TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS (Draft 8)

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Project Title	Readiness for Value Based Contracting

Rationale for the Project

In January 2015, Secretary Burwell announced the goal of having 90% of Medicare fee-for-services payments tied to quality and/or value by 2018. This was closely followed by Washington State's announcement of its goal to move 80% of state –financed health into a fully integrated Managed Care System by 2020. With CMS and Washington State detailing specific targets for transitioning to value-based payment (VBP) and private payers clearly expressing their intent to accelerate the transition, rural providers must create the infrastructure and culture to manage the transition or run the very real risk of being left behind and compromising access and outcomes for the communities they exist to serve.

Thus far payers, including CMS, have not fully considered the unique characteristics of rural medical communities. As such, they have not identified what a transformed rural healthcare environment looks like, nor they have helped to, ensure that rural providers have the right resources and access to the tools needed to meaningfully participate. Overall, healthcare costs in rural communities are actually lower than in urban settings, despite typically higher per-unit costs and lower economies of scale. This is because rural communities have fewer medical resources and lower access to higher cost modalities than do their urban counterparts. Rather, rural communities have leveraged limited capacity and resources through a greater dependency on primary care services and a closer collaboration of locally available medical, social and behavioral services. These dependencies are well aligned with the longitudinal priorities of emerging VBP programs that are now being developed as a part of the transformation. However, rural communities lack the scale necessary to acquire the data analytics and the other tools necessary for fully making the transition and have consequently not been engaged in the development of more formal integrated delivery systems capable of taking advantage of VBP reimbursement methodologies.

Project Description

This project requests funding to create a clinically integrated network of rural providers through the Washington Rural Health Collaborative (the "Collaborative"). This includes the variety of tools needed, including data analytics, practice transformation training and support, quality reporting and improvement initiatives, and care planning capabilities.

The Collaborative is an existing, mature and robust rural network consisting of 13 Critical Access Hospitals; all separately governed and predominately serving the rural areas of Washington. The mission of the Collaborative is to stimulate innovation thru agile partnerships that improve rural health care quality, efficiency and sustainability. Together our members serve more than 4,143 patients a day. Annually we generate more than 7,625 inpatient discharges, 112,187 emergency department visits, 370,190 clinic visits, 499,560 outpatient visits and employ 150 providers. Net patient service revenue was nearly one-half billion dollars in 2013. Collectively, the Collaborative member's service area residents are approximately 67% Medicaid and Medicare.

Our intent with this grant is to further position our member hospitals and health care systems for success; defined as delivering excellent quality of care, at optimized costs, while improving health of the population (the IHI Triple Aim). We believe it is the ultimate destination for the high-performing CAH hospitals and health systems of the future. Achieving the Triple Aim in rural communities will require rural health systems to understand and stratify the needs of the populations they serve while mapping a future that deploys best practices and new partnerships.

Project Goals	Interventions	Outcomes
Improving the patient experience of care (including quality and satisfaction)	• **Care Standardization:** The ability to provide infrastructure that supports use of data to standardize care processes focusing on managing chronic conditions • **Post-Discharge Follow-up:** The ability to support patients post discharge with systematized follow-up (e.g., home health services, structured patient follow-	• Access to health coaches/Care Coordinators in 75% of the clinics and 100% of the hospitals. • Achieve the top quartile in HCAHPS and CG-CAHPS scores. • Over 90% employed physician contracts are tied to quality and

	up protocols). • **Patient Satisfaction Surveys:** Utilize HCAHPS and CGCAHPS survey methods to collect, monitor and improve patient satisfaction and engagement. • **Physician Compensation:** The ability to compensate physicians tied to quality and patient satisfaction. • **Quality Reporting:** The ability to develop and enhance quality reporting capabilities by practices and hospitals, which are benchmarked against one another and publicly available data.	patient satisfaction measures. • Consistent quality improvement as evidenced by PQRS, Core Measures, and other common indicators of quality
Improving the health of populations starting with Medicaid and Medicare	• **Chronic Care Management:** The ability to provide systems and processes that support wellness and management of patients with high-volume, high-cost chronic diseases • **Real-Time Data Access:** The ability to provide meaningful data to care providers at the point of service • **Interoperability:** The ability to aggregate clinical information across networks and between hospitals and physician practices • **Access to Care**: Expand access to primary and urgent care by first analyzing and then closing gaps in access to care	• Data analytics that supports claims data, risk stratification, disease segmentation and quality tracking and reporting. • Identify and implement best practices related to expansion of primary care including virtual MD visit, expanded hours and urgent care clinics. • Utilization of centralized care plans and care teams for complex patients
Reducing the per capita cost of health care.	• **Assessment of Return:** The ability to monitor value-based contracting revenue opportunities versus costs of implementation • **Business Intelligence:** The ability to collect, analyze, and model data. Also anayze the cost and quality data to refer patients to high-quality, low cost specialists.	• Reduce the total cost of per member per month • Reduce hospital and ED utilization rates without damaging Hospitals' financial health

The expected deliverable is a clinically integrated network of providers that follow common clinical protocols, have aligned measures and incentives based on improved value, and obtain joint payer contracts. This will be accomplished by identifying rurally relevant data, which is collected, analyzed and disseminated in real time, supporting providers and staff in practice transformation and quality improvement. The implementation of this model and the outcomes of this work will support Washington state in achieving all four of the Medicaid Transformation goals through a systematic approach that focuses on the whole person centered around the health care system whiling aligning community resources through key partnership.

We believe one outcome of this work will be better retention of rural providers. Rural health care systems are uniquely positioned to positively affect health disparities by ensuring local access to primary and behavioral health care that treats the whole person. Several lines of research suggest that the consistency and stability of the doctor-patient relationship is an important determinant of patient satisfaction and access to care. In addition, having consistent interaction with a primary care provider, and care teams, where appropriate, may help to mitigate minority patient mistrust of healthcare systems and providers.

Key Partners:

- Payers
- Post-acute care facilities to improve outcomes and reduce episode of care costs
- Behavioral Health
- Community Care Alliance (an existing Colorado Network)
- Primary Care & Specialty Care

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Complimentary Transformational Initiatives:
In order to achieve the scale and combined resources necessary to be successful, the Collaborative has partnered with the Community Care Alliance (the CCA). The CCA currently serves a network of 26 small, rural hospitals and healthcare organizations in Western Colorado, as well as two ACO's serving over 20,000 Medicare Beneficiaries, comprised of five Collaborative and nine CCA hospitals and medical communities. The Collaborative and the CCA are both the successful recipients of HRSA Network Development grants. Both grants have focused on the preparing their rural members in the movement from volume to value-based health care. Together, the two networks have formed a partnership to work together to promote shared learnings, exchange of best practices and promoting efficiencies through joint contracting and greater scaled access to high cost services.

Core Investment Components

Proposed Activities	***Cost***
Data Warehouse	*.60 PMPM*
Clinic Data Interface	*$4000 per practice*
**Care Coordinators – Assumes 1:990 covered lives*	*$85,000*
Actuarial Analyst	*$150,000*
Network Quality Director	*$150,000*
Chief Medical Officer	*$300,000*
Data Informatics	*$60,000*
Data Analyst - will develop need based on numbers of attributed	*$60,000*
Director of Care Coordinators	*$100,000*
Payer Negotiator/Contract Development Specialist Consultant	*$100,00*
Legal (Consultant)	*$100,000*

Funding to support the deployment of one local care coordinator for every 990 attributed beneficiaries (1:990). The top 10% (83) of those beneficiaries will receive focused interventions from that care coordinator.

A financial return on investment will be realized both by Healthier Washington and by the participating hospital systems. We anticipate a 2% savings in Medicaid and other HCA insurance programs each year after project completion (over and above the incremental operating costs identified above). The Collaborative would respectfully suggest that this savings be "shared" between the State and the members (thus providing the "capital" for members to continue care coordination and data/ quality initiatives). A 1% savings to the State is estimated. The overall project is expected to take three years. At project completion, we expect to have a rural health delivery system positioned for population health and meaningful and sustainable participation in VBP.

Perhaps more importantly, the State will have a replicable model and best practices that can be undertaken in the most of the other 39 CAH communities within the State. The savings achieved would be very significant.

Project Metrics

The following project metrics will be used to measure the success of the project:
Short Term:

1. Improved access to primary care (6 & 10)
2. Improved patient experience (23)
3. Decrease resource consumption [admissions, ED visits, repeat office visits] (41,42,43)
4. Clinical measures such as A1C for chronic conditions [sustained within target range] (14,15, 16)

Long Term:

5. Reduce annual state-purchased health care spending relative to State's GDP by xx (50)
6. Reduce spending per enrollee by xx (51)

In order to successfully measure the success of the work, participants will need full access to claims data.