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

Alana Knudson, PhD, EdM
Project Director
The Pennsylvania Rural Health Model (PARHM) Evaluation
Director, NORC Walsh Center for Rural Health
Senior Fellow, NORC at the University of Chicago
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
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

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.

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

Thank you.

Alana Knudson, PhD
Knudson-alana@norc.org
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
<table>
<thead>
<tr>
<th>RESOURCES: EVIDENCE-BASED TOOLKITS</th>
</tr>
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### 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.

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

### 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.

### Medication for Opioid Use Disorder Toolkit
- Learn about models and resources for implementing medication for opioid use disorder programs in rural communities.

### Maternal Health Toolkit
- Find resources and models for developing programs to address rural maternal health issues.

### Obesity Prevention Toolkit
- Find out how rural communities, schools, and healthcare providers can develop programs to help address obesity.

### Oral Health Toolkit
- Discover rural oral health approaches that focus on workforce, access, outreach, schools, and more.

### Philanthropy Toolkit
- Find emerging practices and resources for building successful relationships with philanthropies.

### 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 telehealth programs 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.

### 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 Promotion and Disease Prevention Toolkit
- Learn about strategies and models for rural health promotion and disease prevention in the community, clinic, and workplace.

### Tobacco Control and Prevention Toolkit
- Explore program examples and resources for implementing tobacco control and prevention programs in rural areas.

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

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

25+ toolkits, with updates and new toolkits released annually.
Listening Session 2: Incentives for Increasing Rural Providers’ Participation in Population-Based Models

Tom X. Lee, MD, MBA
Chief Executive Officer
Galileo
Encouraging Rural Participation in Population-Based TCOC Models

Thomas Lee MD
Founder & CEO, Galileo

Sept 19, 2023
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.
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
Infrastructure-Related Challenges

- Connectivity
- Labor & Time Matching
- Skills Matching
CARE IN RURAL ENVIRONMENTS

Infrastructure-Related Challenges

- Connectivity
- Labor & Time Matching
- Skills Matching
Advancing Rural Health and Value-Based Care Innovation

**Barriers and Opportunities**

**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
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

REDUCING VARIATION ACROSS POPULATIONS
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
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*

**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 Medicine MIPS Performance by practice setting](chart1)

![Hospital Medicine MIPS Performance by practice setting](chart2)
Emergency Departments deliver equitable results in areas at risk for health 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

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/
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

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


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.PDF
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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
Innovative Approaches for Facilitating Value-Based Transformation in Rural Areas

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

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
More than three out of four of people living in rural areas have household incomes below the statewide median income.


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

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 times 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: 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

**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

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
Appendix
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 RUCAs.

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

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
Rural Emergency Medical Services (EMS)

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

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%).

- Age-adjusted suicide rate in greater Minnesota (17.3) was higher than the 7-county metro area (12.2) for 2015-19.

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: 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

- 73-74.5 years
- 74.51-76 years
- 76.1-77.5 years
- 77.51-79 years
- 79.1-80.5 years
- 80.51-82 years
- 82.1-83.5 years
- 83.51-85 years
## County health ranking results

### St. Louis County

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<th>Health Outcomes 2021</th>
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<td>Physical Environment</td>
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<td>Health Behaviors</td>
<td>47</td>
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<tr>
<td>Social &amp; Economic Factors</td>
<td>48</td>
</tr>
</tbody>
</table>

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.
Mortality rates are higher in rural hospitals.
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

<table>
<thead>
<tr>
<th><strong>Patient volume in rural health</strong> (lower in general, however CV risk factors and disease prevalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human and financial resource-limited, where CV remote monitoring serves as a force multiplier</strong></td>
</tr>
<tr>
<td><em><em>Link compensation to non-cost saving metrics (i.e. % achievement GDMT</em>) in the near term</em>*</td>
</tr>
<tr>
<td><strong>Incentivize team-based care and innovative local community health roles</strong></td>
</tr>
</tbody>
</table>

*Guideline-directed medical therapy*
Rural Health Fits the Digital Health Paradigm

Chronic Management

Rising Risk

Requiring Intervention

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

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

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

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
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
- Provider exodus
- Retirement
- Burnout

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

**New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society**

**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

<table>
<thead>
<tr>
<th>Occupation</th>
<th>2017 projections</th>
<th>2030 projections</th>
<th>Adequacy of supply projection (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supply</td>
<td>Demand</td>
<td>Supply</td>
</tr>
<tr>
<td>Adult psychiatry</td>
<td>33,650</td>
<td>38,410</td>
<td>27,020</td>
</tr>
<tr>
<td>Addiction counselors</td>
<td>91,340</td>
<td>91,340</td>
<td>93,880</td>
</tr>
<tr>
<td>Child psychiatry</td>
<td>8,090</td>
<td>9,240</td>
<td>9,830</td>
</tr>
<tr>
<td>Marriage and family therapists</td>
<td>53,080</td>
<td>53,080</td>
<td>72,650</td>
</tr>
<tr>
<td>Mental health counselors</td>
<td>140,760</td>
<td>140,760</td>
<td>164,320</td>
</tr>
<tr>
<td>Psychiatric nurse practitioners</td>
<td>10,450</td>
<td>10,450</td>
<td>16,900</td>
</tr>
<tr>
<td>Psychiatric physician assistants</td>
<td>1,550</td>
<td>1,550</td>
<td>2,890</td>
</tr>
<tr>
<td>Psychologists</td>
<td>91,440</td>
<td>91,440</td>
<td>103,440</td>
</tr>
<tr>
<td>School counselors</td>
<td>116,080</td>
<td>116,080</td>
<td>218,130</td>
</tr>
<tr>
<td>Social workers</td>
<td>239,410</td>
<td>239,410</td>
<td>513,370</td>
</tr>
</tbody>
</table>

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:

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
Frontier Nursing University
Social Determinants of Health and Effects on Rural Health

Susan E. Stone, DNSc., CNM, FACNM, FAAN
President
Frontier Nursing University

September 19, 2023
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

Average Median Age for Metro and Nonmetro Counties, 2010-2021

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

Adults Reporting 4 or More Chronic Conditions

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

Metro 4.2%

Nonmetro 5.1%

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

Metro 20.9%
Nonmetro 24.0%

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