Rural Health Care Coordination Network Partnership Program Evaluation

Care Coordination Breakout Session

January 14, 2020

About NORC

- Since 2003, the Walsh Center for Rural Health Analysis has been the home for rural health research, evaluation, and program support at NORC.
- The Walsh Center studies a wide range of policy issues affecting public health and health care in rural America.
- Extensive work with FORHP, including previous care coordination related activities.
- Partnered with University of Minnesota's Rural Health Research Center since 2009 on this evaluation effort.

About our Team

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Overview of Care Coordination Pilot Program

- **Funding from FORHP for three years to eight rural health networks**
  - Located in eight states across the United States: Alabama, Illinois, Maryland, Nebraska, New York, South Dakota, Washington, and West Virginia.
- **Innovative or evidence-based care coordination activities**
- **Focused on one or more of the following chronic conditions**
  - Diabetes, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease
- **TA provided by Georgia Health Policy Center**
- **Internal evaluation**

Evaluation

Reminder of Why Evaluation is Important

- Analyze Program Trends
- Establish a Benchmark
- Educate and Engage Staff
- Engage Stakeholders, Policy Makers, and Funders
- Share Successful Program Models/Elements

NORC's Data Collection Activities

Impact	Implementation Effectiveness	Context	Lessons Learned and Best Practices
Annual Telephone Interview	Annual Telephone Interview	Expert Workgroup Input	Expert Workgroup Input
Grantee Reports to FORHP	Grantee Reports to FORHP	Annual Telephone Interview	Annual Telephone Interview
PIMS	PIMS	Grantee Reports to FORHP	Grantee Reports to FORHP
Site Visits (6 total)	Site Visits (6 total)	Site Visits (6 total)	Site Visits (6 total)

= Qualitative Data

= Quantitative Data

- Ability to report at individual level
- Difficulty accessing claims data
- Multiple EHR vendors
- PIMS data reported at aggregate level
- Small number issues
- Cost

+ Recent investments to improve EHRs
+ Prior experience tracking and reporting data
+ Mature networks
+ Strong, sustained leadership
+ PIMS data collected as a grant requirement

Facilitators and Barriers to Data Collection in Rural Healthcare

Key Findings

Care Coordination Pilot Program Grantee Characteristics

- **Lead organizations included:**
  - One Federally Qualified Health Center; two networks; one hospital; two health systems; one independent practice association; and one health department.
- **Staffing approaches included:**
  - A mix of registered nurses; nurse practitioners; social workers; community health workers; case managers; and medical assistants.
- **Primary services included:**
  - A mix of screening and assessments; service linkages; systems integration; diabetes education programs; medication assistance; telehealth services; home visits.

Pilot Program Key Findings: Notable Successes

- **Achieved efficiencies**
  - Linked patients with primary and preventive care services (8)
  - Addressed barriers to patient health through referrals and social services (8)
  - Improved communication between providers (8)
- **Expanded access, coordinated, and improved services**
  - Expanded a range of direct care coordination services (8)
  - Trained staff in care coordination (8)
- **Strengthened the rural health care system**
  - Improved rural health care systems' readiness for value-based payment and delivery models (8)
  - Strengthened partner communication and collaboration (8)
  - Enabled the further development of philanthropic partnerships (2)

Pilot Program Key Findings: Notable Challenges

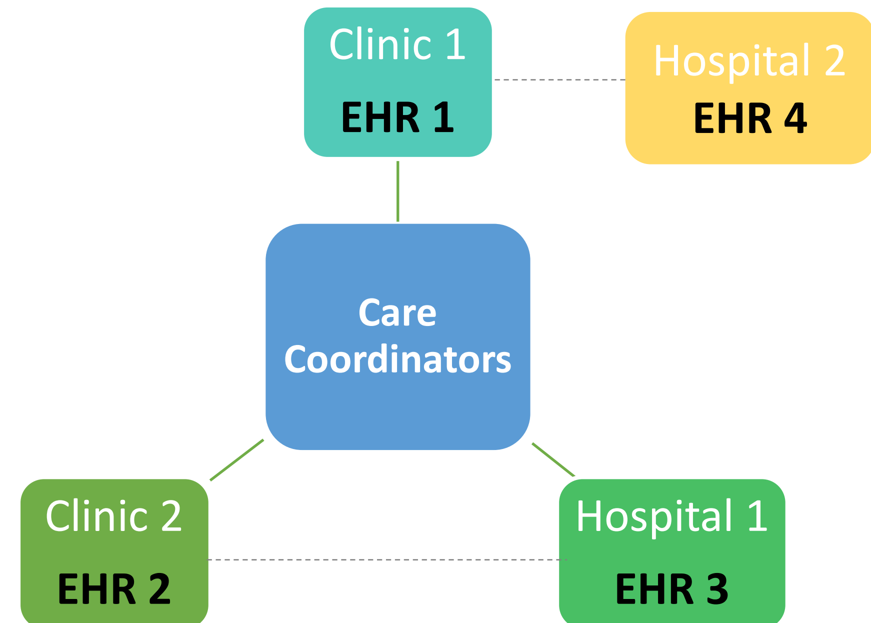
- **Workforce**
  - Difficulty recruiting staff for program activities (2)
  - Staff turnover (4)
- **Systems**
  - Delays in start-up (2)
  - Lack of robust health information technology infrastructure, such as Health Information Exchanges (8)
- **Partnerships**
  - Difficulty engaging participants (2)
  - Difficulty engaging providers (4)

Pilot Program Key Findings: Staffing

- Successful care coordinators have a range of experiential and educational backgrounds
  - Characteristics identified as foundational for success included:
    - Strong communication skills
    - Ability to build rapport with patients
    - Patience with patient behavior change
    - Have a solid understanding of the social determinants of health
- Using a team approach with both clinical and social work perspectives was particularly effective

Pilot Program Key Findings: Technology

- Multiple Electronic Health Record (EHR) vendors used within a network created a significant barrier to tracking patient-level outcomes.
- Grant funding helped awardees become more knowledgeable about the kinds of data and data collection systems needed to report care coordination outcomes.



Pilot Program Key Findings: Quality Metrics

- Tracking and following quality metrics across providers can be burdensome, however, they are important to demonstrate value for a care coordination program.
- To the extent possible, metrics should align with those already being collected for other grant or payment programs.

Pilot Program Key Findings: Patient Engagement

- Rural care coordination programs should include solutions for addressing patient transportation needs.
- Using CHWs was an effective, but resource intensive, approach to providing transportation.

Pilot Program Key Findings: Provider Engagement

- Health care providers in rural settings, particularly those with longstanding practices, may be resistant to care coordination
- Awardees reported success improving provider ‘buy-in’ when the providers observed improvements in patient care and outcomes

Pilot Program Key Findings: Partnerships

- Philanthropic and community stakeholder partnerships require time to develop and often exist before grant opportunities are announced
- Partnerships often rely on a shared vision for a common geographic region

Pilot Program Key Findings: Third-Party Payments

- Agreements with multiple payers are needed
- Patient-Centered Medical Home (PCMH) recognition supports enhanced reimbursement to help cover the costs of care coordination services
- Establishing a relationship and reimbursement infrastructure with a third-party payer may take months or years
- Developing a robust business case is effective for securing third-party funding for care coordination programs

Pilot Program Key Findings: Sustainability Activities

- **Build a Business Case**
  - Bill third-party payers for services (4)
  - Demonstrate Return on Investment (3)
- **Develop Capacity**
  - Build organizational capacity, including policy implementation and workforce training (8)
  - Achieve Patient-Centered Medical Home status (2)
- **Generate Revenue**
  - Secure additional public or private funding (2)

What NORC Heard

[The Care Coordinator] made a huge impact in [the patient's] life and in my life as a provider.
- Physician Assistant in WA

"I can't say enough about how helpful this has been for me."
-Wife of Patient in NY

There is no doubt the care coordination program has helped patients.
- Awardee Leadership in NE

Care Coordination Resources

- One-pager: Critical Access Hospital Network (CAHN), Washington, 2015-2018
- One-pager: Williamson Health And Wellness Center (WHWC), West Virginia, 2015-2018
- Funding Opportunity Announcement Page- FORHP, 2015-2018
- Care Coordination Program Grantee Directory, 2015-2018
- Rural Care Coordination Toolkit- RHIHub
- Care Coordination In Rural Communities, Presentation, Feb 2014
- Government And Philanthropies Join Forces For Rural Health – Article, Jun 2015
- Rural Health Philanthropy Partnership: Leveraging Public-Private Funds To Improve Health – Article, May 2017
- Leveraging Resources For Greater Impact Video- Philanthropy Grantee Highlight, Jul 2017
- Williamson Health And Wellness Center Bonus Video- Philanthropy Grantee Highlight, Jul 2017

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Thank you!

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