GOOD GOVERNANCE CASE STUDY

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Wellmont:
Rural Health System Prepares for Challenging Future

By Elaine Zablocki, *Staff Writer, The Governance Institute*

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ORGANIZATION PROFILED:

Wellmont Health System, Kingsport, TN
Denny DeNarvaez, *President and CEO*
Herbert D. Ladley, M.D., *Senior Vice President*
T. Arthur Scott, Jr., *Chair of the System Board*
Dave Crockett, *Former Board Chair*

Statement of Interest

Rural hospitals and health systems face unique challenges. High acuity patients are generally transferred from rural facilities to the acute tertiary centers. "This means we face unique payment issues," said Denny DeNarvaez, Wellmont's president and CEO. "Payments are based upon case mix index, and since rural hospitals tend to have lower acuity patients, they tend to receive lower payments."

Many hospitals are facing challenges in recruiting primary care physicians, but rural hospitals face an extra-high hurdle. "Physician coverage is a continuing issue," said Dave Crockett, who served as system board chair from 2010 to 2012. "It is difficult today to recruit physicians, but the problem is acute in rural areas. If a person didn't grow up in a rural setting, and already value the benefits of this way of life, then it is very difficult to recruit them. This is a driving force for us and for all rural hospitals."

In addition, Wellmont is in an area with a low wage index, a major factor in setting Medicare payment levels. "We have the lowest Medicare payment rates in the country," Ms. DeNarvaez said. "This system has to survive and at least cover our capital costs even though we often receive $2,000 to $3,000 less per patient compared to the payment offered for the same care in California or New York, or even across the mountain in Asheville."

Facing these challenges, Wellmont has merged two smaller rural hospitals and closed one larger hospital. The system has worked with rural ambulance services to get patients quickly to the most appropriate setting. It uses telemedicine and mid-level providers to offer high-quality care in rural settings.

In addition, in a proactive response to payment issues, Wellmont enrolled in the Medicare Shared Savings Program (MSSP) in January 2013. Its ACO includes 10,000 assigned Medicare fee-for-service beneficiaries, and the system plans to add its own employees to the ACO program. "Rural hospitals need to develop innovative care processes that are not based on the current model of reimbursement," Ms. DeNarvaez said. "Candidly, the reason we embarked on this venture is to get experience on what it is like to start managing risk for our population, and how new care models will apply to our population, so we start to see some returns in response to our innovative efforts."

Organization Profile

Wellmont Health System is a not-for-profit, integrated health system serving the Tri-Cities region of northeast Tennessee and southwest Virginia. It was formed in 1996, when Holston Valley Medical Center merged with Bristol Regional Medical Center. The two tertiary care facilities serve populations of approximately 50,000 each. The system also includes five rural hospitals ranging from 10 to 118 beds each. (The average census in the 10-bed hospitals is about two, while the census in the 118-bed hospital runs about 35.)

The system has more than 40,000 discharges, 208,000 emergency department visits, and 334,000 physician office visits each year. Based on consumer preference studies, it is the preferred healthcare provider for the majority of hospital and physician services in its primary service area.

Wellmont Health System includes:

- Holston Valley Medical Center, Kingsport TN
- Bristol Regional Medical Center, Bristol, TN
- Mountain View Regional Medical Center, Norton, VA
- Lonesome Pine Hospital, Big Stone Gap, VA
- Hawkins County Memorial Hospital, Rogersville, TN
- Takoma Regional Hospital, Greeneville, TN
- Hancock County Hospital, Sneedville, TN

Takoma Regional is a joint venture, 60 percent owned by Wellmont and 40 percent owned by the Adventist Health System. The system has an equity interest in a home health agency and in December 2013 it acquired Wexford, a 174-bed skilled nursing facility.

Wellmont Health System also includes Wellmont Medical Associates, an integrated network of more than 130 multi-specialty physicians and mid-level providers. The group was recently certified at level 3 Patient-Centered Medical Home status by the National Committee for Quality Assurance. The system also includes Wellmont CVA Heart Institute, a 40-physician cardiovascular group practice.

Facing Up to Difficult Choices

Wellmont faces an additional financial challenge since it serves patients in Tennessee and Virginia—two states that currently aren't participating in the Medicaid expansion envisioned by the Affordable Care Act. In Virginia, a committee of the legislature is examining the issue but has taken no action.

The situation in Tennessee is unique. Since January 1994, the state has had its own version of Medicaid, called TennCare, under a waiver from CMS. It has its own standards; certain groups of people who would normally qualify for Medicaid don't qualify for TennCare. If Tennessee decides to expand Medicaid, the federal government will pay for expansion costs, but the state would have to extend coverage to people who would qualify for Medicaid, but don't qualify for TennCare. At present, Tennessee hospitals aren't receiving the extra Medicaid payments that were anticipated under healthcare reform.

In response to recruitment challenges, Wellmont merged two rural facilities under a single provider number. This meant the system was able to consolidate services. Instead of having three ICU patients in one facility and three more in a different facility, now it has six ICU patients in one setting. "This allows us to recruit nurses and maintain an improved staffing model for that patient population," Ms. DeNarvaez said.

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>
> *—Denny DeNarvaez*

In October 2013, the system closed 70-bed Lee Regional Medical Center. "This was one of the most difficult decisions the board has ever made. Our bylaws required a super-majority of 70 percent of the board voting in favor of the closure," said T. Arthur Scott, Jr., current chair of the system board. "We knew we would have to find other ways for these people to access care, and we didn't take it lightly."

However, it was an essential step. Three system hospitals were all located fairly close to each other, about 20 miles apart. The area has a high percentage of dual-eligibles, and therefore low reimbursements. "We attempted a number of different ways to redesign healthcare delivery in the area," Mr. Scott recalled. "But we faced a perfect storm of adverse developments. Virginia did not expand Medicaid. We had to adjust to the lower volumes everybody is seeing nationwide. Finally the census in Lee Regional was so low, we could not justify keeping it open." The system had been providing a hospitalist to cover weekends and nights at Lee Regional. The final straw came when that physician decided to leave and couldn't be replaced.

Whenever a hospital closes, people are naturally concerned about the loss of a community resource and a major employer. They recalculate the distance to the nearest emergency room, and wonder what might happen if they face a sudden health crisis. "There is no solid answer for those questions except to work closely with local EMS services to make sure they have what they need to get patients to the right setting as quickly as possible," Ms. DeNarvaez said. "But you know, the old model where every community has one or two or three local hospitals is drying up across

the country; this is not unique to our area. It is happening now, and I think it is going to continue. Our challenge is how to find the best possible ways to provide patients the care they need."

The system has taken a number of steps to continue to provide appropriate care to people who used to rely on Lee Regional. Emergency cases are going by ambulance to Lonesome Pine Hospital, about 20 miles away, or to Holston Valley Medical Center if the patient requires more acute services. Employed physicians at Wellmont Medical Associates still have offices on the Lee Regional campus, and they now offer extended hours two evenings a week, so people can see a physician after regular work hours.

One essential factor is to make sure all patients have a primary care physician. "When we do find one of these great primary care physicians who wants to practice in a rural area, we surround them with two to four nurse practitioners," Ms. DeNarvaez said. "We find that under this model each PCP office is able to handle a much broader patient base. In addition, we hold certain specialty referral slots open so when our primary care physicians need to make a referral, their patients are seen right away."

Appropriate Care in the Appropriate Setting

The Wellmont service area has patients with extremely high rates of smoking, diabetes, and obesity. Many residents have multiple chronic conditions. "In addition, we face unusual challenges due to geography," Ms. DeNarvaez said. "We have mountains to cross. Here in the Appalachians, what looks like 15 miles to travel on a map could take 45 minutes to drive, depending on the roads. How do we best manage these patients outside the acute care setting? When they do need acute care, how do we get them rapidly to the most appropriate setting, without extra stops along the way?"

Restructuring Emergency Services

Over the past year, Wellmont has worked closely with local emergency medical services to improve care for patients with acute heart attacks. The national standard is that these patients should be treated within 90 minutes with emergency angioplasty, which uses a balloon to open the blocked artery. This means EMS agencies need to be able to do diagnostic 12-lead EKGs in the ambulance and triage patients accordingly.

"We have been working with agencies throughout the region to make sure they are equipped and trained to do EKGs in the field and transmit that information directly to our tertiary hospitals," said Dr. Ladley. "We have three people working on this. We went out to every EMS station and discussed why this is so important. The agencies are quite varied, ranging from very small rural services to more sophisticated organizations in Bristol and Kingsport. In some cases, our foundation was able to help with grant-writing or needed financial support so they could obtain appropriate equipment."

The new system means patients reach the hospitals very quickly. When they arrive the cath lab is already prepared and can act quickly to save heart muscle. "In the past, the patient would go to the local emergency room and determine there whether or not they were actually having a heart attack," Ms. DeNarvaez recalled. "This uses up time, in a situation where every minute counts. Now the rural emergency medical systems are able to transfer patients directly to a cath lab where they can be seen immediately. We avoid the old start and stop scenario… now we can get them immediately to the appropriate site of care."

In a second, innovative initiative, the system has developed protocols so patients with major trauma are rapidly taken to hospitals with specialized trauma centers, where they have a much greater chance of survival.

In January 2013, Wellmont became a shared savings ACO, one of 106 hospitals and health systems joining the MSSP at that time. The Wellmont board had been considering innovative payment models ever since the Affordable Care Act was passed. "Our initial feeling as a board (and management's feeling also) was that we would not do an ACO, because the risk was just too high," recalled Mr. Scott. "We reviewed the initial regulations involving ACOs; we decided that we would embark on experiments designed to reduce the cost of care, but we would not formally enter the ACO program."

In 2011, when the Pioneer ACO program was announced, Wellmont again went through an exploratory process, but in the end decided the risk was too great. "However, when CMS came out with the shared savings ACO, we felt this program makes sense for us. You have a few years within the ACO with almost no risk," Mr. Scott said. "At the same time, you have an opportunity to move towards a more integrated system and explore new ways of doing things. At that point the board decided to go with the shared savings ACO model."

The Wellmont ACO is called the "Wellmont Integrated Network." It includes the primary care and specialty physicians of Wellmont Medical Associates and the Wellmont CVA Heart Institute, as well as the system's hospitals and other care facilities. Wellmont enrolled in the shared savings program as a "one-sided risk model" ACO. This means during the first two years of the program it will share savings 50–50 with Medicare; during the third year it will share both savings and losses. Each ACO is responsible for reporting 33 measures of clinical quality, including aspects of the patient/caregiver experience, preventive health, care coordination and patient safety, and care for at-risk populations.

One continuing problem for Wellmont, and for other MSSP participants, is that only a portion of their service base has been attributed to the ACO. Wellmont's primary care physicians serve about 28,000 Medicare patients, and yet only 10,000 were attributed to the ACO. "That may be because they had two or three visits to a Florida physician, or perhaps a couple of visits to a different specialist," Ms. DeNarvaez said. "This is an issue for us and also for other health systems. The reality is that due to technicalities in the attribution rules, hospitals are not seeing the population we had expected. When I speak with my peers, they tell me they only got 40 to 50 percent of their actual served population attributed to them."

When we look closely at the shared savings program, it requires substantial investments now, while the financial incentives glimmer in a somewhat uncertain future. "Like it or not, the government takes the first piece off the top, and then after that you get to share the savings," Ms. DeNarvaez said. "We are working very hard to reduce waste and create savings, but there are substantial costs: care managers, electronic medical records, clinical support systems. All the costs are borne by the hospital system. Even if we were to get a 1 percent uptick on Medicare payments, it certainly would not reimburse us for the increased infrastructure costs that are essential in order to run the ACO. At the same time, we are now learning how to reduce the cost of care by redesigning the care model itself and intervening with patients prior to a medical need. These learnings can then be applied to our employees as well as other patient populations where we benefit financially from the savings."

Innovations Underway

Wellmont is using the ACO as an opportunity to set aside some of its previous standard protocols and develop innovative ways to reduce emergency room visits and readmissions. "Even though we didn't have detailed data from CMS for several months, we recognized intuitively that helping patients avoid these high cost settings would be a positive thing to do," Ms. DeNarvaez said.

Because Wellmont is in a shared savings ACO, it has extra incentives to reduce costs. The system has developed an innovative way to evaluate patients with chest pain. Three years ago these patients were routinely admitted to the hospital for a workup; if they came in on Friday afternoon, they might well stay over the weekend as an inpatient, waiting for a stress test Monday morning. Now Wellmont has set aside a cardiac fast track observation area. It is staffed every day (including weekends) with dedicated mid-level providers who follow standard protocols on blood enzyme testing, EKGs, and stress testing. "We can now get an answer on the severity of the cause of chest pain, and

have people out of the hospital in hours instead of days," said Herbert D. Ladley, M.D., a Wellmont senior vice president, and the former president of the Heart Institute.

In its smaller, more rural hospitals, Wellmont has been using telemedicine to make the most effective use of top-level resources. For example, a nurse practitioner will interview the patient and review the medical record. Then the patient speaks with a cardiologist in one of the urban centers over a real-time video/audio hookup. "We are able to talk with the patient and explain our current thinking and plans," Dr. Ladley said. "We are able to do a cardiology consult using telemedicine equipment connected either to the office or one of the larger hospitals." One day a week a cardiologist travels to the rural hospitals and sees inpatients, but on other days they are able to manage the service by telemedicine in collaboration with a mid-level practitioner.

An integrated electronic medical record is an essential tool for eliminating duplication and coordinating care across a range of settings. Wellmont is currently transitioning to the Epic electronic medical record, at a cost approaching $100 million. "We didn't really have a choice, since our previous EHR supplier, McKesson, announced they were sunsetting their product about two years ago," Ms. DeNarvaez said. "[Epic] integrates inpatient and outpatient records. We will have 'one patient, one record,' and physicians will be able to access all information about their patients, regardless of the setting." Integrated physician offices moved to the new system in December and by spring 2014 all Wellmont hospitals will be using Epic.

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The system has added coordination services for residents with chronic disease. For example, a hospital-based heart failure coordinator now assists the patient's transition from the hospital to the outpatient heart failure clinic. Wellmont is developing more intensive outpatient management, including frequent visits to a physician or nurse practitioner, to ensure that patients understand how to best manage their own care, and when to ask for additional services.

The health system has also developed an innovative partnership with local employers, called Wellmont LiveWell. This community health transformation initiative is available for everyone who lives in the region. It includes free personal health assessments, newsletters on health topics, and an extensive health library. The Wellmont Health Coach provides thousands of wellness assessments as well as heart and cancer screenings.

Time of Change Poses New Challenges for Physicians and Board

Over the past three years, the Wellmont system has experienced a period of dramatic change, and this poses special challenges for its physicians and for the board. Closing a hospital was particularly difficult. These are community hospitals, supported by countless bake sales and raffles over the years. "Never before have boards been asked to make decisions that make them unpopular in their local communities. This is very difficult, even when decisions are necessary for the system as a whole," Ms. DeNarvaez said "We've been fortunate to have true leaders on our board, people who are able to make carefully considered decisions on behalf of the community as a whole."

The decision to create a shared savings ACO was particularly sensitive because there were competing ACOs in the area that some physicians preferred. "There has been some discontent about our decision, but probably less than we initially feared there would be," Mr. Scott said.

Wellmont has had physicians on its board ever since the system was formed; both Bristol and Holston Valley had physicians on their boards for years before that. But over the past two years, management and board members have invested special efforts in improving relationships with the medical staff. For example, they have attended quarterly medical staff meetings and physician clinical councils as interested observers. Several board members have worked more closely with the chief of staff at both major hospitals. Outside consultants have conducted training sessions to help physicians on the councils understand and problem solve the administrative challenges the hospitals face. "These special efforts are not something we would want to continue indefinitely because you don't want to be viewed as stepping into management's role. Nevertheless it was time well spent, and has definitely improved communications," Mr. Scott said.

Finding a Balance to Face the Future

Rural hospital board members must find a balance between keeping faith with local people and their strong connection to community hospitals, while at the same time being realistic about current options. "For certain, healthcare is not going to be delivered the same way in the future as it has been in the past," reflected Mr. Scott. "We have to be creative; we have to redesign the way care is delivered."

As we go forward, quality of care will become even more significant and transparent than it has been in the past. As locations consolidate, some services may no longer be available locally. But as more quality information becomes available, people will start understanding that outcomes in some smaller facilities are not as good as they could be in a place where a procedure is done more often. "People will come to understand that they are not necessarily losing something," Mr. Scott said. "They are gaining better care; it is just delivered in a different fashion."

What can boards learn and do to prepare for this period of change? Mr. Crockett appeals to board members and to other stakeholders. "During these difficult times, it is so important to try to find the best possible solutions for our communities. I sometimes say, 'when you go into a meeting, check your ego at the door.' We are dealing with very complex issues; we need to listen to many viewpoints. Let's not arrive with preconceived notions. Let's not think in terms of employed versus independent physicians, or board versus administration, or so on. We need to educate ourselves, learn from other viewpoints, and even be ready to possibly change our own opinions."

Over the past few years there's been a great deal of national discussion about movement away from fee-for-service ("pay for volume") and towards a new, value-based system. But at present, Wellmont is like many organizations—somewhere in between. "We have one foot on the boat and one foot on the dock," said Ms. DeNarvaez. "For example, we are trying to reduce readmissions, but at the same time we are still in a fee-for-service business where every admission is a revenue producer. Our efforts to avoid readmissions will limit penalties, but meanwhile our income stream has not increased. We are preparing for a 'pay for value' environment, but we are not there yet."

The ACO model is intended to financially benefit hospitals that are able to provide lower cost and better outcomes, if or when there actually is a shared savings. And ACO start-up costs can be high for some organizations that didn't already have the necessary infrastructure. "Meanwhile, the fact of the matter is that we are doing the right things, but it is costing the hospitals," Ms. DeNarvaez said.

At the end of January, CMS released data on the first cohort of shared savings ACOs (those who enrolled in the program in 2012). Of those 114 ACOs, 54 had lower than projected expenditures during their first 12 months in the program. However, only 29 of those ACOs saved enough to generate bonus payments, which totaled $126 million. Wellmont is one of 106 ACOs that began participating in the program in January 2013. Data for this cohort of ACOs has not yet been released.

"We are learning a lot about our attributed Medicare patients during the first year of the ACO," Ms. DeNarvaez said. "This allows us to develop 'best practice' activities to manage chronic disease. We have found opportunities to use knowledge gained in other ACOs and apply these learnings to our patient population. Our early data review would suggest that we are beginning to see improvements in the cost of care."

Ms. DeNarvaez believes that over time, we will think of our "healthcare system" quite differently. "We find ourselves moving away from the hospital-centricity that has been part of healthcare for the last hundred years," she said. "The hospital has been the place where most of the dollars flow. But think for a moment: we do a million touches for every 30,000 admissions. By 'touches' I mean all the interactions with a nurse practitioner or physician in an office or outpatient setting, all the physical exams, all the face-to-face conversations. When you stop and think about that, when you clearly visualize all those human encounters, then you start to redesign healthcare so that the 'million touches' are at the center of our focus."

Elaine Zablocki, freelance journalist and staff writer for The Governance Institute and National Research Corporation, has been reporting on healthcare for more than 20 years. She has written many articles for The Governance Institute's BoardRoom Press, *as well as* WebMD, Medicine on the Net, Quality Letter for Healthcare Leaders, *and* Great Boards Newsletter.