

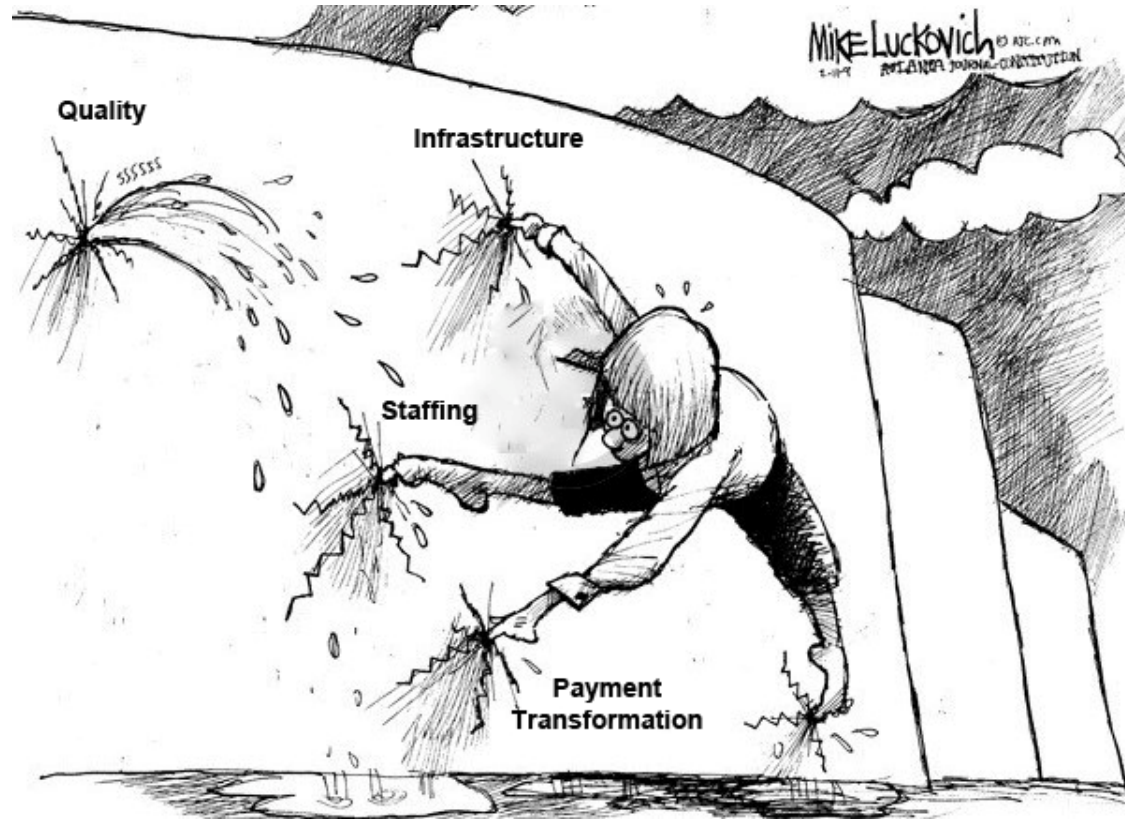
ACO Life on the Frontier



What friends think when I tell them I work in rural health care

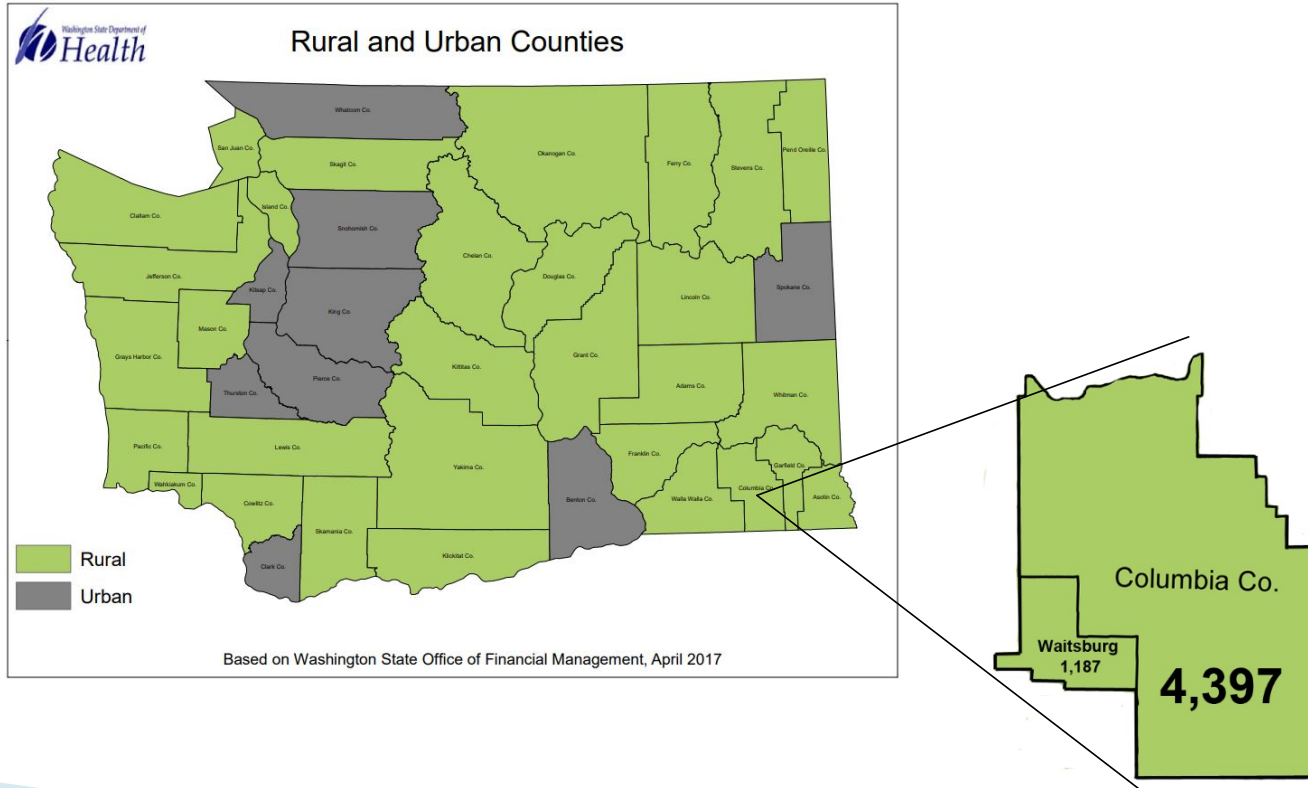


What I think I do in rural health care



Rural is a very broad definition

- ▶ In Washington State, 30 of 39 Counties are Designated Rural:



A perspective on distance



Why we need health care in rural areas



Healthcare in rural Washington is a National Interest

- ▶ Washington State ranks 6th in the Nation for wheat production
- ▶ 60% of Washington's wheat comes from Southeast Washington
- ▶ 46% of the Nations soft, white wheat comes from Washington State: Think cakes, cookies, crackers, pastries and muffins



A new kind of crop

- ▶ 50% of Washington's wind energy comes from Southeast WA
- ▶ 33% is generated in Columbia County alone



People travel to and through rural places



- 200,000 people a year visit Palouse falls
- Palouse Falls is in Whitman County, the Whitman County Hospital is 67 miles away
- Our hospital is closer at 38.6 miles

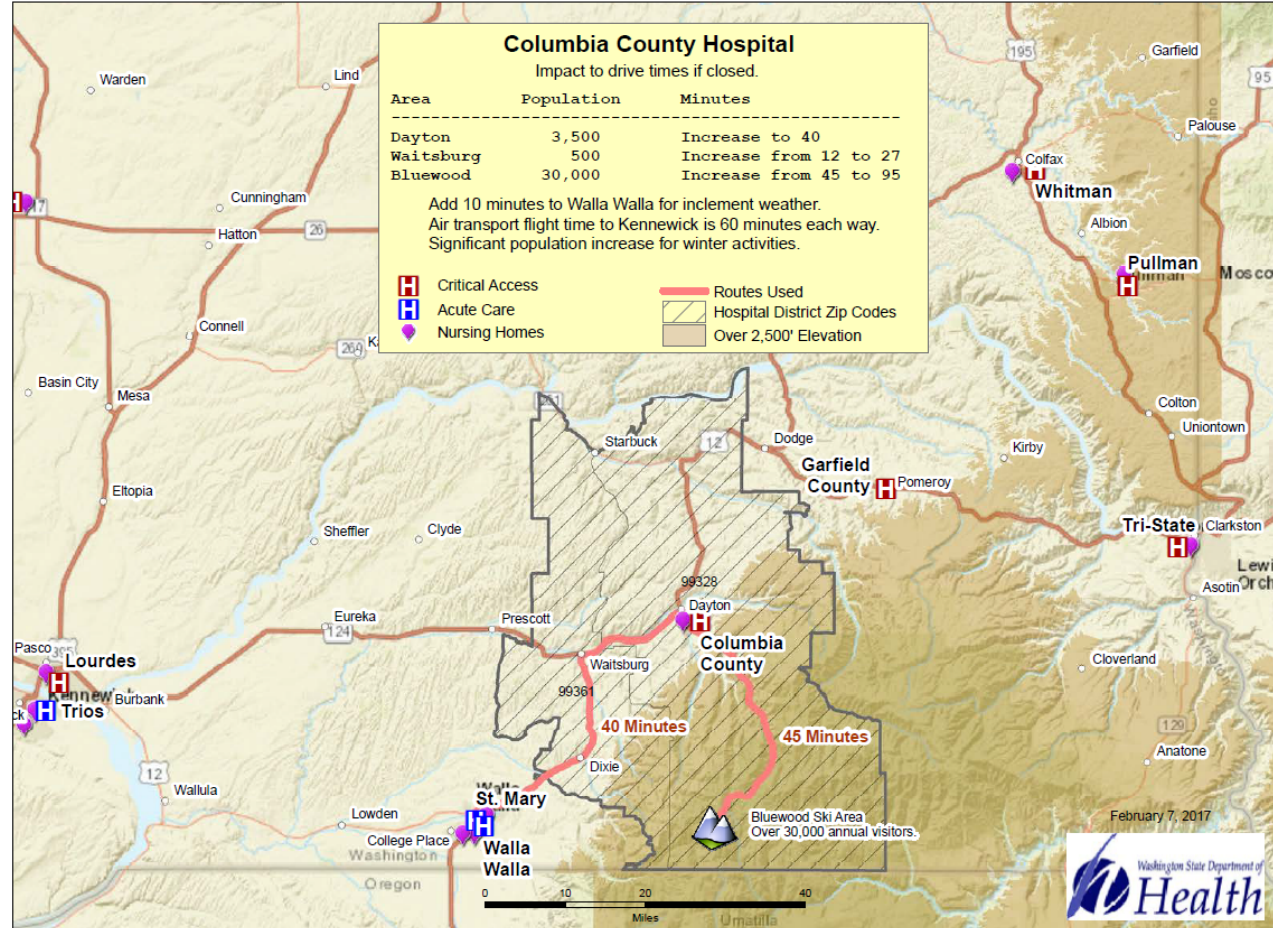


We serve more than our population in the ED

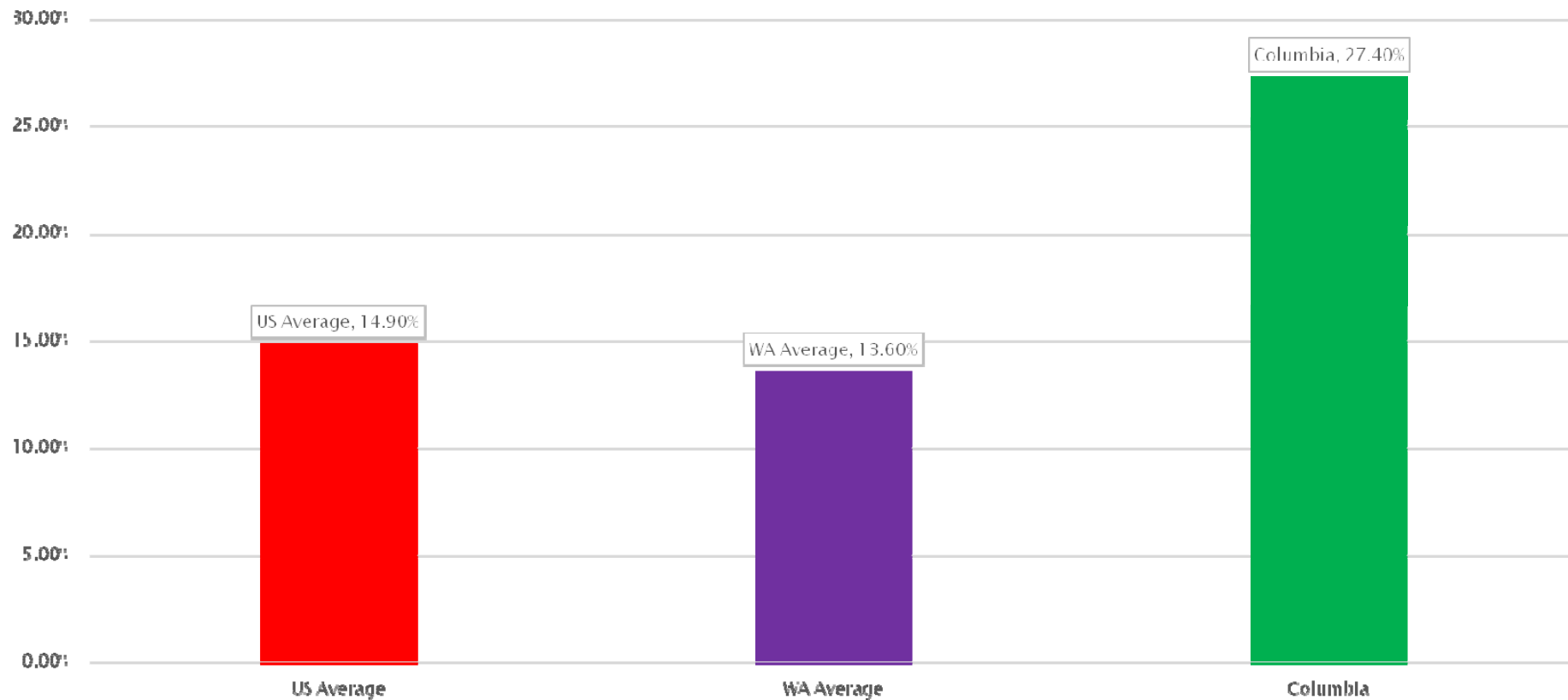
- ▶ Ski Bluewood is 20 miles from Dayton with 40 minutes of winter travel time one direction
- ▶ Annual Number of skiers: 30,000



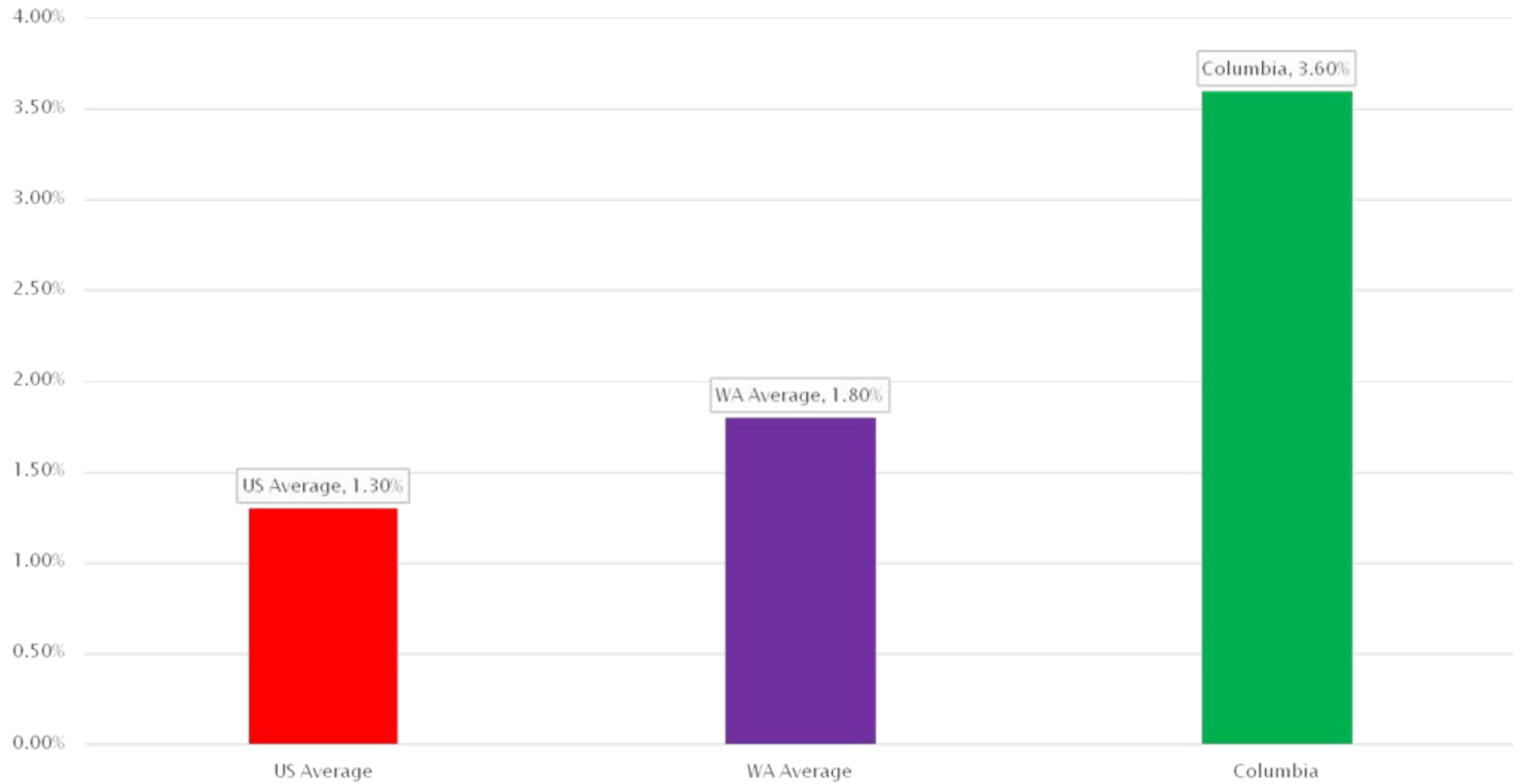
Drive time to the next closest hospital: 40 – 95min



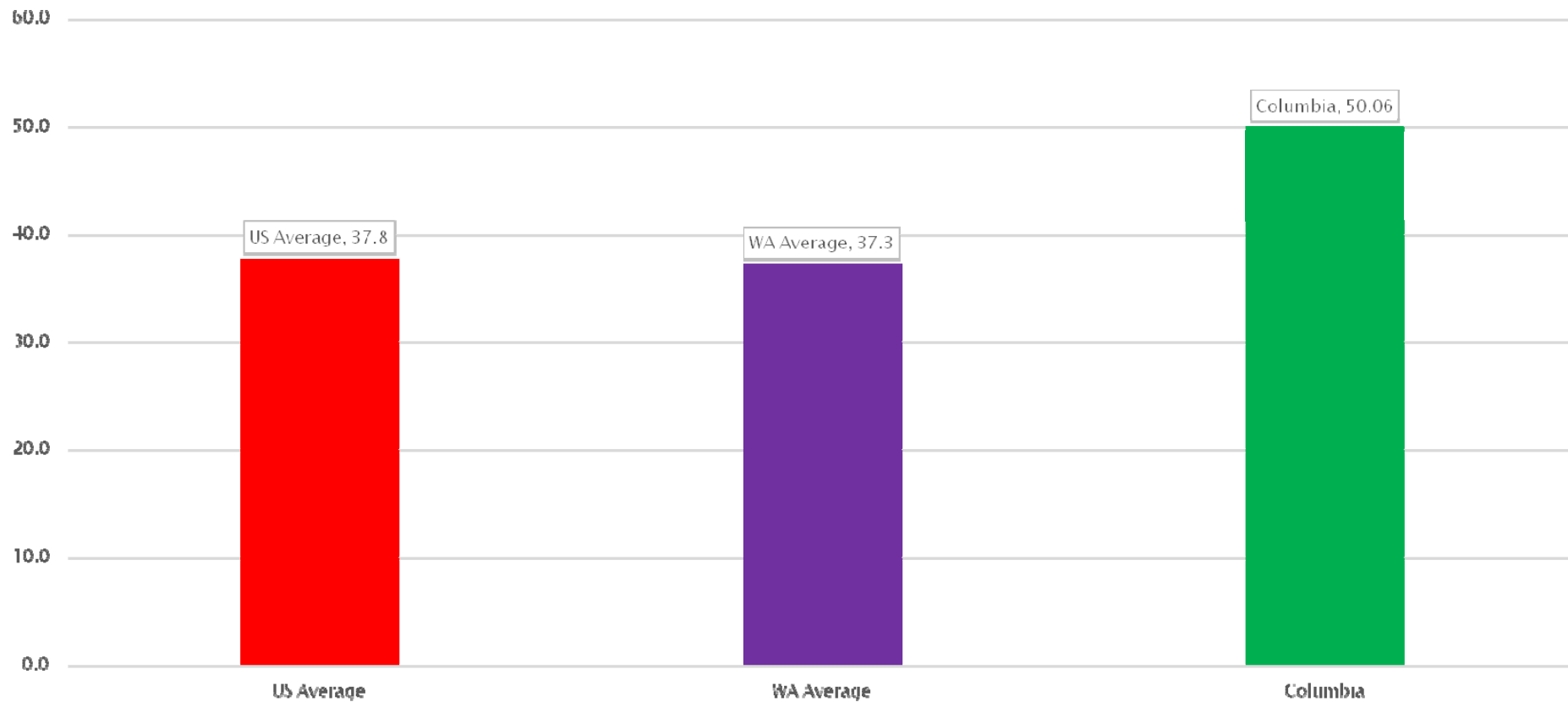
Percentage of Population over 65



Percent of Population over 85



Median Age



Demographic information cont.

- ▶ Columbia County ranks 37 out of 39 in health outcomes– how long people live and how healthy people feel.
- ▶ We rank 22 out of 39 for health factors– Examples: Tobacco use, diet, and exercise
- ▶ Despite ranking 14 out of 39 for Social and Economic Factors and 2 out of 39 for Physical Environment

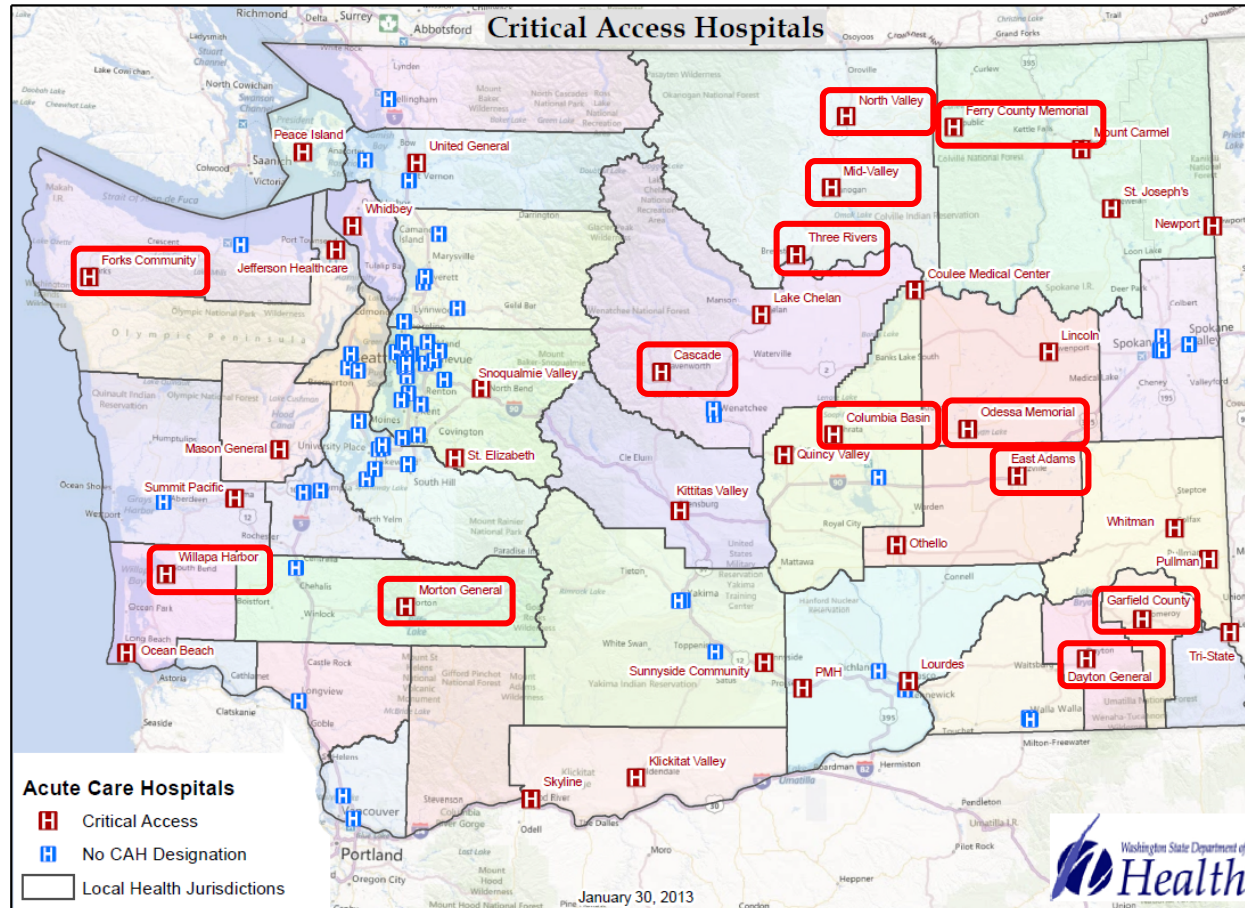


We are cost based reimbursement– yet...

- ▶ 33 of 38 Washington State CAH hospitals are unprofitable
- ▶ Medicare–101% of APPROVED costs Sequestration imposed a 2% reduction to 99% of approved costs.
- ▶ This increased losses by nearly 6 million dollars a year for Washington State CAH's



Financially Vulnerable Critical Access Hospitals



Reimbursement often doesn't cover operational requirements

- ▶ **Rural Health/Primary Care Clinics**
 - 14 Washington PHDs showed significant clinic losses
 - Clinics are largest contributor to overall deficits (30% or more of total)
- ▶ **Emergency Department**
 - 80% of the 14 had losses on ED visits
- ▶ **Nursing Home/Assisted Living**
 - 100% of Frontier PHDs with nursing and/or assisted living facilities had losses
- ▶ **Ambulance**
 - 100% of Frontier PHDs with ambulance services had significant deficits

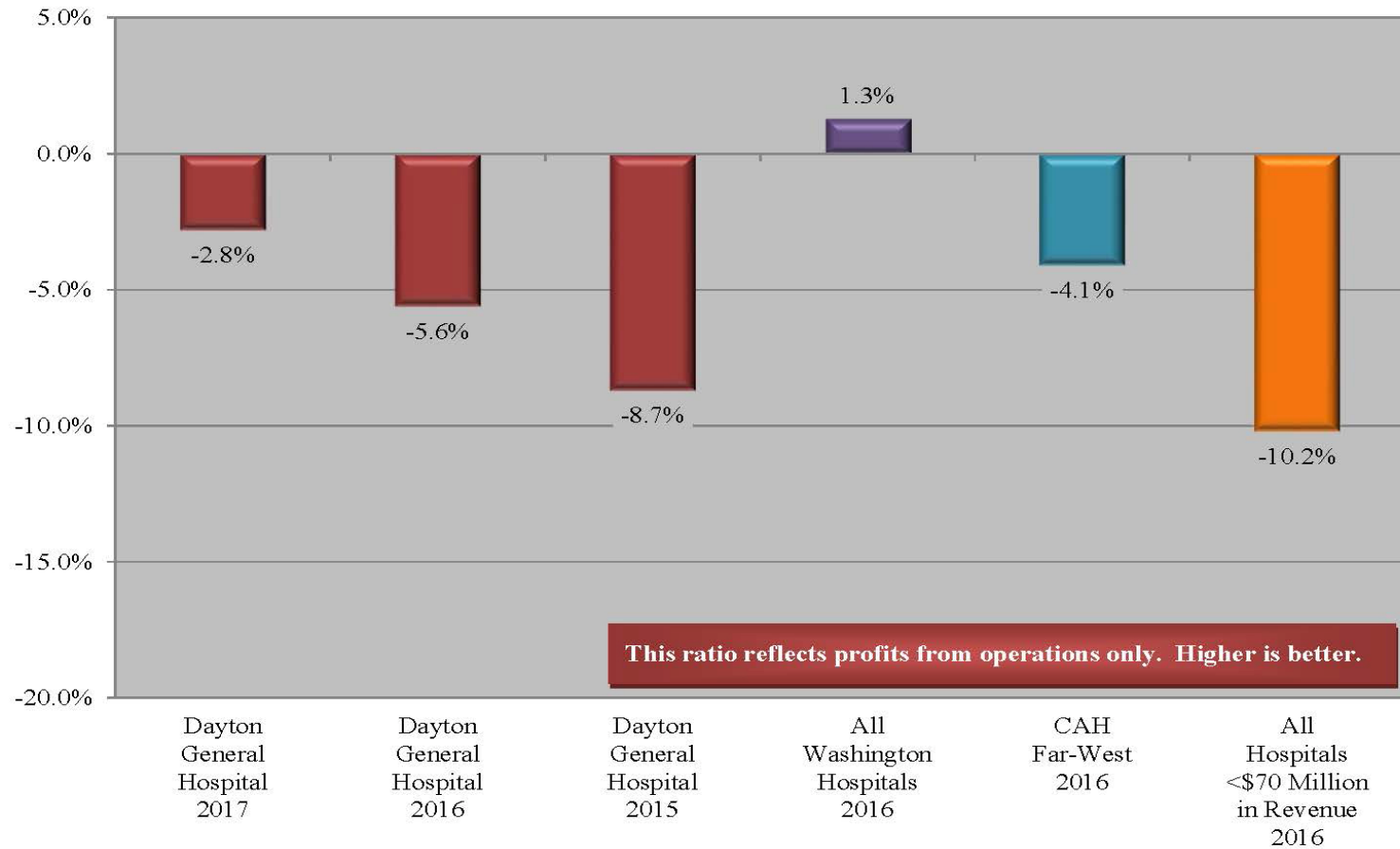


Efficient staffing levels and costs

- ▶ Nursing resources are shared between service lines:
The same nurses cover multiple departments
- ▶ Reducing volumes has little effect on costs; we need 1 nurse and 1 provider available for ED whether 1 patient or 10
- ▶ Primary care providers cover the ED, Clinic, In-Patient, and Long-term care residents



Operating Deficits



We participate in a Caravan Health ACO

- ▶ Caravan has been successful in partnering systems together to reach roughly 10,000 covered lives
- ▶ They provide management oversight, coaching, analytics, and interface directly with CMS
- ▶ Of the 1000 Medicare patients in our community, our attribution is 367

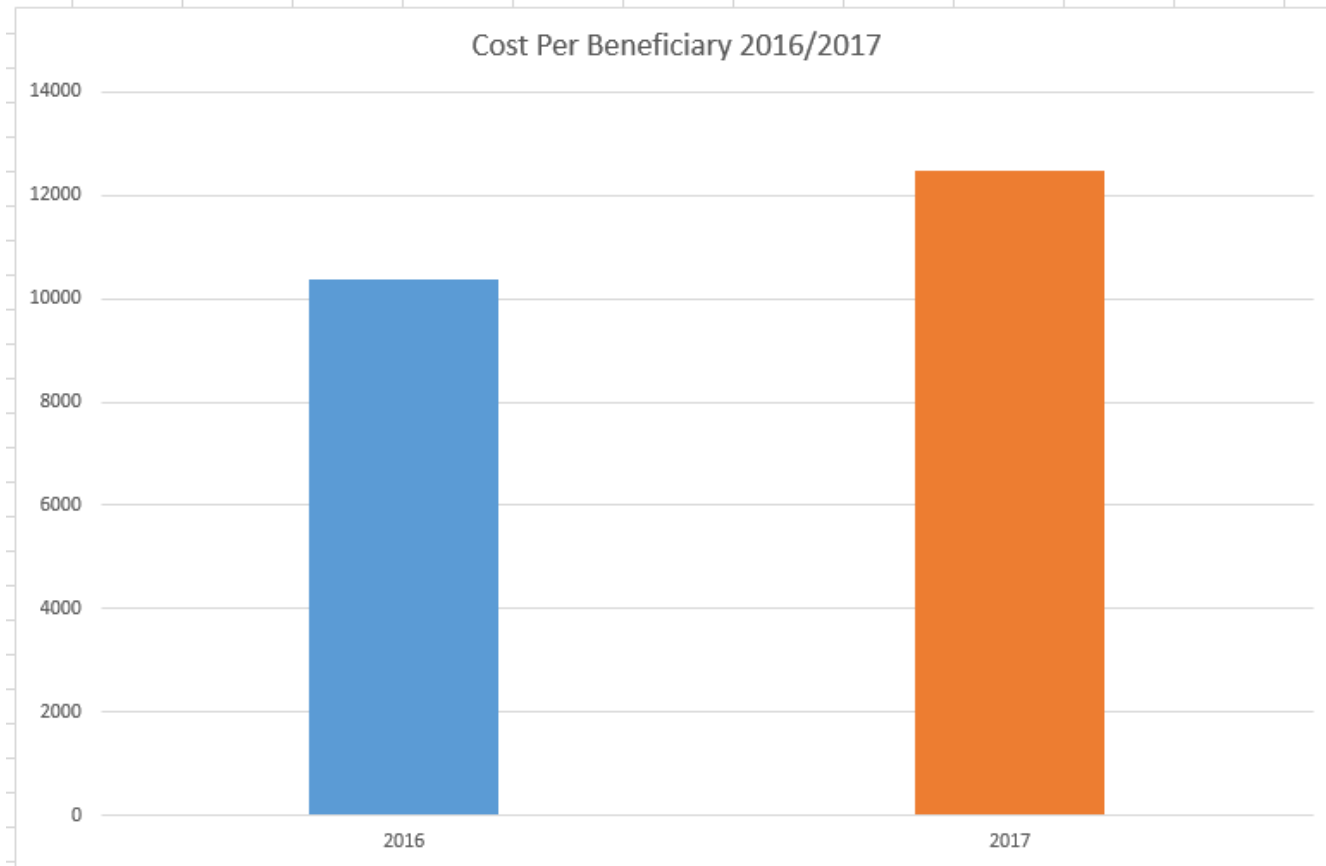


ACO specific metrics

- ▶ In 2016 Magnolia–Evergreen realized shared savings and were recognized as the highest performing ACO within the Caravan Health system
- ▶ 2017 costs have increased despite better management of the attribution and meeting or exceeded most of the ACO goals



Increase in cost per beneficiary

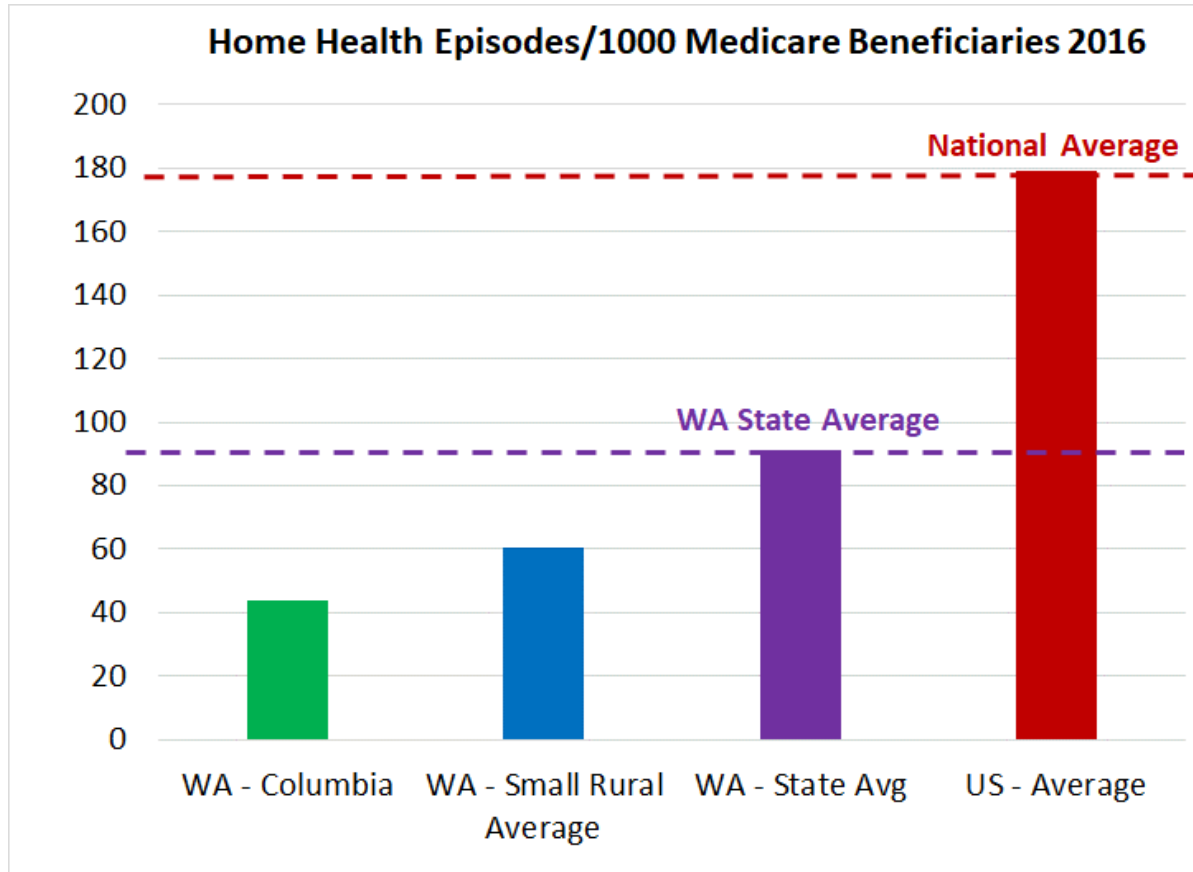


Rural participation in risk models

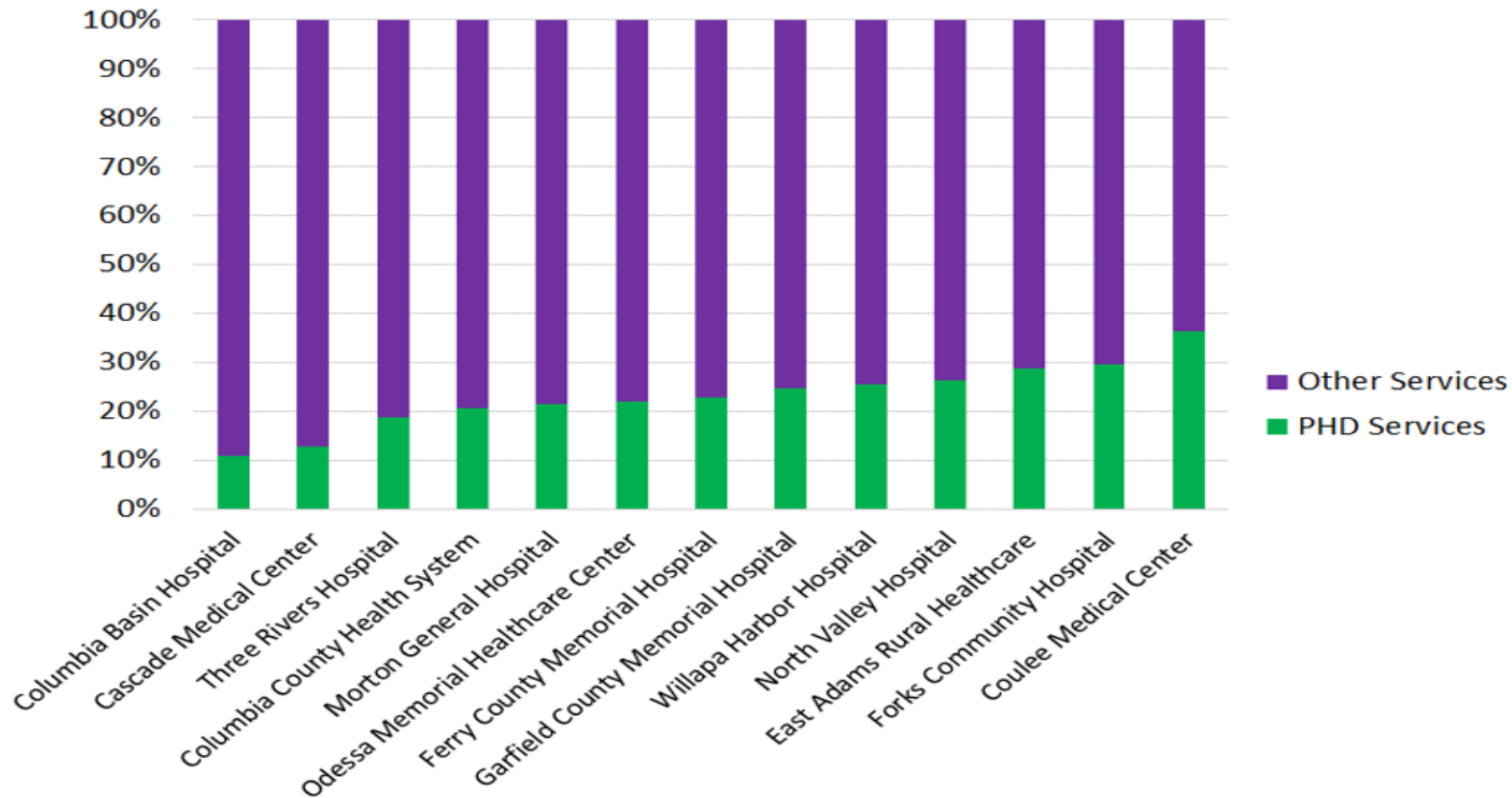
- ▶ The majority of healthcare dollars are spent outside of our healthcare systems
- ▶ Benchmarks for WA rural health systems are already well below national average
- ▶ There are no local Home Health or Hospice agencies
- ▶ A greater percentage of our attributed patients are high risk



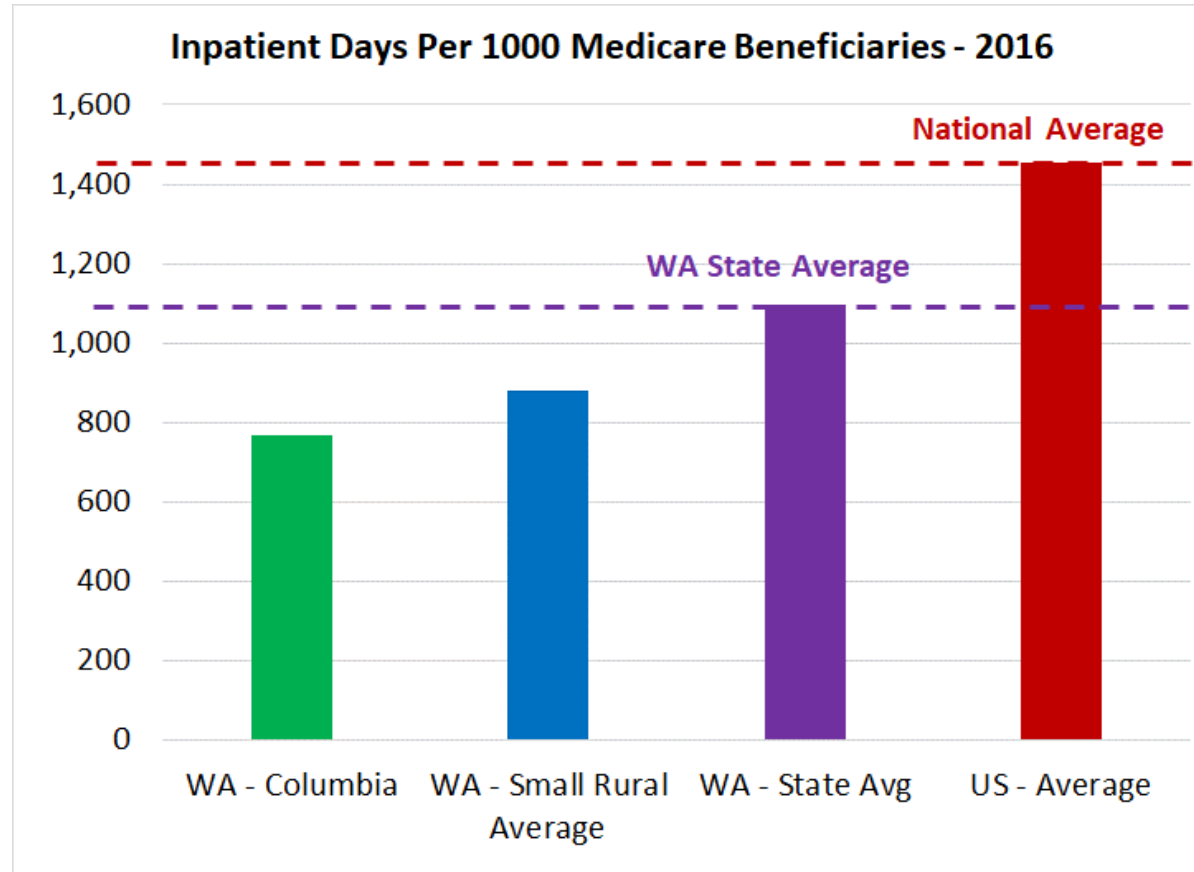
Home Health Availability



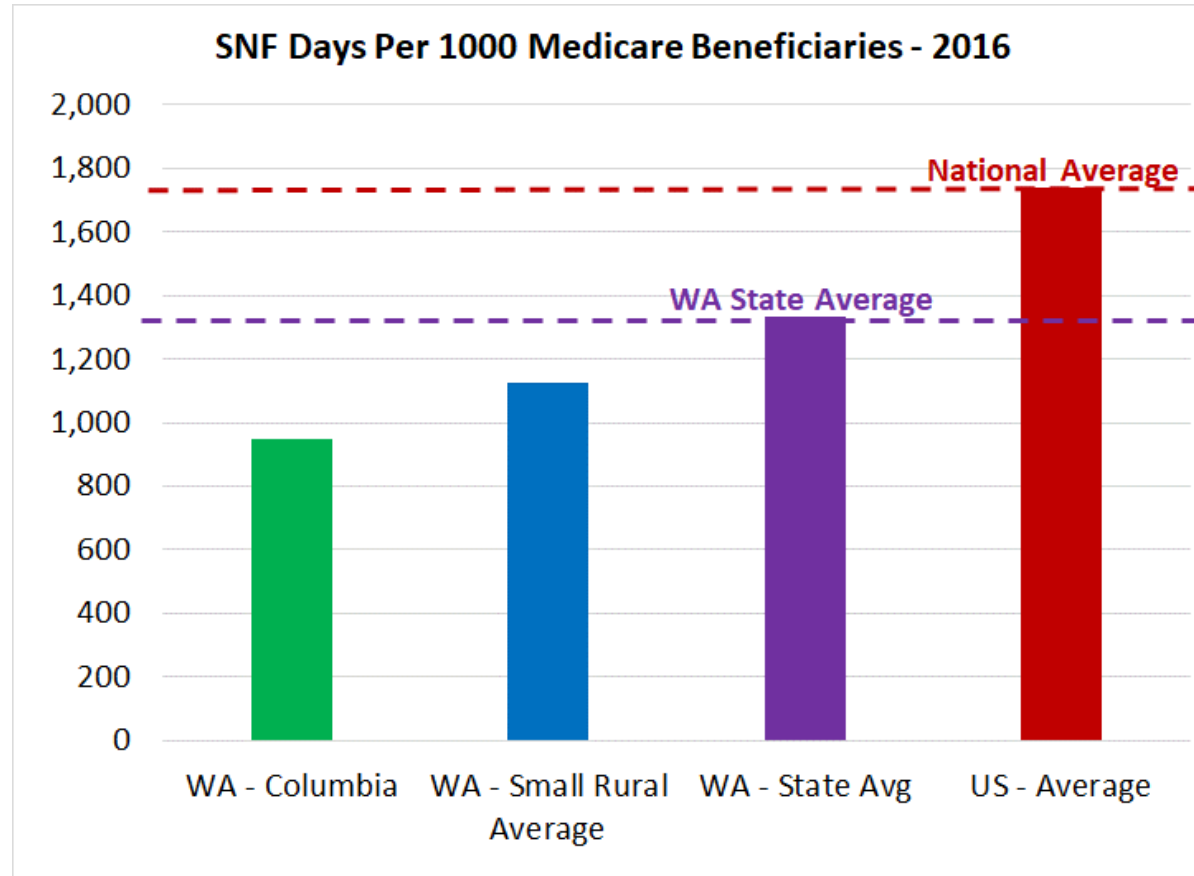
Total Medicaid Medical (Non-NH) Spending on PHD Residents, 2014



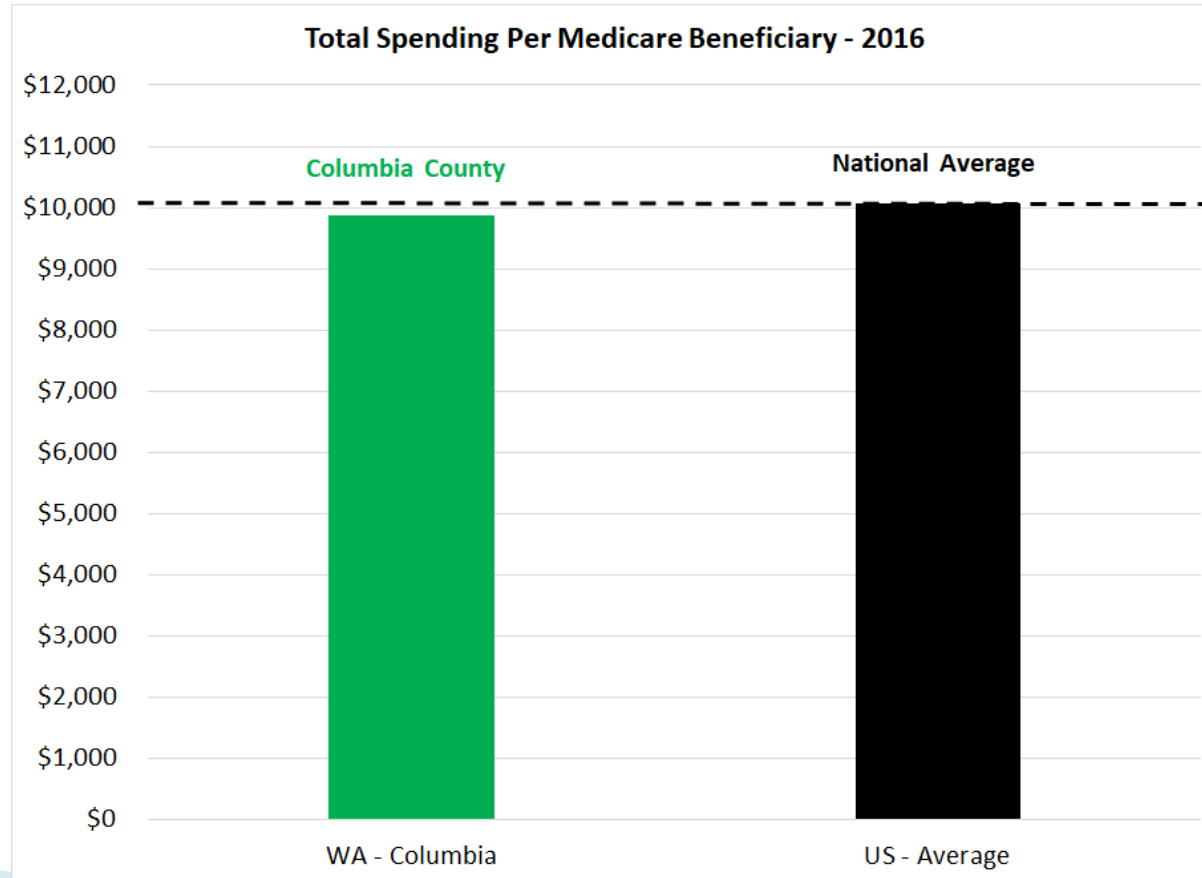
Inpatient benchmarks are lower



Skilled Nursing benchmarks are lower



Per beneficiary costs are lower in Columbia County



Positive ACO influences

- ▶ We are more engaged with our patients
- ▶ Care coordination has led to better outcomes and lower ED utilization
- ▶ Through screening, we discovered the need for behavioral health and substance abuse services



Providing value and long term cost reduction

- ▶ Depression is associated with increased health care costs as well as with higher rates of many chronic medical conditions
- ▶ Despite lack of payment by most payers, we are performing depression and anxiety screening on ALL patients age 12 and up
- ▶ Collaborative care codes pay far less than actual costs



Focused on long term results

- ▶ Managing the cost of aging, especially for those with chronic disease will decrease total costs of care
 - We implemented a Palliative Care program without defined reimbursement
 - We are developing aging in place resources to keep people out of high cost institutions



Financial sustainability

- ▶ With a **-2.8%** operational margin how do we keep innovating ahead of reimbursement?
- ▶ How much longer will rural communities vote to tax themselves to maintain local healthcare options?



Emergency Services

- ▶ Certain aspects of health care are presumed to be essential services: There is an expectation that emergency services are available in the event of a cardiac event, stroke, or traumatic accident
- ▶ Low volume ED services cannot be preserved using Per Visit or Fee For Service reimbursement methods.



Primary Care

- ▶ For most rural hospitals, a multi-payer payment model that supports low volume, primary care services, will be essential for long term sustainability
- ▶ Communities without hospice and home health have higher costs of care per beneficiary; removing primary care from rural communities will increase costs further



Aging in place

- ▶ Since 2010, the number of Washington PHD's providing Long Term Care services have decreased from 11 to 4
- ▶ 69% of the population 65+ will develop disabilities
- ▶ 35% of those will enter nursing homes
- ▶ 5% of those aged 65–69 will have moderate to severe memory impairment increasing to 32% for those older than 85



A payment model that works for frontier

- ▶ Failing to understand the incredible variations in the term “Rural” will perpetuate the trend of hospital closures with the potential of creating healthcare wastelands
- ▶ New payment models must be all payer and support 3, critical service lines: Emergency Services, Primary Care, and Aging in Place



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