Rural Hospital Stabilization - A Three Year Approach

Presentation to: GRHA 2017 Membership Conference
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82 Rural Hospital Closures: January 2010 – Present
Rural Hospital Closures

Hospital Closures since 2001

- Hancock Memorial Hospital  2001
- Dooly County Hospital  2001
- Telfair Regional Hospital  2008
- Calhoun Memorial Hospital 2013
- Stewart-Webster Hospital 2013
- Charlton Memorial Hospital 2013
- Lower Oconee Regional 2014
- North Georgia Medical Center 2016

Closed Emergency Room

- Flint River Hospital 2013
- Cook Medical Center 2017
Index of Financial Distress

Figure 1: Number and Percentage of Rural Hospitals at High Risk of Financial Distress in 2016

Source: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, November 2015
http://www.shepscenter.unc.edu/programs-projects/rural-health/
The Changing Health Care Environment

- Hospital Closures – 7 rural hospitals nationally closed to date in 2017
- At the current growth rate, high deductible insurance plans offered through employers will predominate the market within four years.
- Consumer demand for transparency in healthcare pricing
- Rural-urban affiliations
- Physicians transitioning to hospital employment
- Flattening inpatient volumes - accelerating shift to outpatient care
- Recovery Audit Contractors (RAC)- While they look for both overpayments and underpayments, they are paid based on a percentage of the recovered overpayments. In fiscal year ending September 30, 2015, $359.7 million in overpayments were collected and $81.0 million in underpayments were returned to providers.
- CMS Hospital Penalty Programs
- Physician Quality Payment Program (QPP) – support for small, rural providers!
- Bundled payment models

Providers face new financial uncertainty and challenges as they are required to adapt to the changing market.
The National Quality Strategy pursues three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve health and the quality of health care.

- **Better Care**: Improve overall quality by making health care more patient-centered, reliable, accessible and safe.
- **Healthy People / Healthy Communities**: Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care.
- **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers and government.
NQS Priorities

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.
The Three Goals of the Triple Aim

Achieving the Triple Aim is a complex endeavor that requires healthcare organizations to understand their past and current performance and to then implement interventions to improve.

This entire process requires a strong data foundation and the tools to continuously measure performance. It also requires the ability to combine clinical, financial, administrative, and patient satisfaction data.
• The $10,345-per-person spending figure is an average; it doesn’t mean that every individual spends that much in the health care system. In fact, U.S. health care spending is wildly uneven.

• About 5 percent of the population — those most frail or ill — accounts for nearly half the spending in a given year, according to a separate government study. Meanwhile, half the population has little or no health care costs, accounting for 3 percent of spending.

• Of the total $3.35 trillion spending projected this year, hospital care accounts for the largest share, about 32 percent. Doctors and other clinicians account for nearly 20 percent. Prescription drugs bought through pharmacies account for about 10 percent.

• The report also projected that out-of-pocket cost paid directly by consumers will continue to increase as the number of people covered by high-deductible plans keeps growing.

Increases in Health Insurance Premiums Compared with Other Indicators, 1999–2016

CUMULATIVE INCREASES IN HEALTH INSURANCE PREMIUMS, WORKERS’ CONTRIBUTIONS TO PREMIUMS, INFLATION, AND WORKERS’ EARNINGS, 1999-2016

Percentage of covered Workers - HDHP

*Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information, see the Survey Methods Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

“Instead of payment that asks, How MUCH did you do?, the Affordable Care Act clearly moves us toward payment that asks, How WELL did you do?, and more importantly, How well did the patient do?”

Don Berwick former administrator CMS
TIMELINE

Rural Hospital Stabilization Committee established
April 2014

Rural Free Standing Emergency Department Regulations approved
May 2014

Rural Hospital Stabilization Committee Final Report
“Hub & Spoke” Model Published February 2015

Governor signed budget $3,000,000 hospitals selected
May 2015

Department of Community Health executed grants
July 2015

Initial Meeting Performance Measures Selected
August 2015

Project work plans and budgets approved
October 2015

Grant Extension approved
April 2016

Grant Terminated December 2016
“the right care, at the right time, in the right setting”
Disconnected communication among providers fuels uncertainty and often non-adherent behaviors
"OK. I understand a lot is going to change. But how do I stay the same?"
“WE CANNOT SOLVE OUR PROBLEMS WITH THE SAME THINKING WE USED WHEN WE CREATED THEM”
Framework

1. **DEFINE**
   - Population Identification

2. **ASSESS**
   - Health Assessment

3. **STRATIFY**
   - Risk Stratification

4. **ENGAGE**
   - Enrollment / Engagement Strategies

5. **MANAGE**
   - Management / Interventions
     - Tailored Interventions
     - Care Coordination
     - Disease / Case Management
     - Health Risk Management
     - Health Promotion / Wellness

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**Meeting patients where they are**

- Physically
  - home | school | work | shopping | in the clinic

- In the way that works best for them
  - email | text | internet | phone | video | face-to-face
Population Health Pyramid

**Characteristics**
- Super-utilizers
- Poly-chronic, frail, elderly, urban poor
- Frequent hospitalizations, emergency visits
- Psychosocial and socioeconomic barriers
- Costs make up 45 – 50 percent
- Limited and stable chronic conditions
- At risk for procedures
- Costs make up 30 – 40 percent
- Healthy
- Minor health issues
- Costs make up 10 – 20 percent

**Population/Risk**
- 5% High Risk
- 35% – 40% Medium Risk
- 50% Low Risk

**High-Impact Care Priorities**
- Care coordinators (RN’s or social workers)
- Address psychosocial and non-clinical barriers
- Community resources navigation
- Intensive transition planning
- Frequent one-on-one interaction
- Reduce practice variation
- Systematic care and evidence-base medicine
- Team-based, coordinated care
- Scalable care team
- Practice at top of license
- Focused coordination and prevention
- Movement toward virtual, mobile, anytime access
- Convenience is critical

**Access**

**Community Engagement**

**Patient Engagement**

**Care Teams**
Value through Partnerships

Work Together
Assess Needs & Resources
Evaluate Actions
Act on What’s Important
Choose Effective Policies & Programs
Communicate
Focus on What’s Important

Public Health
Healthcare
Community Development
Government
Philanthropy & Investors
Nonprofits
Educators
Business

http://www.countyhealthrankings.org/roadmaps/action-center
Data Driven Solutions

The healthcare transformation is driving healthcare organizations to be able to manage patient populations to improve health, improve outcomes and reduce costs. They must gain deeper insight into population chronic disease cohorts to enable proactive interventions.

This insight requires the capture and centralization of disparate data sources to enable enterprise wide reporting.

The movement to value based care requires population insights to get the right data to the right place at the right time in order to truly impact patient care.
“If we can’t get to the 98 percent of health care that actually takes place in the bedrooms, bathrooms, and kitchens of people’s homes, we are not going to have the change in the outcomes that we want to have.”

http://www.hfma.org/Leadership/Archives/2016/Winter/Activating_Patient_Engagement_for_Population_Health/#sthash.FQyVMWRK.dpuf
Many stakeholders believe: “Population health management is the way out of the crisis”
“There is nothing more important [in healthcare] than the transition from traditional medicine to population health and the implications that will have. No outcome, no income.”

Dr. David Nash
Founding Dean, Jefferson School of Population Health
“In God we Trust – all others bring data.”

- William Edwards Deming
Data Sources to fuel project development
Community Health Status Indicators (CHSI)

Assess community health status and identify disparities;
Promote a shared understanding of the wide range of factors that can influence health; and
Mobilize multi-sector partnerships to work together to improve population health.

http://wwwn.cdc.gov/communityhealth
County Health Rankings

Find out how healthy your county is and explore factors that drive your health

Overall Rankings in Health Outcomes

Overall Rankings in Health Factors

http://www.countyhealthrankings.org/
Harness the power of business intelligence with HIDI Analytics:
Utilizing the Georgia Discharge Data Set:

✓ Access reports designed to meet the specific needs of PPS and critical access hospitals

✓ Stay on top of the complex and ever changing policy landscape and anticipate the associated financial impact to your hospital

✓ Supplement business cases to justify new or expanding services with decision support driven by data

✓ Identify demographic, socioeconomic and health characteristics for your community health needs assessment with interactive geographic information systems.
Phase 1 – Pilot Hospitals

Appling Healthcare System
Crisp Regional Medical Center
Emanuel Medical Center
Union General Hospital
Rural Healthcare


Strategy narrative

“Through long-term sustainability, we will seek to improve the health opportunities for county residents.”

“In order to achieve long-term sustainability, we will exceed patient and community needs by providing the best rural healthcare services in a modern setting.”

“In order to provide the best services, we will develop business growth opportunities and provide the highest quality clinical and operational services.”

“In order to support our processes for growing services and providing high-quality care, we will be the employer of choice for a highly productive and motivated workforce.”
Overarching Goals

- Increase Market Share
- Reduce Potentially Preventable Readmissions
- Reduce Non-Emergency care and “Super Users” served in the ED
- Increase Primary Care Access
Goal 1 – Increase Market Share

- Emergency Department (ED) Integration with Emergency Medical Services (EMS)
- Existing Service Line Enhancement
- New Service Line Development
Project Snapshots
Designations Supported

• Appling Healthcare System achieved Level IV Trauma Center Designation June 2016
• Crisp Regional Hospital achieved Remote Stroke Designation May 2017
Project Snapshots
EMS/ED Transmissions
Project Snapshots
Enhance Emergency Department Services

- Additional 4 Emergency Department Rooms
- Patient Advocates 7 days a week
- Fast Track
  - Nurse 1st Triage
  - Bedside Registration
- Opioid Prescribing Policy (decrease >50% volume)

- Union General Hospital
Project Snapshots
Enhance Communication

Perception is EVERYTHING
Project Snapshots
New Outpatient Service Lines Developed

Appling Healthcare System -
- Occupational Health

Services Provided
- Drug Screens
- Pre-employment & Post Offer Employment Testing
- DOT Physicals
- Workplace injury evaluation and treatment
- Workplace health and wellness
- Functional Capacity Evaluations

Emanuel Medical Center
Tele-Nephrology program

TeleNephrology
Interacting Goals

• Goal 2 – Reduce Potentially Preventable Readmissions

• Goal 3 – Reduce Non-Emergent Care and “super users” served in the Emergency Department
  – Hospital based Care Coordination
  – Mobile Integrated Health Care and Community Paramedicine (MIH-CP)
  – Specialty Telehealth
Project Snapshots
Care Coordination / Mobile Integrated Healthcare

Care Coordination
- Appling Healthcare System
- Emanuel Medical Center.

Mobile Integrated Healthcare Program
- Crisp Regional Hospital
- Union General Hospital
Project Snapshots
Telehealth Projects

- Emanuel County Nursing Home telemedicine psychiatric management
- Appling Healthcare System Specialty Outpatient Care
- Crisp Regional Hospital Neurology ED/Inpatient Telemedicine
Goal 4 – Increase Primary Care Access

- Federally Qualified Health Center (FQHC) Partnership
- School-Based Health Care
Project Snapshots
FQHC partnership

Appling Healthcare System –

Crisp Regional Hospital –

AAPHC
Albany Area Primary Health Care
Project Snapshots
School Partnerships Projects

• Union General Hospital Telehealth Program
• Appling Healthcare System County Telehealth Program
• Crisp Regional Hospital Telehealth and onsite clinic Program
• Linkages of rural stakeholders with the hospital has proven to be the greatest opportunity and strength of the Rural Hospital Stabilization Program.

• The stabilization funds provided an infrastructure in which hospitals could test innovative programs in response to a rapidly changing health care environment.
OPPORTUNITIES

• Focus data – start with the end in mind
• Data Validity  
  – Standardize measure calculations  
  – Stratify claims data by payor  
  – Issues with hospital claims data
• Need for pre/post data for “intervention” cohort
• Data needed from partners across the continuum of care
Phase 2 TIMELINE

Governor signed budget $3,000,000 hospitals selected
May 2016

Department of Community Health executed grants
September 2016

Project work plans and budgets approved
November/December 2016

Anticipated Grant Termination
June 2018

The $3M investment will span a 2-year project providing each of these rural communities an opportunity to explore options for cost savings, new revenue and service expansion.
Phase 2 Hospitals

Habersham Medical Center
Miller County Hospital
Upson Regional Medical Center
Goal 1 – Increase Market Share

• Emergency Department (ED) Integration with Emergency Medical Services (EMS)
• Existing Service Line Enhancement
• New Service Line Development
Project Snapshots
Enhance Emergency Department Services

• Additional Emergency Department Rooms
• “Safe Room” / Isolation Room
• Medical Screening Exam
• EKG Transmission
• Stroke Care

Miller County Hospital
Upson Regional Medical Center
Habershams Medical Center
Project Snapshots
New Service Lines/Programs

• Geriatric Psychiatric Unit
• Touchstone
• 340B Drug Discount Pharmacy Program
Partnership with Women’s TeleHealth for Maternal Fetal Medicine Clinic
Interacting Goals

• Goal 2 – Reduce Potentially Preventable Readmissions
• Goal 3 – Reduce Non-Emergent Care and “super users” served in the Emergency Department
  – Hospital based Care Coordination
  – Partnership for Post-Acute Care
  – Mobile Integrated Health Care and Community Paramedicine (MIH-CP)
  – Telehealth
Project Snapshots

Care Coordination / Mobile Integrated Healthcare

Care Coordination

- Miller County Hospital

Mobile Integrated Healthcare Program

- Habersham Medical Center
- Upson Regional Medical Center
Project Snapshots
Care Coordination Partnership

Swing Bed Program – Helping Patients Transition from Hospital to Home
Project Snapshots
School Partnerships Projects

- Habersham Medical Center Telehealth Program
- Upson Regional Medical Center Telehealth Program
Goal 4 – Increase Primary Care Access

1. Collaboration with Mercer University School of Medicine, medical staff, and Three Rivers Area Health Education Council to establish a medical student pipeline
Phase 3 TIMELINE

Governor signed budget $3,000,000 hospitals selected
May 2016

Department of Community Health executed grants
October 2017

Project work plans and budgets approved
In process

Anticipated Grant Termination
June 2018

The $3M investment will span a 1-year project providing each of these rural communities an opportunity to explore options for cost savings, new revenue and service expansion.
Phase 3 Hospitals

Bacon County Hospital
Chatuge Regional Hospital
Cook Medical Center
Effingham Hospital
Irwin County Hospital
Jasper Memorial Hospital
Liberty Regional Medical Center
Memorial Hospital and Manor
Mitchell County Hospital
SGMC - Lanier Campus
Washington Regional Medical Center
It is not enough to do your best; you must know what to do, and then do your best.

- W. Edwards Deming
Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

*We are dedicated to A Healthy Georgia.*