Transitioning a Rural Health Network to Value Based Care.

[Lessons Learned to Date]

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Iowa HIMSS Meeting
January 2016

Title; Transitioning a Rural Health Network to Value Based Care, Lessons Learned to Date

Description; This presentation will focus on sharing lessons learned related to Mercy ACO's Medicare Shared Savings Program and its work in rural Iowa. Mercy ACO, one of the nation's largest Medicare Shared Savings Program with greater than 70,000 attributed lives, also has one of the largest rural representations with 31 rural participant organizations. Specific topics to be covered will include an overview of Mercy ACOs Care Model and its adaption to rural based care, successes, challenges faced, and lessons learned.

Learning Objectives;

- Define key differences / opportunities for value based care in a rural setting.
- Identify strategies to value based care in a rural setting.

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Agenda

- Mercy ACO Profile
- Governance Foundation
- Our Care Model and Rural Approach
- Challenges & Successes & Lessons Learned
- So Why? (Closing Thoughts)
- Our ACO's Results
- Q & A

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Our Mission

To improve health, improve care and, lower costs for the communities we serve.

Our Values

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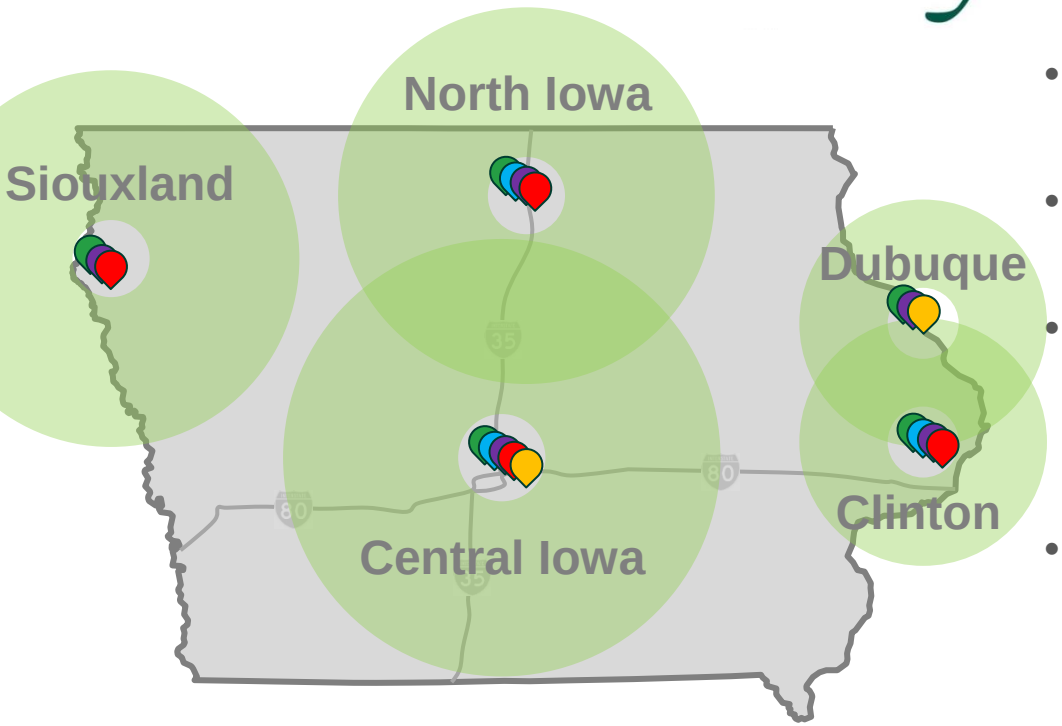

- Medicare Shared Savings Program
- Commercial Shared Savings
- Direct to Employer
- Medicaid
- Medicare Advantage

- Founded in 2012 by CHI-Iowa Corp.
- History of Population Health Success
- Mercy Health Network Foundation
  - 5 ACO Chapters
  - 54 of 99 Iowa Counties
- Independent & Specialty Groups
  - 130+ Participant Organizations
  - 1,800+ Providers (Physicians & Mid-Levels)
- Government & Commercial Value Based Contracts
  - 133,000+ Covered Lives
  - 23,500+ Rural Lives*

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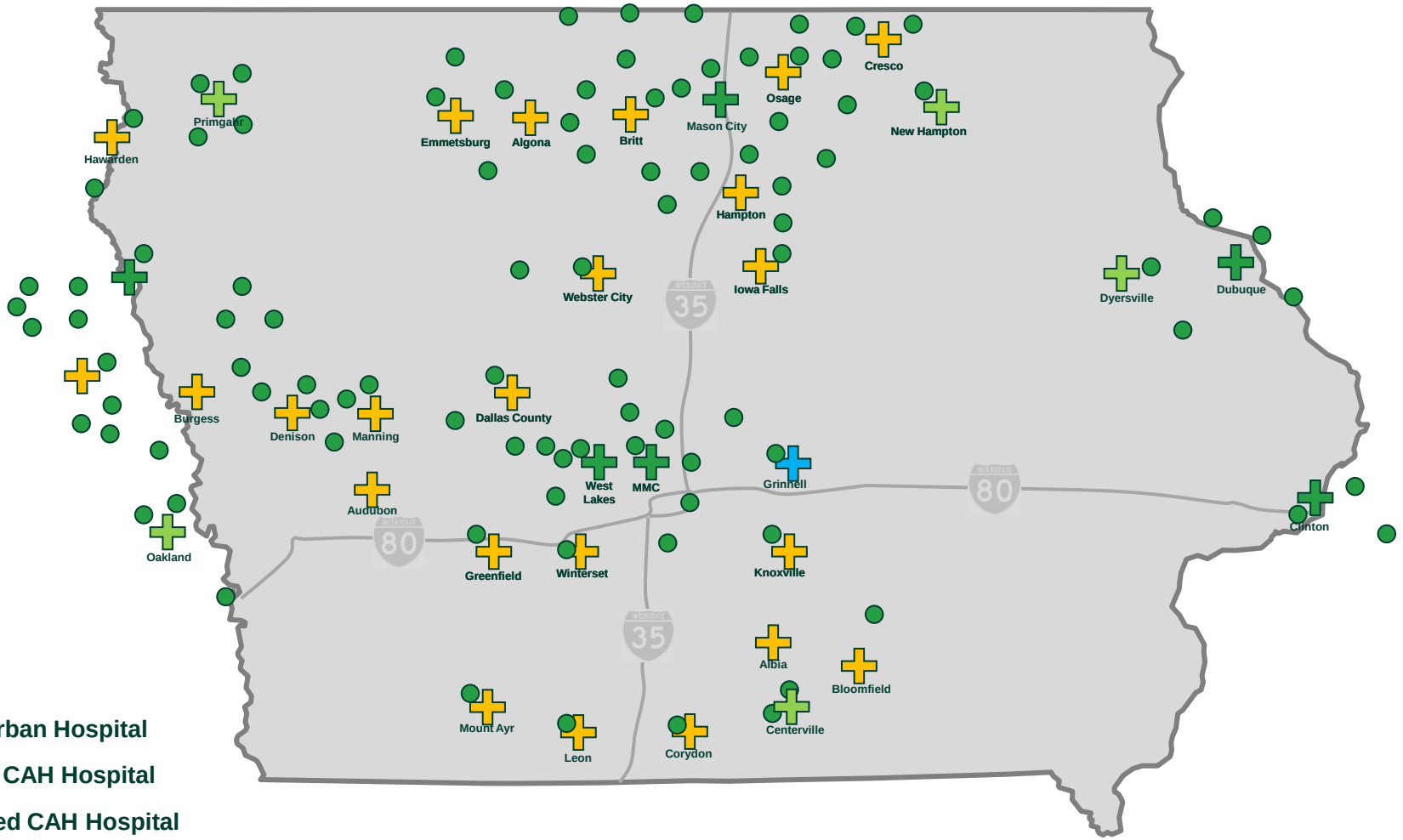
Where we are… “The Mercy ACO Network”



- MHN Urban Hospital
- Owned CAH Hospital
- Managed CAH Hospital
- Managed Rural Hospital
- Primary Care Clinic

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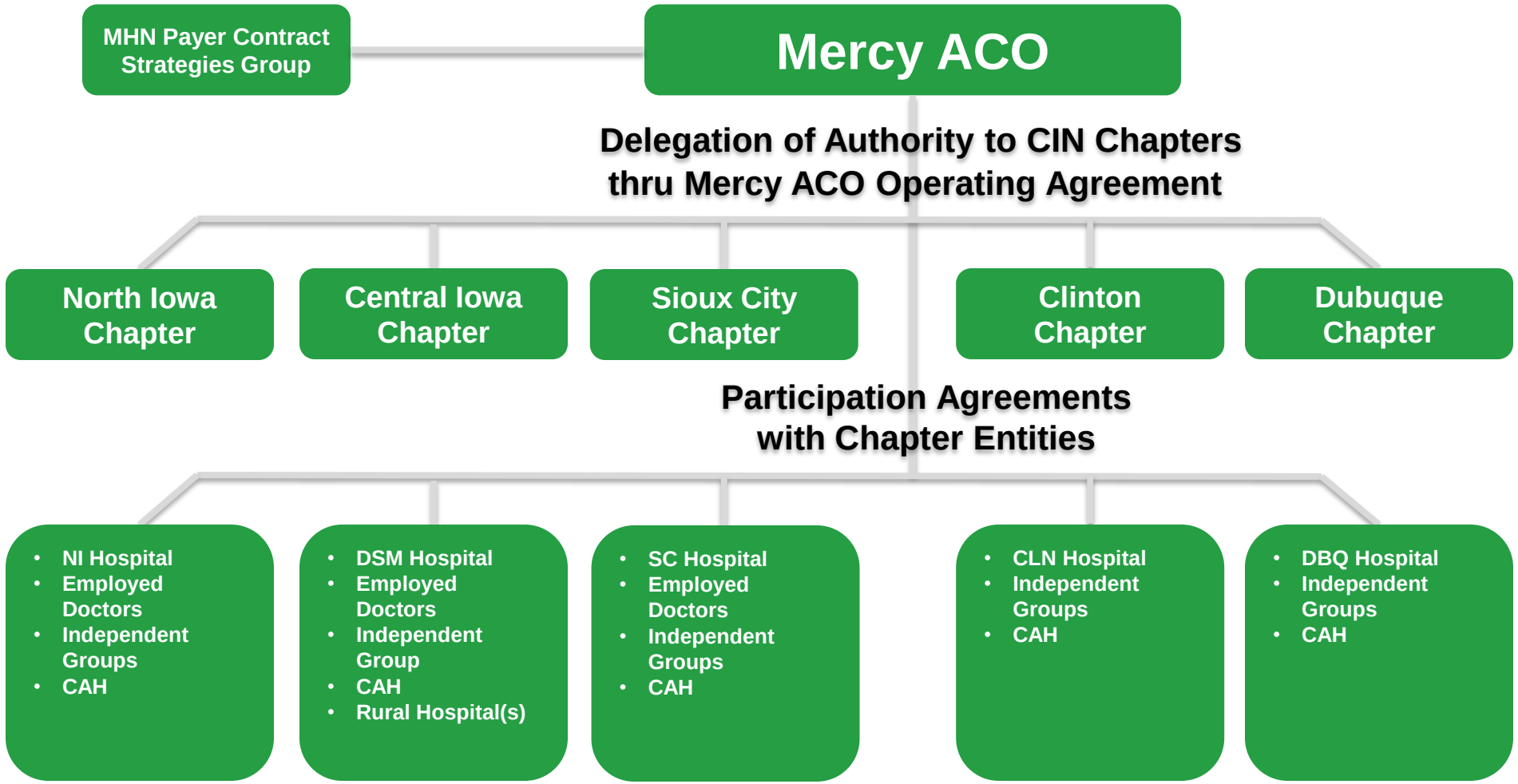
Governance: Chapters as Sub-Committees



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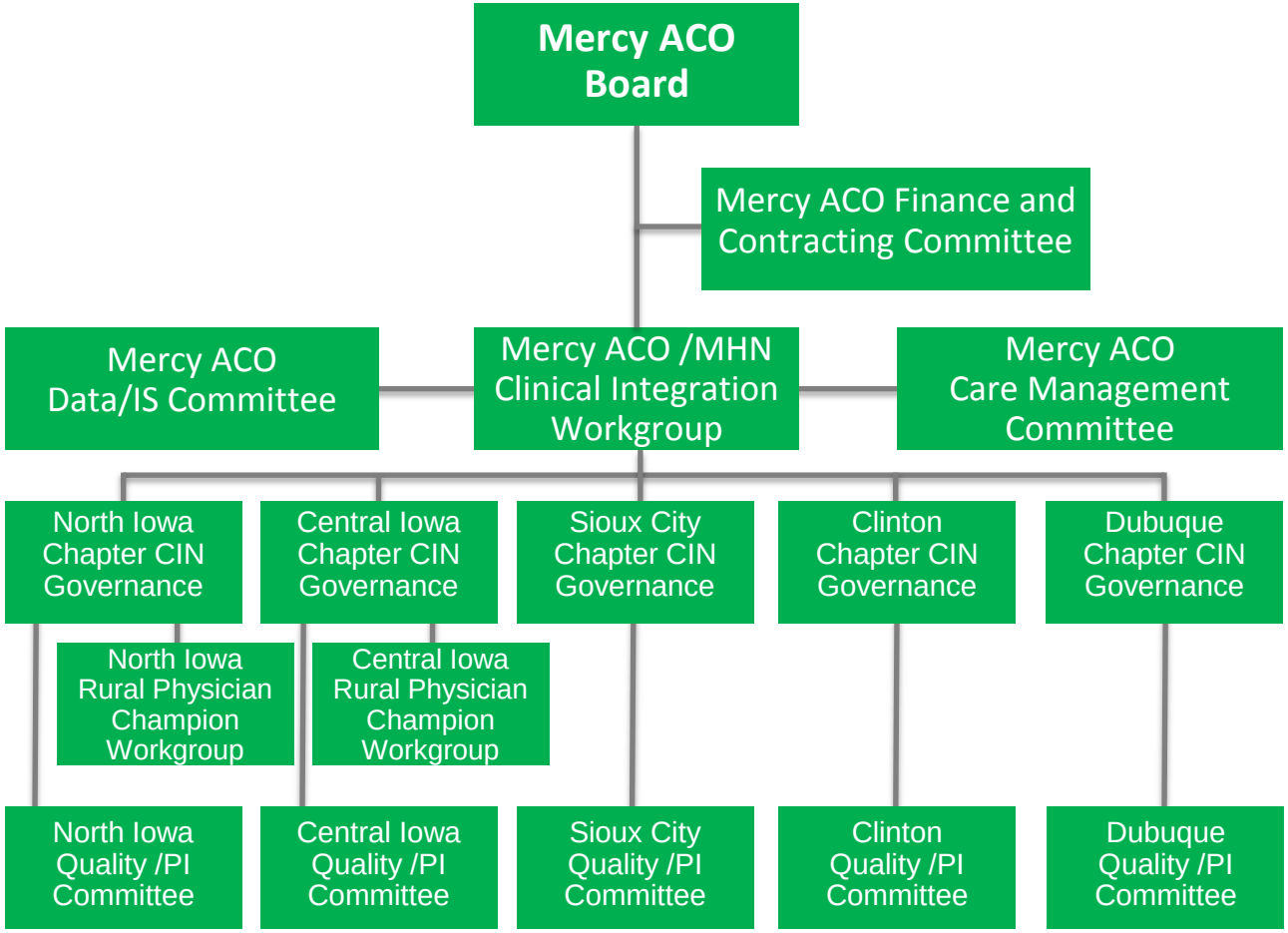
Mercy ACO Governance and Committee Structure



Take Away: It is vital to have rural sites represented at all levels.

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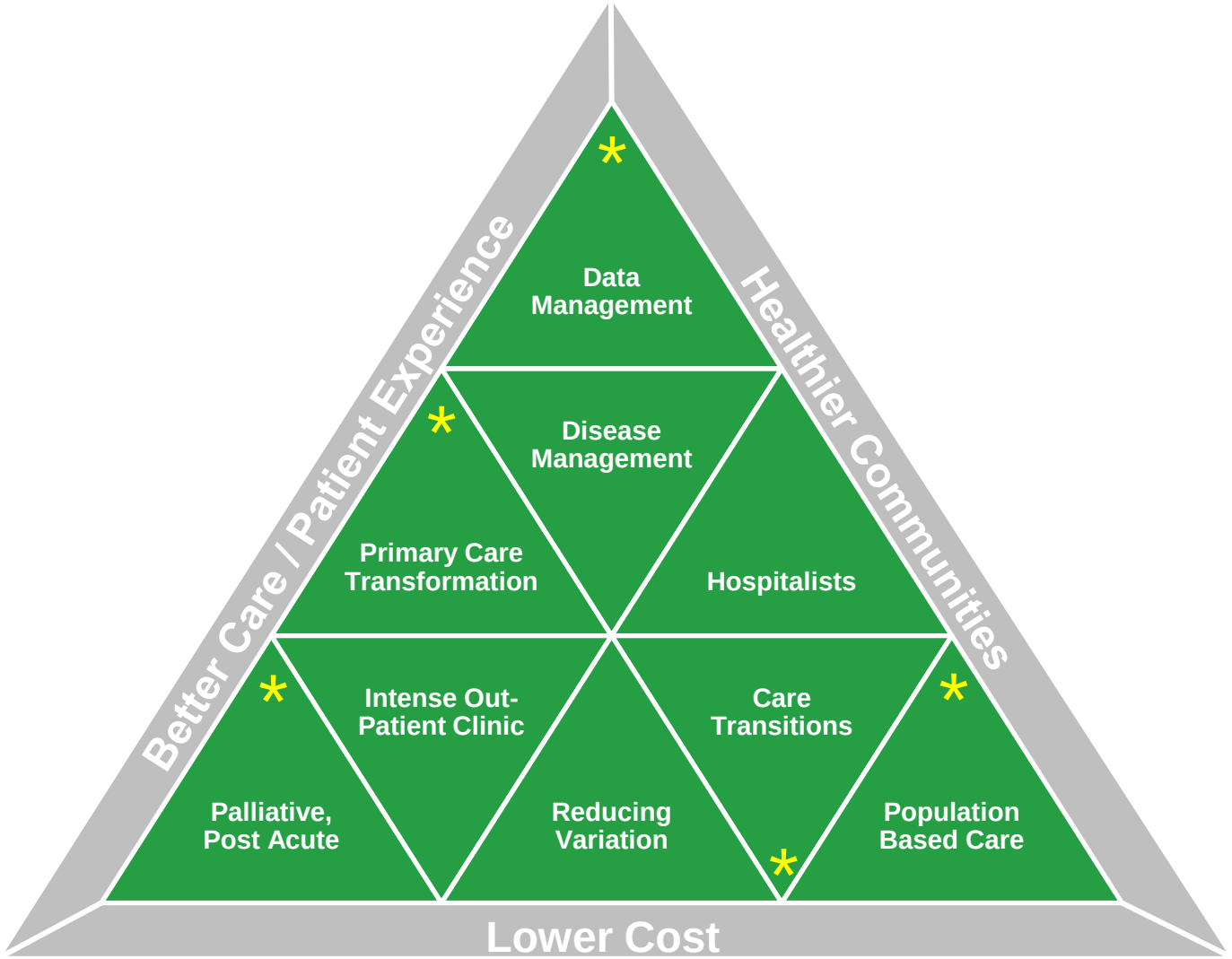
Mercy ACO Care Management Model



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Our Rural Approach

Health Coaching

- Health Coaches & Assistants
- Imbedded in Primary Care
- Maintain Disease Registry
- Care Model Deployment
- Manage the Care Transitions

Community Connections

- Foster/Further Relationships
- CRM ‘like’ Platform
- Clinical Network
- Non-Clinical Network

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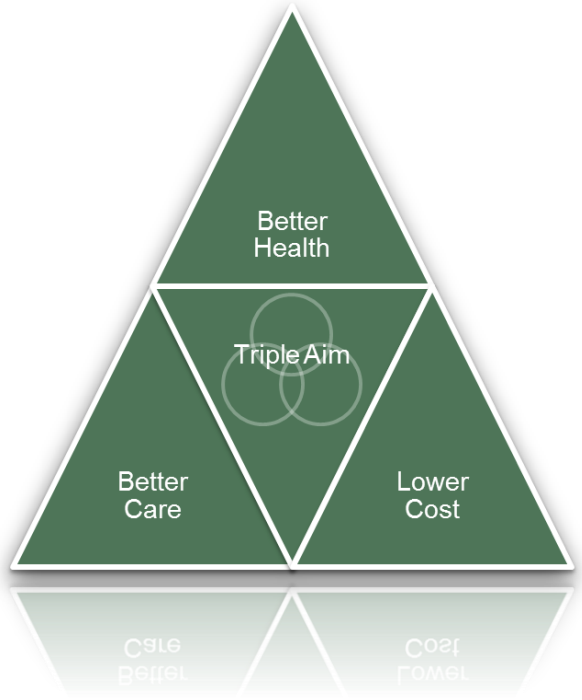

Lean / PEx

(Process Improvement)

- Improve Continuum of Care Processes
- Process Waste Reduction
- Operational Cost Reductions
- Data Analytics Assistance

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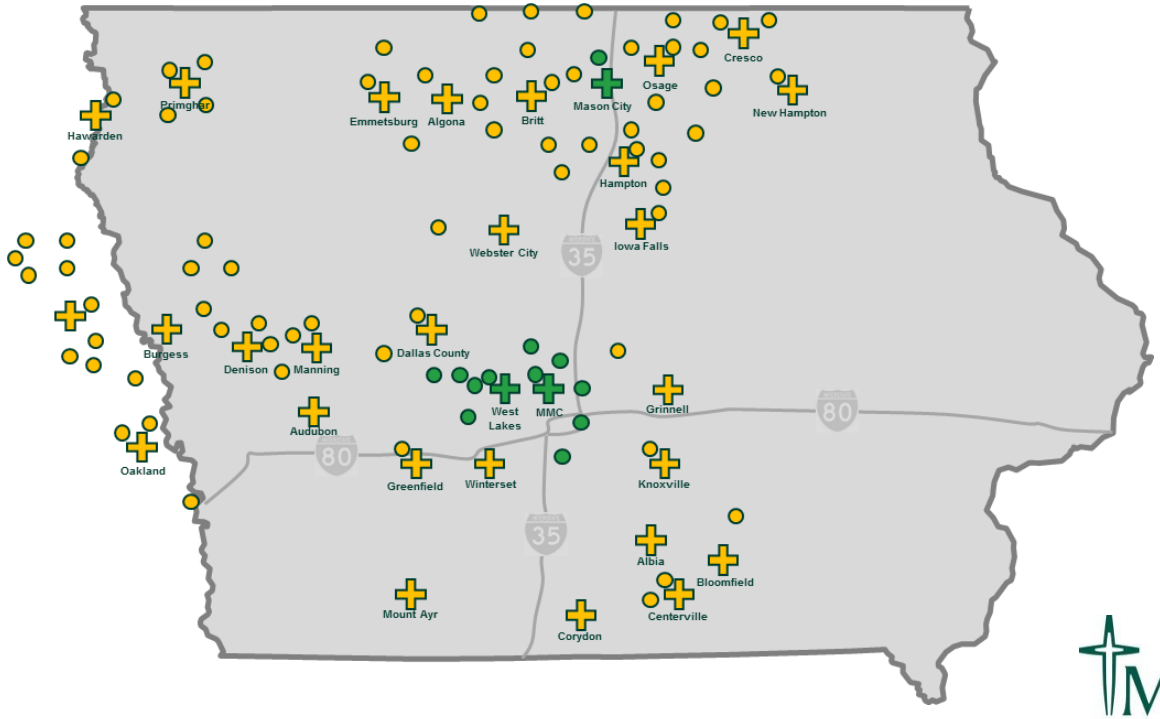
Mercy ACO Innovation Grant

- $10.1 Million (cooperative agreement) with the CMS Innovation Center (2014-17)
- *Mission: Transition a Rural Health Network to Value-Based-Care*
- Participants;
  - 27 Critical Access Hospitals/ Sponsors & 73 rural Primary Care Clinics
  - 3 Mercy Health Network Regions (ACO Chapters)
    - Central Iowa, North Iowa and, Siouxland
- Opportunity; Impact 160,000+ Rural Iowan's Healthcare Experience



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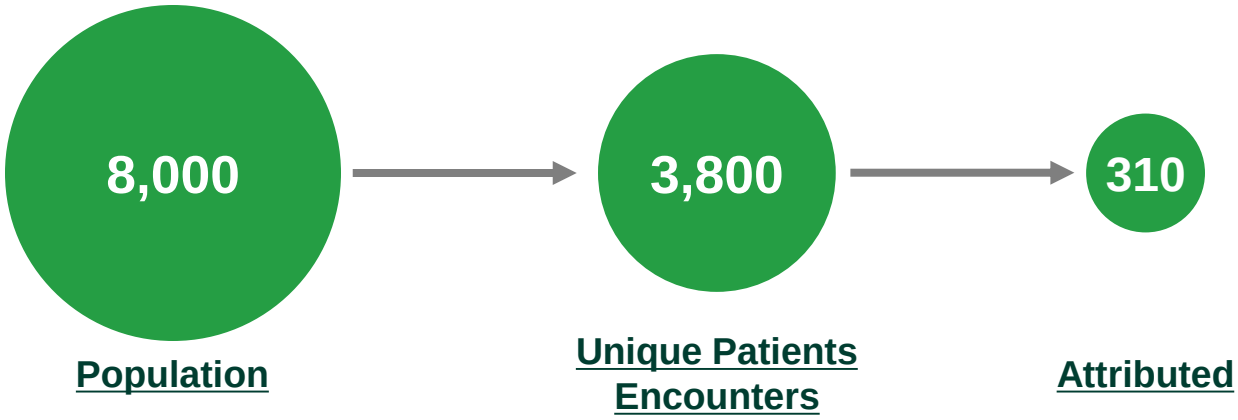
Challenges & Successes & Lessons Learned

Attribution

- Challenge:
  - Low Populations * Low-utilization = Low Attribution



- Successes / Lessons Learned:
  - Utilize local (billing) data to identify opportunities
  - Imbedded Health Coaches in Primary Care Offices
  - Annual Wellness Exams promotions

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Challenges & Successes & Lessons Learned

Data Collection / Integration

- Challenges:
  - Paper Records / Charts
  - 300+ Disparate Data Systems
  - Lack of IT Interconnectivity (Site-to-site or Even within a site)

- Successes / Lessons Learned:
  - Laser Focused - Manual Data Collection (2 metrics to start)
  - Implement a disease registry
  - Perform manual data extracts
  - Identify other (external) data sources
  - Then, establish data connections / interfaces

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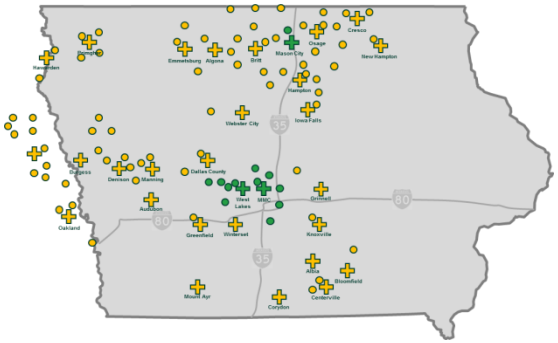
Challenges & Successes & Lessons Learned



(The Opportunity) To Act as a Network

- Challenges:
  - Communication
    - To Providers, Between Health Coaches, Amongst the Network
  - Engagement
    - Physicians, Health Coaches, Leadership and Front-Line Staff

- Successes / Lessons Learned:
  - Shared Data Systems
  - Provider Portal
  - CRM Deployment
  - Physician Champion Engagement
  - Continuum of Care Coordination (Health Coaches)

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Challenges & Successes & Lessons Learned

Leveraging Community Partners

- Challenges:
  - Inventory of area resources (sticky notes)
  - Sharing contacts amongst staff
  - Tracking resources used by patients
  - Which resources to refer to?

- Successes / Lessons Learned:
  - CRM Deployment
  - Identification of Clinical & Non-Clinical Resources Network Wide
  - Successful Patient Hand-Offs
  - Tracking Member Preferences

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Challenges & Successes & Lessons Learned

Rural Reimbursement Structures

- Challenges:
  - Critical Access Hospital Cost Based Reimbursement
  - Rural Health Clinic Reimbursement (Annual Wellness Exams)

- Successes / Lessons Learned:
  - Focus on increasing attribution through Primary Care visits
    - More patients (attribution) = Spreading costs
  - Streamline Annual Wellness Exam pre-work to make ‘break-even’
  - Keep services local = FFS win for the CAH (ie. Colonoscopies)

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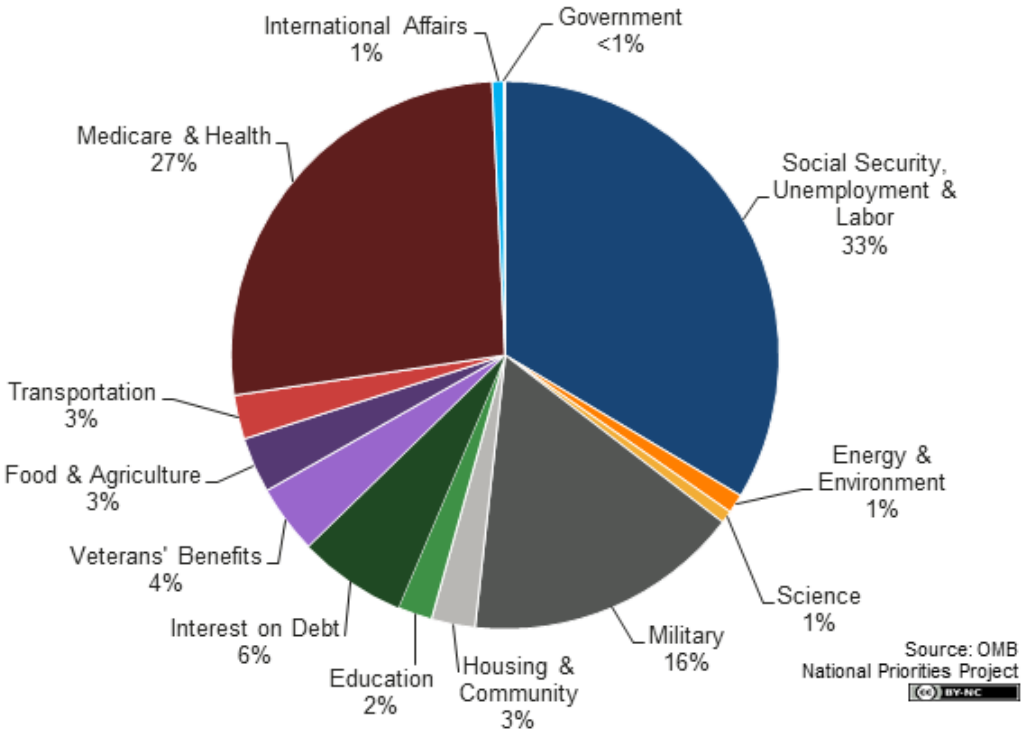
Why would a CAH want to do this?

- Market Forces will push providers and consumers to choose high value networks
- CAH will not be immune to federal budget reality
- Learning to compete in a value based world takes years
- It can be done in a way which does not risk current revenue
- It is the right thing to do for patients



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What can CAHs do Today to Prepare for Value Based Reimbursement?

- Engage local physician champions
- Learn and implement accurate risk coding
- Provide annual wellness visits to CMS patients
- Hire health coaches and optimize them for both value based and FFS reimbursement
- Implement PCMH
- Join a high value provider network

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Conclusions

- Value based payment is here to stay
- Health care providers will increasingly assume risk
- Covered lives will be the measure of growth not hospital admissions
- The only way to reduce cost is to have healthier patients
- Health Coaches and PCMH are keys to early success in value based payment systems
- ACOs align the reimbursement system with our mission and values

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Results: Lower Cost (Cost Trend)

[Compared to Benchmark]

Commercial Shared Savings

2012	▼ 2.9%	$2,545,114
2013	▼ 2.3%	$5,287,321
2014	▼ 4.4%	$3,657,750

Government Shared Savings

2012/13	▼ 3.4%	$9,033,330
2014	▼ 1.7%	$7,560,515

Medicare Advantage

2013	▼ 10.7%	$ 330,647
2014	▼ 7.2%	$ 303,461

Employee Program

2013[2]	▼ 1.9%	$ 708,214
2014	◂▸ 0.5%	($ 191,258)

$29,235,094

Reduced Healthcare Expense for Iowans

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Results: Better Health (Quality)

[YTD 2015 Medicare - Compared to Benchmark]

Key Quality Indicators

CHF Admits	▼	14%
COPD Admits	▼	23%
Bacterial Pneumonia Admits	▼	12%

Utilization

Readmits/1000	▼	6.0%	4,261
Admits/1000	▼	17.3%	12,285
CT Events/1000	▼	7.7%	5,468
MRI Events/1000	▼	0.8%	568
Primary Care Visits	▲	1.7%	1,207

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Thank you.

What Questions do you have?

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