

Health Care Reform and Rural Health Quality

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A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

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Improving Quality through Health Care Reform

- Support for comparative effectiveness research
- Test Medicare payment incentive models (e.g., accountable care organizations, bundled payments, medical homes)
- HIT funding to increase electronic health record adoption

Health Care Reform and Quality

- Medicare payment reform proposed to address problems in current system (e.g., lack of care coordination, payment for poor quality care)
- Demonstration projects have primarily involved large urban integrated delivery systems
- Many challenges for implementation in rural areas (e.g., organizing providers; achieving minimum patient base necessary to assume risk)
- Payment reform increases need to measure and report data on quality of care

Implications for CAHs

- Public reporting of quality measures to Hospital Compare has been voluntary for CAHs
- As we move toward a system that rewards high-quality care, CAHs will need to publicly report on quality measures to demonstrate the quality of the care they are providing
- HIT “meaningful use” will require all hospitals to report data on selected quality measures to CMS to qualify for reimbursement incentives

What Happened to Delivery Side Reform?

- What is in the health reform law?
 - Encourages development of new patient care models such as ACOs
 - Creates CMS Innovation Center to test and evaluate patient-centered delivery and payment models
 - Establishes a national pilot program on payment bundling
- Does it make sense to implement insurance reform without substantial delivery side reform?
- Are we simply providing increased access to an inefficient system?
- Can we achieve cost containment without substantial delivery side reform?

Accountable Care Organizations (ACOs)

- A set of providers (hospital, primary care physicians and specialists) responsible for the quality and cost of health care for a defined population of Medicare beneficiaries
- Goal: constrain costs and improve quality
- Would need a formal organization and structure
 - Could be formed from an integrated delivery system, physician-hospital organization or academic medical center
 - Minimum of at least 5,000 patients

Accountable Care Organizations (ACOs)

- Setting cost targets
 - Base incentives on changes in spending, not levels
 - Need to address geographic variation in spending
 - To be fair to low use areas, adjust for area wages and patient severity, but not regional utilization differences
- Setting quality targets
 - Initially process measures with a limited set of outcomes
 - Future measures could include mortality, hospital readmissions, ambulatory care sensitive admissions, patient satisfaction, improvements in functionality

Accountable Care Organizations (ACOs)

- Rural Challenges
 - Achieving minimum patient base of 5,000 in thinly populated areas
 - Rural providers less likely to have formal organizational structure, integrated providers (How do CAHs, RH clinics, networks etc. fit in?)
 - Many rural areas have historically low costs
 - Financial vulnerability of many rural providers
 - Aligning bonuses (and penalties, if any) with cost-based reimbursement
 - Small volume issues in measuring quality

Bundled Payments and Care Coordination

- Silo structure of Medicare payments reduces care coordination across treatment modalities
- Bundling provides a fixed payment for a set of services (e.g. acute and post-acute care services for pneumonia, stroke, hip fractures, CHF, and AMI)
- In theory, bundled payments should encourage smoother patient handoffs and better coordination of care

Bundled Payments and Care Coordination (cont.)

- It may save money through negotiations across provider types and by choosing less expensive venues
- Challenges to bundling payments include
 - How hospitals form necessary agreements with other providers on allocation of single payment
 - Developing relevant quality measurement and QI initiatives
 - Constructing risk-adjustment systems

Bundled Payments and Care Coordination (cont.)

- Challenges to bundling payments in rural settings
 - Cost-based reimbursement incentives (e.g. for CAHs) are very different than incentives bundling attempts to provide
 - Rural patients may receive hospital care and post-acute care in geographically dispersed facilities making it difficult to “virtually” integrate
 - Some rural hospitals have few options for post-acute care and would be disadvantaged at the negotiating table
 - Changes in reimbursement structures may lead financially unstable rural providers to exit the market

Bundled Payments: Potential CAH Reimbursement Strategies

- Congress and CMS should consider
 - Exempting CAHs from the bundled payment methodology
 - Carving out post-acute services provided by CAHs for bundled payments under the same methodology used for Prospective Payment System (PPS) providers; and/or
 - Creating a “fixed-bonus” payment to support continued operation of CAHs and avoid loss of access to needed services in rural areas without alternative sources of care

Comparative Effectiveness

- The American Recovery and Reinvestment Act provides \$1.1 billion to AHRQ and NIH in federal support of comparative effectiveness research
- Institute of Medicine Comparative Effectiveness Committee identified a list of 100 priorities for CER
- Federal Coordinating Council for CER has recommended uses of ARRA funds for:
 - Investment in data infrastructure
 - Dissemination and translation of CER findings
 - Priority populations: racial and ethnic minorities, persons with disabilities, persons with multiple chronic conditions, elderly, and children.

Comparative Effectiveness: Rural Issues

- Lack of clinical research in rural environments and limited participation of rural patients in clinical trials
- Implementation of practice guidelines in rural settings often lags behind urban settings
- Rural health professionals may have limited access to current evidence-based information; rural patients have difficulty obtaining appropriate information to make health care decisions

Health Information Technology and Quality: Rural Considerations

- *Institute of Medicine report on the Future of Rural Health (2005)*
 - Health information technology (IT) is an important vehicle for improving the quality and safety of health care in rural communities
 - Many rural communities face challenges in health IT adoption (e.g., financial constraints, access to capital, limited health IT workforce, inadequate infrastructure)

CAHs and Meaningful Use

- Critical Access Hospitals (CAHs) were included in health IT provisions of the American Recovery and Reinvestment Act (ARRA)
 - CAH payment incentives for EHRs and potential penalties are based on the current cost-based reimbursement system
- The ARRA financial incentives for CAHs are lower than the incentives for other hospitals

Health IT and Quality in Rural Hospitals

- Our current research is assessing:
 - the extent of health IT adoption by rural hospitals, including CAHs
 - factors that influence rural hospital adoption of health IT, and
 - the relationship between key health IT applications and quality measures for rural hospitals

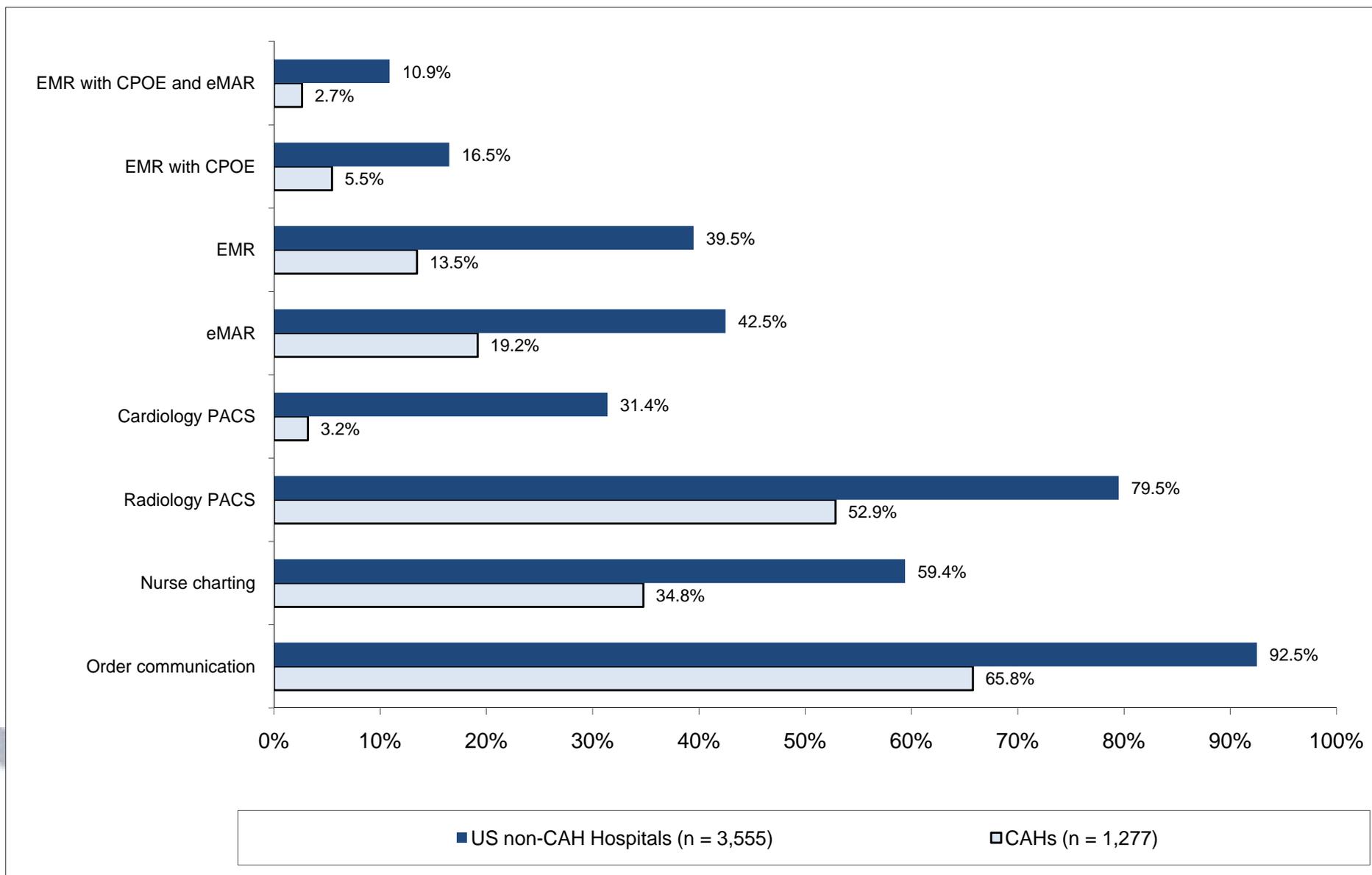
Data on Health IT Adoption by Rural Hospitals

- Healthcare Information and Management Systems Society (HIMSS) Analytics Database
 - Survey questions on > 50 health IT applications
 - >90% response rate
 - 4,832 acute care, non-federal, US hospitals in 2008
 - 1,277 of the 1,300 CAHs in 2008 had a matching record in the HIMSS database

HIMSS Data Analysis

- CAHs are significantly less likely than other hospitals to have adopted several key applications that are preconditions for “meaningful use” of health IT.

Critical Access Hospitals vs. Other Hospitals in 2008



Implications

- Many CAHs will have difficulty implementing systems capable of meeting the “meaningful use” requirements during the timeframe established by ARRA.
- This conclusion is supported by “on-the-ground” assessments from experts with experience implementing health IT in small rural hospitals

Implications

- What is needed for small rural hospitals and CAHs to achieve meaningful use?
 - A longer timeframe and a more flexible phased approach to meaningful use for providers at an earlier stage of implementation (e.g., do not require these providers to meet all Stage 1 requirements at once; defer CPOE implementation until later date)
 - Expanded financial incentives (e.g., allow CAHs to qualify for ARRA Medicaid incentives)
 - Additional financial assistance in the form of federal grants and/or loans for purchasing health IT

Implications

- What is needed for small rural hospitals and CAHs to achieve meaningful use?
 - Technical assistance from Regional Health IT Extension Centers
 - The requirement that a Center support at least 100,000 primary care providers makes it difficult to target rural providers in less densely populated rural areas
 - Clarification that CAHs are priority providers for technical assistance
 - Integrate quality reporting to CMS Hospital Compare and the HIT Incentive program, using measures that are rural relevant and suitable for electronic abstraction

Additional Information

- **Upper Midwest Rural Health Research Center** (University of Minnesota Rural Health Research Center and University of North Dakota Center for Rural Health) www.uppermidwestrhrc.org
- **Flex Monitoring Team** (Rural Health Research Centers at the Universities of Minnesota, North Carolina and Southern Maine) www.flexmonitoring.org
- **University of Minnesota Rural Health Research Center** www.hpm.umn.edu/rhrc

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