PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

+ + + + +

PUBLIC MEETING

+ + + + +

The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

+ + + + +

TUESDAY, SEPTEMBER 19, 2023

PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO*
LAWRENCE R. KOSINSKI, MD, MBA
WALTER LIN, MD, MBA
TERRY L. MILLS JR., MD, MMM
SOUJANYA R. PULLURU, MD
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT PRESENT

JOSHUA M. LIAO, MD, MSc

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STEVEN SHEINGOLD, PhD, ASPE

*Present via Webex
Opening Remarks........................................3
Welcome and Co-Chair Overview – Overview of Discussion on Encouraging Rural Participation in Population-Based TCOC Models Day 2........3
PTAC Member Introductions.........................4

**Listening Session 2: Incentives for Increasing Rural Providers' Participation in Population-Based Models**.................................9

- Alana Knudson, PhD, EdM; Tom X. Lee, MD, MBA; and Randy L. Pilgrim, MD, FACEP

**Listening Session 3: Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas**........85

- David C. Herman, MD; Ami B. Bhatt, MD, FACC; Thad Shunkwiler, LMFT, LPCC; and Susan E. Stone, DNSc, CNM

Public Comment Period............................173
Committee Discussion..............................177
Closing Remarks....................................200
Adjourn...........................................201
CO-CHAIR SINOPOLI: Good morning and welcome back to day 2 of the public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. My name is Angelo Sinopoli. I'm one of the Co-Chairs of PTAC along with Lauran Hardin next to me, here. Yesterday, we began our day with opening remarks from CMS1 Deputy Administrator and CMMI2 Director Dr. Liz Fowler, and she offered some context on how our work fits into the Innovation Center's vision. We also had several guest presenters share their ideas on encouraging rural participation in population-based total cost of care models.

* Welcome and Co-Chair Overview - Overview of Discussion on Encouraging Rural Participation in Population-Based TCOC Models Day 2

Today, we have another great lineup of experts for two more listening sessions. We have worked hard to include a variety of perspectives throughout the two-day meeting,
including the viewpoints of previous PTAC proposal submitters who addressed relevant issues in their proposed models. Later this afternoon, we'll have a public comment period. As a reminder, public comments will be limited to three minutes each. If you have not registered to give an oral public comment but would like to do so, please email ptacregistration@norc.org. Again, that's PTAC registration at N-O-R-C dot org.

Then, the Committee will discuss our comments for the report to the Secretary of Health and Human Services that we will issue on encouraging rural participation in population-based total cost of care models.

* PTAC Member Introductions

Because we might have some new folks online today who weren't able to join yesterday, I'd like the Committee members to please reintroduce themselves today. Share your name, your organization, and if you'd like, you can tell us some experience you may have had with our topic. I will cue each of you as we go around the room.

I'll start. I'm Angelo Sinopoli. I'm a pulmonary critical care physician by
training, spent many years as a Chief Clinical Officer in a large health system, running a large clinically integrated network with all product lines. Most recently, I'm the Chief Network Officer for UpStream, which is a value-based enablement company for networks and primary care physicians. Lauran?

CO-CHAIR HARDIN: Good morning. I'm Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC2 Strategies. I spent the better part of the last 20 years focused on building care coordination and integration models for underserved populations. Currently working deeply on Medicaid waiver implementation in many rural counties, and am a founding member of the National Center for Complex Health and Social Needs. And when I'm not traveling around working with communities, I live in rural Appalachia, in Kentucky.

CO-CHAIR SINOPOLI: And we have at least one PTAC Committee member online. So, Jay, can you introduce yourself?

DR. FELDSTEIN: Sure. My name's Jay Feldstein, trained in emergency medicine, practiced emergency medicine for 10 years, and then was in the health insurance world for 15,
commercial and governmental plans. And for the
last 10 years I've been the President of the
Philadelphia College of Osteopathic Medicine,
and we've operated a primary care center in
rural Pennsylvania. As well as, we've opened a
medical school in rural Southwest Georgia,
Moultrie, a town of 15,000 people. So, we've
got a very vested interest in rural health
care.

CO-CHAIR SINOPOLI: All right, thank
you, Jay. So, I'm going to look to my left and
go to Jennifer.

DR. WILER: Good morning. I'm
Jennifer Wiler. I'm the Chief Quality Officer
at UCHealth in the metro area of Denver,
working with one of the largest health systems
in the Rocky Mountain region. I'm also a
tenured professor at the University of Colorado
School of Medicine and an emergency physician
by training, and I co-founded our Health
Systems Care Innovation Center where we partner
with digital health companies to grow and scale
their solutions. And I was a co-author of an
Alternative Payment Model considered and
approved and endorsed by this Committee.

DR. WALTON: Good morning. Jim
Walton. I'm currently serving in a role as a health care consultant, and I just recently retired from a role as a CEO of a large physician IPA³ in Dallas, Texas, creating an ACO⁴ that had multi-payer contracts. Prior to that, I was at Baylor Healthcare System as their Chief Health Equity Officer, and practiced internal medicine in Waxahachie, Texas.

DR. KOSINSKI: I'm Larry Kosinski. I'm a gastroenterologist by training. I practiced in the Chicagoland Metropolitan Area for 35 years in clinical practice, retiring in 2019. I'm currently the Chief Medical Officer and founder of SonarMD, a company that was developed following a successful proposal here at PTAC back in 2017. For the last 10 years, I've been involved with value-based care, developing full-risk contracts in the gastrointestinal space.

DR. LIN: Good morning. I'm Walter Lin, an internist by training. Founder of Generation Clinical Partners. We are an independent medical group in the St. Louis-
Southern Illinois area, focused on caring for
the frail elderly in senior living, and helping
senior living organizations transition into the
world of value-based care.

DR. BOTSFORD: Good morning. I'm
Lindsay Botsford. I'm a family physician in
Houston, Texas, and I work with a company
called One Medical. I help care for our senior
practices as Chair of our ACO REACH\(^5\) entity.
So, we care for older adults on Medicare in
full-risk, total cost of care contracts.

DR. PULLURU: Good morning. Chinni
Pulluru. I'm a family physician by trade, 20-
plus years in the health care value-based care
transformation and clinical operations space.
Most recently Chief Clinical Executive of
Walmart Health Omnichannel Care, and led their
clinical operations. Prior to that, I led
DuPage Medical, now Duly, a large multi-
specialty group in suburban Illinois. Thank
you.

DR. MILLS: Good morning. My name
is Lee Mills. I'm a family physician. I'm
Senior Vice President and Chief Medical Officer
for CommunityCare of Oklahoma, where for 30

\(^5\) Realizing Equity, Access, and Community Health
years we have operated a total cost of care capitated model health plan owned by two providers operating in the Medicare Advantage, commercial, and exchange space. And prior to that, was involved in medical group leadership, coming through a whole variety of CMMI models. Thank you.

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

CO-CHAIR SINOPOLI: Great, thank you all. So, with all those introductions we'll move forward to our first listening session of the day, Incentives for Increasing Rural Providers' Participation in Population-Based Models. So, at this time, I'm excited to welcome the experts for our first listening session of the day. We've invited three outside experts to present their thoughts on some financial incentives with potential to improve the management of care transitions. You can find their full biographies posted on the ASPE PTAC website, along with their slides. After all three have presented, our Committee members will have plenty of time to ask
questions.

Presenting first, we have Dr. Alana Knudson who is the Project Director of the Pennsylvania Rural Health Model Evaluation and Director of NORC Walsh Center for Rural Health and Senior Fellow at NORC at the University of Chicago. Welcome, and please begin, Alana.

DR. KNUDSON: Excellent. Thank you so much for inviting me. Next. I always begin my presentations with, why should rural areas matter to you? And I begin this because I think it provides an important context. Rural areas are not only the source of much of our food, drinking water, energy production, and outdoor recreation, but one-in-five Americans, including a disproportionate number of veterans and active-duty military, live in rural communities. Making the study of health needs and challenges of rural Americans essential to us all.

And I begin with this to also provide a context about the interdependence that we have between rural and urban providers. It is critical that we address the health needs of rural Americans because they also depend on urban providers, and our rural providers work
in great partnership with urban providers. And in order to ensure the economic viability of rural and urban communities, it's important for us to address the needs in our rural communities across the country. Next, please.

I'm going to share some lessons learned that we've had with rural participation in some Alternative Payment Models. One of the key lessons that we've learned is that it's very important that we include rural health experts in value-based payment discussions. Not only with CMS and CMMI, but also with private and commercial payers. And this also includes rural finance experts.

We have seen numerous times, particularly for Critical Access Hospitals, that participating in some of these models makes it very challenging because of the cost-based reimbursement structure that these, some over 1,300 Critical Access Hospitals across the country operate. And so, it's important to ensure that they have a seat at the table when not only designing but also implementing.

It's also critical that we look at aligning rural providers to meet population thresholds, and I think I can take you back
years ago when the Medicare ACO beneficiary attestation thresholds were too high and did not allow any rural providers to participate. And that really was the impetus to begin Caravan Health, and recognizing the Medicare beneficiary attestation, for example, is an important piece in looking at how we address those population thresholds.

Likewise, we need to look at how rural quality reporting programs are implemented and followed, particularly for small volume providers both in the clinical, as well as in the small hospital space. Many of the different programs are optional in rural, but we need to ensure that our rural providers also have consistent clinical quality metrics so that we are able to monitor over time the quality of care that is being provided.

We already know that our rural providers are serving a disproportionate number of vulnerable people in their communities. But, putting a rural provider at financial risk, when many of our rural hospitals in particular are running at small to negative margins, makes participating in these programs particularly risky, and many of them opt not to
participate. So, it's important to think about how we can invite innovative ways for rural providers to participate, even given those particular challenges.

I think it's also important to recognize that we have some serious innovation fatigue among our rural communities. And I'll give you an example. I worked with a number of frontier hospitals in Montana, those are hospitals serving counties with fewer than six people per square mile. They implemented a community health worker program that was in place for three years. At the conclusion of the program, the grant funding went away, and one of the CEOs shared with me that, although it was an incredibly successful program and the community greatly valued the services that the community health worker provided to the community, because there were insufficient funds locally to continue that community health worker position, the CEO was then hung out to dry, so to speak, because he was no longer meeting a need that the local community felt was valuable.

So, many rural providers, particularly those that have been early
adopters, where a program has either discontinued or was altered in some way, it may be more difficult to get rural providers to participate in the future. Next slide, please.

There are some considerations when we're designing these population-based total cost of care models. And, as I said, it's not only important to encourage and engage our rural providers in the discussion, we also need to bring our community partners together. Particularly for models that rely on our advancing health equity, by addressing the social determinants -- and I like to call them drivers -- of health in the community.

It's also critical that we determine success metrics before implementation. Another key example is that, for many rural hospitals, financial viability is their number one success metric. However, many of the value-based payment models don't include financial viability as the number one success model many of these are looking at for cost savings. We need to make sure that the success metrics are aligned.

Likewise, it's very important to provide up-front funds, not only to support
implementation requirements but also to help
our rural providers in developing
transformation plans as they move from volume
to value. And we've seen this time and time
again as part of our Pennsylvania evaluation of
the rural health model. That is one of the
comments that the participating hospitals
shared with us as part of that evaluation. It
would have been very helpful for them to have
up-front funding to be able to get these care
coordination models and requisite resources in
place before the model started.

Likewise, it's also important to
minimize the new and additional staff and
financial requirements that some of these
models require. As you know, many of our rural
providers have limited resources, and so when
we require them to provide additional data
submissions, that usually requires additional
staff. One of the comments that our rural
providers have shared with us is, please do not
include models that also then require us to
recruit additional staff. Frankly, we've had a
long-term workforce challenge in many of our
rural communities and adding staff,
particularly with expertise in data analytics,
is a tremendous challenge for them.

Likewise, it's really important that there is some type of technical assistance that's provided, not only during the model application but also to support those implementation and ongoing data needs, as well as being able to track progress. Next slide, please.

Another consideration for our rural communities is really to look at that continuum of care. Looking at the long-term services and supports, how the public health community and services connect, as well as the role of community-based organizations. One of the greatest pain points that I am hearing in our rural communities right now is with regard to post-acute care. Swing beds are particularly a concern for our rural providers, so thinking about how all of these different types of services align to be able to ensure that the rural residents have access to the care that they need, but also that they are sufficiently reimbursed to ensure that that care can be continued in those communities.

Of course, it's very important that we align model implementation and performance...
expectations across multiple payment systems. Time and time again, rural providers have shared that there are different metrics, different expectations for data reporting, and this is really untenable for a number of our rural providers. So, thinking up front, how we can align these will best serve our rural providers in participating in value-based models?

Likewise, ensuring that payers are within the same model design so that they, our rural providers, don't have to try to manage again different types of quality metrics, for example, as well as payment systems. Because, again, with limited staff capacity, this makes it very difficult to actively participate. Next, please.

We also recognize that there are challenges with low volumes in performance expectations, particularly with regard to savings. And I'm going to jump down to the fourth bullet. It is critical that we recognize the relative difference between costs directly attributed to patient care, which are variable costs, as compared to cost of infrastructure required to support patient
care, regardless of patient volume. Those fixed costs, those are the costs that are required in order to meet conditions of participation.

There are also a number of costs for rural providers that are necessary for readiness, such as for emergency medical services, and those need to be factored in. Because, one of the challenges that our rural communities have is that issue of surge, and we definitely saw that during COVID, as well as different types of weather and other natural disasters that our rural providers have responded to.

It's also challenging to look at potential avoidable utilization reductions to reduce the overall payer expenditures, because, again, this cost reduction is in the short term, and it doesn't affect those fixed costs that are foundational to be able to meet those conditions of participation. It's also important that, as I mentioned before, that we look at including the recommendations from the 2022 National Quality Forum, the MAP\textsuperscript{6} Rural Health Workgroup Report, that also provides

\textsuperscript{6} Measures Application Partnership
important quality measures that can be used when we're looking at implementing new models. Last slide, please.

It's important, as well, to link financial risk to performance other than cost savings if financial risk is mandated. This is a big issue for many of our rural providers, and it's also a concern not to place essential local services at financial risk, including primary care, public health, and EMS\(^7\). And again, I'll give you a concrete example. I visited a frontier hospital that had, not only the Rural Health Clinic co-located but also public health, and they had to move public health out of the facility. And, by the way, this is a community of 1,100. The public health had to find a different facility because it played negatively into the cost report. So, again, we do not want to put our essential local health services at financial risk.

Also, applying financial risk only to aspects of performance controlled by the model participants is important. Because, one thing that we often see in our rural communities is that, a patient will receive

\(^7\) Emergency medical services
some type of surgical care or intensive medical care in an urban tertiary, they are released, and they come home and they show up in the ED\textsuperscript{8}, for example, in a rural community. And it is important not to put those types of care provisions at risk.

Also, thinking about models that don't rely on fee-for-service, again, because of that fixed cost, because of the low volume, think about opportunities per member per month, as well as other types of capitation. Also, looking at reducing innovation and alignment barriers through regulatory waivers. Particularly, for example, if you're looking at the Chronic Care Management using, for example, community paramedicine in some of our rural communities.

And lastly, I have a number of resources for you at the end of this presentation. We are part of the Rural Health Information Hub Partnership. We develop and design all of the toolkits that are provided to provide support for rural providers as they transition from volume to value. There's also another important slide called, “Am I Rural.”

\textsuperscript{8} Emergency department
And lastly, the Federal Office of Rural Health Policy funds rural health research centers to conduct analyses specific to the implementation of rural programs. Thank you.

CO-CHAIR SINOPOLI: Great. Thank you, Alana, that was a great presentation. Next, we'll hear a presentation from Dr. Tom Lee who is the Chief Executive Officer of Galileo. Tom, go ahead.

DR. LEE: Thanks for having me. My name is Tom Lee. I'm a primary care internist by training and currently lead an organization called Galileo. It's a new care model really designed to improve the quality and affordability of care for all Americans, but particularly focused on rural and underserved communities. Next slide, please.

Just as context, my background, I did my medical training in the rural Northwest, so I have worked in a variety of rural care settings and have used that kind of experience to inform my perspective on how rural care could be reimagined. Most of my career has been focused on entrepreneurial activities, focused on improving the quality and affordability of care. First, at a mobile
device company called Epocrates, thinking about point-of-care decision-making on pharmacy information. Then, at One Medical, thinking about how do you innovate on the primary care model, really looking at mostly urban populations? And ultimately, leading to my current journey on building Galileo, which is really looking at how do you serve last mile populations more effectively and efficiently with a higher-quality model? Next slide.

Just a bit of background on how we approach care in the rural and underserved communities. At Galileo, we've really tried to look at care in general and break it down into the components that need to be most effectively delivered. Because, you know, care in the primary care setting, particularly in rural environments, is particularly challenging. Putting the resource where it is best fit, with the right skills, is kind of what the goal has been to kind of service rural communities.

So, what that means is, we operate a digital-first model of care where appropriate, for populations that can interact with a digital form factor. That includes phone-based and other consultative services, digitally and
remotely delivered. And then, we also go to
the home as the other first place of care when
frail and elderly patients cannot really travel
to the office, we really look to meet patients
in the home, particularly under -- around
complex and capitated frameworks.

And then, we operate brick and
mortar where needed as the second place of
care. So, it's a bit of an inversion of the
traditional care model. We wanted to design a
care model that could scale much more reliably
across rural communities and, almost by
definition, be less dependent on brick and
mortar to do so. Next slide.

We were asked to talk a little bit
about some of the challenges related to rural
medicine as it relates to infrastructure, but
obviously there are many other dimensions and
challenges well-described in the presentation
and preparatory materials here. But, we'll
talk a little bit briefly about our perspective
on how we look at some of the infrastructure
challenges. Obviously, there's the connectivity
lens, but we also think about labor and time
matching as an infrastructure-related
challenge. Skills matching, facilities
capabilities, and payment alignment are all kind of interrelated to the underlying architecture of what creates challenges in, particularly, rural environments. Next slide.

How we thought about it at Galileo is really just to start to look at each dimension and solving for, how do you be more effective with more patients more cost efficiently to make the feasibility of operations in low-density markets more possible? So, obviously, connectivity can be an obstacle, but we really look at multi-modality. We're agnostic to the form factor, so yes, cellular and/or broadband access can be limited in some markets and regions, but the landline is also available as are home modalities if and when needed.

When we look at the -- next slide, please -- the home modality is particularly challenging, given labor and time matching challenges. And so, whenever we've looked at, how do you operate within low-density markets, it's constantly, how do you get the right supply to the right demand in the most cost-efficient manner, to make the model operate, work within most payment frameworks? This is
probably the most challenging aspect, we think, to rural medicine.

And I do think that some infrastructure, meaning tech, data, and/or connectivity solutions can help facilitate some of these labor challenges. But, a discipline around matching the appropriate supply to the demand is one of the key aspects that we found to be critical to managing a sustainable practice in rural environments.

And then -- next slide, please -- the third dimension, which is related to labor and time matching, is skills matching. And obviously, there's a dearth of the right specialists in the right markets for the right communities. And so, what we try to do is leverage remote connectivity, remote skills, and a team-based approach to care that can make what we call, fixed cost, behave more variably so that the expertise can be delivered across a broader geography, where appropriate. So, those are some ways that we've looked at it, specific to these areas.

Lastly, on the next slide, we just talk about more broadly ways to think about advancing, kind of, rural health and value-
based care innovation across these five dimensions. On workforce, we really think about workforce training, workforce supply, and how do we improve the ability for the workforce to be up-leveled in any given local community, given the challenges.

The second is obviously member density. We think about how can partnerships across communities, within communities, further reduce the challenge to member density as a dimension to kind of consider?

The third is really looking at, how do you improve the regulatory and reimbursement frameworks to support home-first care? We think that these are important, critical aspects to care, provided that the regulatory and reimbursement flexibility is there. On a related note, the tech enablement, certainly during the pandemic, there were exceptions to payment that facilitated tech-enabled care. We would like to see those continue, particularly as we're looking to innovate into rural communities with more supportive infrastructure.

And lastly, the investment. Thinking about facilitating utilities or other
data or tech hubs that can help facilitate the up-front investment that might be needed by individual practices or communities that could be supported more centrally. So, those are some dimensions to consider. And thanks for the time.

CO-CHAIR SINOPOLI: All right. Fascinating presentation, really appreciate that. So, next, we're excited to have Dr. Randy Pilgrim who is the Enterprise Chief Medical Officer at SCP Health. Welcome, Randy, and go ahead.

DR. PILGRIM: Thank you very much. Thank you to the Committee for hosting this, thanks to my colleagues. The next slide will give you an overview of what I want to use for my initial comments here. I was asked to comment on the unique health equity challenges, so I'll briefly touch upon that, because again, we have a very learned audience here today.

I want to review the most important measures for social determinants of health, and health-related social needs, and I will spend a little bit of time reviewing examples of prior value-based models that may be applicable and instructive for how we consider rural-based
transformation into the value-based world.

And particularly, potentially how to approach integrating health equity into value-based transformation as we review those things. And then as my colleagues have already addressed in some fashion, increasing the probability of participation by clinicians in future value-based models. The next slide just is a fundamental slide. Again, I will spend only a little time here.

But I do want to point some basic definitions, and an index that I'll use a little later when I share some data. Equity of course is about creating the level playing field where everyone has the opportunity to achieve their full health potential. Disparities arise when there are preventable differences. So, health equity volatiles in value-based transformation really should go at preventing differences that are in fact preventable.

The social determinants of health we know well now, and thankfully there are even more data and information that are growing about this. But they can yield to health-related social needs, the unmet or adverse
social conditions that do contribute to the poor health, and are frequently arised from those social determinants.

And finally, new to some of you perhaps is the Area Deprivation Index, a zip code-based ranking of socioeconomic disadvantage, where a high number is bad or more challenging, a low number is better or less challenging. I'll review that in the data. Next slide. As we know, rural populations often experience disproportionate challenges in health-related social needs.

It's well known that health rural communities are 19 to 20 percent, so one out of every five Americans lives in a rural environment. Although variably defined, it is defined often. Lower income, more uninsured, more elderly, more chronic disease. And so, on these two sides of the same slide I have arranged what often are sort of a Maslow's-like hierarchy.

If these are the fundamentals that in fact our rural colleagues and citizens experience, then our models must actually get at those things. So, transportation, food, and geographic isolation being the most fundamental
challenges. Housing and utilities, and connectivity being the next layer.

And you really, until the middle of the triangle, don't even get to clinical care as we would often think about clinical care per se. Most of that is very fundamental, like food, housing, et cetera, and then insurance, I put at the top, is empowering access to care, but itself not delivering the care. It empowers access frequently.

Those are the kinds of challenges. So, as we think about integrating health equity into value-based transformation, we have to think about those in terms of priorities, and how those can best be met. The next slide shows that if we are to achieve health equity, proposing here kind of a three-legged stool that equitable access to care is one leg on that stool.

Equitable delivery of clinical care is the next leg on the stool. And equitable transitions and continuity. This may be a framework we could consider as we think about transforming into value-based models so that if you don't have access to care, you can't get the delivery of the care. If many have access
and that's equitable, the care has to be
delivered equitably to various cohorts of the
population.

And then where a lot of work is, is
in the transitions and continuity. So, using
this as a framework, on the next slide I do
want to review the first two of four models
that have given some framework for us to
consider how to think about rural models, and
again, value-based transformation.

The first model, very familiar to
one of us sitting here, Dr. Jen Wiler of the
Metro Community Provider Network, the Bridges
to Care Model. An excellent model that
supported post-emergency department patient
navigation, utilization, decision-making.
Coming back to the emergency department,
advanced imaging, et cetera, primary care.

And in particular, this model used
on-site patient engagement during an emergency
department visit for those frequent emergency
department patients. That on-site engagement
model subsequently dealt with social
determinants of health, and interestingly, also
substance abuse and mental health patients were
included in that model, frequently a challenge
that models may not always include.

The findings, in very brief, again, Dr. Wiler can detail this like none other. But there was a significant reduction found in post-visit emergency department visits. A significant program savings, and of importance, using the initial ED visit as a real time engagement opportunity is particularly effective. I will get back to that in my final comments before my time is up.

But thinking about how we can leverage existing resources in rural communities that programs are already investing in. So, for example, the Rural Emergency Hospitals, the Critical Access Hospitals, and other things are really important in terms of making sure that we have sustainable systems.

The second model, very different, but had similar outcomes. The Global Budget Payment Reform System that's in the state of Maryland aligned hospital revenue not with patient volume or services delivered, but with a global budget.

What resulted from that was care transformation when hospitals and services, and clinical services in particular were aligned
with that; subsequent studies found that repeat visits to the emergency department, admissions from the emergency department, and returns at both three days and nine days were positive findings in subsequent studies done by Dr. Jesse Pines and his colleagues.

Lower utilization, ED returns, admission, but also some stable mortality and ICU stays showed that we were probably not adversely affecting the sickest of the sick while we were also trying to impact the volume and services that were delivered. The findings here showed that economic alignment with hospitals can safely reduce total cost while you're working on this.

Now again, that sounds self-evident, once you do this, but these are examples of how this has relatively worked well, certainly plenty of challenges about where you set budgets, and what's included or not. But there were opportunities also found to address disparities among the ED returns.

So, this was not a highly equitable outcome that we found. We did find opportunities, subsequently I'll talk a little bit about how we might be able to address that.
The next slide shows something that Dr. Wiler actually mentioned in her introductory comments as well. I was also a co-author of this, the Acute Unscheduled Care Model, which has been seen by this PTAC back in 2018, approved and recommended.

It was the first risk-bearing APM\(^9\) for emergency medicine, and while emergency medicine is frequently seen as a threat or a failure in many APM models, this model looked at how we could actually leverage an existing fixed cost, which my colleagues have already mentioned in prior comments, to reduce hospitalization, foster coordination, and reduce post-ED safety and risk events after an index emergency department visit.

The waivers for telehealth, home visits, and transitional care management now being available to the emergency physician in the proposal, including behavioral health patients in mature phases of the plan. Once again, the PTAC looked at this after the rigorous review was recommended, and once again, the value here had more to do with the retrospective evaluation of whether a model

\(^9\) Alternative Payment Model
like this mathematically should work, economically could work, and practically could be rolled out.

The next model on the bottom part of the slide, although the AUCM\(^\text{10}\) as proposed to CMS was not in fact implemented yet, the principles of the AUCM model, using the safe discharges, patient navigation, care coordination, and quality measures are being used now. Our group in particular, and there are other groups I know that are looking at this, are using this with commercial plans, with Medicare Advantage, and considering this with Medicaid as well.

There are models that are live now, and they include various levels of risk and economic reward, along with quality measures and safety measures. The high patient engagement rates also mirror what the Bridges to Care model found, which is the direct follow-up from the physician group and the hospital after an initial emergency department visit resulted in notably reduced return visits.

The patient experience was markedly

---

\(^{10}\) Acute Unscheduled Care Model
improved, and the overall cost was improved. So, we have some reason to think that there are some principles that might be compelling. Some potential models, and learnings, and opportunities.

And importantly also, as rural communities struggle most frequently with sustaining models once they're there because of the resource constraints, it's compelling to think about whether we can leverage existing resources in service of other objectives. The next slides will briefly note that when you use existing services, that being the hospitals that exist, and the emergency departments that exist, there are equitable outcomes that might be achievable.

These are, on the left-hand side, 300 emergency departments in 32 different states showing that there are relative — using one measure of quality, which is MIPS\textsuperscript{11} performance, that's only a single measure, these are six MIPS measures by the way, all aggregated in terms of performance.

And as you see, the rural, the small

\textsuperscript{11} Merit-Based Incentive Payment System
practice, the HSSA\textsuperscript{12}, low-volume, and hospital-based practices had very similar results. We believe that that is because the patients had equitable access, equitable care delivery, and there were simply no barriers in order to get this done, and there was a good amount of data, and feedback to the clinicians that occurred.

Similar results happened in hospital medicine after the patients were discharged. So, once again, using hospital-based clinical services may in fact yield opportunities for equitable outcomes. Next slide. Looked at a single area, again, this is just some data that may be worthy of discussion.

In 55 emergency departments, of which three-quarters are in rural environments, the Area Deprivation Index was applied, again, a ranking of socioeconomic disadvantage where the deeper blue colors are actually the most deprived, if you will. The scale is from zero to 10, anything over four is indicated in the orange bars.

We found that in looking at the primarily rural environments, three-quarters of them, again, of the 55, are rural. The core

\textsuperscript{12} Health Shortage Service Area
measures, MIPS, sepsis bundle, and substance use evaluation outcomes were similar. Once again, there are structures that promote this, and the next slide begins to detail those.

As we look at, again, sustaining, there's enough compelling -- there are enough compelling models out there that make us think that we may be able to do something here to engage rural health providers and communities in equitable care. What are the reasons to think that that may actually last?

In terms of equitable access, there is an EMTALA\textsuperscript{13} requirement that guarantees patients from a federal law standpoint, access to care, assessment of an emergency condition, and stabilization within the resources of the hospital. There's a prudent layperson standard, and there's public reporting of certain measures, including quality measures.

So, there are things already in place that would tend to promote that. In terms of equitable delivery, not only established standards of care, but increasingly telemedicine oversight in rural communities, but there is also certification and regulation

\textsuperscript{13} Emergency Medical Treatment and Labor Act
that can apply.

Again, the Rural Emergency Hospital setting talked about how to do the certification and regulation standards so that the processes, the outcomes, and the governance are supportive on a longitudinal basis. And finally, where I think the most work is, is the transition and the continuity of care.

Increasing screening, HRSN\textsuperscript{14} and identification, care coordination, and after care, frequently the issues that have to be funded longitudinally, but with waivers and other access to opportunities. Those may be, again, sustainable. The next slide begins to show one potential framework for inclusion of health equity into value-based models.

And the bottom bullets under each of these three legs of the stool that I've repeated now, may be the most important. Actually, on the access to care, not only did you achieve access to care for your population, but was it a representative population of your community, as opposed to a cherry-picked population, or a selective population if you weren't doing the picking, but it was actually

\textsuperscript{14} Health-related social need
picking for you.

So, in other words, if you achieve quality measures, or operational measures that are in the middle column, you would actually be paid well if it was an economically at-risk model if you applied those quality and operational measures consistently for all patient groups. You would be paid less well if in fact it was not.

So, there are opportunities to sort of risk-adjust the payment, the risk, or the benefit under a model, depending on how well you serve the population itself. Under equitable transitions and continuity, frequently those will be process measures and transition indicators. As I put in parenthesis, very important to align primary care specialists and non-rural resources with those.

But oftentimes the kind of integration of health equity into value-based models has to do with whether or not in fact you really did assure the continuity and transitions occurred. And then ultimately the outcomes will follow. Next two slides are my final ones, and that is again, this learned audience knows a unified mission and clear
objectives are very key.

I do think it is very important of course to establish what clinical objectives we are looking for. Then align an operational model, then align an economic model, and then make sure that the consistent and adaptable model is a result. Consistent meaning the infrastructure, and the outcomes, and the sort of fundamentals are the same.

But there's enough adaptability, because as we all know, rural is not rural, is not rural. I personally grew up in Minnesota. The largest town I've ever lived in until recently was 2,500 people, and I spent my entire emergency medicine career practicing in rural environments, and they are all so different.

I do however think it's entirely possible to have consistency with a model, but adaptability. Next slide summarizes what I said. Access, delivery, and continuity. The three pillars. Might be, again, compelling to leverage existing structures and mechanisms to achieve health equity objectives.

I really think this is a frontier for consideration. The opportunity to use what
we have better than we've been using it rather than connect new resource staff, and then find that the resources dwindle over time, as does the program eventually, is a compelling thought. Thank you very much.

CO-CHAIR SINOPOLI: Thank you, great presentation. So, now I'd like to open up the discussion to our Committee members for questions. To indicate that you have a comment or question, if you'd flip your name tent up, or if you're on Webex, Jay, just raise your hand in Webex, and I'll ask if there's anybody that has any initial questions they'd like to ask. I can't see, does Jay have his hand up?

DR. FELDSTEIN: Yeah, I have my hand up as well.

CO-CHAIR SINOPOLI: Okay.

DR. FELDSTEIN: Yeah, this question is for Tom. I'm really interested in what you're trying to do. Do you see your company as a standalone solution for rural care, or do you kind of bolt onto existing infrastructure, in certain rural communities, and kind of fill in the gaps, or is it both?

DR. LEE: The way we've designed it is both. There are gaps where there aren't any
providers, where we fill in gaps in networks to
services, regions. And then we intentionally
wrap around local providers, and provide
infrastructural support and other collaboration
with established providers.

Definitely in rural communities, we
think that the fabric of care needs to be
maintained if not supported. So, a lot of what
we do is help facilitate handouts,
communication, establish [inaudible], and CBOs\textsuperscript{15}
in any given local community.

DR. FELDSTEIN: And about how many
markets are you in right now?

DR. LEE: Digitally we operate
across all 50 states, and that includes just
rural care digitally delivered. We do have a
home-based presence in four states, soon to be
five. Those are particularly in rural
communities, but we also can operate in urban
communities, but that's the current scale that
we're at.

DR. FELDSTEIN: Thanks.

CO-CHAIR SINOPOLI: So, I'd like to
expand on that question a little bit, and maybe
ask it of all three of our panel members. So,

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{15}] Community-based organizations
\end{itemize}
\end{footnotesize}
we've heard a lot over the last PTAC meetings, public meetings about the need for actual contact with patients, actual physical contacts, and team members, and kind of a multi-modal interaction with patients, and how effective that is.

So, obviously in the rural environments, that's much more difficult to do. And so, I'm hearing more about digital intervention, and more about even today, telephonic intervention, virtual intervention, certainly coupled with community health workers and mobile care.

But I'm curious as to whether you see that those other interventions are actually working in the rural environments. If they are working, what's the key to the success of those interventions, as opposed to the thought process generally that telephonic care management doesn't really work, and is effective as interventions, or otherwise? So, let's start out with Randy, and we'll work our way through.

DR. PILGRIM: Yeah certainly, Angelo. So, we do have some experience in our own group on this, and I'm aware of other
groups that are doing the same. Once we establish, I'll use our own experience, just because I know it best. Once we established a 24/7 nurse call center for the sole purpose of following up on an initial emergency department visit to ensure continuity, help patients with navigation, connect them with primary care.

We found that there was about a 60 or 70 percent rate of returning calls from that nurse center. A series of three calls, an escalation, and so forth, just to return the call. Once we appended that with a text message, the initial text of which went out right after the emergency department visit.

So patient is typically in the parking lot leaving the emergency department for their ambulatory discharge, that 60 or 70 percent raised to 90 percent. So, that was a much different patient engagement result, and then there were other follow-on results that occurred after that.

We found that the key was simply getting ahold of and establishing post-emergency department contact with the patient. Texting certainly helped that. We are working also on a web-based interactive site that
actually is diagnosis or follow-up specific for them. So, those results are yet pending.

I think your question is does that work in rural areas? Yes, absolutely it does. We are not in some of the most discrete rural areas if you will, so we're not in Alaska, for example. Where some of the connectivity, and some of the infrastructure there may be more challenging.

But where there are broadband capabilities, Wi-Fi capabilities, and cell phones, we found some very compelling results, and they were much more cost effective.

CO-CHAIR SINOPOLI: Great. Alana, can you comment on that?

DR. KNUDSON: Certainly. We actually did a study looking at the use of telehealth services pre-pandemic and during the pandemic. And one of the interesting pieces on this is that we found that the use of, for example telehealth visits for behavioral health, had a level of continuity over time, especially when we saw increases like in omicron.

We saw those peaks, however, in talking with a lot of rural providers, and
looking at the data, the use of, for example, telehealth visits has not sustained, it has not continued to be high in rural communities. That is not the way a lot of the current cohort of older adults in rural communities choose to access care.

However, I think as we see our baby boomers continue to age, that are much more digital, they have a greater digital literacy than some of our other older adults, I think we will see that shift. But I will also caution that when we look at, for example, behavioral health, we don't have enough behavioral health providers now.

And even with telehealth, and different types of applications, we still have waits for people to be able to access that care. So, I just want to caution that there's a lot of opportunity, but we still need the workforce to be able to provide those services via telehealth.

CO-CHAIR SINOPOLI: Great, thank you for that. So, Tom?

DR. LEE: So, to maybe address it a little bit, we've found that each modality has a purpose given the context and given the
individual. So, our bias has been to use the right modality, and the right moment in time for the right patient. And so, the ideal organization has a range of capabilities so that they can better use their labor in the most effective way.

Because of the travel distances required, you have to be more discrete about who is traveling to whom, when, and how. And so, because the digital form factor helps support that relationship in the absence of physical presence, we think that that actually compliments, and augments the providers' effectiveness and efficiency wherever it can be done.

It's rarely for us, a playbook of always A, or always B. Because, for example, in the first patient visit we will go to the home by design. That's an inefficient quote unquote visit, but so much is learned, so much trust is built, that then you can form a digital connection thereafter.

And then you also better understand the infrastructural limitations of the home to know that a phone-based encounter is probably going to be more effective than a digital-based
encounter. So, a lot of this, I think needs to be built into organizational muscles so that they can use the full range of connectivity devices to patients for the right purposes.

So that the needs can be better met in a more cost-effective way. So, that's kind of our notes on it.

CO-CHAIR SINOPOLI: Perfect, thank you. Lauran?

CO-CHAIR HARDIN: All three excellent presentations. I have so many questions for you, but I'll start with one. So, I spend a lot of time in partnering with rural communities, and it's really expanded my perception of who can do care management, who can really deliver services. So, I have been part of designing models that involve ministers as the core person.

So, I'm curious, workforce is such a huge issue in rural, what creative roles or disciplines are you seeing set forward as key and also possible to tap into in rural? And are there any policy changes that would facilitate integration of those roles on a broader level?

DR. PILGRIM: I'll start. Our
experience has been a surprising amount of -- a surprising contributor, out of proportion to what we ever thought to the ultimate outcomes that we're looking for, or to interval outcomes, has been simple navigation and wayfinding. We typically use nurses, occasionally nurse practitioners or PAs.\textsuperscript{16}

Very frequently, not at the clinical license level, but to do those kinds of things increasingly, we're finding that that's simply not necessary. In fact, we're not even sure we need an LPN\textsuperscript{17} at times to do that kind of basic wayfinding, navigation, appointment achievement, and satisfaction.

So, it may be important from a policy standpoint to consider whether or not there are compensable actions that support ultimate continuity and transitions of care that do not require a clinical license of any kind. Again, we've been very surprised at how simply the first, second, or third step with a patient is all you need.

And as we try to not become their entire health care service provider, but

\textsuperscript{16} Physician assistants
\textsuperscript{17} Licensed practical nurse
transition to the correct one, navigation and way finding has been huge.

DR. LEE: Maybe the analog for us, I agree with Randy's comments in that area, what we have been investing in is local rural markets because of the lack of available skilled talent in all the markets, we've really focused on hiring local talent from local communities to build relationships with patients, and sort of as a way finder and navigator.

So, a community health worker, but in a much more kind of advanced context. That's how we've looked at labor opportunities for local markets. And the beauty is, obviously, they're from the local community, and really understand the nuances naturally. So, agree, reimbursement architectures to support that framework are always helpful.

DR. KNUDSON: I would also add that community health workers are really critical in rural and in tribal communities because of that connection, and that trust factor that I think is really important, especially as we're looking at advancing health equity, that is foundational. But I will also counter that
with the challenges of getting those different people reimbursed.

And I am at a rural meeting today sponsored by the National World Health Association, and that is the exact discussion that we're having. Community health workers are not always reimbursable, and yet they are really key in making those important connections.

CO-CHAIR HARDIN: Thank you.

CO-CHAIR SINOPOLI: Chinni?

DR. PULLURU: Thank you to the panel for the really thoughtful dialogue. My question is regarding something that Tom had mentioned, and it's to Tom, as well as the other panelists. Tom, you had mentioned in your presentation a decrease of sort of the regulatory infrastructure, or regulations that now govern certain parts of care delivery.

Yesterday, it was brought up, obviously some of the regulations around telehealth, in person requirement, as well as some of the other things. Can you give us more details on your thought processes around this? Because given the construct of sort of the Committee, and our recommendation, this seems
like it's something that is something we can take on.

DR. LEE: Yeah, it's probably beyond my expertise to give the specifics. I think the general lay of the land, and I'm happy to refer to our counsel, who probably has a much more specific lane of conversation around each state. So, it's obviously programmatic, state-based, but they generally fall into two areas.

One is about labor and workforce, so what services are reimbursable in what settings by whom? So, a lot of that has to do with kind of what labor and workforce can be deployed into kind of which setting. The second would be reimbursement, and reimbursement flexibility, particularly around digital modalities. So, I think those would be the two general areas.

And then I would probably just defer to my senior team to kind of comment more specifically.

DR. PULLURU: Thank you. Randy?

DR. PILGRIM: Yeah, it's a good question. I mean, the whole idea of telemedicine was to bring a clinician to the patient. I think anything that supports that,
and has the right sort of framework around it so that it's not promoting misuse, or even abuse of clinical care, is a good thing.

So, anything that we can do, as COVID has shown us, as the extension of telehealth capabilities has also been provided for through 2024, those things are generally good. Once again, I'm actually quite surprised at how at times the clinical objectives of the telehealth visit are not always as concrete.

Some people just know they just want to see a doctor, and this is one way to do that. And if it's entirely patient-driven, which I'm a very big supporter of, but if it's entirely patient-driven, sometimes the ultimate objective gets lost in the setting of longitudinal care and ultimate health outcomes.

So, I'm a big fan of bringing clinicians to patients wherever it can possibly be done, but also aware that there have to be certain guidelines around the utilization, so that in fact you don't just get a lot of care delivered, but no ultimate outcomes for that care.

DR. KNUDSON: I would add, one place in rural that's really important to look at
some of the regulatory, particularly face-to-face, and that is with regard to hospice care. Having telehealth be used instead of face-to-face, especially in the later stages of hospice care, is an important addition.

You don't want to take vulnerable patients out of the home if you don't have to, and many providers are not able to go to the home. So, that telehealth visit really supports not only the patient, but also that family.

DR. PULLURU: Thank you, Alana, that was really --.

CO-CHAIR SINOPOLI: Thank you. Jim?

DR. WALTON: Thank you for your comments. Randy, I was struck by some of your comments. I was going to kind of just do some reflection. When I was practicing in a rural area, one of the things that seemed to be recurring a lot was the emergency department at my local hospital served as a reservoir, so to speak, or an opportunity to decant patient overflow when we were overwhelmed.

We would often tell the patients in the middle of the day, please go to the emergency room, because we already had so many
patients to take care of we couldn't possibly work them in, even though we had an open schedule. And what I think that I'm reflecting on, and that also happened at night right, when we were on call taking care of folks. And so, one of the things that I was struck by your data, which was the amount of equity of care delivery that took place once the patients got to the emergency room. And I really think that that was a very helpful piece of work to illustrate that. But one of the things that kind of comes to my mind around this idea of a value-based model, kind of if we move forward with the next idea of incorporating equity in a real time way, is do you see emergency department activity, and actors, and reimbursement for emergency department activity connected to primary care? So that there is a combined responsibility for chronic disease outcomes, and completion of preventive care services that we know, by evidence, reduces the downstream demand for health care, and also will reduce morbidity and mortality.

So, in a future value-based model, would you see emergency department physicians
and primary care doctors being, if you will, an integrated team, particularly in the rural areas? And being accountable for the way they receive payment rewards, being accountable for not only measuring the community's health disparities, but also being accountable for moving them, or closing them, or shrinking them together by some kind of concerted activity?

And I think Tom, I'd like to hear your response to that too, from what you're doing with Galileo. But I think this really kind of, you stimulated me with your comments, so I just thought we would explore this a little bit.

DR. PILGRIM: Yeah, listen, I really appreciate that. I would have a couple of thoughts to your comments and question. First of all, I do not think the current reimbursement environment, and the realities of how we are paid in emergency medicine is aligned well. I do not think that at all. I do think that there is every possibility that in fact we can change that.

The emergency department being sort of, in some sense a safety net, a backstop, a failsafe of sorts, it's very difficult to take
a failsafe, and a back stop, and turn that into an opportunity that actually does what you were talking about, which is align around health disparities, and prevent them where preventable, and make sure that you have the chronic care.

And ultimately the utilization of the system is right sized. Our current system does not support that well. There are systems that do that, in concept and in theory. The AUCM model was one of those. And I think it is harmonizable with other existing systems, rather than it being stand alone.

So, I really liked your comment about making sure that the primary care and appropriate specialty care is aligned with the emergency department. I absolutely believe it's possible. It will take change from the current system. The current system does not do that well. It may also take, and this will be an edgy comment, but it may also take some revision of the requirement under EMTALA, which is a very high standard of assessment.

With a requirement of near perfection to identify a potential emergency medical condition, that chews up a lot of
resources to meet that standard when in fact you don't always have to meet that standard in order to make sure that the longitudinal care for the patient is appropriate and aligned with primary care.

So, I think there is work to be done here on this, and particularly in rural areas, we need to make sure that we don't trip ourselves up with existing structures, but at the same time leverage what's already there.

DR. LEE: Yeah, just briefly. You know, obviously, this primary care ED access is an important access in a lot of communities in general, and I agree the reimbursement alignment is challenging. I think it's a noble goal. I think organizationally, and financially, I think it could be complicated, given the just inherent natures of the different types of services in the organizational infrastructures.

But I think if you could solve that, it would be interesting. The way we've looked at it is at the end of the day, people and individuals choose to go down the path of least resistance, all things being equal, and so the ED in general can be the easiest place for most
people.

And so, I think coming up with some alternatives, creating some financial alignment for those alternatives, I think can also kind of redirect patients to the appropriate resource first. Those can be done digitally, and through phone-based services, and, or other ways to support the infrastructure of better places of care.

So, I think I always look at kind of path of least resistance, and how do you kind of change those incentives and architectures to better support the right flows and dynamics. I do think communication between those groups is still critical regardless. And so, I think something needs to kind of help facilitate that.

Certainly, the information for whenever go into a community is pretty low, in terms of ADTs\textsuperscript{18} and otherwise. It does take a lot of effort to wire those up. And so that's another opportunity for better communication between those two important provider types I think as well.

\textsuperscript{18} Admission, discharge, and transfers
CO-CHAIR SINOPOLI: Perfect, thank you. Larry?

DR. KOSINSKI: Thank you, Angelo. This was a very sophisticated set of presentations. I really enjoyed all three. And I jotted down a number of the statements that each of you had made, and I love Alana's comment about utilization reduction only affects variable cost. I thought that struck me. Tom, I love the fact that you flipped, and had digital first, and brick and mortar last.

And that you want to make fixed costs act more variably. I love that comment as well. And Randy, rural is not rural, is not rural, you got me with that, and I love your focus on access. My question to the three of you is we've learned in previous PTAC sessions on different meeting dates that we need to have a proactive primary care model.

I heard a lot of reactive from the three of you. What are each of the three of you doing to proactively reach out to this population that may not even realize that they need care?

DR. LEE: I can maybe start. We participate in risk-based arrangements, and so
we take accountability for populations. So, I think that just the mere concept of accountability helps, and then you have to look at payment alignment and operational alignment to do so. We’ve designed pop-up services, or what we call proactive services by design, because it accomplishes multiple goals.

Engagement with patients, preventative care, chronic care, quality of care, but also builds trust so that when we're doing the transactional reactive care we have better context, and better nature of how to service the individual patient. So, we think proactive care is an important component to population-based care in general.

And a lot of the capitated, and, or quality programs help foster that alignment. That being said, it is very hard to do this work on a scaled basis if you're in a very busy primary care practice. And so, that unwinding of time to find more time to play offense in the general community I think is quite challenging.

And so, there needs to be a tech and data infrastructure to know which cohorts have which gaps. There needs to be a reasonably
scalable labor force to build, engage, close those gaps. And then what I call the appropriate clinical connectivity of the primary care team so that there's alignment with a primary care plan, not what I call kind of two different teams operating in very different environments with different objectives.

So, I think those are the challenges to it, but I think those are kind of some of the elements that we face in our operations.

DR. PILGRIM: I'll mention something next. Another great question, I really think that articulates the various roles that health care entities in a community play. In the emergency department we've been classically doing absolutely nothing about reaching out to the population. In fact, it's one of the things that has held us back from participating in value-based models over years, and years, and years, has been our population is actually whoever comes to see us. It's 100 percent unscheduled, 100 percent patient-driven, where the patient or someone on their behalf comes to seek their care. So, that's held us back as opposed to a
roster-based mechanism where a primary care may get a list, here is your patients, take care of them, allowing them the opportunity to reach out ahead of time.

In trying to bridge that, however, there is actually an answer to, are you doing anything? In some of the models that I mentioned in my presentation, the outreach after an initial emergency department visit, because that's now our population. You came to me, now I can reach out after you.

Interestingly, that outreach becomes the outreach prior to the next visit. So, it's after the first one, but it's prior to the next one. That's where we found most of our opportunity, and mainly, not to replace primary care, but to connect them with primary care, which of course requires that there be primary care to connect them with.

But most of that outreach, amazingly, even though it's after the first event, has been effective. I think there's opportunity there, but it still does leave a gap, Larry, that I think you point out very nicely, which is what if no one ever does come? Have we seen about their health care, and let
alone equitable care in the process of that?

I think that's a gap that we need to think about very carefully in rural areas especially.

DR. KNUDSON: And I guess I also go back to finance drives function. And when you're looking at primary care and what people are reimbursed to do, I often talk about windshield time in rural. Because similar to Randy, I grew up in a community of 434 people. Trying to get care out in some of those areas requires actual windshield time if you're going to go to these homes.

So, that is also an issue. But I just want to take you to two demonstrations that we have in progress right now. The Pennsylvania Rural Health Model is a model that funds hospitals. And hospitals work with communities, but the interesting part is that primary care is foundational to all of the work that we do, and all of the outreach in being able to advance population health outcomes.

So, we need to have models, and payment systems aligned so that hospitals, and primary care, and ED, everybody is aligned, and going along the same path. If we have a
different value structure, or a different incentive for the hospital than we have for providers, we are going to have a misalignment. Likewise, when you look at Maryland and the total cost of care, it's always important to remember there is an all-payer rate that is foundational to the success of that model. And so, it helps to be able to align not only incentives, but payment. And so, as we're thinking about this, think about how payment needs to be aligned not only across hospitals, EDs, primary care, behavioral health, the whole continuum. But also think about the alignment across payers.

CO-CHAIR SINOPOLI: Great, thank you. Lauran, are you next? Or Chinni next? Okay.

DR. PULLURU: Thank you to the team. Alana, and then Tom, as well as Randy, adding on to the construct of payment reform, how do you see differences in attribution, and changes that could potentially happen given that there's low density in rural areas to attribution? What are your thoughts around how that could be changed?

DR. KNUDSON: Well, the Rural
Emergency Hospital designation that began January 1st of this year provides up-front funding for these rural hospitals. And I think if we start thinking about rural hospitals from the standpoint, or rural providers, if you will, from the standpoint that we look at, for example, police, fire, different requirements that we need to maintain our rural communities.

I think we need to also think about having those essential services be available. And looking beyond - volume-based is piecemeal, so that creates a lot of trouble for those low volumes, that's what we're talking about. Those low volumes are really challenging. When we get into value-based, even when you look at global budgeting for a value-based payment model, you are also always starting at the basis of the history of what was sought using volume.

And so, when we're thinking about new payment, what if we think about it in a structure where you have a base payment for rural hospitals that provides incentives and accountability to address population health metrics? And not just rural hospitals, but rural providers. I talk about rural providers
more holistically.

As I said, it needs to be hospitals, primary care, and also those community partners as a unit. Because in a rural community, these types of efforts are blurred, and we were just speaking before about ED services. I can't tell you how many rural providers share with me that their ED is the safety net for mental health problems.

People show up at the ED because there's nowhere else to go. And the only place that some of our rural providers have to provide care for these folks is either through the hospital, or they send them back to the county jail, or the local jail facility. So, there's a lot of intricacies that need to be thought through.

And if we had, for example, some kind of a grant program, or an up-front payment for these rural hospitals that address the population health needs, that would better suit the low-volume facilities.

DR. PULLURU: Tom?

DR. LEE: Yeah, so, I'll give my, again, naive lens, given that the regulatory, financial, technical constraints are beyond my
pay grade. But in general, for me the concept is, in these low-density markets, is there a concept of a regional utility that can kind of float above the PCP\(^{19}\) groups, and or local hospital, that can kind of centralize, and share some of these functions more globally?

Similar to an IPA, but perhaps with a slightly different business intent or organizational intent. To me, it allows you to overcome these sub-scale issues with a common mission purpose that kind of floats outside the organization, per se. To me, that's one way to start to think about it, so that there's alignment.

Because there aren't that many options to aggregate in a local market. You kind of have to build this consortium together, and then there's a lot of shared functions that are needed by this community. If you think back in the days it was the RHIO\(^{20}\), but it's RIO with broader services kind of concept. So, that's how I think about it.

We're trying to just innovate on our own individually, sub-scale, and that creates
challenges for us. But when you really look at how do you foster with the communities, my guess is something that kind of helps facilitate aggregation at some level.

DR. PULLURU: Randy?

DR. PILGRIM: Yeah, look, if this group could solve the accountability quandary, and the attribution quandary in particular, I would love that. I know that's a very thorny thing to do. Couple of thoughts just to add to this. I think of attribution a couple of ways. One is accountability for care that is delivered once care has been contacted.

So, the patient comes to me, I've delivered something, I should have an attribution piece of that assigned to me because I did something with the patient. There may be also attribution in terms of accountability for a population whether or not they came to see me as a clinician.

And so, I think being very clear, when I have approached this in the past, including my brief actuarial background, we've really been tripped up a lot about attribution with respect to a clinical event, as opposed to attribution with respect to a population for
which I am accountable. I think there's a real need for clarity around that.

I know in brief comments here I'll not be able to do this, but I will say the accountability for outcomes can occur, and be attributed to an accountable group, particularly a clinical group whether or not they see the patient or not. There are some patients that self-treat, and do fine, and the outcomes that we're looking for even for some conditions are okay.

However, if I ever touch that patient, they do come to me for care, I elect to deliver care, the attribution in some fashion or another should attach in fact to me. And again, the intricacies of working all that out, and across attributional complexities in systems are pretty daunting at times.

Sometimes I have found though, that again, as the earlier comment was, aligning primary care and acute care around attribution, something in that direction is highly important, and there is very little of that to my knowledge, scalably being done right now. So, I would really encourage the group's thinking around combining acute care with
longitudinal care and combining the attribution scheme around those things. Again, more detail, happy to talk offline if desired.

     DR. PULLURU: Thank you.

     CO-CHAIR SINOPOLI: Okay, Lauran?

     CO-CHAIR HARDIN: This is a bit of a follow-on question from your conversation there. So, one of the things that's emerged the deeper we get into the needs of rural, along that theme of what's most helpful in looking at this as an all-payer approach, really taking into consideration the standby costs, and the need for capacity building. So, one thing I've started to see across the country, it's emerging a lot related to the Medicaid waivers, but it applies in this context related to rural, is an interest, and a cry for hubs, and we've heard that from other presenters. So, a way to bring a community together, whether that's on a county level, or a regional rural level to concentrate and share some of those standby costs to look at co-location, facilitate community partnerships, to build the response system for health-related social needs. And also, some of that is also bringing forward a central way to
address the need for technical assistance, quality assurance, data analytics, grants. So, I wonder if you are seeing that as well.

And any successful models emerging, or recommendations related to payment for that. And Alana, you are starting to address that with the base payment for the rural hospitals as a hub.

DR. KNUDSON: We are seeing some hospitals coming together, for example in Texas, they have the clinically integrated network, and I believe they're up to 23 hospitals in Texas that is part of that, and I can share more information regarding that group. But we also are seeing it not just in hospitals and clinics, but we are also seeing it in some long-term care.

Because of the issues with staffing and pulling together resources at a regional level so that there is a way to share those types of resources, as well as to anticipate staffing shortages. And, as we know, CNAs\(^ {21} \) and other nursing, and frankly staffing across the board in many of our rural nursing homes is at a critical level.

\(^{21}\) Certified nursing assistants
DR. PILGRIM: I'll go next Tom. If you have thoughts. I think one of the most vexing things, besides attribution, is the expensive nature of hospital-based acute care. And so, your question about the funding of standby capacity capability, responsiveness, that's expensive. It's just expensive, that's one of the biggest downsides of trying to utilize something that's already inherently expensive in order to accomplish other health care or outcome objectives.

However, the opportunity is it's already there, and it's already being paid for in some fashion or another. So, as we've talked in other comments about modifying what you're paying for, I think there is opportunity to your comment. Again, I appreciate this, not just to use hospital-based whatever form they are, critical access facilities, Rural Emergency Hospitals, or existing full acute care hospitals, and their emergency departments, or their ancillary services.

There's a lot of money there, and a lot of that money has to be spent, particularly in the workforce deprived areas that Alana was talking about. You've got to respect that, and
you have to not invade that, otherwise you will get upside down with that objective. But I do think there is opportunity to be more clear about what those standby costs and capabilities are for.

And to expand them in service of the equity objectives we've talked about, and the fuller community perspectives. I think clarity, and as Alana said earlier, I agree with this entirely, the functions will follow what the funding is for. And as long as that actually is thoughtfully done, I think there's opportunity there to leverage things that we have.

DR. LEE: Yeah, maybe just one minor add-on to Randy's comments, which agreed. I don't know specific examples of the hub zone otherwise, but I think the tension here, a little bit to Randy's comment about rural is rural, is rural. A common framework would be helpful for these, but perhaps not a prescriptive program design allowing communities to shape the elements of them, shape the anchoring of them, the standards of them, that might facilitate a more scalable, and customized, localized hub framework without
being too prescriptive. Again, easier said than done, but I do think that because of the nuances in any rural community, making sure that it's not overly prescriptive I think will help facilitate engagement and design at a local level.

DR. KNUDSON: And if I could just add one comment to that as well, it's really important to have some kind of a glide path, or some way to provide a place of convening to determine how that hub is going to work. Because the trust and the ability for these local entities to work takes time, and it takes dedicated staff.

It doesn't just happen. So, really thinking about what is that structure, and how is that structure coming together, and how is it funded?

CO-CHAIR HARDIN: Thank you.

CO-CHAIR SINOPOLI: All right, Walter?

DR. LIN: Thank you to our experts for just fascinating presentations. It’s been a really informative session for me. My question is primarily for Tom. It is a really innovative model that you've created through
Galileo, and I wanted to just raise a few questions based upon your comments, and some of the supplemental information in the slides that you've given us.

So, in terms of reimbursement, you mentioned that you have risk-based reimbursement that is working right now, that provides what seems like really great rural health care. I'd love to understand kind of what reimbursement model that Galileo uses to support its operations, one. Two, one of your slides at the end there talks about high acuity member management.

And it just made me wonder if Galileo focuses on a certain sub-segment of the rural population that are more high acuity, or is this model applicable to all members in rural settings across the board? And three, one of your slides mentioned the impact of the model, which you document as 46 percent fewer specialty visits.

We've heard from prior sessions, just the dearth of specialists in rural areas, and I just kind of wanted to unpack that a little bit. Whether this kind of model with much fewer specialty visits is something that
works really well from a patient quality perspective.

Is this something that we can use to think about in terms of maybe substituting more intensive primary care for specialty visits given the difficulty of obtaining specialty expertise in some of these areas?

DR. LEE: Yeah, happy to maybe clarify a bit. So, the current form factor of medicine in almost any context is an office-based synchronous encounter. And so, there you're blending general knowledge, specialty knowledge, a bunch of other intangibles into one form factor.

With Galileo we've tried to be more discrete about what form factor is needed for what type of care, for what type of patient in the appropriate context. And so, by doing so we have changed the framework a bit to knowledge-based care, and what we call translationally-based care. So, knowledge-based care is what we all grow and learn as clinicians about.

What we're trying to do there is improve the quality of the knowledge, the quality of the decision-making, the breadth of
the interdisciplinary nature of the decision, what we call a multi-specialty lens to any decision through a digital form factor. That allows us to be more unit price efficient, because the time for a provider to solve any clinical situation is more effective, and efficient.

Provider satisfaction is higher too. They’re not spending all their time collecting information and repeating a bunch of information. So, the unit price is lower, which allows us to operate within most fee-for-service environments, and or risk-based environments with a preference towards risk on our side.

The corollary to that is by spending more efficient care on the digital side for the stuff that can be accessed digitally, we then have more time to invest in complex care, home-based care, what we call the people intensive side of care, where that interaction is much more labor intensive.

So, we’re bifurcating into more efficient care and more intense care against the cohorts needed. And so we, in any rural population, can service a low complexity
individual to a high complexity individual. And then with respect to specialty care, a lot of specialty care is knowledge-based.

And so, that knowledge can be adjudicated digitally, or sometimes in the situation where there's not a mobile app, a phone-based consultation. And then the physical nature of specialty care and or primary care is then typically allocated to the office. So, the use of resources better allocated to where the cap ex is.

And so, therefore we think that not only improves the quality, but the affordability of the care in general, and obviously under a value-based arrangement, the alignment is there as well. It's a lot, but hopefully that helps clarify.

DR. LIN: It does, thank you.

CO-CHAIR SINOPOLI: So, we only have five minutes. I'm going to end with one kind of broad question. So, as we have listened over the last two days, and with the research that PTAC has been provided, and what's been constantly in our face is that these rural and or frontier markets consist of much older patients, sicker patients.
The geographies have less primary care doctors, significantly less specialty providers, less health care resources, less community resources, a historical poor coding activity by the physicians. And actually because of all that, we wonder how can a practice even survive in that kind of environment, and have been actually been shared with us some practices that have failed because of participating in Alternative Payment Models that stress their practice.

So, my question to you all, if you know, is so how are practices surviving in these rural and frontier geographies with all of that against their success? And of the ones, are you seeing practices fail, are you seeing them being unwilling to participate in APMs?

And if they're participating in APMs and being successful, what's different about those practices that will allow them to be successful in an ACO or an APM that distinguishes them from others? If you've had that exposure, or can answer that. So, I'll start with Alana.

DR. KNUDSON: I think those that are
successful are more willing to take risk, and they're also innovative, and they draw on their strengths. And I'll give you a great example. We worked with the Maryland Health Care Commission on a rural health problem that they had with Chestertown, Chestertown was about to close.

We worked with them, and identified the strengths of that community. It has a high proportion of older adults. They were committed to ensuring that there was access in their community, and providers, and the community worked together. And I think a lot of the success of the providers that are able to continue in value-based care models are because they have aligned with their community, and got buy-in.

People are not bypassing, they are staying local. And that is critical to any of these rural providers being able to be successful, having that community buy-in.

CO-CHAIR SINOPOLI: Great --

DR. PILGRIM: I'll add --

CO-CHAIR SINOPOLI: Go ahead, Randy.

DR. PILGRIM: Yeah, sorry. I'll add, I do think a progressive mindset when
we've seen success is definitely helpful. But a real reason to invest in the community for either the clinicians or their staff are both, as well as aligning as Alana just mentioned, those are keys to when people have succeeded.

When things have failed, what we have found is we've looked at the communities, and again as I mentioned, 62 percent of our 300 emergency departments are in rural and underserved communities. So, we see a lot of what happens in communities when they fail, and a lot of times the practices do not have natively the capital to invest.

Or at least affordable capital to invest in order to get themselves to a place where they can utilize telemedicine, texting capabilities, or other functionalities that are required, that support them and expand their capabilities. So, access to capital is a key.

And another thing is a reasonable backstop to any risk-bearing arrangement. Sometimes there are unreasonable backstops, which are really sort of nothing. And then people really don't want to invest, and they have capability, and they're already there. So, again, you can't take all risk away out of
risk-bearing value-based programs.

But reasonable backstops that are considerate of the kinds of risks that are actually being encountered by practices are important.

CO-CHAIR SINOPOLI: Thank you. Tom?

DR. LEE: Yeah. My observations have been interacting with a broad range of provider groups across rural and urban environments, is the ones that are surviving tend to have leaders who are rooted in the community and are more operationally and financially savvy than the average primary care provider.

I think the average primary care provider is not financially and operationally savvy just based on the nature of our training and who we are as people. And so, I think the vast majority of providers are struggling, and the ones that are rooted are figuring out a way to survive, but I think it's challenging.

The reimbursement, or ability to potentially uplift these practices I think needs to be facilitated, not necessarily just done through reimbursement. Only in the sense that reimbursement is a bit of air, but I think
the structures are really the challenging aspects to most of these practices.

And I think the operational savvy to do so can be challenging regardless of reimbursement. So, I think reimbursement is, in my mind, just air to a suffocating provider, but doesn't allow them to truly innovate. So, I think a combination of air and or structures to plug into, I think could be a helpful formula to think about to lift the average struggling provider in the community.

CO-CHAIR SINOPOLI: Great insight, thank you for that. So, I appreciate the panelists’ time. As Larry said, you've been a very sophisticated group, and have given us a lot of information and things to think about. We'll have another listening session this afternoon at 10:50. And so, for now we're going to adjourn at 10:40 for a short 10-minute break until we come back. So, thank you all.

(Whereupon, the above-entitled matter went off the record at 10:41 a.m. and resumed at 10:52 a.m.)

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

CO-CHAIR HARDIN: Welcome back.

I'm Lauran Hardin, Co-Chair of PTAC, and very excited to welcome you to this session where we've invited four experts who have real world experience in innovative approaches to facilitate value-based transformation in rural environments.

At this time, I'd like to ask our presenters to go ahead and turn on your videos, if you haven't. All four, after all four have presented, our Committee members will have plenty of time to ask questions.

The full biographies of our panelists can be found on the ASPE PTAC website, along with other materials for today's meeting.

So, I'll briefly introduce our guests. First, we have Dr. David Herman, who is Chief Executive Officer at Essentia Health. Welcome back, David. Please go ahead.

DR. HERMAN: Thank you very, very much. And I really appreciate PTAC having these sessions. I learn a lot more than I'm sure than of the content that I provide where others are learning from me.
As you can see, there's a great body of knowledge and a lot of committed people that want this to work. Next slide, please.

Just a little bit of background. At Essentia Health our mission is we are called to make a healthy difference in people's lives. And I'll think you'll note from that, it's not about whether they're in our clinics or in our hospitals, but it also includes the communities.

There's the resources that we have. I do recognize that we are likely more resourced-rich than a lot of small practices, yet our commitment is to rural health. Next slide, please.

What I'd like to share today is that we've been on a value-based care journey since 2016 in our organization. But I'd like to talk a little bit about some of the things you've already heard a lot of detail on: the unique challenges of providing care in the rural communities and how we embarked on that value-based care, what we've learned along the way, and then most importantly, how these models serve as a pathway to the future of rural health care and gaining better health outcomes.
for the rural communities that we're all
privileged to serve. Next slide, please.

You've heard ad infinitum about the
rural health care challenges. This is our
service area in Minnesota. And I'm going to
show some other slides that back this up.
Lower household incomes; much older; less
education; certainly more health concerns.

The distance to care, particularly
in northern Minnesota is very, very great. And
these communities and the people that reside
within these communities are relatively
resource-poor. There are many food deserts.
There's unreliable, if existing, broadband
connectivity. The provider practices that exist
in these rural communities are smaller. And
there certainly is a lack of specialty services
either within the community or within an hour's
drive away. Next slide, please.

As you can see, in this brown is
significantly below median state income for the
state of Minnesota. And as you can see, the
small town rural and isolated rural, the area
that we're privileged to serve, certainly has
its disproportionate share of those below the
median state income. Next slide, please.
Health insurance is another thing that many of our communities and our patients struggle with. As you can see, a large proportion of Minnesota patients in rural areas are on Medicare, medical assistance, MinnesotaCare, or other supported programs.

And I can tell you that when you look at employer-sponsored plans and it says rural, they're at 39.4 percent. We at Essentia Health are right around 23 percent on that.

And to outline, the challenges with that, Minnesota has not re-based its Medicaid compensation since 2017. And the world that we live in, particularly since 2020, has had significant inflation in everything that we use to serve these patients. Next slide, please.

Travel to care, significantly different. 85 minutes for mental health. 38 minutes, on average, for maternity and neonatal care. Other med-surgical care, 60 minutes.

So, it's a long ways away. Telehealth certainly helps, can provide and close some of those gaps. But still, when a person needs to travel, particularly when they're aged, it's not just them that needs to get in the car but generally their son and
their daughter. The opportunity costs, as well as the time and travel costs, are tremendous. Next slide, please.

So, really what it took for us to get started on this was an organizational commitment to the work. We decided in 2016 is that if we were going to be taking care of the communities that we're privileged to care for, we had to focus on the quality of their care and their outcomes rather than just on the volume of the care that we provided.

In order to do that well, we had to have an emphasis on prevention and wellness.

Because the distances are so far, keeping someone healthy within their community is a great benefit to the patients and the communities.

In order to make sure that we're doing well with our patients, coordination and integration of care is tremendously important. Showing up at the wrong clinic at the wrong time after a two-and-a-half hour drive is not serving our patients well.

Also, and I don't know if any of you have tried to navigate the health care system within the last several years, but even for the
best of us, even when we're feeling well, it's incredibly complex and confusing.

In order to do this, we had to transform our organization. We couldn't just remodel around the edges. And that transformation had to be clinician-driven. And I'm very proud of my colleagues that have helped navigate our way through that. Next slide, please.

So, our approach -- and I wanted to do this. I had my colleagues put pictures of some of our buildings in there to remind you that this is not about the buildings, this is not about capital spent for patients to go, this is how we care for our patients on a day-to-day basis.

The first thing we needed to do is identify the patients, not just the ones that are "attributed to us," but everyone in the communities we're privileged to serve.

Then we needed to determine what their care needs were. And I'll talk a little bit more about that in just as second.

We need to manage their chronic illnesses and provide their care needs in a proactive and coordinated way.
One of the things we think about is that everybody should have a mother or a grandmother that you can call when you have a health question and get pragmatic advice that you can use on a moment's notice. We want utilization to be appropriate. That also drives lower health care spending.

There's also tremendous health-related social factors within our communities, things that we can do on a day-to-day basis in partnership with community partners that can really make a difference in the health outcomes of the people we're privileged to serve.

And then we want to be a bridge organization and provide partnerships with government, private payers, and the community organizations to make sure that we're being good stewards not just of Essentia health funds, but the funds in the community, and the funds that are provided to us by government and other entities. Next slide, please.

We first started with community level priorities. Every hospital does a community health needs assessment and implementation plan. But what do you do after you do that?
We decided that in order to make progress, we need to strategically invest in community projects. Whether that's dollars or expertise depends upon the project.

We need to be fully engaged in these community coalitions. They have resources and knowledge that we do not have as a health care organization.

And then sometimes it takes an organization to kick, get these things kick-started. And what we want to be able to do is implement and then evaluate for success those strategies that have been defined within those implementation plans.

And then work together to create community conditions, not just health care conditions, that empower all of us in our communities to realize our optimal health. Next slide, please.

So, our approach is what we call the three A's: analytics, then action, and accountability. And what we strive to do in each one of these communities is create a model of care delivery that is as standard as possible and, yet, as unique as necessary to meet the needs of our patients and communities.
That infrastructure can certainly be common. But even communities that are as close as 20 miles apart often have very different and disparate needs to maintain health outcomes within their communities. Next slide, please.

What we use our analytics for is, first, risk stratification. Who needs resources now and who needs them a little bit later.

The evaluation and utilization patterns. Which one of our patients aren't seeing us often enough or seeing us too often but in the wrong ways. Through that, identify the care gap identification and design to close those. And then referral management. Not just telling a patient you need to see a cardiologist, but to be able to cultivate that and curate that and get those patients and their care connected. Next slide, please.

Then that comes to action. We need alternative care delivery models, such as virtual care, remote monitoring, home EMS services. Improving those transitions of care to make sure that the patient does not fall through a care gap that we may have. Addressing those social factors that influence health and
well-being at home and within their community. Closing their care gaps. And then, of course, chronic illness management.

I'm proud to say that we're one of the best organizations in the country for lack of readmissions after an admission for congestive heart failure, as an example. And it's because of the system that we've built about the patient. Next slide, please.

Accountability. We all know what we're responsible for, yet we hold ourselves accountable for that. We establish goals through our governance structure, all the way up to the board.

We provide oversight coaching on performance to make sure people are doing the things that they need to do, and helping them redesign those care models literally on the fly.

We have transparency. We share quality data across our organization. Any of our providers if they want to know how they're doing on their quality, they can click it. If they want to know how anyone else in our organization is doing on our quality measures, they have access to that information very
easily as well. We track that progress.

And then we just don't wait till the end of the year or the end of a quarter. We have ongoing improvement strategies. If we're not meeting our goals, if we're not closing those gaps, what are we going to be doing differently tomorrow than we're doing today to be better as an organization to better serve our patients and communities? Next slide, please.

All that starts for us addressing the needs of our communities because that's where health starts. We want to at the individual level address immediate, non-medical needs of a patient. I'll talk about that in just a second.

That organizational part, develop those partnerships to tackle those needs beyond the medical setting.

And then, in our community, collaborate with community members and local stakeholders to identify the needs and then close those gaps.

There are skills that the communities have that we will never have as an organization that can lead to better health for
the people we're privileged to serve. Next slide, please.

One of the things we've used to address the needs of our community is each one of our primary care patients at each visit, because their status can change, completes a five-question screening in MyChart. Our Community Care Associate then follows up with that. And then we make community referrals and partnerships to make sure that we can close those gaps, not just identify them. Next slide, please.

Last year we did 185,000 screenings, identified 20,000 patients who identified at least one need. We had 10 Community Care Associates who have worked with the patients. We made 12,000 referrals, and 20 percent of those patients with a social need are connected with a new resource at that time of the visit to help them maintain their wellness and their health. Next slide, please.

We use a tool called "Resourceful" that's immediately available within our EPIC, our EHR. We then have a public site also where community members can access this as well.

22 Electronic health record
to make those connections when our community partners find that they need a resource that they may not have. Next slide, please.

As you can see on this map, we have 664 programs. It's a living thing: things roll in, things roll out. And it works across our entire service area. Next slide, please.

We have been very successful in Medicare Shared Savings and the Minnesota Integrated Health Partnership. You can see the numbers there. Nearly 40 percent of our revenue flows through value-based programs.

And about 80 percent of those value-based contracts have downside risk. We are willing to take upside and downside risk because that helps us drive our ability through these programs. Next slide, please.

The lessons that we've learned. First of all, commitment as an organization is crucial. We've heard a lot over the last 20 years about having one foot on the dock and one foot in the boat. I believe unless you jump right in the water and get wet, and make a commitment, you really can't do this as an organization.

It requires design infrastructure to
support it. Just asking our colleagues and clinicians to do better every day does not meet our patients' needs. We need to know what our patients need and the community needs, and then work together to close those gaps in care.

I do believe that organizational strategies can be different whether you're capacity-limited versus the demand-limited as an organization.

Our organization is capacity-limited. So, when someone says, what am I going to do with my excess capacity when we take better care of patients? We do not have excess capacity. There is another person that needs to get in for health care. That may be different than other organizations, particularly in very rural areas where they may be demand-limited.

And then building the systems within your organization and the partnerships with the community that make the right thing to do the easiest thing to do. Next slide, please.

Thank you very much. Look forward to the conversation.

CO-CHAIR HARDIN: Thank you so much, David. And thanks for returning again. Your
presentation was very helpful.

Next, I'd like to welcome Dr. Ami Bhatt, who is Chief Innovation Officer at the American College of Cardiology and an Associate Professor at Harvard Medical School. Please go ahead, Ami.

DR. BHATT: Thank you so much for having me.

So, I just wanted to echo a few things that David started with. I think the first is the organization's commitment to doing its work is really important. And so I just want to start by saying at the American College of Cardiology, we have a value-based care forum where we really get together. Clinician does not silo from all the other institutions that are relevant in making this happen.

And so, I will refer you to an American Heart Association Journal article -- and I can maybe include that in the chat later so they can take a look at -- that came out that really puts together all of our thoughts about where we start from, what the key things to look at are, and where we might end up.

Today specifically I've been tasked to talk about interventions and models for
value-based transformation in rural areas. And so, even though a lot of the work can be echoed in that paper, I'm taking a slightly different take on it to help share it with you. Next slide.

Is it too loud in the background here by the way? Are we okay? It's okay. Okay.

I want to start with just two key things. When we talk about rural care for cardiovascular care, this is often what we see.

Procedure rates are lower in rural hospitals, for the Critical Access Hospitals.

Here you see in the top chart acute myocardial infarction, or heart attack, in blue are rural hospitals. In red are urban hospitals. And we see decreased rates of cardiac catheterization, intervention or placement of stent, or coronary artery bypass grafting.

And then similarly, we also see in stroke care our decreased rates in ischemic thrombolysis or intravascular therapy. Next slide.

We also see mortality is higher in rural hospitals. And this is across the board,
whether it's heart attack, heart failure, or ischemic stroke in the top panel, or acute MI\textsuperscript{23}, heart failure, and ischemic stroke at 90 days in the bottom panel. Next slide.

The point I'd like to make today is I think we have to really differentiate chronic from acute care when we talk about how are we going to make progress in the initial stages of value-based models that include cardiovascular care. And for that, root cause is essential in improving Critical Access Hospital outcomes.

So, similar to what David was saying, we need to move into the communities where these people live in order to be able to catch these diseases far earlier than we're currently catching them. And that's inherently the root of our problem in cardiovascular disease outcomes.

It is possible -- I'll only talk about this once and not again -- to strengthen our telehealth and our transfer networks for the acute care between rural and non-rural hospitals. Especially in stroke care, the use of telestroke care has been incredibly helpful in really changing our ability to medically

\textsuperscript{23} Myocardial infraction
treat stroke patients.

However, for purposes of this discussion I think I want to concentrate on the other side, which is we do think about how we will provide more care. We have a workforce shortage in rural areas in cardiovascular, across the board but clearly in cardiovascular.

And we often talk about whether we need to implement community-based or hospital-focused telehealth. And I’ll say I think we need to move even earlier than that because our quality in certain efforts that are centered on improving telehealth based out of the brick-and-mortar institutions are still not as successful as we see with behavioral health and other fields where we're implementing home-based telecare.

And the real incentives for staying close to home are clear: our population in cardiovascular disease overlaps with a large majority of the mental health population. So, in fact those studies are studying our patients a large majority of the time.

Lastly, I want to point out that Medicare Advantage does already demonstrate differences in preventive versus acute care
when it comes to cardiovascular disease. Now, I recognize that Medicare Advantage versus the rest of Medicare may be a select population, but we are seeing that value-based efforts already are showing differences both at 30, 90 days, but even at 365 days. Next slide.

So, how do we approach this? I think one of the most important things is to build up rural cardiovascular care infrastructure. There are some excellent groups that are already working on this.

But first is rural-oriented design. We are really focused at the ACC\textsuperscript{24} on expansion of the team. I'm currently in New York City for the UN General Assembly 2023 meeting where we're talking about workforce shortage. And I only bring that up because our approach globally is really very similar to our approach when we think about rural underserved areas in the U.S., which is that team, yes, will include physicians, it can include allied practitioners, nurse practitioners, or physician assistants. So, we have to lean on the out team, we have to lean on pharmacists.
And oftentimes, community health workers are really a key part of our answer to be able to provide care all the way down to the communities where people live, especially rural areas. And so, we're really kind of just thinking about what does the expansion of the team look like?

Also, what does payment for the expansion of the team look like? Right? How does that change payment models is important.

The second that we've focused on in our value-based care forum that we have at the American College of Cardiology and Heart Health started with atrial fibrillation as a single diagnosis that we could then care for. We're not going to have a single diagnosis in a single episode. We're actually seeing it over the life of a diagnosis. What happens to these patients?

And from that we're learning that disease-based closed loop programs may actually be the way for us to be able to achieve value-based care.

The other two areas this would be relevant in are heart failure and hypertension, times where we can help educate the community,
we can diagnose earlier. We can then implement
care in the communities where people live, and
then take those patients when we realize that
they need further care and get them to the
right person at the right time.

There needs to be a unique blend of
community-based care, telemedicine, and then
larger practices. I think we have to recognize
that we can't say it's going to be 20 percent
telemedicine and 80 percent in-person, and
everybody is going to do that.

And so, I think a little bit of
loosening of the reins on this is the
percentage we do on any given practice is
important. I say that only because as we build
practices, oftentimes we say, well, how much
are you going to do this? And the answer is we
really don't know. So, we need the flexibility
to know when we're going to be using
telemedicine, when we're using digital health
or remote monitoring for cardiovascular
disease, and when we need people to be seen in
person, either in the homes where they live or
in the local institution.

One of the collaborations that we
have had for the past several years is with a
group called Dispatch Health. And that's been a great example for us in starting to learn about how to get to the communities, to patients' homes. And what kind of care can we provide there that the patient understands and feels safe, and that we do as well.

One of the key things that we really focus on is ensuring that by having cost-saving care or care in areas that may have less access to specific types of testing, although increasing what we can get through the home, we're not actually decreasing the quality of that care. And so, really starting to think about what are the metrics and what is the balance between cost and quality, and it is an important part of work. And partnering with some of these organizations helps us study that.

And then, lastly, we really want high-impact, low-complexity digital health. You are hearing about, and I'm going to bring it up, AI\textsuperscript{25}, and ChatGPT, and clinical decision-making. And the more complicated we get with the digital health interventions, the harder it's going to be for us to be able to build the

\textsuperscript{25} Artificial intelligence
infrastructure upon which that can then grow.

So, we really are still focused on lower complexity digital health to reach the areas we need to reach to establish that infrastructure. At the same time, you'll hear organizations studying the more complex parts of AI and digital health. However, we can't think about starting with that first necessarily.

I can answer more questions about that later. Next slide.

So, what are the advantages? There are a couple advantages to cardiology in terms of taking care of rural populations.

So, the first is we know the patient volume in rural health is lower in general. And this is the problem with the shutting of hospitals, it's simply that we have lower volume.

However, our cardiovascular risk factors in disease are quite prevalent. So, you can really fairly say that if we're talking about doing population-based care together between subspecialties and primary care, cardiovascular disease is going to overlap, overlap at least 60 to 80 percent of the time,
depending on which age group we're looking at.

So, for us that's a great opportunity to study together and not set cardiovascular separate from primary care.

Second, we know we are human and finance resource-limited. However, for cardiology we're pretty good at remote monitoring services. And that's a great force multiplier.

So, if we really only have one physician to be able to look over an area, we can set up those remote monitoring systems, and set up the alerts to get us the right care at the right time. We can actually force-multiply the workforce that we currently have because remote monitoring is so well established in our field.

We have a way to link compensation to non-cost saving metrics as well. The last time I spoke with PTAC I know that I brought this up as well. But achieving what we call guideline directed medical therapy for almost any cardiovascular disease, we have very clear algorithms and goals for these are the medications, these are the therapies that people should receive.
We are also clearly not meeting that goal, guideline directed medical therapy goal in the United States right now, especially in rural and, actually, inner-city as well.

And so, I think linking compensation to those non-cost saving metrics and what part of the population achieves guideline directed medical therapy, because we know that guideline directed medical therapy will turn into better outcomes, morbidity, and mortality. Could be a near term mechanism for us to start to test and build infrastructure.

And, lastly, and I mentioned this earlier, we need to incentivize team-based care. And we need some innovative local community health roles. The more time we spend thinking about global, the more we think about how relevant what we're doing there is to rural America. And really thinking about who are the community health workers that we could up-skill, educate, who may be providing primary care right now or urgent care right now, but could really help us provide cardiovascular care at the same time, and create a novel mechanism of team-based care. Next slide.

This is my favorite digital health
paradigm. Rural health fits it perfectly. We have chronic management, which is the bulk of what cardiovascular disease is. And that partnership with primary care needs to happen. It's patient-centric. It reduces low-value specialist care. And when we have a workforce shortage, that's really important.

It helps us identify rising risk in the community so that we can identify illness and then manage it either locally in their homes, out of primary care, or coming to a specialty practice. And it really does enable us to take those patients who require intervention that I started with on the first slide who are having worse outcomes and worse mortality in the Critical Access Hospitals, and instead be able to get them specialty care in the appropriate place where they belong.

And some of those patients will do excellently at the Critical Access Hospital. And we can identify those who may not. But we can only do that if we're doing digital health and we're measuring these patients earlier on.

Next slide.

I'm going to end with the patients. What are we working on at the ACC? So, we are
really thinking about how do we take education, which is what the American College of Cardiology produces, and revise it to make it relevant to rural team caregivers and patients. How do we do that? What does that look like? Partnering with other programs, with other tests.

The second is accepting use of blended care and not be fixed in what that looks like. Use phone, use video in addition to being seen in person. And accept that those, again, those ratios can change from day to day, and that's okay.

Realize our patients' potential by making digital interfaces easier to engage with for self-monitoring. We need to start thinking about the systems that allow self-monitoring, and how we can really make those digital interfaces as easy as the rest of the digital world.

And we can't say rural America doesn't have digital interaction. They, in fact, have quite a bit. But the people who are interacting with them have entire fields and teams who are building how easy it is to use those interfaces. And we're not doing that
just yet. And I think that's a priority for us in terms of innovation at the ACC.

We do need to match rural needs with the interventions that are offered. So, I think what we refer to as case mapping, which is which are the areas that have the ability to have good connectivity, and have high hypertension. Those are the areas where remote blood pressure monitoring programs make sense.

But if we have areas that don't have good connectivity and we just can't do the square peg/round hole, we should think about who the community-based health care groups are and design different tools for those areas.

So, I think the one-size-fits-all, we need to do even better than that.

And then, lastly, and this is a new area that we're working in but I wanted to share with everybody is to start to lead registries and trials. We do a lot of this in cardiology. But, generally, it comes from us.

We have a registry. A clinician puts the data in. We run a trial. And rather, using some of the novel registry mechanisms that are actually patients able to get onto a cell phone and sign up, or get onto a web.
Again, it requires some connectivity, but minimal. And sign up themselves to be part of a registry.

And so, the patient-led registries are an area we have great interest in because our patients are motivated. They want the care. And they're being developed in a way that's already addressing a user interface that we're trying to think about, and turning our clinical work to do something that is with a good user interface for the patient.

And so, these registries are really being stated as, hey, patients, go ahead and sign up for this.

What happens next? When a patient signs up, they give permission for us to be able to then extract their digital health records from the EHR, whether it's a local one or a large conglomerate, and then be able to help analyze that data, set up remote monitoring systems for them.

And so, having patient registries, and I would say, you know, it's hard to say rural patient registry, it's a very large and amorphous idea, but other specific disease processes where we want to really be able to
engage patients to enroll themselves. And then their clinicians will come along and be onboard as well.

So, I think that's a real interesting area. I'm happy to talk more about that later.

I think that might be my last slide.

Okay.

Thank you so much. And apologies again for the background noise.

CO-CHAIR HARDIN: Thank you so much, Ami. That was very interesting.

Next, we'd like to welcome Thad Shunkwiler who is an Associate Professor at the Department of Health Science, and Director of the Center for Rural Behavioral Health at the College of Allied Health and Nursing at Minnesota State University, Mankato.

Welcome, Thad. Please go ahead.

MR. SHUNKWILER: Good morning. Thank you, everyone, for having me join this, this webinar today to share a little bit about my professional expertise and, honestly, my personal passion.

I'm a bit of an odd outlier, given some of the topics we've had so far, in that my
presentation is exclusively focused on behavioral health, and really about the workforce. And I think it is important to have that conversation because it doesn't matter how you pay for care if there are -- if there's no one to provide the care is how I've always framed that conversation.

And so, I just want to spend about 10 minutes to talk about some of the challenges and opportunities, and how we're going to move forward in solving some of these issues within rural behavioral health. Next slide.

Now, all of us are aware there are multitudes of challenges going on across health care in various capacities. But none that is getting the attention that mental health and behavioral health is having. You know, the attention that our media is focusing in on some of these issues, as well as some of our decision makers and policy makers at the state and federal levels, they are, they are zeroing in on what's going on with people.

And rightfully so. People are unwell. We are seeing rates of mental unwellness and emotional distress that we historically have never seen before. And so,
these challenges are very real and impact every facet of what we do, whether we're a CEO of an entire system or a cardiologist, I mean, all of us are impacted professionally, and many of us personally by these challenges.

The story that's often missed when we're having these conversations is about the treatment gap. And what I mean by that is there are more people who need services than the providers who can provide it. And so, we kind of refer to this as the treatment gap. Next slide.

The challenge with that treatment gap, among many, is that it's not geographically equitable. The rural, rural America has a huge gap of behavioral health services.

And this graphic here kind of really outlines it. It's from HRSA\textsuperscript{26}. It's the Health Professional Shortage Areas [HPSAs] for mental health.

And everywhere that it's a dark is a, is an HPSA for mental health. And so, you can see pretty much the entire country, other than the highly-concentrated metropolitan

\textsuperscript{26} Health Resources and Services Administration
areas, qualifies as a Mental Health Professional Shortage Area.

In Minnesota, where I am from, 80 percent of our counties qualify as an HPSA.

South Dakota, our neighbors to the west, 100 percent of their counties are Mental Health Professional Shortage Areas.

So, this issue, this treatment gap that we talk about, it's important to recognize that it is, it is impacting our rural communities at a much higher rate than our metropolitan counterparts. Next slide. One more I think. I think we skipped over a couple. Okay. Oh, never mind, we've got it right here.

The issue as a professor, we're always kind of couched as being the doom and gloom folks. And I'm going to be a little bit doom and gloom before we get to some of our opportunities.

This problem is getting worse. We are seeing unprecedented increasing demand for behavioral health services. For those of you in the room who are providers, you're probably seeing this from across your desk.

Here in Minnesota, our state
association just did a survey of the community mental health clinics. And we have 70,000 children on waiting lists in Minnesota for mental health services. And it's not getting any better. All the underlying metrics show us that things are getting worse, as far as people's emotional well-being.

On top of that we're seeing an unprecedented provider exodus from behavioral health care, in part due to retirements. I think the professional on its own, particularly in rural communities, our providers tend to be a little bit older.

In Minnesota, for example, over half of our behavioral health professionals in Minnesota are 55 years of age or older. And that's a problem because we're not graduating students going into these programs at the rate in which people are retiring simply just reaching that age.

The other, the other issue that is facing health care across the board but is really impacting behavioral health is burnout. And folks who are leaving their careers, or reducing their hours worked, or going to a cash-only payment structure to reduce some of
the administrative burden, we're seeing a lot of our providers burning out and leaving the field or reducing their capacity to treat patients.

And so those two things combined just really kind of highlight just how -- I mean, we're in a crisis. And it's going to get considerably worse if we, if we don't act. Next slide.

Now, HRSA would have us believe that we're going to have everything that we need in the next three years. This is the infamous 2020 projection report that told us that we would have two social workers for every job here by 2030.

And I can tell you, that's the furthest thing from the truth on the ground in what's going on. I mean, there are substantial vacancy rates across health care, but mental health care often has the highest. At least in Minnesota, one out of every four positions in Minnesota is vacant according to Department of Economic Development data.

So, the HRSA projections are wrong. And the other thing they didn't take into account is the next slide.
One of the conversations we're also not having when we're thinking about the future of the workforce is where is the pipeline going to come from?

The well-known issue within higher education and but less known everywhere else is that we are about to fall off an enrollment cliff. But there are going to be fewer high school graduates across this country going into college. That's not taking into account economic factors and other factors that may dissuade someone from obtaining higher education. This is simply there are not enough kids graduating high school that will be eligible.

So, when we think about the future pipeline, we are going to have to do more with even less. Next slide.

So, I'd like to give just a couple solutions to some of the issues that were raised by the GAO’s report to Congress about the behavioral health workforce. And so, if you've not read that report, basically Congress asked them to say what are the barriers to growing the behavioral health workforce?

---

27 Government Accountability Office
And so, they really looked at both the recruitment and retention side of things. And I won't go through each of these bullet points individually.

But a couple of things that I think that are important to highlight when we're thinking about workforce:

One is, obviously, the financial commitment that students make to get an advanced degree, whether that be a master's degree, or a doctoral degree, or in medicine, a medical degree. And we have great student loan repayment programs, National Health Service Corps, state-level programs.

And what we have found through our work at the Center for Rural Behavioral Health is that we should really take that model and flip it over. And we should really invest in grants and scholarships on the front end to incentivize and recruit more people into this profession. It doesn't cost us as taxpayers anymore, it's just taking that repayment plan and putting it on the front end.

The other piece around the academic pipeline issues, it's important for us to recruit. For rural health care in general, the
literature is very clear: if you want a health care workforce in rural communities, you have to grow it yourself. The transplant model is ineffective, doesn't work at the same rate that if you were to invest in growing that pipeline organically in those communities that is shown, that is shown to work.

In addition to that, we have to increase the training capacity of our rural institutions. Research is very clear, students tend to practice, at least within behavioral health, within a kind of geographical catchment area of where they trained. And so, how do we increase the training capacities of our programming?

In Minnesota we wrote a paper this spring for our legislature that they asked us why don't we have more behavioral health professionals?

And what we found through our work is that in Minnesota we turn away 100 qualified students every year who want to pursue an advanced degree in behavioral health because of training capacity limitations. So, at a time when we're having unprecedented demand for services and workforce shortages, how are we
turning away kids who want to do this, and are qualified to do it, but we just don't have the seats in our courses for them?

So, how do we solve some of those challenges? Next slide.

And with retaining I think, you know, the great work that you're all doing around reimbursement rates, Alternative Payment Models, those things, that work has to continue. I think it's the oldest story within mental health is that we're not paid enough. Which is true. But, you know, how are we going to innovate and solve some of those challenges around that?

The last piece about burnout, right, some of the exodus of our providers to burnout, I think it's important for us as an industry to shift from a self-care model to a system-care model. Stop putting the responsibility on the individual, and then they own some of that, but ultimately as a system, how are we going to attack this burnout issue more holistically across the board? Next slide.

We can go ahead. Oh, go back a couple more. One more. Thank you. Now we'll go ahead.
When we think about the -- yeah, we'll go to the slide that says, "Opportunities: Data Driven Policy Solutions." I think it's two slides from this forward, please. There we go.

So, how do we, how do we solve this issue? I think it's important for us to lean on the data.

I think when we talk about mental health, there's a lot of personal feelings, there's a lot of emotion when it comes to it. We should really let the data drive the conversation on how we solve this, particularly when it comes to things like policy. And so, how do we enact policy that builds workforce capacity, both for the professionals, the licensed providers like myself, but also our para-professional colleagues?

How do we increase their roles? And how do we, as Ami talked about, pay for those individuals to be part of that care team?

Expand APMs that improve access to care. Prioritize upstream intervention. I think I just want to share just one piece about what I mean by that.

There's a phenomenon happening
across the country, and it happens in your settings I'm sure, that our EDs are full of people with mental health challenges and nowhere else to go. In Minnesota it's a, it's a crisis, particularly with our young people, our children and adolescents who are sitting in emergency departments sometimes for days, weeks, and in some cases months before they can go and receive appropriate care.

When the legislature talks about how we solve this problem, their solution is build more hospital beds, or open up more beds. And I think, how silly. Right? Like, why don't we go upstream and prevent them from having to walk into the doors of the EDs in the first place?

We have 7,000 kids on a waiting list. Some of those kids aren't going to get care, many of those kids won't get care, and they are going to end up in the ED because we are not upstream intervening on some of those challenges.

And the last piece I think is important is prevention. The best treatment is always preventing it. And we don't often think about mental health prevention and building
resilience. And how do we kind of adopt a
type, a system? How to we pay for that to
tically incentivize some of those preventative
practices so that we don't need the demand
which we're seeing? Because we will never out-
supply this and dig ourselves out of this hole.

Next slide.

The last thing I just want to
highlight is some of the great work that we're
doing here in southern Minnesota on this issue.

The Center for Rural Behavioral
Health is an academic research center that is
trying to solve this issue for Minnesota and,
frankly, across this country. We're one of the
few academic research centers in the United
States that is exclusively focused on rural
behavioral health. And we're hoping that what
we're learning from our faculty and our
research team can really, hopefully, solve some
of the challenges that we have spent the last
few minutes discussing.

So, thank you so much for having me.
And I look forward to the question-and-answer
series.

CO-CHAIR HARDIN: Thank you so much,
Thad. That was very interesting.
And, lastly, we have Dr. Susan Stone, who is President of Frontier Nursing University.

Welcome, Susan. And please go ahead. And we can't hear your sound.

DR. STONE: Okay, sorry.

CO-CHAIR HARDIN: There we go.

DR. STONE: Just a little bit more about myself.

I spent the first half of my career working in rural areas in Upstate New York -- Little Falls, New York; Herkimer, New York; Cooperstown, New York -- and then later moved on to Kentucky where I developed a practice in southeastern Kentucky at a tiny rural hospital with Frontier Nursing Service.

In listening to the other presentations today, it's very inspiring and hopeful that we can make some differences in rural health care. But I did, when we talk about prevention, I wanted to share this little story that somebody told me just last week that has been kind of stuck in my brain.

Picture a river and there are health care providers, and EMTs\textsuperscript{28}, and everybody's

\textsuperscript{28} Emergency medical technicians
standing around the river. And there's babies coming down the river. And everybody's pulling the babies out, and doing resuscitation, and doing all kind of health care with them.

When somebody looks up and says, hey, maybe we better go upstream and find out who's throwing the babies in the river in the first place.

And I think that's what we really have to think about when we're talking about social determinants of health. What are we doing upstream to cause these significant problems that we're having?

So, next slide, please.

So, what are the social determinants of health? You know, you all know. I've heard it today and yesterday, too. And I cited to a couple of presentations.

But they're "the conditions in the environment 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."

So, rural persons, as we know, we've heard that today, David Herman was very eloquent in his delineating this, but they
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 health care services.

We're at our wits end over this data on maternal deaths, with all the work that we've been doing, the CDC\(^{29}\) reports that maternal deaths nearly doubled over the last three years. So, our maternal mortality rate rising. In rural communities, where maternal mortality is almost double what it is in urban areas, really struggle to access lifesaving maternal health care. And this is a good example of the struggles. Next slide.

So, we're going to go quickly through these slides. But just you can see in the rural areas, people are older. Next. People are more likely not to have a high school education. Next. People are more likely to have, to report four or more chronic conditions in a rural area. Next. And they're more likely to use the emergency department for their visits, and indicating a lack of primary

---

\(^{29}\) Centers for Disease Control and Prevention
health care providers. Next slide. They are poor. They have less income to deal with every year. Next slide.

Okay. So, I love this, this diagram put out by the CDC. Social determinants of health are really complex issues. And it's going to take all of our resources to really address them. Health care providers cannot address all of these issues. It's a team approach.

But it does take policy and laws. We have to be collecting data and surveillance. And then we have to evaluate that data. We have to find out what strategies work and what don't work. We have to build our evidence.

Partnerships are absolutely critical in order to solve some of our rural health issues.

And we have to involve the communities because we cannot create solutions for communities without involving them in what are their issues and what are we doing.

The infrastructure and capacity, we've heard about that. Not having internet, not -- I mean, just think about saying, okay, now we're all going to use electronic medical
records. In a tiny Critical Access Hospital with very few resources, you know, IT resources, things like that, these kinds of things are a struggle. How are we helping to make that happen?

And one of our most important issues is equity. We have to pay attention to equity. We know that there's crisis in our health care system. We can absolutely see that in the outcomes.

Again, I refer back to maternal mortality where women of color are three times more likely to die of childbirth and related issues than a white woman is in our country. So, there's a very complex issue.

I like this diagram. I think I'm going to put it on my desk so I remind myself every day that we have to look at everything.

Next slide, please.

So, you know, there's different kinds of rural areas. The Census Bureau said if it's not urban, it's rural. And the National Rural Health Association basically says, well, we have to have definitions specific to the purposes of the programs, for the programs that are being used. And these
are referred to as programmatic designations.

But the bottom line is really that not all rural areas of communities have the same challenges.

It's important to do a community assessment to identify the major issues in designing programs for rural communities.

When I worked in Herkimer, New York, honestly a little bit similar to Hyden, Kentucky, in many ways, but on the other hand the resources were different. We could drive an hour and be in Albany, or drive an hour the other way and be in Syracuse. Where down in Hyden, it was more than two-and-a-half hours to the university setting health care system.

So, even the mountains of Hyden were a challenge because they would not do helicopter transfers unless the weather was perfect. We had too many bad outcomes. You know, we actually had two helicopter crashes with very bad results.

So, you can just see, like, that even though they're similar, they're very different, and the challenges can be very different. And we have to pay attention to that. Next slide.
So, how are we currently addressing some of these? There's lots of programs like the comprehensive asthma home assessments and education.

Some Federally Qualified Health Centers even provide legal assistance, you know, to help with housing, and immigration, and financial security.

It's important -- I think that David did mention this, too. I was very impressed with your presentation, David. So, but creating web-based systems that identify community resources, and the referrals that are made to those resources, and the outcomes of the referrals, if we could do that electronically, it would help so much.

Offering telehealth services when appropriate is very helpful in a rural setting.

And hiring community health workers, this is a very important issue. You know, if we can't go in and do the home visits ourself and be out there in the community, we have to have health workers that are out there assisting with patient contact, education, facilitating partnerships, making those referrals happen.
And I think that we need to invest in a lot more community health workers to assist us in their work. Next slide.

So, promising models that improve outcomes. Again, technology systems that allow health care providers to screen for social needs and identify resources in those communities, if the resources are there. That's another issue.

Connecting these systems to the medical record would allow tracking of outcomes and better coordination. And this is so important because, you know, just telling someone they need to go to WIC isn't, just isn't enough.

This would also help us to determine what works. And it's really important for us to grow the evidence of what works.

The Medicare Shared Savings Program "Pathways to Success" does allow the organization of Accountable Care Organizations. And the outcomes to date have showed comparable or better outcomes with decreased costs with the ACO compared to the traditional physician fee-for-service practices. And I'll talk about

30 Women, Infants, and Children
that more in a minute.

So, partnering with doulas also to give information and support to pregnant women.

Recruiting nurse-midwives to provide first -- provide first-line comprehensive maternity care that does address the social determinants of health.

And in our university, which is a kind of unique university, we only educate advanced practice nurses and nurse-midwives: family nurse practitioners, psychiatric mental health nurse practitioners, women's health care nurse practitioners. It is done through distance. We've been doing this for 30 years now.

And so, our students come to campus only twice during their educational program and spend some days with us. It's very interactive educational online. And we are recruiting from the rural and underserved areas. 22 percent of our students do live in rural areas right now. And over 60 percent live in rural and underserved areas overall.

So, we are educating these nurses to be nurse practitioners and nurse-midwives to stay in their communities and work in their
communities. We use community, we use their community as the classroom. So, they have to learn more about the community, what the resources are, you know, what the needs are in that community.

And we have evidence to show, one, they have very high board pass rates. I know people are suspicious about distance education. But I promise you it works, with 30 years of evidence to show it.

They do stay, largely stay in their communities. And a report from employers are that they are ready to practice when they hit the ground.

So, this is a way of getting more providers, nurse practitioners, and nurse-midwives at least, and I'm sure it would work for other types of commissions, to be able to stay in their community and become educated and serve their home community.

Next, community concordant care. You've probably heard of racial concordant care. We know that racial concordant care improves outcomes. Well, community concordant care does too.

It's important for us to put
providers in the community who know the community, are part of the community, and know the challenges of those communities.

When I used to work in Hyden and the National Health Service Board would send scholars, so they would pay for them to get rid of their student loans, and then send us a graduate from Long Island to live in Hyden, Kentucky, and provide care.

They rarely lasted very long. It was very difficult for them to really understand that whole community and live in a community with no, no movie theaters, the restaurants are DQ\textsuperscript{31}, and, you know, the nearest mall is two hours away.

So, you know, that is important, too, community concordant care. And we can do that also by having more doulas, more community health workers who really know the community and can help us to make bridges.

Next slide, please.

So, the hub and spoke model relies where larger hospitals partner with smaller hospitals that are at risk of closure, is really positive. Similar models in which

\textsuperscript{31} Dairy Queen
hospitals either develop clinics in places where they are most needed, and 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.

So, I mentioned the one in Texas because I read about it, and it looked really good.

I worked at the one in Bassett Healthcare. And I worked at the one at Mary Breckinridge Hospital.

Bassett Healthcare, pretty well-resourced, 13 Rural Health Clinics all run by nurse practitioners. The nurse-midwives visited weekly to provide care to maternity patients in those areas.

And then, of course, if there was any medical issue that needed a physician's attention, they would come into the hospital.

So, that worked really, really well. And it still works really well today.

Mary Breckinridge is a little bit different. A tiny Critical Access Hospital. Average daily census was about 17. And there
were six Rural Health Clinics. A faculty practice of nurse practitioners and nurse-midwives ran the Rural Health Clinics and also had a small maternity practice within the hospital.

They had a physician who provided collaboration care on an ongoing basis. And that physician spent time in the Rural Health Clinic that was at the hospital, so could deal with more high-risk cases and cases that needed a physician's care and attention.

That really worked well, too. I think those types of practices are really hopeful for rural hospitals, for rural communities. Next slide.

So, the Alternative Payment Model really helps tremendously. So, when I worked in places where everybody got paid a salary and, basically, it didn't matter how many patients you saw, I mean, the physicians might get bonuses at the end of the year if they did extraordinary things, and that was great. That was really great.

But this allowed providers to build a team, to relax, and not feel as if you had to see XX number of patients for hour. Fee-for-
service can incentivize a provider to see more patients with a decrease in time spent with each patient.

I remember sitting in meetings and watching them review how many patients. And the business people would say, Look, Dr. So-and-So saw 40 patients the other day. Yay.

But what can you really do when you're seeing 40 patients in a day?

So, I really do support Alternative Payment Models and not fee-for-service models.

Also, we had situations where obstetricians felt they had to do the births because otherwise we would not get reimbursed if the nurse-midwife did the birth.

So, those kinds of things happen and should be thought about.

If an APM is thoughtfully developed with provider input, the result can be a system that facilitates team-based care, innovations in methods to delivery health care, and collaboration with APRNs\textsuperscript{32}, PAs, and other allied health professionals. Next slide, please.

Okay. It's important when we're

\textsuperscript{32} Advanced practice registered nurses
talking about quality of care and measuring the quality of care, with rural patients they're sicker, and so you have to be careful that you're not comparing things that are really due to one group of patients being sicker than another group or patients.

Traditional risk assessments focus on medical complexity, such as we see with the Hierarchical Condition Category. We need to add to the assessment of 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 these social risk factor assessments so that it can compare clinician performance and patient outcomes that are attributable to differences in the quality of care. Said by Milbank. And I just think that's well said. Next slide.

Okay. This is my last slide.

So, we have to think about the heterogeneity of rural areas. And this has particular implications for health care performance measurement.

Variations in geography, population
density, availability of health care 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.

Now, this was important, too, we see in, for example, down in Hyden where the nurse practitioner out in the Rural Health Clinic might see 11 patients in a day. She is seen as less productive than -- it was a she -- than the physician who is working in the Rural Health Clinic and had as many patients to see in the hospital Rural Health Clinic.

But is it still important to do those 11 visits? And how many minutes do we need in the visit to provide care that includes the social determinants of health? We can't do all five-minute maternity visits where all you do is check the blood pressure, check the heart rate, and say, How are you doing? And measure the belly. We have to have some time if we're going to provide that kind of care that addresses social determinants of health.

So, the National Quality Forum has developed a core set of "Rural Relevant Measures." They did so in 2018, and updated it
in 2022. Which can be helpful in addressing these issues.

So, in summary, rural persons struggle more with the social determinants of health than our urban population. And this is clear in their health outcomes.

And it takes a variety of approaches to address these issues as defined by the CDC in all of those things that we have to take into consideration.

Not all rural communities have the same challenges, so programs have to have the flexibility in application to be effective.

And we have to operationalize social risk factor assessment in order to measure what's working and what's not as we move forward in helping our rural population be healthier.

So, thank you very much.

CO-CHAIR HARDIN: Thank you so much, Susan.

At this time we're going to turn to our Committee members for questions. And as usual, if you have a question, please flip your name tag up, name tent up, or raise your hand.

And, let's see who would like to
start with questions. Larry?

DR. KOSINSKI: Thank you everybody, for your great presentations.

My question's going to be for David. I was very impressed with your passion for what you're doing there in rural Minnesota.

And you made the statement that 40, I think it was 40 percent of your revenue was coming from value-based contracts. That's impressive.

So, how does that filter down to your providers? That's at the entity level; that's where the revenue's coming in.

So how do you incentivize for your providers, specifically your specialists?

DR. HERMAN: Well, that's a very good question. So, we don't treat any of our patients differently than we do our value-based care patients. So, we take the infrastructure that we have underneath that and provide it to everybody along the way.

We are not, I think this gets to a point that I tried to make, is that we are not capacity, we are capacity constrained, not demand constrained.

So, if as an example, someone
doesn't need hip surgery, the orthopedist although they are paid by RVU$^{33}$, knows that if that patient doesn't need it, I can have that time for another patient that does need it.

So that's one of those things where if you're capacity constrained, or demand constrained. So, we are capacity constrained with that.

We used to provide incentives for quality of care. It was the least happy thing that I've experienced in the organization.

So what we did is we said we're not paying for quality care anymore. What we're doing is we're designing standard work to make sure that quality care is delivered.

Minnesota has what they call the Minnesota Community Measures, where every health care system is measured on more than 20 different metrics.

We are number one in the state, because we've designed that standard work to make the right thing to do, the easy thing to do.

So, we are very transparent. I can look at my measures. A colleague can look at

---

33 Relative Value Unit
his or her measures, and can look at my measures.

And so, we pay basically some people are on salary. Some people are on productivity. But we measure the quality in everybody's practice and make the right thing to do, the easy thing to do.

Our providers are busy enough, and that's, was one of the, there are you know, very few silver linings to some of the clouds over rural health care.

But being relatively understaffed by specialty, means that someone isn't well-incented to provide care that's not necessary.

Let's get that care back to the primary care provider, and let's reserve my high-level specialty care for the patients that really need.

CO-CHAIR HARDIN: Jay, please go for it.

DR. FELDSTEIN: So, this is a combo question for both David and Ami.

We know the leading cause of death is cardiovascular disease. And, the greatest discrepancy in the death rates between urban and rural populations, is cardiovascular
disease, which is both due to chronic disease, and acute events, which Ami, you just showed in terms of the mortality of acute events.

You don't want to have your acute MI in a rural hospital without an interventional cardiologist. Let's cut to the chase.

So, how do you address that in balance, in rural settings? You know, because a small community hospital cannot support an interventional-based cardiologist.

And quite frankly, you don't want to go to someone who's doing 10 stents a year. You want somebody who is doing 10 stents a week.

So, how do you balance that so you can actually make an impact on the acute event death rate, as well as putting the things into place you know, for chronic care and prevention, you know, which will prevent people from dying from CHF\textsuperscript{34} when they're 80 years old?

DR. BHATT: Yes, , I'll go first and then David will say something brilliant and my whole mind will be blown.

It is a real problem. We have to accept that some of those ratios of mortality

\textsuperscript{34} Congestive heart failure
being worse in a rural hospital, will continue
to be higher as we move to getting the systems
ready to recognize those patients at risk
earlier in their diagnosis.

And so the key is not how are we
going, I think we've been going about it a lot
of like, how are we going to staff those
Critical Access Hospitals? How are we going to
reassure?

We can't staff them with those
people. Now, are we working on things like
virtual half practice, so that people get more
numbers under their belts for those areas in
the meantime? Absolutely.

However, I think we have to really
be proactive about who is the highest risk
before we lose the opportunity.

How do we find them? And we smile
but it's actually doable. With the right
systems, we can find the rising risk.

And those are the people where, you
know, if we know you have diabetes, why are you
not on a statin? Give me a good reason, right?

If we know that you have
hypertension, have we talked to you and taught
your family the symptoms of stroke? The answer
is likely no.

And so, I think those populations, we really need to have an active effort for both patient education, and then getting people to get on to guideline-directed medical therapy.

And, you kind of can't do it by just instructing I think, one person in the primary care rural area after another.

We can do a lot of education, but we can automate some of this. If you're on this dose and you have this diagnosis, unless someone's arguing, you've got to go to the next step.

By the way, the doctor or nurse can overlook that and say hey no, actually there's a really good reason.

But the majority of time, we're going to have to start opting out of guideline-directed therapy, rather than opting in, to be able to get there.

But I kind of, I know what you're saying. I'm going to answer you the best I can, and that's what I can do.

For stroke, I will change my answer, which is when I look at those ischemic stroke
rates, it reminds me at least here in the Northeast, Lee Strong was my mentor.

And he started telestroke. And we saved millions of lives. And millions of dollars.

So I think telestroke is a little different. But doing an interventional catch, we got to catch them and really control them better, in that rising risk phase.

David, what can I do better?

DR. HERMAN: I think you covered a lot of that, but I will start out that when you live in a rural area, you make choices regarding quality of life.

And you go into it I think, with your eyes wide open recognizing that I may live in Ely, Minnesota, where I don't have a cardiologist within seven minutes, but I like living in Ely, Minnesota, and it contributes to the quality of my life.

The other part of it is prevention. And so, that's where it gets to the Minnesota Community Measures.

More than 80 percent of like, over 20,000 of our patients who have hypertension, are well controlled. We have built processes
to make sure they're seen.

It doesn't just require the primary care provider, but we have pharmacists that are involved in that step therapy that's driven by protocols, that goes to that.

So, the primary thing is prevention. But then you do connect all of the, your local EDs with the mother ship, to make sure that you have recognition.

Because one of the things is someone comes in. We make sure that we can get the enzymes even in our smallest hospitals, all that forward, and get that going.

And then, design your system the best you can to get to those areas where they can get the intervention.

But the most important thing is that prevention, and then that recognition. And, you have to design your system around that.

I think the same thing happens with maternity care. There's been 56 hospitals since the first of February across the United States, that have reduced some sort of care within their hospital. The vast majority of that has been labor and delivery care.

Just because you can't provide that
quality of care, science will tell you for fewer than 200 patients, but then how do you design that system to support those people within the small communities without labor and delivery services?

So, it's really about design. But I think what Ami brought out is you can't leave it to chance.

You can't say, just because you live there, you have to take a lower standard of care. Here's the standard of care that we can provide in this community, and we're going to provide it each and every time reliably.

And that requires designing it, staffing it, and requiring the standard work.

DR. FELDSTEIN: Thank you.

CO-CHAIR HARDIN: So, in many of our presentations we've heard in the last two days, about the importance of community collaboration.

Sort of hub structures, bridging organizations like you talked about, David, that are really helping to bridge the gap in resources, reduce costs by sharing some of the infrastructure.

And also, address some of the
workforce issues.

So, I wondered if each of you could talk a little bit about what coordinating hub-type structures you're seeing in the markets you're in.

And, what recommendations you might have for financing or facilitating, future development of that. And any of you can start.

DR. HERMAN: I'll jump in. I think the first requirement for any health care provider, or any health care system, is humility.

When you reach out and you talk with community partners, health care systems, we have a tendency to want to do things our way.

Okay, we want a medicalize everything. And the community has a tremendous amount of knowledge.

So, unless we bring humility to the table, we probably can't come to the solutions that we need to come to.

Another one we need to do is to find out, what we've done in our health care system when I came, we were giving money everywhere.

If you were the Duluth Community Garden, you could get money from Essentia
Health. And I know that gardening is probably good to your health, for your health, but we're not funding those anymore.

We have strict criteria that allow us to say, here's the limited amount of resources that we have. Here's what we're going to fund in these communities because number one, it will have an impact on the health of the community.

Number two, it will have an impact on our partners and they'll be able to do better work. And then, we will learn from it and be able to spread that to further communities.

There's a lot of other stuff that we could sit down and talk about, but our challenge was the humility.

No, we're Essentia Health, we want to do it our way. And I think you need to step back from that and have the right people in your organization, that are having the conversations with the community partners.

CO-CHAIR HARDIN: Any of our other panelists like to comment?

DR. STONE: I will speak to the bridging.
So, Mary Breckinridge Hospital, which was a small, is a small Critical Access Hospital, was really suffering financially, and resource-wise.

I mentioned that things like just the technology, the leadership, all of the things that need to be in place in order to run a hospital.

And, it almost failed. But Appalachia Regional Healthcare ended up taking over Mary Breckinridge Hospital.

I would say that Frontier Nursing Service sold the hospital to them, but that would be, I think almost was paid to take the hospital.

But, the bottom line is that that happened 10 years ago. And, Mary Breckinridge Hospital is still operating in that community.

And it's so much stronger. There was so much resistance from the community to allow that to happen, because they felt that was their hospital.

And, as well as the people within the hospital. But those partnerships are really strong and can be extremely helpful, allowing that sharing of those resources such
as technology, and leadership, and all of those things across the system.

So, it's just one small example of the importance of, in collaborations for even keeping a small hospital within a community.

DR. BHATT: So --

(Simultaneous speaking.)

MR. SHUNKWILER: And I'll just add a little bit to that -- oh, go ahead, Ami.

DR. BHATT: No, no, go ahead, go ahead, Thad. I'll go after you.

MR. SHUNKWILER: Yes, I was just going to add the, you know, from that workforce perspective, I'm blown away at the number of times I'm in committees, or meetings around the health care workforce.

And, there's nobody representing the university systems. There's nobody representing the training institutions in those conversations.

And so we've been very deliberate about how do we, how do we connect the training institutions to the provider organizations in the community, to make sure that there is that pipeline, and we start developing those relations early on.
With the Center for Rural Behavioral Health, we were very intentional about finding community-based partners to really support our mission.

And, we have brought some unusual suspects to the table. We receive funding from ag lending banks, from the Minnesota Pork Association, provided funding.

And, really what it's about is they all are invested, they're all vested in the outcome of ensuring behavioral health access in those communities.

So, it does really take a convening to really bring these resources together. But I think it's paramount to make sure higher education is at the table.

DR. BHATT: I love that. I think that's essential.

I think I agree with everyone so I won't say it again. The only thing I'll add is specifically, if we're thinking about systems where we're saying disease management.

Randy mentioned hypertension earlier. I mentioned atrial fibrillation being an area that we worked at.

Really clearly defining what is the
continuum of shared accountability. So I'm not talking so much about the location of care. But who is the person providing the care, and what can they do?

So if you have a new diagnosis and you need a work-up, that should generally be done in the primary care/cardiology realm.

But if you need rhythm control, which requires a specific set of medications that others may not be as familiar with, that is when we then say you need to see electrophysiology.

If your symptoms are mild, you can be here. If your symptoms are severe. And we really broke it down into what are all the things that can go into this one diagnosis' management at a time?

And where should it live? And then get buy-in from both the patients, and their caregivers, in addition to the clinical caregivers, that like, this is how our system is going to work.

It's a lot of work. However, once created, it's actually somewhat reproducible because the disease is not that different.

You know, there are certain
variations you can have, but once you learn where you're going to go for this variation.

So, I think a continuum of shared accountability for whatever diagnosis, explaining it, understanding it, educating to it if it's community health workers.

I would say that's probably the one other thing about infrastructure, that's really important.

And we don't think of it as infrastructure, but in fact, that understanding is the infrastructure that helps us.

And probably why, you know, people like my colleagues here are all so successful.

CO-CHAIR HARDIN: So helpful.

Team, community members, or Committee members and community members, any additional questions?

Larry?

DR. KOSINSKI: You know me, I can't help but ask questions. I actually have two. One follow-up for David, and one for Ami.

My follow-up for David is, of that 40 percent of your revenue, how much of that is coming from commercial, other than, you mentioned the public funding? But is any of
that from commercial?

DR. HERMAN: Yes, a lot of it is from commercial, as a matter of fact. Although the vast majority is from public programs.

Mostly from public programs because they have the data. Insurance companies aren't very good at having data, other than claims data.

We have a very strong partnership with Medica here in the state of Minnesota, and in North Dakota.

And, we actually share the bottom line on a variety of different programs and services that they provide to employers.

So, our big challenge has been expanding that within the commercial realm by developing those partnerships with the payers, where we call it joint accountability model, where we're going to work together, decide what each of us is accountable for within this. And then work together and then share the bottom line.

If we do something and that product that they have loses money, we lose money, as well. If we put together a product and it makes money, we all make money together.
I think that's the best way to do, but it requires a lot of different conversations. All of us in our conversations with payers have something in our brain stem from the last 30 years of negotiating with payers, that makes it win/lose.

And it requires a lot of a CEO's time, and a lot of leadership time, to call time out, say this is about building relationships, and taking care of our patients, rather than winning on a particular point.

DR. KOSINSKI: Okay, great. Now for you, Ami.

I could see, I can imagine the remote monitoring for rhythm disturbances will lend itself very well to a remote capture.

How have you moved beyond that? What other, what are your target conditions where you've had success outside of the rhythm space?

DR. BHATT: Yes, so blood pressure's been another one which I know primary care has done well also.

But remote blood pressure monitoring, we've also been doing remote cholesterol monitoring.
So those blood pressure programs that I'm talking about, we started really thinking about how do we, we are starting a driving urgency for LDL\textsuperscript{35} screening throughout the country.

Which is a real, large, now funded play to get everybody to at least get that done. Now whether or not you think of LDL as the cure-all to, you know, preventing cardiovascular disease is not on the table right now.

It's simply that we need to be checking something, so we're going to take the, the base.

And so, hypertension is a very well established one. Heart failure has pockets, because heart failure requires a real hub and spoke model, with heart failure doc present there.

However, heart failure preserved ejection fraction, these are people who have the heart failure symptoms but actually don't have weak heart muscle.

That is probably the next area that we can grow out of for remote monitoring, based

\textsuperscript{35} Low-density lipoprotein
on what we're learning from hypertension, what we're learning based on weight scales.

Similar to what David said, but I'll say two things. So a-fib, heart failure, hypertension, and cholesterol screening, main areas of interest for us.

As we're working on that, one of the things we're doing from the innovation side, and so I put that hat on for a second, is really partnering with the monitoring companies that we think are doing it right.

That are willing to work with us to fit into the existing workflow, or make a reasonable workflow for clinicians and teams to be able to use them.

And so, to really similar to what David was saying, be there at the table with them and say, you know, our name is with you. Your success is with us.

We have a small LLC that actually puts in minimal actually not of dollars because we are a nonprofit, but some dollars and invests in some of those companies saying, we really believe your success is going to be our clinicians' and patients' success.

And so, I think you do need to show
these remote monitoring tech companies, we can't have a million of you.

We're going to need to narrow down the ones who can achieve success, or the ones who are going to be willing to work with the clinicians, rather than saying our square peg, your round hole, but let's develop it together.

So, hopefully there will be more things. But a-fib, heart failure, hypertension right now, and moving towards LDL screening.

CO-CHAIR HARDIN: David, I see you have your hand raised. Please go ahead.

DR. HERMAN: Yes. Ami put a question in the chat that said, this is great but culture change is hard. How long before the progression to value-based care did the messaging start?

I believe the culture change is the only thing that makes this work, because culture is what's very durable in your organization. That's what makes it so hard to change.

Ed Stein, who wrote a book on you know, corporate or organizational culture, is a good friend of mine.

And what he used to say is that
culture is the behaviors that are successful within an organization.

So it's not what you say your culture is, it's what someone can come in and observe these are the behaviors that are successful.

So what we did is we said okay, we're going to make sure that these behaviors are successful in our organization. We're going to design our organization around those behaviors that align with value-based care. We're going to reward people that do that by just attention, and thank you's.

We had someone that raised their hand at one of our leadership things that says, you know, why did we fire somebody in this organization that has 200 outstanding charts, and we don't do anything for the person that has 200 patients that should be on a statin, that aren't?

And, it really changed the culture of our organization. You have to measure and reinforce, and support the right behaviors. And then that will change the culture.

And then that will make it very durable, that keeps people from tipping you off
this value-based care journey, sometimes when it's very difficult, and sometimes when it just is a very fair thing to do with the patient that sits across from you.

CO-CHAIR HARDIN: That's great.

DR. BHATT: I love to hear that because as we really start thinking about quality measures, and accreditation based on quality measures, Centers of Excellence for Diseases, we're basing it all on we're going to do the same quality, no matter how you're getting paid right now.

And then we will hope that the culture will change enough from fee-for-service.

I mean, we have so many procedures that there are, you know, parts of cardiovascular care that are more preventive.

And those people will get on value-based care. And then there are those who you know, got into it to do procedures and are paid for them.

And, I understand where they come from. They have a mortgage, and their kids' college depends on that. But I think we can get there in a way where everybody is
copacetic. Thanks, David.

CO-CHAIR HARDIN: I'm going to shift to a really heavy question. So, David, we have a question for you.

If single-sided risk and/or double-sided risk is a realistic goal for the typical rural provider, and, what would the glide path be in order to prepare and encourage more rural providers to participate in APMs and accept risk?

DR. HERMAN: So, the first question I would ask is that does it require accepting risk to change behavior?

Because what you're talking about really is changing behavior. And you're using risk either single-sided or double-sided risk, as an incentive to change that behavior.

So, I would ask the question, what are the behaviors that you really want to change, and what is the best way to do that?

We are happy to take upside and downside risk, because we made the commitment and built the infrastructure to support it.

And, we like taking that risk because we do well in it. It spurs our quality, and we go on.
There may be other providers as was mentioned, they may not have the numbers. They may not you know, one patient can tip a small practice from being very successful, to being regarded as a failure in a particular statistic.

So, what I would say is, what mechanisms, what toolkit of mechanisms, can we have that incent the right behaviors in a particular practice?

I think we've heard from every one of us today that what we've said is, you know, a standard is possible, but as unique as necessary.

You can certainly, there aren't an infinite number of classifications of rural health care providers.

But there's certainly enough to say, how do we incent the behaviors that we want in a particular practice, so their patients get better care, and that that practice is sustainable?

And I don't know if that's an answer to your question or not, but that's my philosophy on it.

CO-CHAIR HARDIN: Great, very, very
helpful.

Any other advice about the glide path to get there?

DR. HERMAN: I would say you have to measure the glide path. And, we actually use the term glide path for every one of our quality measures within our organization.

So you can pull up the dashboard, and using hypertension as an example. And if we're not making it, we have you know, 124 people that are not meeting their goal on hypertension.

The key to it is to start to measure it within your practice. Making the outcomes of your patients, and making the processes that you have within your practice to get those outcomes transparent, is the best way to start.

It is very challenging for small practices to build that level of analytics. I think there could be a toolkit that you could put and have a lot of different practices share, rather than have them to develop it on their own.

But until you get that transparency agreement on what your goals are, and the transparency of where you are along the
journey, I think you're not planning for
success, you're just hoping for success.

CO-CHAIR HARDIN: Thank you, David.

Jim, please --

(Simultaneous speaking.)

DR. BHATT: So maybe I'm just going
to add to that for one second, if it's okay.

We have atherosclerotic
cardiovascular disease risk score, ASCVD risk
score, and it's based on blood pressure, LDL,
et cetera.

And we've created in a way that in
most people's electronic health records, one
can actually just have those fields pulled.

And, it will give you the percent
likelihood that your patient will have a heart
attack in the next 10 years, which is what we
use to determine taking a statin.

But we can also use it now to say,
but if your blood pressure comes down this
much, then this risk will go down.

If your LDL comes down this much.
And so we've started to use it more as a
teaching tool for the patient.

Dieticians, nutritionists can use it
as well. Our pharmacists are using it. And
so, I think those kind of tools are helpful to people.

Eventually, once we roll out those tools, so, I think what David's saying is right. The next step needs to be now you know how to use the tool, now we are going to measure our use of the tool.

That's still scary for clinicians, but I think it has to be that next step.

DR. HERMAN: And what we do every year is we, at the end of the year, we translate it into actual lives saved.

So, if we are you know, at 85 percent on colon cancer screening, that translates to this many lives saved.

Hypertension, statins, all the other stuff that, breast cancer screening, mammograms, we transfer that, we translate that to lives saved.

And I think that really helps us get alignment within the organization, that our mission is, we are called to make a healthy difference in people's lives.

And, this is the healthy difference. These are the people that will you know, see their grandchildren's graduation, or their
daughter getting married.

And really translate that into impacts on lives, rather than just statistics on a dashboard.

CO-CHAIR HARDIN: So helpful.

We're right at time for public comment but Jim, do you have a fast question, or?

Okay, we want to thank our presenters so much. This was really valuable dialogue, and just encourage you to stay on if you'd like to continue to hear the conversation today.

* Public Comment Period

So, we do have a public comment. There's one person that signed up to give public comment.

And I want to open it up to Elizabeth Foster, from Columbia Gorge Coordinated Care Organization, an Oregon CCO.

And, Elizabeth, please go ahead.

DR. FOSTER: Can you hear me okay?

CO-CHAIR HARDIN: We can hear you perfectly.

DR. FOSTER: Excellent.

Good afternoon. My name is Dr.
Elizabeth Foster, and I'm a rural family physician, and a founding member of the Columbia Gorge Health Council, the public partner of our rural coordinated care organization.

We are addressing rural health disparities with community health workers. We need payment reform to support clinically effective cost saving care to address health disparities in rural parts of Oregon.

Community health workers, CHWs, are system navigators, health educators, patient advocates.

They connect patients with resources and services. They help patients and family members understand and advocate for their own health care needs.

Often bilingual and bi-cultural, CHWs are trusted to provide patient-centered care for racially and culturally diverse patients, and families.

Oregon has a long history of incorporating CHWs in clinical and community settings since the late 1980s, targeting diabetes education, migrant farm worker outreach, perinatal care, access to housing,
Clinic-based community health workers. Connected care for older adults is a pilot that uses community health workers, and evidence-based age-friendly protocols to provide improved care for frail, older adults in rural areas.

Currently being tested in the Columbia River Gorge, the clinic-based pilot is conservatively projected to result in a return on investment of 5.15 over three years.

Our community-based CHW program has also demonstrated medical cost savings. Community health workers provide effective interventions that save public funds, reduce health care costs, decrease hospital days, increase use of primary care and behavioral health services, provide fragile older adults with access to resources, improve patient and clinician satisfaction, and save money.

The projected return for investment on the connected care for older adults CHW pilot is over five times in three years.

Problem. Community health worker services are not currently reimbursed at viable rates, or at all.
Current billing mechanisms do not support community health worker travel, home visits, coordination of care, outreach, connecting patients with community services, et cetera.

They are currently funded through unsustainable, unstable grant cycles and local investment.

Solution. Add a wrap payment to cover CHW services at FQHCs, RHCs, and community-based hubs.

Wrap payments are used for cost-based reimbursement for RHCs and FQHCs. They cover actual costs, and are paid as a block fee to cover the differences between Medicare and Medicaid payments, and actual costs of visits.

Because the scope and breadth of care a community health worker performs varies a lot, and much of the work is not done in the visit, the wrap payment could be tied to panel size, PMPM payments, with expectations that delivery of evidence-based services are available to those who are empaneled and capitated.

---

36 Federally Qualified Health Centers
37 Rural Health Clinics
38 Per member per month
Number two, currently private insurers are not required to pay for CHWs as essential services. Action. Require private insurers to cover CHW services.

We are available to share our evidence-based program and cost savings information with you.

Thank you for your time.

CO-CHAIR HARDIN: Thank you so much, Dr. Foster. Amy, are there any other public commenters?

Okay, hearing none, this is the end of the public comments.

* Committee Discussion

And now the Committee members and I are going to discuss what we've learned yesterday and today from our guest presenters, panel discussions, and background materials.

PTAC will submit a report to the Secretary of HHS\(^{39}\) with our comments and recommendations, based on the public meeting.

Members, you have a document on potential topics of discussion and deliberation tucked into your binder, to help guide the conversation.

\(^{39}\) Health and Human Services
If you have a comment or question, please flip your name tent up, or raise your hand in WebEx.

And we'll be discussing this until about 12:15.

Who would like to start?

DR. FELDSTEIN: All right, I'll make it easy, Lauran, and I'll start since nobody wants to start.

CO-CHAIR HARDIN: Thank you, Jay.

DR. FELDSTEIN: I started yesterday. I'll start today.

You know, another great set of panels. I think again, you know, kind of reiterating yesterday about the ecosystem between you know, hospitals and primary care.

I think it got sharper and focused today with some of our presenters in terms of the hospital.

The emergency department often sometimes they're staffed by organizations. They're not hospital employees. A lot of ED staffing is outsourced to private enterprises.

They all have to be aligned for rural health care, from my perspective, for survival. In addition, whatever payment
methodologies and Alternative Payment Models, and total cost of care, it really does have to be across all payers.

Because the Medicare population, or the Medicaid population alone, is not enough to support them on an ongoing basis.

So, we really have to be cognizant of that. You know, we can talk about up-front costs, up-front costs all we want.

But where are those dollars, where's the money going to come from? And you know, it's not just enough for CMS.

This needs to happen at the state level, and the local level. You know, everybody's got to come together if we're really serious you know, as Jim alluded to yesterday, we need a moonshot if we're really going to have, make an impact on rural health care.

CO-CHAIR HARDIN: So helpful. Thank you, Jay.

So, what I'd like to do is go around the room and just capture what additional insights or things, should we emphasize or call out as a result of this meeting?

Lee, would you kick us off? Thank
you.

DR. MILLS: Yes, it's all still gelling, I think.

But I was really struck by many of David's comments about Essentia, and how they are pretty deeply connected to their community, and doing deep learning about what the community needs to truly be effective, and change health metrics.

But then not, but then being very specific in building the culture where doing as he said several times, doing the, you know, the right thing to do is the easy thing to do.

So he's building the systems that deliver that outcome reliably, which was fairly striking.

A lot of times I think, in standard practice, it's more haphazard that the right thing happens to do when all the forces align randomly. And, we can't count on that moving forward.

I was also struck by the statement that until you have transparency of data and concrete action, you're just open for success, not planning for success.

And, I think that can be applied to
a wide variety of learnings from this meeting.

CO-CHAIR HARDIN: That's great, thank you. Chinni?

DR. PULLURU: Building on, great day, building on some of the themes from yesterday. What I have written down is something that was said in this panel, which standard is possible, unique is necessary.

And so, I do think going back to rural archetypes, and how we differentiate and create both standardization and some level of uniqueness, is important.

I was struck by something that Tom Lee said, which is you know, one of the things that is necessary in implementation, is unwinding of time to find more time to play offensively, to play offense. I'm sorry, play offense.

And so, I think that you know, it's really important to look at how the time expectations of the primary care physician, and other providers, is handled in reimbursement. That is important.

And from today, one of the things that struck me across the board was, the importance, and I think this has been said many
times before, of data.

   And data infrastructure. And the ability to re-stratify on the front end.

   While this is important, I think everywhere in value-based care, it seems to be the largest opportunity and gap, that exists in rural areas that they don't have the tools and enablement in order to be able to actually actualize even the basics, right. And so, that's very important.

   And so, that struck me as a theme from today was really across the board, you know, how do we get that resource proactively, so people can actually start the process?

   And lastly, from our public commenter I wanted to sort of also double-click on you know, paying for, having sort of you know, having private insurers, as well as CMS, pay for wrap-around payments for CHWs.

   But also, all allied health professionals in a way that, I think that's the challenge is to do that in a way to maintain budget neutrality, but really figure out how that team-based payment can work.

   So, we bring, so it behooves people to actually bring those allied professionals
under the tent.

CO-CHAIR HARDIN: Very helpful, Chinni. Lindsay?

DR. BOTSFORD: Yes, thanks for the conversation.

I mean, I think the theme that came through almost every presentation is that it's hard to think about cost savings, as we think about applying that lens to rural providers and hospitals, when right now financial viability or existence, is the primary concern.

I think a couple themes resonate. Whether it's a proposal for a hub and spoke model, or using AHCs\textsuperscript{40} to provide support to rural areas or rural hospitals, figuring out a way we leverage resources and don't expect rural hospitals and providers to get out of this on their own, needs to be part of the solution.

We heard the theme of upright, up-front funds on multiple occasions. But I also found today the concept of you know, it doesn't necessarily have to be more money, but what do we pay rural hospitals to do.

And if we provide stable funding to

\textsuperscript{40} Accountable Health Communities
do different things, could we influence the
problem of volume needing to drive
sustainability?

We heard again today the need for
all-payer alignment, and I think even some
tinges of where can, where can state
involvement in terms of promoting the amount of
primary care spend, or aligning on quality
measures for state problem -- programs.

How could that also decrease some of
that administrative burden that our, our rural
providers feel intensely?

A couple themes around flexibility.
I think I heard that flexibility for a home-
based, or alternative sites of care can be
especially important for rural communities.

And flexibility in telehealth space,
particularly in things like hospice care, or
other at-risk models.

If we're paying you for outcomes,
let's not worry as much about how you are
delivering that, or where you are delivering
that.

And then the last thing that Chinni
highlighted is, you know, what are those
compensable actions that don't require a
clinical license, that drive value either on non-medical drivers of health, or improving health-related social needs?

Where are those people, whether they be community health workers, or actions that we would expect a rural provider to, to have for our patients that currently don't have a way to get reimbursed?

And, that cost plus reimbursement isn't enough to be able to make those people exist in communities. I'll end there.

CO-CHAIR HARDIN: Thank you, Lindsay. Walter?

DR. LIN: First, I just wanted to thank the hard work of the PCDT\textsuperscript{41}, ASPE, NORC staff, for just another outstanding public session. It's been really informative.

And as I've listened through these past two days of superb experts kind of sharing their insights and wisdom, I was reminded of the famous opening line of a Charles Dickens novel.

It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of

\textsuperscript{41} Preliminary Comments Development Team
belief, it was the epoch of incredulity.

And, I really do think we have a tale of two health systems in America. One urban, which we're so familiar with; and one that's often not so much in the news and the limelight, the rural health system.

And in many ways, these two health systems are quite unique and face different issues.

I ended my comment yesterday with the idea that I think the task before us as a Committee is to help suggest or recommend payment model redesign, to support innovation and team-based care delivery models tailored to rural health.

And just to kind of dissect that a bit further, you know, I, this idea of team-based delivery models tailored to rural health, is something that I think I'm all the more convinced is important after our experts today.

The idea that maybe we can address some of the shortages of resources in rural health through telehealth, that leverages more intensive primary care to decrease the need for specialist care.

The idea that we can use non-
licensed health care workers to leverage the presence of primary care resources in rural America, I think is really fascinating.

And, maybe through kind of the better utilization of non-health care resources, or primary care resources, we can create more specialist capacity, more primary care capacity, and address some of the problems that we've heard about these past couple days.

So, this whole idea of innovating care delivery models I think is important, and I really appreciate it also the comment of Dr. Foster around community health workers.

I think it speaks to that concept of creating more effective FTEs\(^\text{42}\) of licensed professionals, through the use of team-based care. And hope that that's something that we can encourage CMMI to explore.

CO-CHAIR HARDIN: Thank you, Walter. Larry?

DR. KOSINSKI: We heard a lot of common themes. We certainly I think Alana said it well, that finance drives function.

And, we need to, if we want value-based care, we have to pay for value-based

\(^{42}\text{Full-time employees}\)
care. We have to figure out a way of doing it.

One of the other comments she made that stuck with me and I wrote down, is that the providers are suffering innovation fatigue.

And, I think it stems from the fact that we haven't done the moonshot. As Jim mentioned yesterday, we've been tweaking, and tweaking, and tweaking around the edges.

And the providers are tired of it. And I think we need to tighten our timelines. We need to be bolder in what we're doing. Because the tweaking is just going to continue to alienate them.

This Committee has come up with a model. And we said earlier, we reported to the Secretary last year that the model should be high-touch proactive care. Team-based, high-touch proactive care.

Well, if that's the model, then let's push it and figure out how it should be paid for.

I think our provider entities are screaming for it. And they're waiting for us to act.

This goes to the heart of why this Committee exists. This Committee exists to
allow the groundswell of innovation from the provider community, to actually reach an implementable crescendo.

    I think we're seeing that, but somebody needs to take it over the other, other side before the wrong entities prevail in the market.

    If we want the right things done, we have to be bold and push the right things.

    Those are my takeaways from today. And yesterday.

    CO-CHAIR HARDIN: Thank you, Larry. Jim?

    DR. WALTON: I would prefer not to have to follow that. That was brilliant.

    Number one, I feel privileged to be here to, for the last six or nine months sitting with the Committee, and learning so much about how this, how this works.

    And, I'm really grateful that there was a theme that was decided to listen around rural health care providers, and their participation in total cost of care, value-based arrangements.

    And I really appreciate the fact that citizens get a chance to you know, both
talk at, from their homes and then people like us get to come here and to hang out with people that are, dedicated their lives, the staff, to dedicate their lives, their careers, to doing something that really can promote scale.

When we asked our, when we've asked ourselves this question about rural health providers, we are then as providers if you will, representing what we think we heard from our colleagues.

And one of the things that I take away from our meeting, in addition to what you're saying, Larry, is this sense of urgency, but that I got an impression that I think can be proven with a little bit more research.

That there's probably unintended, unmeasured, health disparities existing in rural America because of value-based care. And, it may be getting worse.

I feel like that's what I heard from the SMEs. And, I think that's the subtext, is they're feeling something from the patients.

And they're feeling something about themselves. And they're feeling something about their infrastructure. And the perceived

43 Subject matter experts
And Larry, I think you're spot on, is that there are market forces that are more than willing to respond to that vulnerability.

And so, so as a consequence, I think what I in addition to what everybody brilliantly said, I think one of the things that we've not explored well enough is this idea that there are agencies and departments in the government, who are, who have funding, and people, and talent, and programs that touch health. And health care.

And they could be arrayed and coordinated in a way, to help the providers on the frontline in rural America.

And help them help the patients, and their families, to reduce the inequality that exists in the United States.

And as we said yesterday, this is a bipartisan opportunity because it speaks to the very heart. And oftentimes, we talk about the rural areas of the heartland of our country.

And someone, one of our speakers yesterday said food, fiber, and fuel. You know, these, this is the bedrock of our country.
And oftentimes, you know, in rural America, we can see some of the issues that they confront often like we would see a developing country. Or a country who is challenged, a whole nation that's challenged.

And it's quite possible that we could actually approach the problem in rural America, as you might approach a developing country's problem of developing their infrastructure, and developing their human capital, and their economic development.

And I think that that plays to both the red and the blue in us. You know, or the American-ness in us, right, that we're all Americans.

And we all are very, very deeply concerned if there are both providers and patients experiencing avoidable morbidity and mortality as an unintended consequence of a well-meaning model, or policy.

And so, I would call us to think through this idea of can we organize in a way, can we, PTAC, recommend something that's unique, that we would organize?

Or agencies and departments whose
activities can be identified and can be said, that's a health-related activity that deals with labor and the need for behavioral health workers, our community health workers.

There's a communication and infrastructure area, or transportation, or food, or public health, or payment, you know, Medicaid and Medicare payments.

And of course, anti-trust. We know about consolidations.

So, I think there's this opportunity for us as a Committee to report and ask for the Secretary to consider a project that would kind of reimagine kind of how we would help our rural providers and their patients, but arraying the entire federal structure that we have, that touches health.

So, I'll leave it there.

CO-CHAIR HARDIN: Thank you, Jim. Jen?

DR. WILER: I, too, want to give my gratitude to the numerous people who contributed to making really exceptional, valuable last two days.

There were four things that in addition to all the previous comments and our
comments yesterday, that I heard that I'd like
to note.

The first is that moving from volume
to value has no place in our rural community
construct when we think about our value-based
care delivery models and payment models. It
just doesn't work.

We heard a lot around you know, the
challenge around low volume. And, I'm
convinced after these last two days that just
aggregation of patients for attribution, or
being able to apply a risk methodology, is the
wrong approach.

And what we heard is, or a question
was asked that I thought was a really important
or thought provoking one, is risk necessary to
change behaviors?

And I think the answer in this
situation again after these two days, I think
the answer is no.

What we heard is that you know,
financial viability is the number one success
factor.

And so, thinking about how to create
a sustainable workforce and delivery network
that touches our rural patients, and props up
our delivery system providers, including our various forms of acute care hospitals, seems important. It's part of critical infrastructure.

And when our rural providers are already in a practice environment that is by nature at risk, delivering care to our vulnerable patients who are not healthy, not only is it a call to us around the fragility and the fact that it's breaking, but I think we need to be laser-focused on how to create maintenance and sustainability.

Because I think point number two, what I heard early on the session yesterday and then again today. I think we all agree that the first principle is to be home first. Which means community first.

And in order to do that, there's a cost of availability, much like our utilities that we've talked about before.

And I thought lots of good conversation that I won't replicate here, but we heard that most of the cost of, from a delivery perspective, is fixed in these communities.

And so really, we need to pivot our
thinking around leveraging this fixed cost to be more effective, and to be more efficient.

And we have these payment structures that it sounds like are preventing us from being able, being able to do that. And leverage some of those assets that are already in those communities.

The last thing I heard dovetails on what I think Jim is raising, and that's I think it's become clear we have to double down on public-private partnerships.

And that in these communities, conveners are really critical. If that's from portfolio management and seeking funding, and implementing funding through grants, or operationally, you know, project managing, how to do that implementation, there's a need for that within at least the provider community.

So, my last point is, it sounds to me like a community-based ACO program, which CMMI has already started thinking about, and implementing.

But I think really getting sophisticated and understanding what a community-based ACO looks like, with regards to funding and unique partnerships.
With regards to this idea of fixed costs and utilities. With regards to unique, I don't even think community health workers are no longer innovative. They're critical infrastructure.

So there might be an innovative care model, but that asset is one that's no longer innovative.

And there's a real opportunity for us to think about how to keep care at home. And when appropriate, an escalation to an interventional cardiologist, not in the acute care phase, but right in the diagnostic phase.

But what are those things that can be kept closer to home with the resources that exist? Thank you.

CO-CHAIR HARDIN: Thank you so much, Jen. Angelo?

CO-CHAIR SINOPOLI: Yes, thank you.

So again, just like everybody else I'll start out by commending this team, the PTAC Committees and all of our support from ASPE and NORC, and others that have participated in this.

And particularly to our panelists who clearly dedicated a lot of time to putting
their presentations together, have years of experience that they brought to the table.

And a lot of their discussion, I think has been eye-opening to me, and I suspect a lot of people around the table.

We had a good discussion yesterday after yesterday's meetings, and I just want to kind of rapidly highlight a couple of those that.

And what we heard is lack of capital investment. We heard a lack of community resources, and a lack of ability to partnership, or organize as community resources.

We heard a lack of definition of rural and the recognition of the different archetypes of rural.

We heard that VBC⁴⁴ just doesn't work in the rural community. We heard that the quality measure dysfunction that we experience even in the urban areas, is magnified in the rural areas.

We heard the lack of data. And we heard that this is a public emergency. And so, and we talk about it only being 15 percent.

---

⁴⁴ Value-based care
It's 15 percent. It's 15 percent of all the people in the United States, of which no other area has the capacity to absorb those 15 percent.

And so, I just want to emphasize those things. And what it really says to me, is that the rural components emphasize the fact that we don't really have a health care system.

We still have fragmented care, fragmented programs, et cetera. And so I am looking forward to that day when we actually can develop a system where maybe we need a rural ACO, but wouldn't it be nice if we had a health care system that alleviated the need to have a rural ACO?

That actually all the systems were integrated. That we supported the rural hospitals. Connected them to the urban and academic medical centers.

That the specialists in those areas were connected to the rural primary care physicians and specialists.

And that we work to create true integration. And that's what we talk about. We have a model that we've talked about as the model.
What we've not talked about is how does that get operationalized and integrated across all geographies in the United States? And I think that's where we need a thought process around.

And then the last thing I'll mention is, you know, even in my previous work going back to a lot of what Jim talked about.

There's a huge amount of resources in state agencies, and governor cabinet resources that deal with health care day in and day out.

And those things are not coordinated with all the other health care resources that are available in the health care system. And they should be.

And so, lots of opportunity. All this is fixable. Somebody's got to step up and make a decision that we're going to pull all this together, so.

* Closing Remarks

CO-CHAIR HARDIN: Thank you so much, Angelo. Audrey, or any of the staff have any questions or comments?

I want to thank all of our esteemed presenters and also our wonderful experts on
the Committee itself, for your active engagement. Really important comments.

    And really key themes. We've explored a lot of facets regarding and encouraging rural provider participation, and population-based total cost of care models.

    And, I think we will continue to gather information on our theme through our Request for Input on our topic.

    We'll be posting that on the ASPE PTAC website, and sending it out through the PTAC Listserv.

    You can offer your input on our questions by October 20th.

    The Committee will work to issue a report to the Secretary with our recommendations from this public meeting.

* Adjourn

    And with that, the meeting is adjourned. Thank you.

    (Whereupon, the above-entitled matter went off the record at 12:57 p.m.)
This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 09-19-23

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

[Signature]

Court Reporter