Listening Session 2: *Incentives for Increasing Rural Providers' Participation in Population-Based Models*

Presenters:

Subject Matter Experts

- **Alana Knudson, PhD, EdM** - Project Director, The Pennsylvania Rural Health Model (PARHM) Evaluation; Director, NORC Walsh Center for Rural Health; and Senior Fellow, NORC at the University of Chicago
- **Tom X. Lee, MD, MBA** - Chief Executive Officer, Galileo
- **Randy L. Pilgrim, MD, FACEP** - Enterprise Chief Medical Officer, SCP Health

Listening Session 3: *Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas*

Presenters:

Subject Matter Experts

- **David C. Herman, MD** - Chief Executive Officer, Essentia Health
- **Ami B. Bhatt, MD, FACC** - Chief Innovation Officer, American College of Cardiology, and Associate Professor, Harvard Medical School
- **Thad Shunkwiler, LMFT, LPCC** - Associate Professor, Department of Health Science and Director, Center for Rural Behavioral Health, College of Allied Health and Nursing, Minnesota State University, Mankato
- **Susan E. Stone, DNSc, CNM** - President, Frontier Nursing University

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Incentives for Increasing Rural Providers' Participation in Population-Based Models

Healthcare – Public Health (HPH) Sector's Government Coordinating Council (GCC)

19 September 2023

Alana Knudson, PhD

NORC WalshCenter
FOR RURAL HEALTH ANALYSIS

Rural areas are not only the source of much of our food, drinking water, energy production, and outdoor recreation, one in five Americans—including a disproportionate number of veterans and active-duty service members—live there, making the study of the health needs and challenges of rural Americans essential to us all.

NORC Walsh Center for Rural Health Analysis

Lessons Learned: Rural Participation in APMs

- Include rural health experts in the VBP discussions within CMS, including rural finance experts
- Align rural providers to meet population thresholds
- Establish a Rural Quality Reporting (RQR) program for small-volume providers in both the clinic and small hospital space
- Rural providers are already serving vulnerable populations, by definition, placing a provider into their own financial risk is not a healthy way to invite rural innovation participation
- Recognize innovation fatigue, particularly from rural participants that were early adopters only to be left in the desert as CMS/CMMI ended or altered the innovation program

Considerations for Designing Population-Based TCOC Models for Rural Providers

- Engage rural providers and community partners in the design of the model
- Determine “success metrics” before implementation
- Provide upfront funds to support implementation requirements (e.g., data) and development of transformation plans
- Minimize new and additional staff and financial requirements (RHV)
- Provide technical assistance during model application (grant-writing), implementation, and operation (RHV)

Source: Rural Health Value, (RHV) How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report, https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf

Considerations for Designing Population-Based TCOC Models for Rural Providers

- Consider models that engage the continuum of care and the rural community (e.g., long- term services and supports, public health, and community-based organizations)
- Align model implementation and performance expectations across multiple payment systems
- Align all payers within the same model redesign, such that rural VBC model participants need not manage different and sometimes misaligned care and payment systems with limited capacity to do so

Source: Rural Health Value, How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report, https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf

Model Implementation Considerations

- Recognize the unique challenges of low volumes in performance expectations
- Employ meaningful and appropriate comparisons for data benchmarking
- Use recommendations from the 2022 National Quality Forum MAP Rural Health Workgroup Report (e.g., NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR))
- Recognize the relative differences between costs directly attributable to patient care (variable costs), costs of infrastructures required to support patient care regardless of patient volume (fixed costs), and costs necessary for readiness to deliver care anytime (standby costs).
- Recognize that while potentially avoidable utilization reductions will reduce payer expenditures, such cost-reduction strategies will only reduce hospital variable costs (at least in the short-term). Variable costs represent a small percentage of rural hospital costs.

Source: Rural Health Value, How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report, https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf

Feasibility for Rural Providers to Participate in PB-TCOC Models

- Link financial risk to performance other than cost savings (if financial risk is mandated)
- Do not place essential local services at financial risk, including primary care, public health, and EMS
- Apply financial risk only to aspects of performance controlled by model participants
- Consider models that do not rely on fee-for-service
- Reduce innovation and alignment barriers through regulatory waivers

Source: Rural Health Value, How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report, https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf

Thank you.

Alana Knudson, PhD
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Research You Can Trust™

RHI hub
Rural Health Information Hub

NORC
WalshCenter
FOR RURAL HEALTH ANALYSIS

RHIhub
Rural Health Information Hub

Your *First* **STOP** for *Rural Health* **INFORMATION**

- **Visit the website**
  - Online library
  - Funding opportunities
  - 50+ topic guides on key rural health issues
  - State guides
  - Community Health Gateway - toolkits and model programs
  - Am I Rural tool
  - More...
- **Sign up for email updates**
- **Contact our Resource and Referral Service**
  800.270.1898 or info@ruralhealthinfo.org

All services are *free!*

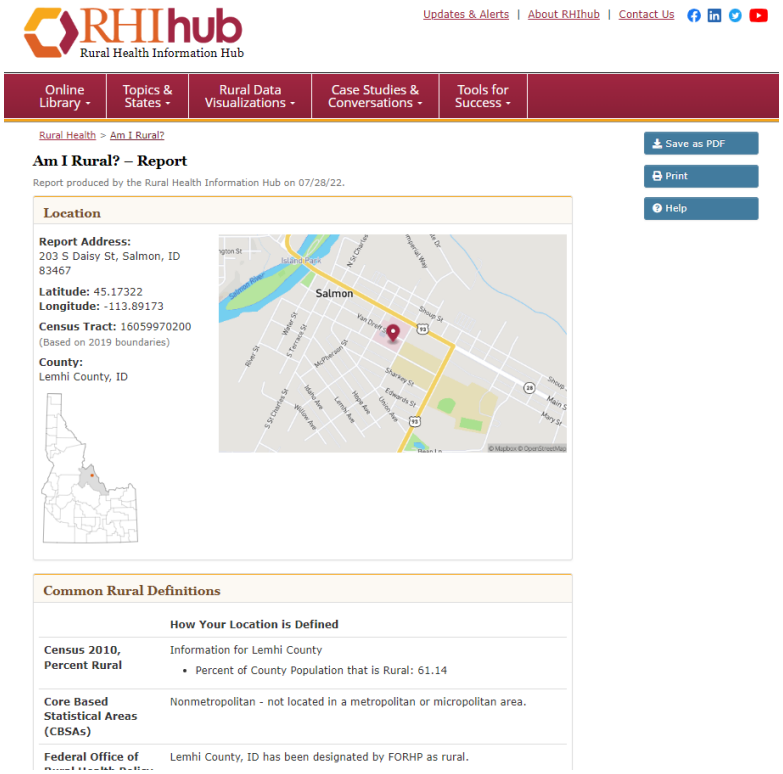
https://www.ruralhealthinfo.org/am-i-rural

Search exact address, town/city, ZIP code, or county

Common definitions: UA/UC, CBSA, RUCC, UIC, RUCA, FORHP, and FAR

Program eligibility for CMS Rural Health Clinics (RHCs) and FORHP grants

Shortage designations: Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population



Rural Community Health Toolkit

Start here for a guide to building rural community health programs to address any type of health issue. Learn how to identify community needs, find evidence-based models, plan and implement your program, evaluate results, and much more.

Aging in Place Toolkit

Explore program models and approaches to support rural aging in place.

Care Coordination Toolkit

Find models and program examples for delivering high-quality care across different rural healthcare settings.

Chronic Obstructive Pulmonary Disease Toolkit

Learn how to develop programs to address COPD in rural communities.

Community Health Workers Toolkit

Learn about roles community health workers (CHWs) fill, as well as CHW training approaches.

Community Paramedicine Toolkit

Discover models and resources for developing community paramedicine programs in rural areas.

Diabetes Prevention and Management Toolkit

Find resources and best practices to develop diabetes prevention and management programs in rural areas.

Early Childhood Health Promotion Toolkit

Learn how to develop early childhood health promotion programs in rural communities.

Emergency Preparedness and Response Toolkit

NEW

Discover strategies, resources, and case studies to support rural emergency planning, response, and recovery.

Health Equity Toolkit

Explore evidence-based frameworks and promising strategies to advance health equity in rural communities.

Health Literacy Toolkit

Discover resources and model programs for improving personal and organizational health literacy in rural communities.

Health Networks and Coalitions Toolkit

Find resources and strategies to help create or expand a rural health network or coalition.

Health Promotion and Disease Prevention Toolkit

Learn about strategies and models for rural health promotion and disease prevention in the community, clinic, and workplace.

HIV/AIDS Prevention and Treatment Toolkit

Explore models and resources for implementing HIV/AIDS prevention and treatment programs in rural communities.

Mental Health Toolkit

Discover resources and models to develop rural mental health programs, with a primary focus on adult mental health.

Obesity Prevention Toolkit

Find out how rural communities, schools, and healthcare providers can develop programs to help address obesity.

Philanthropy Toolkit

Find emerging practices and resources for building successful relationships with philanthropies.

Services Integration Toolkit

Learn how rural communities can integrate health and human services to increase care coordination, improve health outcomes, and reduce healthcare costs.

Suicide Prevention Toolkit

Find evidence-based models and resources for implementing a suicide prevention program in rural areas.

Tobacco Control and Prevention Toolkit

Explore program examples and resources for implementing tobacco control and prevention programs in rural areas.

Maternal Health Toolkit

Find resources and models for developing programs to address rural maternal health issues.

Medication for Opioid Use Disorder Toolkit

Learn about models and resources for implementing medication for opioid use disorder programs in rural communities.

Oral Health Toolkit

Discover rural oral health approaches that focus on workforce, access, outreach, schools, and more.

Prevention and Treatment of Substance Use Disorders Toolkit

Learn about models and resources for developing substance use disorder prevention and treatment programs in rural communities.

Social Determinants of Health Toolkit

Discover evidence-based models and resources to address social determinants of health in rural communities.

Telehealth Toolkit

Discover program examples and resources for developing a telehealth program to address access issues in rural America.

Transportation Toolkit

Explore how communities can provide transportation services to help rural residents maintain their health and well-being.

25+ toolkits, with updates and new toolkits released annually

Archived toolkits: Additional toolkits are available in a PDF format but are no longer updated.

RURAL HEALTH EQUITY RESEARCH CENTER

Listening Session 2: *Incentives for Increasing Rural Providers' Participation in Population-Based Models*

Tom X. Lee, MD, MBA
Chief Executive Officer
Galileo

galileo

Encouraging Rural Participation in Population-Based TCOC Models

Thomas Lee MD
Founder & CEO, Galileo

Sept 19, 2023

Background

WASHINGTON · IDAHO · WYOMING · MONTANA · ALASKA

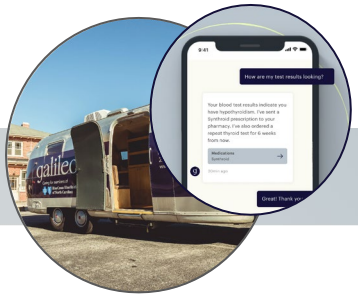
WWAMI

UW SCHOOL OF MEDICINE

Regional Campuses

epocrates

one medical



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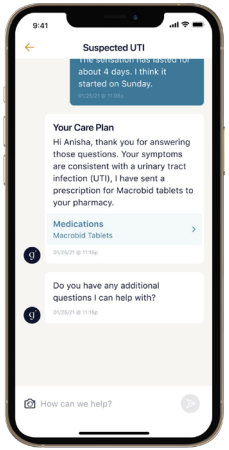
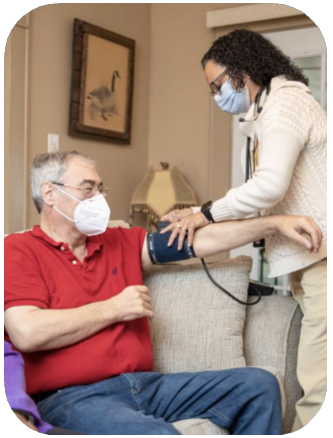
ABOUT GALILEO

Designed for Rural & Underserved, Caring for All Patients

Full Scope Capabilities • Healthy to Complex • Rural to Urban • Pediatric to Geriatric





Digital-First

Longitudinal, value-based care designed for most of the population.

Home-Based

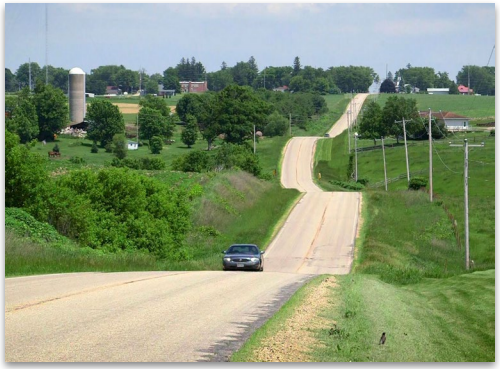
In-person care designed for more complex populations including MA, complex Medicaid, and duals.

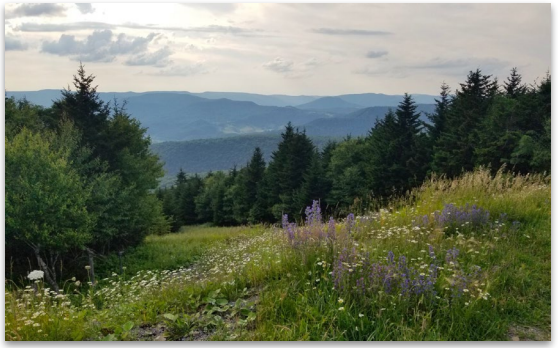
galileo

CARE IN RURAL ENVIRONMENTS

Infrastructure-Related Challenges

- Connectivity
- Labor & Time Matching
- Skills Matching
- Facility Capabilities
- Payment Alignment





CARE IN RURAL ENVIRONMENTS

Infrastructure-Related Challenges

- **Connectivity**
- Labor & Time Matching
- Skills Matching

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Infrastructure-Related Challenges

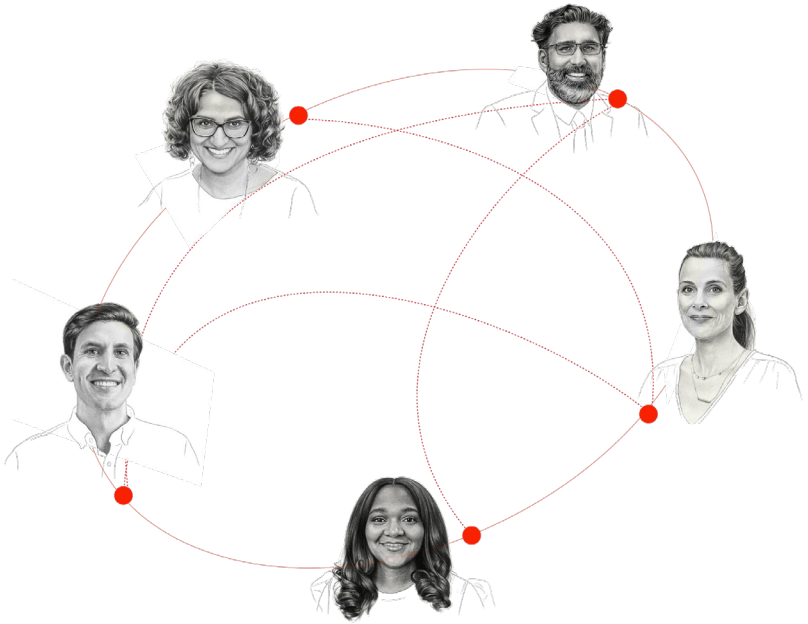
- Connectivity
- Labor & Time Matching
- Skills Matching

galileo

CARE IN RURAL ENVIRONMENTS

Infrastructure-Related Challenges

- Connectivity
- Labor & Time Matching
- Skills Matching



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BARRIERS AND OPPORTUNITIES

Advancing Rural Health and Value-Based Care Innovation

Workforce

Overcoming clinician shortages requires cross-provider creativity and collaboration

Member Density

A sufficient population size is required to take on risk in low density markets; fostering partnerships is key

Home-First

Care complexity, logistics, and execution of home-first models require regulatory and reimbursement flexibility

Tech-Enablement

Permanent and adequate coverage of phone and asynchronous care is needed to ensure access

Investment

Emerging models must cover upfront costs to support gradually transitions to risk

Discussion

REDUCING VARIATION ACROSS POPULATIONS

High-Intensity Digital Medical Practice

Uses data-driven expertise to enhance care for remote and complex populations.

- **Virtual Care Across 22+ Disciplines**
  Including urgent/acute, BH, women's health, neuro, endocrinology, GI, ID, MSK, and derm.
- **Full-Time Providers Nationwide**
  Multilingual support, with embedded Spanish
- **Online-to-Offline Integration**
  Seamless transfers to in-person care, and CBOs/social services
- **Care Navigation**
  In-network & point solution referrals
- **Population Health**
  Care Management, Quality + HEDIS Initiatives, Care Transitions, Hotspotting
- **Impact**
  <10% referral rate
  46% fewer specialty visits
  11%+ cost savings

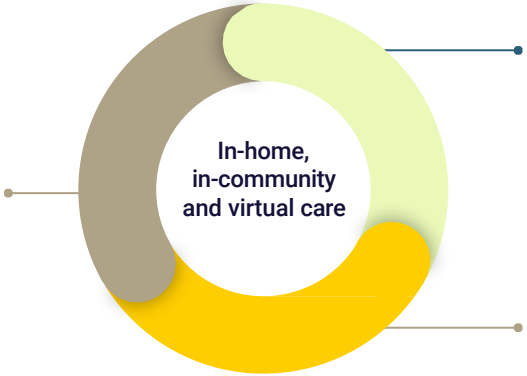
galileo

CAPABILITY SNAPSHOT

High Acuity Member Management

MEDICAL

- Dedicated, multi-specialty team of in-person and virtual clinicians, health advocates, and support staff, addressing the root medical causes of illness
- 24/7 access to Galileo clinicians to manage acute medical needs and avoid acute care utilization



BEHAVIORAL

- Identifying patients with complex mental illness to tailor BH-first pathways, including targeted engagement strategies, specialized care team members, and care model interventions
- Prioritized programs aimed at stabilizing patients with high utilization carrying a significant burden of mental illness

SOCIAL

- Comprehensive intake to assess social risks including housing and food security, social isolation, caregiver burnout, and health literacy.
- In-house social services program to address high acuity needs with close referral ties when appropriate

Clinical Intelligence Platform

Patient Segmentation | Assessments | Referral Management | Medication Management | Quality and Risk Management

galileo

Listening Session 2: *Incentives for Increasing Rural Providers' Participation in Population-Based Models*

Randy L. Pilgrim, MD, FACEP
Enterprise Chief Medical Officer
SCP Health

Integrating Health Equity into value-based transformation

Randy Pilgrim, MD, FACEP, FAAFP
Enterprise Chief Medical Officer
SCP Health

September 19, 2023

Overview

For rural providers and communities:

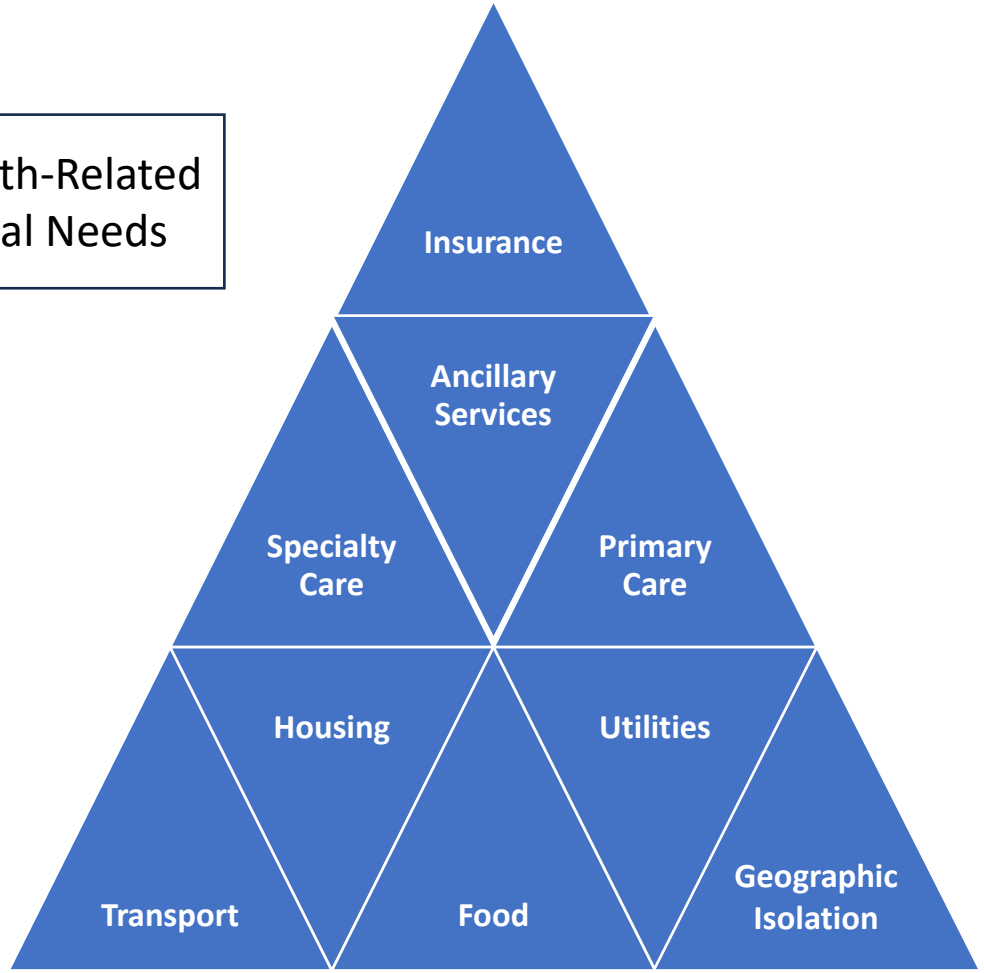
- What are unique health equity challenges?
- What are the most important SDOH and HRSN measures?
- Previous examples of participation in value-based models
- Approaches for integrating health equity into value-based transformation
- Considerations for increasing rural participation in future value-based models

Fundamentals

Equity	Creating a level playing field where everyone has the opportunity to achieve *full health potential*
Disparities	*Preventable differences* in disease burden or health outcomes
Social Determinants of Health (SDOH)	Conditions in which people are born, grow, and live, including economic, political, and social systems
Health-Related Social Needs (HRSN)	A person's unmet or adverse social conditions that contribute to poor health and are the result of underlying SDOH
Area Deprivation Index (ADI)	Zip code-based ranking of socioeconomic disadvantage. Higher rankings indicate areas of greater disadvantage.

Rural populations often experience disproportionate HRSN challenges*

*Health-Related Social Needs



First level:

- **Access to food** (food desert, distance to store; no delivery services)
- **Geographic isolation** (distance to access services/limited services)
- **Transportation challenges** (reliable transportation, lack of public transportation, taxis)

Next level:

- **Limited housing options**, including accessibility (wheelchair, mobility)
- Large **utility grids** with little redundancy

Additional:

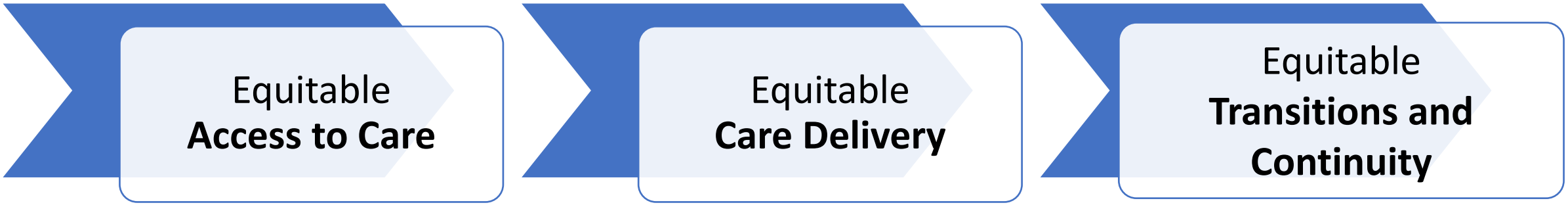
- **Internet/Wi-Fi** dead zones limiting virtual care options
- **Agricultural work** (for patients and caregivers): 7 days a week during business hours; in person medical appointments are problematic

Achieving Health Equity

Requires three fundamental clinical functions.

Clinical foundations of health equity:

- Equitable **access** to care
- Equitable **delivery** of care
- Equitable mechanisms for **continuity** of care
  - Both episodic and longitudinal care



Current and Previous Models

Metro Community Provider Network (Colorado): Bridges to Care Model

- Supported post-ED patient navigation and utilization decision-making
- On-site patient engagement during an ED visit for frequent ED patients
- Included work with SDOH, substance abuse and mental health patients
- Findings: Significant reduction in ED visits and program savings
  Using an initial ED visit as a real-time patient engagement opportunity is particularly effective

State of Maryland: Global Budget Payment Reform

- Hospital revenue is independent of patient volume or services delivered
- Subsequent studies evaluated ED visits/1,000, admissions from the ED, and ED returns (at 72h and at 9 days)
- Findings: Lower ED utilization, ED returns, and admissions
  Stable mortality and ICU stays among returns
  Economic alignment with hospitals can safely reduce total cost
  However, opportunities to address disparities among ED returns were identified

Current and Previous Models

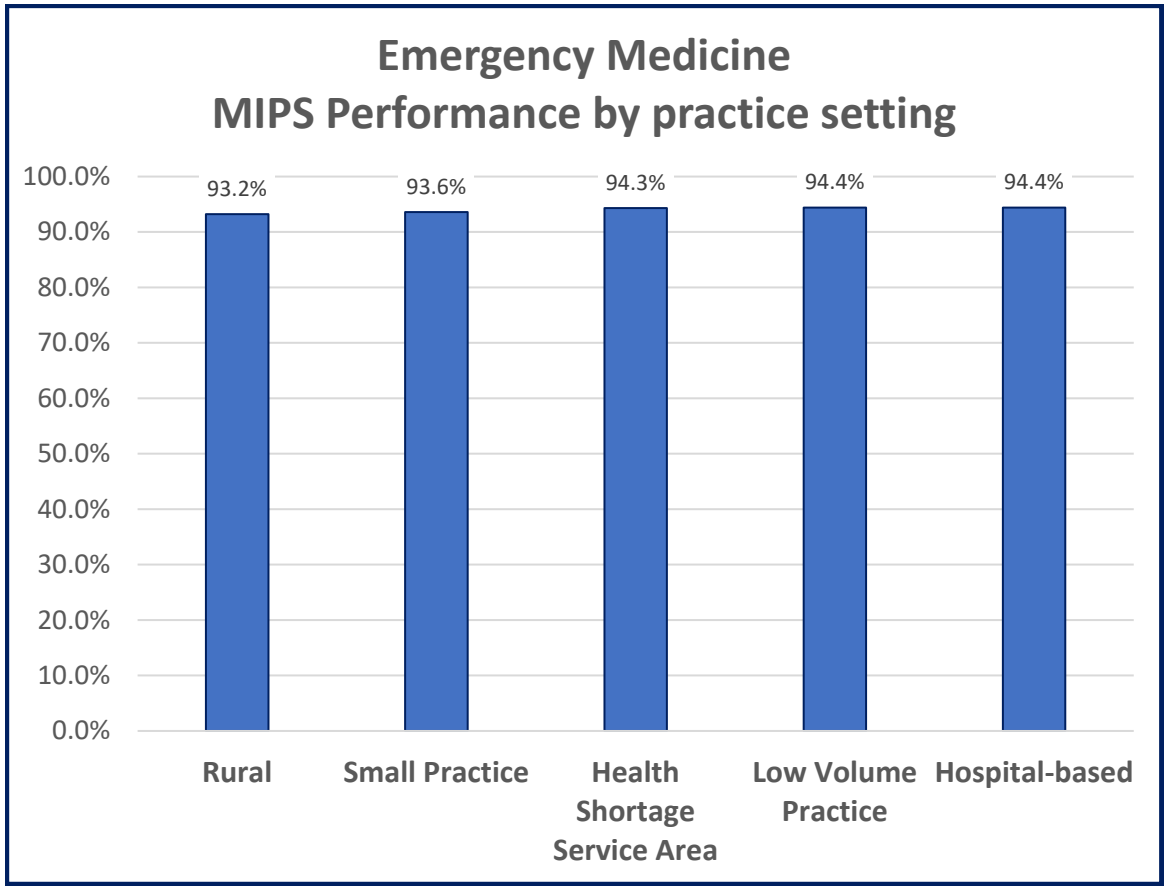
Acute Unscheduled Care Model (AUCM- proposed)

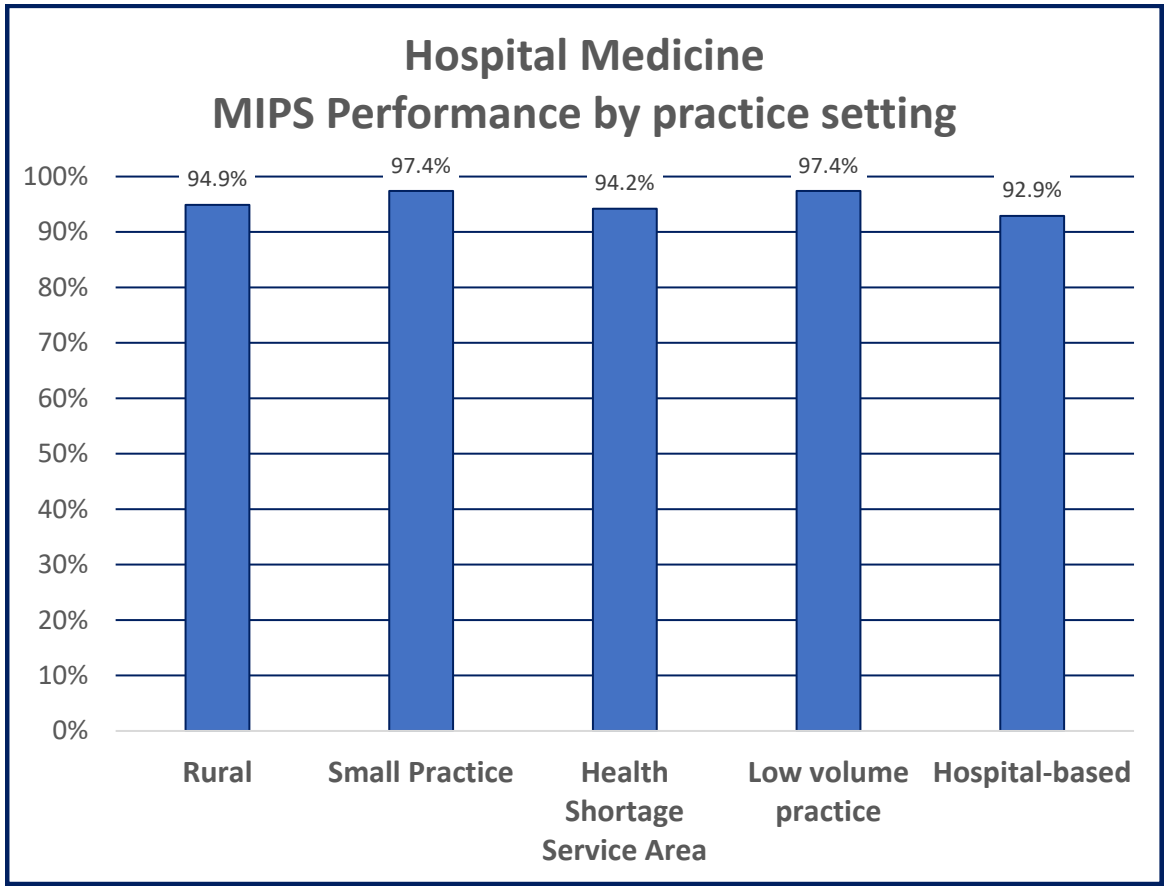
- Risk-bearing APM for emergency medicine that promotes safe discharges to home while reducing overall cost
- Goals: reduce hospitalizations, foster care coordination, and reduce post-ED safety events after an initial ED visit
- Includes waivers for telehealth, home visits, and transitional care management for emergency physicians
- Behavioral health patients included in mature phase
- PTAC recommended the proposal to the Secretary of HHS for implementation during a public meeting in 2018
- Findings: ED-centric model leverages patient engagement from an initial ED visit to achieve program goals
  Extends emergency physician/department accountability in a value-based model
  Proposed model not yet implemented, but similar models are used with commercial health plans

Emergency physician partnerships with health plans

- Value-based engagements with commercial payors (commercial plans; Medicare Advantage)
- Utilizes principles of the AUCM model (safe discharges, navigation, care coordination, quality measures)
- Flexible structure includes various levels of economic risk and reward
- New resource requirements are offset by program savings
- Findings: High patient engagement rates through direct follow-up from physician group
  Notably reduced ED return visits, patient experience improved, reduced overall cost

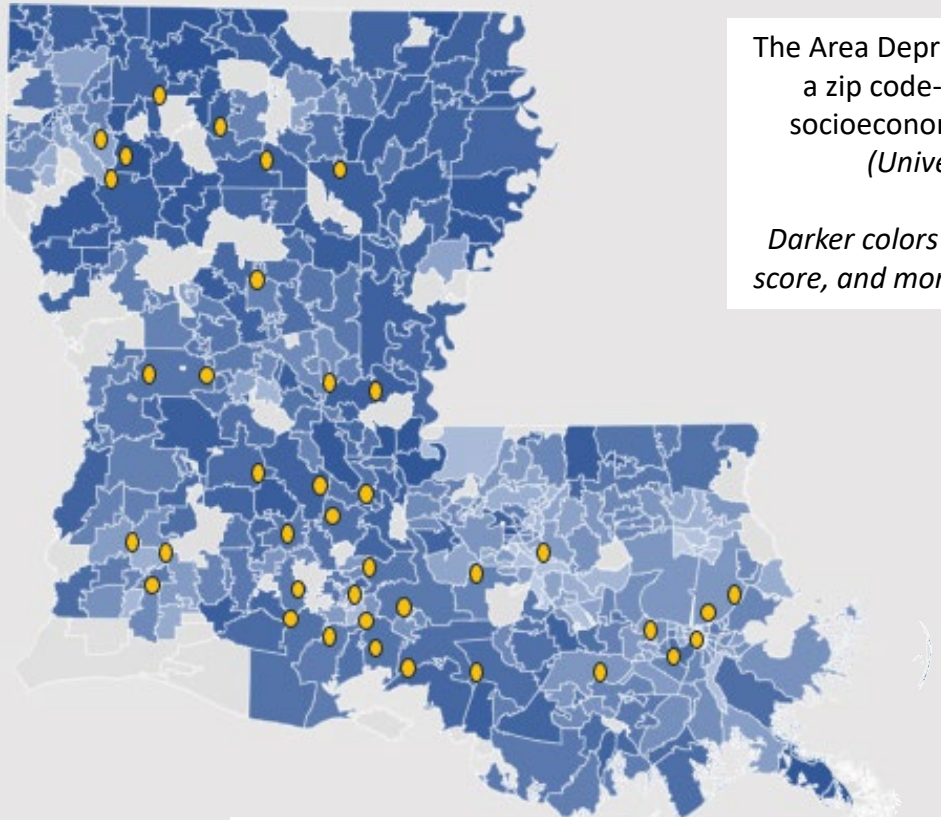
Hospital-based clinical services provide equitable care in various settings





Emergency Departments deliver equitable results in areas at risk for health disparities

Area Deprivation Index in Louisiana by Zip Code
(Dots indicate Emergency Medicine Sites Included in outcomes analysis)

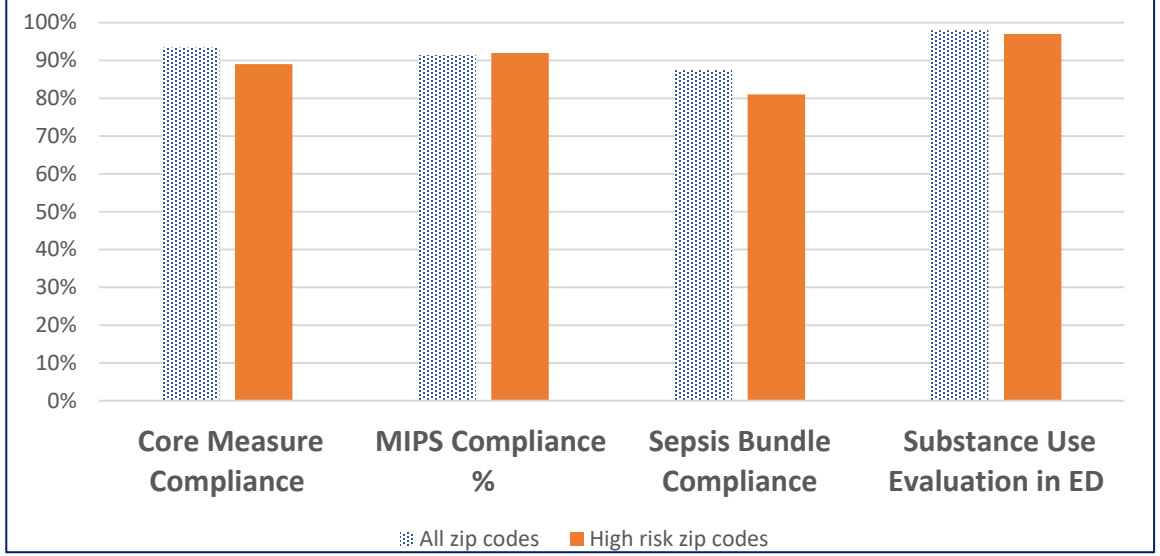


The Area Deprivation Index (ADI) is a zip code-based ranking of socioeconomic disadvantage. *(University of WI)*

Darker colors indicate higher ADI score, and more risk for disparities.

https://www.neighborhoodatlas.medicine.wisc.edu/

Health outcomes for ED patients in high-risk zip codes (ADI >4) show similar health outcomes compared to all zip codes.



An opportunity to advance health equity

Integrating rural Emergency Departments into value-based models

Equitable **Access to Care**

- **EMTALA requirement**
- **Prudent layperson standard**
- **Public reporting**

Equitable **Care Delivery**

- **Initial clinical care**
- **Established standards**
- **Quality measures**
- **Certification/regulation**

Equitable **Transitions and Continuity**

- **SDOH Screening**
- **HRSN Issues**
- **Care Coordination**
- **Aftercare**

Existing laws, regulations, and processes support equitable access and care delivery, and provide a foundation for equitable continuity.

Integrating health equity into value-based models

Equitable
Access to Care

- **Representative population?**
- **Increased access for underserved populations?**

Equitable
Care Delivery

- **Quality measures**
- **Operational measures**
  - Wait times
  - Throughput times
- **Consistent results for all patient groups**

Equitable
Transitions and Continuity

- **Process measures**
- **Transition indicators**
- **(Aligned primary care, specialists, and non-rural resources)**

Incentivizing key factors promotes equitable outcomes.

Overcoming rural challenges requires:

A unified mission

Clear clinical objectives

Effective operational model

- Optimizes rural resources
- Access to necessary external resources
- Effective system for transition and coordination
- Supportive infrastructure

Aligned economic model

- Resources aligned with objectives
- Broad-based participation

Consistent and adaptable model

Summary

- Rural communities often experience significant health equity challenges.
- Achieving health equity requires effective **Access** and equitable care **Delivery**, with equitable **Transitions and Continuity**.
- Current, previous, and proposed models provide important learnings for the design and deployment of future value-based models.
- Emergency Departments offer opportunities to leverage existing structures and mechanisms to achieve health equity objectives.
- Measurements and incentives that promote health equity can be integral components of value-based models in rural settings
- Success requires an effective clinical, operational, and economic model, broad participation, and aligned resources.

Appendix

Additional Resources

Rural Health Promotion and Disease Prevention Toolkit

Rural Health Information Hub:
https://www.ruralhealthinfo.org/toolkits/health-promotion

Area Deprivation Index

University of Wisconsin School of Medicine and Public Health
https://www.neighborhoodatlas.medicine.wisc.edu/

References

Health Equity Overview: Centers for Disease Control and Prevention; Office of Health Equity
https://www.cdc.gov/healthequity/index.html

Area Deprivation Index (ADI): University of Wisconsin School of Medicine and Public Health; Center for Health Disparities Research
https://www.neighborhoodatlas.medicine.wisc.edu/

RHIhub: Rural Health Information Hub; Rural Health Promotion and Disease Prevention Toolkit
https://www.ruralhealthinfo.org/toolkits/health-promotion

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Bridges to Care (B2C)
https://doi.org/10.1377/hlthaff.2017.0612

Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions A Physician-Focused Payment Model (PFPM) for Emergency Medicine
https://aspe.hhs.gov/system/files/pdf/255906/ACEPResubmissionofAUCMtoPTAC.PDFhttps://www.ruralhealthinfo.org/toolkits/health-promotion
https://aspe.hhs.gov/system/files/pdf/255906/ACEPResubmissionofAUCMtoPTAC.PDF
https://www.acep.org/federal-advocacy/federal-advocacy-overview/APM
https://doi.org/10.1016/j.annemergmed.2019.09.008

Listening Session 3: *Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas*

David C. Herman, MD

Chief Executive Officer

Essentia Health

We are called to make a healthy difference in people's lives.

Innovative Approaches for Facilitating Value-Based Transformation in Rural Areas

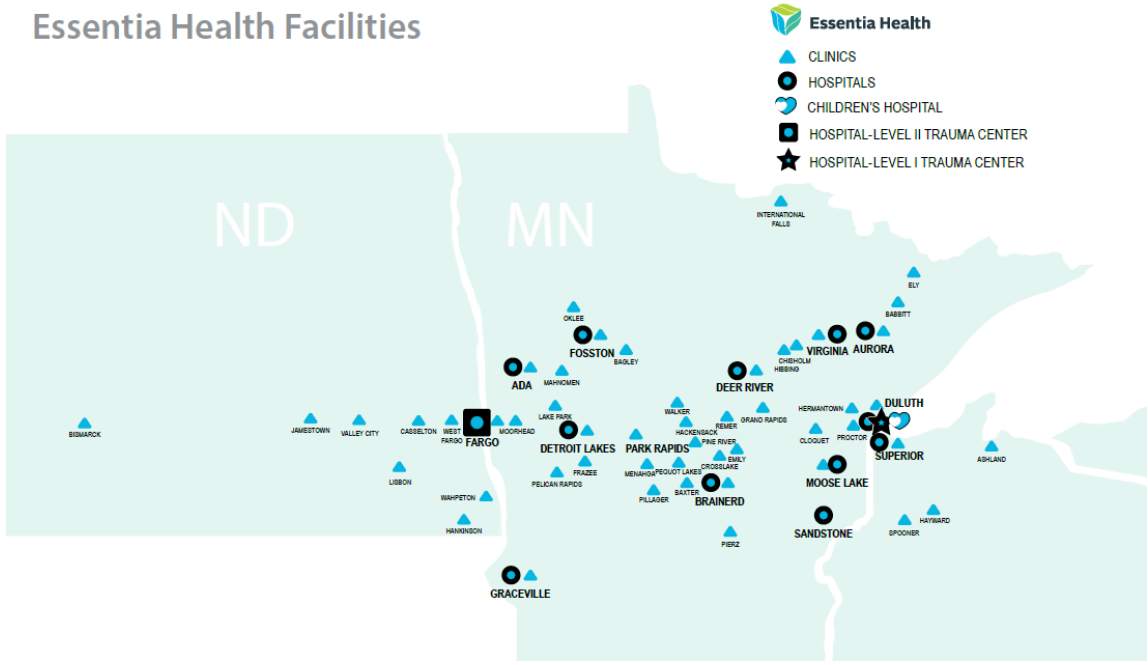
David C. Herman, MD
Chief Executive Officer
Essentia Health
September 19, 2023

Essentia Health

Welcome

Our mission: We are called to make a healthy difference in people's lives.

- **15,800** colleagues
- **14** hospitals
- **78** clinics
- **6** long-term care facilities
- **6** assisted living & independent care facilities
- **7** ambulance services
- **1** research institute



Quality | Hospitality | Respect | Joy | Justice | Stewardship | Teamwork

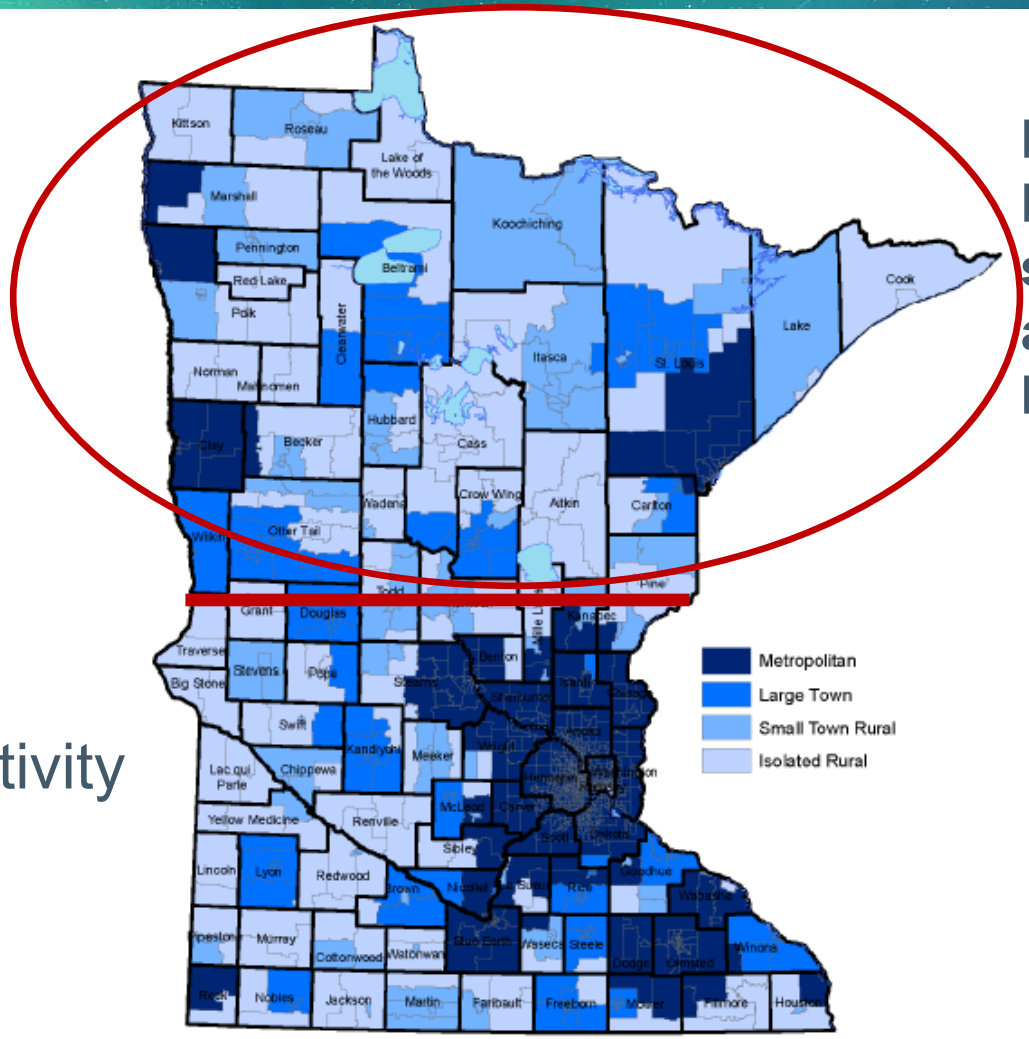
Value-Based Care

TODAY'S DISCUSSION

- The unique challenges providing care in our rural communities
- How we embarked on value-based care models
- What we've learned along the way
- How these models serve as a pathway for the future of rural health care

Rural Health Care Challenges

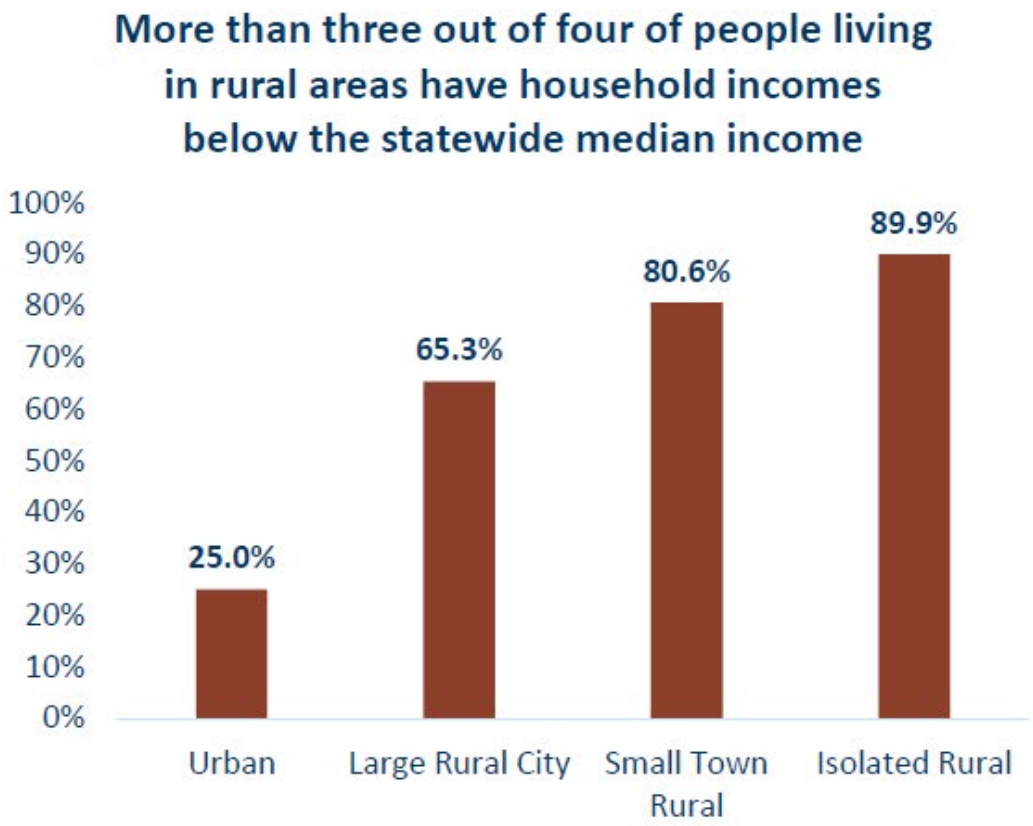
- Lower household incomes
- Older
- Less education
- More health concerns
- Distance to care is greater
- Relatively resource poor
  - Food deserts
  - Unreliable broadband connectivity
  - Small provider practices
  - Lack of specialty services

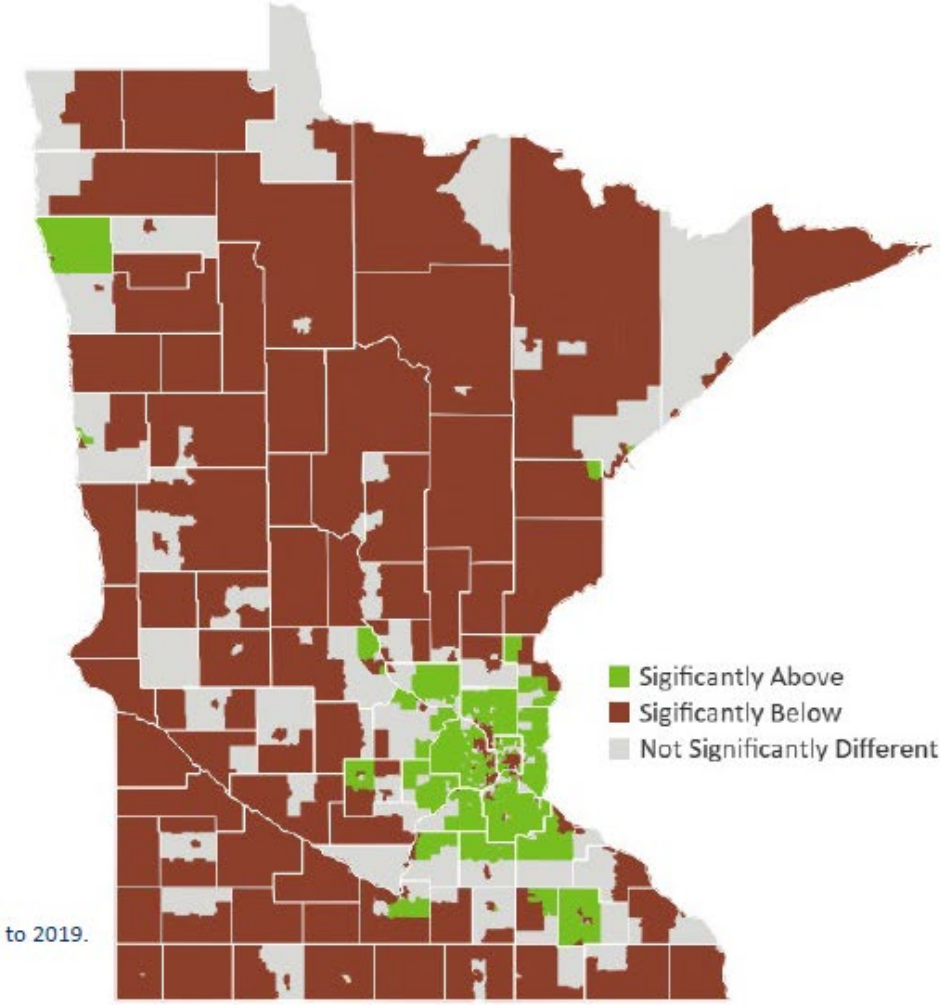


Essentia Health service area in Minnesota

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Household Income



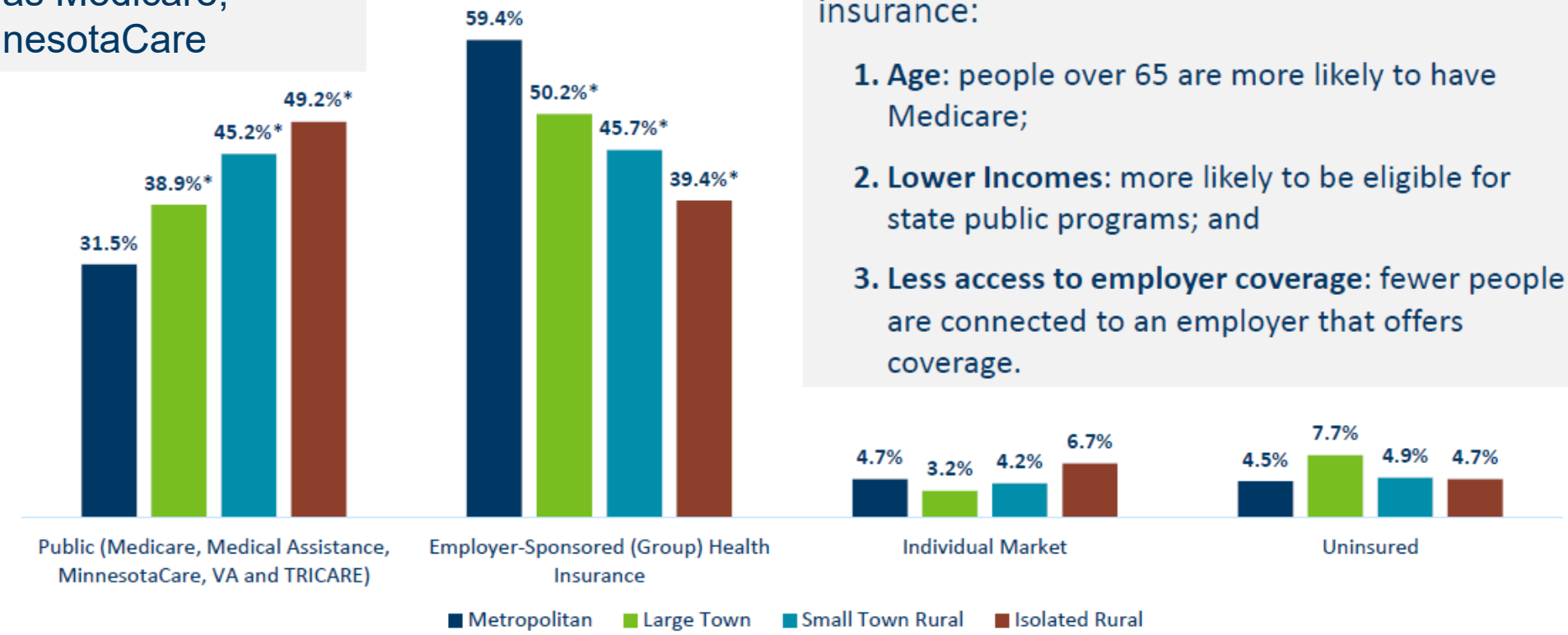


Source: MDH/Health Economics Program analysis of the American Community Survey Five-Year Estimate 2015 to 2019.
RUCA based on census tract
Summary of Slide

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Health insurance coverage

Rural Minnesotans are more likely to have public health insurance coverage, such as Medicare, Medicaid or MinnesotaCare



Source: Minnesota Health Access Survey, 2019; Geographies based on RUCA zip-code approximations.
*Indicates significant difference from Metropolitan at the 95% level.

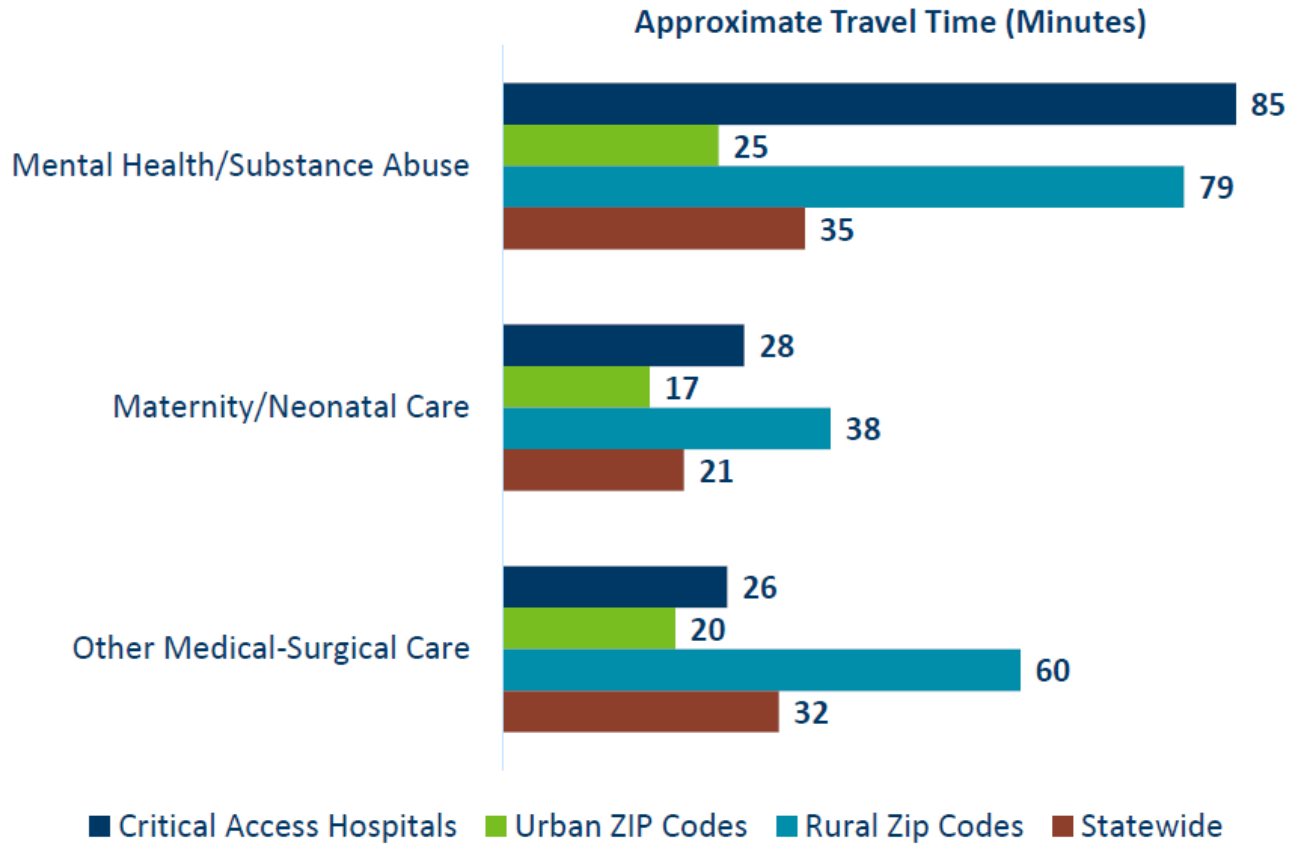
Reasons for higher rates of public health insurance:

1. **Age**: people over 65 are more likely to have Medicare;
2. **Lower Incomes**: more likely to be eligible for state public programs; and
3. **Less access to employer coverage**: fewer people are connected to an employer that offers coverage.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Additional travel to care

- Rural patients seeking inpatient mental health and chemical dependency treatment travel more than three time longer than urban patients
- Patients receiving medical/surgical care at Critical Access Hospitals experience shorter travel times than those traveling to other types of hospitals

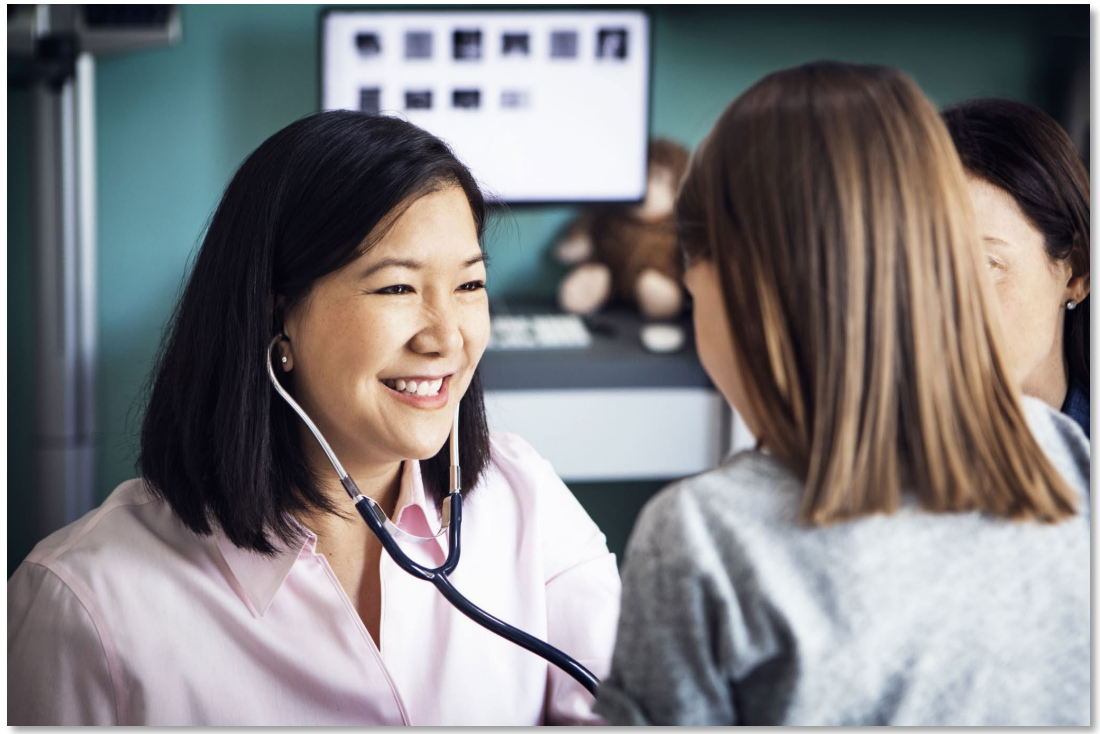


Source: MDH analysis of Minnesota hospital administrative (discharge) inpatient records for medical-surgical care, obstetrics care, and mental health or chemical dependency care for 2016 to 2019. The analysis calculated the distance between the geographic centroid of each ZIP code to respective hospitals and excluded hospital stays that were transferred to another hospital to avoid duplication. Patients with planned services, such as surgeries, may intentionally travel longer distances. Non-metropolitan ZIP codes are classified as 'rural' using RUCA.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

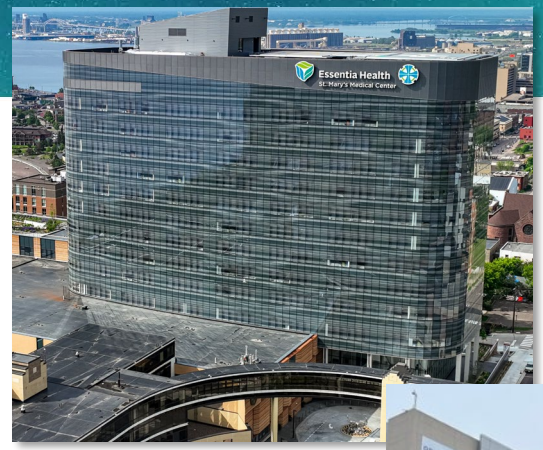
Organizational Commitment to this Work

- Focus on quality of care and outcomes rather than volume
- An emphasis on prevention and wellness
- Coordination and integration of care
- Transformation and clinician-driven innovation



Essentia's Approach

- Identifying the patients
- Determining patients' care needs
- Managing chronic illness
- Providing care needs in a proactive and coordinated way
- Driving appropriate utilization – lower health care spending
- Addressing health-related social factors
- Partnerships with government, private payers, and community organizations



Community-level priorities

- Creating Community Health Needs Assessment and Implementation Plan for each hospital
- Strategically investing in community projects
- Engaging in community coalitions
- Implementing and evaluating strategies identified in the Implementation Plans
- Creating community conditions that empower us all to realize our optimal health

Essentia's Approach

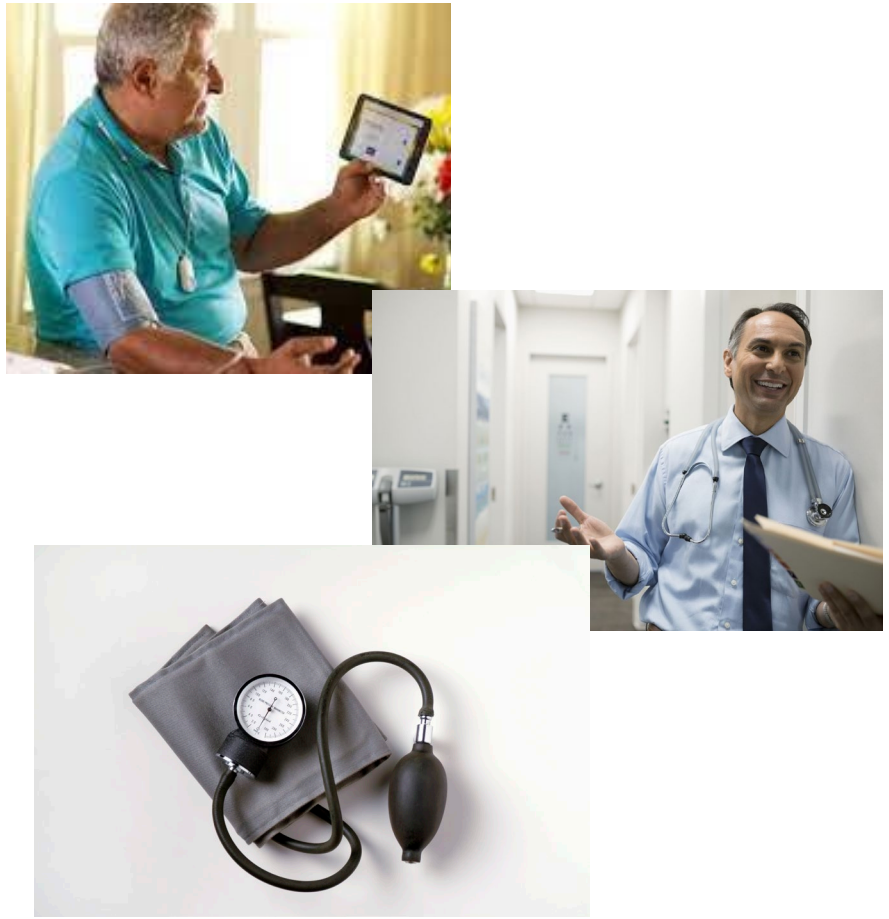
- Analytics
- Action
- Accountability

Create a model of care delivery that is as standard as possible and as unique as necessary to meet the needs of our patients and communities.

Analytics

- Risk stratification
- The evaluation of utilization patterns
- Care gap identification
- Referral management

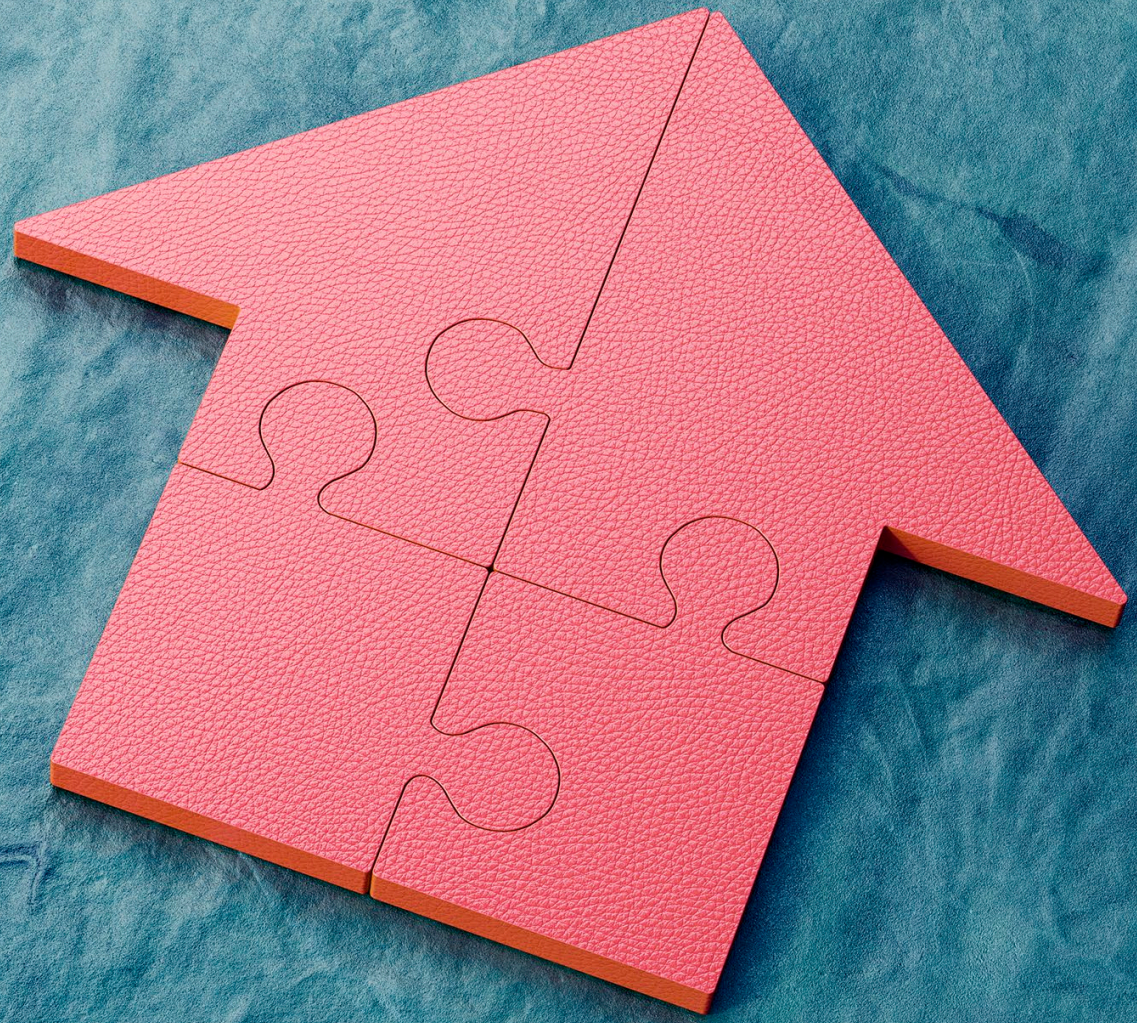
Action



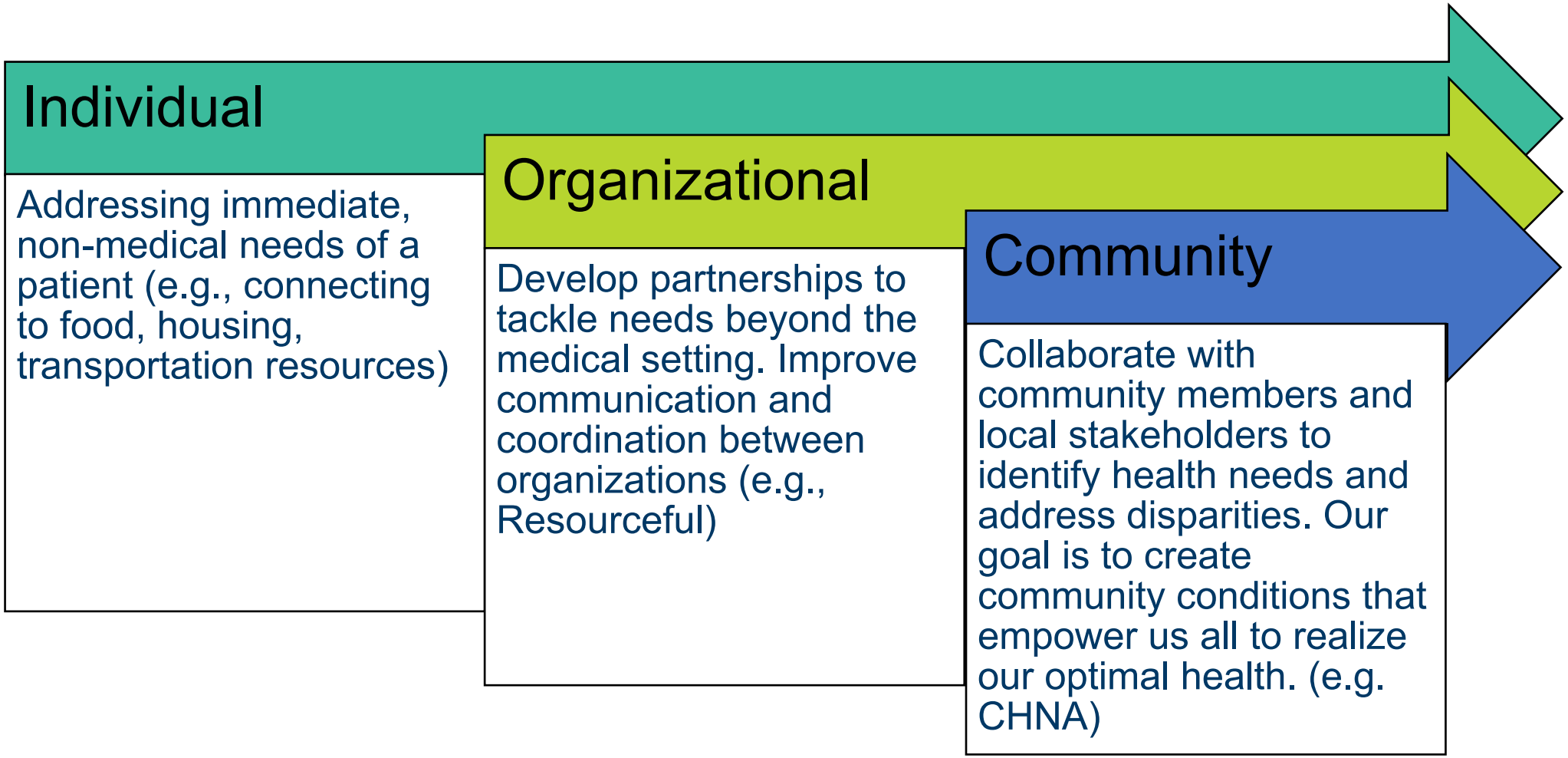
- Alternative care delivery models, such as virtual care and remote monitoring
- Improving transitions of care
- Addressing social factors influencing health and well-being
- Closing care gaps
- Chronic illness management

Accountability

- Establish goals through governance structure
- Provide oversight on performance
- Transparency
- Dashboards to track progress
- Ongoing improvement strategies



Addressing the Needs of Our Communities



Addressing the Needs of our Communities

Patients complete five-question screening in MyChart or during in clinic/virtual visit rooming process

Community Care Associate follows up with patient and provides counseling on local resources

Make referrals to community partners & provide education on local resources

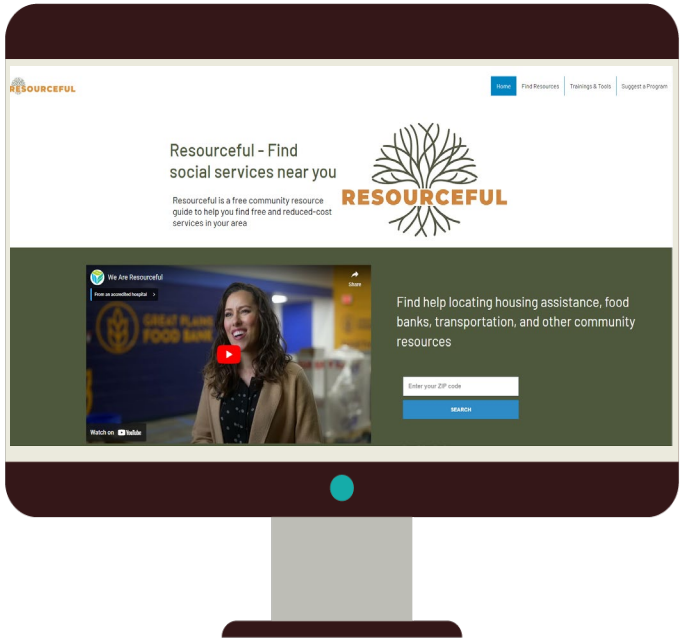
Patient Screenings by the Numbers

- 185,000 patients completed screening
- 20,000 patients identified at least one need
- 10 community care associates worked with patients
- 12,000 referrals to community-based organizations
- 20% of patients with a social needs are connected to a new resource

Timeframe: July 1, 2022-June 30, 2023

Help from ‘Resourceful’

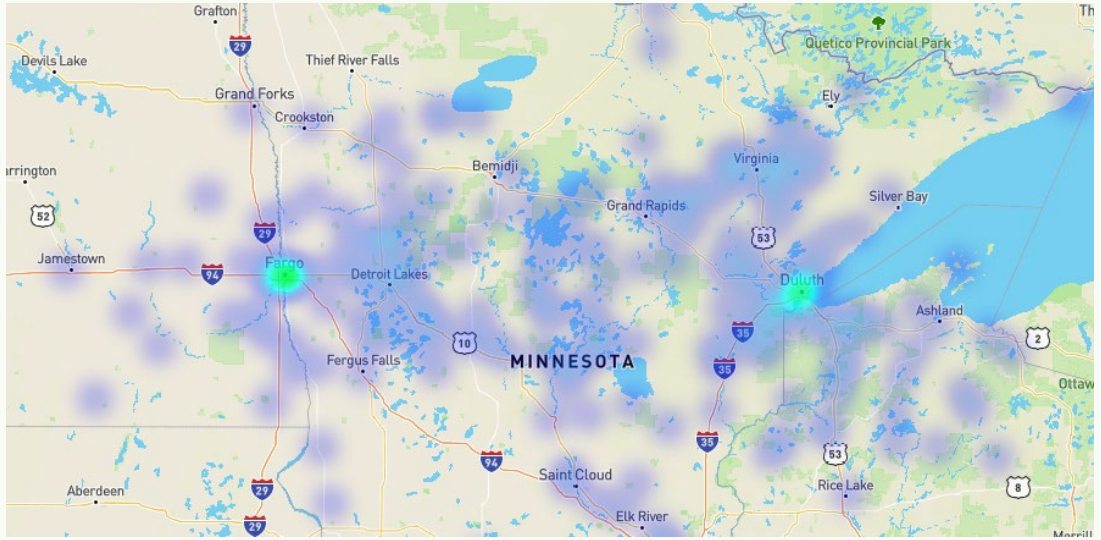
- Resourceful is our community resource guide to help people find free and reduced-cost services in categories such as food insecurity, transportation, mental health, and housing
- Staff can access through Epic
- Public site where community members can access as well



www.WeAreResourceful.org

Helping Community Members

- 664 programs added to Resourceful
- 296 programs claimed
- Better than a brochure: Enabling referrals so we can directly refer patients instead of handing brochures or giving phone numbers
- Working across our entire service area



Heat map shows engagement with Resourceful

Success in Value-Based Care

- Medicare Shared Savings Program (MSSP) savings of $42.4 million from 2018-2021
- Minnesota Integrated Health Partnership (IHP) savings of $28 million from 2018-2021
- Nearly 40% of our revenue flowing through value-based programs
- Approximately 80% of value-based contracts having downside risk

Lessons Learned

- Commitment is critical
- Requires infrastructure to support
- Know what patients and communities need
- Capacity limited vs. demand limited design
- Make the right thing to do the easiest thing to do

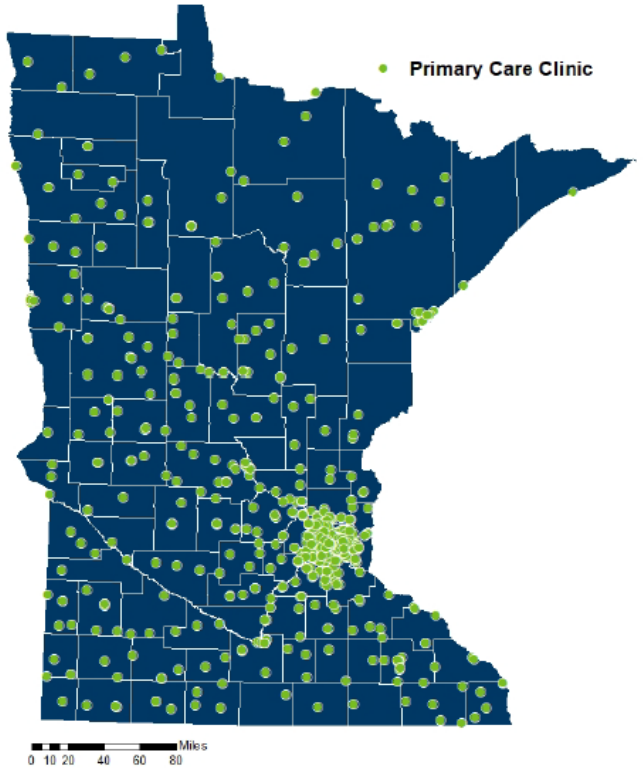
We are called to make a healthy difference in people's lives.

Appendix

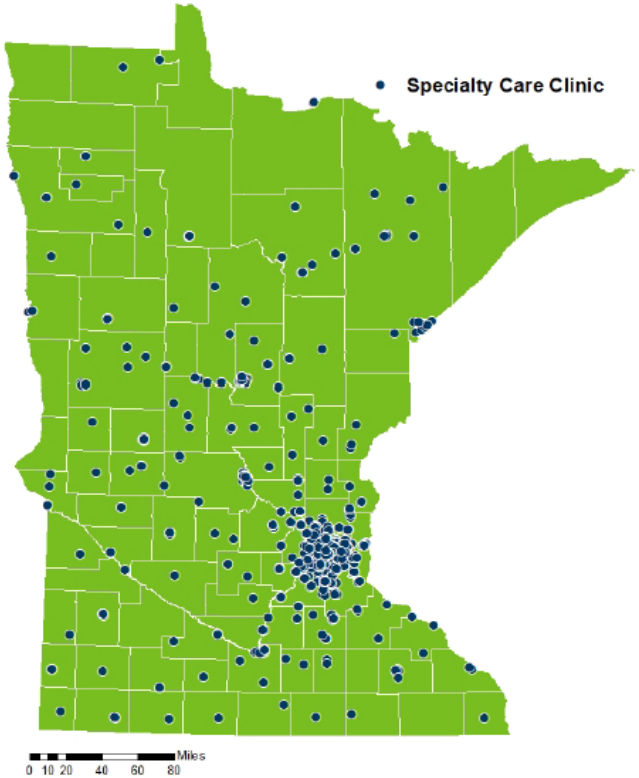
Essentia Health

Primary and Specialty Clinics

Primary Care Clinics, 2020



Specialty Care Clinics, 2020



- 37% (242) of all primary care clinics (661) are located in rural areas.[1]
- 19% (208) of all specialty care clinics (1,070) are located in rural areas. [1]
- Minnesota Community Health Centers had 720,846 medical, dental and mental health visits in 2020.[2]

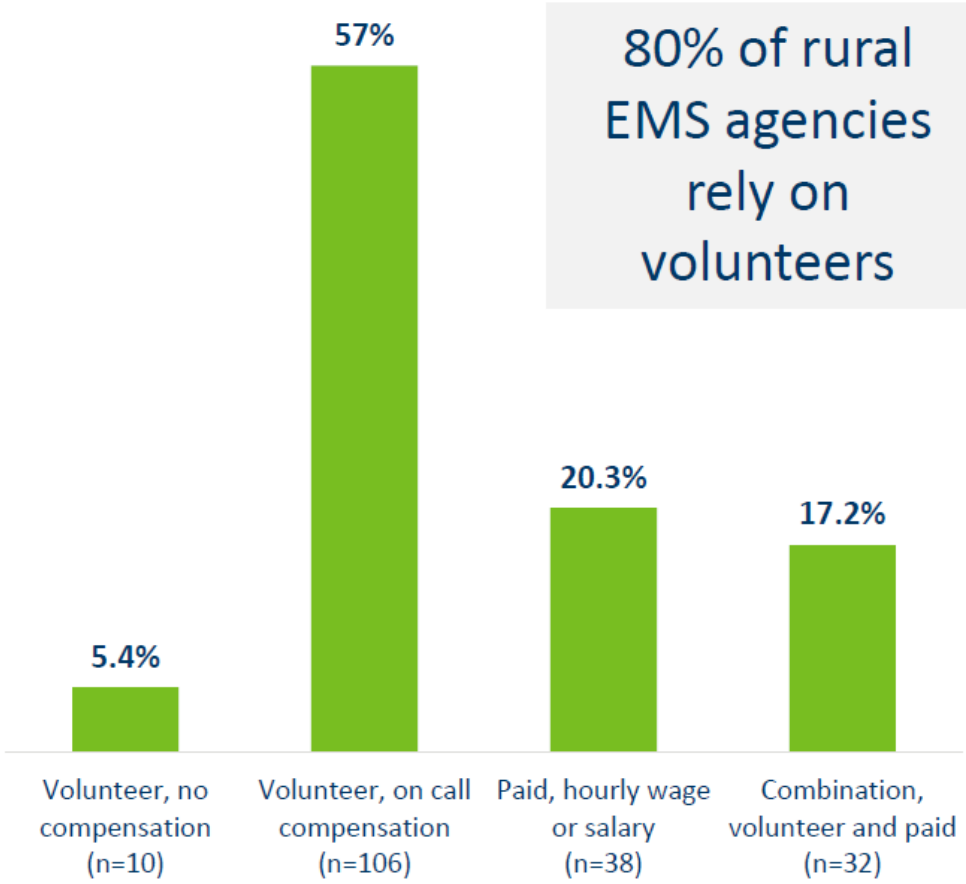
Map Notes: Dots represent the number of clinics, and do not account for patient population or number of practicing physicians. Primary Care includes general family medicine, general internal medicine, and general pediatrics; Specialty Care includes one or more non-primary care specialty. 74.3% of the population lives in urban areas, and 25.7% of the population lives in rural areas based on 2019 5-year population estimates and census tract RUCA codes.

[1] Source: MDH Health Economics Program analysis of the Minnesota Statewide Quality Reporting and Measurement System 2020 Physician Clinic Registry; also source for maps.

[2] Source: https://issuu.com/mnachc/docs/mnachc_2020_annual_report.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Rural Emergency Medical Services (EMS)



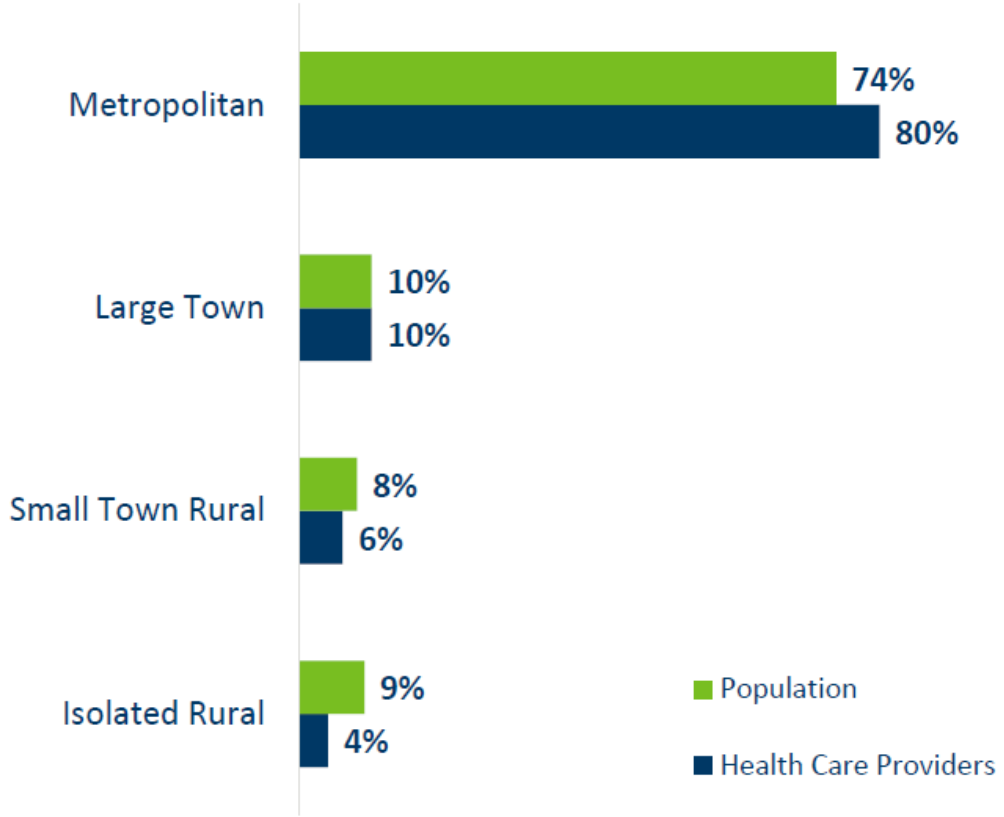
80% of rural EMS agencies rely on volunteers

Source: https://www.health.state.mn.us/facilities/ruralhealth/flex/docs/pdf/2016ems.pdf
Summary of Slide

- Rural EMS agencies rely on volunteers, but face decreasing volunteer roster sizes, and many shifts (weekdays, weekends, holidays) are difficult to fill.
- About 60% of agencies have inadequate staff to cover their call schedule without undue burden.
- 59% of agencies do not have all of their shifts covered at least 24 hours in advance.
- 88% of agencies provide Basic Life Support (not paramedic level services) to their communities.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Rural health care providers

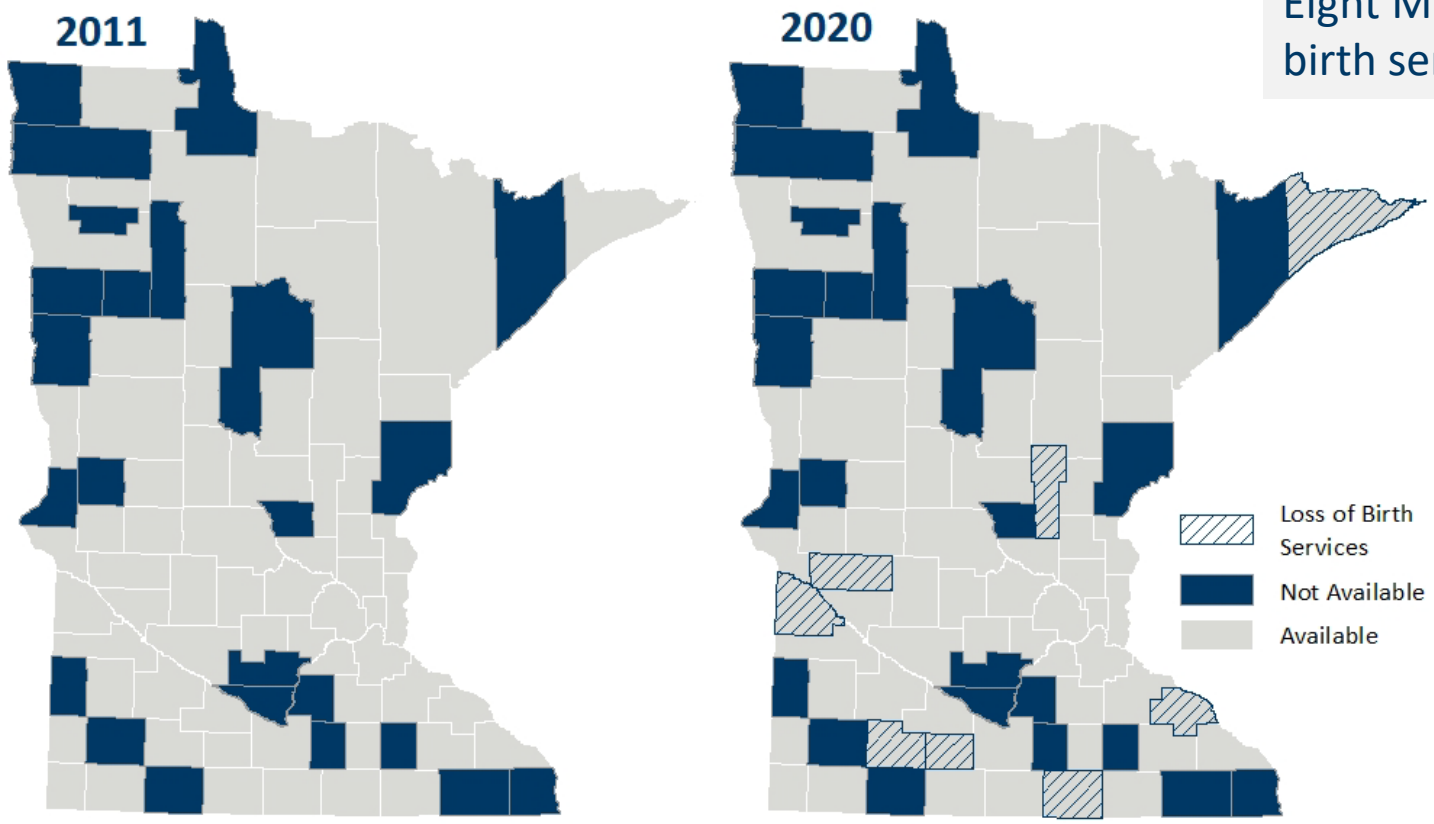


Very few licensed health care providers work in rural areas.

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, August 2021. Data includes: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Hospital birth services



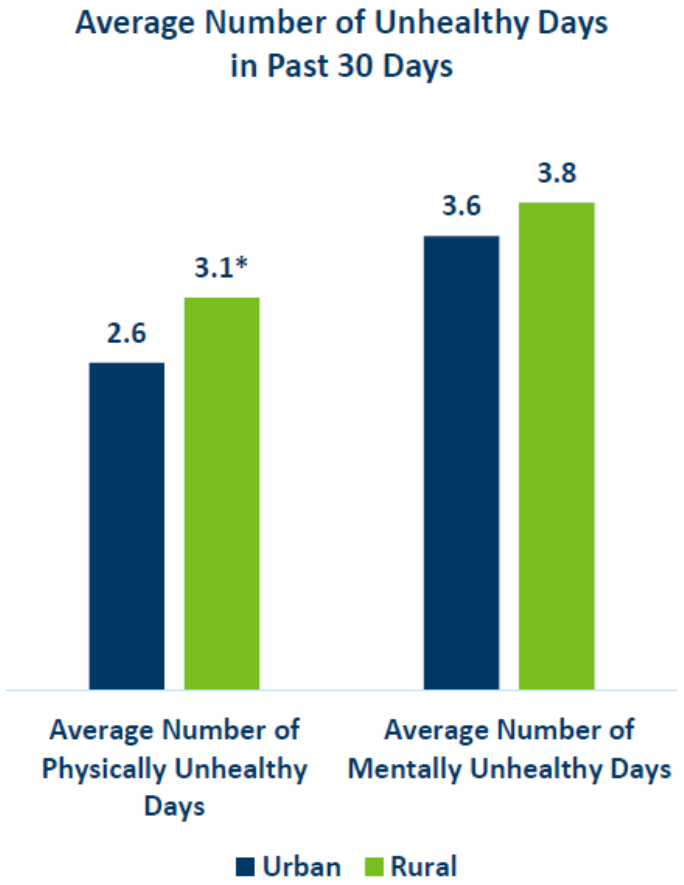
Eight Minnesota counties lost hospital birth services between 2011 and 2020

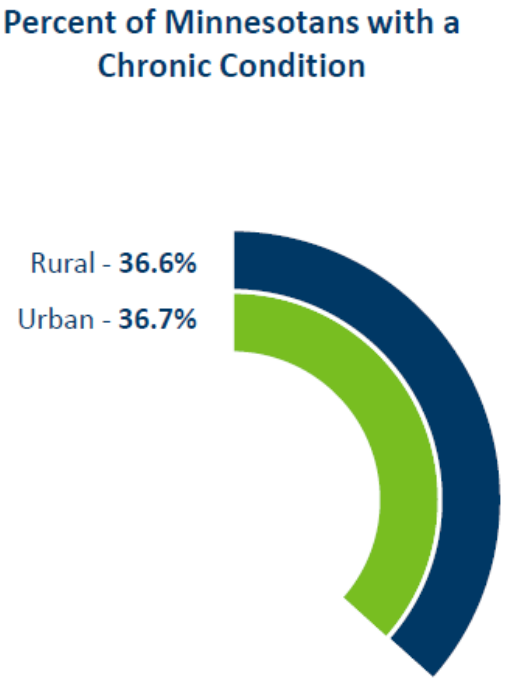
Increases in pre-term births have been associated with the loss of hospital birth services in rural areas.

Note: Due to a merger, the hospital in Mower County was no longer an independent licensed entity as of the end of 2014; however, birth services were offered at that site under the license of the remaining corporate entity. The other hospital of the merger, in Freeborn County, no longer has birth services.
Source: Minnesota Department of Health, Health Economics Program Analysis of hospital annual reports, September 2021; 2020 data is considered preliminary; U.S. Census Bureau (County Designations)
Definition: Community hospitals were categorized as not offering birth services if they did not have at least one routine birth and had no licensed bassinets or stated that services were not available.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Rural residents report more unhealthy days



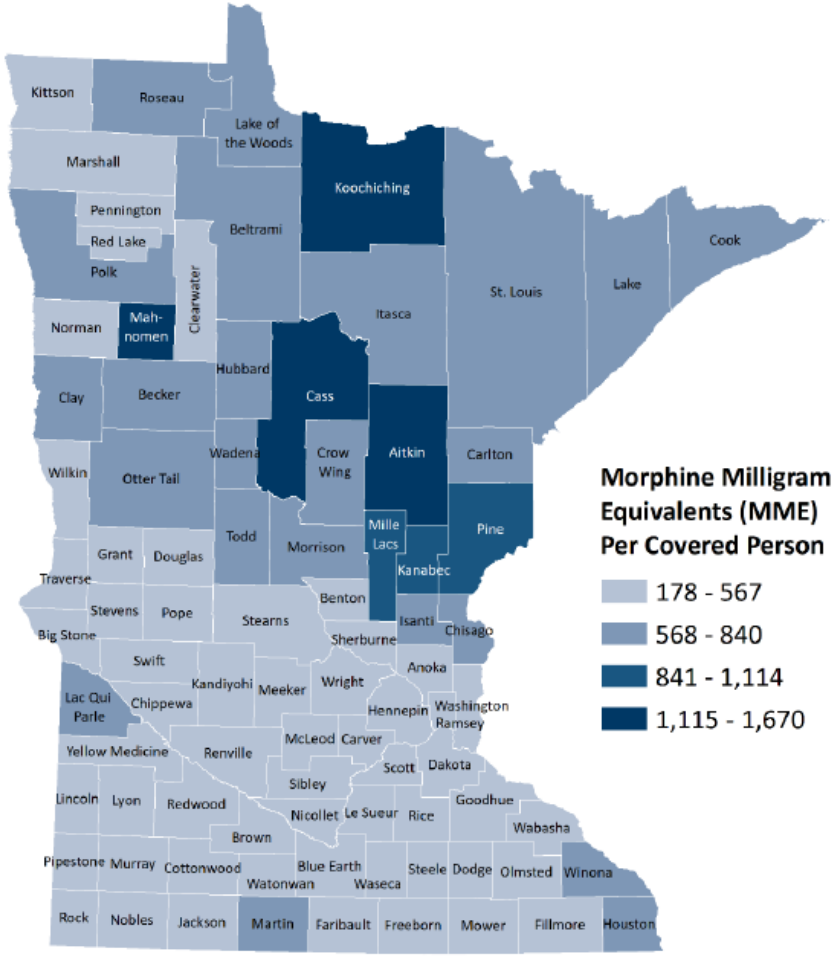


- Minnesotans living in rural areas reported frequent mental distress at about the same rate (12.4%) as those living in urban areas (10.4%).[1]
- Age-adjusted suicide rate in greater Minnesota (17.3) was higher than the 7-county metro area (12.2) for 2015-19.[2]

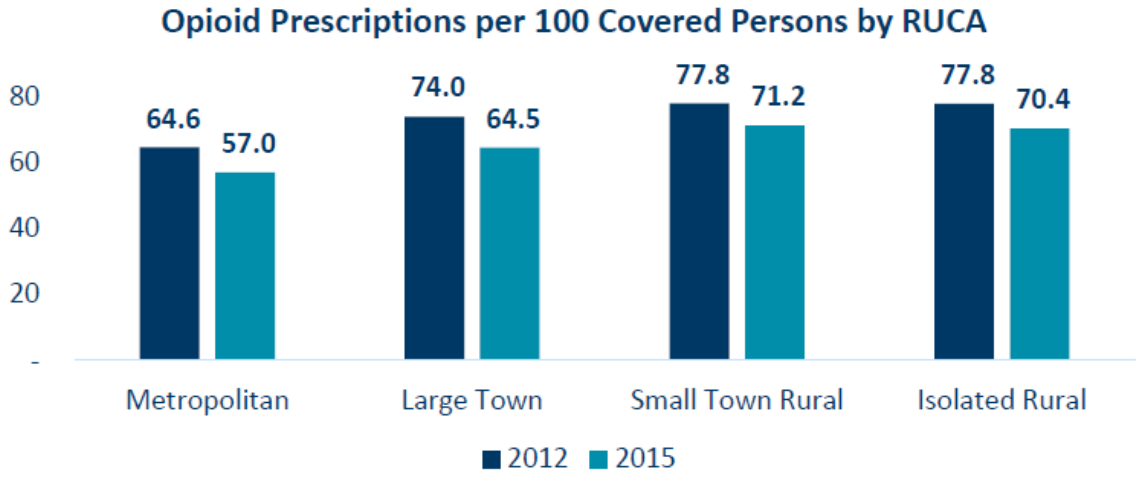
[1] Source: Minnesota Health Access Survey, 2019. Urban and Rural defined based on RUCA zip-code approximations. Difference was not statistically significant.
* Indicates significant difference from Urban at the 95% level.
[2] Source: 1999-2019: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death on CDC WONDER Online Database, released 2020.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Prescription Opioid Use



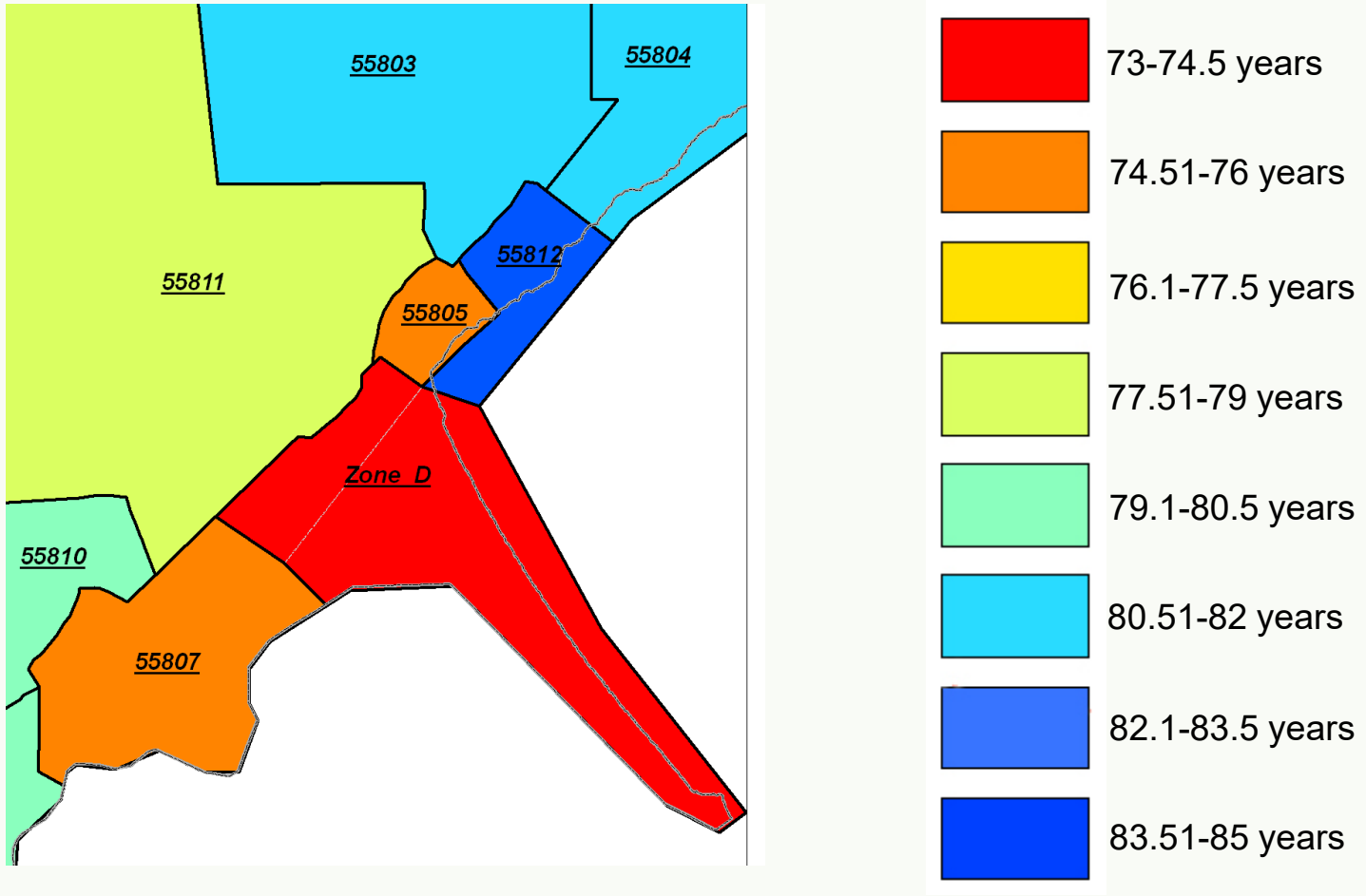
- Prescription opioid use has declined over time – but is still higher in rural areas.
- Some counties in Northern Minnesota have especially high rates of prescriptions.



Source: MDH Health Economics Program and Mathematica Policy Research "Patterns of Opioid Prescribing in Minnesota: 2012 and 2015," April 2018.
https://www.health.state.mn.us/data/economics/docs/opioidbrief20185.pdf

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

Life expectancy by ZIP code in Duluth



Source: St. Louis County Health Status Report, 2010

County health ranking results

St. Louis County

Health Outcomes 2021	Ranked 69 (out of 87)
Length of Life	72
Quality of Life	71

Health Factors	Ranked 45
Clinical Care	13
Physical Environment	69
Health Behaviors	47
Social & Economic Factors	48

Source: County Health Rankings & Roadmaps 2021

Listening Session 3: *Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas*

Ami B. Bhatt, MD, FACC
Chief Innovation Officer
American College of Cardiology
Associate Professor
Harvard Medical School

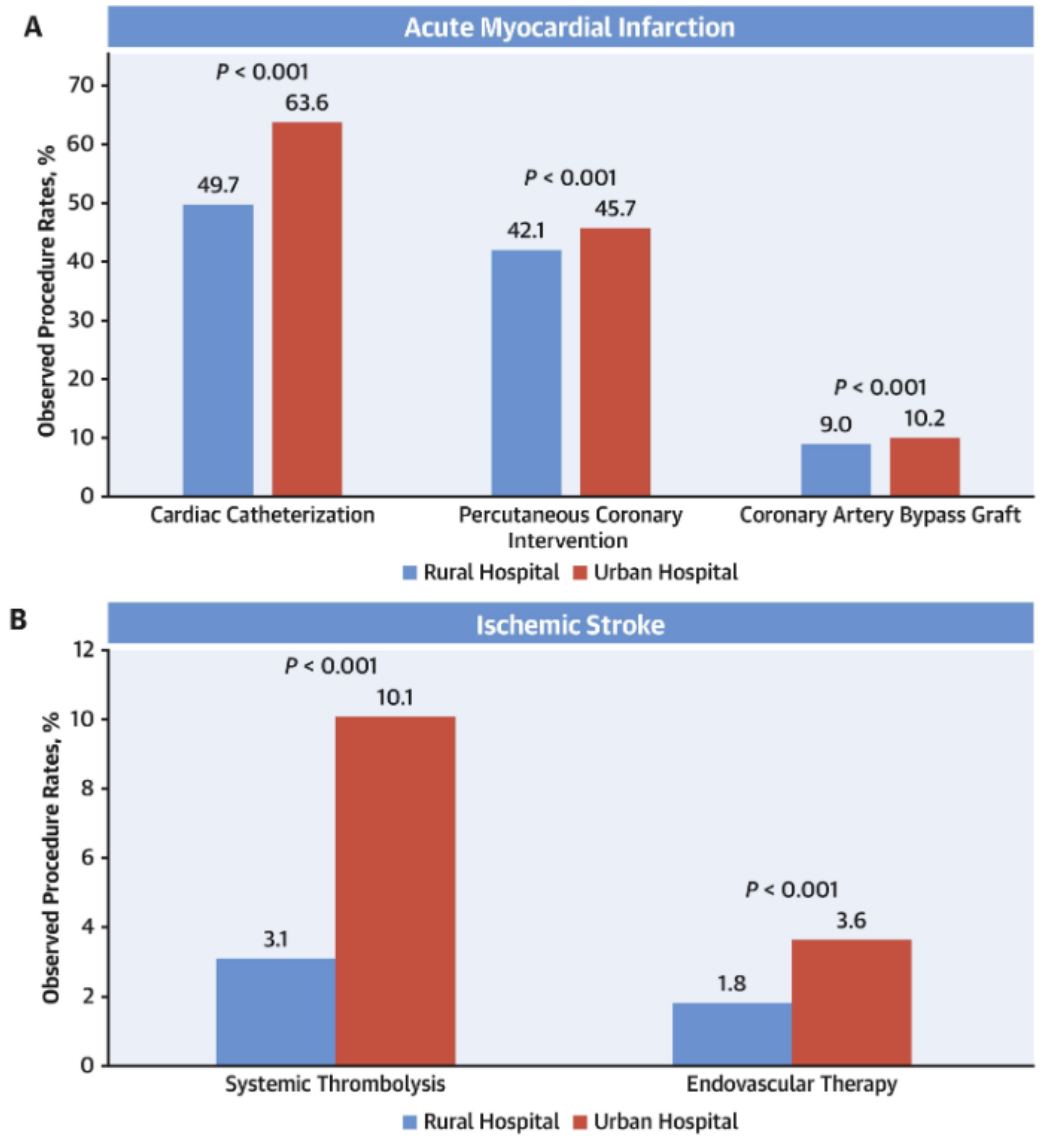
Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas

PTAC 9/2023

Ami B. Bhatt, MD, FACC
Chief Innovation Officer, American College of Cardiology
Associate Professor, Harvard Medical School

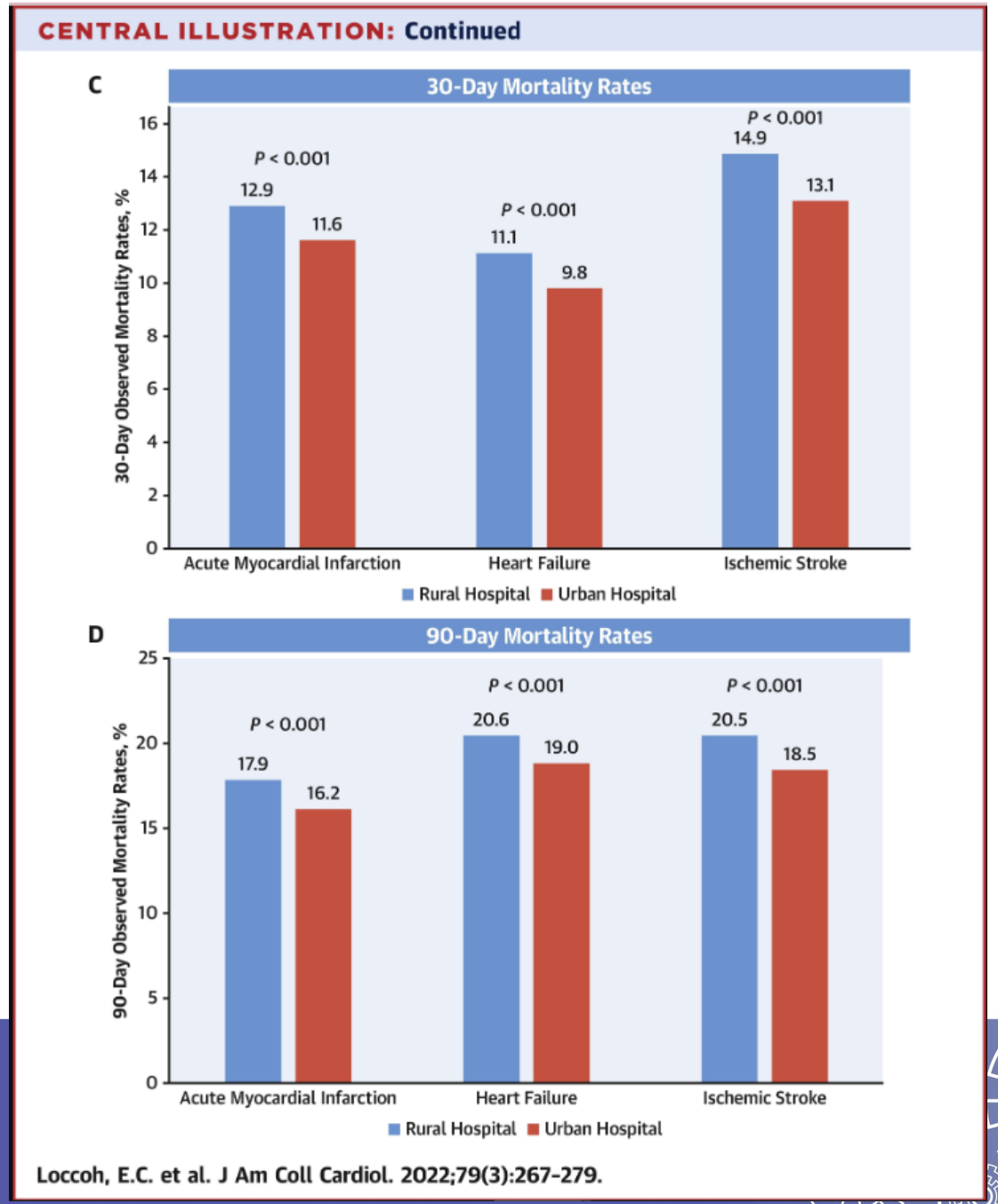
Procedure rates are lower in rural hospitals

CENTRAL ILLUSTRATION: Observed Procedure and Mortality Rates for Acute Cardiovascular Conditions at Rural Versus Urban Hospitals



Loccoh, E.C. et al. J Am Coll Cardiol. 2022;79(3):267-279.

Mortality rates are higher in rural hospitals



Loccoh, E.C. et al. J Am Coll Cardiol. 2022;79(3):267-279.

We must differentiate chronic from acute care

- Root cause is essential in improving critical access hospital outcomes
- Care delivery and availability of subspecialty and procedural care
  - Strengthen telehealth and transfer networks between rural and nonrural hospitals
- Time/distance, preferences for staying close to home
  - Implement home and community based rather than hospital-focused telehealth and quality improvement efforts
- Medicare Advantage notes differences in preventive vs acute care

Building the Rural CV Care Infrastructure

- Rural-Oriented Design: expansion of the team
- Disease based closed loop programs (Atrial Fibrillation, Heart Failure, Hypertension)
- Rural Relevant Care Delivery Systems: unique blend of community, tele, and practice
- Utilize high impact, low complexity digital health to increase access

Cardiovascular Rural Health Advantages

Patient volume in rural health (lower in general, however CV risk factors and disease prevalent)

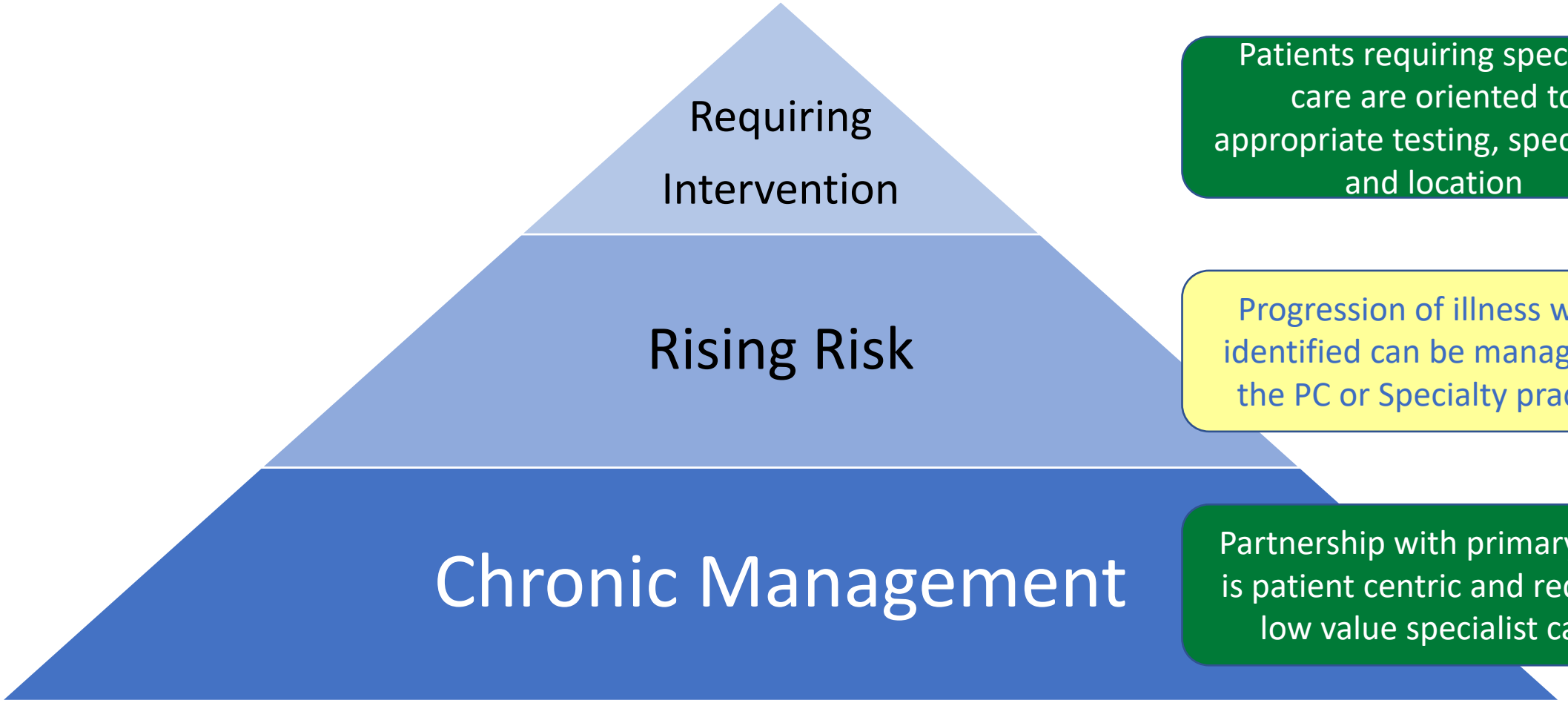
Human and financial resource-limited, where CV remote monitoring serves as a force multiplier

Link compensation to non-cost saving metrics (i.e. % achievement GDMT*) in the near term

Incentivize team-based care and innovative local community health roles

*Guideline-directed medical therapy

Rural Health Fits the Digital Health Paradigm



Patients requiring specialty care are oriented to appropriate testing, specialists and location

Progression of illness when identified can be managed at the PC or Specialty practice

Partnership with primary care is patient centric and reduces low value specialist care

Engaging the patients is essential

- Revise local education to address rural team caregivers and patients
- Use Blended Care: In-person and Virtual synchronous visits (phone or video)
- Realize patient potential by making digital interfaces easy to engage with for self-monitoring
- Analyze rural needs to match them with the interventions that are offered
- Lead registries and trials via patient initiation, by having them drive the process

Thank you

AMERICAN COLLEGE of CARDIOLOGY

The ACC Vision

A world where **innovation** and **knowledge** optimize cardiovascular care and outcomes.

Listening Session 3: *Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas*

Thad Shunkwiler, LMFT, LPCC
Associate Professor, Department of Health Science Director
Center for Rural Behavioral Health
College of Allied Health and Nursing
Minnesota State University, Mankato

Rural Behavioral Health

Challenges, Opportunities and the Path Forward

Thad Shunkwiler, LMFT, LPCC, ACS, CCMHC, NCC

Associate Professor- Department of Health Science

Director- Center for Rural Behavioral Health

MINNESOTA STATE UNIVERSITY, MANKATO

CENTER FOR RURAL BEHAVIORAL HEALTH

COLLEGE OF ALLIED HEALTH & NURSING

MINNESOTA STATE UNIVERSITY MANKATO

Challenges

90% of US adults say the United States is experiencing a mental health crisis, CNN/KFF poll finds

By Deidre McPhillips, CNN

Updated 11:17 AM EDT, Wed October 5, 2022

Farmers confront a mental health crisis

What is driving the high suicide rate among farmers?

DEC 9, 2022 2:45 PM | BY SHARITA FORREST | RESEARCH EDITOR | 217-244-1072 | AGRICULTURE

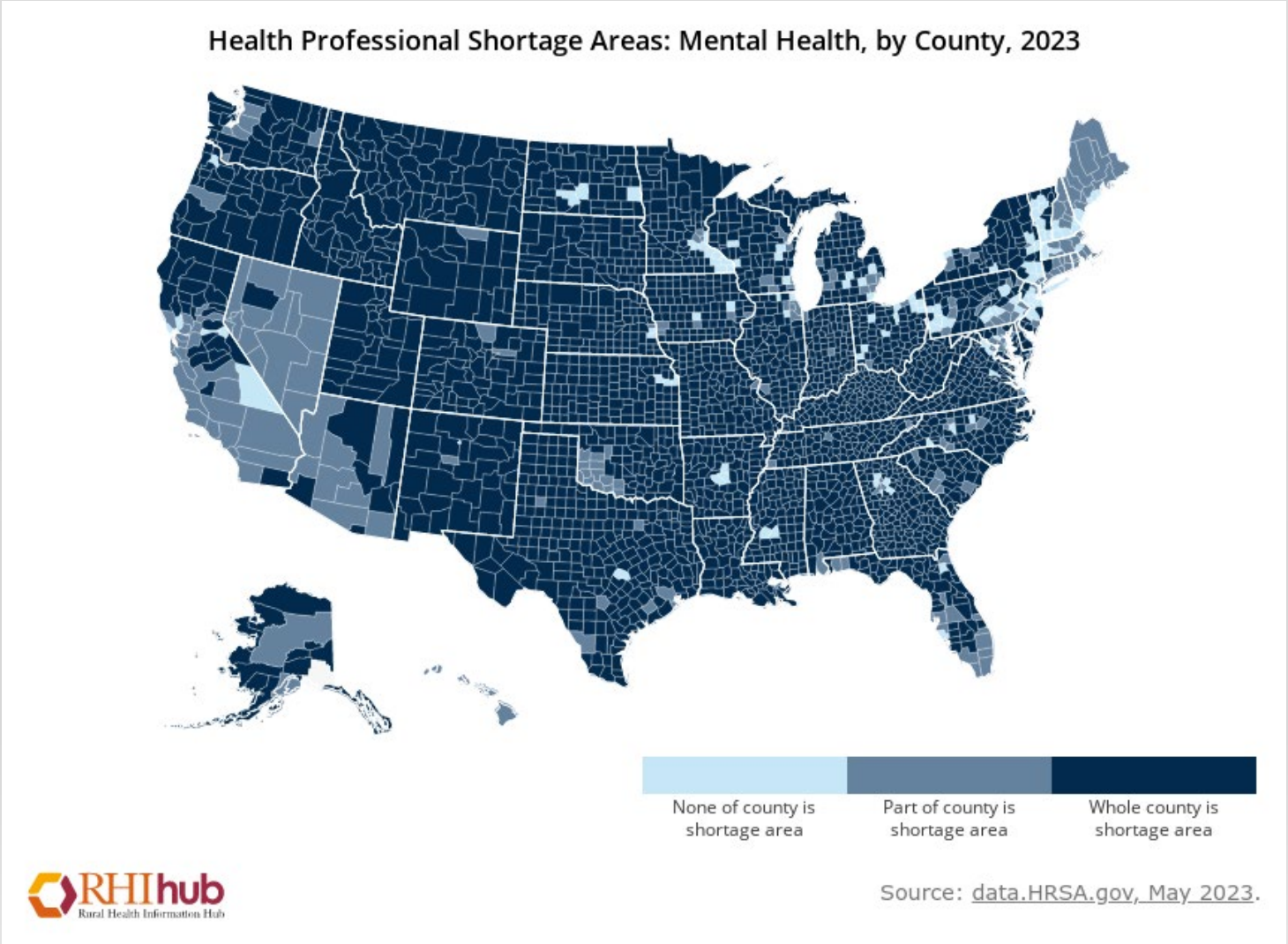
Rural America is in mental health crisis

Drug overdose deaths top 100,000 annually for the first time, driven by fentanyl, CDC data show

By Deidre McPhillips, CNN

Challenges

The "*Treatment Gap*" is not geographically equitable



Challenges: *It's Getting Worse*

- **Increasing demand for services**

HEALTH ›

Overflowing demand for mental health care stretching hospitals, new data shows

New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society

- **Provider exodus**
  - **Retirement**
  - **Burnout**

Burned-out mental health treatment and substance use care professionals call on lawmakers to act

Practitioners are overworked and burned out, and they need our support

Future projections according to HRSA

	2017 projections		2030 projections		
Occupation	**Supply**	**Demand**	**Supply**	**Demand**	**Adequacy of supply projection (percentage)**
Adult psychiatry	33,650	38,410	27,020	39,550	68
Addiction counselors	91,340	91,340	93,880	105,410	89
Child psychiatry	8,090	9,240	9,830	9,190	107
Marriage and family therapists	53,080	53,080	72,650	57,970	125
Mental health counselors	140,760	140,760	164,320	158,850	103
Psychiatric nurse practitioners	10,450	10,450	16,900	12,050	140
Psychiatric physician assistants	1,550	1,550	2,890	1,670	173
Psychologists	91,440	91,440	103,440	95,600	108
School counselors	116,080	116,080	218,130	119,140	183
Social workers	239,410	239,410	513,370	268,750	191

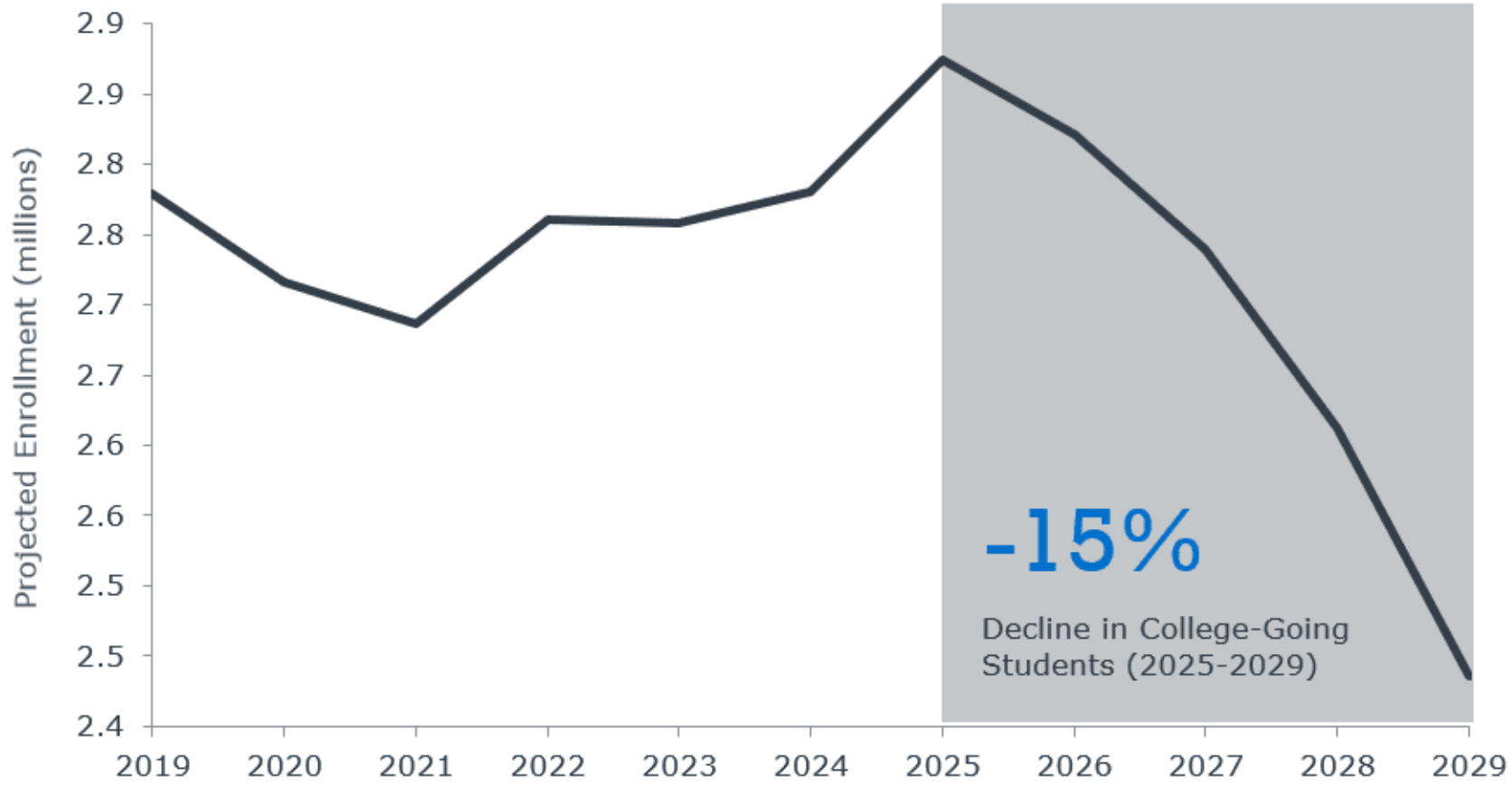
Source: Department of Health and Human Services, Health Resources and Services Administration's 2020 projection report, "2017-2030 Behavioral Health Workforce Projections." | GAO-23-105250

Provider Pipeline

U.S. Department of Education

Enrollment Projected to Drop Sharply After 2025

Forecasted Number of College-Going Students in the U.S. (millions), by Year of High School Graduation



Solving the issue: *Recruit*

What are the barriers to ***recruiting*** providers to rural areas?

- Financial
  - **Issue*:** Student loan debt
  - **Solution:** Enhance scholarship/grant programs
- Educational
  - **Issue*:** Academic pipeline issues
  - **Solution:** Direct recruiting from rural areas and increase training capacity of rural institutions
- Workplace
  - **Issue*:** Not enough approved clinical supervisors
  - **Solution:** Develop more supervisors, particularly ones who serve rural areas

***US Government Accountability Office- Congressionally Requested Behavioral Health Workforce Report, October 2022**

Solving the issue: ***Retain***

What are the barriers to ***retaining*** providers to rural areas?

- Financial
  - **Issue*:** Low reimbursement rates
  - **Solution:** Enforce parity in reimbursement and/or alternative payment models
- Educational
  - **Issue*:** Continuing education requirements
  - **Solution:** Develop accessible high-quality CME trainings
- Workplace
  - **Issue*:** Provider burnout
  - **Solution:** Shift from a "*self-care*" model to a "*system-care*" model

***US Government Accountability Office- Congressionally Requested Behavioral Health Workforce Report, October 2022**

Opportunities: *Data Driven Policy Solutions*

- Build workforce capacity
  - Professional and para-professional
  - Rural *and* urban
- Expand APMs that improve access and deliver better care
- Prioritize upstream intervention
- Decrease demand through prevention

Opportunities:

MINNESOTA STATE UNIVERSITY, MANKATO

CENTER FOR RURAL BEHAVIORAL HEALTH

The Center for Rural Behavioral Health is dedicated to *improving access* to behavioral healthcare for residents in outstate Minnesota to include recognized Reservations through research, workforce development, and continuing education.

Listening Session 3: *Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas*

Susan E. Stone, DNSc, CNM
President
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Social Determinants of Health and Effects on Rural Health

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September 19, 2023

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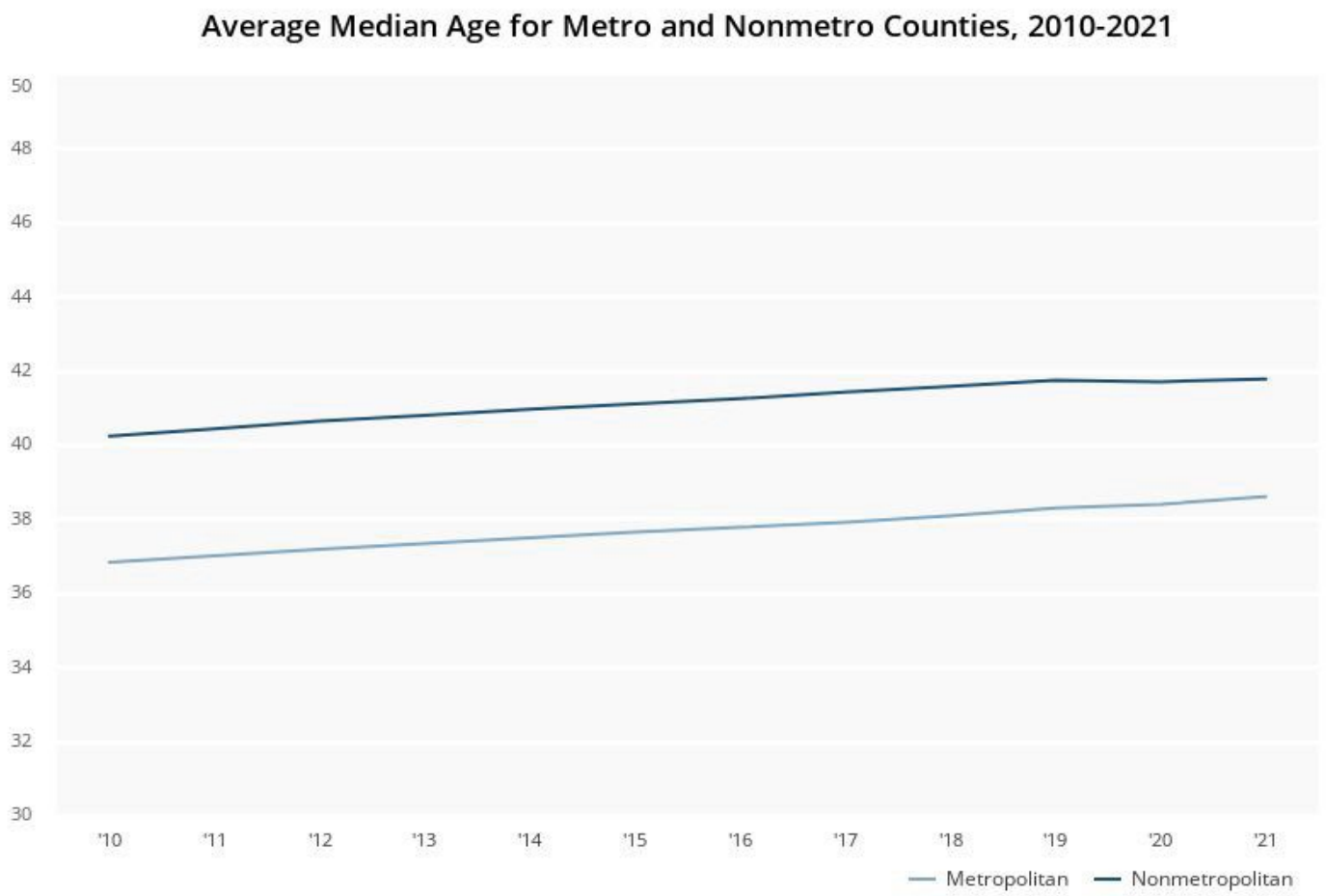
Social Determinants of Health for Rural People

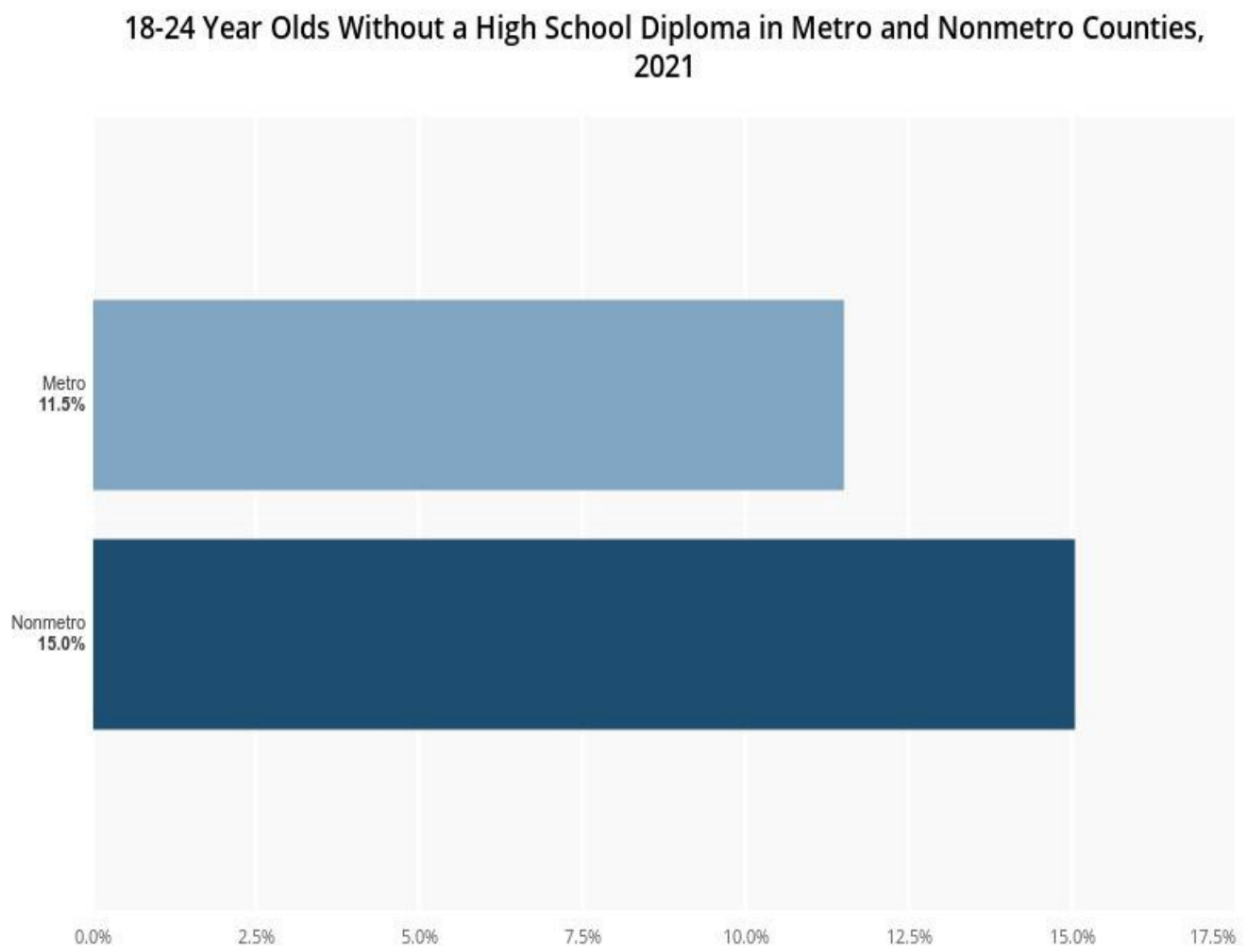
- What are the Social Determinants of Health?
- “The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” Healthy People 2030.
- Rural persons are more likely to experience contributing social factors that negatively impact health. These can include poverty, lack of literacy including health literacy, access to safe and affordable transportation, access to safe homes, environmental health such as water quality, access to healthy and affordable food, and access to healthcare services.
- CDC reports that maternal deaths nearly doubled over three years, with over 1,200 deaths in 2021. Rural communities, where maternal mortality is almost double urban rates, struggle to access lifesaving maternal healthcare.

Average Median Age



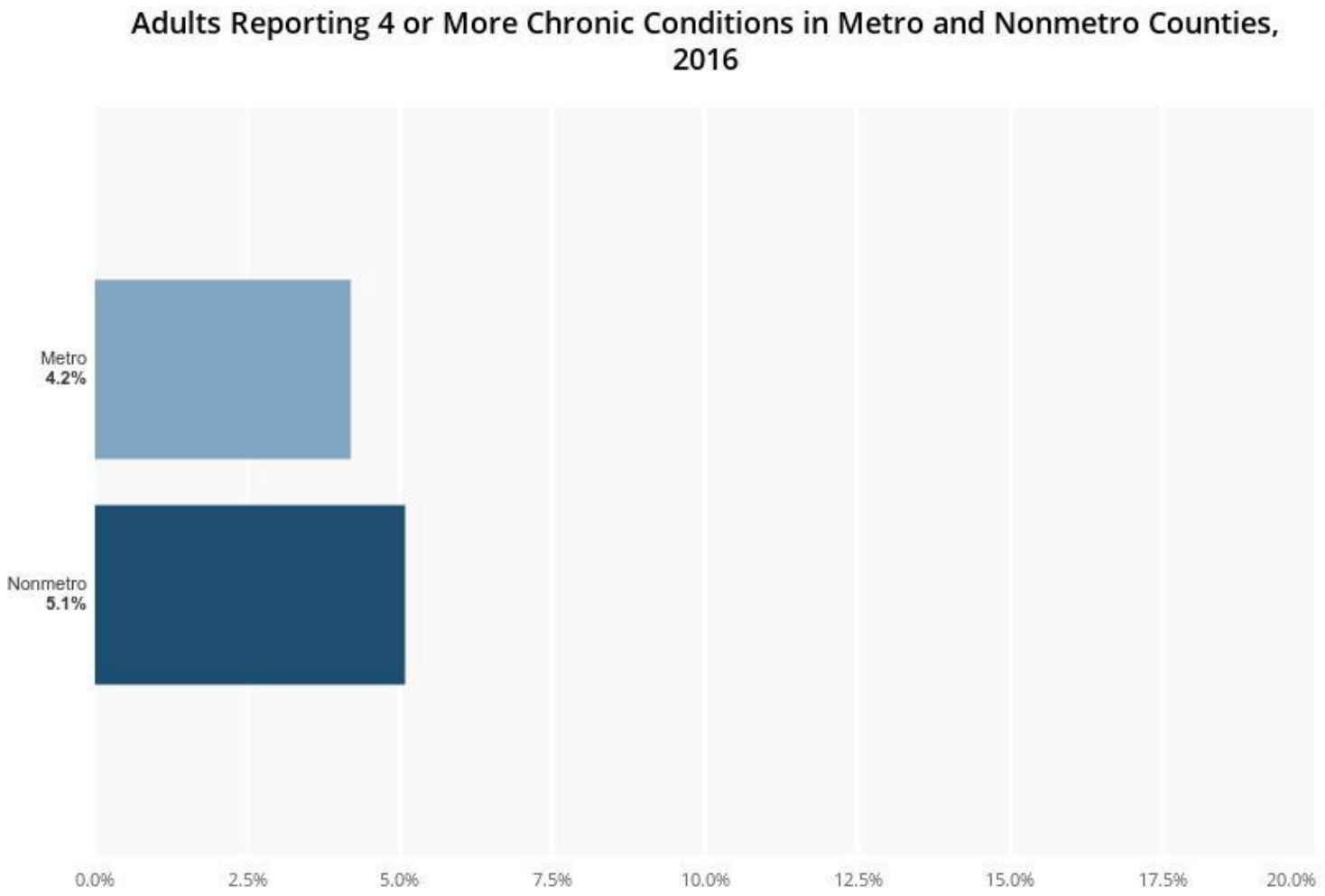
Source: US Census Population and Housing Unit Estimates, 2010-2021.

18-24 Year Olds Without a High School Diploma



Source: U.S. Census ACS, 2010, 2016, and 2021 5-year estimates.

Adults Reporting 4 or More Chronic Conditions



RHIhub Rural Health Information Hub

Source: Health, United States, 2017 — National Center for Health Statistics.

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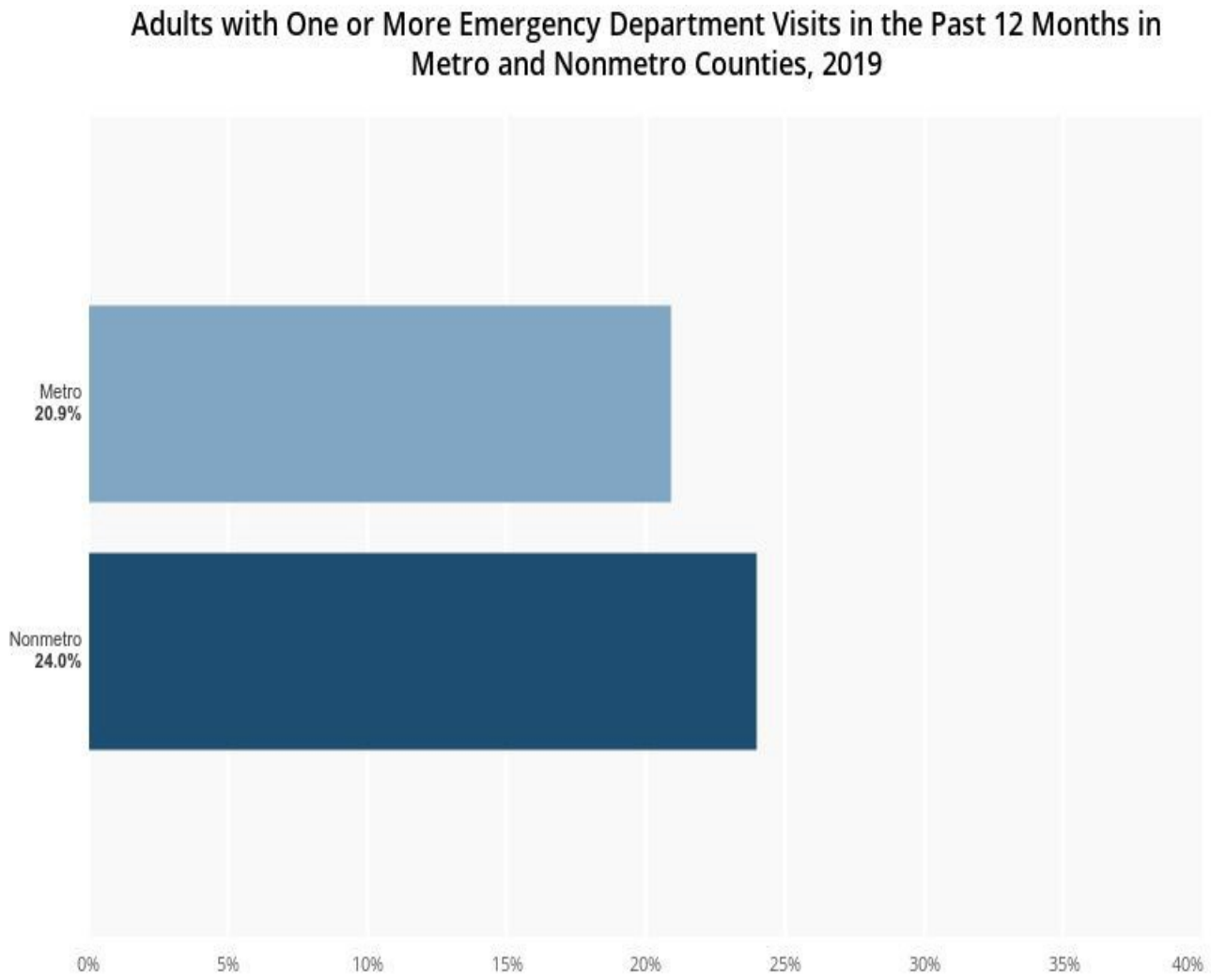
Adults with One or More Emergency Dept Visits in the Past 12 months



RHIhub Rural Health Information Hub

Source: Health, United States, 2020 — National Center for Health Statistics.

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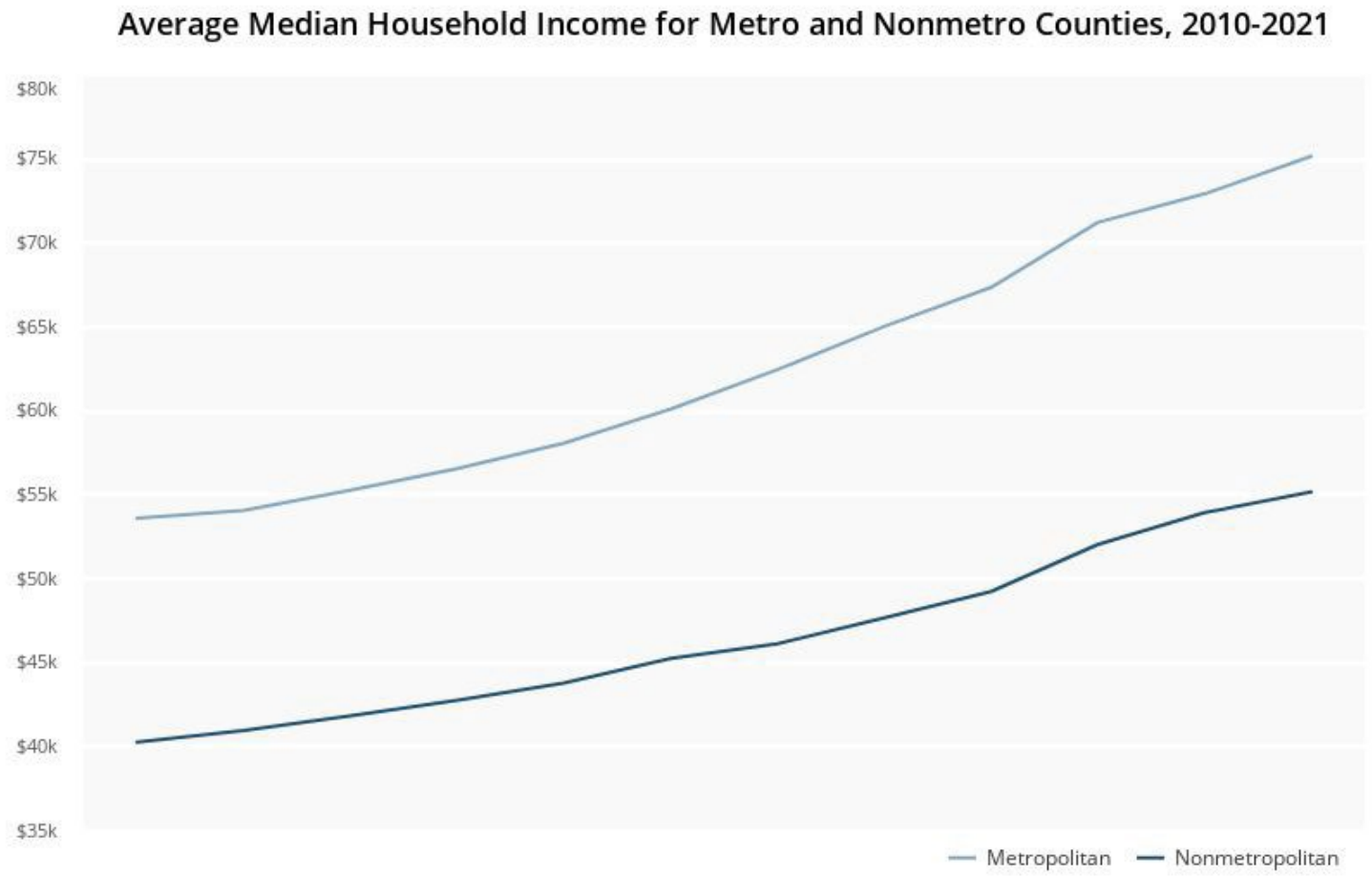
Average Median Household Income for Metro and Nonmetro Counties



RHIhub Rural Health Information Hub

Note: Metro and nonmetro averages are calculated by weighting county median household income by ACS 5-year estimates of total households.
Source: US Census Small Area Income and Poverty Estimates, 2010-2021.

Strategies to Address the Social Determinants of Health - CDC 2021

SDOH Impact on Different Kinds of Rural Areas

- Census bureau states that if it is not urban, it's rural.
- The National Rural Health Association strongly recommends that definitions of rural be specific to the purposes of the programs in which they are used and that these are referred to as programmatic designations and not as definitions. (https://www.ruralhealth.us/about-nrha/about-rural-health-care)
- The bottom line is that not all rural areas or communities have the same challenges. It is important to do a community assessment to identify the major issues when designing programs for rural communities.

How are Social Needs Currently Addressed by Providers? Opportunities for Improvement.

Many strategies are in place. Examples include:

- Comprehensive asthma home assessments and education.
- Some FQHCs provide legal assistance related to housing, immigration and financial security,
- Creating web based systems that identify community resources, referrals made to those resources and outcomes of the referral.
- Offering telehealth services when appropriate.
- Hiring community health workers to assist with patient contacts, education and facilitating partnerships and referrals to community organizations.

Promising Models that Improve Outcomes for Rural Patients

- Creating technology systems that allow health care providers to screen for social needs and identify resources in their communities.
- Connecting these systems to the medical record would allow tracking of outcomes and better coordination. This would also help us to determine what works. Important to grow the evidence.
- The Medicare Shared Savings Program “Pathways to Success” allows the organization of Accountable Care Organizations. The outcomes to date have showed comparable or better health outcomes with decreased costs with the ACO compared to traditional physician fee for service practices.
- Partnering with doulas to give information and support to pregnant women.
- Recruiting nurse-midwives to provide first-line comprehensive maternity care that addresses the SDOH.
- Scholarships for graduate nursing education using their community as their classroom through distance learning mechanisms that allow the nurse remain in their community during their graduate education.
- Community concordant care.

Promising Models that Have Been Implemented and Sustained

- The hub and spoke model where larger hospitals partner with smaller hospitals at risk of closure. Similar models in which hospitals either develop clinics in places where they are most needed or partner with existing clinics staffed by nurse practitioners or nurse-midwives. These clinics can effectively bring primary health care closer to those who need it and using the larger hospital center for more serious medical needs.

- Examples:
  - Willis-Knighton Health System - Desoto General Hospital - TX
  - Bassett Healthcare - 13 rural health clinics and 3 rural hospitals - NY
  - Appalachian Regional Healthcare - Mary Breckinridge ARH Hospital - KY

How Can Alternative Payment Models Support Patient Centered, Multidisciplinary Care in Rural Areas?

- An Alternative Payment Model can allow providers to build a team and to relax and not feel as if you must see XX patients per hour. Fee for Service can incentivize a provider to see more patients with a decrease in time spent with each patient. This does not allow for that extra time needed to address the SDOH. FFS can also breed competition between providers to see more patients.

- If an APM is thoughtfully developed with provider input, the result can be a system that facilitates team based care, innovations in methods to deliver health care and collaboration with APRNs, PAs and other allied health professionals.

Disproportionate Impact of SDOH and Behavioral Health Needs of Rural Populations Related to Related to Performance Measurement

- Important to assure we are measuring quality of care and not seeing the result of one group of patients being sicker which can be reflected in their outcomes.

- Traditional risk adjustment focuses on medical complexity; example is the Hierarchical Condition Category (HCC) scores. We need to add to the assessment a social risk factor adjustment. For example, we could measure differences in smoking, history of drug use, education, income, employment, social support and community resources.

- We need to operationalize social risk factor assessment so that it compares clinician performance and patient outcomes attributable to differences in quality of care. Milbank, 2021.

What Measures are Needed to Evaluate Rural Quality of Care

- The heterogeneity of rural areas has particular implications for healthcare performance measurement. Variations in geography, population density, availability of healthcare services and other factors make modifications for different areas necessary. There is also the possibility of not having enough patients to have a valid result.

- The National Quality Forum published “A Core Set of Rural Relevant Measures and Measuring and Improving Access to Care: 2018 Recommendations from the MAP Rural Health Workgroup” which is extremely helpful in identifying rural measures of quality of care.

- Additionally, the NQF recently published the “2022 Key Rural Measures: An updated List of Measures to Advance Rural Health Priorities”.