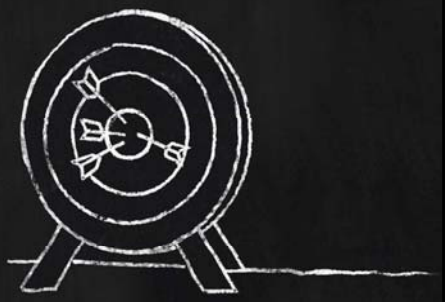
Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Preparing Now for What's to Come: Improving Access to Services When None Exist

May 3, 2017



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AGENDA

- The Paradigm Shift From Volume to Value
- Access and the Quadruple Aim
- Defining Vulnerable Communities
- Provision of Essential Health Benefits
- Strategies to Improve Access
- Putting Concepts Into Action - Case Studies
- Building an Access Initiative in Your Community

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Objectives

- Provide a baseline understanding of how access fits into the Quadruple Aim
- Learn to define vulnerable populations and set community health improvement priorities

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The Paradigm Shift From Volume to Value

The National Health Care Landscape

- The paradigm shift from volume to value
- Increased emphasis on quality
- Essential integration of services—particularly behavioral health and primary care integration
- Transformation (change the way care is delivered)—often incentivized through national, regional, and local initiatives
- Impact of evolution from the Affordable Care Act

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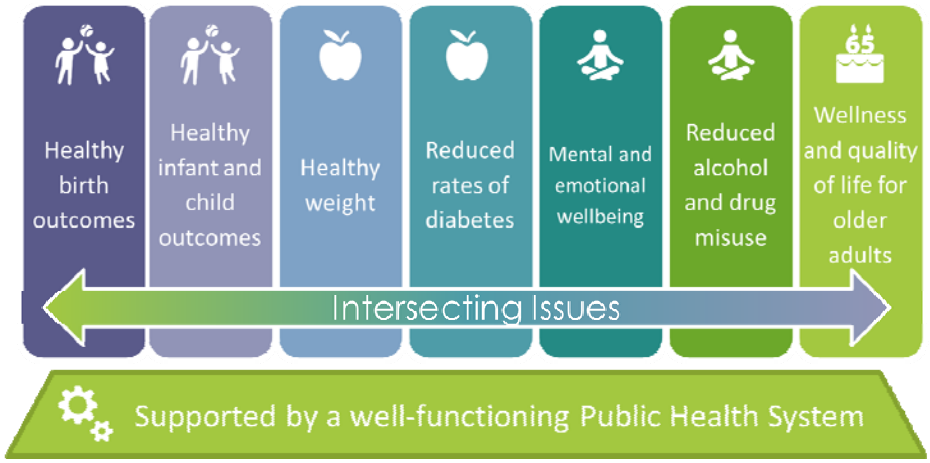
Health - How do we measure it?



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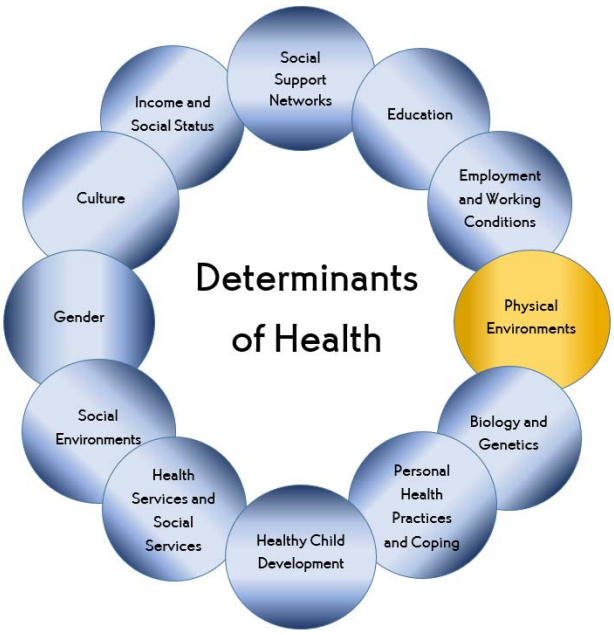
Determinants of Health



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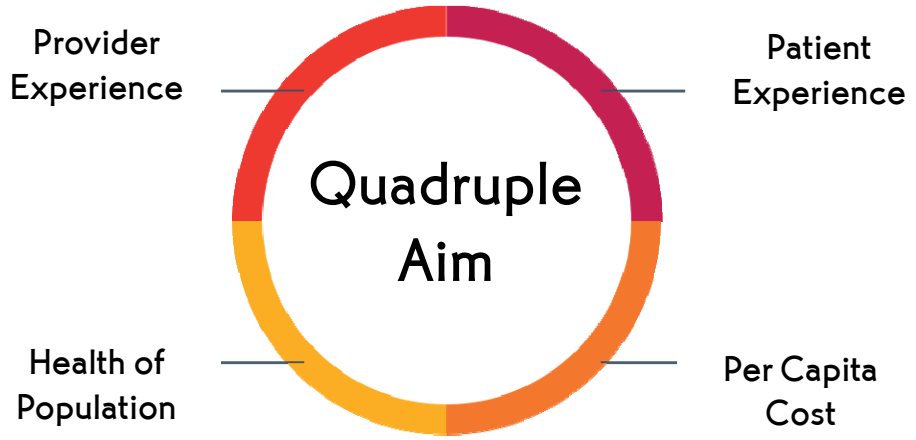
Access and the Quadruple Aim

Where Does Access Fit Into the Quadruple Aim?



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Federal Grants to Achieve the Quadruple Aim

- Population health management
- Cost effectiveness
- Patient outcomes
- Provider experience and workforce development

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Grants and Incentive Programs - 1115 Waiver

- **Delivery System Reform Incentive Payment (DSRIP)** pools:
  - Federal program available in all states to incentivize care transformation
  - Eight states currently participating: California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas
- California used the 1115 Waiver to initiate the following programs:
  - **Health Homes -** Population focused
  - **DSRIP**, beginning in 2005 with public hospitals
  - In 2015, rebranded as **PRIME**, adding 37 district hospitals
  - **Whole Person Care Pilots** - 12 sites in 12 of 58 counties.
    - Mandates a collaborative approach to whole person care
    - Mandates integration of behavioral health and primary care

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Billions of Dollars at Stake - California Example

One County Hospital: $21 million annually for five years

One District Hospital: $6 million annually for five years

$3.7 billion over five years in California as a whole

Whole person care pilots: $1.5 billion over five years

Goal: Change the way care is delivered as measured by improving clinical metrics in the target population.

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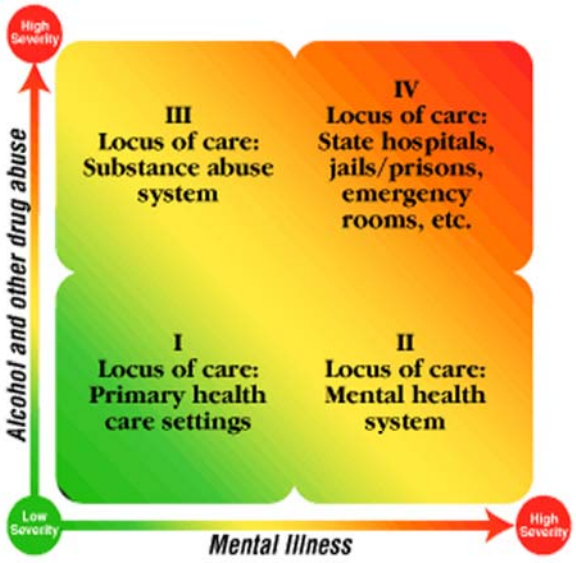
Behavioral Health and Primary Care Integration



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Grants and Incentives

Medicare Rural Hospital Flexibility (Flex) Grant Program

- 45 states are eligible (excludes Connecticut, Delaware, Maryland, New York, and Rhode Island).
- Requires CMS-approved plan for rural and critical access hospitals (CAHs).
- Assess the state for needs in areas of quality and operations.
- All CAHs must participate in order for the state to retain its Flex dollars.
- Wipfli is currently working with a number of states to address needs (financial/operational/quality improvement).

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Federal Budget for Behavioral Health Expansion 2016-17

$500 million allocated for expanding access to the following value-driven, quality behavioral health services:

- Expansion of state-certified community behavioral health clinics; currently eight states are participating in pilots (California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas
- Increased access to early intervention programs that address serious mental illnesses
- Expansion of behavioral health workforce through training programs and scholarships
- Focused interventions for suicide prevention by identifying risk factors
- Enhanced behavioral health services in for Native Americans

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Why do we Want to Create or Enhance Access?

- Population health management requires access to certain services and is critical to managing the health of the population
- Critical to cost containment
- Essential to patient satisfaction
- Impact on provider satisfaction and referrals

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Defining Vulnerable Communities

Access in Vulnerable Communities

Why is this important to CAHs and safety net hospitals?

- Millions of Americans live in vulnerable communities, both rural and urban.
- Vulnerable communities look to hospitals as their only source of health care. They also have other social needs such as food, clothing, and shelter.
- Collaboration and partnerships are the only way for rural and CAHs to provide access to essential health benefits.

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Access in Vulnerable Communities

AHA Task Force on Ensuring Access in Vulnerable Communities, 2015

- Addressed challenges and examined ways for hospitals to ensure access to care for essential health care needs.
- Provided a menu of strategies for communities to adopt based on an assessment of their unique needs and vulnerable populations.
- Implications for vulnerable communities and most hospitals.

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Access in Vulnerable Communities

Parameters of Vulnerable Communities - Urban and Rural

- Lack of access to primary care
- Poor economy and high unemployment
- High percentage of uninsured and underinsured
- Cultural differences
- Low education, literacy, and health literacy
- Environmental challenges

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Characteristics of Vulnerable Communities

Rural

- Declining population, business closures, inability to attract new businesses, and an aging population

Urban

- Lack of access to basic needs such as food, clothing, and shelter. High disease burden.*

Source: *Patients with mental health diagnoses (schizophrenia, bipolar disorder, and major depression) die 10 to 25 years earlier than those without these disorders. World Health Organization Information Sheet, 2013

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Provision of Essential Health Benefits

Essential Health Benefits

- **Three health benefits at a minimum:**
  - Access to primary care
  - Emergency medical services
  - Treatment for mental health disorders (MHDs) and substance use disorders (SUDs)
- **Six additional benefits depending on community needs:**
  - Prenatal care
  - Transportation
  - Diagnostic services
  - Home care
  - Robust referral capacity
  - Dental/oral health

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Essential Health Benefits

1. <u>Access to Primary Care</u>:
   - How long does it take to get an appointment with a primary care provider for preventive care?
   - How long for nonurgent, routine health care?
   - Is specialty care available in the community?
   - Where can a patient go for after-hours care without going to the emergency department (ED)?

   Measured in:
   - Wait times for new patients to be accepted by a provider
   - Wait times for appointments to be scheduled
   - Preventive health clinical indicators: immunization rates, cancer screening rates, and vaccinations for flu and pneumonia

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Essential Health Benefits

2. Emergency Medical Services:

   Is emergency medical care/trauma service available in the community?

   Measured in:

   - Transportation time to the ED and trauma services
   - EMS response times
   - Availability of EMS transport vehicles
   - ED wait times

"Time saved to the patient is quality."

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Essential Health Benefits

3. MHD and SUD Treatments:

   Access to evaluation and treatment of a MHD in a facility designated to provide care under a legal hold.

   Measured in:

   - Wait times in EDs for transfer to appropriate facilities - "Board Times."
   - Access to age-appropriate treatment services (i.e., children, seniors).
   - Access to inpatient and outpatient levels of care—the "care continuum."
   - Distance to travel for services (i.e., child psychiatric beds).

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Strategies to Improve Access

AHA Strategies to Ensure Access

- Addressing the social determinants of health
- Global budgets/capitation
- Inpatient to outpatient transformation strategy
- Emergency medical center - Stand-alone ED
- Urgent care/psych emergency services and crisis stabilization units
- Virtual care/telemedicine
- Frontier health services - High emphasis on collaboration and coordination of care
- Rural hospital strategy - Link rural hospitals and health clinics for coordinated care
- Health services for Native Americans

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Barriers to Implementation - Examples

DOMAIN	BARRIER
State	Fraud and abuse regulations Medicare payment rules
Federal	Licensure for providers and telehealth provision
Community	Lack of committed providers to implement the strategy
Provider	Investment required for Implementation (i.e., time, effort, and money)

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Needed Policy Changes

- New Medicare payment methodologies
- Expansion of demonstration projects
- Modification of conditions of participation to support new strategies
- Modifications of laws to allow for integration of providers and insurers
- Modification of Medicare payment rules toallow providers to place patients in the best level of care for their needs
- Expansion of payment for telehealth

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Putting Concepts into Action - Case Studies

Case Study #1

- Two hospitals (one safety net) came together to address the older adult mental health needs within their service areas.
- One hospital had space for inpatient and outpatient services, the other had clinical expertise and a research interest.
- Both hospitals had participated in a community health needs assessment which indicated:
  - An aging population
  - Alzheimer's as the third leading cause of death
  - Suicide rates highest in the elderly population
  - Lack of access: 50% of the population who required or sought mental health care stated they did not get access to that care

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Case Study #1

- The two hospitals developed a joint vison for a high- end behavioral health center for older adults. Inpatient and outpatient services were determined as the anchor services for the facility with plans for wellness clinics and other behavioral support services in later phases.
- Hospitals engaged Wipfli to determine project feasibility.
- Final Outcome: The two hospitals determined they would form a joint venture and proceed with the project, adding 47 geriatric psych beds to serve the community.

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Case Study #1 - Areas to review

- **Financial Feasibility:** Feasibility study was undertaken; however, traditional methodology did not get to all the information:
  - Geriatric psych DRGs are not usually found in an acute medical hospital because higher paying DRGs are primary.
  - Skilled nursing facilities will not admit patients with acute psychiatric diagnoses; consequently, we cannot assess their DRGs for potential volume.
  - Primary care providers are hesitant to "label" patients as "psych" unless they have a good intervention/treatment plan for the patient.
- **Bed Needs/Capacity Analysis:** Traditional methodology and use rates are not enough to tell the whole story of a regional behavioral health center providing services not yet available in the region.

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Case Study #1 - Additional Considerations

- The Community Health Improvement Plan identified mental health and older adult needs in their top three priorities.
- The safety net hospital is participating in the DSRIP incentive program, which mandates integration of primary care and behavioral health. This includes screening and referral programs to acute behavioral health services for seniors. This project helps them achieve milestones and receive financial incentives for increasing access to quality behavioral health care; ultimately, contributing to best practice clinical outcomes.
- Mental health care is a minimum health benefit for vulnerable populations in both urban and rural settings and must be provided to achieve success in any of the essential health benefits.
- Collaboration and partnering for service delivery are required to improve the health of the population.

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Case Study #1 - Results - How Do We Define Success?

- Using traditional and nontraditional methodology for the market assessment, the feasibility study and bed/capacity analysis yielded unpromising results.
- Adding in the impact of new service programs to address an unmet need within the community had a major impact and made the project viable.
- Traditional methods may kill your new service right out of the gate.
- Utilizing a "community health needs" focus on increasing access according to the quadruple aim and managing the health of the population is a winning strategy that improves patient care and outcomes, costs less, and reduces provider frustration and burnout.
- Federal incentives are available to support these initiatives and transformation of care.

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Case Study #2

- **The Opportunity:** A CAH noted that many patients were hospitalized for wound care, which could be managed on an outpatient basis. These patients filled valuable inpatient beds that could have accommodated other more acute patients.
  - There was poor access to primary care, and home health services were sporadic due to difficulty in recruiting and retaining RNs.
- **The Outcome:** Local EMTs were recruited and trained, during their down time, in proper wound assessment and general treatment, measurement of wounds, and documentation of clinical outcomes.
  - The EMTs document and communicate with the patient's local primary care provider, and the clinic RN provides telephone follow-up to support the wound care team and patient improvements.

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Case Study #2 - Benefits/Outcomes

- Access to hospital beds was improved by reducing unnecessary admissions.
- Primary care access was created by the EMT follow-up visits.
- The EMT/RN/PCP care team fully engaged the patient in self-management, which improved medication compliance and resulted in faster and more-thorough healing of wounds.

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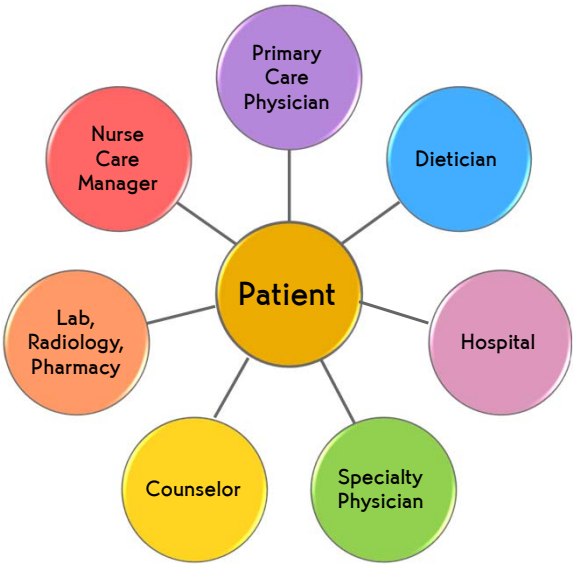
Patient-centered "Whole Person Care"



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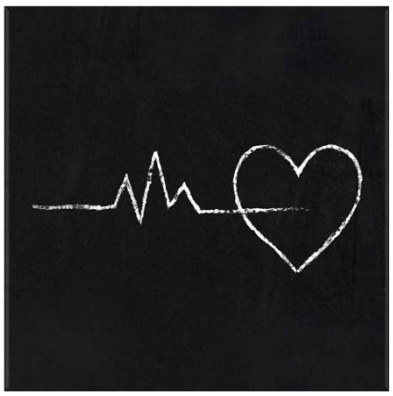

Building an Access Initiative in Your Community

Getting Started

Do Your Research

- Review your most recent community health needs assessment report. Ensure that it is current/relevant. If none exists, build one to guide your work. (This is an IRS requirement!)
- Identify data resources and review local/regional data:
  - State health department
  - County health department
  - Publications by local community foundations

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Seek Input

Assemble a multidisciplinary stakeholder work group:

- Public health department leadership
- Business leaders
- Area Agency on Aging
- Physician groups
- Social Services agencies
- Behavioral health groups
- School districts
- Church groups

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Seek Input

- Conduct a series of community focus groups to understand the consumer's perspective on access issues and health care needs.
- Brainstorm potential solutions.
- Encourage partnerships to resolve access issues.
- Keep your eye on the Quadruple Aim:
  - Enhanced patient experience
  - Improved quality of community health
  - Improved physician satisfaction
  - Reduced cost of care overall

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Identify Priorities

Assimilate stakeholder organization-level data:

- What health priorities are noted by the school district?
- What community support is needed by private physician groups?
- What are the gaps in care for the elderly within your community? Care for the disabled?
- What are the primary diagnoses for use of the ED?
- What are the primary diagnoses for hospital admission?
- What is the chronic disease burden within the community?
- Are there shortages of health care professionals within your service area? How can you recruit qualified professionals to fill those gaps?

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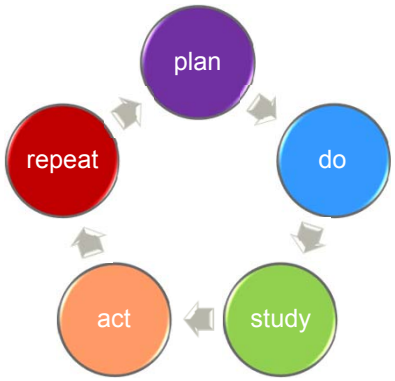
Develop your plan

- Develop your Community Health Improvement Plan.
- Identify milestones and timeline.
- Measure success of your interventions and implementation.
- Document and feedback successes to stakeholders.



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Questions?
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Thank you!
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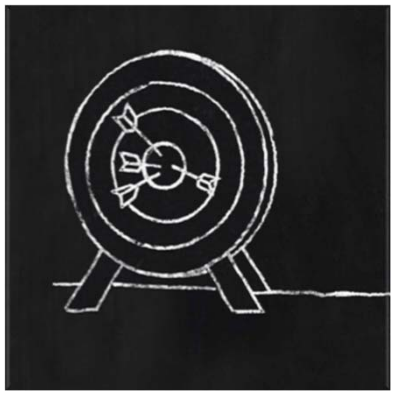

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