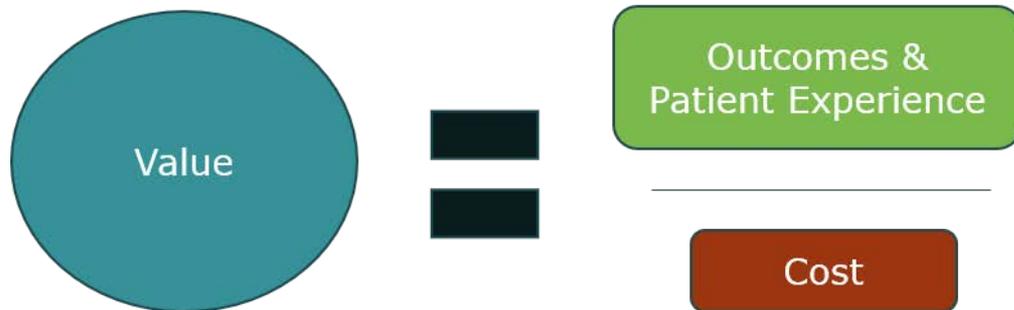
Oh, and then there is the tyranny of small decisions....

What results when a person, group of people, business or organization make a number of small decisions over a period of time. These decisions are not bad decisions on their own but, taken together over a period of time, the result of the decisions are diametrically opposite from the outcome desired.

**Unintended Consequences, missed opportunities**



# What Value do Rural Providers offer to CMS and other payors payors?

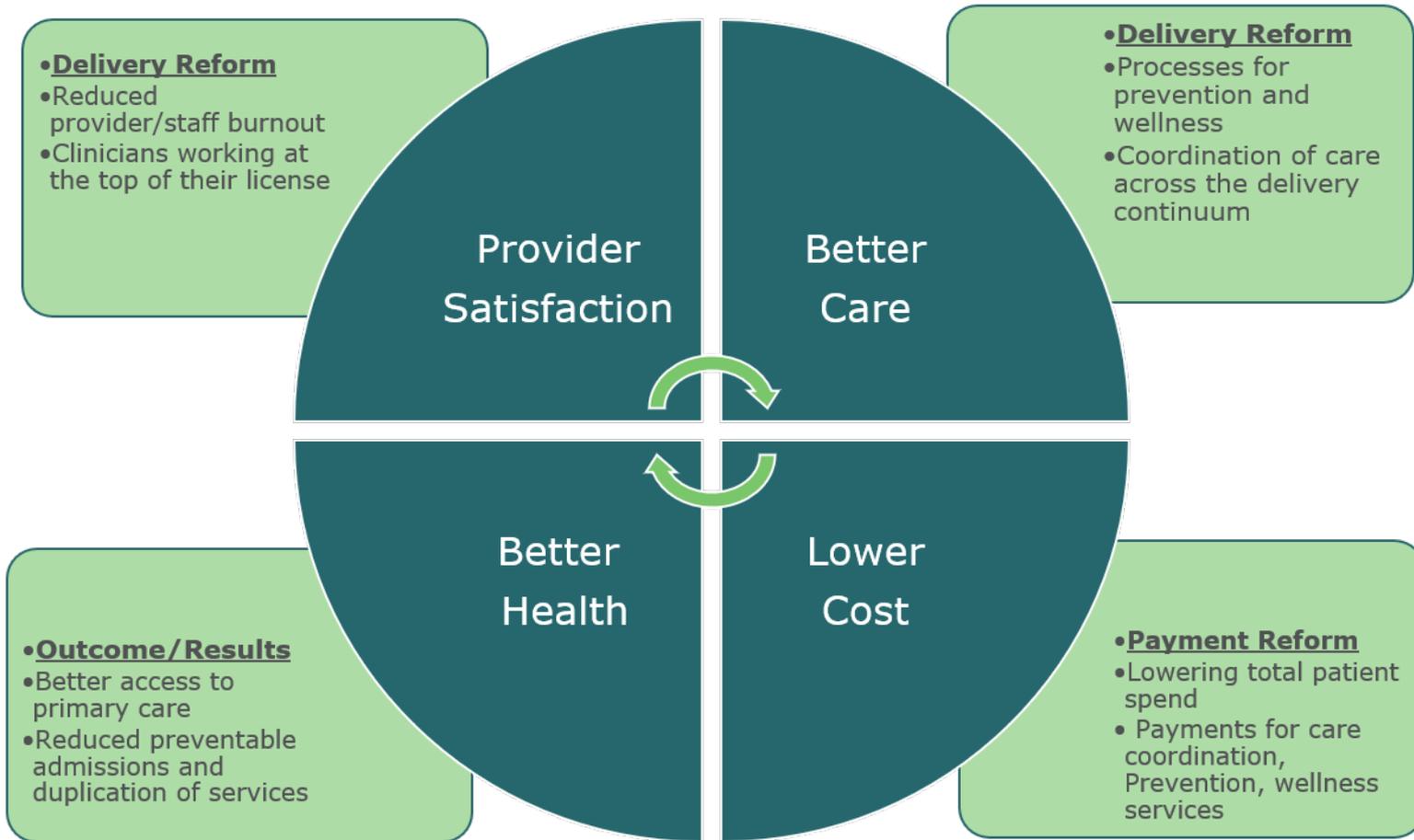


# Value is measured in Cost and Quality

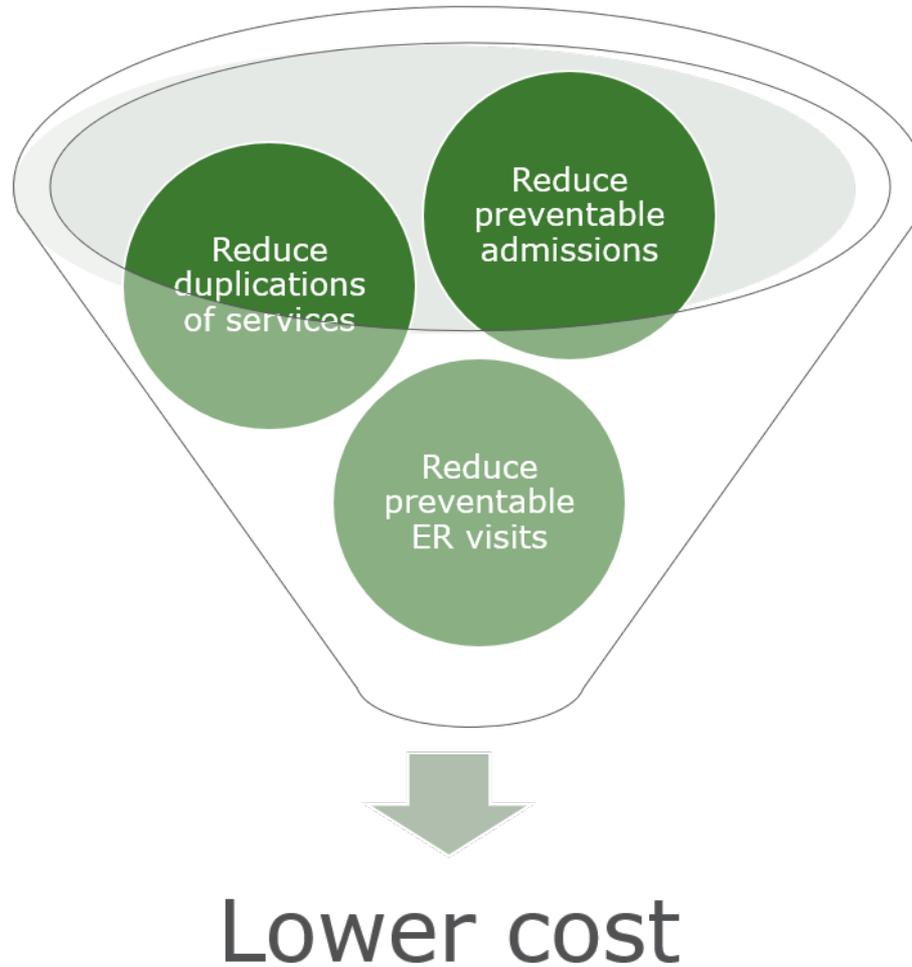
## *Components of an Alternative Payment Model*

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

# 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
- ✓ Managed the chronically ill



# 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

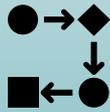


Prevention and Wellness



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





## **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
- Deploy Secondary Prevention
  - ✓ Providing Early diagnosis and treatment





# 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



What  
is the  
*Rural Value  
Story?*



# Become the **Outliers that are really important!**

Carry a lot of weight, and/or give important information that the more “normal” data don’t.

Become most coveted high-quality providers, measured in their metrics but in our terms.



# The Big Picture - Results Matter

**Sustainability is dependent on fair and equitable payments;**

**Payment is dependent on documented results!**

- Results = measurable positive changes in available data.
- Available data = claims + some reports.
- Providers are measured on results found in claims data and other publicly available data; and their revenue is directly impacted by these data



data

MUST

reflect your story

in order to demonstrate

value



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