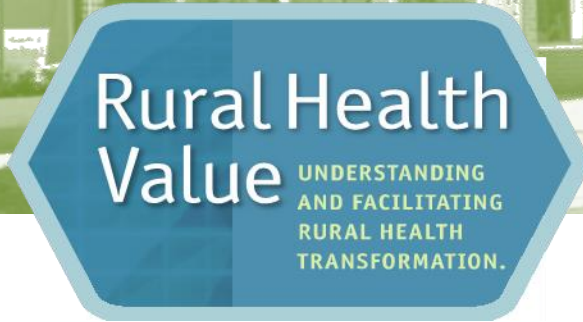


Center for Rural Health Policy Analysis



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.

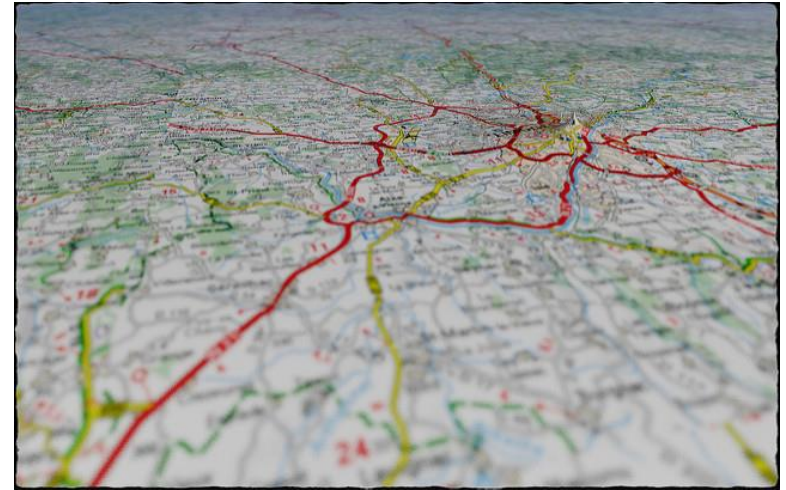
Building the 'Car' for Population Health

- **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.

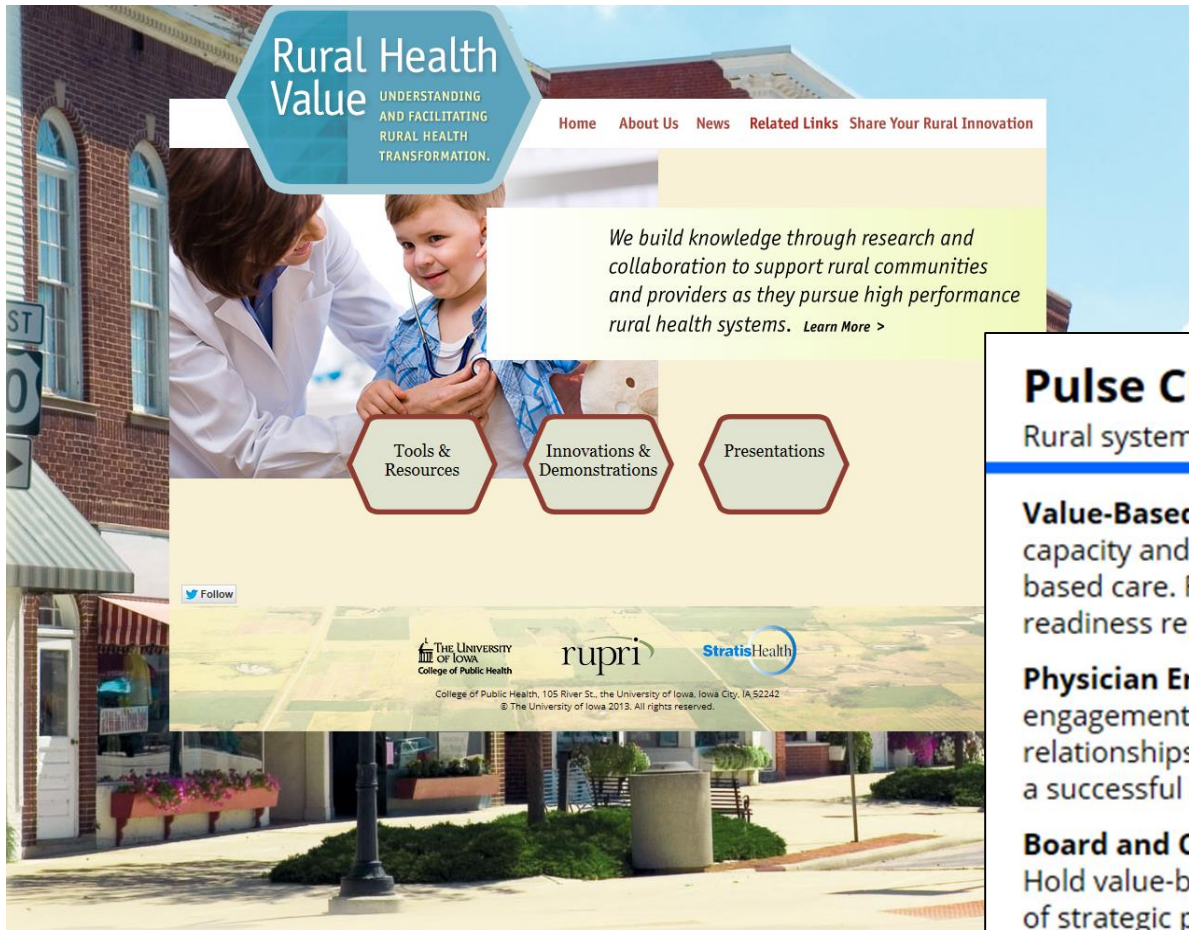
Source: Rural Health Information Hub Case Study: [Community-Based Pulmonary Rehabilitation Program](#)

- 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](#)



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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