Pathways to Locally Based Integrated Health Care

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Say What?

- Locally-based: care starts and continues in locality of choice
- Locally-based: essential, time-sensitive services as a necessary but not sufficient core
- Integrated care: primary care paramount as the foundation
- Integrated care: across the continuum

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The Local Focus: Primary Care

- First contact
- Continuous
- Comprehensive
- Coordinated
- Undifferentiated by population or disease/organ system

Barbara Starfield (1994) Is primary care essential? *The Lancet* 344: 1129-1133. 22 October.

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Context of Population Health

- Realize better health outcomes
- Extend to patient panels for population health
- Extend to all residents in the community for better health objectives

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Elements of Primary Health: Care

Moving beyond clinical to include:

- Education
- Water and sanitation
- Nutrition
- Maternal and child health

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Elements of Primary Health Care

- Immunization
- Prevention of endemic disease
- Treatment
- Drug availability

Maria Mona (2016) Key Elements of Primary Health Care (PHC) *Nursing Exercise*. June 11. www.nursingexercise.com/primary-health-care-elements-principles/ accessed 5 June, 2017.

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Integrated Care

- The essence of comprehensive and continuous care
- As much being delivered locally as feasible (quality and cost considerations)
- Connected to **available** services elsewhere

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Intersection of Local Development with Policy Trajectories (general outline)

- Reminders of trajectories
- Threats and opportunities
- Navigating a path to best meet local needs

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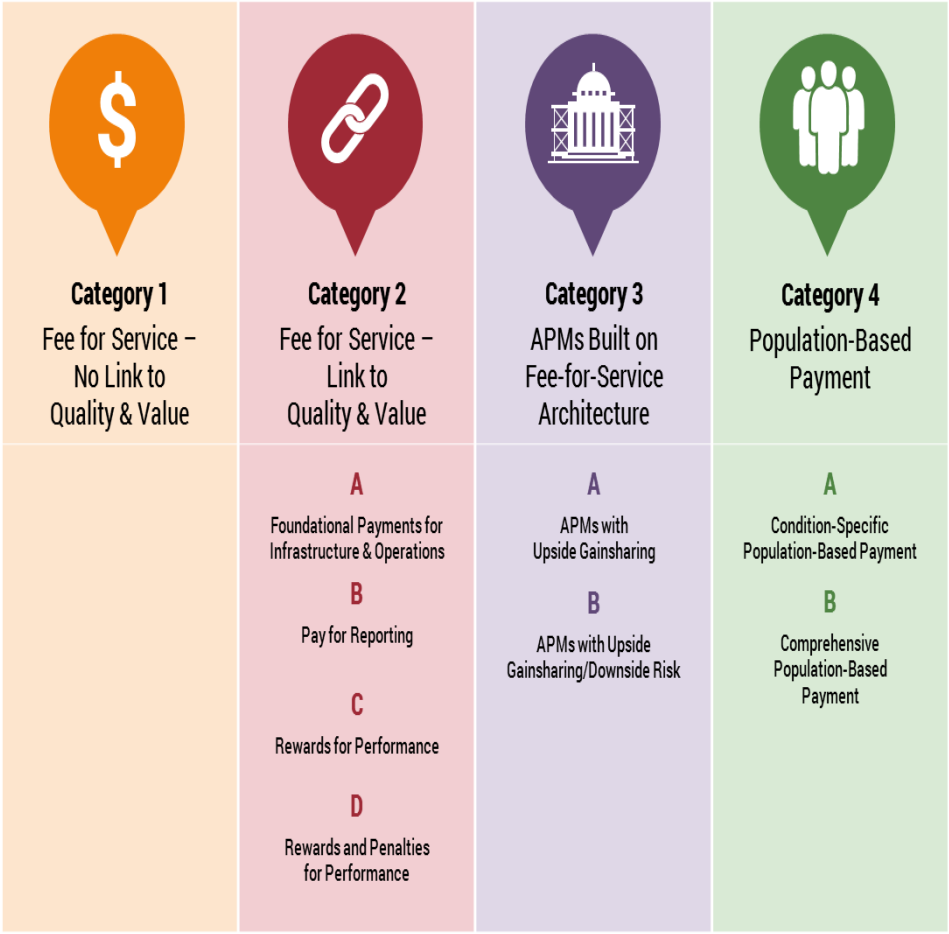
Policy Trajectories

- Medicare payment goals
- Medicare payment reduction and Medicare Advantage
- Pushing Medicaid to the states

Evolution of Medicare Payment Through Four Categories

Figure 1. APM Framework (At-A-Glance)



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Building blocks to achieve healthy populations

- Patient-centered medical homes; person-centered health homes: per member per month payments
- Chronic care management: new payment codes such as 99490 in Medicare
- Comprehensive primary care initiative

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Accountable Care Organizations Have Come to Rural America

- Data extracted from Centers for Medicare & Medicaid Services public information for years 2012 – 2015, plus "first look" at 2016
- Non-metropolitan presence (defined as participating provider) in each cycle
- Non-metropolitan presence in three models: Pioneer demonstration, Advanced Payment demonstration/Medicare Shared Savings Program, ACO Investment Model, Next Generation demonstration
- Increased rural presence across time

By the Numbers …

- ACOs operate in 72.% of metropolitan counties, 39.7% of non-metropolitan counties
- 7.6 million beneficiaries now receiving care through ACOs
- Rural sites in all four census regions

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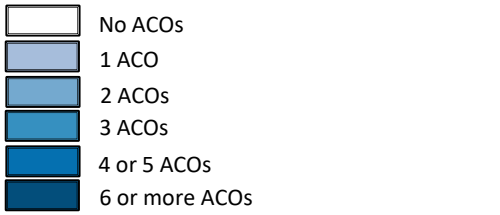
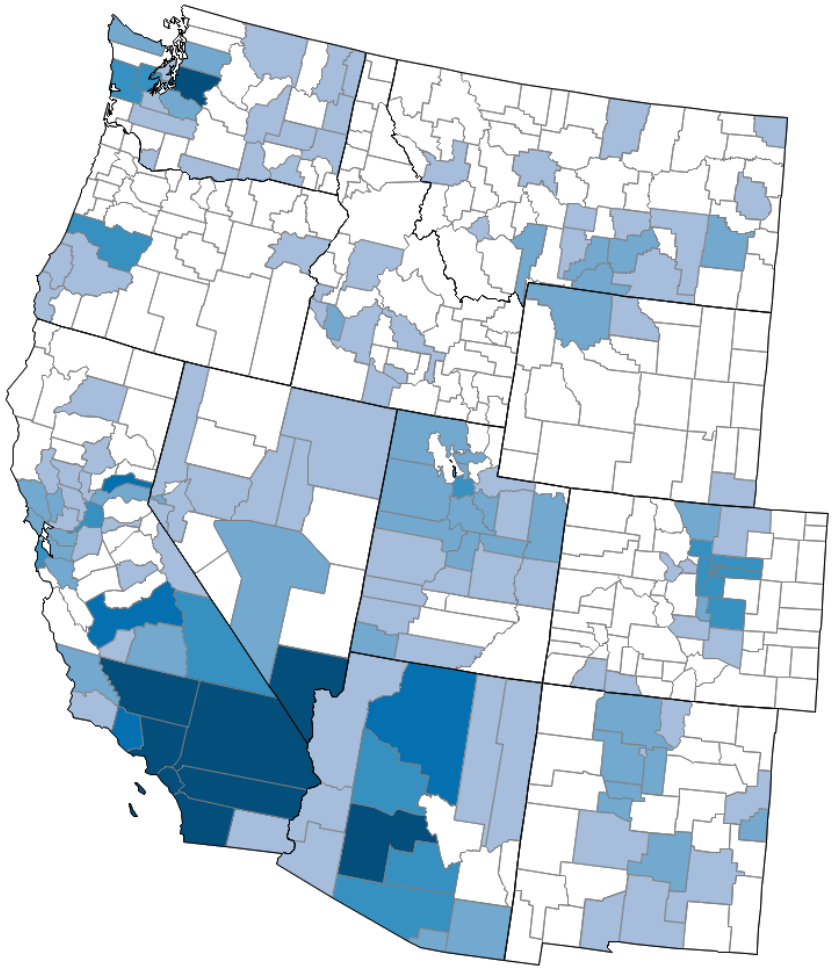
County Medicare ACO Presence

West Census Region



Alaska and Hawaii not to scale.



CMS-designated sites as of February, 2015
Produced by RUPRI Center for Rural Health Policy Analysis, 2017

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Innovations in ACOs

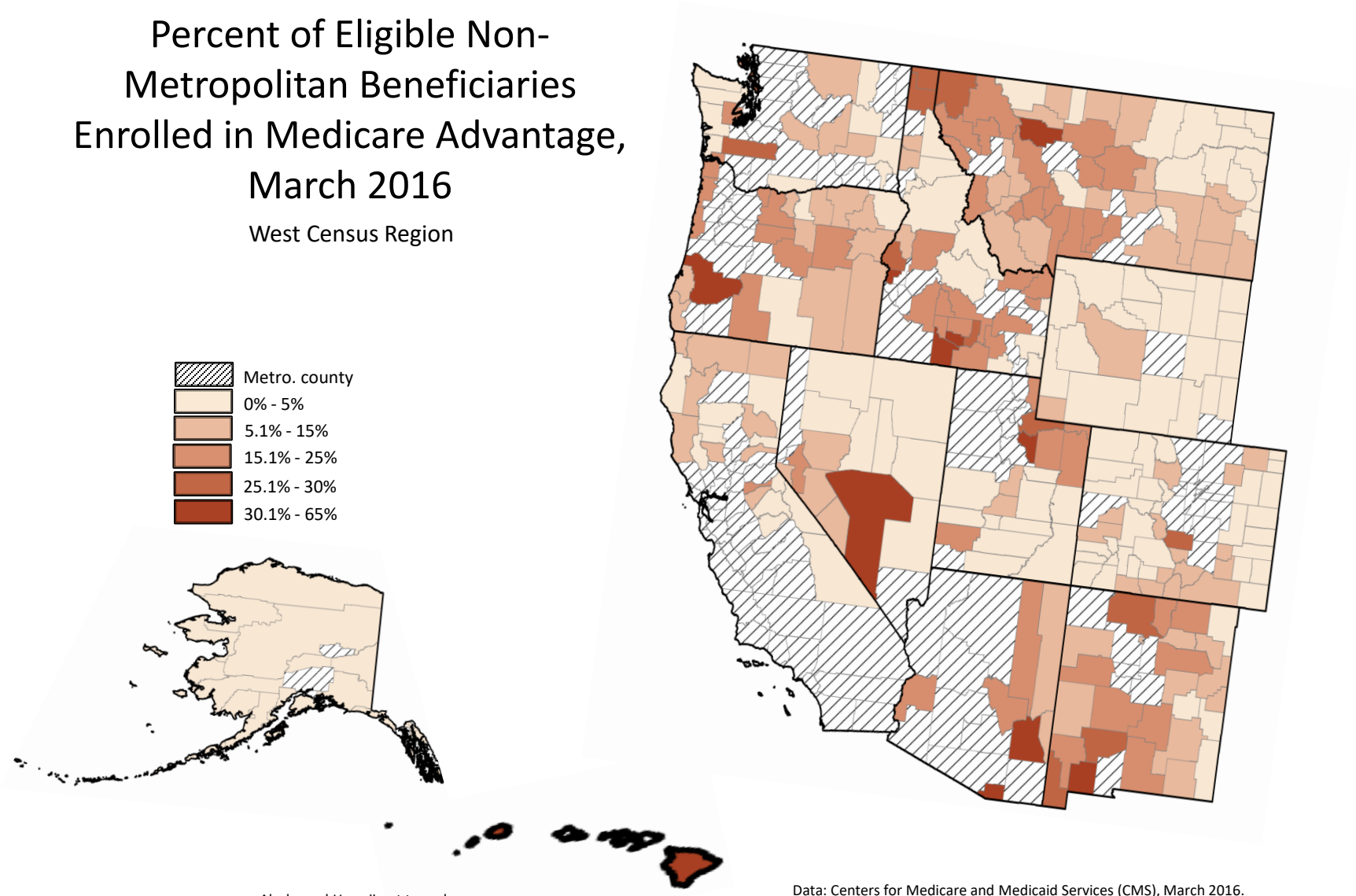
- Care management to meet the quality of care targets and achieve savings
- Signing multiple ACO contracts (Medicare, Medicaid, commercial, with large employers)
- Accepting financial risk: Tracks 2 and 3; Next Generation
- Addressing social determinants of health
- Qualifying as advanced alternative payment models

Additional Medicare Payment Considerations

- Sequestration continues
- Budget pressures on total payment – from general fund needs and trust fund scare tactics
- Medicare Advantage plans and any squeeze on bottom line if changes made in federal payment

Percent of Eligible Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage, March 2016

West Census Region



Alaska and Hawaii not to scale.

Data: Centers for Medicare and Medicaid Services (CMS), March 2016.
Produced by RUPRI Center for Rural Health Policy Analysis, 2017

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Changes coming in Medicaid programs

- Federal push of fiscal risk to the states
- Capping federal matches may discourage and/or alter private contracting
- Which may create opportunities for creativity
- And there is Nevada …

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Private Policy Trajectories

- Use of value-based contracting
- ACOs, again
- Push and pull regarding new delivery modalities, including telehealth
- Population health a dominant theme, but starting with high users

Pulling Public and Private Trajectories Together

- Doing different with less
- But **doing different** – break molds cast since 1997 and before
- Ideal is all payer system supporting innovation and redesign
- But much more likely – communities and providers have to make it happen

Threats

- Reduced payment without reform
- Contracts based on scale in single locations, or regions
- Systems seeking enrolled lives for centralized services

Opportunities

- Case for equity during disruptive change
- Enhanced recognition of rural needs
- Still in an era of demonstrations to change systems (Center for Medicare and Medicaid Innovation)

Opportunities

- New affiliations with investment potential
- Revenue pegged to performance, general population – more flexible
- Meeting community-based mission

Navigating a Path to a Better Future

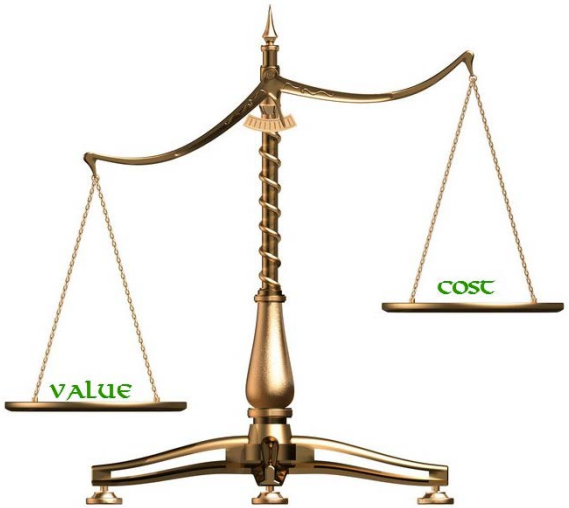
- Decisions about appropriate system elements – local, regional, and distant
- Decisions about affiliations
- Attention to population health
- Reach out for help – start with SORHs, include others like AHA, Rural Health Value, Rural Health Resource Center
- Illustration of what is available as resource

Example: Demonstrating CAH Value

- Purpose is to demonstrate value to a potential partner (insurer, managed care organization, provider-based health plan, accountable care organization, health care system, network or alliance)
- Know the challenge
- Process to prepare for discussion

Challenge in Demonstrating Value

- Matching CAH strengths to potential partner interests and motivations
- Quantitatively demonstrating CAH strengths
- Presenting the CAH value message



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Three-step Process to Prepare for Discussions With Potential Partners

1. Understand the interests and motivations of potential partners
2. Identify CAH strengths and characteristics that align with those interests
3. Develop a succinct and data-supported CAH message that demonstrates value

Potential Partner Interest and Motivation Examples

- Expand market share or geographic footprint
- Increase revenue
- Meet network adequacy standards
- Sell additional products or services
- Obtain a platform for value-based contract testing

Identify CAH Value Proposition

- Market: market share dominance in primary service area
- Services: strong primary care practice affiliation (ownership the strongest posture)
- Experience: demonstrated clinical quality, patient safety, and/or patient satisfaction
- Structure/finance: CAH financial strength, including projected operating margins and reserves

Presenting the CAH Value Message

- Purpose of letter or presentation
- CAH introduction
- Environmental scan
- The offer

System design: Whither the Hospital?

- Start by clearly articulating the service needs of the community
- Then a configuration of services including professional and physical plant
- (Re)purposing community assets

Options in absence of inpatient care base

- Independent Practice Clinic
- Hospital-owned primary care practice
- Provider-based rural health clinic
- Independent rural health clinic

Options in absence of inpatient care base

- Federally qualified health center (FQHC)
- FQHC look-alikes
- Urgent care clinic
- Off-campus emergency department
- Freestanding emergency department

Policy Proposals for Inpatient Care Alternatives

- 24/7 Emergency Department (Option1) Proposed by MedPAC
- Clinic and Ambulance (Option 2) Proposed by MedPAC
- Frontier Extended Stay Clinic (FESC) Demonstration under CMS Authority

Policy Proposals for Inpatient Care Alternatives

- Rural Emergency Hospital: Senate bill proposed by Grassley (IA), Klobuchar (MN), and Gardner (CO)
- 12-Hour Primary Health Center: proposed by the Kansas Hospital Association, Rural Health Visioning Technical Advisory Group
- 24-Hour Primary Health Center: proposed by the Kansas Hospital Association, Rural Health Visioning Technical Advisory Group

RUPRI Health Panel (2017) After Hospital Closure: Pursuing High Performance Rural Health Systems without Inpatient Care. *Policy Paper* June. http://www.rupri.org/areas-of-work/health-policy/

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Beyond the Hospital Walls

- The process of needs assessment: use all available data
- Use available decision guides and tools
- Addressing social determinants of health illustration

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Social Determinants of Health Learning Module Sections

- Defining the Social Determinants of Health
- Understanding Why Social Determinants are Important to Rural Health
- Using Cardiovascular Disease to Understand Social Determinants of Health
- Using diabetes to Learn About Social Determinants of Health
- Discussing What You've Learned

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Format of Sections

- Read/research: includes links to more information; understand the facts about social determinants
- Analyze/discuss: guide for discussing among a team
- Plan/act: specific planning activities

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Transformational Change: All Hands on Deck

- Physician engagement
- Board engagement
- Broader engagement in health sector
- Engaging other sectors

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Leveraging Policy Shifts

- ACOs as illustration of using initial investment to leverage change; also as platform
- Shaping payment alternatives: global budgeting in MD, PA
- Cost effective partner to others

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Leveraging Market Focus

- Much more challenging given market-scale association
- Focus on outcome measures
- Keep costs as low as possible

Return to Basics

- What rural residents need
- Primary care base
- Appropriate high quality services off that base

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For further information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org

Rural Telehealth Research Center
http://ruraltelehealth.org/

The Rural Health Value Program
http://www.ruralhealthvalue.org

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