NOSORH REGION E

The Future of Rural Health
July 2013

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Agenda

- Current & future rural health
- National Rural Accountable Care Organization (ACO)
- Oregon, Montana & Alaska experience
- Your thoughts on how to get paid in the future

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OBAMA SIGNS SWEEPING HEALTHCARE REFORM BILL AFTER PASSAGE BY THE HOUSE

THE MOMENT IT ALL CHANGED

Every sector of the industry starts sifting through hundreds of pages of legislation to assess the law's financial and regulatory impact / Page 6

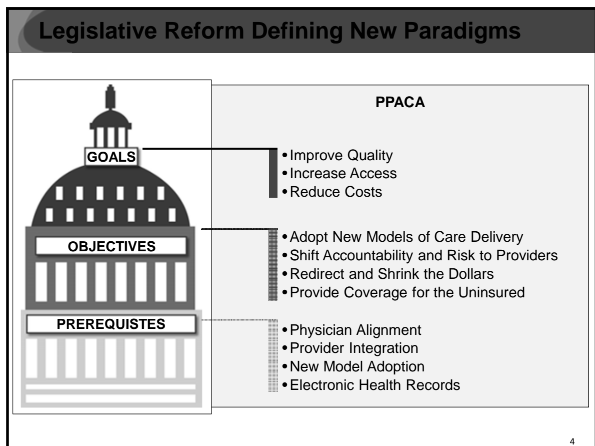
March 2010
PPACA Made Law

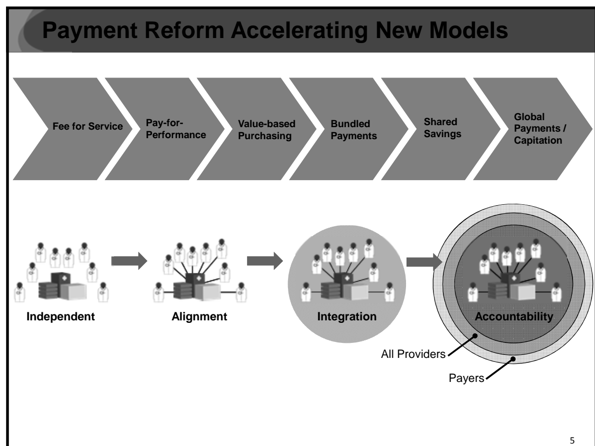
U.S. HOUSE - HEALTH CARE
HOUSE PASSES SENATE BILL
AHEAD - Vote on Reconciliation Bill
H R 3590

	YEA	NAY	PRES	NV
DEMOCRATIC	219	34		
REPUBLICAN		176		2
INDEPENDENT				
TOTALS	219	210		2

TIME REMAINING 0:00

C-SPAN





The Future of Rural Health

- Evolutionary development over past 2+ years
  - Primary care workgroup
  - Evolution of small rural hospital workgroup
  - The Future of Rural Health Workgroup
    - 60+ members plus the Rural Health Congress of NRHA
  - Approved as NRHA policy February 2013

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Status of Rural Health

- Heard during development:
  - Rural is different
  - Health system is going through rapid and radical change
  - Rural must outline a meaningful, phased and non-destructive approach to the future

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Status of Rural Health

- Rural health is fragmented
  - Licensure & certification silos lead to inefficient care
  - “Special” rural payments are based on separate infrastructure and regulatory requirements rather than a communities need
  - Providers often have a disincentive to collaborate

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Environment for Change

- Value-based models may not work well in rural areas
  - Rural provider regulatory issues
  - Low population density
  - Low provider volumes
- May be an opportunity for real change in rural health

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Community Opportunities

- Rural community – not a specific and precise geographic area, possibly REGIONAL
- "Cluster of Communities" – no specific definition – similar to a large-scale "medical neighborhood"
  - A set of relationships including clinicians, social and public organizations

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Community Elements

- Regulatory environment that supports fundamental, patient-centered community services appropriate to clusters of rural communities
- Financial incentives for improved health, lower costs and improved systems of care
- Strong and well-respected local leadership
- Broad base of provider groups, knowledgeable of current and future patient-centered health delivery and payment systems, significantly vested in the process.
- Willingness to acknowledge and address local limitations and build working relationships with providers in other communities through networking

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Community Elements

- Skilled outside facilitators and other well-developed technical assistance
- Access to and use of reliable epidemiological and financial data
- Adequate financial resources to support planning and implementation phases
- Adequate financial incentives to drive collaboration and integration (or at least removal of disincentives driving systems in the opposite direction)
- Agreed-upon measures of success and reward for achieving specific goals relating to improving population health, decreased cost and commitment to ongoing-improvement.

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Health System

- Built by a community to maximize resources to keep people healthy
  - Patient Centered
  - Pre-natal to death
  - Comprehensive wellness & support – not simply treating illness
- Clusters of communities have the responsibility for determining scope

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Community Resources

- Communities may not be able to afford all services independently
- What is affordable and available keeps changing
- Community multidisciplinary engagement necessary to identify local and regional needs

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Future Challenges

- The ability to adapt current systems to allow payment for preventive health measures and care coordination is central to future success.
- Hospitals and physicians/clinics are characterized as a focal point, looking beyond bricks and mortar to their role as a physical or virtual hub of service delivery.

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Future Challenges

- Flexibility is essential. Whether outlining incremental change through transitional approaches to current frontier and rural programs, or transformational models designed to capitalize on the primary care foundation of rural health delivery, all require the ability to maneuver.
- Perhaps most importantly, the need for transitional support cannot be over emphasized, noting rural payment and delivery policies must "**preserve what we have until we have clarity of where we are going**."

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Foundational Concepts

- Community involvement and investment: acknowledging the variances between rural communities and thus encouraging the use of "place-based policies" in which a health system is tailored to the needs of each individual community, ideally with high levels of community ownership of the system.
- Form follows finance: regardless of the type system, providers will conform to "how the money flows"
- Importance of compiling and reporting "best practices": an organized method by which providers can share models that produce desired results on patient care and financial sustainability

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Foundational Concepts

- Balance present concerns with future needs: recognizing the need to provide a transition strategy from current dysfunctional systems of care to seamless patient-centered care
- Appropriate relationship of rural to urban health care systems: appropriate incentives to encourage rural providers and urban systems to collaborate to provide seamless, non-duplicative patient care services

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Primary Care

- Primary care is and must remain at the core of rural health
  - Comprehensive health services at the point at which people enter the health care system
    - Diagnosis
    - Prevention
    - Treatment
    - Management

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Concepts & Principles

- The system must be **patient-centered** and oriented to providing quality care using best practices
- **Communities differ**: frontier solutions will be different from those of more densely populated rural areas
- **Local determination** of how best to address local needs: communities have primary responsibility for addressing needs, securing resources and stewardship of those resources
- Access to a **full range of services for all populations** - prevention, (physical, dental, mental health/behavioral health) – primary care, home care, extended care-long term care, acute care, rehabilitation, public health, emergency and pharmacy

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Concepts & Principles

- **Core set of services provided** at the community level or through arrangement(s) with regional providers based upon need and capacity
- **Health information technology is a critical component**, including health information exchanges
- Expansion of **telehealth is essential**: including not only inpatient and outpatient care but also patient monitoring, home care management, etc.
- Development and stability of **skilled healthcare workforce** is necessary: physicians, mid-levels and all healthcare technicians including administrative and infrastructure personnel i.e. HIT, financial, human resource staff, etc.

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Concepts & Principles

- **Change Workforce Paradigm**. Development of new community health workers: community paramedics, health coaches, care coordinators, patient navigators, etc.
- Allow all **providers to practice 'at the top of their license'** and skill level
- The system must be **affordable and accessible** to rural citizens
- **Community health focus** rather than continuing to 'fix problems'
- **Patient and population education** is an integral part of system

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Services Reasonably Available

- Basic Mental Health Services
- Basic Substance Abuse Services (Alcohol and Drugs)
- Basic Oral Health Services
- Emergency/Urgent Care Services
- Surgery and Obstetrics
- Pharmacy and Medication Services
- Eye Care and Audiology Services

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Services Reasonably Available

- Public Health
- Education, Prevention, Health Literacy, and Cultural Competency
- Inpatient Acute Care
- Outpatient Diagnostic, Treatment, Rehabilitative and Therapeutic Services
- In-home Care and Monitoring
- Long-term Institutional Care
- Transportation Services

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SO WHERE DO WE GO FROM HERE

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Medicare Changes

- Hospitals face many changes:
  - Value based purchasing
  - Quality reporting
  - Reduced Medicare and Medicaid DSH
  - Bundled payments
  - Hospital Acquired Conditions
  - Unnecessary readmissions
  - Productivity reductions

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Medicare Changes

- Hospitals face many changes – since ACA:
  - Medicare bad debt reductions
  - Outpatient therapy limitations
  - Many more – the intent is to reduce payments

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STATEMENT

IN ACCOUNT WITH

WAYNESBORO HOSPITAL

Waynesboro, Pa., 10-15-49

To Barnhart, Mrs Elizabeth

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DESCRIPTION		CHARGES	
Balance Acct. Rendered			
ROOM AND CARE	6 days @ 6.50	39	00
OPERATING ROOM			
DELIVERY ROOM		7	50
CARE OF INFANT	6 days @ 1.00	6	00
X-RAY			
DRESSINGS		1	00
DRUGS		1	00
LABORATORY FEE AND PATH. EXAMINATION		1	00
SPECIAL NURSE BOARD			
ANESTHETIC			
CAST			
ASSISTANT			
TELEPHONE	to Chambg.		18
Birth Cert.			25
	TOTAL	55	93
CREDITS	advance	45	50
	BALANCE AMOUNT DUE	10	43

Received Payment Waynesboro Hospital Eleanor C. Fauhel

Bills must be paid before patient leaves Hospital.

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WAYNESBORO HOSPITAL WAYNESBORO, PENNA.

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Continued Trend from IP to OP

- Continuing trend from inpatient-based care to outpatient-based care
  - Decreasing average length of stay
  - More procedures on outpatient service
  - Improved, coordinated care of chronic conditions will decrease inpatient admissions and emergency visits

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Technology is Essential

- Electronic Medical Records – more than "meaningful use"
- Exchange of health information
- In-home monitoring
- Telehealth:
  - Stroke & other emergency medicine
  - eICU
  - Mental health

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Innovations

- CMS Center of Innovation – "to test innovative payment and service delivery models to reduce program expenditures".

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Models Being Developed

- Rural Accountable Care Organizations
- Value based purchasing demonstrations
- Community-based models
- Community paramedic
- FQHC-CAH-RHC cooperative models
- Re-definition of CAHs

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The Future We Know

- Sequestration – started 4/1/13 and continues until 2021 unless Congress acts
- Physician fees – reduction of 24.4% 1/1/14 (SGR – Sustainable Growth Rate)
- Medicaid payments to equal Medicare for primary care 2013-14
- Medicare 10% bonus for primary care and general surgery in 2011-2015

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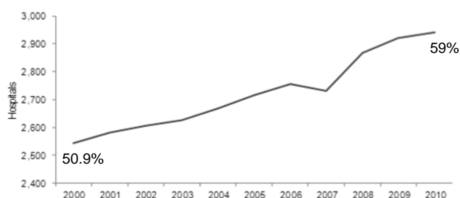
Hospital – Hospital Alignment Accelerating

Number of Hospitals in Health Systems,[1] 2000 – 2010



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2010, for community hospitals.
[1] Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.

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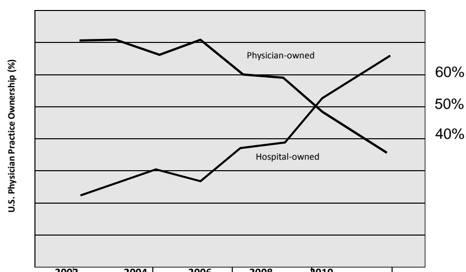
Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals, 2002-2010



Source: Physician Compensation and Production Survey, Medical Group Management Association, 2003-2009.

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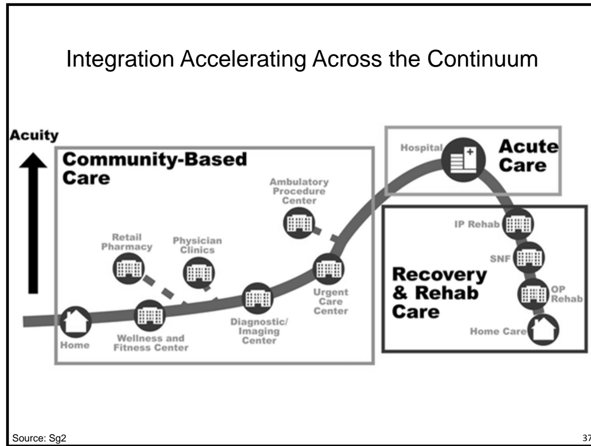

The Future We Don't Know

- How will practice change?
- How will providers get paid?
- How much will providers get paid?
- Can we eliminate the silos of care and payment?
- More questions than answers!

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State Experiences & NOSORH Project

- Oregon
- Montana
- Alaska
- NOSORH project
- Others?

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Future Payments

- If you can start over or have a blank slate – how would you like to be paid?
- So we have to work with what we have – what are your ideas about how to change rural delivery & payments?

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