Sustaining Rural Health Care in Kansas
The Primary Health Center Model

Kansas Community Hospitals

124 Kansas Community Hospitals
- Including 82 Critical Access Hospitals
Health Care Policies Creating Challenges

Challenges Facing Rural Hospitals and Communities
Rural Hospitals – National View

• 107 hospitals have closed since 2010
• 673 hospitals are considered vulnerable
  *Represents over 1/3 of all rural hospitals*
• 41% of rural hospitals are operating at a loss

Kansas at a Glance

• 5 hospitals have closed since 2010
  – Central Kansas Medical Center – Great Bend
  – Mercy Hospital – Independence
  – Mercy Hospital – Fort Scott
  – Oswego Community Hospital – Oswego
  – Horton Community Hospital - Horton

• 73% KS hospitals are operating at a loss

• Median days cash on hand for KS CAHs is 44.93

• 66 counties have fewer than 10 persons per square mile
Newest Studies

• Chartis Group/IVantage
  – 84% of KS hospitals have a negative operating margin

• Navigant Health
  – 29 KS hospitals at high financial risk
  – 25 hospitals are essential to their community

Use of Inpatient Beds Declining

<table>
<thead>
<tr>
<th>Average Daily Census</th>
<th>2013</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 patient per day</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>1 – 1.9 patients per day</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>2 – 2.9 patients per day</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>3 – 4.9 patients per day</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>5 + patients per day</td>
<td>61</td>
<td>60</td>
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2018 AHA Annual Survey
Vision and Principles

Sustainable Rural Health System

- Improve Health
- Provide Access
- Encourage Collaboration
- High Quality
- Promote Efficiency and Value
- Embrace Technology
- Financed Fairly to Address Population Health

Overview of the Model

New Health Care Option for Rural Communities
Overview of Services Provided
Treating Patients Up to Inpatient Admission Criteria

CORE SERVICES
- Primary health care, including prenatal care
- Urgent care
- Emergency care
- Emergency and non-emergent transportation
- Observation (Part of Transitional Care)
- Outpatient and ambulatory services
  - Minor procedures
  - Ancillary services to support primary care and basic diagnostic
- Care coordination, chronic disease management and other approaches to population health
- Active telemedicine (All emergency care patients – may include access to specialist for emergency purposes)

OPTIONAL SERVICES
- If unavailable locally, may be included in the payment model:
  - Rehabilitative services
  - Subacute care (Transitional Care)
  - Behavioral health
  - Oral health
  - Specialty care (via telemedicine or visiting specialists on site)
- Other services needed within a reasonable distance (Must be consistent with community need and documented in data)

Staffing:
- RN(s) on site during hours of operation
- Physician, APRN, PA on call (Note: physicians not required)
- Active Telemedicine (emergency support, supervision if no physician)

Partner Organization

Required
- CAH or PPS Hospital
- Acute Care
- Physician
- Surgery
- Transfer and transportation Plan

Willingness
- Clinical Integration and shared protocols to improve quality and care coordination
- Share/provide operational resources to provide efficiencies and reduce costs

Optional
- Based on local and regional resources and need
- Obstetrics
- Financial support
- Trauma system participation
- Ownership or management
- Common medical staff
- Other services as needed
Primary Health Center
Role in Regional System of Care

• Retain Local Governance
  – Also be strong partner in regional system
• Formal Agreements
  – Partner Organization
    • Outline expectations and mutual benefit
    • Operational efficiencies
  – Clinical Relationships
  – Local and Regional Service Providers
  – Off Ramp ... Return to current status if model doesn’t work

Kansas Paper Test: Clinical Findings

946 Cases Reviewed
70% ER

Patient Age - All Cases

Patient Transportation (All Sites)

70-75% of patients could be served in New Model – more with transitional care?
## Payment Methodology

<table>
<thead>
<tr>
<th>Payment Methodology</th>
<th>Description</th>
</tr>
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</table>
| **$ Fixed Payments** | - Tied to inclusive budget for all services with capital allowance  
- Portion of budget paid monthly 1/12th, no back-end reconciliation  
- Operational incentive to be efficient and effective to meet budget  
- Could be determined as set % across all settings or site specific |
| **$ Encounter Payments** | - New fee schedule to account for fixed payments paid by participating payers  
- Traditional fee schedule reimbursement for non-participating payers  
- Co-pays and deductibles tied to encounter amount and collected in traditional manner |
| **$ Grants** | - Annual federal grant to ensure access to emergency services  
- Annual local financial support at a minimum of 10% of federal grant  
- One-time, transformation grants to support moving to new model |
| **$ Value Incentive** | - +/- 2% Risk/Reward of fixed payment  
- Based on accountability measures, aligned with scope of services and operations  
- Phase in – Report, Reward, Risk |

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## Win, Win, Win, Win

### Quality Improvement
- Accountability for quality and operational efficiencies  
- Measures = Services/Size  
- Value Incentive – Risk and Reward  
- Regional Care Coordination  
- Common Protocols with Partner  
- Embedded community and pop health

### Cost Savings
- Up front budget expectations  
- Fixed payments during low volume  
- Patient co-pay tied to encounter  
- Budget based Transitional Care payments  
- Reduced administrative burden related to regulatory requirements  
- Eliminate or repurpose unused acute beds  
- Better align physician and facility incentives

### Preserve and Improve Access
- Core services for less mobile populations  
- Transitional/sub-acute care  
- Community health and care coordination  
- Preserved access to emergency transportation and care  
- Added local services to provide transportation for care coordination  
- Potential for improved access to oral and mental health services

### Financial Sustainability
- Cash flow addressed through fixed costs  
- Reduction in acute services and costs  
- Simplification of payment program  
- Regional operational efficiencies  
- Engaged commercial payers  
- Federal grant support for emergency transportation and care  
- Local support for emergency transportation and care
Recent Discussions and Activities

• Further Engagement with:
  – CMMI
  – Legislative Leadership
  – Kansas Insurance Commissioner’s office
  – Other state health care provider groups
  – Regional HHS Administrator
  – AHA and NRHA
  – Kansas Stakeholders

Recent Discussions and Activities

• Support and Commitments offered by:
  – KDHE and the Governor’s office
  – Kansas Congressional delegation
  – Blue Cross and Blue Shield of Kansas
  – Kansas Farm Bureau
  – KHA Board
  – KHERF Board
Two Pronged Approach

- CMMI Demonstration Opportunity
  - Release expected soon
  - Competitive application process

- Congressional action
  - REMC Bill introduction
  - Collaborate with other interested states

Getting Organized in Kansas

- Educate hospitals and key stakeholders
- Continue to seek letters of support
- Look at potential state-level legislation
- Identify sites willing to participate in a demonstration
 Community Conversations

• Grant funded project

  • Engage up to 10 communities

Community Conversations

• Kick-off Fall 2019

• Facilitator
Key Topic Areas

• Current state of hospital/health delivery system at local level
• Future projections
• Discuss essential services
• Potential options

Structure

• Stakeholder Meeting (8-15 people)
  – Health care providers, local government, EMS, business leaders
  – Approximately 2 hours – most likely in afternoon
  – Presentation by subject matter expert
  – Discussion/reactions
Structure

• Community Meeting
  – Open to anyone in community
  – Approximately 2 hours – most likely in early evening
  – Education stations will share background information
  – Presentation by subject matter expert
  – Engagement/reactions

Participation Requirements

• Staff time/resources to assist with meeting preparation
• Development of invitation lists
• Assist with distribution of meeting invites
• Provision of data/info to be used in presentations
• Staff and board participation in meetings
• Assist with distribution of summary after meeting
Considerations

- Are you ready to be transparent about your current situation?
- Are you willing to think outside the box?
- How ready is your board?
- How ready is the medical staff?
- How ready is your staff?

Next Steps

- Complete application and return to KHERF
  - Engage up to 10 communities
  - Kick-off Fall 2019
- Reach out if you have questions or need help
- Primary Contact: Jennifer Findley
  jfindley@kha-net.org
Primary Health Center Resources

Find tools for board discussions and other resources on KHA Website.

https://www.khanet.org/CriticalIssues/RuralIssues/

Thank You!