RURAL ACOS
CAN WORK AND LEAD THE WAY
Nebraska Rural Health Association
September 20, 2017

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Rural Princeton

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Agenda – Rural ACO
- Illinois Rural Community Care Organization (IRCCO)/Statewide Rural ACO
- IRCCO – Our Story Infrastructure and Development
- Changing the Conversation
- Return on Investment – Value Impact
- Lessons Learned as an ACO
- Moving Forward – Opportunity for Rural
Illinois Critical Access Hospital Network

ICAHN is a not-for-profit 501(c)3 corporation established in 2003 for the purposes of sharing resources, education, promoting efficiency and best practice and improving health care services for member critical access hospitals and their rural communities. ICAHN, with 55 member hospitals, is an independent network governed by a nine-member board of directors.

- Members = 38 Independent; 17 Systems
  - 8 providing OB Services
  - 11 Long Term Care
  - 1 Inpatient Psych Unit
  - Incubator for rural programs and services
  - Statewide rural network
  - Illinois Rural Community Care Organization

Moving from Volume to Value Based Care

Health Care Reform – What does that mean for rural?

- Triple Aim
- Clinically Integrated Networks
- Coordinated Care Program – Navigator Programs
- Transitional Care and High Costs
- Primary Care Driven
- Quality Reporting and Data Based Decisions
- Consumer – the new patient
- Market Share – fast growing systems
- Changing Reimbursement System
- Accountable Care Organizations

Starting An ACO – IRCCO Plan

Activity: Building Infrastructure
- Building Infrastructure, Credibility
- Outreach, Benchmarks
- Implementation/Marketing
- Evaluation
- No Shared Savings 2015
- Quality Success

Activity: Building the Service – Customer Service, Primary Care and Local Access
- Patient Centered Medical Home standard
- Care Coordination Program – each participant
- Medicare Well Visit Program
- Reducing Variability – evidence based chronic care standards for rural
- Primary care – management of patient group
- Quality reporting
- Data Management

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IRCCO
Illinois Statewide Rural ACO
- 24 Critical Access and Rural Hospitals
- 35 rural health clinics
- 15 Independent physician practices
- >250 Medical providers
- Providing care for >30,000 Medicare Beneficiaries
- Medicare Shared Savings Program Year 3; AIM Investment Funds 2016
- BCBSIL ACO 2017-2018
- www.iruralhealth.org

IRCCO Governance

Medical Staff Engagement - Critical
- Chief Medical Officer / Family Practice
- Inclusion in Governance/Decision-making
- Medical Provider Workgroups (chronic care)
- Physician Meetings
- Importance of Culture Change
- Consideration work flow/schedule
- Standards and Data
- Patient Outcomes
IRCCO Population Health Strategies

- Healthy Patients
  - 50%
  - Early Onset Chronic Disease
  - Full Onset Chronic Disease
  - Complex Diseases

- Medicare Well Visits
- Screenings
- Immunizations
- Healthy Eating
- Exercise Programs
- Newsletter
- Patient Education
- Building relationship with patients

Provider Benchmarks
- Diabetes
- Hypertension
- Cholesterol
- Mental Health
- Positive screen
- Medication abuse
- Traumatic injury
- Arthritis
- Cardiac Rehab
- Physical Therapy
- Group counseling
- Support Groups
- Primary care monitoring

Chronic Disease Management
- Chronic Care Management
- Health Coach
- Community Care Worker Program
- Self-management skill-building
- Specialty care referral monitoring
- ADTs

All beneficiaries should be in a care coordination program.

Start Here

ACO IT Support – What do I need?
- eClinicalWorks – Platform to manage claims and build dashboards
- ADTs (Admission Discharge Transfers) Alerts – support through Central Illinois Health Information Exchange (HIE)
- Care Management Module / case management
- PQRS provider monitoring
- CAREFUL….what do you really need and can pay for?

To Change the Culture/Value
- Change must come from within the hospital and practice setting
- Move from volume to value
Goal: Reduce Beneficiary Cost 5%

$10,600 average cost per beneficiary (2015 adjusted)

- Strategies on how do we reduce 5%
  - Breaking down the $10,600 using dashboards
  - ED Utilization – target more than 4 visits per year; CHF and COPD
  - Primary Care – target more than 4 visits per year
  - Hospitals (participant and tertiary care)
  - Well visits
  - Utilizations
  - Skilled Care/post hospitalizations (coming soon)
  - Medications – Benchmark of 90% generic utilization
  - Too many procedures (coming soon)
  - Patient engagement (coming soon)

Heart of ACO: Care Coordination “IRCCO Regional Approach”

Regional Care Managers

- Connect with assigned hospitals (8-14)
- Host weekly individual calls with each member
- Host monthly regional calls and/or regional boutique meetings
- Ensure all members are on track for success
- Provide ongoing resources and assistance in all facets of care coordination
- Assist with PCMH and office workflow
- IRCCO Care Coordination Playbook
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**CMS - Chronic Care Management Program**
- IRCCO CCM Consulting Services
  - IRCCO providing CCM consulting services to other states
  - State of the art tools and procedure manual
  - Turn key approach
- CMS pushing new codes and a growing “must”
- CCM in your clinic? Practice?

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**Care Coordination - Learning**
- [https://www.iruralhealth.org/](https://www.iruralhealth.org/)

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**Value of Primary Care**
- Care Coordination – case management
- Coding!!!
- Revenues – primary care
  - Medicare Well Visits
  - Chronic Care Management
  - Transitional Care Management
  - Gap Closures/prevention screening
- Increase primary care – loyalty
- Transfer process evaluation
- Patients are our neighbors – high
Data Management
“What claims tell you”

- Beneficiary usage – local or specialty
  - Ex: Medicare patient visited ED 150 times/18 months
- Hospital care – Inpatient and Outpatient
- Post Acute Care – ED Usage
- Primary Care
- Cost Utilization
- Coding – health of beneficiary
- Participant – Provider – Other organizations
  - ACO IT Platform….drills down to provider level

Benchmark Comparison

IRCCO's ED UTILIZATION COUNT ANALYSIS, (NYU) ALGORITHM,
57% AVOIDABLE VISITS = SAVINGS AVAILABLE
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What Claims Do Not Provide

- Immediate care and treatment – 3 to 6 months old
- What action to take for better management
- Disease registries – B/P; A1C
- Time frames – comparison pricing
- Social Services
- Medication costs
  - Use EMR and other tools for care management
  - Screening/prevention

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Quality Improvement - Scores

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>2015 Actual</th>
<th>2016 Estimated</th>
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<tbody>
<tr>
<td>ACO-13 Screening for Future Fall Risk</td>
<td>22.20%</td>
<td>58%</td>
</tr>
<tr>
<td>ACO-14 Influenza Immunization</td>
<td>52.71%</td>
<td>66%</td>
</tr>
<tr>
<td>ACO-15 Pneumonia Vaccination Status for Older Adults</td>
<td>46.62%</td>
<td>63%</td>
</tr>
<tr>
<td>ACO-16 Body Mass Index (BMI) Screening and Follow-Up</td>
<td>58.15%</td>
<td>66%</td>
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<tr>
<td>ACO-17 Tobacco Use: Screening and Cessation Intervention</td>
<td>86.38%</td>
<td>87%</td>
</tr>
<tr>
<td>ACO-18 Screening for Clinical Depression and Follow-Up</td>
<td>13.35%</td>
<td>34%</td>
</tr>
<tr>
<td>ACO-19 Colorectal Cancer Screening</td>
<td>32.79%</td>
<td>52%</td>
</tr>
<tr>
<td>ACO-20 Breast Cancer Screening</td>
<td>54.52%</td>
<td>63%</td>
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<tr>
<td>ACO-21 Screening for High Blood Pressure and Follow-Up Documented</td>
<td>70.36%</td>
<td>65%</td>
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<tr>
<td>ACO-22 Slab Therapy for the Prevention and Treatment of Cardiovascular Disease – At-Risk Population</td>
<td>80%</td>
<td>93%</td>
</tr>
<tr>
<td>ACO-23 Depression Remission at Twelve Months - - -</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ACO-24 Diabetes Mellitus: Hemoglobin A1c Poor Control</td>
<td>25.63%</td>
<td>12%</td>
</tr>
<tr>
<td>ACO-25 Diabetes: Eye Exam</td>
<td>38.63%</td>
<td>34%</td>
</tr>
<tr>
<td>ACO-26 Hypertension: Controlling High Blood Pressure</td>
<td>67.86%</td>
<td>76%</td>
</tr>
<tr>
<td>ACO-27 Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic</td>
<td>80.88%</td>
<td>93%</td>
</tr>
<tr>
<td>ACO-28 Heart Failure: Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>93.58%</td>
<td>99%</td>
</tr>
<tr>
<td>ACO-29 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF&lt;40%)</td>
<td>75.20%</td>
<td>96%</td>
</tr>
</tbody>
</table>

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IRCCO Finances

- Hospital Participants $10,000/year each
- 2015 (1st Year) - $180,000 to operate
- ICAHN Managed – sharing of resources and office
- Expenses
  - Management
  - ACO IT Platform
  - Training and Education/Meetings
  - Insurance
  - Office Support
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AIM Funding 2016 – **Difference!**

- Allows IRCCO to “Ramp Up”
- Funds for:
  - Regional Care Managers (2)
  - Chief Medical Officer/paid position (part time)
  - Clinical Informatics Specialist
  - Chronic Care Manager Specialist/Trainer
  - Provider Training and Compliance Support
  - Build IT Infrastructure – connectivity and care management/care plan tool “Roundingwell”

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**Most Important!!**

- We have changed the Conversation...
- Practitioner - Hospital discussions are now about care of the patient

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**So What Has IRCCO Learned?**

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Healthcare Today

- How we take care of patients has not changed; it is how we manage the care of the patient that has. Pat Schou

Value of the ACO - Participant

- Access to information – knowledge about beneficiary use
- Monitor market share and develop tools to grow primary care/loyalty
- Quality Reporting (90%+) / MIPS
  - IRCCO 70% Quality Scores (50% aggregate + 20% participation in APM)
- Learn how to better manage patients/population
- Access to Good Commercial Payor Contracts

IRCCO Participant
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Chief Medical Officer Guidance
...Outreach to Hospitals and Providers

- Individual participant meetings – present data
  - CMO, Regional Care Manager, Hospital CEO, Providers (ex. Group PMPM $800 – Hospital PMPM $850...discussion on making change)
  - Risk adjust comparison
- Opportunities to improve
  - Using data to make changes
- Rural relevant care
  - Managing specialty referral – how to?

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Primary Care Market Share

- Local rural health care = lower costs
- Reduce beneficiary spend = seek increase volume and/or new revenue sources
- Well Visits, Gap Closers, CCM, Prevention
- Can then begin to manage population health
- Population will seek providers/practitioners who focus on health and cost savings
- Rural refocus on its services
  - IL CAHs lost 10% market share/year

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Post Acute Hospitalization

- Rural providers – high cost is not necessarily due to swing beds
- Other reasons
  - Beneficiaries use all available Medicare days
  - Limited management and supervision of care in skilled and long term care
  - Frequent readmissions or to ED and patient has a DNR
- Solution – hospital and nursing home readmission huddles; transition care tracking includes medication evaluation
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**Care Coordination – Best Practice**

- Need a committed team in place
- Cannot dilute and daily reassign staff
- **Must** manage high risk/high cost patients
  - Top 20%
- Makes the difference for “buy in” and should be why better care for patient
- Tools - track activity, outcomes and cost
- Pulling in community resources for social needs

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**Hospital Concerns**

- Why Change?
  - If the goal is reduce Medicare beneficiary spend and IRCCO is able to do so, what about the hospital or practice’s bottom line?
  - What is my return on investment (ROI)?

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**Pivotal Lesson Learned**

- Hospital staff and providers are involved and committed – make great strides
- If administration and providers are not committed, minimal change
- Change is not easy – understand ROI and improve workflow
- Care coordination is the initial key to success
- Care transitions - rounding at nursing homes is important to reduce readmissions
Challenges for Rural ACOs

- Geography – Independent hospitals and their providers spread out
- Hospitals – limited financial and human resources
- Rural Health Clinics – mid-level providers and do not have beneficiaries initially attributed; not included in MACRA/MIPS
- Emergency Department – inappropriate use as many communities do not have 24/7 prompt care; EMS transport

Other Challenges

- Limited access to behavioral health services
- Social determinants rural versus urban
- Care giver availability for rural elderly living alone
- Specialty referral okay but seldom are patients returned to local community
- Rural Medicare beneficiaries – many have not seen a medical provider for 20 years (i.e. farmers)
- Controlling “downstream” spend /PRIORITY

SUCCESS... IRCCO Moving Forward

- Renewal application 2018-2020... stayed Track 1
  - Plan to move to risk 2019 & Shared Savings Goal!
- Commercial Payors – BCBS Shared Savings Program start 2018 (18,000 beneficiaries)
  - Contracts for Specialty Care; Aetna ACO; Medicaid
- Financial stability – consulting services shared services/revenue streams
New Opportunities for Rural Providers

- Health coaching program for high-risk employees (hospital or local business community, self-funded plans)
- Risk analysis – plans of care
- Wellness with ROI on prevention
- Revenue stream for IRCCO and Hospital and Medical Providers (identification of new patients)
- "Win-Win" to continue

Benefits of Rural ACO

- Rural is primary care and the basis for MSSP
- Share best practices and learn from each other – ideas and problem solve
- Leverage numbers as a small provider to make change
- Support group decision-making for both hospitals and medical providers
- Understand the value of community

IRCCO Participants – Say “Yes”

- Be prepared for value based care – CMS
  - Ready for 2020 and Population Health
  - Understand leverage of numbers moving to risk
  - Better together – sharing of resources
  - Best practices and learning from our data for improvements
- Real patient situations where better management of care has made the difference
Still about the patient…

Rural ACOs can Lead the Way

Questions/Comments

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