A Journey in Financial Improvement

Preparing for the Volume to Value Transition

March 21, 2018

Iowa Rural Hospital Learning Opportunity Program

Provided by the Iowa Department of Public Health and HomeTown Health through the HRSA Critical Access Hospital FLEX Grant 2017-2018, Iowa Grant #5888CAD4.

Iowa Rural Hospital Learning Opportunity Program

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- All attendees are in "Listen Only" mode
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  - Type in comments or questions.
  - Comments will be monitored throughout webinar.
  - Questions will be addressed at end of the webinar.

Iowa Rural Hospital Learning Opportunity Program

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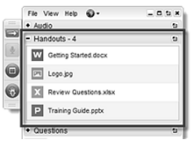

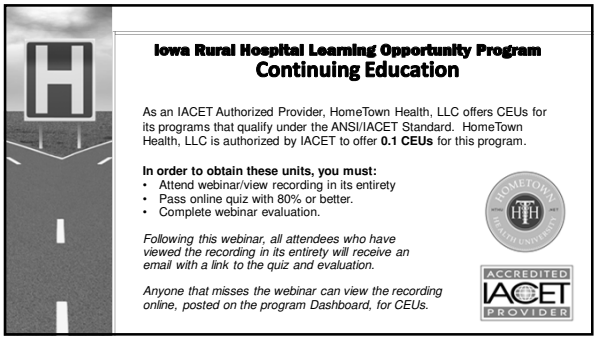
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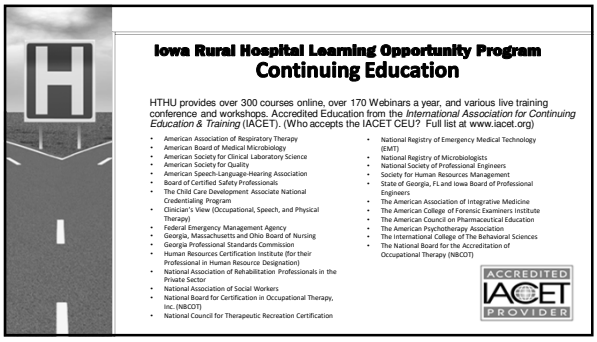
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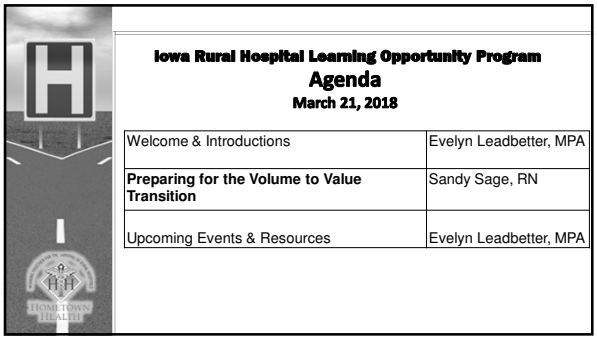
of those in attendance with you in the questions pane.



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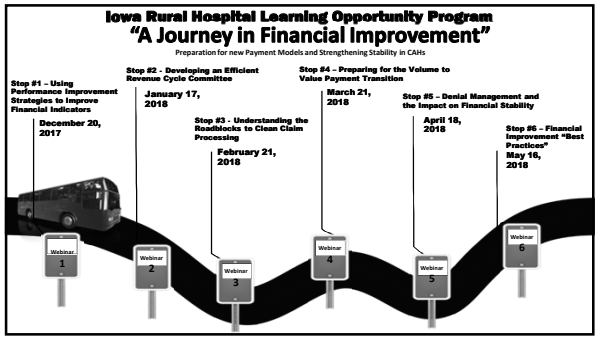

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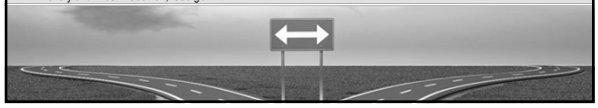
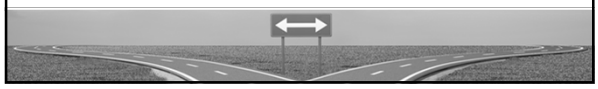
Sandy joined the HTHU team in 2009 as an instructor and has developed many of the courses related to the revenue cycle. She has been a Registered Nurse for over 25 years, having begun her career as a clinical manager and in 2000 transitioned to the position of Revenue Cycle Analyst. Sandy has worked as a consultant for rural hospitals helping them with revenue cycle process development and Chargemaster compliance. She became a member of the HTH team in November of 2016. Sandy has been the Team Lead for the Small Hospital Improvement Program in Georgia and Florida and developed the Rev Up Your Revenue Cycle program for our hospitals. Her responsibilities include revenue cycle education, grant implementation and she will be working closely with our hospitals to help them succeed in this complex healthcare environment. A native of California, she moved to Georgia with her family at age 12 and now considers herself a Georgia girl. She has two grown daughters, Amber and Mallory and lives in Cochran, Georgia.

Sandy Sage,
Revenue Analyst



Preparing for the Volume to Value Transition

Presented by: Sandy Sage, RN
Revenue Analyst - HomeTown Health, LLC



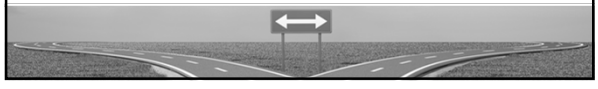
Learning Outcomes

- Identify different payment models in Value-Based Purchasing
- Discuss how population health will benefit you financially
- Understand how to identify high risk populations
- List barriers for rural hospitals in value-based purchasing
- Identify what you can do to prepare for the transition from volume to value reimbursement

Value Based Purchasing

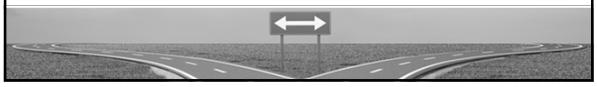
Linking provider payments to improved performance by healthcare providers.

Value or Volume



CMS Value Based Programs

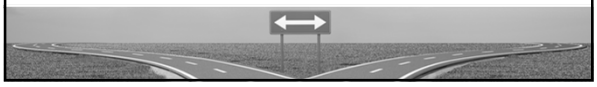
- Have not yet impacted Critical Access Hospitals
- HCAHPS is now required for CAHs
- MBQIP is the beginning of value monitoring for CAHs
- Don't wait for mandatory program implementation



VBP Terms

Accountable Care Organizations (ACO)

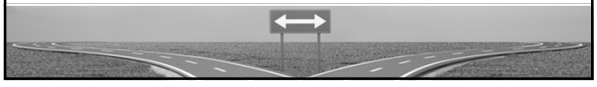
- A group of providers who collaborate to provide quality care to patients, prevent duplication of services, and prevent medically unnecessary care while reducing errors and cost.
- Providers are responsible for clinically and financially caring for the patients.
- Share in risk, cost savings and accountability for the patient population assigned to them.



VBP Terms

Alternative Payment Model (APM)

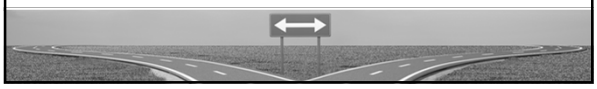
- Reimbursement structuring that rewards healthcare providers for furnishing low cost, high quality care for their patients.
- Payments can be structured in several ways, capitation, outcome based, clinical condition based, i.e. CHF, COPD etc.
- Medicare has several APMs.
- Next Generation ACO, Medicare shared savings programs, comprehensive care for joint replacement payment programs and more



VBP Terms

Global Capitation Payments

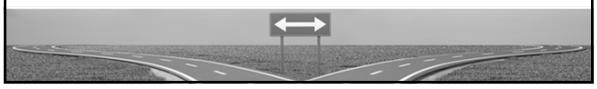
- Providers receive a set amount of reimbursement per patient life, usually per patient, per month.
- Providers in the network determine how to disperse the money among their provider members.
- This may be the ultimate goal of VBP, providers can either lose or make money based on the cost of care they are providing each patient.



VBP Terms

Bundled Payments

- Similar to capitation but the single payment is based on a condition or procedure.
- Payments are based on historical costs of specific conditions or procedures and are adjusted based on patient regional locations.
- Providers can make or lose money, determined by the cost of care.
- Example: Total joint replacement



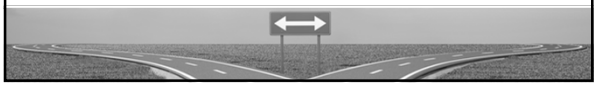
VBP Terms

Medicare Access and CHIP Reauthorization Act (MACRA)

- CMS ties reimbursement to quality outcomes.
- 2 different tracks: MIPS and Advanced APM

Pay For Performance Models (P4P)

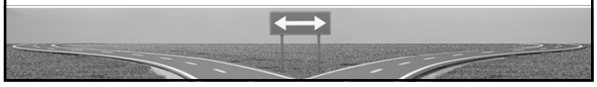
- Reimburses providers for achieving, advancing, or exceeding performance on certain quality and cost measures.



VBP Terms

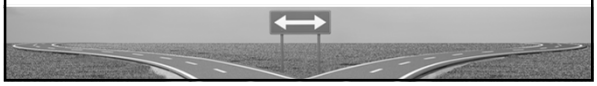
Pay for Reporting Models

- Reimbursement incentivizes providers to report quality and cost data by rewarding them for complete submissions.
- Example: PQRS for physicians that was replaced by MACRA



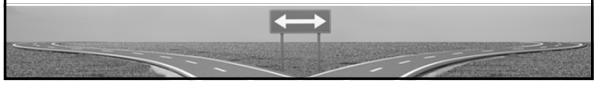
VBP Models

- The goal of VBP models is to keep patients out of the hospital by improving health outcomes.
- Keeping high risk patients out of the hospital will improve your reimbursement in risk/reward models.
- A small population of high risk patients can use most of the available resources.
- VBP models encourage partnerships between providers.



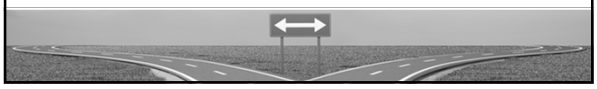
Electronic Health Records

- Improve interoperability between providers to prevent unnecessary testing and duplication of services.
- Improve data collection and reporting methods.
- Improve communication methods to be able to share information in real time between providers.
- Clinical systems should be communicating with financial systems.
- Use data to measure Key Performance Indicators (KPI) to show quality and improvements.



Key Performance Indicators

- Monitor and measure value-based metrics to allow your organization to show improvements in quality of care and in financial processes.
- Use the KPI data to improve your contract negotiation positions.
- Use available quality reporting measures (MBQIP) to prepare for volume to value transitions with Medicare and Commercial third-party payers.
- Be flexible with the indicators being measured.

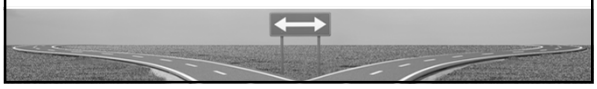


Population Health/Care Management

Use data collected to identify high risk patients

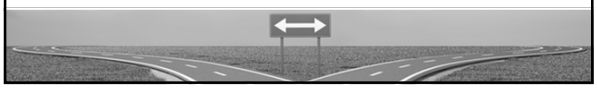
- Frequent Flyer ER patients
- Patients with multiple co-morbidities
- Patient with chronic conditions

Develop care management programs to work with the identified patients that your hospital chooses to focus improvement efforts on.



Population Health/Care Management

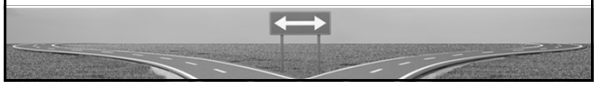
- Once a patient population is identified, determine how their care management would align with VBP.
- Which payers would you benefit from when improving outcomes for these patients?
- Calculate the costs vs. benefits
- Establish your metrics to measure success and improved outcomes



Population Health/Care Management

Example: CHF patients: The assessment

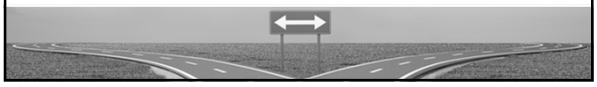
- Extract data from your EHR that shows you patients have the highest cost of care per day or per admission.
- Find that these patients have the highest rate of readmission within 30 days.
- ER utilization between hospitalizations is higher than other chronic patients.
- Determine that the population of patients with chronic CHF is the patient type on which you will focus you care management program.
- Find that you can participate in a capitation program for these patients.



Population Health/Care Management

Example: CHF patients: The Plan

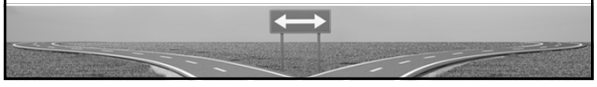
- Use risk assessments for your inpatients allowing your case managers to identify patients with chronic CHF that are at risk for readmission and high cost care.
- Partner with primary care providers to assist in the identification and care of these patients.
- Evaluate staffing to determine if you have the care management staff needed for this population.



Population Health/Care Management

Example: CHF patients: The Plan

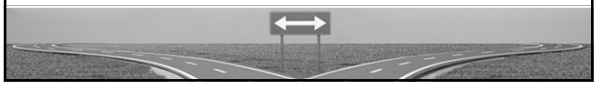
- You may determine that you will need additional staff to accomplish care coordination, care transitions and patient outreach.
- You will need to provide training for current and new staff including your goals for this patient population and how it will benefit the hospital financially.
- Begin to develop post acute care partners. Use community resources, long-term care-providers, and other available resources. (Council on Aging, Meals on Wheels, Aging and Disability Resource Center, Family and Children's Services etc.)



Population Health/Care Management

Example: CHF patients: The Implementation

- Use Care Coordinators to follow the patients through the continuum of care.
- Assist patients in coordinating follow up physician visits, transportation, obtaining and understanding medication regimens.
- You may add post discharge home visits in addition to follow up phone contact to ensure discharge plan is being followed.
- Work with partner providers to coordinate needs assistance.

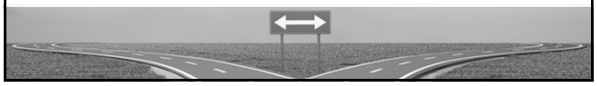


Population Health/Care Management

Example: CHF patients: Monitoring and Tracking

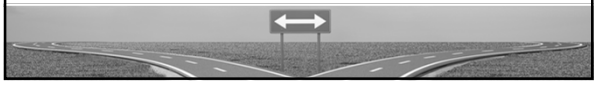
- Readmissions
- ER Utilization
- Medication Compliance
- Other resource utilization

Track and trend results for reporting and add other populations as you see improvements.



VBP barriers in Rural Health

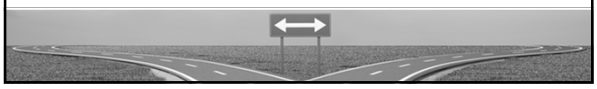
- Limited financial resources to take on risk models
- Small patient population skews the numbers for outcome measures
- Geographic challenges in rural areas
- Providers resistant to change
- Data collection and reporting burdens
- Shortage of qualified staff



VBP barriers in Rural Health

Financial Barriers

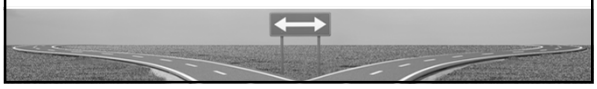
- Interoperable IT between hospitals and other providers is costly.
- Reimbursement can be delayed in VBP models while payers evaluate performance.
- Hiring additional staff is costly and must happen prior to payment.
- Training can be costly for staff and physicians.



VBP barriers in Rural Health

Small Population for Data

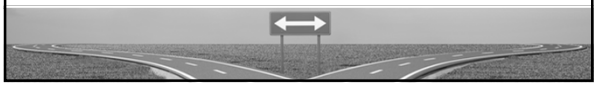
- If you have 6 patients and 3 are readmitted you only show improvement in 50% of your population.
- With rural hospitals relying heavily on Medicare and Medicaid populations for reimbursement, commercial payer population is not diverse enough to carry financial burdens.
- MBQIP measures have been created with the smaller population of rural providers in mind.



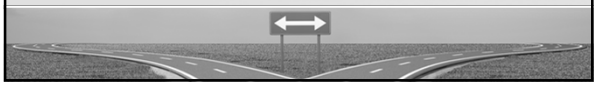
VBP barriers in Rural Health

Geographic Challenges and Provider Resistance

- Rural populations are spread out over a larger area than urban patients making access and patient follow up more difficult.
- Rural providers cannot always direct patient care locations and under VBP models, care at out-of-network facilities is still counted against your risk/reward amounts.
- Rural physicians tend to be older and more resistant to change and need more encouragement and training.



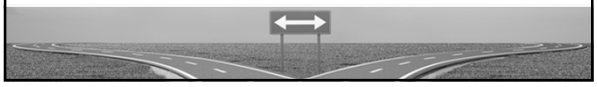
Poll Question



VBP barriers in Rural Health

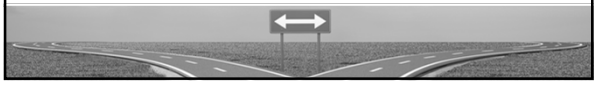
Data Collection and Reporting

- Data collection and reporting creates a big administrative burden if you do not have adequate and interoperable IT systems.
- Rural hospitals partnered with larger hospitals depend on the larger urban facilities for the majority of care and data.
- Reporting for CAHs and PPS facilities is not the same across the board.
- Communication is a barrier between urban and rural facilities.



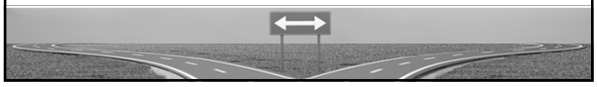
Strategies for Preparing to Transition

- Evaluate your EHR systems to ensure adequate data collection and extraction for reporting.
- Use MBQIP to show quality improvements and quality care results.
- Watch for trends in your patient populations to have baseline data for potential target populations.
- Educate current staff on care coordination and how it translates to financial impacts on the hospital.
- Use all resources made available to your hospital.

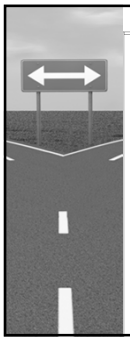


HCAHPS

- HCAHPS are heavily weighted in the VBP program in place now for PPS hospitals.
- Continue to work on improving your scores to show payers the quality of care you are providing.
- HCAHPS now required, other reporting requirements will follow.



Current Quality Measures



MBQIP

Medicare Beneficiary Quality Improvement Project

- CAHs have historically been exempt from quality reporting due to low volumes and limited resources.
- MBQIP is part of the FLEX grant program.
- CAHs are encouraged to report to demonstrate the quality of care they are providing as we move toward Value based reimbursement.
- MBQIP is a proactive way to make sure that you are ready for future quality reporting requirements.

Poll Question

Core Measures

Patient Safety/Inpatient

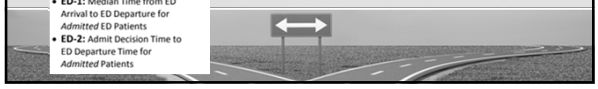
OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(Facilities report a single rate for inpatient and outpatient settings)*

IMM-2: Influenza Immunization for inpatients

Antibiotic Stewardship: Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey

Inpatient ED Measures:
- **ED-1:** Median Time from ED Arrival to ED Departure for *Admitted* ED Patients
- **ED-2:** Admit Decision Time to ED Departure Time for *Admitted* Patients

- Do you have a program in place to ensure employees are receiving their Flu Vaccines?
- Do you ask every patient if they have received the Flu Vaccine?
- Is that information documented consistently?



Core Measures

Patient Safety/Inpatient

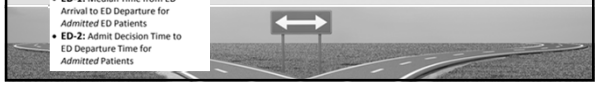
OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(Facilities report a single rate for inpatient and outpatient settings)*

IMM-2: Influenza Immunization for inpatients

Antibiotic Stewardship: Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey

Inpatient ED Measures:
- **ED-1:** Median Time from ED Arrival to ED Departure for *Admitted* ED Patients
- **ED-2:** Admit Decision Time to ED Departure Time for *Admitted* Patients

- Antibiotic Stewardship Program
- Do you have processes in place to monitor antibiotic usage and results?
- It is part of the Medicare Conditions of Participation for your hospital that you have a good infection control program in place.



Core Measures

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- **ED-1:** Median Time from ED Arrival to ED Departure for *Admitted* ED Patients
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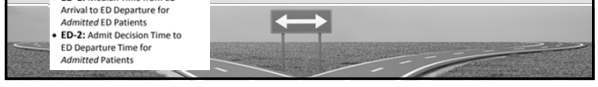
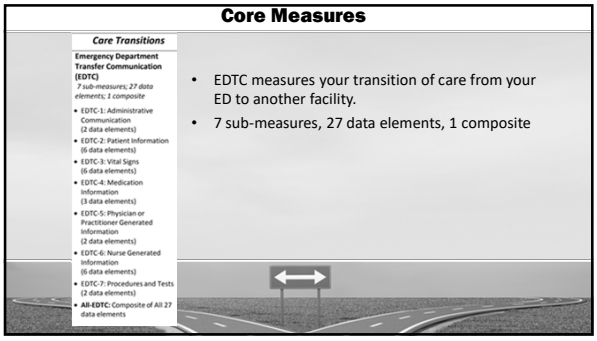
- Inpatient ED Measures
- Are you tracking time from arrival to admission for patients being admitted from the ED?
- Are you tracking the time from decision to admit to actual admission to the floor or unit for patients admitted from the ED?



Core Measures



- EDTC measures your transition of care from your ED to another facility.
- 7 sub-measures, 27 data elements, 1 composite

References

- https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/impptdis/index.html
- https://www.ruralcenter.org/resource-library/mbqip-quality-reporting-guide
- https://revcycleintelligence.com/news/flexibility-value-based-payment-key-to-rural-hospital-success?elqTrackId=84368a20b8d04ad9b5b482ed6ed1e074&elq=fbdb14f9f8014739bfa69ba491534e7d&elqaid=4626&elqat=1&elqCampaignId=4292
- https://revcycleintelligence.com/features/preparing-the-healthcare-revenue-cycle-for-value-based-care

Learning Outcomes

- Identify different payment models in Value-Based Purchasing
- Discuss how population health will benefit you financially
- Understand how to identify high risk populations
- List barriers for rural hospitals in value-based purchasing
- Identify what you can do to prepare for the transition from volume to value reimbursement

Questions?

Contact Sandy Sage, RN

Sandy.sage@hometownhealthonline.com

or email

hthtech@hometownhealthonline.com

Iowa Rural Hospital Learning Opportunity Program

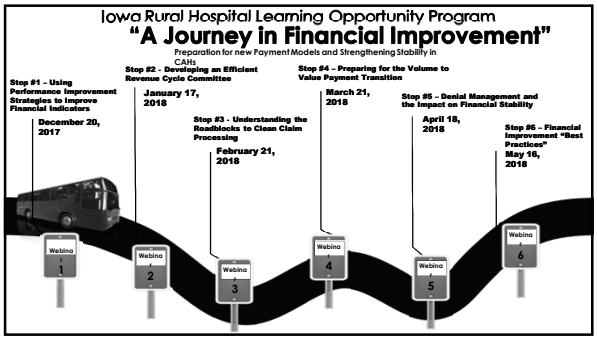
Announcements & Upcoming Events

Evelyn Leadbetter, Network Services Manager

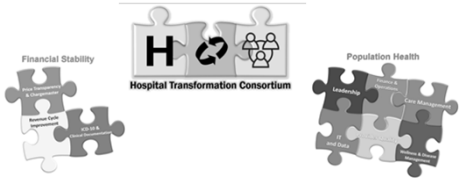
Iowa Rural Hospital Learning Opportunity Program

"A Journey in Financial Improvement"

Preparation for new Payment Models and Strengthening Stability in CAHs



2018-2019 SHIP Grant Kickoff
May 30, 2018 1:30 pm CST



Dashboard & Resources

A recording of today's webinar, handouts & resources, and future webinars dates can be found on the Program Dashboard located at: www.hthu.net/iowarhlop18

Don't forget about your CEUs!

Following this webinar, all attendees who have viewed the recording in its entirety will receive an email with a link to the quiz and evaluation.

Anyone that misses the webinar can view the recording online, posted on the program Dashboard, for CEUs.

Win a $100 Amazon Card!!!

Listen to all six webinars (live or online), then take the post-test and evaluation. You will be entered into a drawing to win. Drawing to be held June 4th.