Rural Hospital Strategy for Value-Based Care Success

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Center *for* Rural Health
University of North Dakota
School of Medicine & Health Sciences

CIBOLO

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Agenda

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1. Rural Hospital Challenges
2. Clinically Integrated Network
3. North Dakota Case Study – Rough Rider High Value Network
4. Triple Aim
5. Clinically Integrated Network Solutions

AGENDA

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Cibolo Health

- Cibolo Health is dedicated to strengthening rural health care by connecting independent hospitals through collaborative networks.
- We're here to ensure rural hospitals can maintain their independence and enhance the high quality and affordable care rural communities count on.

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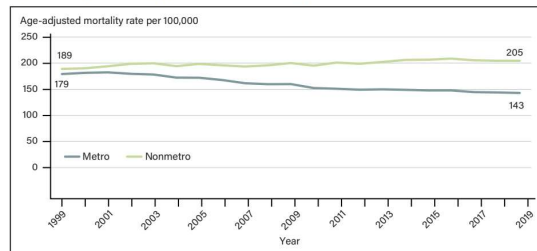
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Why Change Is Needed

In 1999, the natural-cause mortality rate for rural working-age adults was only **6 percent** higher than that of their city-dwelling peers. By 2019, the gap had widened to **43 percent**.

The gap highlights how persistent difficulties accessing health care, and a dispassionate response from national leaders, can eat away at the fabric of rural communities.

KFF Health News April 15, 2024

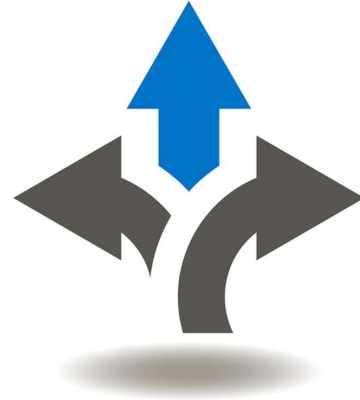Age-adjusted prime working-age natural-cause mortality rates, metro and nonmetro areas, 1999–2019

Age-adjusted mortality rate per 100,000

189
179
205
143

Metro   Nonmetro

Year

www.ers.usda.gov/webdocs/publications/108702/eib-265.pdf?v=4077.9

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National Investment in Primary Care

- **National Companies are building health systems without hospitals** (Optum)
- Focus is **primary care** – estimated $40B in 2024
- Walmart Clinics investing billions (75 locations)
- CVS acquired Oak Street Health – $10B
- CVS acquired Signify (Caravan) – $10B
- Amazon acquires One Medical – $4B
- Dollar General launches mobile clinics
- BCBS-ND announces VitellaCare

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Why the Investments?

- Receive value-based payments
  - 100% Traditional Medicare to be in accountable relationships by 2030.
  - 52% Medicare Advantage penetration, and rural is growing faster than urban.
  - Commercial payers follow CMS.
- Control total cost of care
  - Primary care controls cost of care.
  - Get closer to the healthcare dollar through payer/provider partnerships.
- Grow bigger (health systems)
  - Become "indispensable" in the market.

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Rural Hospital Challenges

- Loss of operational control through health system affiliations.

- Patient and service volumes too low for value-based care contracts.

- Payer-designed programs do not recognize rural hospital realities.

- Under-resourced performance improvement systems.

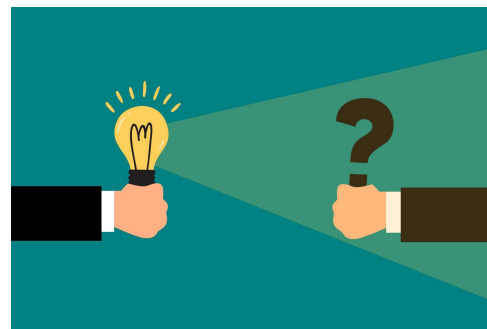- Inaccurate or incomplete performance data held by payers.

What Does This Mean for Rural?

- Historic approach
  - Affiliate with a large health system, or
  - *Hope* fee-for-service revenue remains adequate. (The status quo is <u>not</u> risk-free!)

- *Enlightened* approach
  - Horizontal integration in a **clinically integrated network (CIN).**
  - Maintain local ownership and control.
  - Achieve economies of scale.
  - Share resources.
  - Allow single-signature contracting.

- *Independence through interdependence*

5/2/2024

A CIN is a *Cooperative*

- A **cooperative** is a membership organization, whose members work together to achieve ***common goals***.
- Members have
  - Mutual authority
  - Collective accountability
  - Shared savings/profits
- The rural hospital clinically integrated network is <u>not</u> anti-payer or anti-system. **It is pro-rural!**

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CIN – The Legal Viewpoint

- A CIN is an organized system of care in which like-minded hospitals and clinics share quality and efficiency goals that result in ==improved quality and coordinated care at a lower cost==.
- A CIN allows providers to negotiate jointly with payers (single-signature contracting).
- CIN participants must share substantial risk and/or share protocols to demonstrate the interdependence needed to achieve "clinical integration" and survive FTC scrutiny.

1996 FTC Enforcement Memo

CIN members must

"Share substantial risk."

<u>or</u>

"Implement an active and ongoing program to evaluate and modify practice patterns."

<u>to</u>

"Create a high degree of interdependence."
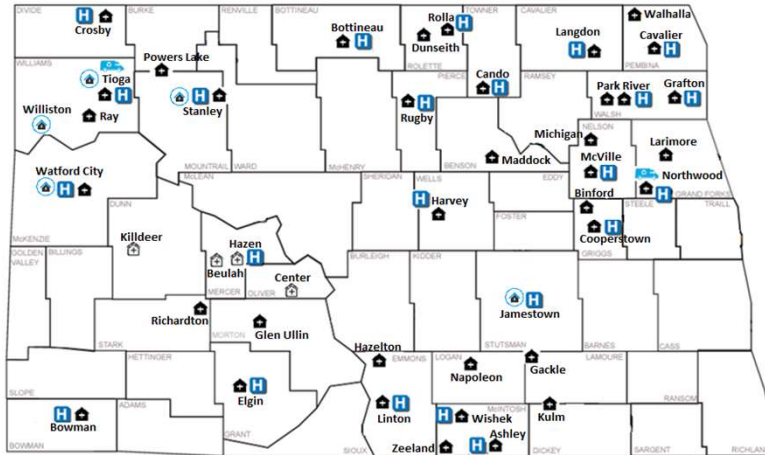
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CIN Core Components

Legal Structure	Legal entity with ownership, governance, and operational structure.
Physician Leadership	Clinical Integration Committee and related physician leadership, tasked with clinical priorities.
Payer Contracting	Payer contracting strategy geared towards creating value-based care opportunities.
Participation Criteria	Evidence-based clinical guidelines required for CIN participation.
Performance Objectives	Protocols to monitor providers' compliance with participation criteria and financial incentives tied to performance.
Operations Infrastructure	IT tools and platforms necessary to support CIN performance, including data acquisition, reporting, and analytics.

Rural Challenges

- Loss of operational control through health system affiliations. → Maintain control through *interdependence* with peers.

- Patient and service volumes too low for value-based care contracts. → Combine patients to gain scale for value-based care contracts.

- Payer-designed programs do not recognize rural hospital realities. → Design health plans to recognize and reward rural strengths.

- Under-resourced performance improvement systems. → Share performance improvement and data analysis resources.

- Inaccurate or incomplete performance data held by payers. → Control your own data with a shared population health platform.

Case: Rough Rider High Value Network

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RRHVN Cooperative Strength

- 23 rural North Dakota hospitals and their 41 clinics (37 RHCs and 4 FQHCs)

- ~225,000 persons – 65% of North Dakota's rural population

- ~$500 million in net patient revenue

- New Headwaters High Value Network (Minnesota) will quadruple this footprint.

- Like a farmers' cooperative, we are stronger *together*.

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RRHVN Mission

To create and advance the Rough Rider High Value Network – a sustainable network of rural North Dakota Critical Access Hospitals and clinics that increases clinical quality, pools member resources, manages financial risk, and improves community health.

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RRHVN Committees

- Business Integration Committee
  - CFO (or similar) from each member
  - All business issues ; e.g., shared services identification and payer negotiations
- Clinical Integrations Committee
  - Physician or APP from each member
  - All clinical issues; e.g., quality improvement and data analysis
- Care Coordination Committee
  - Care coordinators, quality directors, and/or clinic managers from each member
  - All workflow issues; e.g., team-based care and care coordination
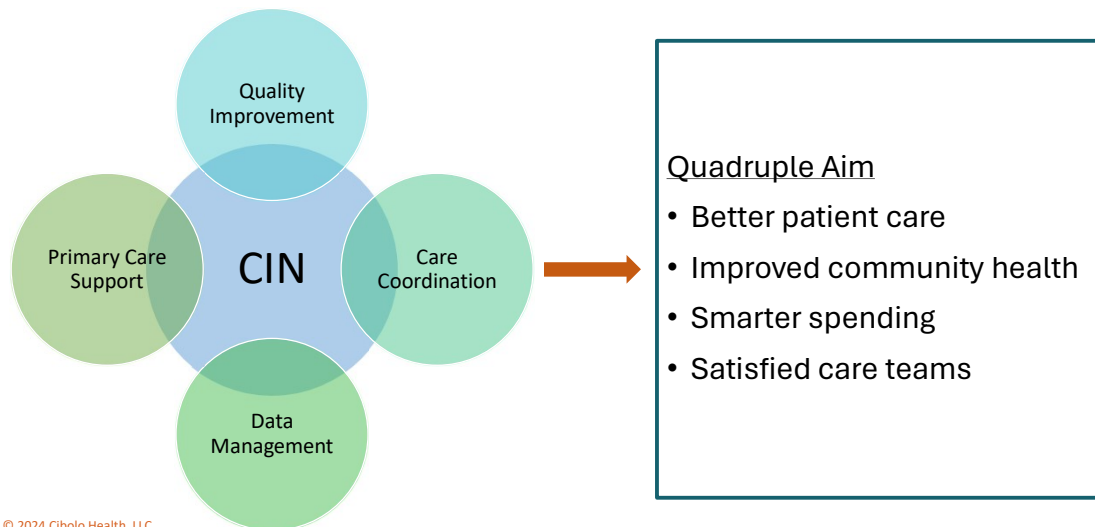

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Triple Aim and the CIN

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Better Care	Improved Health	Smarter Spending

- What most people expect of the healthcare system!
- A **clinically integrated network** is the *vehicle* to deliver the Triple Aim to rural people and places.
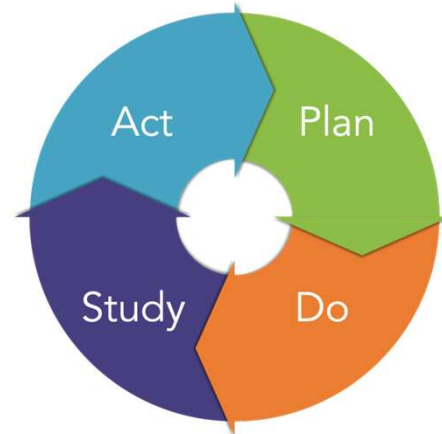- Let's also consider the Quadruple Aim.

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Clinically Integrated Network Venn

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Quality Improvement

Primary Care Support

CIN

Care Coordination

Data Management

Quadruple Aim
- Better patient care
- Improved community health
- Smarter spending
- Satisfied care teams

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CIN Solutions – Quality Improvement

- Too many measures! Focusing on all means focusing on none.
- Clinical Integration Committee selects 10 quality measures each year for the CIN.
- Each member then selects 1-2 for a *focused* improvement project.
  - SMART performance improvement goal
  - Baseline data
  - Specific intervention
  - Performance measurement plan
  - Start and end dates
  - Person responsible

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CIN Solutions – Care Coordination

- Primary care team
  - Physicians, APPs, nurses, managers, coders, care coordinators, registration, and more
- Local team
  - Primary care team, Public Health, pharmacists, community health workers, community-based organizations, and more
- Virtual team
  - Supports, not supplants, local team
  - Services not available locally

Requires a consistent care coordination *system* to assure health care occurs at the right place and at the right time without duplication or waste.

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CIN Solutions – Data Management

- Population health platform (IT)
- Quality and cost data management
- Data collection, analysis, reporting
- Reports must be *actionable* by care teams and CIN leadership
- Payer-agnostic
- CIN "owns" its data in perpetuity
- Very expensive to purchase and operate – requires a collaborative

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CIN Solutions – Primary Care Support

- Practicing Primary Care *Wisely* Project
- Project goals
  - Continuous clinical quality improvement
  - Increased primary care practice efficiency
  - Improved primary care team satisfaction
  - A culture of belonging as RRHVN members
- Team-based care focus
- Designed to return time in the workday to busy professional.
- Consultant: A consortium from Stratis Health, AMA, QHA, and Blue Agilis

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CIN Solutions – *Leadership*

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- Governed by a volunteer board of seven member CEOs.
- Operations managed by full-time president and five part-time staff.
- Working committees
- Members are all *independent* – requires leadership based on social capital
- Strive to facilitate a sense of belonging and allegiance.
- For success, members must engage – lean in and speak up.

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Clinically Integrated Network Summary

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- Provides solutions to many rural hospital challenges.
- Allows independence through interdependence.
- Allows payer negotiations and single signature contracting.
- Requires strong organization and leadership.
- Offers an opportunity to advance the Quadruple Aim – serving rural people, places, and providers.

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