Achieving Value Based Care through Rural Population Health

FORHP Rural Partnership Development Meeting
January 14, 2020
Rockville, MD
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
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
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.
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
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
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
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
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](#)
www.ruralhealthvalue.org

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.