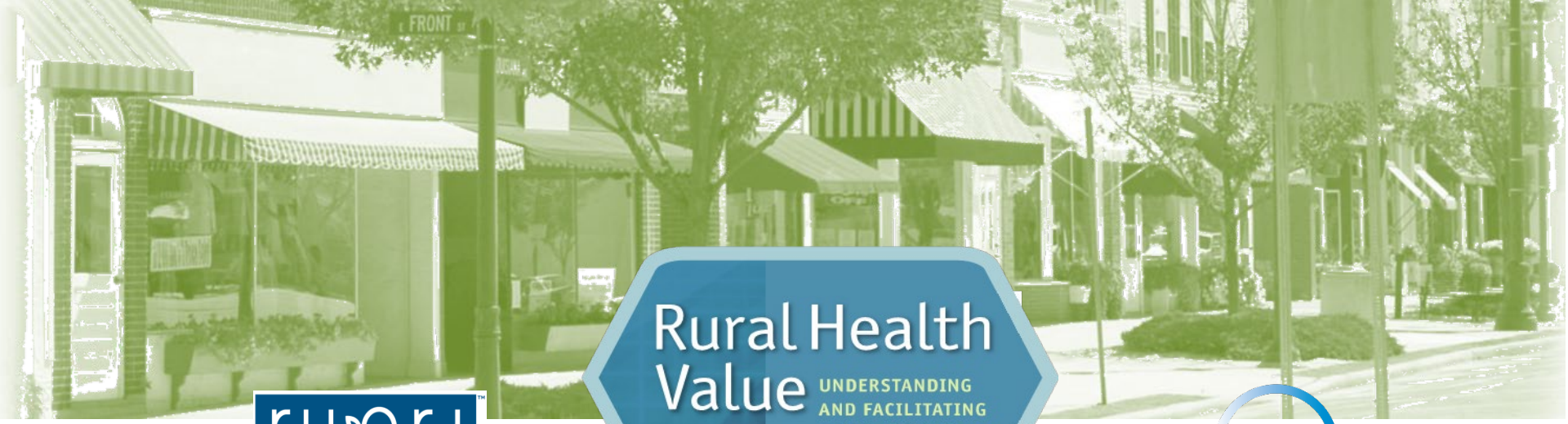

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Rural Health Value — UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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# *Basics of Value-based Care and Payment*

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**Stratis Health and Rural Health Value**

***For Rural Healthcare Provider Transition Project (RHPTP)***
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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) program started in 2012.
- Partners:
  - University of Iowa RUPRI Center for Rural Health Policy Analysis
  - Stratis Health
- Activities:
  - Provide technical assistance, raise awareness, and engage in communication strategies



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# Today's Session

- Shift to value-based care and payment began more than a decade ago
  - But has been more slowly adopted in rural health care delivery and payment
- Today's session is a brief orientation to where we are today in value-based care and payment through the rural health lens
  - The objective is to give you the core knowledge and shared language to be conversant in value-based care and payment, and to help you develop action steps to be on the path to value



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# What is value-based payment?

- Value Based Payment (VBP) is a method by which purchasers of health care (including government, employers, and consumers) and payers (public and private) hold the health care delivery system (physicians and other providers, clinics, hospitals) accountable for both quality and cost of care.
  - VBP rewards healthcare providers for keeping people healthy

# What is value-based care?

- To be successful in value-based payment models, you need to deliver value-based care:
  - emphasize prevention and wellness, in addition to treatment
  - focus on improving outcomes
  - help patients navigate the healthcare system
  - integrate and coordinate care
  - help patients address their social determinants of health

The “value” in value-based care is derived from measuring quality and patient experience against the cost of delivering the health outcomes.

# A Road Trip Analogy…

Let's look at:

- The road to value-based payment
- The components of a 'car' that supports the drive to value-based care
- The key factors in mapping a route to value



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# The Road: Value-based Payment Models

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


Reference: HCP-LAN APM Framework



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# Accountable Care Organizations

- CMS' largest value-based payment program
- Groups of providers (generally physicians, clinics, and/or hospitals) that receive financial rewards to maintain or improve quality of care for a group of patients while reducing the cost of care for those patients
- Accountable Care Organizations
  - > 1,000 public and private ACOs
  - ~ 33 million patient enrollees
  - 477 Medicare ACOs (January 2021)
  - Nearly 30% of Medicare FFS beneficiaries are served by an ACO.


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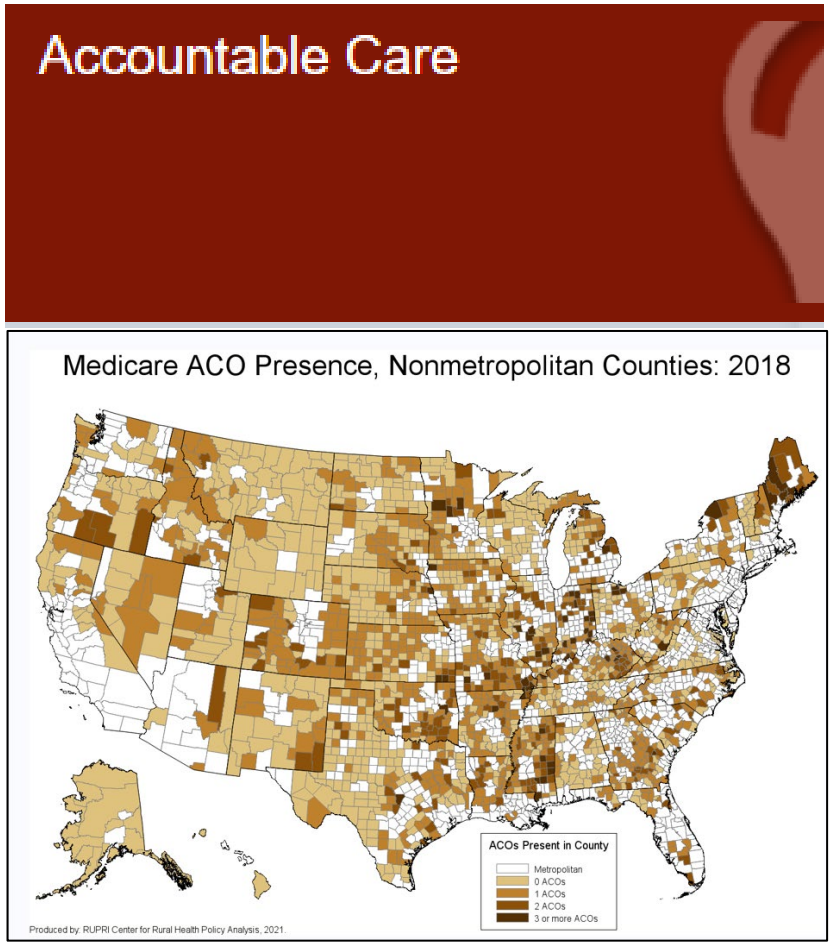
# CMS Shared Savings Plans (ACOs)

- Cost savings and quality performance required
- CMS **shares savings** (if any) with the ACO.
- Quality measures assess outpatient care (not hospital care!).
- Patients are attributed to ACO through primary care visits.

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# The Road: Value-based Payment Models

- The faster the lane, the more we are talking about value-based payment.
- 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

# Your Journey

- What does the road to VBC look like in your neighborhood (or your state)?
  - Is there a fast lane? Moderate? Not started?

# How do you build your value-based care "car"?

- **Driver: Leadership**
  - Facilitate and/or support community planning, coalitions, and connections
  - Identify resources and invest strategically
  - Engage 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 without good tires
  - Maintaining tire pressure: spreading resources to meet needs through the appropriate agency or partner



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# How can you map a route to value?

- 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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# How can you map a route to value?

- Assess your capacity to deliver value-based care
- Resource: Value-Based Care Assessment Tool


**Five Tasks**

1. Assess financial risk
2. Engage physicians
3. Expand community care coordination
4. Embrace interdependence
5. Understand culture change



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# Your Journey

- Have you identified a VBC route?
- What direction(s) does your route take?
- What areas are you addressing or planning to address?



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# Rural Can Do This Well!

- While the road isn't always smooth, rural communities and health care organizations can and are delivering value-based care and succeeding in value-based payment programs.
- Specific rural examples are provided on the following slides:
  - Addressing Patient Social Needs
  - Tackling Local Health Issues
  - Aligning Services with Community Need

# 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.
  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.
  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.
  Rural Innovation Profile: Medical-Legal partnership Addresses Social Determinants of Health

# Tackling 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.
  RHI Hub Rural Monitor: Lakewood Engage Tackles Food Insecurity in Rural MN

- 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 with middle school outreach, and added a focus on working with teen boys.
  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.
  RHI Hub Case Study: ARCare Aging Well Outreach Network



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# Aligning 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.

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



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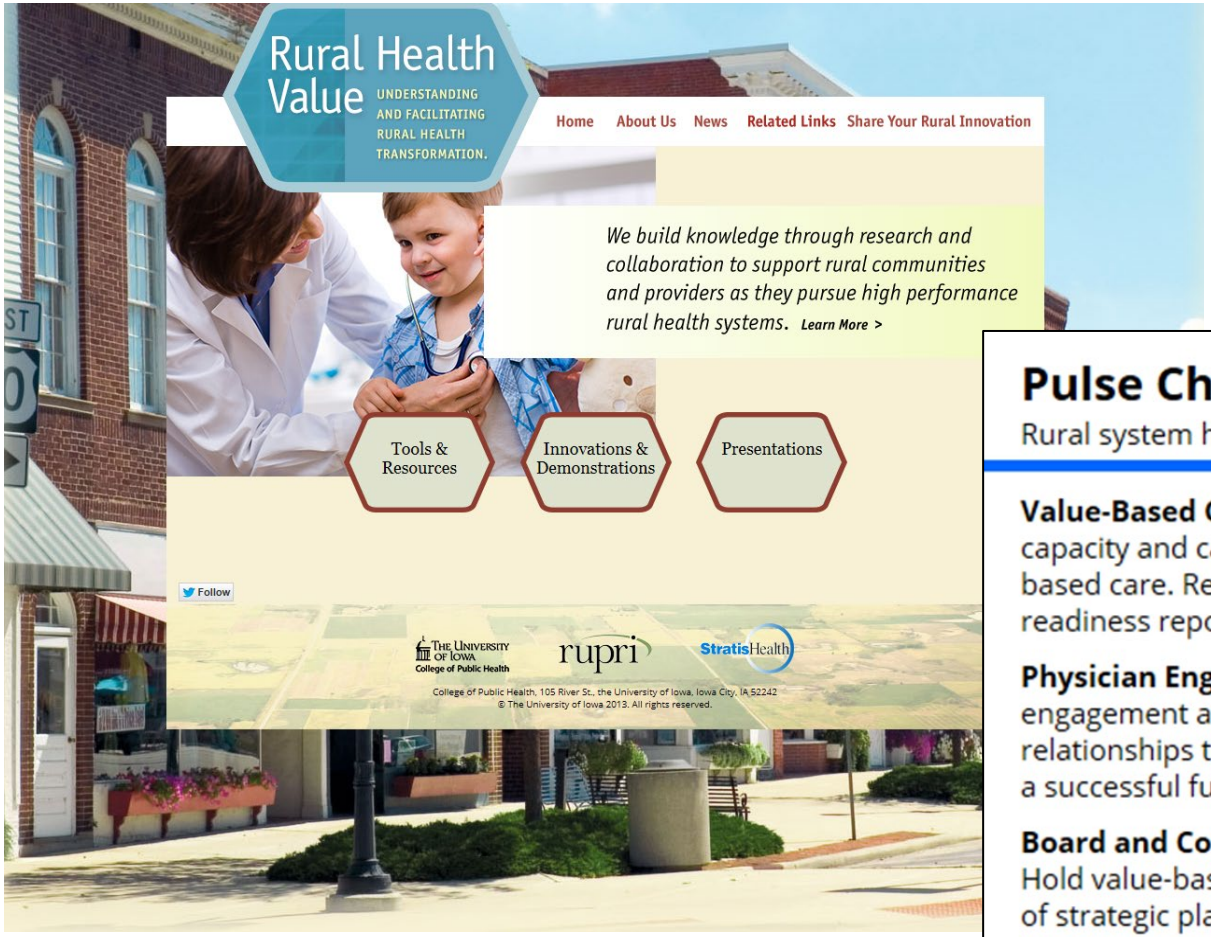


## Pulse Check

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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# Upcoming Learning Collaboratives

- **LC-3: July 26, 2021**
  - *Leadership's Commitment to Building Population Health*

  Speaker: Dr. Alana Knudson, NORC Walsh Center for Rural Health Analysis

- **LC-4: August 30, 2021**
  - *Staff Resiliency*

  Speakers: Dr. Jane Pederson and Betsy Jeppesen, Stratis Health