Physician-Focused Payment Model Technical Advisory Committee

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

Physician-Focused Payment Model Technical Advisory Committee

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

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

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Project Director
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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)

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
Knudson-alana@norc.org

⟡ Research You Can Trust™

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!*

ruralhealthinfo.org

RHIhub
Rural Health Information Hub

https://www.ruralhealthinfo.org/am-i-rural
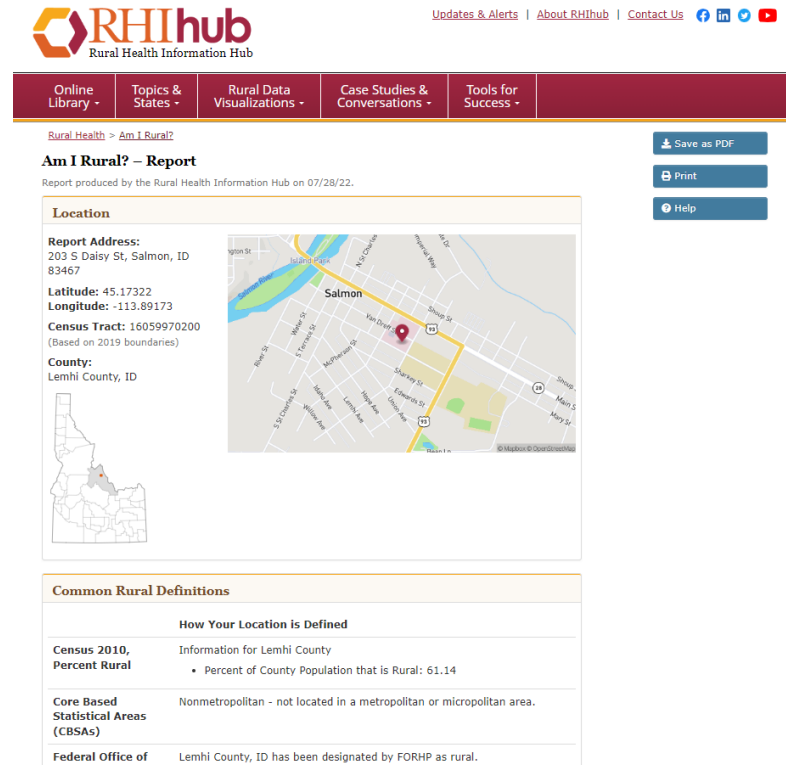
Search exact address, town/city, ZIP code, or county

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 Research Gateway

WEBINAR

Availability of Post-acute Care and Long-term Care Services in Rural Areas

September 14, 2021
10:00 AM/PST | 11:00 AM/MST
12:00 PM/CST | 1:00 PM/EST

rupri — RURAL POLICY RESEARCH INSTITUTE

Rural Health Research Gateway

Learn More About Upcoming Webinar

Rural Health Research Gateway

The Rural Health Research Gateway provides easy and timely access to research conducted by the Rural Health Research Centers, funded by the Federal Office of Rural Health Policy. Gateway efficiently puts new findings and information in the hands of our subscribers, including policymakers, educators, public health employees, hospital staff, and more.

- Gateway flyer
- Popular rural health products and topics, 2020-2021
- Learn more

Rural Health Research Recaps
- Access brief summaries on key rural health issues
- Key findings from the work of the Rural Health Research Centers
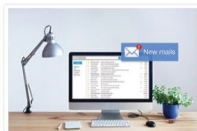
Research Alerts
- Email notifications when new research products are completed
- See five most recent alerts

Research Publications
- Access policy briefs, chartbooks, journal articles, and other products developed under the Centers' Research Projects

Research Centers
- Learn about the Rural Health Research Centers Program
- View list of currently funded research centers
- Learn about their areas of expertise

Dissemination Toolkit
- Learn how to create health research products
- Tips for developing policy briefs, fact sheets, journal articles and more

Email: info@ruralhealthresearch.org

RURAL HEALTH EQUITY RESEARCH CENTER

Listening Session 2: *Incentives for Increasing Rural Providers' Participation in Population-Based Models*
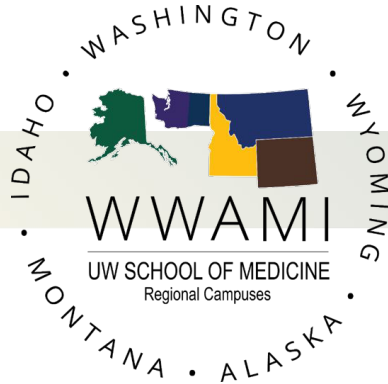
Tom X. Lee, MD, MBA

Chief Executive Officer

Galileo

galileo

Encouraging Rural Participation in Population-Based TCOC Models
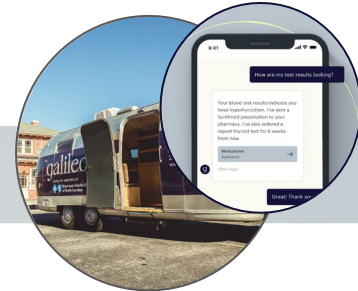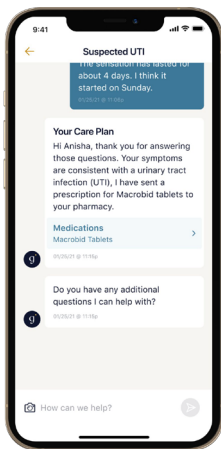
Thomas Lee MD
Founder & CEO, Galileo

Sept 19, 2023

Background

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.

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Infrastructure-Related Challenges

Connectivity

Labor & Time Matching

Skills Matching

Facility Capabilities

Payment Alignment

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Infrastructure-Related Challenges

Connectivity

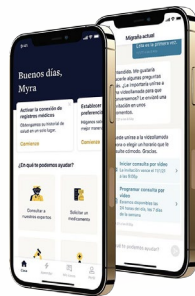Labor & Time Matching

Skills Matching

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Infrastructure-Related Challenges

Connectivity

Labor & Time Matching

Skills Matching

galileo

Infrastructure-Related Challenges
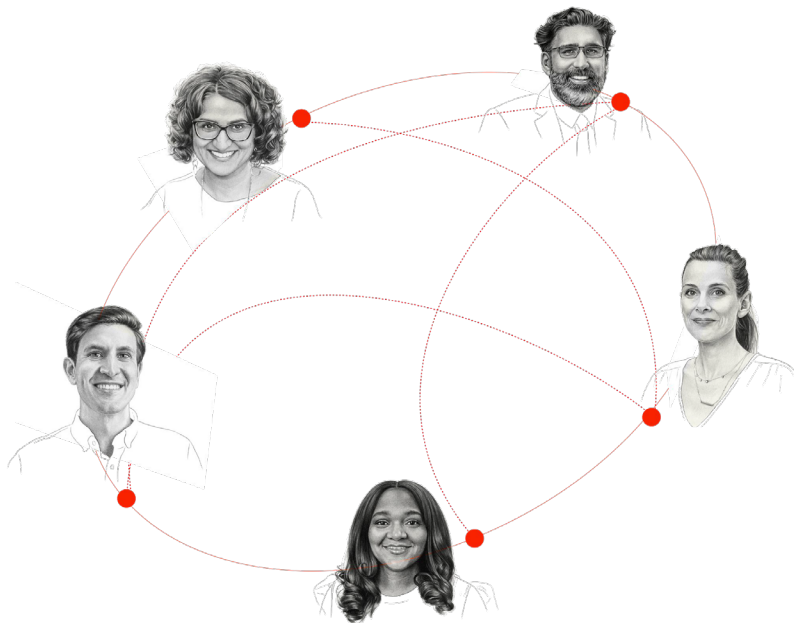
Connectivity

Labor & Time Matching

Skills Matching

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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

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Discussion

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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
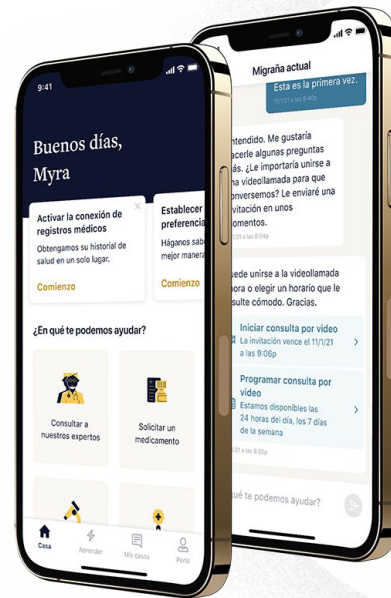In-network & point solution referrals

Population Health
Care Management, Quality + HEDIS Initiatives, Care Transitions, Hotspotting

Impact
<10% referral rate
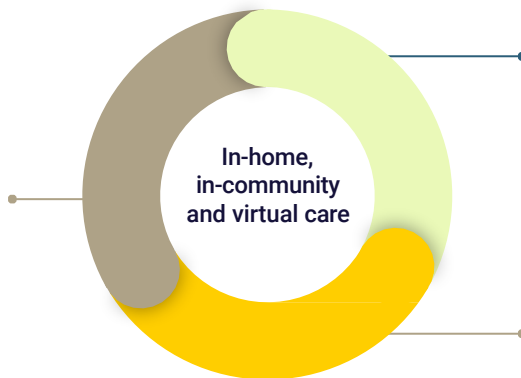46% fewer specialty visits
11%+ cost savings

galileo

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

In-home, in-community and virtual care

Clinical Intelligence Platform

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

galileo

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
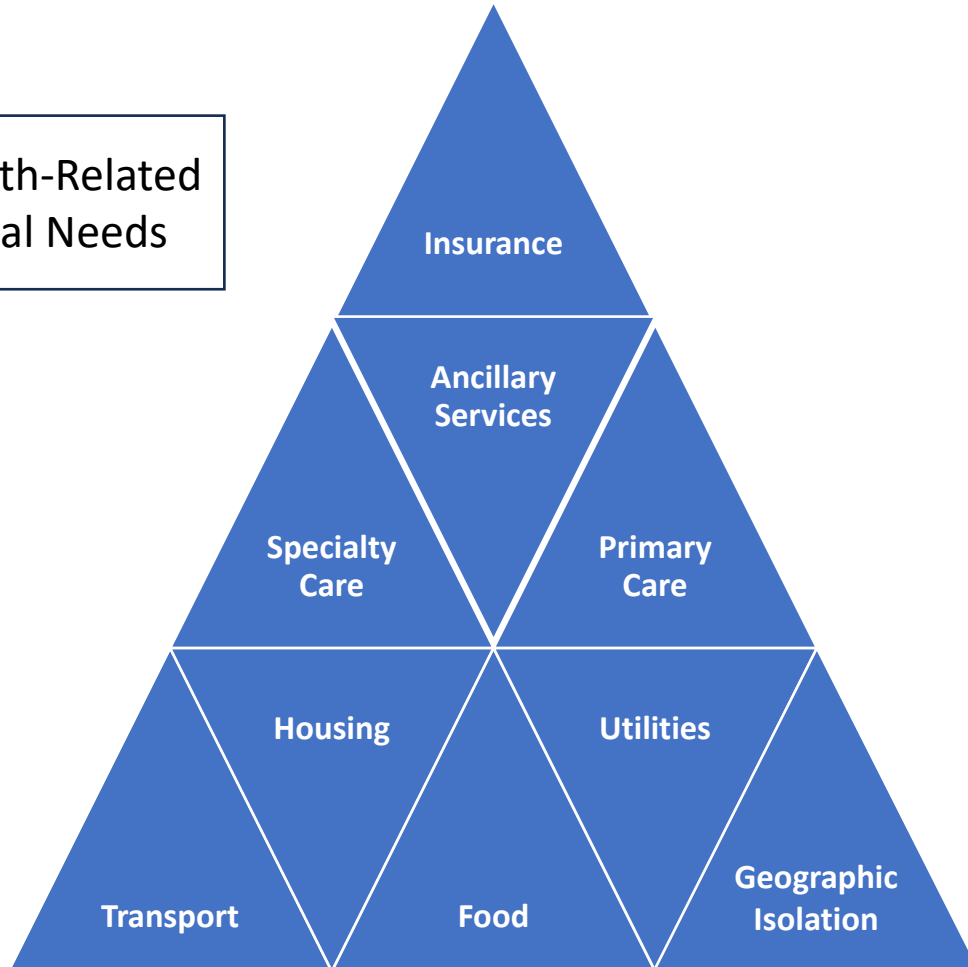
First level:

- **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

4

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

Equitable
Access to Care

Equitable
Care Delivery

Equitable
Transitions and Continuity

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
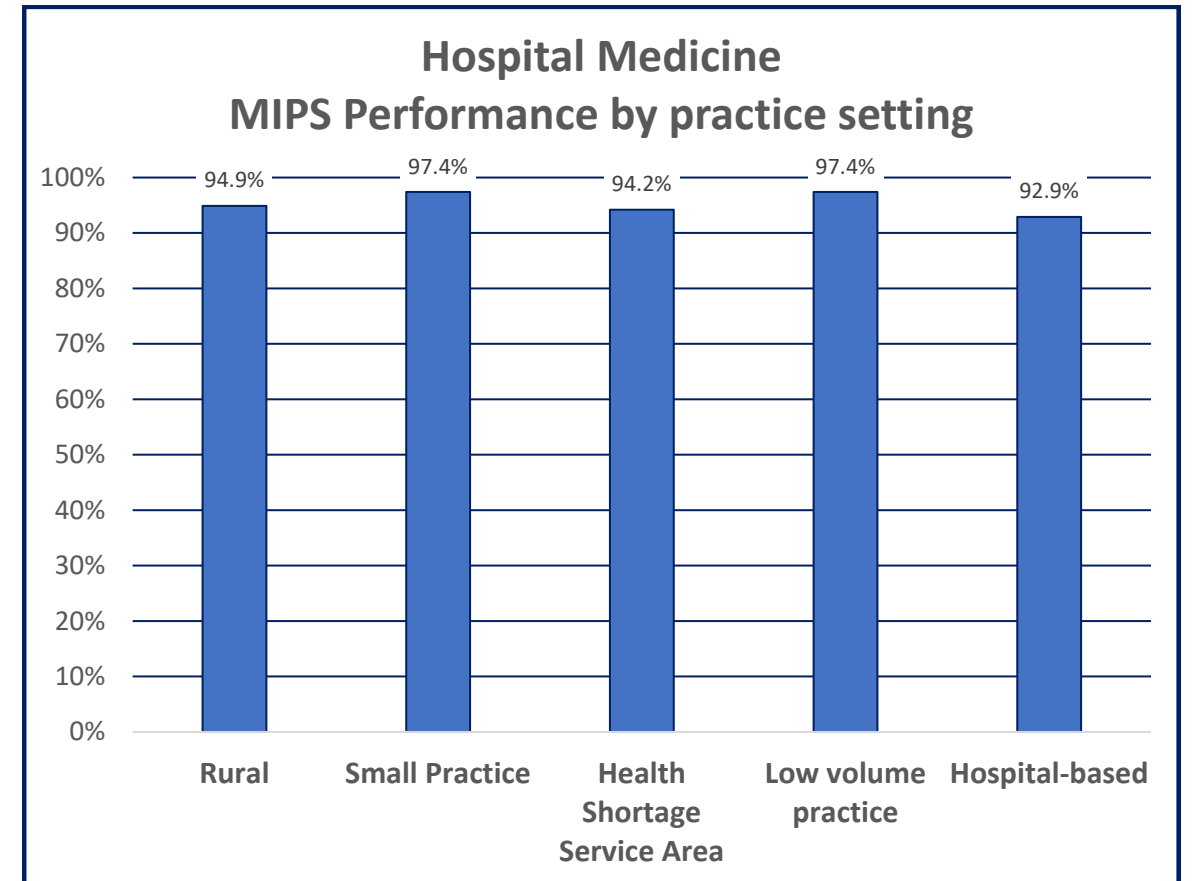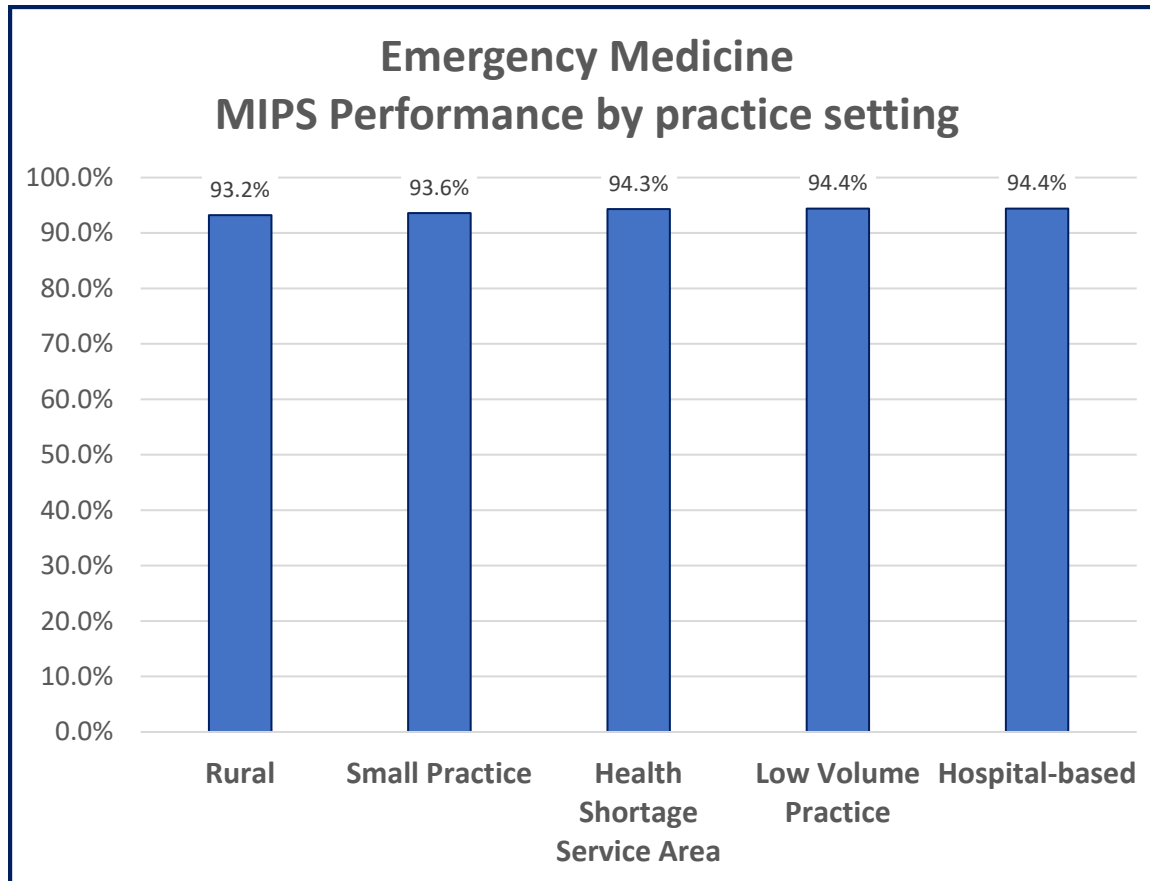
Current and Previous Models

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

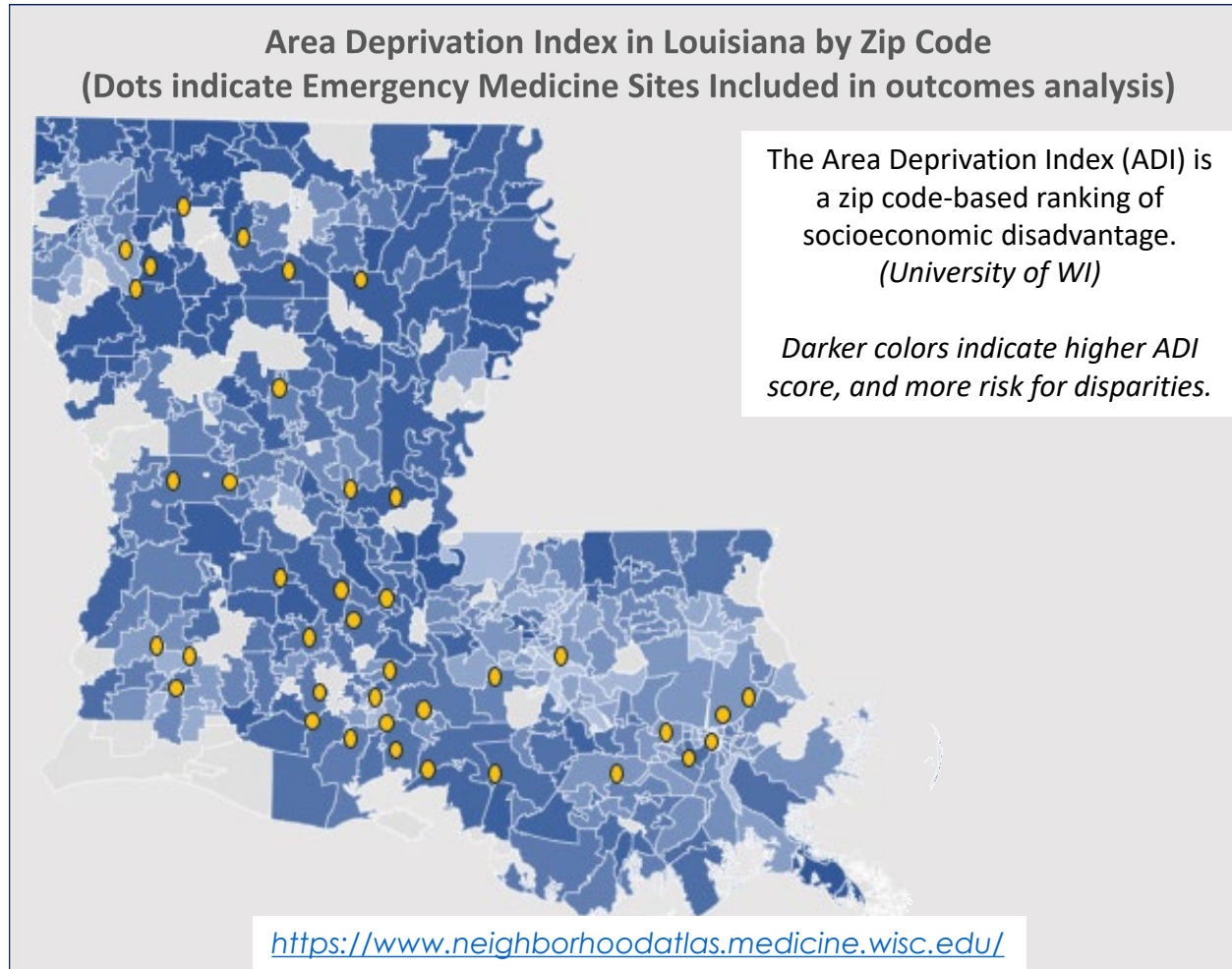## Emergency physician partnerships with health plans

- 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

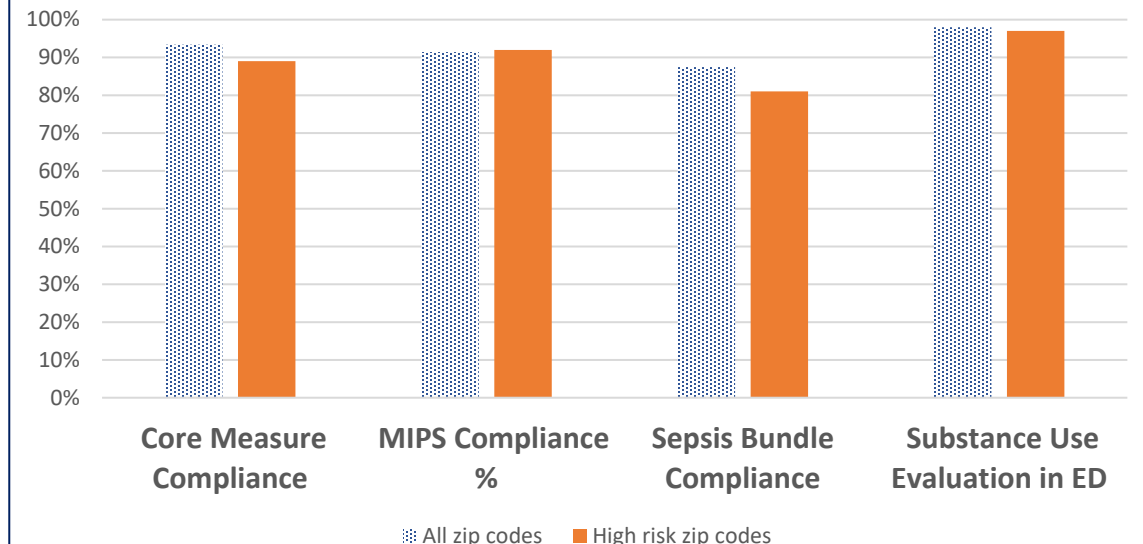# Hospital-based clinical services provide equitable care in various settings

Emergency Medicine
MIPS Performance by practice setting

Hospital Medicine
MIPS Performance by practice setting

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)*

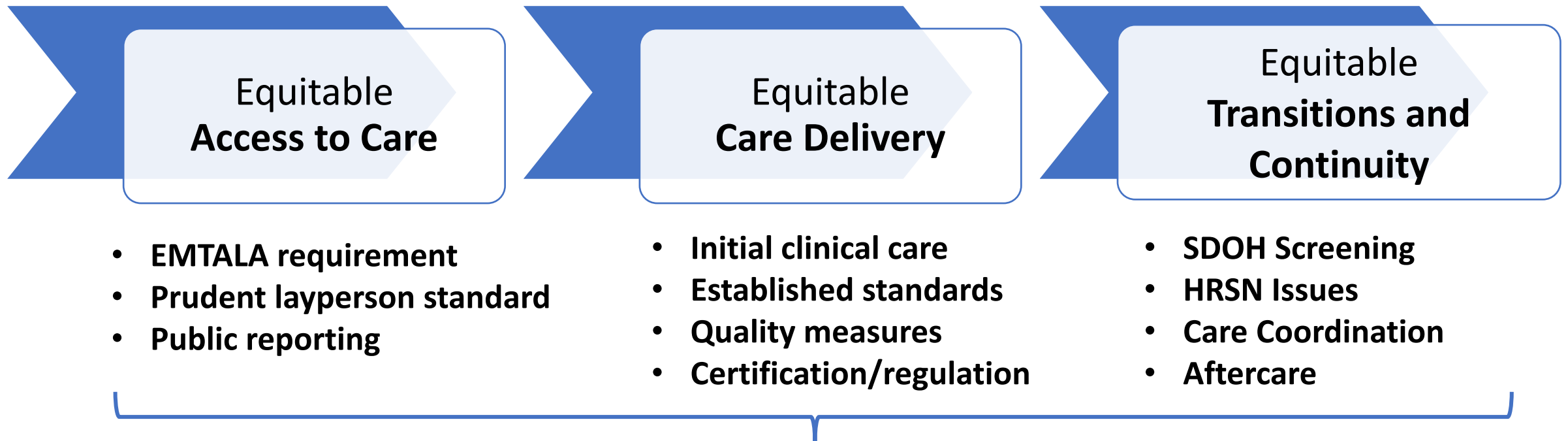*Darker colors indicate higher ADI score, and more risk for disparities.*

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

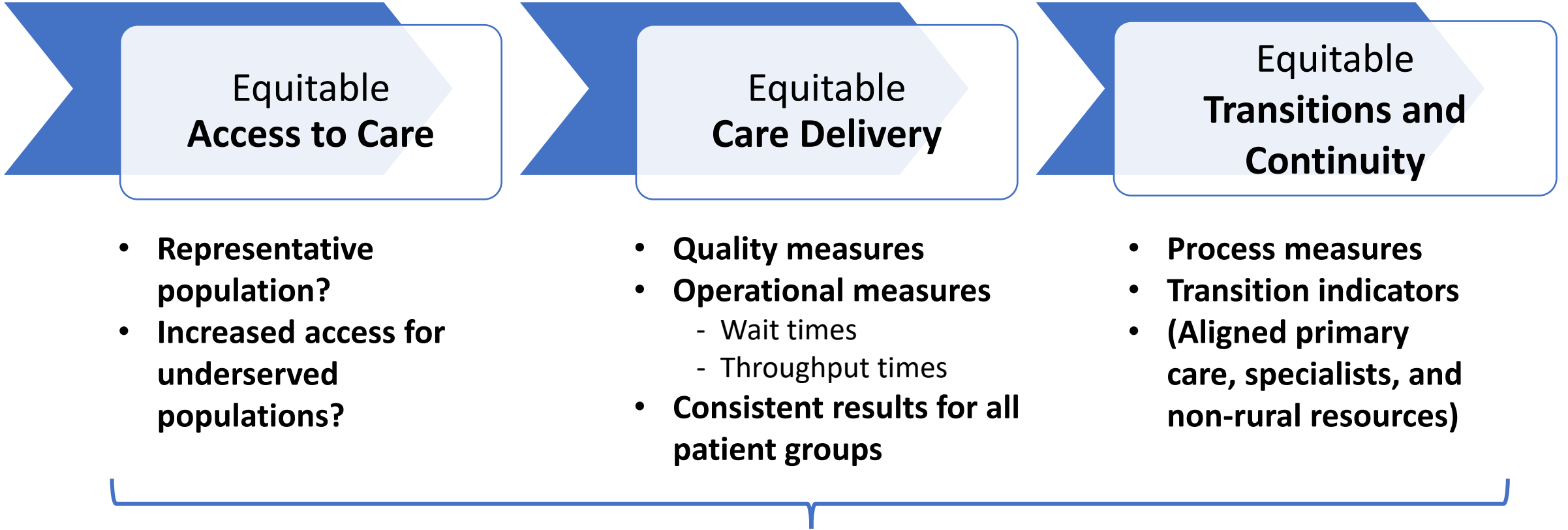**Emergency Medicine outcomes for 55 Louisiana Emergency Departments**

	Core Measure Compliance	MIPS Compliance %	Sepsis Bundle Compliance	Substance Use Evaluation in ED

Legend: ▒ All zip codes   ▮ High risk zip codes

An opportunity to advance health equity

Integrating rural Emergency Departments into value-based models

Equitable **Access to Care**

Equitable **Care Delivery**

Equitable **Transitions and Continuity**

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

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

- **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

Haber S, Beil H, Morrison M, et al. Evaluation of the Maryland All-Payer Model. Centers for Medicare & Medicaid Services website. 2019. Accessed June 23, 2021.
https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf

Galarraga JE, Black B, Pimentel L, et al. The effects of global budgeting on emergency department admission rates in Maryland. *Ann Emerg Med* **2020; 75(3): 370-381.**
https://doi.org/10.1016/j.annemergmed.2019.06.009

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

Physician-Focused Payment Model Technical Advisory Committee

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

David C. Herman, MD

Chief Executive Officer

Essentia Health

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

Essentia Health Facilities

Essentia Health
- CLINICS
- HOSPITALS
- CHILDREN'S HOSPITAL
- HOSPITAL-LEVEL II TRAUMA CENTER
- HOSPITAL-LEVEL I TRAUMA CENTER
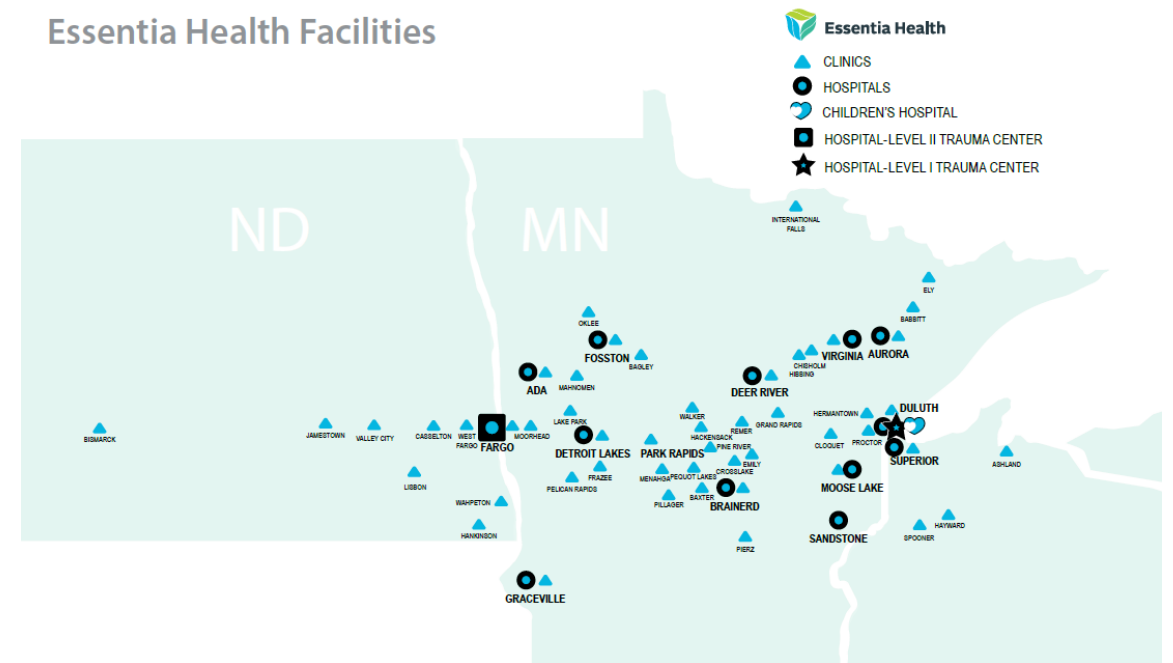
Value-Based Care

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
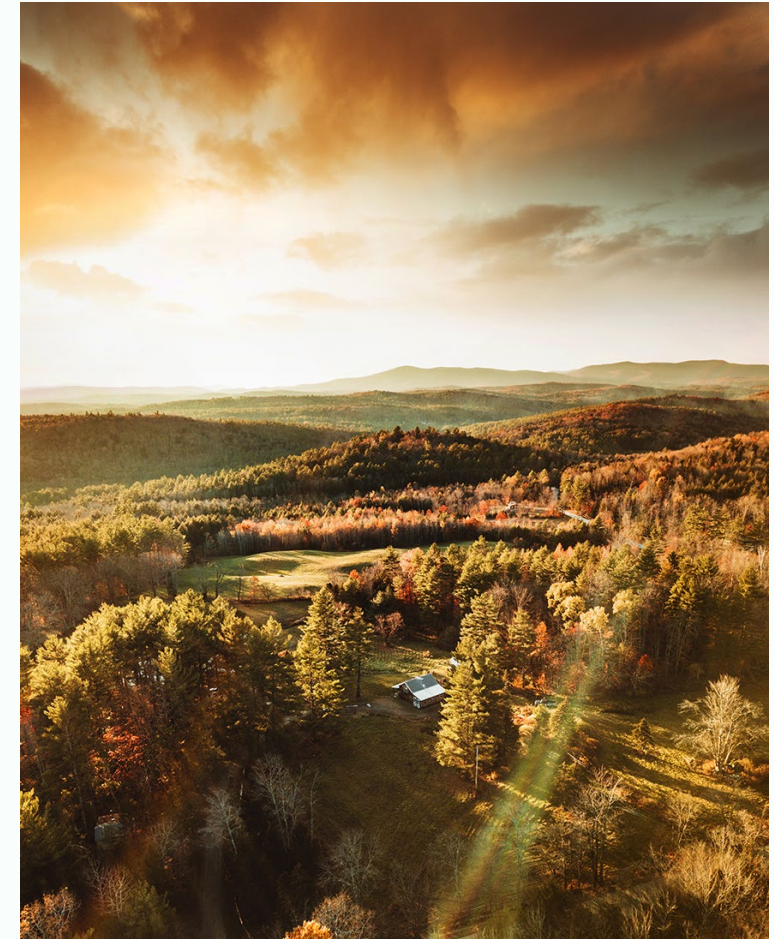
Rural Health Care Challenges

- 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

Legend:
- Metropolitan
- Large Town
- Small Town Rural
- Isolated Rural
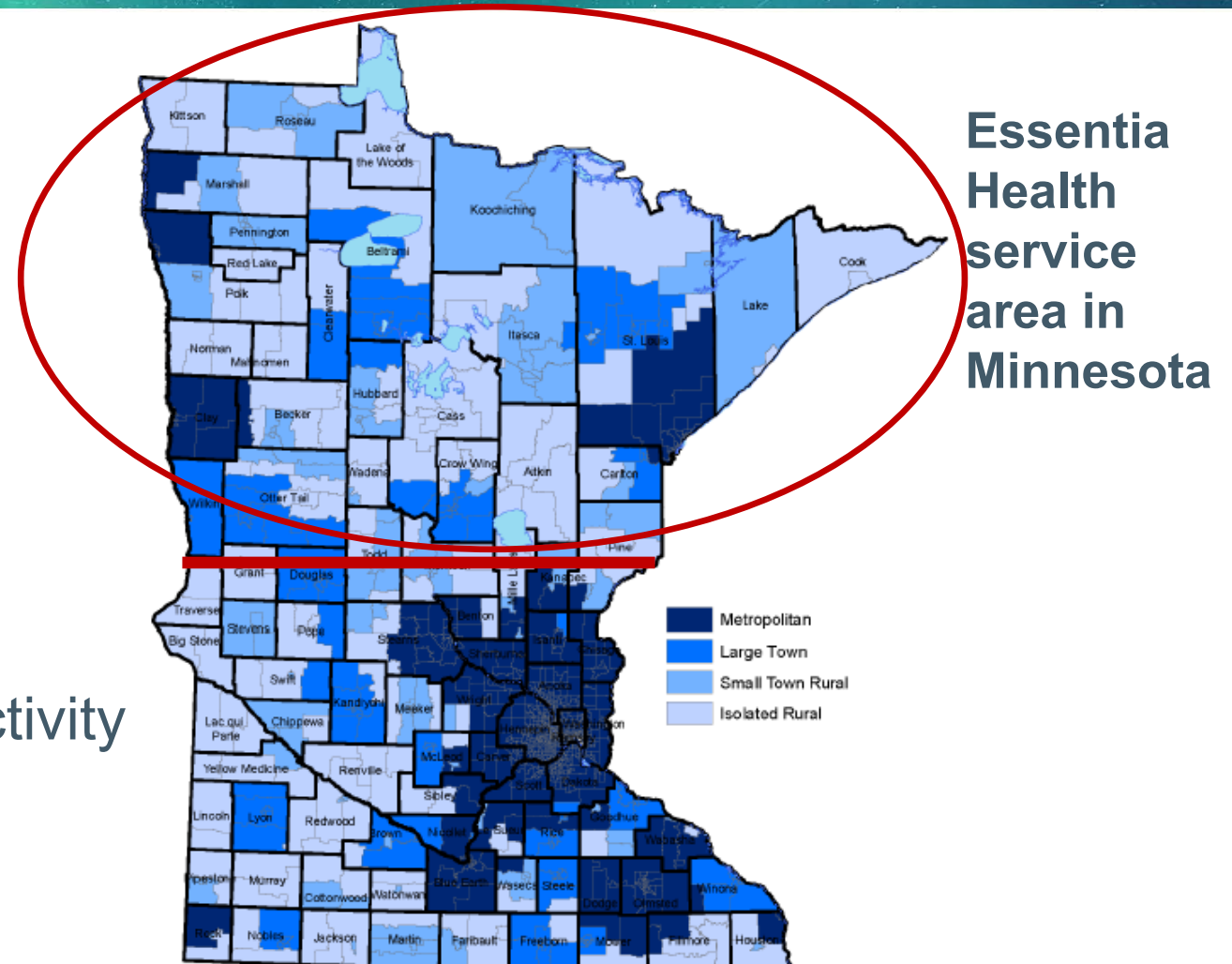
Household Income

More than three out of four of people living in rural areas have household incomes below the statewide median income

Bar chart values:
- Urban: 25.0%
- Large Rural City: 65.3%
- Small Town Rural: 80.6%
- Isolated Rural: 89.9%
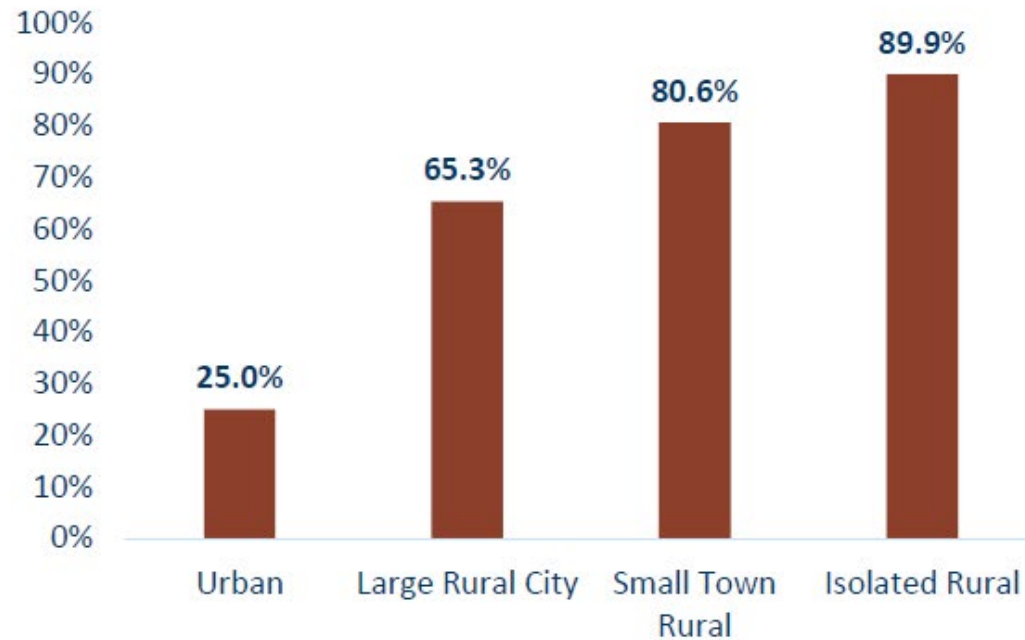
Source: MDH/Health Economics Program analysis of the American Community Survey Five-Year Estimate 2015 to 2019. RUCA based on census tract
Summary of Slide

Map legend:
- Sigificantly Above
- Sigificantly Below
- Not Significantly Different
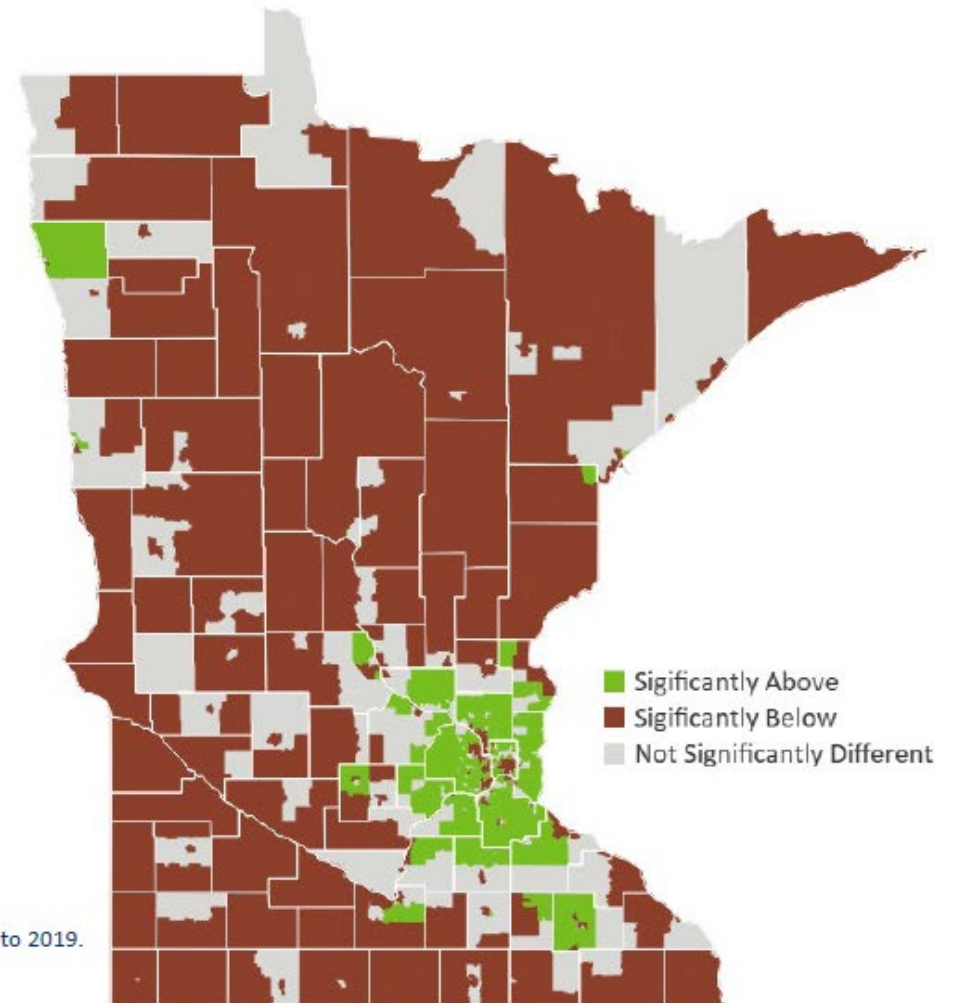
Health insurance coverage

Rural Minnesotans are more likely to have public health insurance coverage, such as Medicare, Medicaid or MinnesotaCare
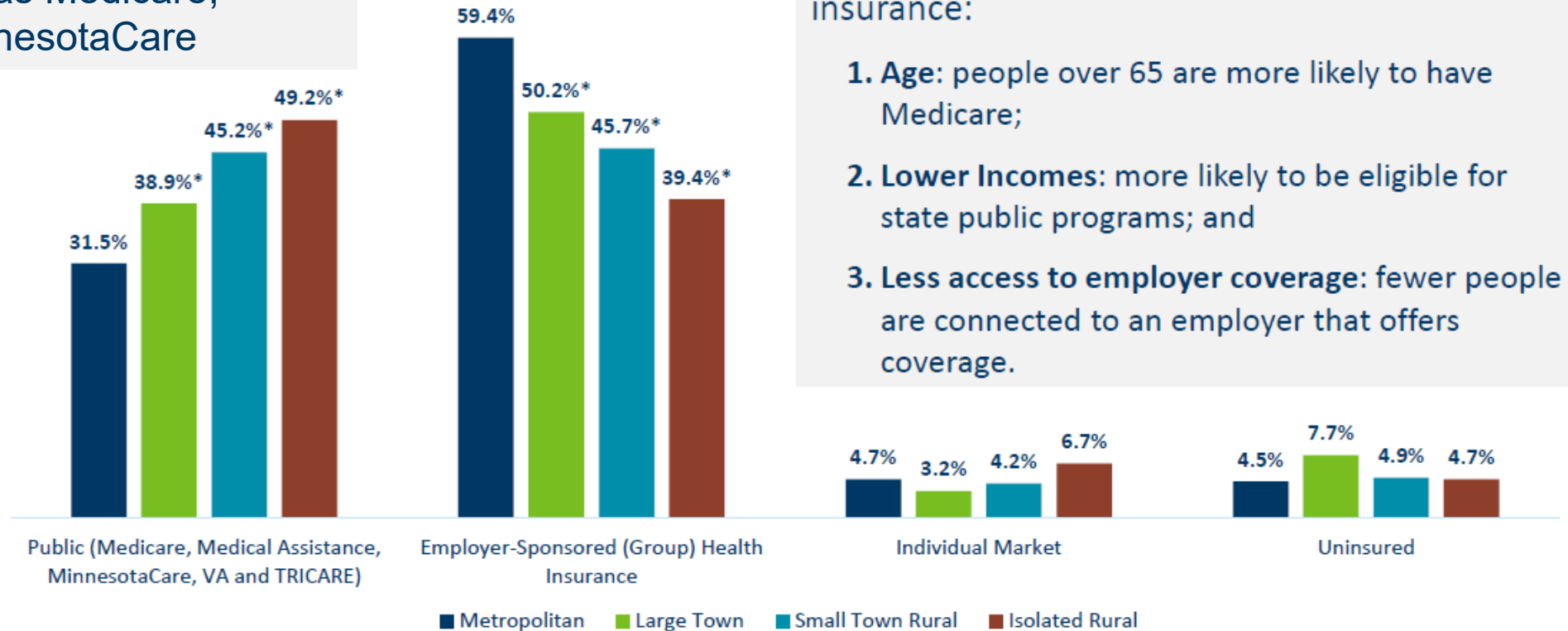
Reasons for higher rates of public health insurance:

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.

Public (Medicare, Medical Assistance, MinnesotaCare, VA and TRICARE)
- 31.5%
- 38.9%*
- 45.2%*
- 49.2%*

Employer-Sponsored (Group) Health Insurance
- 59.4%
- 50.2%*
- 45.7%*
- 39.4%*

**Individual Market**
- 4.7%
- 3.2%
- 4.2%
- 6.7%

Uninsured
- 4.5%
- 7.7%
- 4.9%
- 4.7%

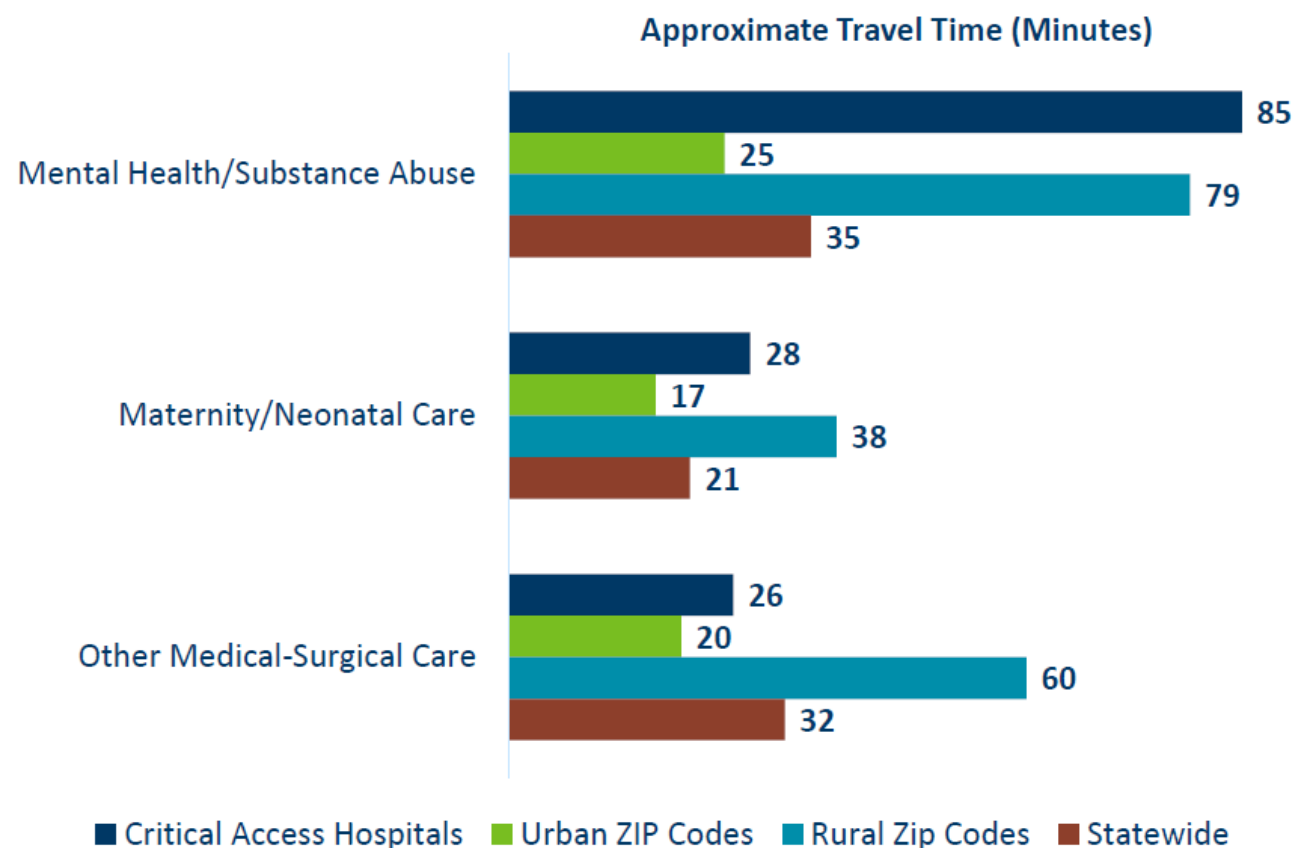■ Metropolitan ■ Large Town ■ Small Town Rural ■ Isolated Rural

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

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

Approximate Travel Time (Minutes)

Mental Health/Substance Abuse
- Critical Access Hospitals: 85
- Urban ZIP Codes: 25
- Rural Zip Codes: 79
- Statewide: 35

Maternity/Neonatal Care
- Critical Access Hospitals: 28
- Urban ZIP Codes: 17
- Rural Zip Codes: 38
- Statewide: 21

Other Medical-Surgical Care
- Critical Access Hospitals: 26
- Urban ZIP Codes: 20
- Rural Zip Codes: 60
- Statewide: 32

■ Critical Access Hospitals　■ Urban ZIP Codes　■ Rural Zip Codes　■ Statewide

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.

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
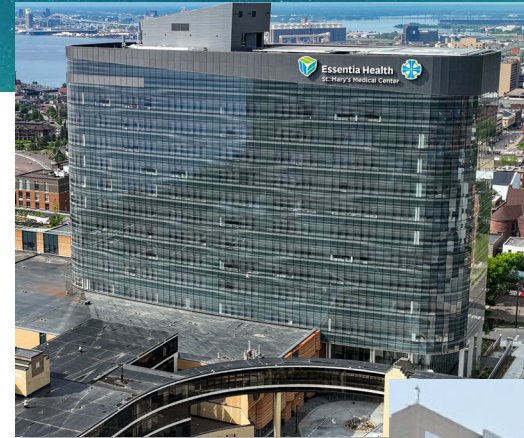
Community-level priorities

- 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
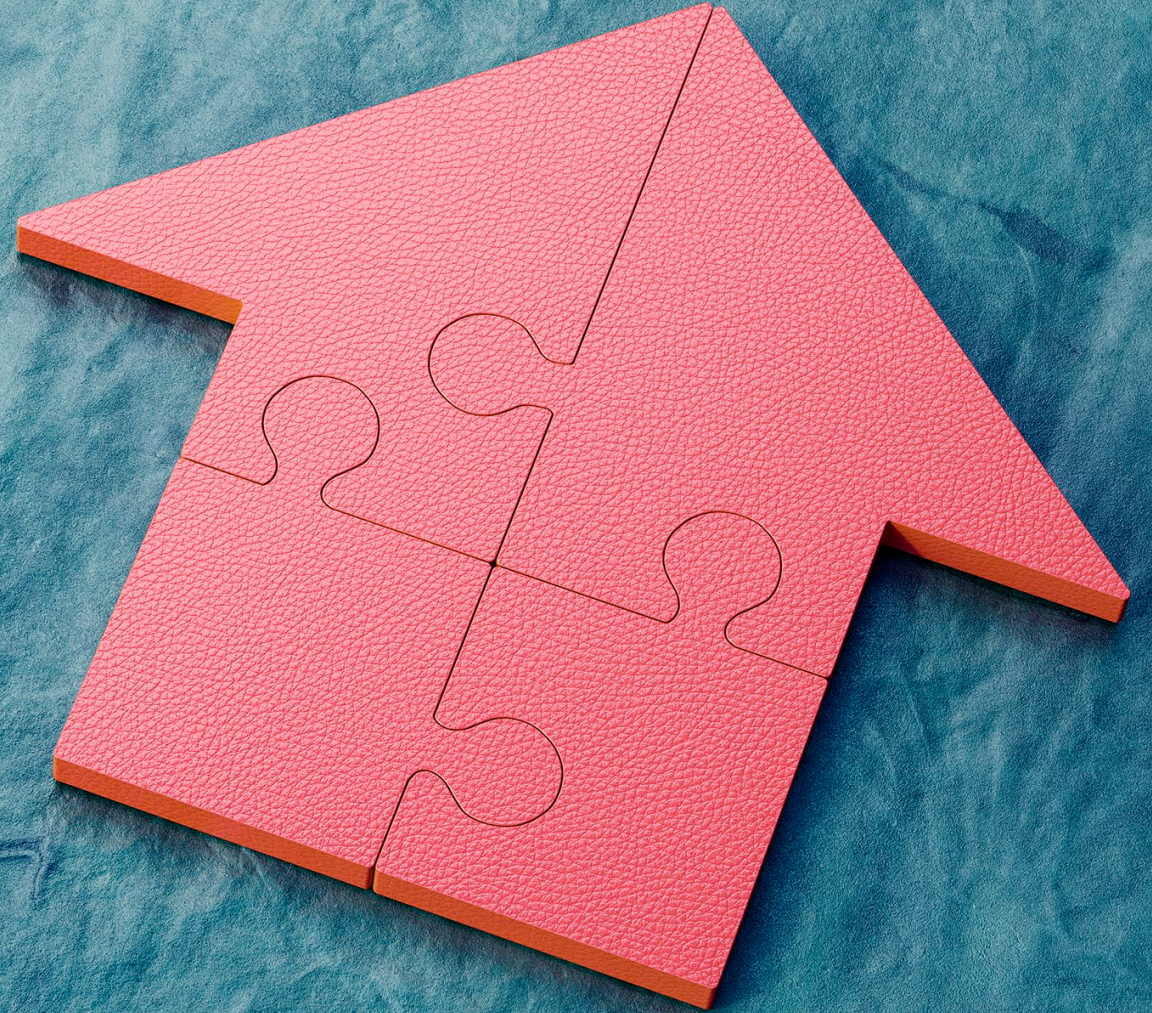- Care gap identification
- Referral management

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
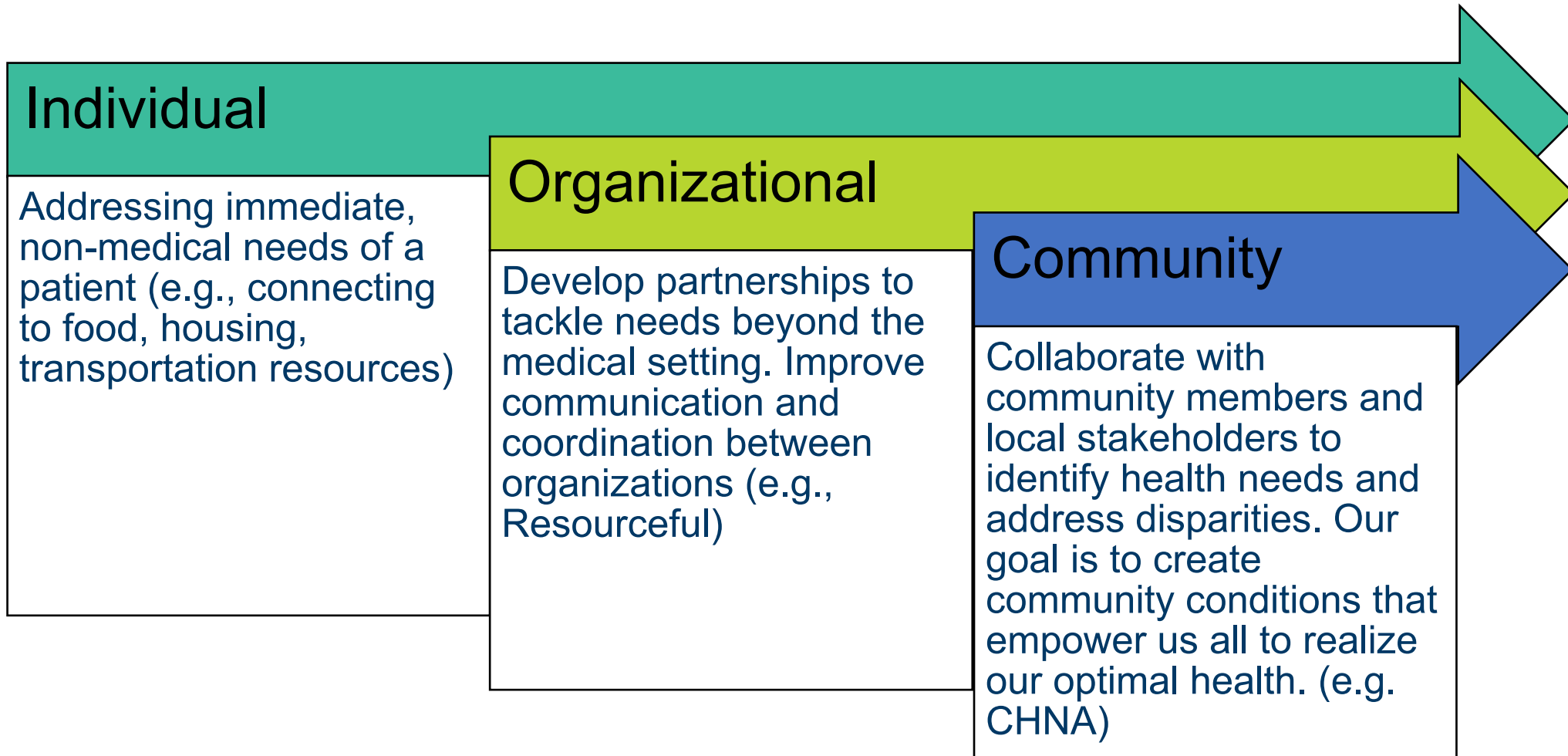- Chronic illness management

Accountability

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

Addressing the Needs of Our Communities

Individual

Addressing immediate, non-medical needs of a patient (e.g., connecting to food, housing, transportation resources)

Organizational

Develop partnerships to tackle needs beyond the medical setting. Improve communication and coordination between organizations (e.g., Resourceful)

Community

Collaborate with community members and local stakeholders to identify health needs and address disparities. Our goal is to create community conditions that empower us all to realize our optimal health. (e.g. CHNA)
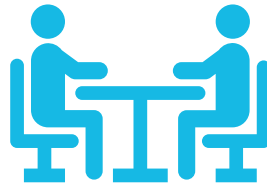
Addressing the Needs of our Communities

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

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

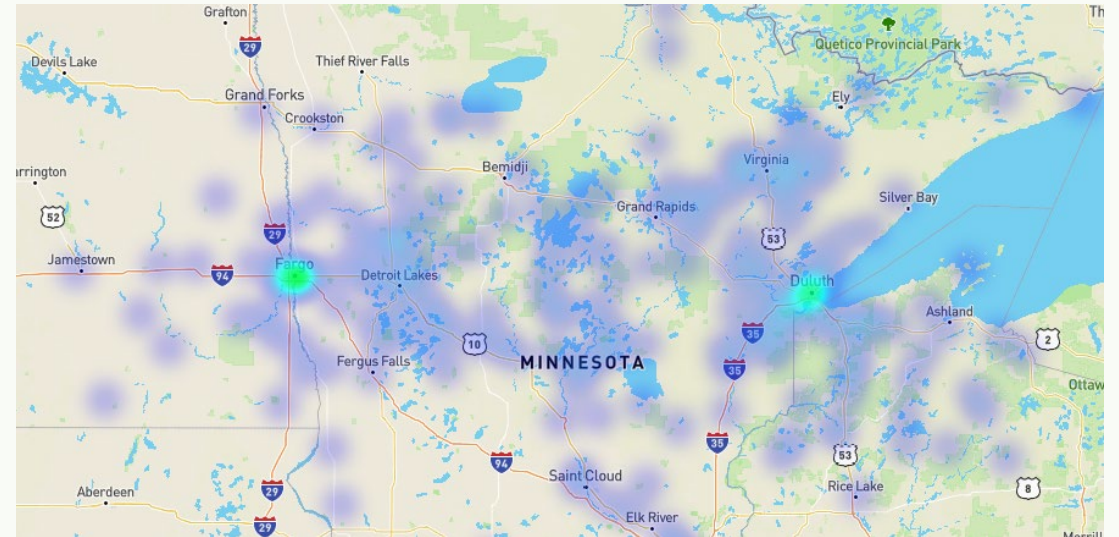- Public site where community members can access as well
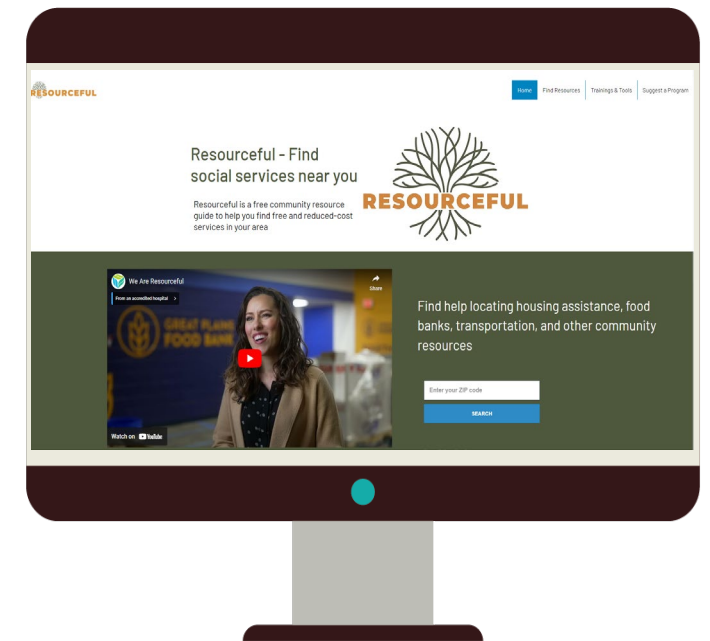
www.WeAreResourceful.org

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

Essentia Health
Here with you

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

Appendix

Essentia Health
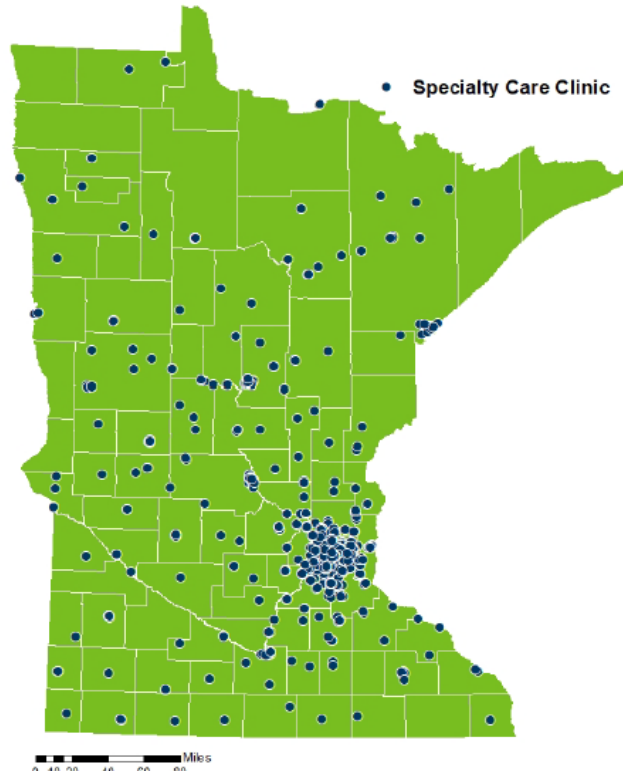
Primary and Specialty Clinics

Primary Care Clinics, 2020

Primary Care Clinic
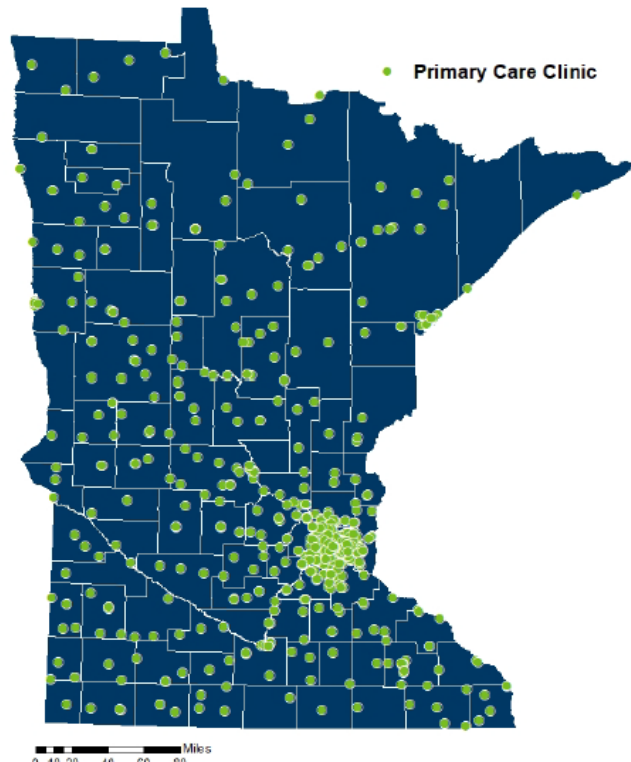
Specialty Care Clinics, 2020

Specialty Care Clinic

- 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]

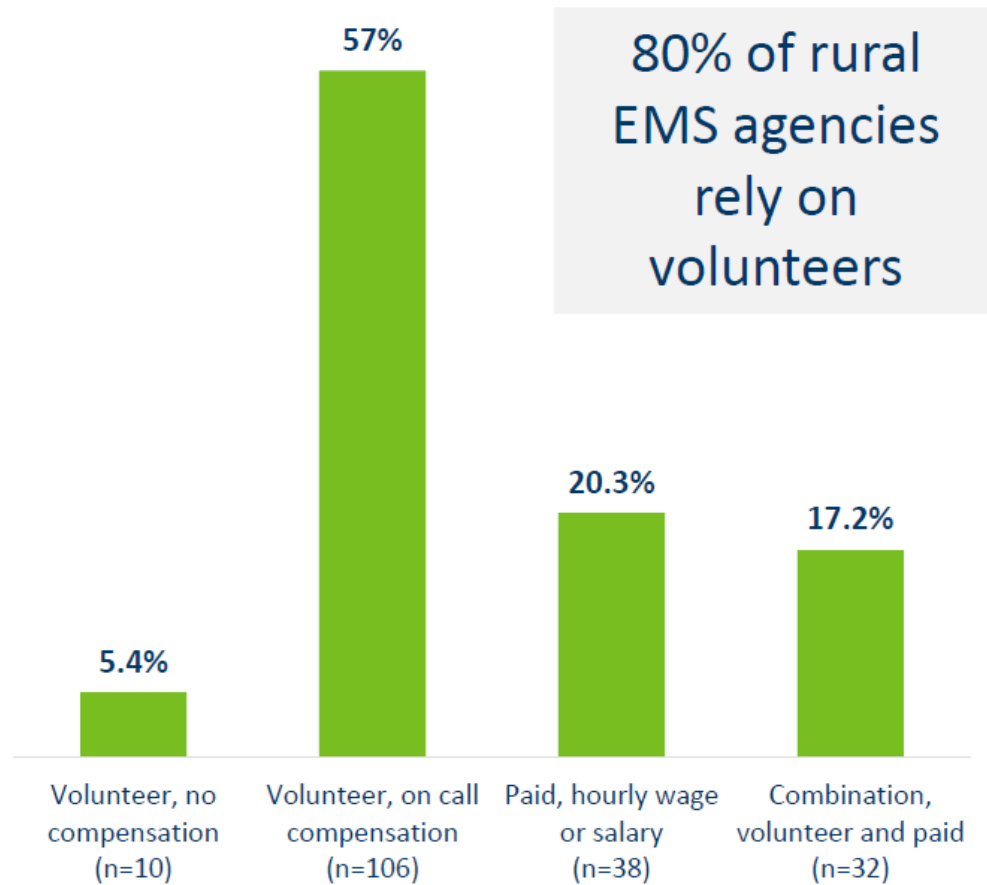- Minnesota Community Health Centers had 720,846 medical, dental and mental health visits in 2020.[2]

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.

Rural Emergency Medical Services (EMS)

80% of rural EMS agencies rely on volunteers

Chart:
- Volunteer, no compensation (n=10): 5.4%
- Volunteer, on call compensation (n=106): 57%
- Paid, hourly wage or salary (n=38): 20.3%
- Combination, volunteer and paid (n=32): 17.2%

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
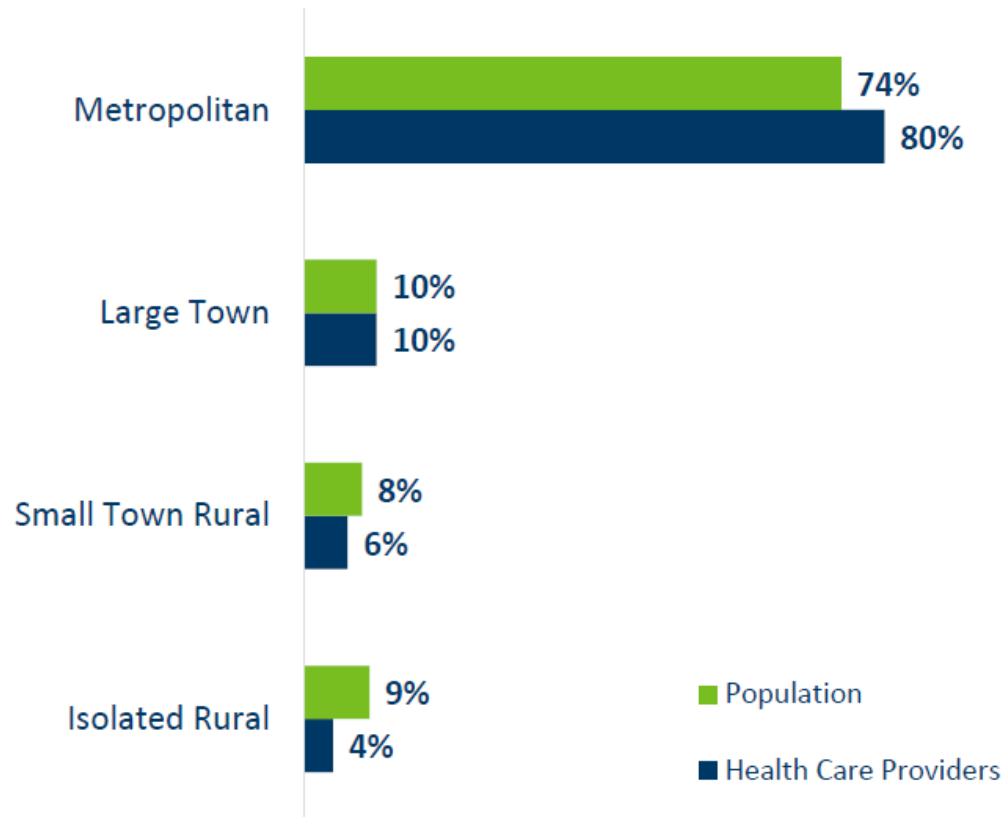
Very few licensed health care providers work in rural areas.

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.
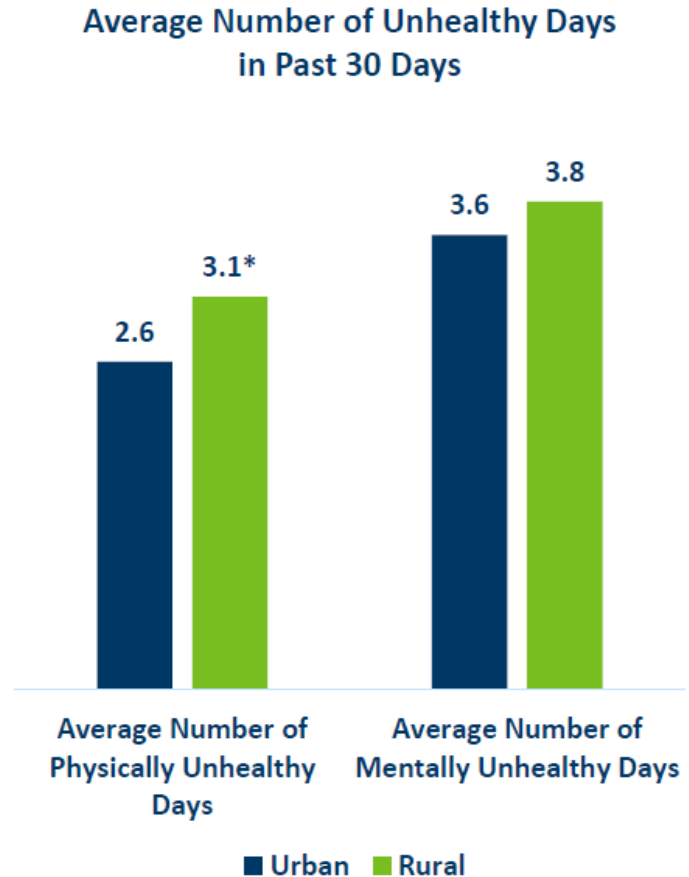
Hospital birth services
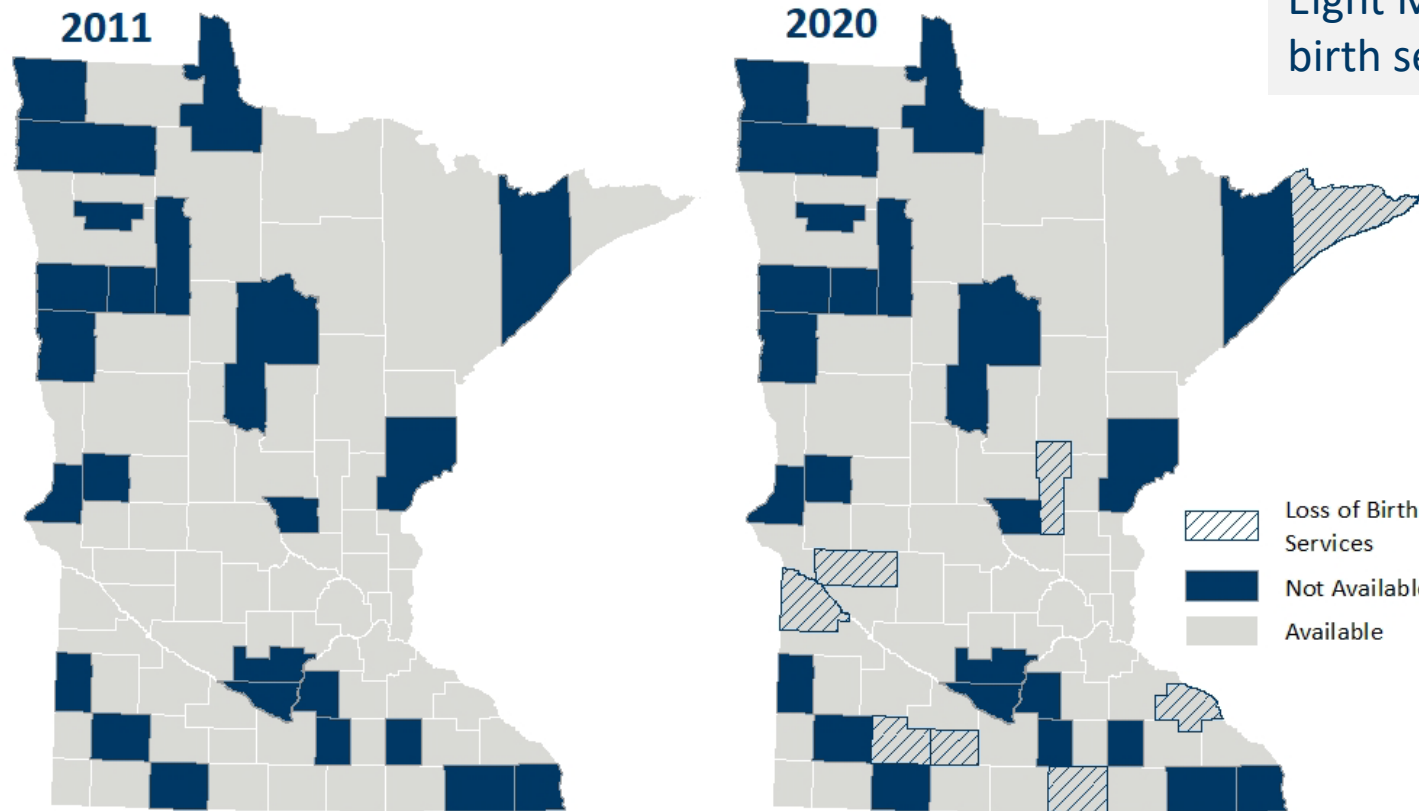
2011

2020

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.
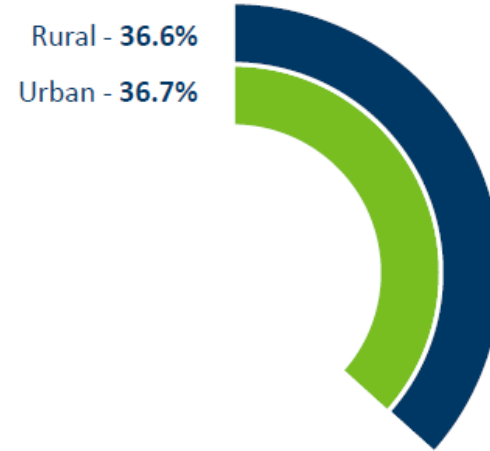
Loss of Birth Services

Not Available

Available

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.

Rural residents report more unhealthy days

Average Number of Unhealthy Days in Past 30 Days

2.6   3.1*   3.6   3.8

Average Number of Physically Unhealthy Days   Average Number of Mentally Unhealthy Days

■ Urban   ■ Rural

**Percent of Minnesotans with a Chronic Condition**

Rural - 36.6%
Urban - 36.7%

- 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.
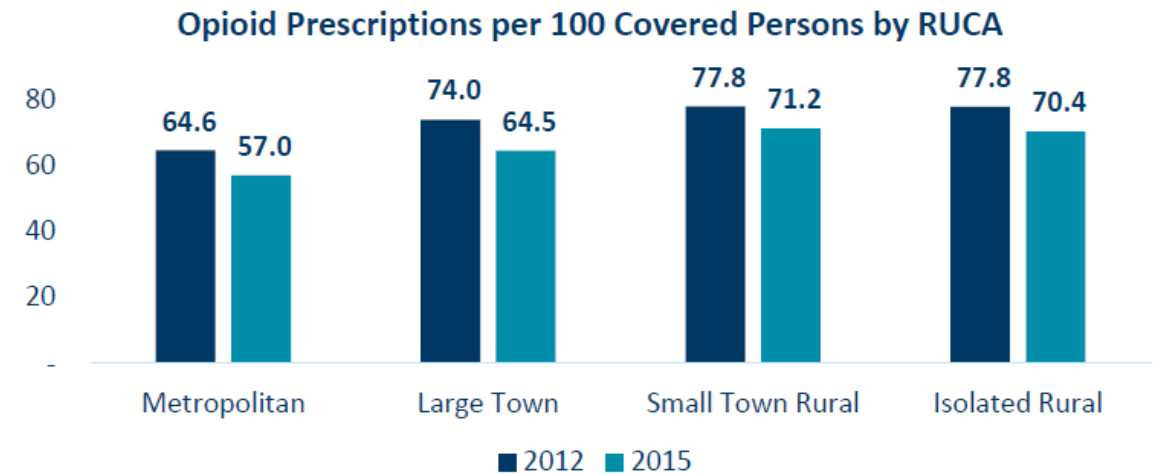* Indicates significant difference from Urban at the 95% level.
[2] Source: 1999-2019: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death on CDC WONDER Online Database, released 2020.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
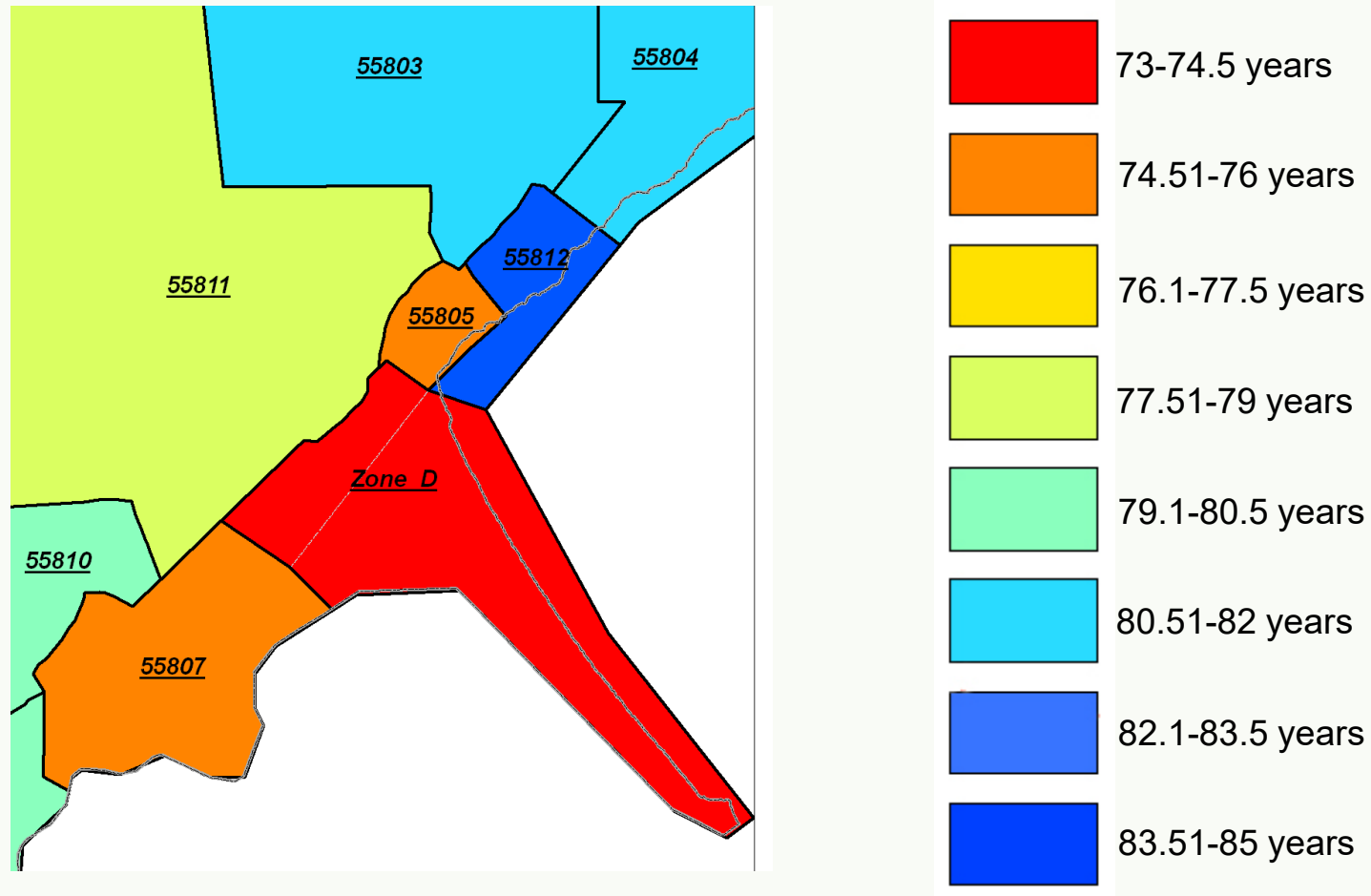
Prescription Opioid Use
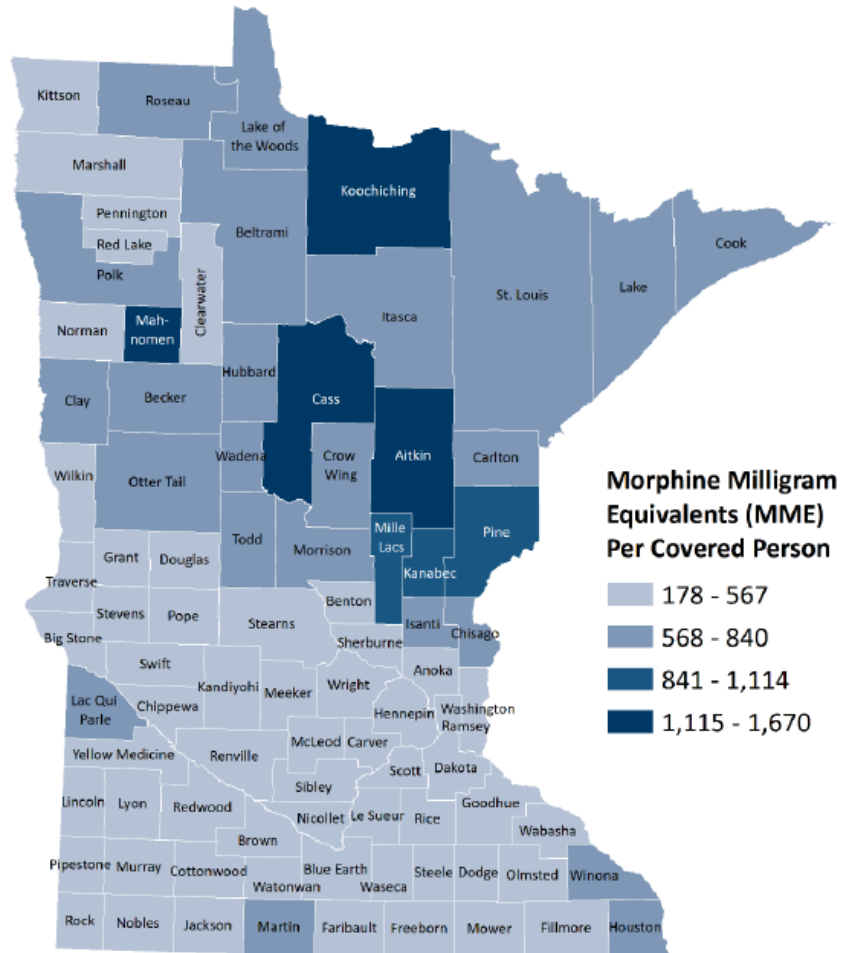
- Prescription opioid use has declined over time – but is still higher in rural areas.

- Some counties in Northern Minnesota have especially high rates of prescriptions.

Morphine Milligram Equivalents (MME) Per Covered Person
- 178 – 567
- 568 – 840
- 841 – 1,114
- 1,115 – 1,670

Opioid Prescriptions per 100 Covered Persons by RUCA

	Metropolitan	Large Town	Small Town Rural	Isolated Rural
2012	64.6	74.0	77.8	77.8
2015	57.0	64.5	71.2	70.4

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

Procedure rates are lower in rural hospitals

CENTRAL ILLUSTRATION: Observed Procedure and Mortality Rates for Acute Cardiovascular Conditions at Rural Versus Urban Hospitals
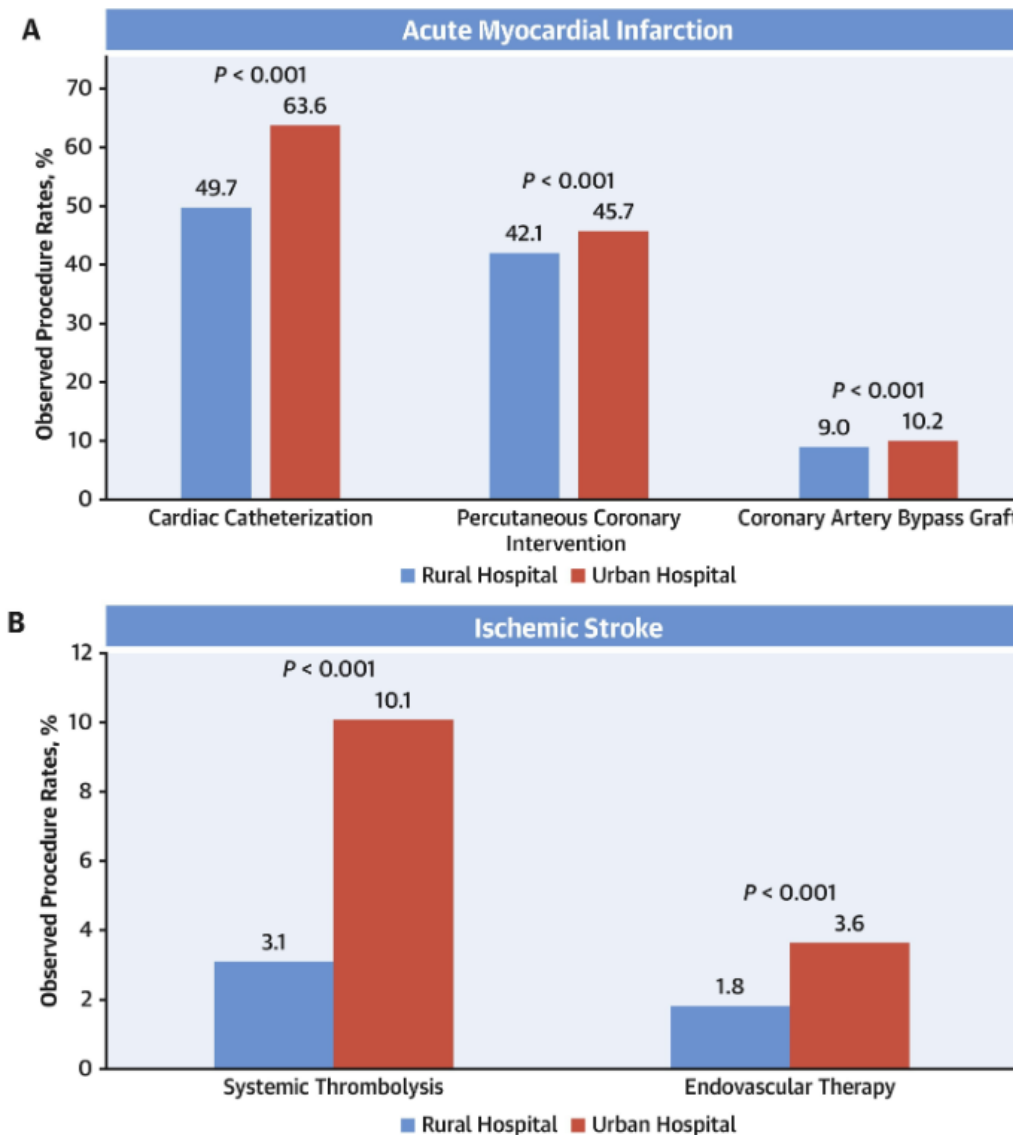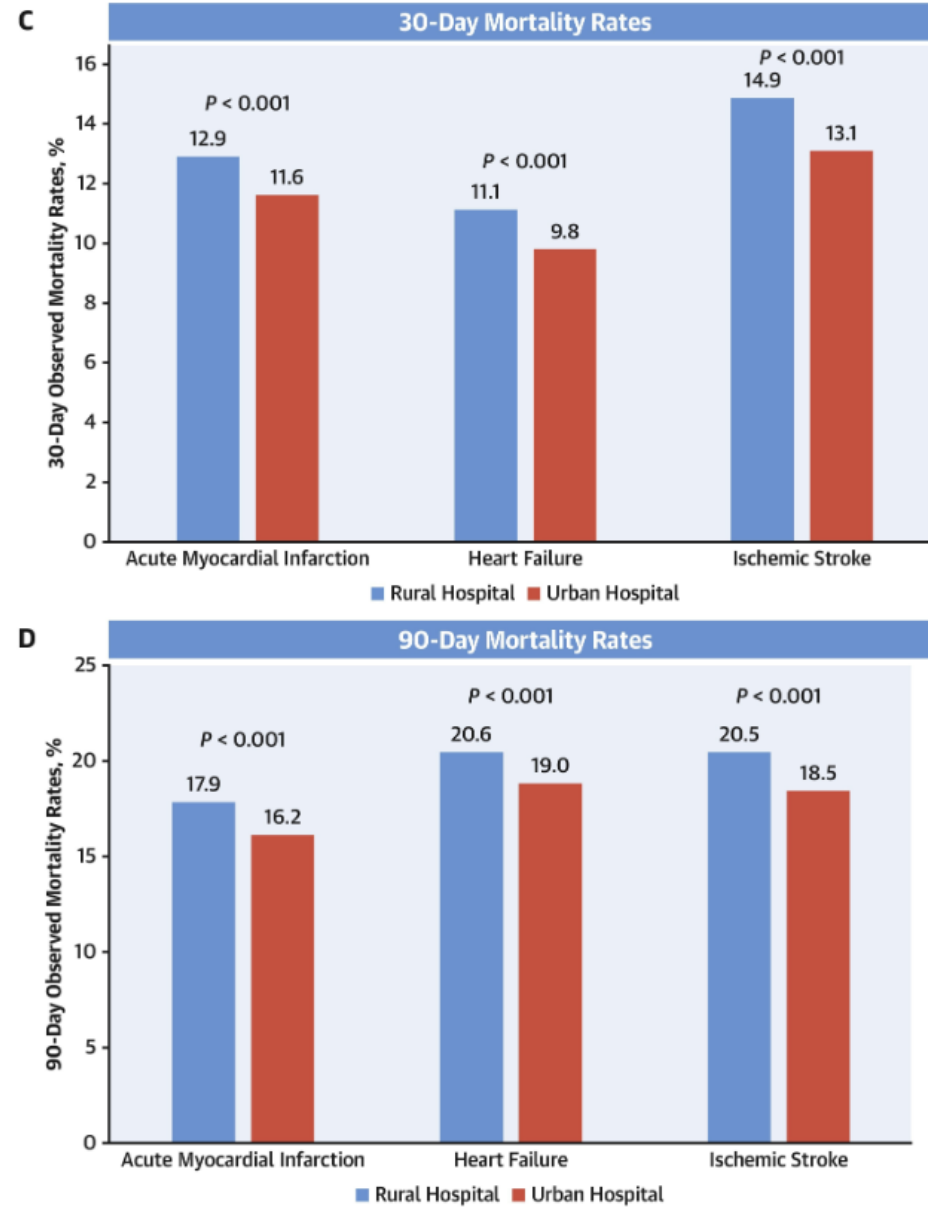
Loccoh, E.C. et al. J Am Coll Cardiol. 2022;79(3):267-279.

Mortality rates are higher in rural hospitals

CENTRAL ILLUSTRATION: Continued

C — 30-Day Mortality Rates

D — 90-Day Mortality Rates

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

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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

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

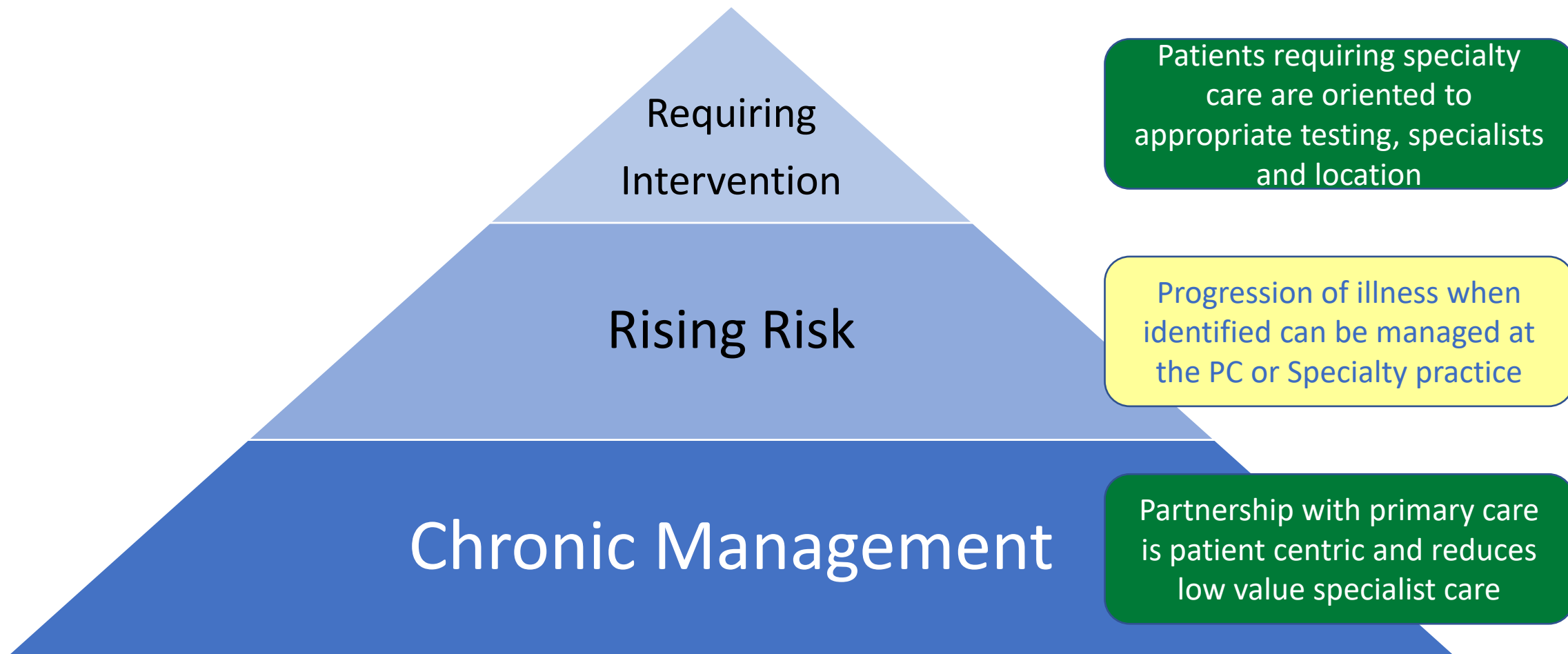Incentivize team-based care and innovative local community health roles

*Guideline-directed medical therapy

Rural Health Fits the Digital Health Paradigm

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

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Advancing Heart Care Worldwide

ACC INNOVATION PROGRAM

Thank you

The ACC Vision

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

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

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

Health Professional Shortage Areas: Mental Health, by County, 2023

None of county is shortage area | Part of county is shortage area | Whole county is shortage area

Source: data.HRSA.gov, May 2023.
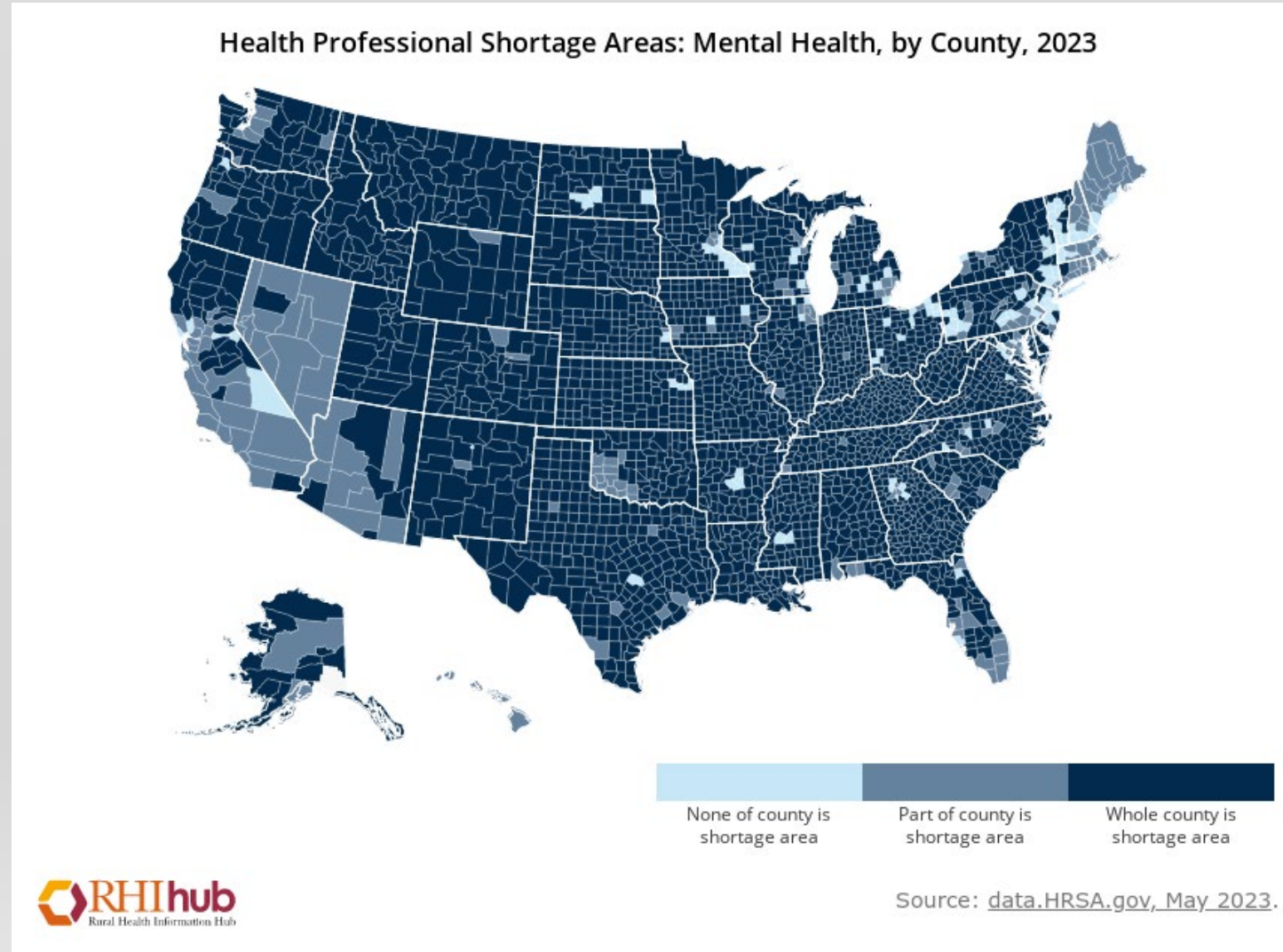
Challenges: *It's Getting Worse*

- **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

| Occupation	2017 projections		2030 projections		Adequacy of supply projection (percentage)
	Supply	**Demand**	**Supply**	**Demand**	
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

-15%

Decline in College-Going Students (2025-2029)
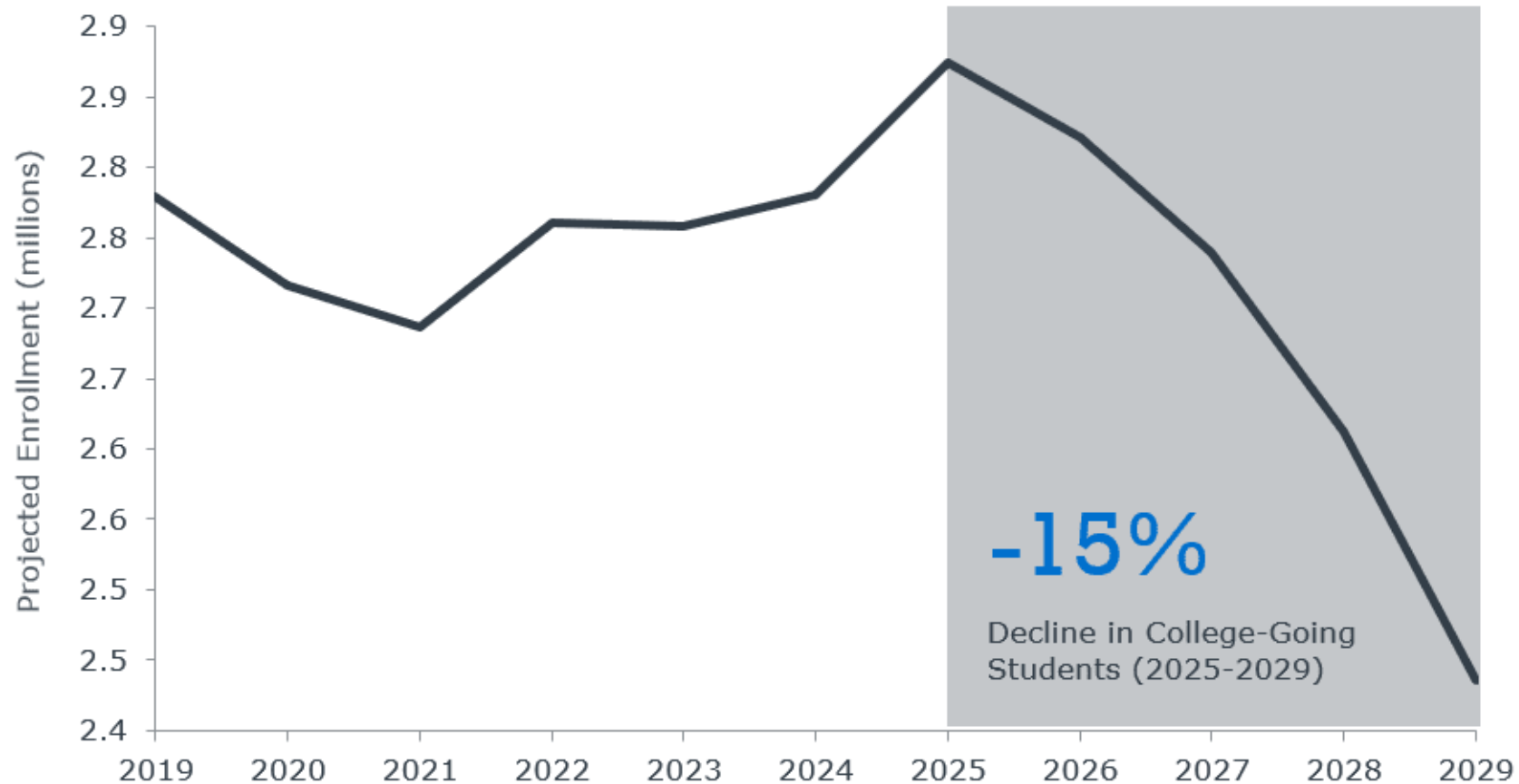
Solving the issue: *Recruit*

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.

- 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.
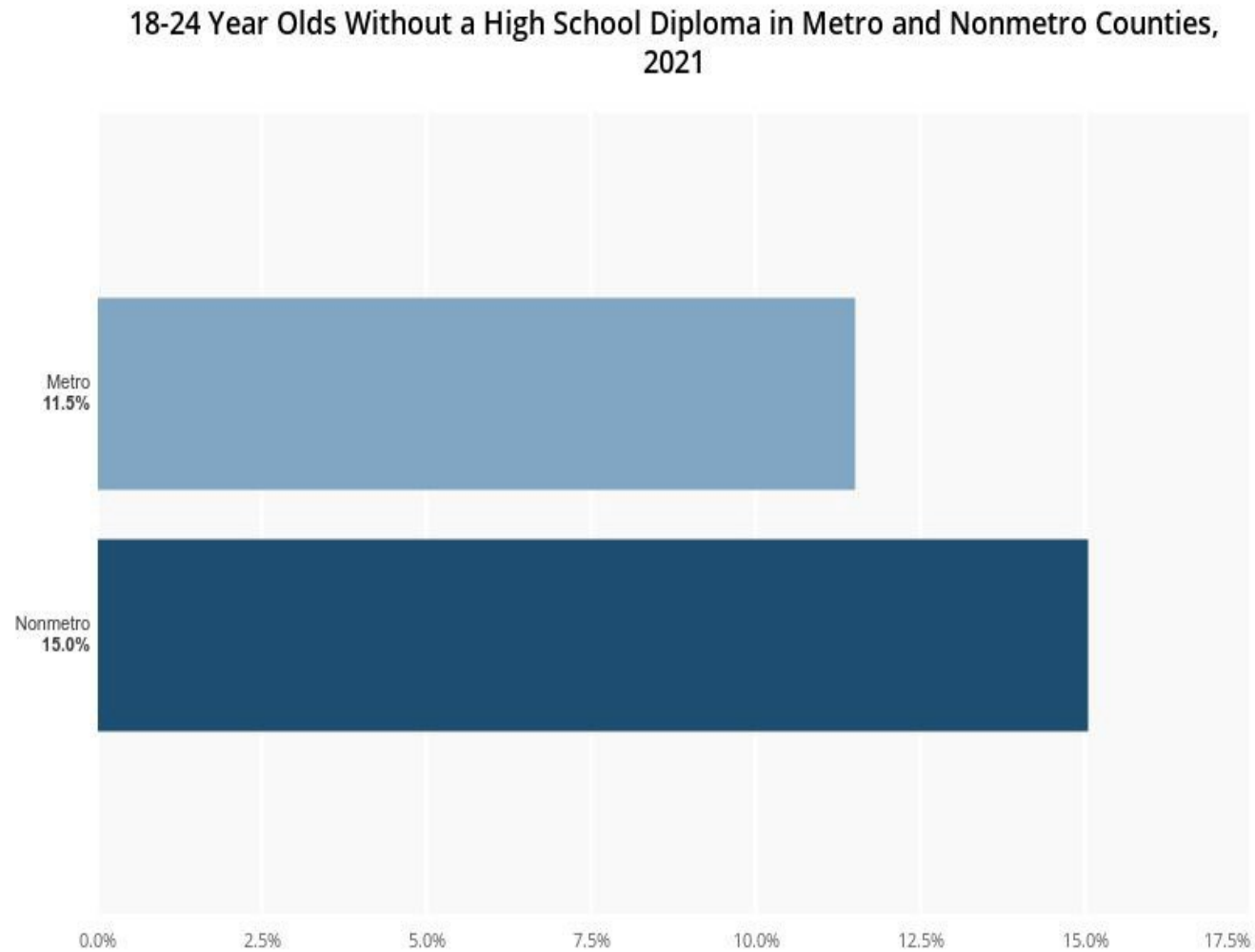
frontier.edu

Average Median Age

Average Median Age for Metro and Nonmetro Counties, 2010-2021
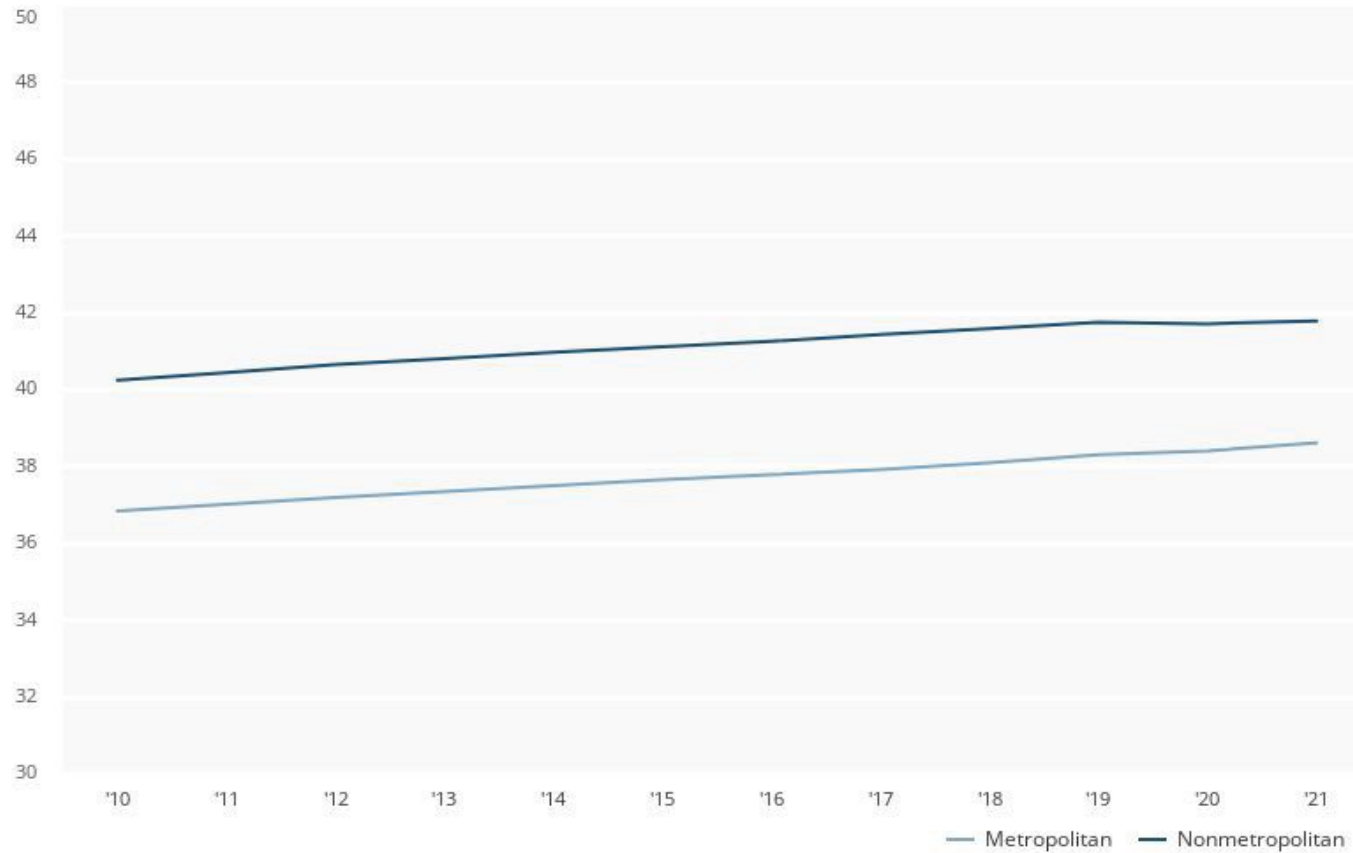
Source: US Census Population and Housing Unit Estimates, 2010-2021.

18-24 Year Olds Without a High School Diploma in Metro and Nonmetro Counties, 2021

Metro 11.5%

Nonmetro 15.0%

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

frontier.edu

Adults Reporting 4 or More Chronic Conditions

Adults Reporting 4 or More Chronic Conditions in Metro and Nonmetro Counties, 2016

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

frontier.edu

5
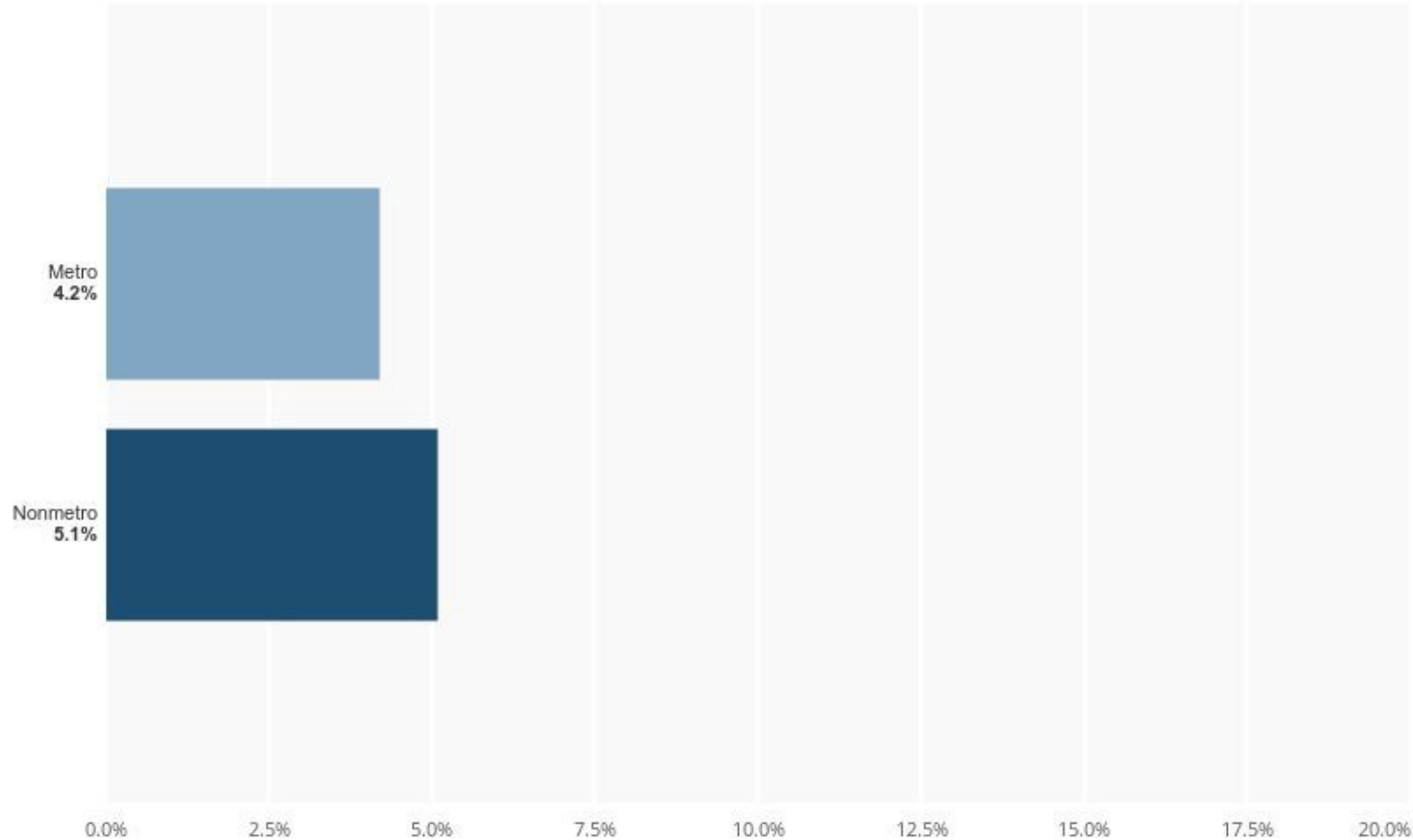
Adults with One or More Emergency Dept Visits in the Past 12 months

Adults with One or More Emergency Department Visits in the Past 12 Months in Metro and Nonmetro Counties, 2019

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

frontier.edu

6
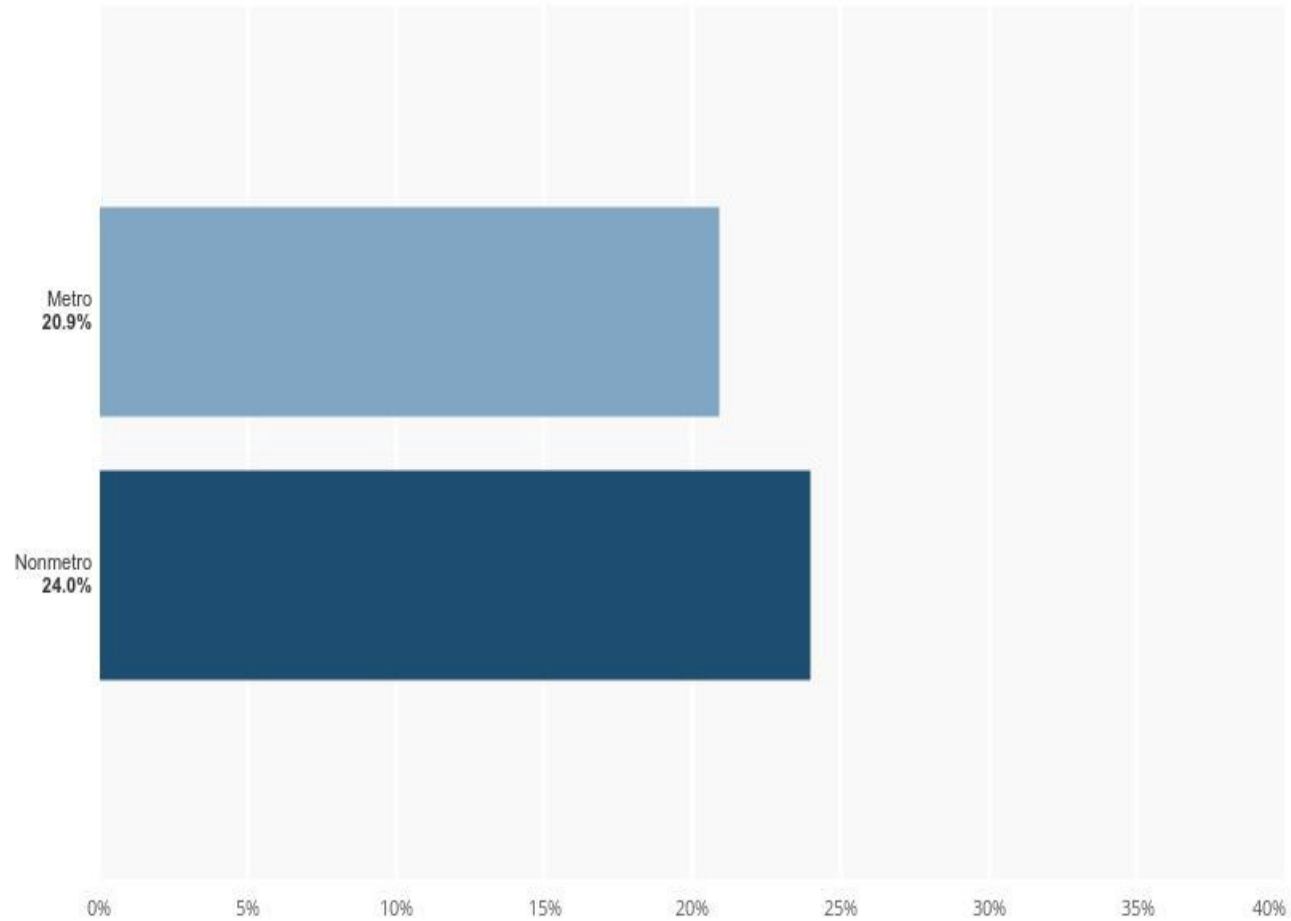
Average Median Household Income for Metro and Nonmetro Counties, 2010-2021
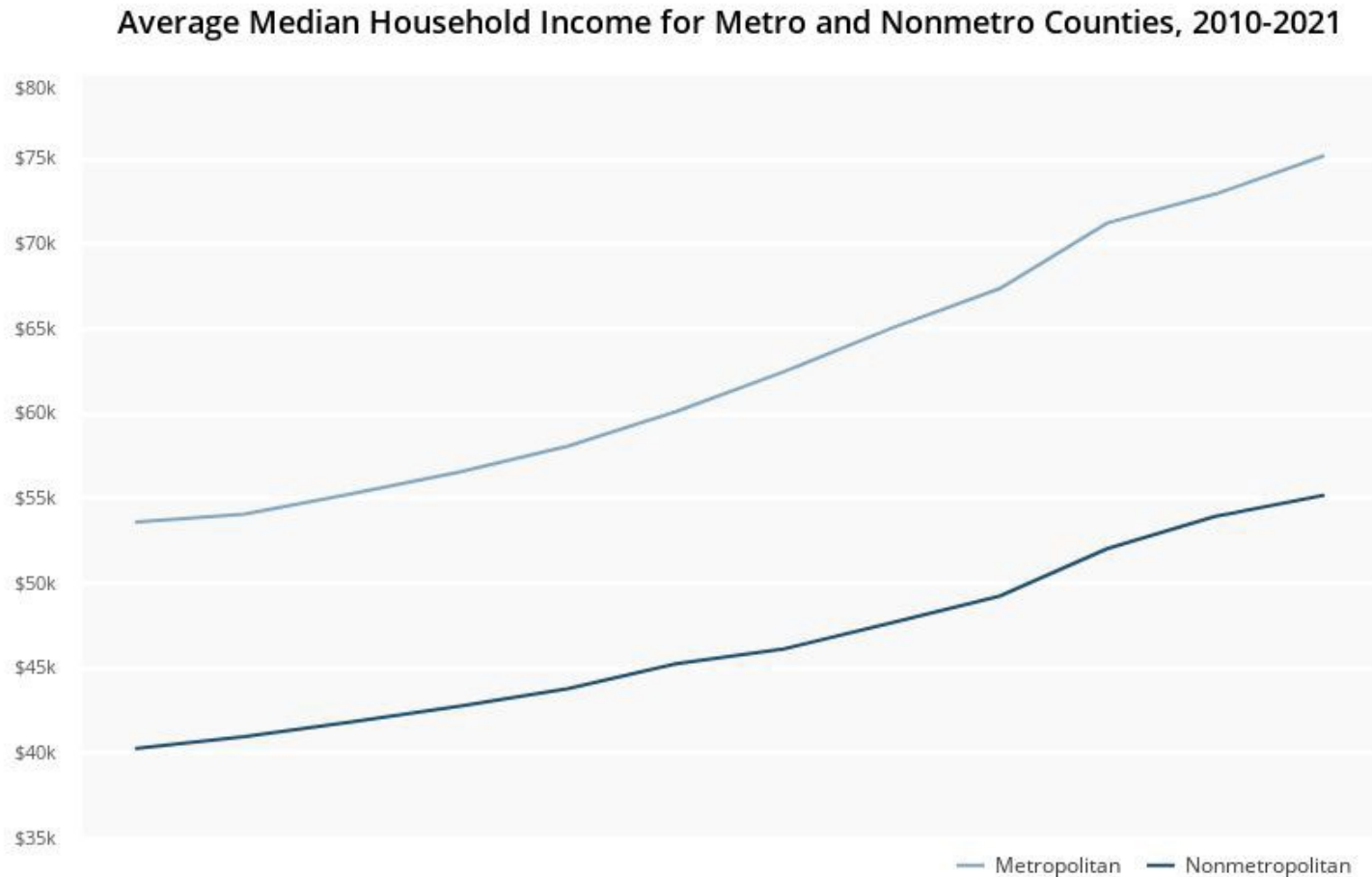
Note: Metro and nonmetro averages are calculated by weighting county median household income by ACS 5-year estimates of total households.
Source: US Census Small Area Income and Poverty Estimates, 2010-2021.

- 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.

- 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.

- 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".