Center *for* Rural Health

Value Based Care in a Sea of Change for Rural Health

North Dakota Hospital Association Conference

October 10, 2023
Fargo ND

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The University of North Dakota
School of Medicine & Health Sciences

- 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

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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

Why are things Changing?

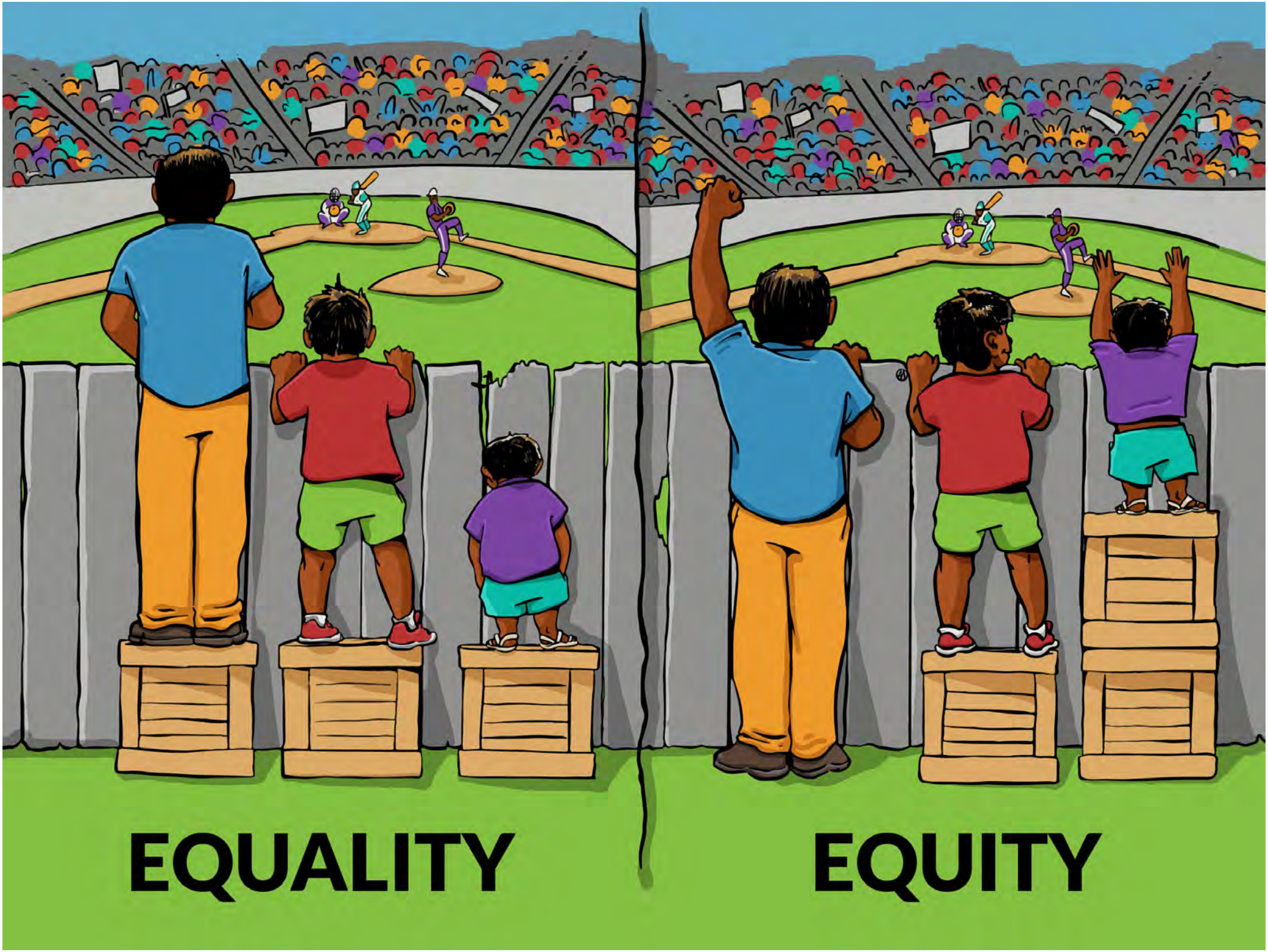
What is in the Water?

Systemic Change –Some say Transformational 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 and Health PLanning, HCFA/CMS, PPS, HITECH, ACA with pop health and 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- family costs, maintain 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.


EQUALITY
EQUITY

Systemic Change –Some say Transformational 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 (over 50)– 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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But what is value based care, what does it mean?

Public health policy embedded the ACA created and mandated policy change to improve population health. A significant change in how we think of health and health care –policy values.

"**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. IHI Triple Aim.

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 - leads to improved performance on quality measures. Improved quality is central to population health and cost control.

New concepts for hospitals and PC- Pop Health, SDOH, Health Equity, Health Disparities.

Moving from a **"sick care**" system to a **"well care**" system

Community Engagement: Better understanding within the community of available services and care management supports can drive more appropriate utilization (better care, improved health, and lowered costs).

- 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, public health, transportation, park district, school, health and wellness, economic development – **health of the community.**
- Align and leverage resources/efforts – avoid duplication – maximize impact.

More appropriate utilization impacts the cost and outcome of care.

Systemic Change –Some say Transformational Change

938 ACOs, 10% of the population

456 Medicare MSSP ACOs, > 11 million persons

718 ACOs in 3 types of Medicare ACO-ACO REACH

Medicare –over 13 million persons.

Multiple CMMI models (over 50) including

- Rural hospital global budgets
- Primary care – partial capitation
- ACO –many types
- Maryland All Payer and Total Cost
- Bundled Payments
- Associated with specific health conditions

Many Medicaid and commercial insurer value-based plans (e.g., Blue Alliance)

CMS says all providers should be "accountable" by 2030

Systemic Change –Some say Transformational Change

- **CMS Goal**: 100 percent of Medicare beneficiaries to be in an APM by 2030 and most Medicaid. (In 2021 over 40% in APM but 90% value).

- **1/3 (35%) of all US CAHs in an ACO** – 467 CAHs out of over 1,350. 8 in ND (but more in 2024). Nationally about **59% upside/downside**.

- Over **1,600 RHC** in Shared Savings

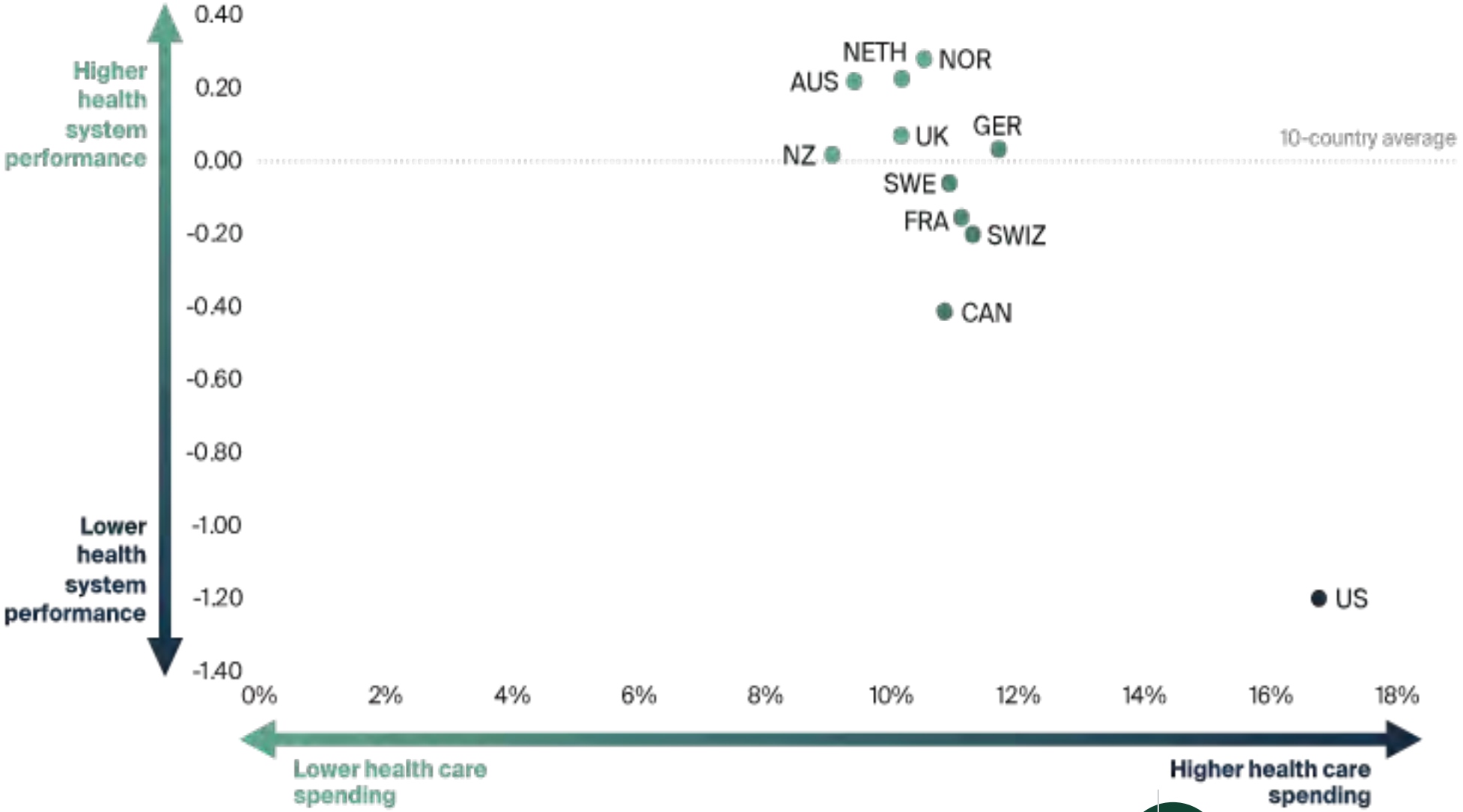
- **29 states require an MCO to have value program** and 26 define the model under Medicaid.

- **More CMMI demonstrations in the works** – new rural focused option (8 states). – CHART model "did not work well." States dropped out.

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.

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



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Key Concepts and Definitions

Population Health

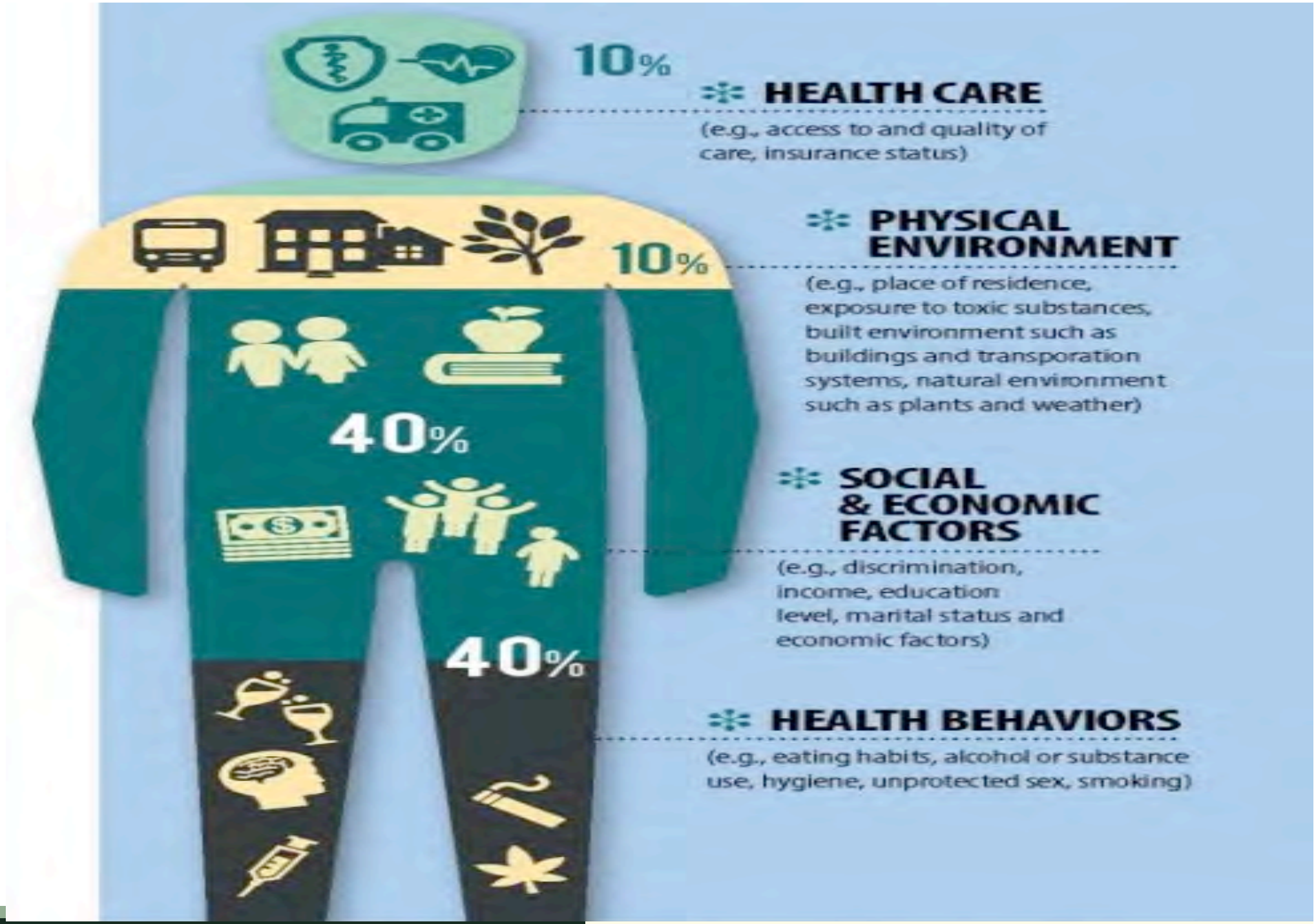
"Health outcomes of a group of individuals, including the distribution of such outcomes within the group."(Kindig, *What is Population Health?*)

- 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?

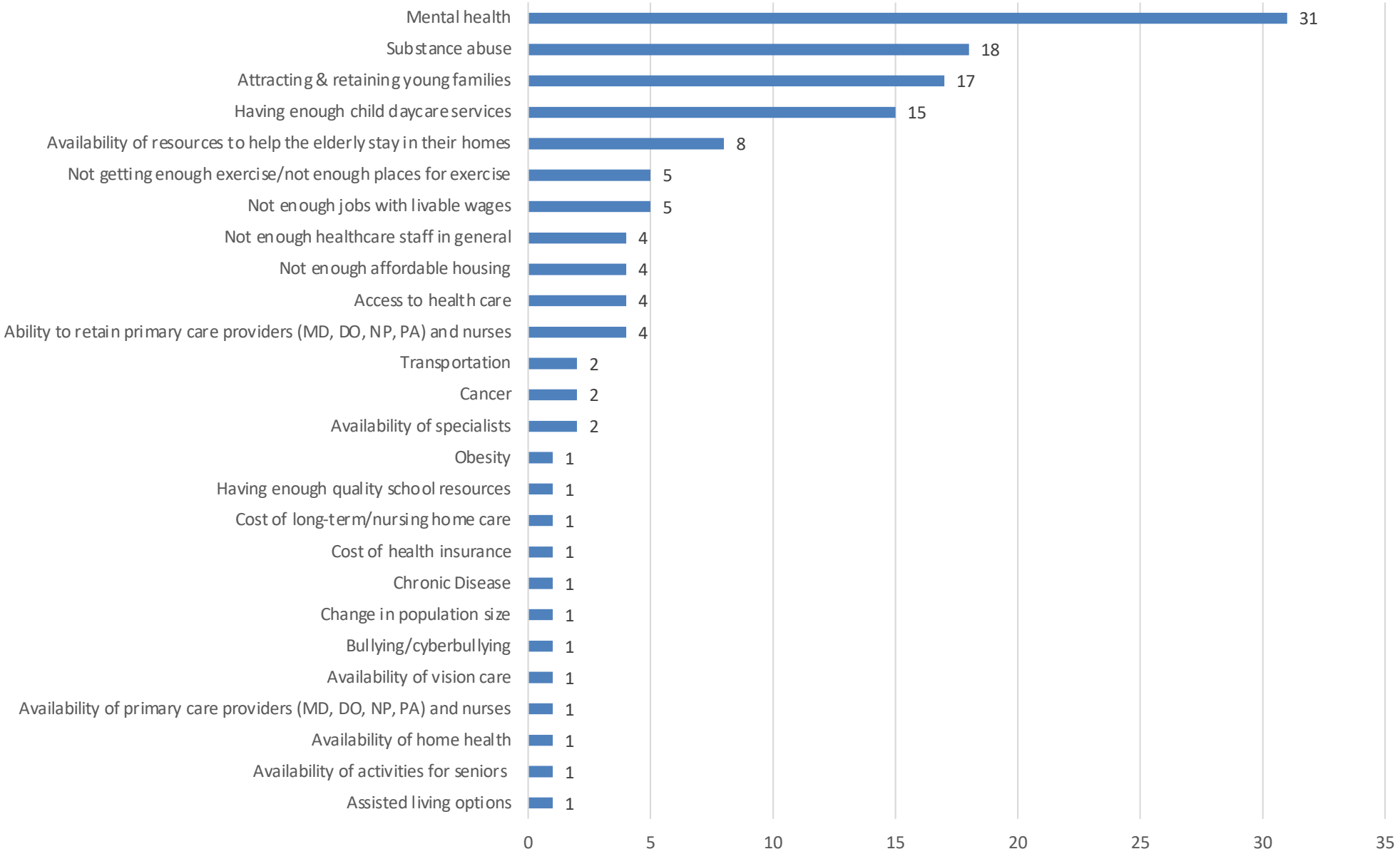
Social Determinants

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."


10%
HEALTH CARE
(e.g., access to and quality of care, insurance status)
10%
PHYSICAL ENVIRONMENT
(e.g., place of residence, exposure to toxic substances, built environment such as buildings and transporation systems, natural environment such as plants and weather)
40%
SOCIAL & ECONOMIC FACTORS
(e.g., discrimination, income, education level, marital status and economic factors)
40%
HEALTH BEHAVIORS
(e.g., eating habits, alcohol or substance use, hygiene, unprotected sex, smoking)

ND CHNA Top Needs Identified through 4th cycle since ACA implementation (2020-2022)

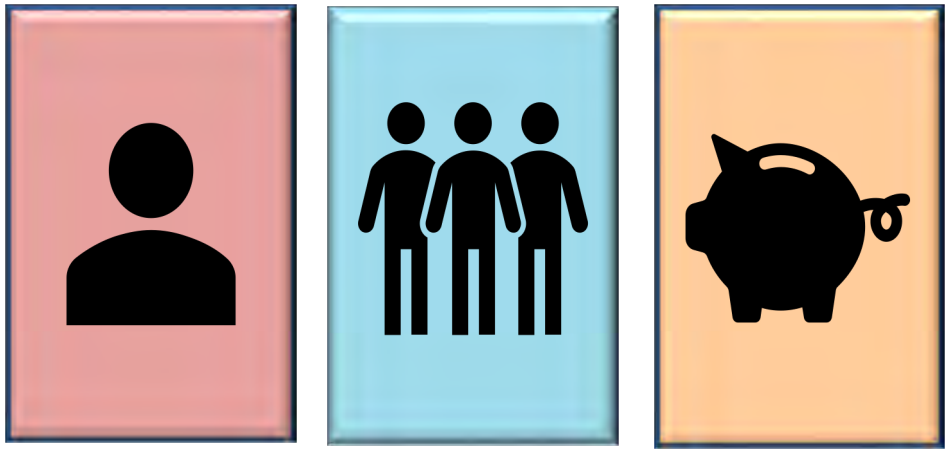


Rural ND and VBC
(Structural Changes for Population Health)

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**.

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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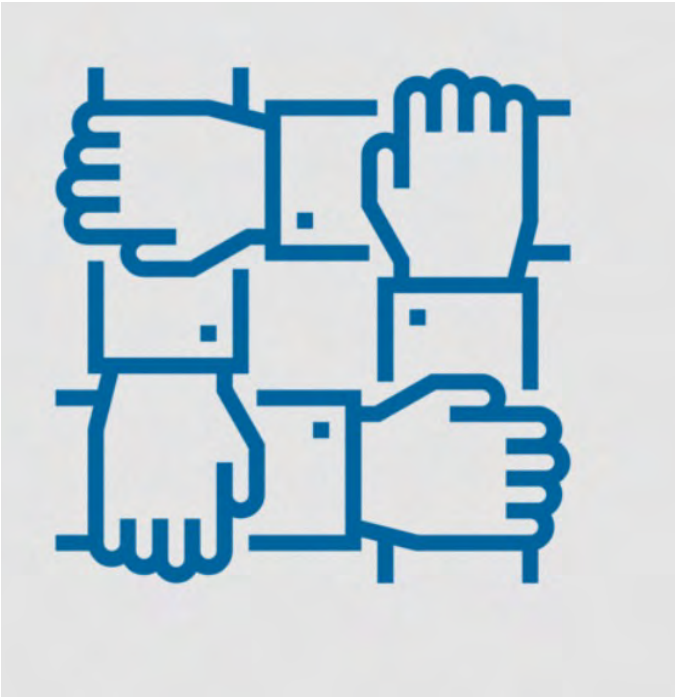
From Now Until When

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



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…

The Value Conundrum

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

Fee-for-service

Shared Savings

Full or Partial Capitation

Global Budgets (PA model)

Market-based

Single Payer

Total Cost of Care (Maryland All 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.

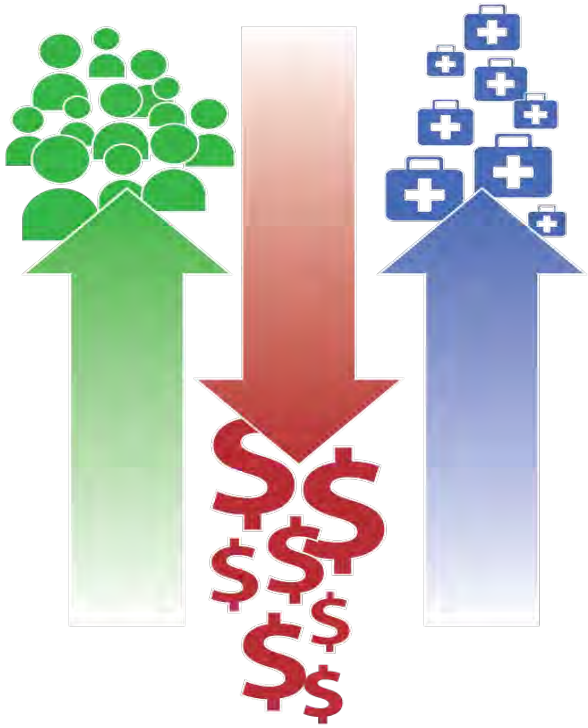
Value-Based *Payment*

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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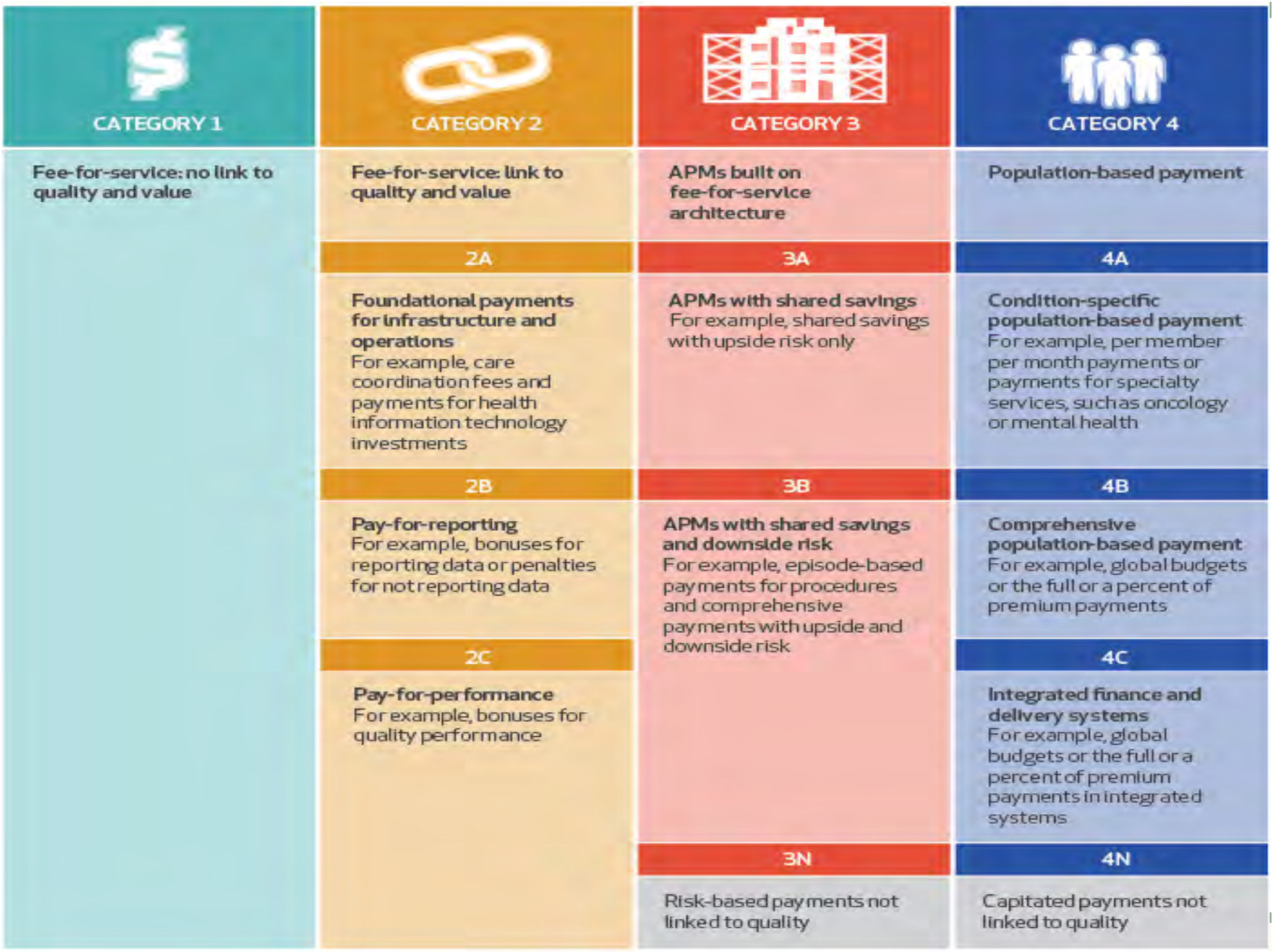

CATEGORY 1
CATEGORY 2
CATEGORY 3
CATEGORY 4
Fee-for-service: no link to quality and value
Fee-for-service: link to quality and value
APMs built on fee-for-service architecture
Population-based payment
2A
3A
4A
Foundational payments for infrastructure and operations
For example, care coordination fees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

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

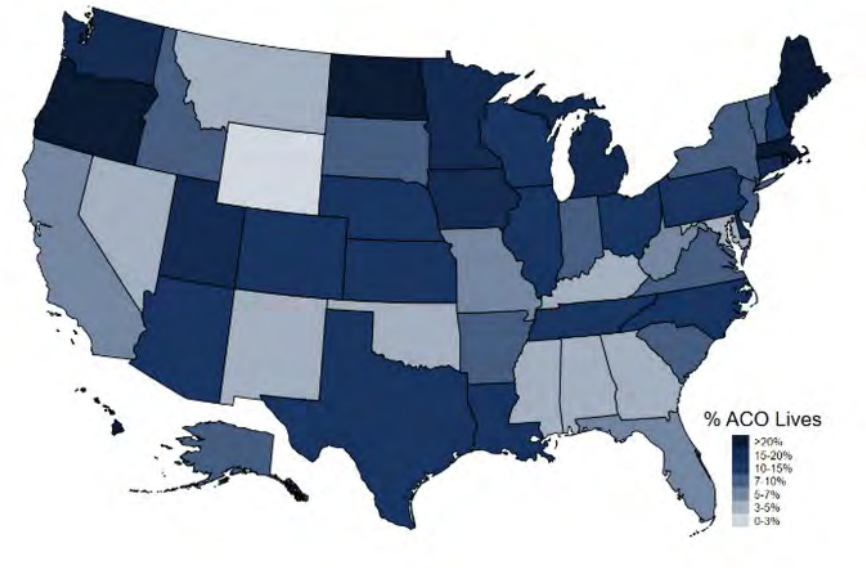
To receive a **share** of cost savings

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.

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

Where is North Dakota in this Discussion on Health Value?

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

- **Rural Health Value North Dakota (RHV-ND)**
  - CDC Health Equity funds – CRH over $3 million - 5 projects.
  - Volume to Value is 1 of the 5 projects – October 2022 – May 2023.

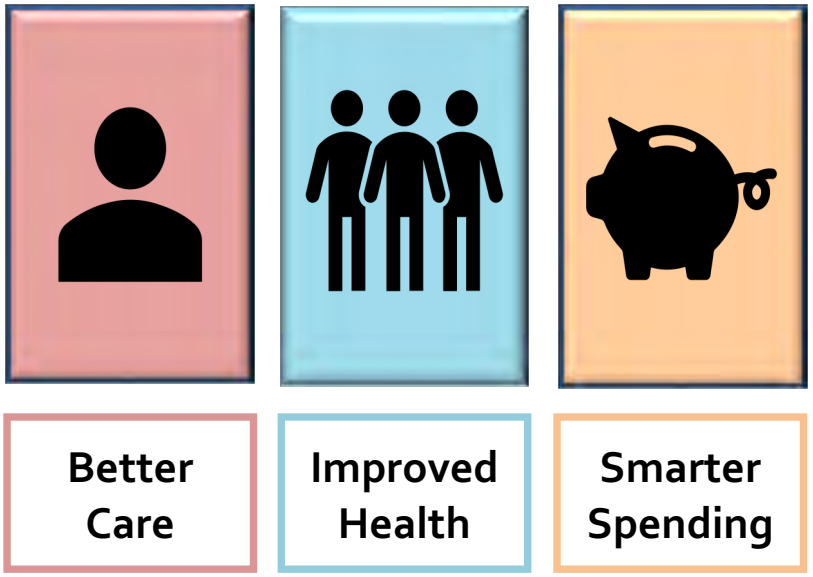
- **Rough Rider High Value Network.**
  - 23 CAHs – independent (will grow)
  - Non-Profit. Legal entity.
  - Maintain independence and autonomy but work as a network.
  - Shared services – new services difficult for one hospital to establish on own.
  - Joint purchasing.
  - Develop value-products/process, prepare for contracts
  - Population health focus – improve health, better care, lower cost

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.



This activity is federally funded by Grant No. NH75OT000095, National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities, Centers for Disease Control and Prevention, awarded to the North Dakota Department of Health and Human Services, sub awarded as G19.1334 to the University of North Dakota, Center for Rural Health.

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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 & recommendations	• 5 Core ND CAHs • VBC Assessment survey and action planning • Community engagement plan • Financial scenarios • General VBC consultation	• All 37 ND CAHs • VBC landscape • VBC assessment and planning • Community engagement strategies • Financial modeling scenarios results

5 Core Critical Access Hospitals

A small group of North Dakota CAHs were selected in Fall 2022 to participate in activities from October 2022 through May 2023.

Participating, or *core*, CAHs received 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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Outputs & Outcomes to Date

- **Four Statewide education webinars**
  - 30 of 37 CAHS attended at least 1 webinar
  - 21 of 37 attended more than 1 webinar
- **Core 5 VBC Assessment & Action Planning**
  - Transportation (2)
  - ACP (2) Advanced Care Planning
  - Behavioral Health
  - Expand use of quality data
  - Care coordination
  - Address high ED utilization

Outputs & Outcomes to Date

- **Convening of Policy Stakeholders**
  - 9 of 13 invited entities attended virtual meeting
  - Identified educational needs for constituents
- **Policy Roadmap**
  - How RHV-ND Project can inform state and federal policy
- **Environmental Scan**
  - Physical Environment
  - Payment and Policy Environment

For all related project documents:
https://ruralhealth.und.edu/projects/flex/rural-health-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. **Engagement with Signify Health.**

Rough Rider High Value Network

- **Shared Services-** an agreed upon process whereby separate organizations operating through a network can achieve both efficiency 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.

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.

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.**

CRH Next Steps in Assisting on ND Rural Health Value

- **This is just the beginning – Center for Rural Health is 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, and with NRHA on CFO and CNO training.

- **Continue with RHV-ND**
  - Manager and Director training for Core 5 CAHs
  - Educational resources for ND policy partners (i.e. professional associations such as long-term care, public health and others)
  - Educational Policy Summit based on Policy Roadmap
  - Engage with public health to identify opportunities to align with local health systems and VBC strategies

CRH Next Steps in Assisting on ND Rural Health Value

- **NEW – Rural Path to Value (from National Rural Health Resource Center)**
  - 12 month cohort of 7 ND CAHs beginning October 2023 (2 are previously a Core 5 CAH from RHV-ND project)
  - Supports CAHs and RHCs taking early steps to adopt population health practices while working towards value
  - Customized to unique needs of the communities served by each CAH
  - Training, tools and strategies provided to
    - Accomplish population health improvement
    - Improve and sustain community partnerships
    - Conduct organizational planning
    - Help communities navigate transition to population health

This project is/was supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U2WRH33321 through the Medicare Rural Hospital Flexibility (Flex) Program's $1,209702.00 and 0% is financed with nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.


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