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US Health System is Changing: What is Health Value, Value-Based Care/Payment and Why the Change?

ND HFMA Conference

May 9, 2023
Ramada Hotel
Bismarck ND

Presented by Brad Gibbens, Acting Director and Assistant Professor

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- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country's most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Home to seven national programs
- Recipient of the UND Award for Departmental Excellence in Research

Focus on

- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

ruralhealth.und.edu

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The Importance of Values

Ultimately our values guide our perceptions toward health, health care, our view of the importance of "community," and the development of public health policy

"It is not what we have that will make us a great nation, it is how we decide to use it"
Theodore Roosevelt

"Vision is the art of seeing things invisible"
Jonathan Swift

"Americans can always be relied upon to do the right thing…after they have exhausted all the other possibilities"
Sir Winston Churchill

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Why are things Changing?

What is in the Water?

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What is value based care, what does it mean?

- Increased focus on prevention, wellness, and chronic disease management which leads to improved performance on quality measures.
- "Volume to value" less reliance on fee-for-service and more on care and payment associated with outcomes and performance.
- Why? US needs to provide better care, improve health, and lower costs.
- New concepts for hospitals and PC- Pop Health, SDOH, Health Equity, Health Disparities
- Moving from a "sick care" system to a "well care" system
- Better understanding in the community of available services and care management supports can drive more appropriate utilization (better care, improved health, and lowered costs).
- More appropriate utilization impacts the cost and outcome of care.
- Engaged community partners advocate for increased access to care and services.
- It is a significant change in how we think of health and health care.

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Systemic Change –Some say Transformative Change

- From PPS/DRG to Value – Many years of change.
  - Threats/barriers –how to adapt? Health policy uses payment to drive, control costs – Nixon W&P Control, HMO Act, CON, HCFA/CMS, PPS, ACA with CMMI-
  - "Alterative Hospital Models" MAF, CAH, REH and the Value era – PPS, cost based, "from volume to value"
  - CMS goal by 2030 ALL Medicare in a APM.
  - US Health System is confusing – mix of public and private.
  - US Health System is intimidating and even scary- insurance.
  - US Health System has conflicting values – rights vs. privilege, equality/equity.
  - What is the role of public health policy? Who determines policy?
- We spend more than other countries yet our outcomes are not as positive.
- Mantra: improved health, better care, lowered costs – IHI Triple Aim.
  - Focus on improving health – "well-care not sick-care"
  - Focus on population health- health status for defined groups.
  - Focus on SDOH and disparities – move to health equity.

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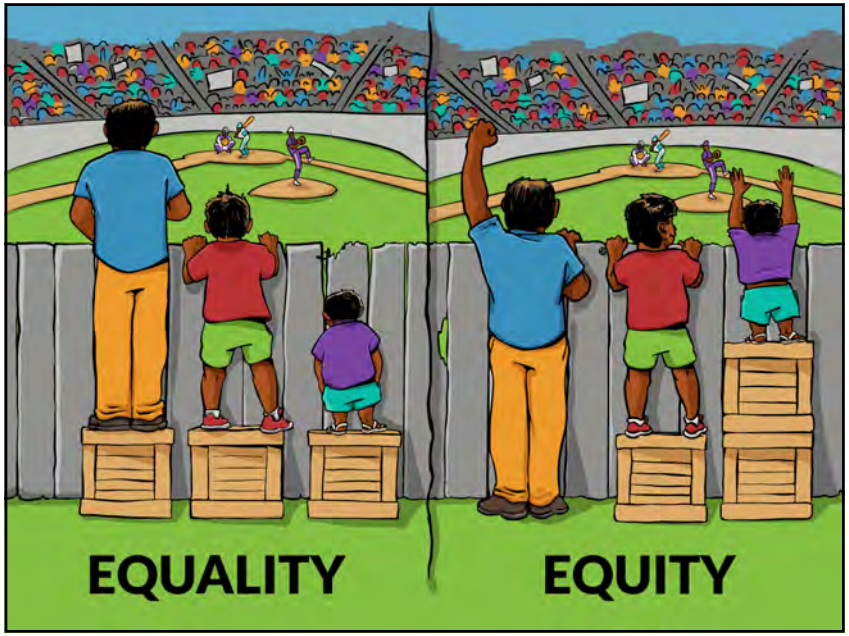

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Systemic Change –Some say Transformative Change

- Affordable Care Act – profound policy change. Most significant since Medicare/Medicaid.
  - Shift to population health. Triple Aim influence. Refocus on primary care. Population health, health disparities, health equity, Social Determinants of Health –refocus.
  - Increase access points, expand coverage, and changing process – Private insurance changes, Marketplace (Public), Medicaid Expansion.
  - Experimentation in models – CMMI – range of models – Medicare as the driver.
- More emphasis on Integrated Health Systems.
  - Safety in numbers, size – market- What is Amazon and Walmart doing here?
  - Models of integration –ACO Shared Savings, CIN

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Systemic Change –Some say Transformative Change

- CMS Goal: 100 percent of Medicare beneficiaries to be in an APM by 2030 and most Medicaid.
- Number of Medicare shared savings ACO's has declined (438 Medicare ACO) but number of people covered increased – consolidation. 11 million Americans in ACO.
- 1/3 (35%) of all US CAHs in and ACO – 467 CAHs out of over 1,350. 8 in ND.
- 29 states require an MCO to have value program and 26 define the model under Medicaid.
- More CMMI demonstrations in the works – new rural focused option likely in 2024 (ND can be ready). –CHART model "did not work." States

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Systemic Change –Some say Transformative Change

- **Pillars of "Transformative Care" (from AHA).**
  - **Shift from sick care to well care.**
  - **Expand innovative capacity – calculated risk taking, sustainable.**
  - **Digital transformation.**
  - **Navigate competitive environment – competition and new partners.**
  - **Positive organizational change – empower workforce resiliency.**

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Systemic Change –Some say Transformative Change

- **Value-Based care – use of care management and coordination, annual wellness visit, motivational interviewing, importance of primary care including nursing, community health services, prevention, CDM, wellness - built into the system of care.**
- **Community engagement is crucial.**
  - Formal networks, informal coalitions, individual partners in community.
  - Shared priorities and shared work that involve many partners – population health creates the need for a range of groups-aging, transportation, park district, school, economic development – focus on health of the community.
  - Align and leverage resources/efforts – avoid duplication – maximize impact.
- **Access to care is still the focus but likely more integrated with partners.**
  - Focus on the benefit of integrated care for community based services.

General Observations on the Health Care System

- Most people give too much credit to health care/clinical care when thinking of their health and not realizing it is likely 10-20% of health status.
- US spends more on health care than any other country at about $4.3 Trillion a year in 2022 ($12,900 per capita vs. Germany, $6,700; France, $5,500; Canada, $5,400; United Kingdom, $5,200; and Japan, $4,700. (2020 data). (Source Commonwealth Fund
- 18% of US GDP – Germany, 11%; Canada, 11%, and GB, 10%.
- We spend more yet health outcomes are lower.
  - Lower life expectancy with the US at 78.6 years and Switzerland at 83.6 years. (Varies by race). American Indian is about 73 years.
  - US has highest chronic disease burden.
  - US has highest suicide rate.
  - US has highest rates of obesity.
  - US residents visit medical providers less frequently.
  - US second highest rate of hospitalization for hypertension and diabetes.

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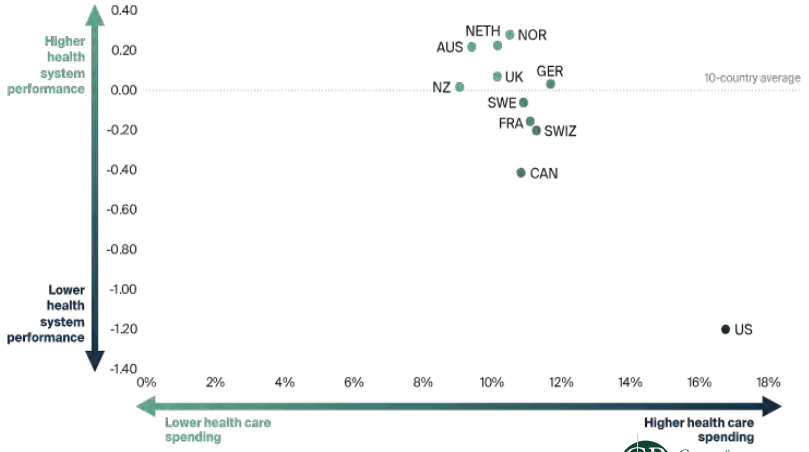
Health Care System Performance Compared to Spending (August 2021 Commonwealth Fund)



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Change and Issues in ND Rural Health

- **Viability and survivability** – Steady battle for over 35 years - adjustment and response to change–less facilities.
- **Pandemic.** It was real, it had an impact on facilities.
- **Workforce –** it is all inclusive not only health providers**.**
- **Regulatory and Payment environment.**
- **Medicaid Expansion and movement to Medicaid Value.**
- **Concern over big actors.** The Market has Changed.
- **Demographic and Economics of Rural Communities.**
- **Community Awareness and Community Understanding-lead to a need for Community Engagement.**

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Key Concepts and Definitions

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Population Health

"Health outcomes of a group of individuals, including the distribution of such outcomes within the group."(Kindig, *What is Population Health?*)

- Groups can be based on geography, race, ethnicity, age, language, or other arrangements of people
- Focus – Health Outcomes (what is changed, what are the impacts, what results?)
- What determines the outcomes (determinants of health)?
- What are the public policies and the interventions that can improve the outcomes?

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Health Equity

- "Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." (Healthy People 2020)
- Equity is aspirational and it relates to previous discussion on our personal and societal values. (e.g. health care as a right)
- To achieve some level of equity we must first address disparities.

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Health Disparity

- "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." (Healthy People 2020)
- Social Determinants of Health are factors to consider.
- We work to address SDOH to address disparity so as to achieve health equity and to improve population health (very simple ☺).

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Factors Contributing to Health

Outside Health Care System		Related to the Health Care System	
Societal Factors		**Care Delivery**	**Regulatory Environment**
• Food Safety		• Quality of care	• Medicare payment rates and policies
• Health food availability		• Efficiency	• Medicare and Medicaid care delivery innovation
• Housing conditions		• Access	• CON regulation
• Neighborhood violence		• Physician training	• Medicaid/CHIP policies (payment rates, eligibility)
• Open space and parks/recreation availability		• Health IT system availability	• Implementation of ACA
• Genetic inheritance		• Distance to and number of hospitals, primary and urgent care centers, retail clinics, etc.	• Local coverage determinations (LCDs)
• Disease prevalence		• Provider supply (MDs, RNs, etc.)	• Other local, state, and federal laws that impact the way health care is delivered and which treatments are provided
• Income levels		• Physician mix (primary versus specialty care)	
• Poverty rates		• Payer contracts	
• Geographic location		• Physician employment and payment structure	
• Unemployment rate		• Disease management	
• Uninsured/underinsured rate		• Populations subgroup disparity	
• Median age		• Advanced technology availability	
• Sex		• Care integration and coordination	
• Race/ethnicity		• Behavioral health availability	
• Pharmacy availability		• Cultural and linguistic access	
• Care-seeking behaviors			
• Health literacy			
• Patience choice			
• Morbidity rates			
• Transportation availability			

Source: Hospital Research Education Trust, *Managing Population Health, The Role of the Hospital, AHA, 2012*

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Social Determinants

World Health Organization definition:

"the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

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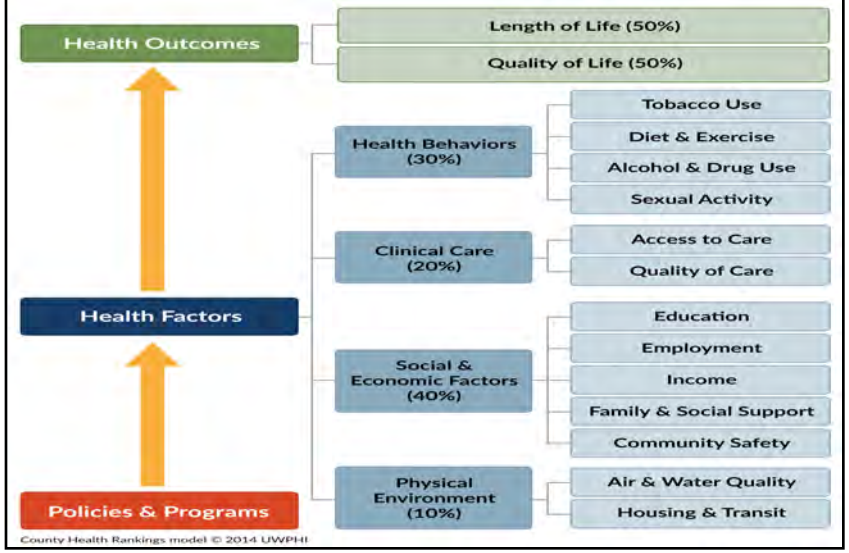
County Health Rankings Model



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SDOH Toolki

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Health Disparities – What do the numbers say?

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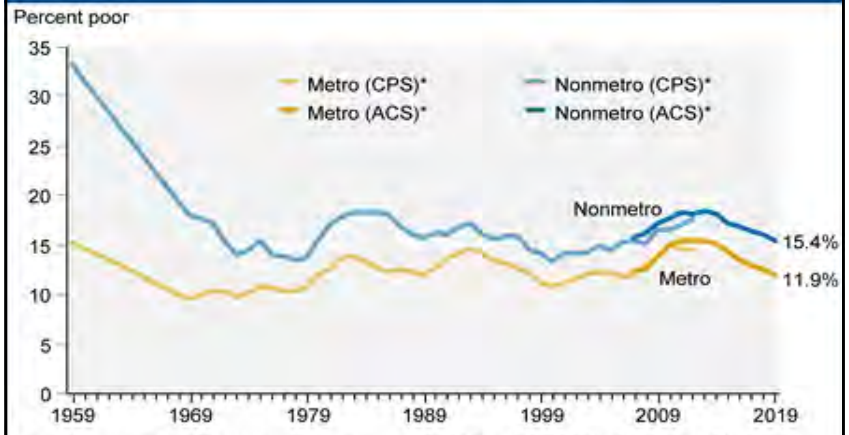
Poverty rates by metro/nonmetro residence, 1959-2019



Note: Metro status of some counties changed in 1984, 1994, 2004, 2014, and 2018.
*CPS poverty status is based on family income in prior year and ACS poverty status is based on family income in the past 12 months.
Sources: USDA, Economic Research Service using data from U.S. Department of Commerce, Bureau of the Census, Current Population Survey (CPS) 1960-2013 and annual American Community Survey (ACS) estimates for 2007-19.

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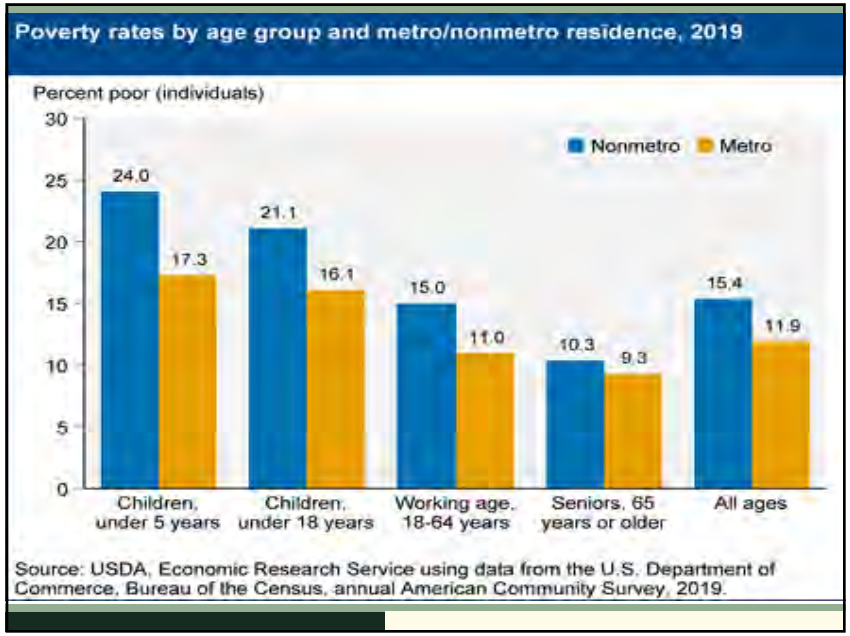
Poverty rates by age group and metro/nonmetro residence, 2019
Percent poor (individuals)
30
25
20
15
10
5
0
Nonmetro
Metro
24.0
17.3
21.1
16.1
15.0
11.0
10.3
9.3
15.4
11.9
Children, under 5 years
Children, under 18 years
Working age, 18-64 years
Seniors, 65 years or older
All ages
Source: USDA, Economic Research Service using data from the U.S. Department of Commerce, Bureau of the Census, annual American Community Survey, 2019.

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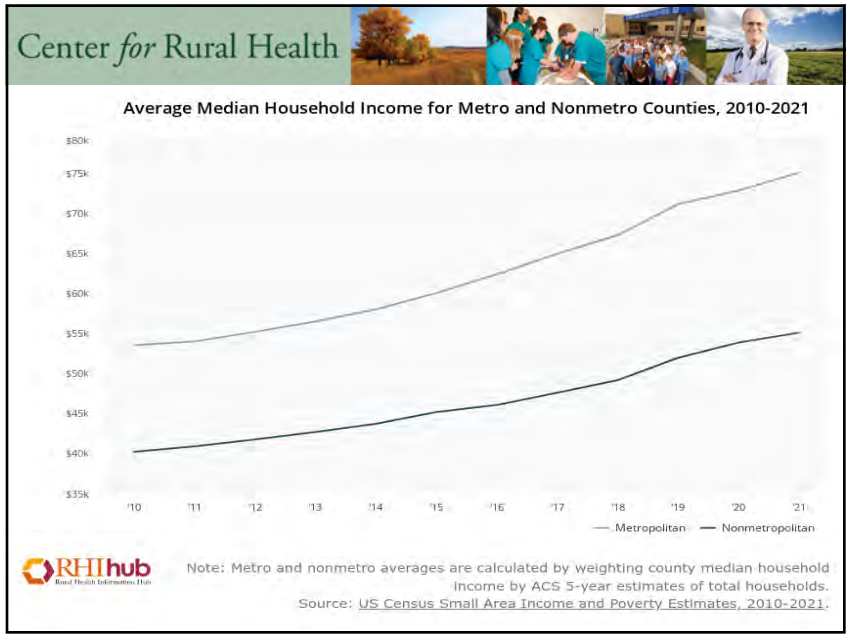
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Average Median Household Income for Metro and Nonmetro Counties, 2010-2021
$80k
$75k
$70k
$65k
$60k
$55k
$50k
$45k
$40k
$35k
'10
'11
'12
'13
'14
'15
'16
'17
'18
'19
'20
'21
Metropolitan
Nonmetropolitan
RHIhub
Note: Metro and nonmetro averages are calculated by weighting county median household income by ACS 5-year estimates of total households.
Source: US Census Small Area Income and Poverty Estimates, 2010-2021.

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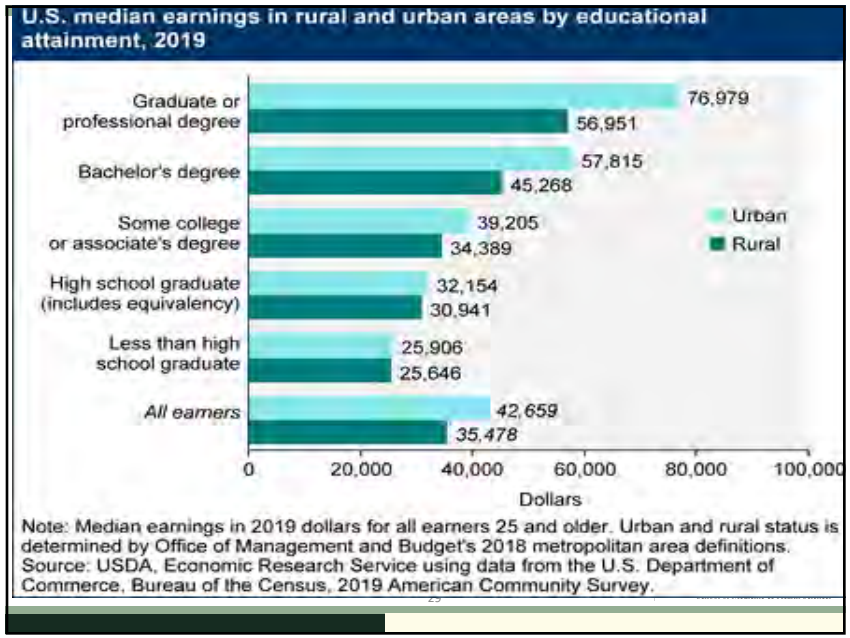
U.S. median earnings in rural and urban areas by educational attainment, 2019
Graduate or professional degree
76,979
56,951
Bachelor's degree
57,815
45,268
Some college or associate's degree
39,205
34,389
High school graduate (includes equivalency)
32,154
30,941
Less than high school graduate
25,906
25,646
All earners
42,659
35,478
Urban
Rural
0
20,000
40,000
60,000
80,000
100,000
Dollars
Note: Median earnings in 2019 dollars for all earners 25 and older. Urban and rural status is determined by Office of Management and Budget's 2018 metropolitan area definitions.
Source: USDA, Economic Research Service using data from the U.S. Department of Commerce, Bureau of the Census, 2019 American Community Survey.

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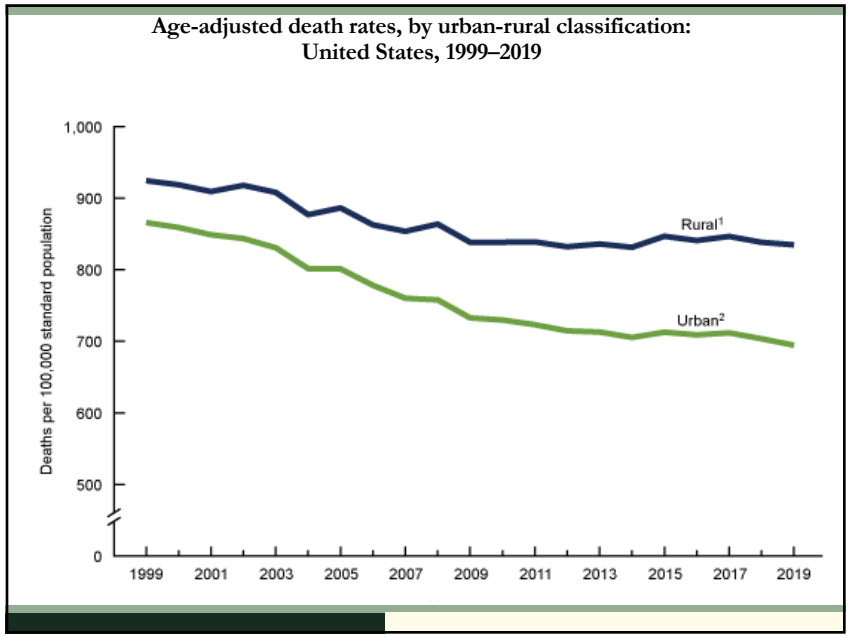
Age-adjusted death rates, by urban-rural classification: United States, 1999–2019
Deaths per 100,000 standard population
1,000
900
800
700
600
500
0
Rural[1]
Urban[2]
1999
2001
2003
2005
2007
2009
2011
2013
2015
2017
2019

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Health Issues According to Rural North Dakotans 2020

- **CRH Community Health Needs Assessment Process (CHNA)** in 2017-2019 conducted with rural hospitals and many public health units (required under ACA for non-profit)
- All 36 CAHs reporting
- Top 2-5 ranked community health issues -139 needs ranked (3.9 per CHNA) -25 categories
- **Issues**

Substance Abuse	30 of 36 CAH communities
Mental Health	30 of 36 CAH communities
Attracting and retaining young families	16
Having enough child daycare services	11
Ability to retain primary care providers	11
Availability of resources elders in their homes	6
Not enough jobs with livable wages	5
Cancer	4
Obesity	4
Affordable Housing	3
Bullying/Cyberbullying	3
Cost of health insurance	3

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Where is North Dakota in this Discussion on Health Value?

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Rural ND on a Pathway to Value (Structural Changes for Population Health)

- **North Dakota Rural Health Value (ND RHV)**
  - CDC Health Equity funds –CRH over $3 million -5 projects.
  - Volume to Value is one – 2022-2023.
  - ND RHV – U of. IA, Stratis Health, HealthPoint Health – 1 year project.
  - 5 CAHs intensive, all 37 overview, Environmental Scan, Community Engagement, modeling of ND CAH data on various value models.
- **Rough Rider High Value Network.**
  - 23 CAHs – independent (will grow)
  - Non-Profit. Legal entity.
  - Maintain independence and autonomy but work as a network.
  - Shared services –new services difficult for one hospital to establish on own.
  - Joint purchasing.
  - Develop value-products/process, prepare for contracts
  - Population health focus – improve health, better care, lower cost

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Rural ND on a Pathway to Value
(Structural Changes for Population Health)

What are the 3 main components of a population health model?

- **Information-powered clinical decision-making.**
- **Primary care-led clinical workforce.**
- **Patient engagement and community integration**.

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Rural Health Value - North Dakota

A federally funded project sponsored by the University of North Dakota **Center for Rural Health**.

Designed to assist rural North Dakota Critical Access Hospitals (CAHs) prepare for value-based care (VBC) and payment.

Technical assistance provided by **Rural Health Value** (University of Iowa and Stratis Health) and **Newpoint Healthcare Advisors** at no cost to North Dakota CAHs.

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Project Overview

RHV-ND Value-Based Care and Payment Project

Environmental Scan	Technical Assistance	Statewide Education
• ND health care provider landscape • ND population health • ND VBC contracts • National comparisons • Lessons learned and recommendations	• Core CAHs only • VBC Assessment survey and action planning • Community engagement plan • Financial scenarios • General VBC consultation	• VBC landscape • VBC assessment and planning • Community engagement strategies • Financial modeling scenarios results

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Project Consultants and Coaches

Rural Health Value

- Jennifer Lundblad, PhD
- Clint MacKinney, MD, MS
- Keith Mueller, PhD
- Kelly O'Neill, RN, BSN, MPA
- Fred Ullrich, BA
- Karla Weng, MPH, CPHQ
- Kristin Wilson, PhD

Newpoint Healthcare Advisors

- Peggy Altamura, RN, MBA, FACHE
- Joe Lupica, JD, FACHE
- Brett Norell, MHA, FACHE
- Nate White, JD

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Project Timeline

Fall 2022	Winter 2022/2023	Spring 2023
Recruitment webinar	VBC Assessment survey	VBC Assessment, Community Engagement, and Financial Scenarios webinars
Core CAH kick-off webinar	VBC action planning session with coach	Consensus building for statewide plan
Statewide VBC and payment webinar	Community engagement plan	Statewide plan recommendations
CAH Data Profile	Financial scenario development	Wrap-up core CAH calls
Core CAH data and information submission	Interim presentation	Final presentation and report

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5 Core Critical Access Hospitals

CAHs will be selected in Fall 2022 to participate in activities from October 2022 through

Participating, or *core*, CAHs will receive coaching and support to help prepare for VBC and payment.

Core CAHs will provide input and information for broader state-level policy and strategy discussions.

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Benefits for a Core CAH

- **Professional consulting** assistance to prepare for value-based care and payment
- Comprehensive community **health and healthcare data profile**
- CAH-specific **VBC strategic assessment and action plan**
- VBC-aligned **community-specific engagement plan**
- CAH-specific **value-based payment financial scenarios**
- **Two coaches** assigned to each CAH for VBC planning and financial scenario development
- **Networking** with other value-oriented CAH leaders and teams
- **Access** to educational resources for VBC planning and implementation
- Opportunity to **inform** state-based policy and program decisions
- Opportunity to **lead** rural North Dakota health transformation

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Expectations for a Core CAH

- Submit relevant **data and information** (with appropriate NDAs): market data, operational information, financial data, quality, data, and community health needs assessment
- Commit staff time (3-5 hours per month) for data submission and coaching sessions
- With support from coaches: complete **VBC Assessment** survey and develop a VBC action plan, develop a **community engagement plan**, and **review financial scenario results**
- Identify **primary/secondary contacts** responsible for communication and support
- **Remain active** in the project throughout the duration of the initiative
- Agree to **public recognition** as a project participant, but CAH-specific data will be de-identified
- **Share experiences** and lessons learned with key partners and other CAHs

Triple Aim and Why It's Important

Better Care | Improved Health | Smarter Spending

What most people expect of the healthcare system!

Shouldn't we be paid for what our patients and communities deserve?

Let's also consider the *Quadruple* Aim.

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Triple Aim Leads to *Value*

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$$\text{Value} = \frac{\text{Quality + Experience}}{\text{Cost}}$$

From Now Until When

Today: fee-for-service predominates
- Pays for each unit of service
- Rewards industriousness and efficiency
- Contributes to high-cost health care
- Worsens professional satisfaction

Future: **value-based care**
- Requires team-based care
- Rewards better care and efficiency
- Increases healthcare quality
- Reduces healthcare costs (?)
- Improves professional satisfaction

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Value-Based *Care*

Value-based care prioritizes high-quality, person-centered, and efficient care.

Value-based care does NOT prioritize the volume of services provided.

Robust primary care practices are an essential ingredient (as in person-centered health homes).

But we have a problem…

Person + Family

Quality-Focused

Proactive Care

Team-Based

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The Value Conundrum

You can always count on Americans to do the right thing – after they've tried everything else.

Fee-for-service

Full capitation

Market-based

Single payer

What about paying for **healthcare value**?

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Form Follows Finance

How we *deliver* care depends on how we are *paid* for care.

Healthcare reform is changing <u>both</u> payment and delivery.

Payment supplies fuel for the Volume → **Value** transition.

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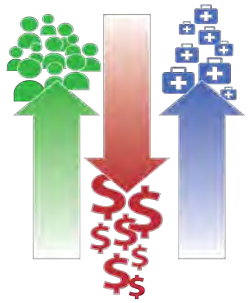
Value-Based *Payment*

Payment for one or more parts of the Triple Aim

- Better patient care
- Improved community health
- Smarter spending

Not payment for a "service," that is, NOT fee-for-service

To *receive* value-based payment, we must *deliver* value-based care



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Why discussing payment, not care?

Money is a medium of exchange.

Incentives drive behavior.

Not all incentives are financial, but finance remains important.

Let's incentivize the Triple Aim.

Make it easy to do the *right* thing.

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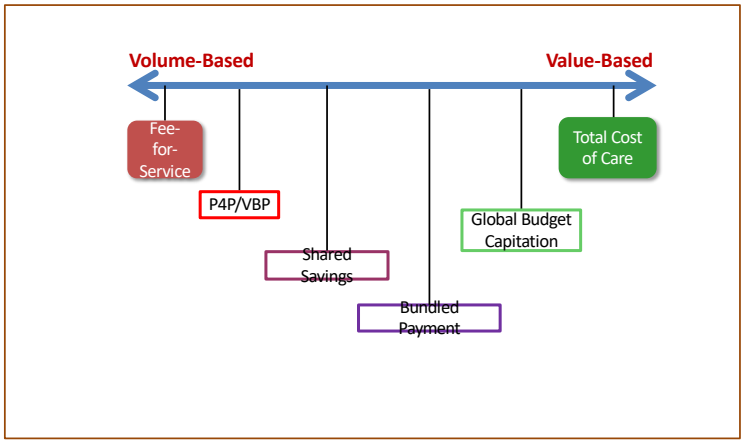
Payment Continuum



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CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Fee-for-service: no link to quality and value	Fee-for-service: link to quality and value	APMs built on fee-for-service architecture	Population-based payment
	2A **Foundational payments for infrastructure and operations** For example, care coordination fees and payments for health information technology investments	3A **APMs with shared savings** For example, shared savings with upside risk only	4A **Condition-specific population-based payment** For example, per member per month payments or payments for specialty services, such as oncology or mental health
	2B **Pay-for-reporting** For example, bonuses for reporting data or penalties for not reporting data	3B **APMs with shared savings and downside risk** For example, episode-based payments for procedures and comprehensive payments with upside and downside risk	4B **Comprehensive population-based payment** For example, global budgets or the full or a percent of premium payments
	2C **Pay-for-performance** For example, bonuses for quality performance		4C **Integrated finance and delivery systems** For example, global budgets or the full or a percent of premium payments in integrated systems
		3N Risk-based payments not linked to quality	4N Capitated payments not linked to quality

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Table 3. Broad State of Evidence from Alternative Payment Models

Program Type	Cost	Quality	Equity
Accountable Care Organizations (Medicare Shared Savings Program)	Gross savings of 1% to 4%, increasing as years in ACO increase. Net savings to Medicare of <1% per beneficiary after paying out shared savings	Modest improvements in several quality dimensions, e.g., readmissions, patient experience, and care coordination.	Providers in communities serving low-income and minority populations less likely to participate. Mixed evidence of risk-selection.
Bundled Payments (Medicare Bundled Payments for Care Improvement and	Varies by condition and procedure. 1.5-2% per-episode gross savings for some surgical episodes (e.g., hip and knee replacements), but	Varies by condition and procedure. Some evidence of improved functional status, no change in mortality,	Hospitals caring for vulnerable groups less likely to receive shared savings. Some data suggesting populations with social risk factors not harmed.
Comprehensive Care for Joint Replacement)	no net savings to Medicare after paying bonuses. Smaller savings for some medical conditions (e.g., congestive heart failure), with no savings for others (e.g., oncology).	readmissions, or patient satisfaction.	
Comprehensive Primary Care Programs (CPC and CPCI+)	No savings to Medicare.	Some evidence of improved quality and reduced ED use	Practices located in wealthier, highly educated areas are more likely to join.
Medicare Advantage	Some evidence Medicare Advantage has lower per-beneficiary spending, but Medicare payments to Medicare Advantage plans remain high.	Evidence of improved quality and reduced utilization.	Mixed evidence. Racial minorities may have improved access to screening under Medicare Advantage, but other evidence shows higher readmission rates.

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Value-Based Payment Examples

Shared savings/losses
- Medicare Shared Savings Program (ACO)

Global hospital budget
- Pennsylvania Rural Health Model

Partial capitation
- Primary Care First Model

Total cost of care
- Maryland TCOC Model

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Value-Based Payment by the Numbers

- 938 ACOs, 10% of the population
- 438 Medicare ACOs, > 11 million persons
- Multiple CMMI models including
  - Rural hospital global budgets
  - Primary care – partial capitation
- Many Medicaid and commercial insurer value-based plans (e.g., Blue Alliance)
- CMS says all providers should be "accountable" by 2030

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Accountable Care Organizations (ACOs)

- ACOs are also known as **shared savings** organizations.
- Groups of providers (generally physicians and/or hospitals) that receive financial rewards for improving the quality of care for a group of patients while reducing the cost of care for those patients.

Accountable Care Organization Goal

To receive a **share** of cost savings

Requires

- *Outpatient* care performance
- Primary care visit attribution
- Population health management
- Financial risk management
- *Robust* primary care

Still fee-for-service however

Significant rural participation

Source: "All-Payer Spread Of ACOs And Value-Based Payment Models In 2021: The Crossroads And Future Of Value-Based Care", Health Affairs Blog, June 17, 2021.

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North Dakota Value-Based Contracts

Signify Health – Medicare Shared Savings Program (ACO)

Blue Alliance – three value-based care levels will be available

North Dakota Medicaid – ?

Primary care – partial capitation

It's just the beginning…

Signify Health membership map – Eight members located in North Dakota

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Rural ND on a Pathway to Value
Rough Rider High Value Network

- **Clinically Integrated Network** –A CIN is a selective partnership of physicians and other medical providers and hospitals to deliver evidenced-based care, improve quality, efficiency, and coordination of care, and demonstrate value to the market.
  - Rural Wisconsin Heath Cooperative -1979
  - Illinois Critical Access Hospital Network (ICAHN) -2003
  - MaineHealth ACO – 2011

- **Rough Rider High Value Network (RRHVN)** – A North Dakota CIN involving 20 or more CAHs with medical providers working to improve patient and community care to achieve higher efficiency of operations, population health outcomes, financial viability, and to prepare for value-based systems and payment.

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Rural ND on a Pathway to Value
Rough Rider High Value Network

- **Shared Services-** an agreed upon process whereby separate organizations operating through a network can achieve both effieiecncy of operations and offer services that are difficult for only one organization to provide.
  - Expand what is available to community members.
  - Shared services could entail:
    - Joint purchasing.
    - Clinical and other health operations/services.
    - Peer review
    - Telehealth.
    - Mental health.
    - Behavioral health.
    - Workforce development.
    - IT.
    - Coding.

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Rural ND on a Pathway to Value
Rough Rider High Value Network

- Build viable, sustainable rural health systems.
- Increase organizational efficiencies and expand necessary services.
- Expand access, facilitate coordination, and improve quality of health care services so as to advance patient health status (population health).
- Enhance community health and reduce rural population health disparities.
- Develop statewide pathway to value-based payment contracts.

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Rural ND on a Pathway to Value
Rough Rider High Value Network

- **Three Key steps**
- **Develop Clinical Integration Committee.**
  - Each hospital will have one clinical member.
  - Assess clinical needs
  - Evidenced based clinical care processes.
  - Develop peer review and support process.
  - Assess workforce needs.
- **Develop Business Integration Committee.**
  - Each CAH has a member -23
  - Work on business model, planning, agreements within and external.
- **Community and Non-member outreach.**

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CRH Next Steps in Assisting on ND Rural Health Value

- This is just the beginning – we are committed.
- RHV fits in Flex and SHIP
  - Continue CAH Quality Improvement – inpatient and outpatient.
  - Continue Operational and Financial Improvement TA.
  - Continue CAH Population Health Improvement TA.
  - Continue DON calls, nurse residency, and with NRHA on CFO training.
- Continue to some degree with RHV.
- NEW – Rural Pathway to Value (from NRHRC)
  - Continue to work with the 5 Core CAHs.
  - Expand out – Look at 7 applied but not funded.
  - Model/Approach similar to RHV and assured they can adapt.
  - Not repeating or doing over for CORE 5 but steps forward.
  - Additional CAHs also assessment and CE.

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