Concurrent Breakout Sessions B:

Achieving Value Based Care Through Rural Population Health

1:50-2:30 p.m.
January 14, 2020

Value-Based Care:
Federal Landscape and Considerations for Rural Population Health

Kerri Cornejo, MPH
Policy Coordinator
Federal Office of Rural Health Policy

Value-Based Care Defined

HHS is working to transform our system from one that pays for procedures and sickness to one that pays for outcomes and health, focusing on four areas:

- Maximizing the promise of health IT, including through promoting interoperability.
- Boosting transparency around price and quality.
- Pioneering bold new models in Medicare and Medicaid.
- Removing government burdens and barriers, especially those impeding care coordination.

- U.S. Department of Health and Human Services (HHS). Secretary Priorities. July 2018.

Source: https://www.hhs.gov/about/leadership/secretary/priorities/index.html#value-based-healthcare

A Brief Timeline of Value in Reimbursement Models

1980s
- Prospective Payment

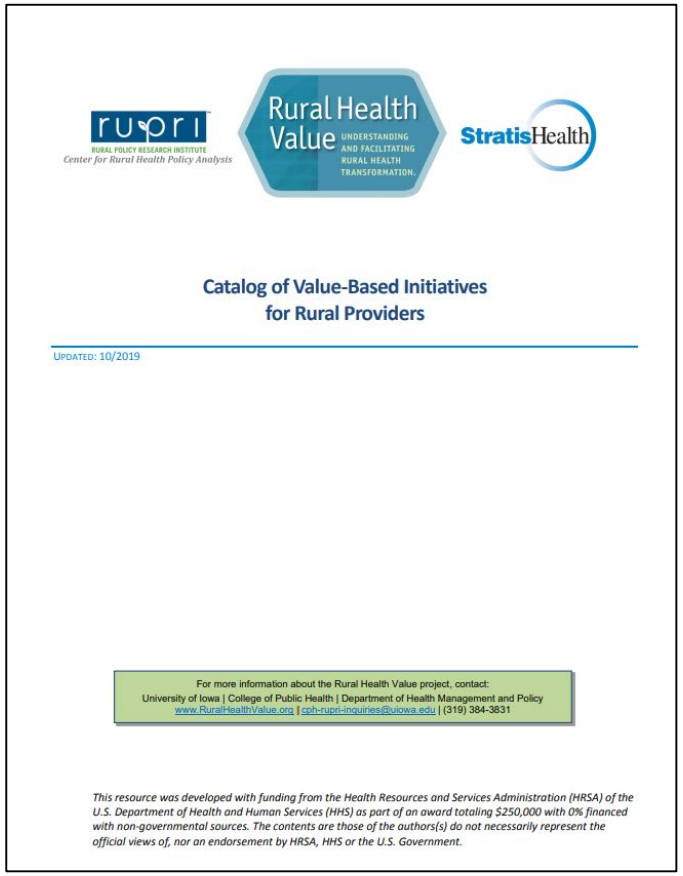
1990s
- Managed Care

2000s
- Pay for Performance (P4P)

2010s
- Alternative Payment Models (accountable care, etc.)

2020s
- Population-Based Payments

Catalog of Federal Value-Based Models



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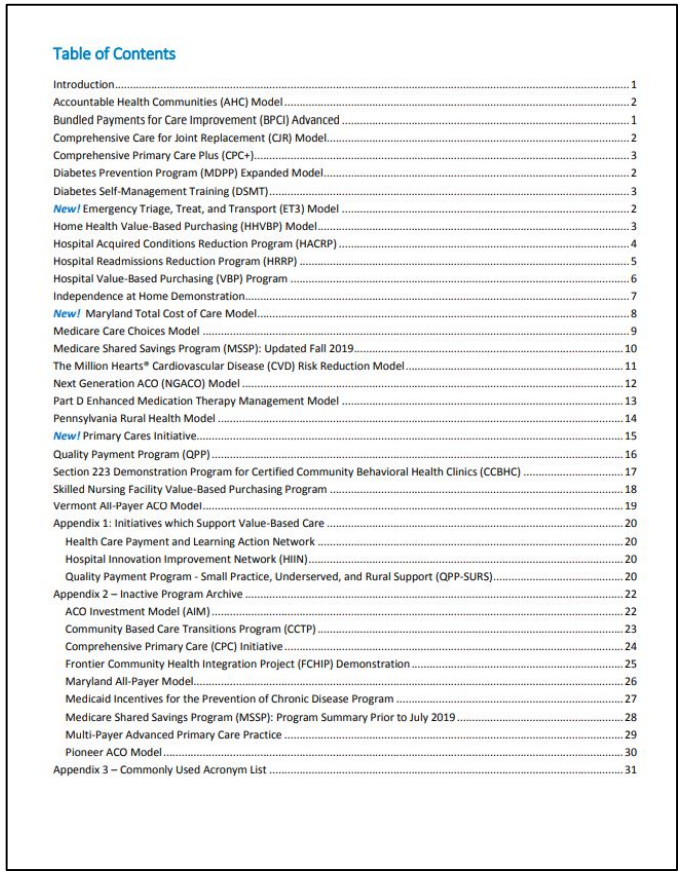
Catalog of Value-Based Initiatives for Rural Providers

UPDATED: 10/2019

For more information about the Rural Health Value project, contact:
University of Iowa | College of Public Health | Department of Health Management and Policy
www.RuralHealthValue.org | cph-rupri-inquiries@uiowa.edu | (319) 384-3831

This resource was developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $250,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.



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Source: https://ruralhealthvalue.public-health.uiowa.edu/files/Catalog%20Value%20Based%20Initiatives%20for%20Rural%20Providers.pdf

Rural Considerations:

Value-Based Care and Population Health

- Low Patient Volumes
- Financial Constraints
- Different Payer Mix
- Different Patient Population

Federal Programs and Resources:

Rural Value-Based Care, Care Coordination, and Population Health

HRSA's Federal Office of Rural Health Policy

- Funding Opportunities (e.g., grants)
- Technical Assistance (e.g., Rural Health Value)
- Toolkits (e.g., RHIhub)
- Health Policy Research

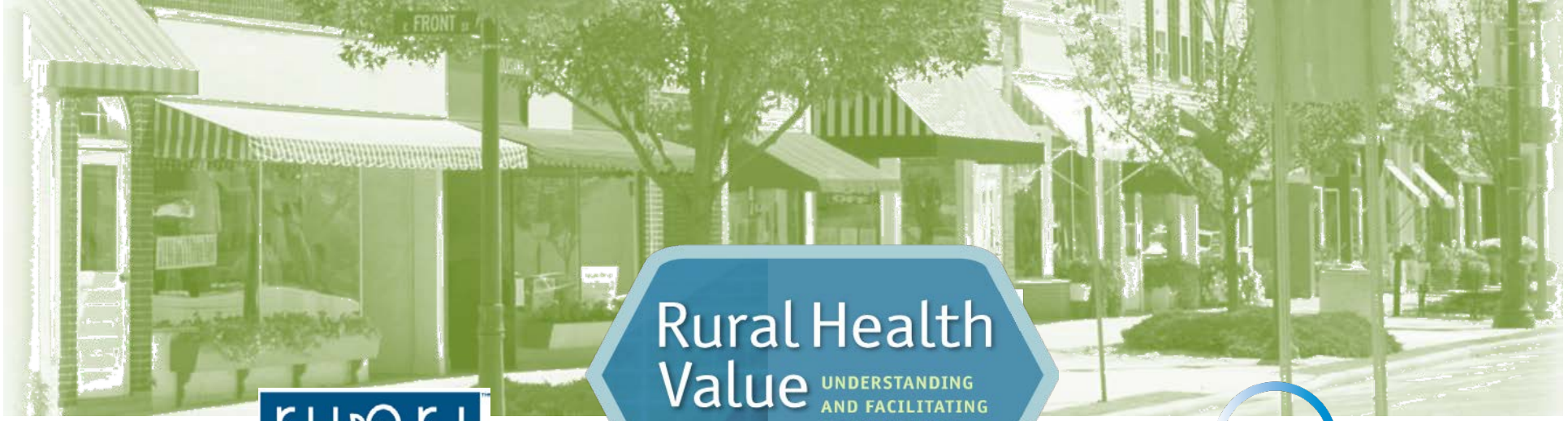
CMS

- Innovation Models (e.g., PA Rural Health Model)
- Reimbursement Opportunities for Care Coordination and Management
- Technical Assistance (e.g., Quality Payment Program Support for Small, Underserved, and Rural Practices)

Resources

- **Funding Opportunities:** https://www.hrsa.gov/grants/find-funding?status=All&bureau=642
- **Rural Health Value:** http://www.ruralhealthvalue.org/
- **RHIhub:** https://www.ruralhealthinfo.org/
- **Rural Research Gateway:** https://www.ruralhealthresearch.org/
- **Connected Care for CCM:** http://go.cms.gov/ccm
- **QPP SURS TA:** https://qpp.cms.gov/about/small-underserved-rural-practices
- **Questions:** RuralPolicy@hrsa.gov

These slides are presented to FORHP recipients for technical assistance purposes and do not constitute official US Government guidance on the topics discussed



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Achieving Value Based Care through Rural Population Health

FORHP Rural Partnership Development Meeting
January 14, 2020
Rockville, MD

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Rural Health Value

- **Vision:** To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems.
- Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) Cooperative agreement started in 2012.
- Partners:
  - University of Iowa RUPRI Center for Rural Health Policy Analysis
  - Stratis Health
- Activities:
  - Resource development and compilation, technical assistance, research

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An Analogy…

- How fast is the road to value-based payment for your organization?
- Components to building a ‘car’ that supports the drive to population health
- Mapping a route to population health

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The Road: Value-based Payment Models

- **Starting line:** Fee-for-service (FFS)
- **Slow lane:** Incremental modifications with incentives (ex. quality scores)
- **Moderate lane:** Elements of restructuring health finance but leaves in place current FFS infrastructure (ex. ACO)
- **Fast lane:** Blows past current structure to a total redesign of payment, aligned with quality measures (ex. global budget)

Caveats:

A shift to the fast lane is underway:

- **Road conditions matter**: different paces in different places and from different payers.
- If you are currently sitting at the starting line… Consider ways to start building momentum!
- Population health is a key element of value-based care, regardless of how fast you are driving.

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Building the ‘Car’ for Population Health

- **Driver: Leadership**
  - Facilitate and/or support community planning, coalitions, and connections
  - Identify resources and invest strategically
  - Engaging staff, clinicians, patients, and caregivers
- **Engine: Finance**
  - It may take multiple types of ‘fuel’ to get you going
  - It can take time to build up speed - look for opportunities to pilot and test.
  - Watch your gauges, a balanced set of indicators is important
- **Body: Strategies to Improve Health and Value**
  - Consider ways to address pressure points: inappropriate ED visits, increasing preventive services, care management, behavioral health
  - Develop reinforcements and safety features such as data analytics, Health Information Exchange (HIE), appropriate coding and billing
- **Wheels: Community Partnerships**
  - It is hard to move past the starting line with out good tires
  - Maintaining tire pressure: spreading resources to meet needs through the appropriate agency or partner

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Mapping a Route to Population Health

- Understand local community health needs
  - Ideally in collaboration and partnership with other stakeholders
  - Prioritize and develop community-based action plans
- Consider strategy alignment with value-based care incentives
  - Potentially avoidable utilization
  - Quality metrics
- Common starting points for your journey:
  - Address patient/client social needs
  - Tackle local health issues
  - Align services to meet community need

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Addressing Patient Social Needs

- Health Care Collaborative of Rural Missouri is **addressing social factors** and community needs in a patient-centered, community-based, collaborative approach with committees addressing key areas, such as homelessness, food access, transportation, and newly released incarcerated individuals.
  Source: Rural Innovation Profile: Rural Health Network Thrives on Innovation in Whole-Person Care

- Tri County Rural Health Network in Helena, Arkansas has created non-traditional partnerships using lay community members as "**Community Connectors**" to connect Medicaid-eligible seniors and adults with disabilities with home and community based services so they can continue to live safely in their homes.
  Source: Rural Innovation Profile: Using Community Connectors to Improve Access

- FirstHealth of the Carolinas in Pinehurst, NC, and Legal Aid of North Carolina **integrated legal services** into a broad array of clinical and community support services offered to low-income chronically-ill patients discharged from the hospital.
  Source: Rural Innovation Profile: Medical-Legal partnership Addresses Social Determinants of Health

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Tackle local health issues

- In Staples, MN, Lakewood Health System has developed and implemented the “Engage” program partnering with schools, community and public health organizations to improve health and well-being through a **focus on access to healthy foods** including access to Community Supported Agriculture (CSA) shares, a “Food Farmacy”, and home based food delivery in senior housing.

  Source: Lakewood Health System *Engage*

- In 2012, Union General Hospital in Farmerville, LA began a community outreach program called “It’s a Girl Thing! Making Proud Choices” to help **address high rates of teen pregnancy and STDs**. By educating and engaging high school girls on topics such as self-esteem, dating and violence, finances and the consequences of teen pregnancy. The program has since expanded through middle school outreach, and added an additional focus on working with teen boys.

  Source: Hospital Spotlight: Union General Hospital "It's a Girl Thing: Making Proud Choices"

- Run by an FQHC in rural Cross County AR, the ARcare **Aging Well Outreach Network**, provides services like falls prevention assessments, transportation to appointments, medication management, and senior-specific exercise opportunities.

  Source: RHI Hub Case Study: ARCare Aging Well Outreach Network

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Align Services with Community Need

- Implementation of **outpatient pulmonary rehabilitation** programs in 2 Federally Qualified Health Centers and a Critical Access Hospital in West Virginia to support evidenced-based chronic lower respiratory disease management options for rural Appalachia patients, where lung disease rates are among the highest in the country.

  Source: Rural Health Information Hub Case Study: Community-Based Pulmonary Rehabilitation Program

- Western Wisconsin Health in Baldwin WI worked **to integrate behavioral health providers and services with primary care**, including a focus on financial sustainability and cultural change to focus on whole-person care.

  Source: Rural Innovation Profile: Behavioral Health Integration into Primary care

- Care Partners of Cook County in Grand Marais MN created a **palliative care program** that utilizes local healthcare professionals and volunteers to provide universal care to patients and caregivers.

  Source: Rural Health Information Hub Case Study: Care Partners of Cook County

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Pulse Check

Rural system high performance

Value-Based Care Assessment - Assess capacity and capabilities to deliver value-based care. Receive an eight category readiness report.

Physician Engagement - Score current engagement and build effective relationships to create a shared vision for a successful future.

Board and Community Engagement - Hold value-based care discussions as part of strategic planning and performance measurement.

Social Determinants of Health - Learn and encourage rural leaders/care teams to address issues to improve their community's health.

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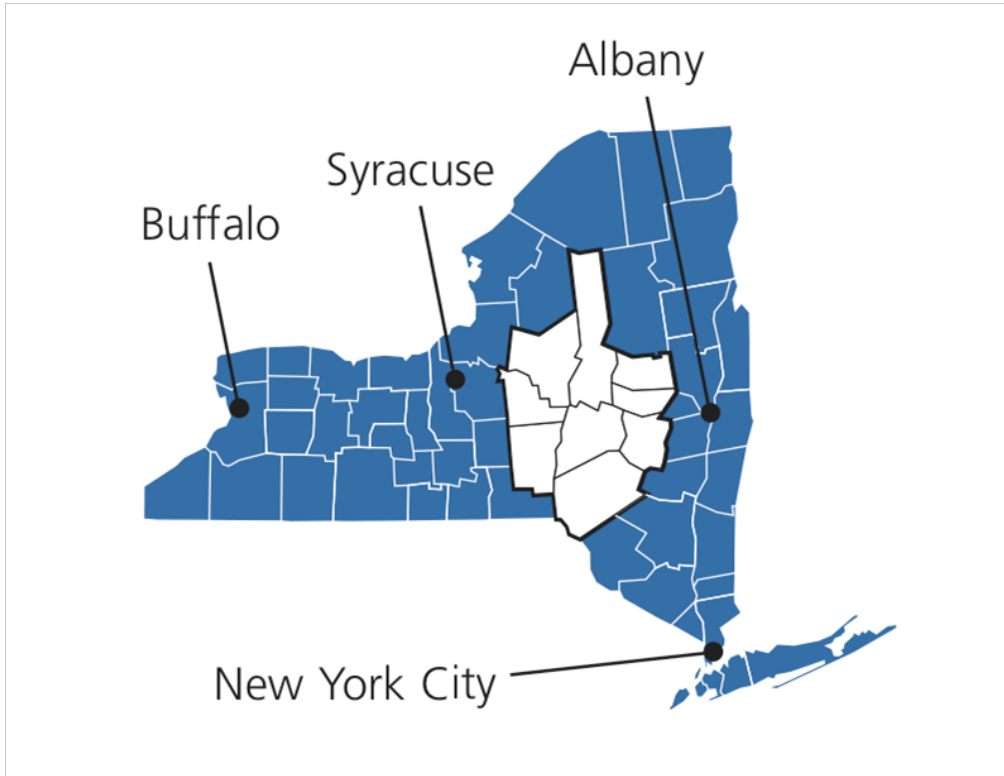
Quality Improvement in Rural Primary Health Care

David Strogatz, PhD, Lynae Wyckoff, MS



Diabetes Self-Management Program

Self-Management Resource Center

Target Population: Adults with Type 2 diabetes receiving primary care at one of eight health centers, emphasis on those with HbA1c greater than 9%

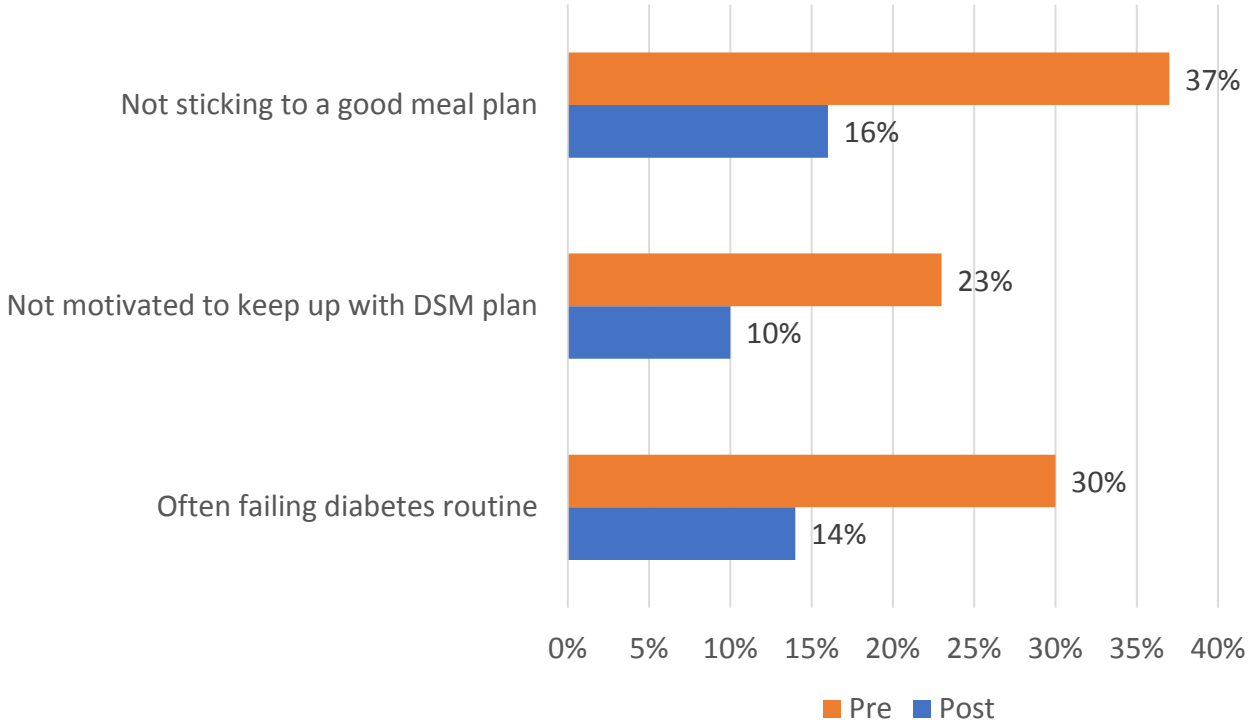
Multiple modes of recruitment, e.g. clinician referral; patient bulk communication; clinic materials; media

6 (+1) weekly 2.5 hour small group sessions led by trained **community-based peer leaders**

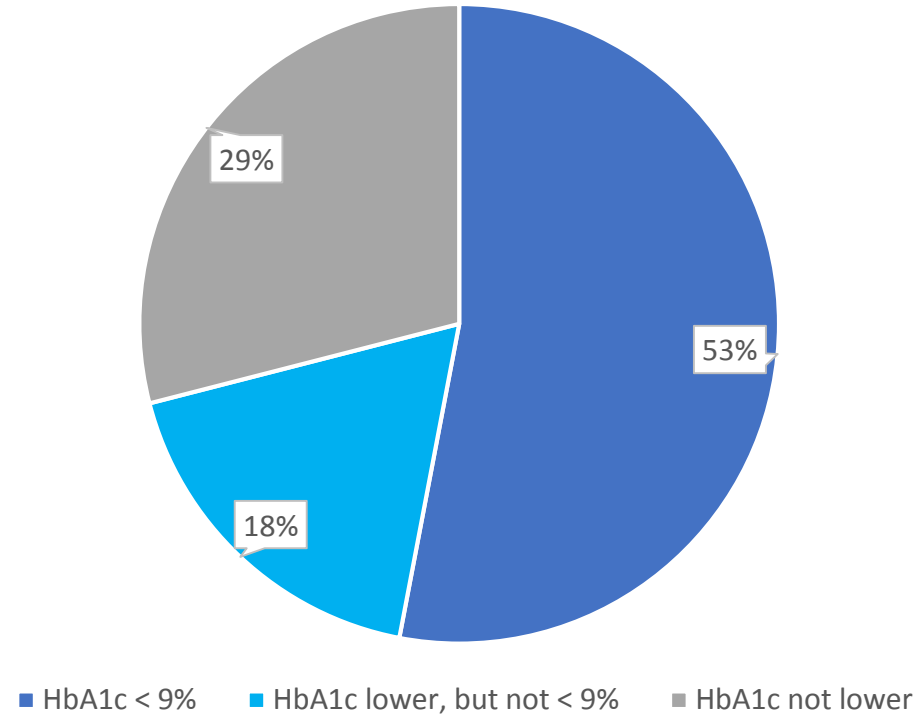
Content

- Exercise, healthy eating, use of medication
- Dealing with fatigue, pain, hyper/hypoglycemia, emotional problems (e.g. depression, anger, fear)
- Develop and implement weekly action plans, shared experience and problem solving
- Session 7 with local diabetes educator/Walk with Ease

Pre/Post Diabetes Self-Management Questions

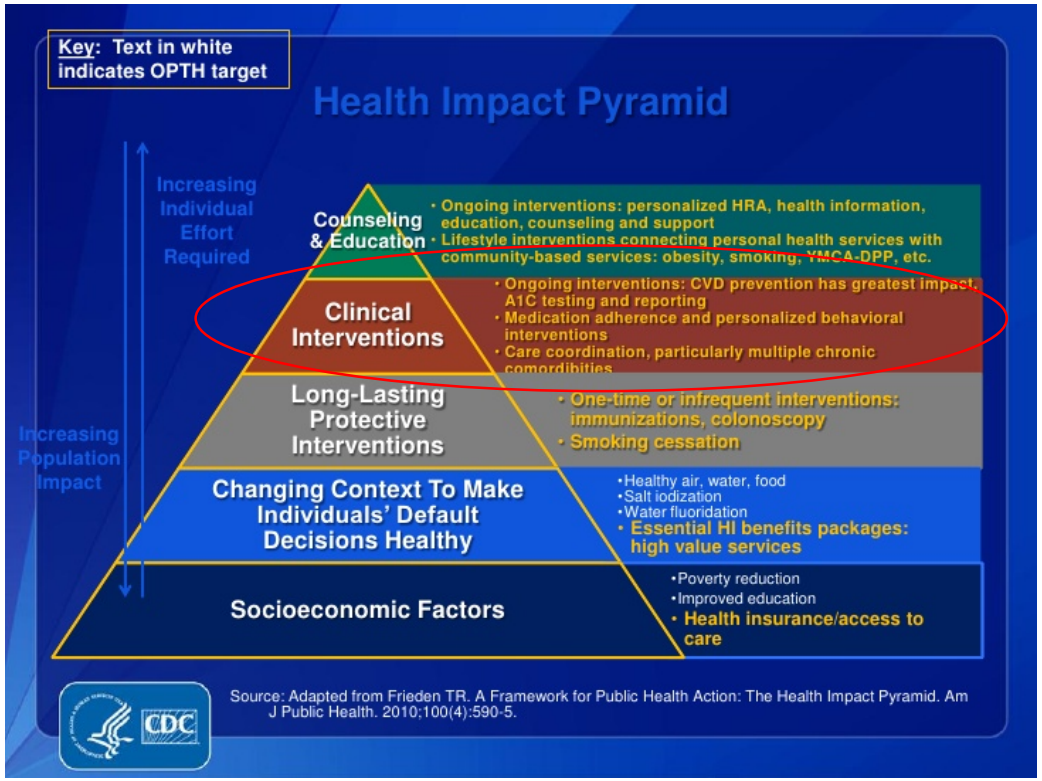


Follow-up HbA1c for Participants with HbA1c ≥ 9% at Baseline



Implications for Value Based Care & Population Health Management

- Health care organizations can deliver value through population health interventions that **link patients with Community–Based, Evidence-Based Interventions (EBIs)**
- This linkage is critically important as health care organizations are paid for outcomes vs fee for service
- Sustaining EBIs is possible when aligned with community-based organization's mission

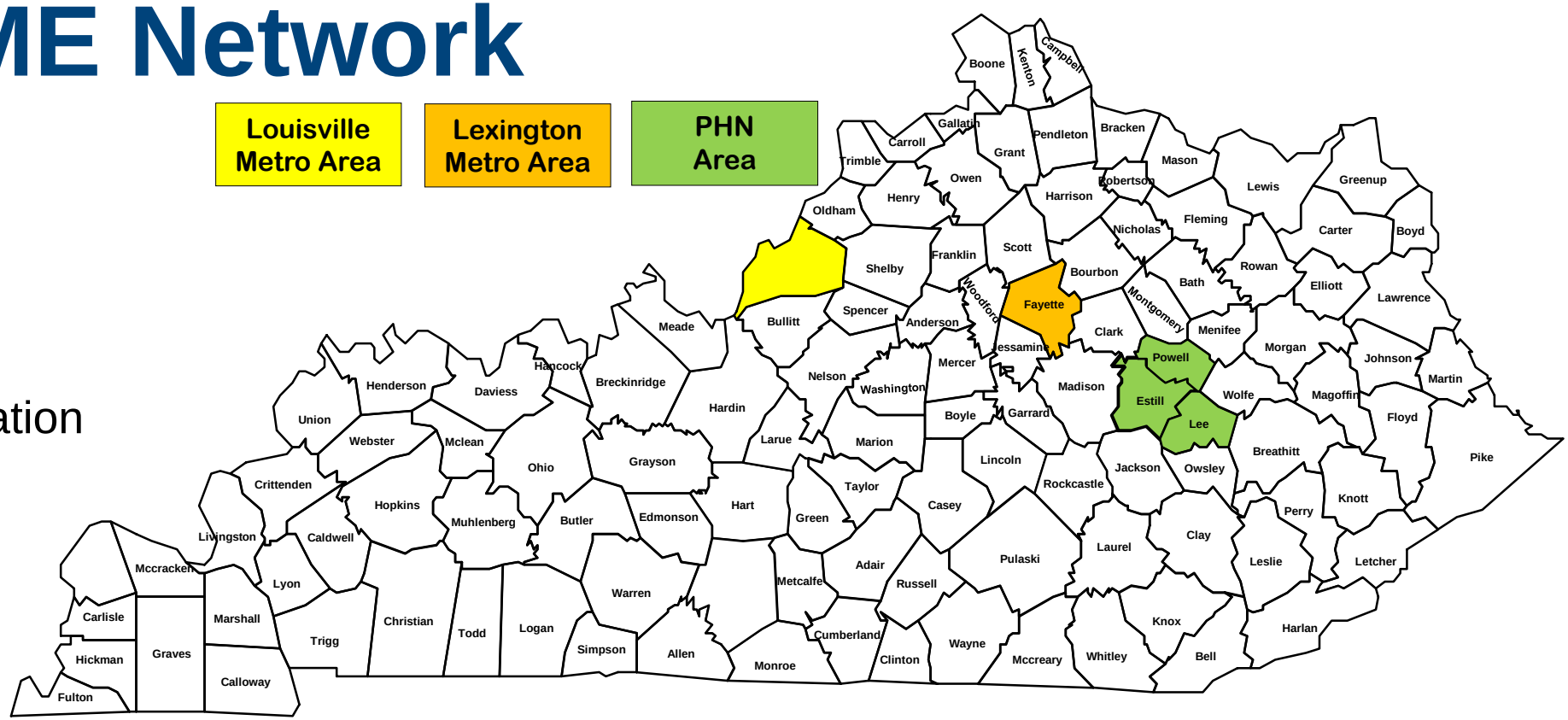


Project HOME Network

John Isfort, Director
Mercy Health Marcum and Wallace Hospital
Irvine, Kentucky

Project HOME Network

- Mercy Health Marcum and Wallace Hospital
- 2004
- 18 Agencies
- 3 Counties
- Mission – Foster Collaboration and Avoid Duplication of Services
- 34,000 Population



Kentucky

- Nickname: Bluegrass State - How Do You Pronounce the Capital City: Loo-a-vul or Louie-ville? Frankfort
- Kentucky's Health Ranking: Good or Bad? Bad (46)

Value Based Care

- All clinics in Project HOME Network are PCHM Level III
- All clinics have an active care gap program and work closely with payors
- All clinics are participating in care gap incentive programs. Several programs can provide up to $18.00 per patient per month
- The Population Health Management Program is aimed at several chronic diseases that plague our community
- Several clinics are members of low risk Independent Provider Associations (IPA)

Projects

- **Behavioral Health Telehealth (RHND)**

Using LCSW to provide BH services to the Emergency Department (ED) and area primary care clinics via telehealth (Anticipate seeing 4-5 patients per day). Current data - 27 patients seen, and 44 services provided.

- **Medication Therapy Management (SHCPQI)** ***No Cost Extension***

Pharmacist provided medication therapy management (MTM) to primary care clinics as well as medication reconciliation (Med Rec). Approximately 1,120 patients served. 17% reduction in ED Visits and $105,000 in savings

- **Population Health Management (SHCPQI)**

Chronic care management program (CCM). Focusing on Hepatitis, OUD, Atrial Fibrillation, COPD, CHF and Diabetes. PHM team consisting of a Pharmacist, Physician and Nurse Practitioner (NP)

- **Healing, Empowering Living Program (RCORP)**

Holistic approach to addressing the local opioid crisis. Focus on Prevention, Treatment and Recovery. Development of Quick Response Team (QRT) and Overdose Task Force

Challenges

- Behavioral Health Recruitment!
- Billing & Reimbursement (MTM, BH, PHM, RCORP)
- Corporate Infrastructure Related to Telehealth
- Local Drug Epidemic

Successes

- Recruitment - Sign On Bonus, Preceptor for LCSW Students, Be creative
- Advocacy - Changes in Kentucky Law for Telehealth Medicaid Billing
- Clinical/Financial - Care Gaps, PHM and Incentive payments
- Financial - 17% decrease in ED Visits. Over $105,000 in Savings

The Story (VBC)

- A 72 y/o female was referred to our MTM service after a recent hospitalization. In the last year, the patient had 5 ED visits and 5 Inpatient stays due to poor management of her CHF and COPD. During the encounter, the pharmacist assessed disease education, affordability and potential to optimize the patient's current medication regimen. After interviewing the patient, the pharmacist identified the patient's high deductible insurance plan as a barrier to care. The patient also mentioned utilizing samples (as available) to help manage her chronic conditions. The pharmacist made recommendations to the provider for alternative therapy regimens that would allow the patient to utilize our 340b program. To date the patient has not had a single ED visit or hospital stay.

Thank You

- John Isfort, Director
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