Arguments for a Rural Integrated Service System (RISS)

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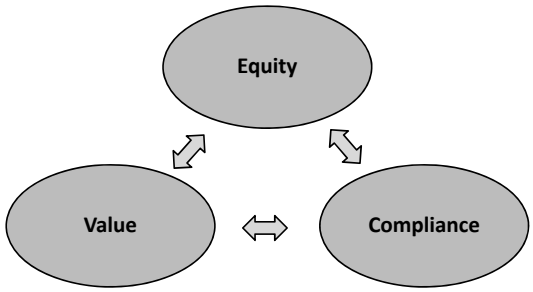
Arguments for Rural Health Services



Arguments for Rural Health Services

- **Equity**:
  - Rural residents deserve, as a matter of public policy, access to key services equal to that of urban residents.
- **Value**:
  - A rural-based health system is a more cost-effective way to provide key services to rural residents than is a consolidated regional health system.
- **Compliance**
  - Rural health services must be provided to assure compliance with health insurance regulatory requirements.

Defining a Rural Integrated Service System

- **Key Question: What services should be provided in a rural community?**
  - The RISS model specifies a range of services that could reasonably be expected to be available in different types of rural communities.
  - Rationale for the selected services is based on a combination of value, compliance and equity.
  - RISS Also identifies services not available locally that would need to be linked to the local system.
  - Specifies a broad level of each service to be expected.
- **The RISS does not specify how services should be organized in any rural community.**
  - Communities can build a local health system with these components in many different ways.

What RISS Is/Isn't

- **The RISS model is**:
  - **A comprehensive set of *recommended* services.**
    - **Few communities have all these services, so it is a menu for long-term development.**
    - **Communities can select priority sets of services for implementation, based on local needs.**
- **The RISS model isn't**:
  - **A specific recommendation for how services should be structured locally.**
  - **A minimum standard for local health system.**

Models for Three Target Communities

- **Service expectations are not the same for all rural/frontier communities.**
- **In developing the RISS model, we discussed three different local community service systems:**
  - **Core system:** for communities without a hospital.
  - **CAH-Small Hospital System:** for communities with a CAH or small hospital with a limited range of services.
  - **Acute Care Hospital System:** for communities with a larger general purpose acute care hospital.

RISS Service Expectation Levels

- **Full-time services**:
  - Available at least 8 hours a day, 5 days a week.
- **Part- time services**:
  - Available on a regular part-time basis, with scheduled service each week.
- **Scheduled occasional services**:
  - Available on a scheduled basis less than once a week.
- **Referred services**:
  - Available by referral outside of rural service area.

Treatment Services

- **Primary Care**
  - **Medical**
  - **Oral Health**
  - **Behavioral Health**
- **Laboratory Services**
- **Pharmacy Services**
- **Radiology/Imaging Services**
- **Specialty Care**
- **Ancillary Therapies**
  - **Respiratory Therapy**
  - **Physical Therapy**
  - **Occupational Therapy**
- **Public Health Services**
  - **Clinical Preventive Services**
  - **Health Promotion/Disease Prevention**
  - **(See also System Integration Services)**

- **Emergency/Transport Services**
  - **EMS**
  - **Trauma Care**
  - **ACLS**
  - **Non-Emergency Transport**
- **Inpatient Services**
- **Long-Term Care**
  - **Skilled Nursing Facility**
  - **Intermediate Care Facility**
  - **Swing Bed**
  - **Home Health Care**
  - **Hospice/Home Hospice**

System Integrating Services - 1

- **Patient Care Management Services**
  - **Chronic Disease Management**
    - Clinical Chronic Care Management
    - Self-Care Education
    - Chronic Disease Care Manager Services
    - Patient Follow-up Services
    - Home Visiting/Care
  - **High Risk Patient Care Management**
    - May include many of same services as chronic disease management
  - **High Service Utilization Patient Care Management**
    - May include many of same services as chronic disease management

- **Care Transition Management Services**
  - **Outpatient to Inpatient**
  - **Hospital to Outpatient**
  - **Hospital to LTC**
    - Home Health
    - Nursing Care
    - Swing Beds
    - SNF/ICF
    - Hospice/Home Hospice
  - **Primary Care to Specialist**
    - Clinical Referral
    - Primary/Specialist Clinical Care Coordination

System Integrating Services - 2

- **Community Health Promotion/Disease Prevention**
  - Community Health Education
  - Patient Education
  - Patient Clinical Prevention
  - Patient Follow-up for Preventive Services
- **Practice/Operations Improvement**
  - Clinical Effectiveness Improvement
  - Patient Safety Improvement
- **Emergency Department Utilization Reduction**
  - Screening/Urgent Care Diversion
  - Patient Advice Service/Assurance Service
  - SBIRT

Specification of Service Expectations - 1

	Rural System Category		
Treatment Service Category	**Core**	**CAH - Small Hospital**	**Acute Care**
Pre-Hospital Services			
Emergency Medical Services	EMT-B-Basic; Higher-trained personnel where possible; First Responder Network in Outlying Areas; transport based in-area where feasible; medical control and EMT supervision from out of area through telecommunication and written protocol.	EMT-B-Basic; Higher-trained personnel where possible; First Responder Network in Outlying Areas; transport based in-area.	EMT-Intermediate; Higher-trained personnel where possible; First Responder Network in Outlying Areas; transport based in-area; medical control and EMT supervision managed by through and written protocol with a combination of local and out-of-area clinicians.
Automated External Defibrillators	AEDs located in key community locations. Training provided to first responders and other key individuals.	AEDs located in key community locations. Training provided to first responders and other key individuals.	AEDs located in key community locations. Training provided to first responders and other key individuals.
Primary Care - Medical			
Primary Care - Generalist	Full-time non-physician clinician or part-time physician; staffing may be supplemented by additional intermittent clinicians as needed. PP/GP services at minimum.	Full time clinician - either physician or non-physician; staffing may be supplemented by additional part-time clinicians, as needed.	Full time practice of multiple practitioners; may include combination of physician and non-physician clinicians; may include combination of generalist and primary care specialist staff (e.g. pediatrics or general internal medicine) as determined by local community.
Primary Care - Specialties (pediatrics, general internal medicine, obstetrics/gynecology)	Referral to out-of-area primary care specialists. Periodic on-site primary care specialist clinics. Local generalist care coordinated with specialist for continuity.	Part-time primary care specialists. Some periodic primary care specialist clinics. Referral to out-of-area primary care specialist care. Local generalist care coordinated with specialist for continuity.	Some full-time primary care specialists. Additional part-time primary care specialists. Supplemental referral to out-of-area primary care specialists as needed. Local generalist care coordinated with specialist for
After-Hours Coverage	24-hour telephone advice and triage service available on local call exchanges. Coordinated scheduling of care for non-emergent cases. Coordinated EMS transport for emergency situations.	24-hour telephone advice and triage service available on local call exchanges. Limited on-call coverage by local providers for appropriate cases. Coordinated scheduling of care for non-emergent cases. Coordinated EMS transport for emergency situations.	24-hour telephone advice and triage service available on local call exchanges. On-call coverage by local providers for appropriate cases. Coordinated scheduling of care for non-emergent cases. Coordinated EMS transport for emergency situations.

Specification of Service Expectations - 2

	Rural System Category		
Integrating Service Category	**Core**	**CAH - Small Hospital**	**Acute Care**
Patient Care Management Services			
Chronic Disease Management	Part-time outreach, follow-up, care coordination and management service, as needed.	Full-time outreach, follow-up, care coordination and management service, as needed.	Full-time outreach, follow-up, care coordination and management service, as needed.
High Risk Management	Part-time outreach, follow-up, care coordination and management service, as needed.	Full-time outreach, follow-up, care coordination and management service, as needed.	Full-time outreach, follow-up, care coordination and management service, as needed.
High Service Utilization Management	Part-time outreach, follow-up, care coordination and management service, as needed.	Full-time outreach, follow-up, care coordination and management service, as needed.	Full-time outreach, follow-up, care coordination and management service, as needed.
Care Transition Management Services			
Hospital to Outpatient Transition	Part-time discharge planning, follow-up and outreach, as needed. May be based off-site at hospital.	Part-time discharge planning, follow-up and outreach, as needed.	Full-time discharge planning, follow-up and outreach.
Hospital to Long Term Care Transition	Part-time discharge planning, follow-up and outreach, as needed. May be based off-site at hospital.	Part-time discharge planning, follow-up and outreach, as needed.	Full-time discharge planning, follow-up and outreach.

New PPACA-Related Service Structures

- **Several new innovative service structures are emerging related to PPACA demonstrations.**
  - **Patient-Centered Medical Home.**
  - **Accountable Care Organization.**
  - **FCHIP/FHS.**
- **Each model includes a different provider structure and a different combination of services to be provided.**
  - **A commonality in these new service structure is the addition of new integrating services.**
- **None of the new structures provides as comprehensive a set of services as is specified in the RISS model.**

Patient-Centered Medical Home

- **Service Structure**: individual primary care practice or primary care center.
- **Target Group**: enrolled patients of practice/health center. Potentially limited to those with a given insurance coverage.
- **Services included**: primary medical care services, care planning including behavioral health, chronic care management services, clinical preventive services management, and enhanced patient self-care support. (NCQA model).
- **Payment Mechanism**: supplemental fee to practice, typically PM/PM.
- **Outcomes Anticipated**: Reduced inappropriate service utilization, improved service continuity, reduced cost, improved health outcome.

Accountable Care Organization (ACO)

- **Service Structure**: Regional network organization of primary care practitioners, specialists and inpatient service providers. Under federal model governance emphasis on primary care providers.
- **Target Group**: Participating Medicare enrolled patients – minimum of 5,000 willing enrollees.
- **Services Included**: primary medical care, specialist care, hospital care, care coordination services, transition management services, and practice improvement initiatives.
- **Payment Mechanism**: Per patient budgeted fee with incentives for reduced cost/utilization. Shared savings incentives. May include a risk-sharing option.
- **Outcomes Anticipated**: Reduced inappropriate service utilization, improved service continuity, reduced cost, improved health outcome.

Frontier Community Health Integration Project (F-CHIP) – Frontier Health System (FHS)

- **Service Structure**: Local rural network organization of CAH, primary care provider, home health and nursing home. Limited currently to target counties in select states.
- **Target Group**: Medicare enrollees in local communities.
- **Services Included**: Hospital services, home health services, primary care services, EMS, transition management services, patient-centered medical home services, chronic care management services, practice improvement.
- **Payment Mechanism**: Cost-based payment for bundled services. Capped to assure savings.
- **Outcomes Anticipated**: Reduced inappropriate service utilization, improved service continuity, reduced cost, improved health outcome.

Linking Rural Community-Based Services to Regional Services

- **The shift of community-based services to regional centers (consolidation) is a challenge for rural residents.**
  - **It shifts costs from providers to consumers, who must incur travel costs to access services.**
- **The RISS model must include integrating services, including referral management and transition management services, which make the provision of services across community lines as seamless as possible**

A Population-Based Approach for Integrating Services

- **What are the important target sub-populations for integrating services:**
  - **Populations with chronic conditions**
    - **Heart disease**
    - **High blood pressure**
    - **Diabetes**
    - **COPD**
    - **Asthma**
  - **Pregnant women with high-risk conditions**
  - **Individuals with severe and chronic behavioral health problems, including substance abuse**
- **Subsets of sub-population based upon insurance coverage.**
- **Subsets of patients based upon service provider registration.**

Where should Integrating Services be Located In Rural Communities?

- Individual outpatient practices
- Hospitals/CAHS
- Community-wide programs
- Hybrid
  - Combinations of the above

Steps in Development of the RISS Model

- Specify plans/priorities/pathways for RISS development.
- Specify alternative RISS structures.
- Specify RISS payment mechanisms for different structures.
- Develop the case for RISS:
  - Show estimated reduction in unnecessary health care cost.
  - Show estimated costing/cost saving
  - Show estimated improved health outcomes.