Center *for* Rural Health

The US Health System is Changing: Population Health and Value-based Care

ND DHHS Community Engagement
Meeting the Challenge Conference

May 4, 2023
Bismarck State College
Bismarck ND

Presented by Brad Gibbens, Acting Director and Assistant Professor

Center *for* Rural Health
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

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 are the environmental factors?

What is value based care, what does it mean?

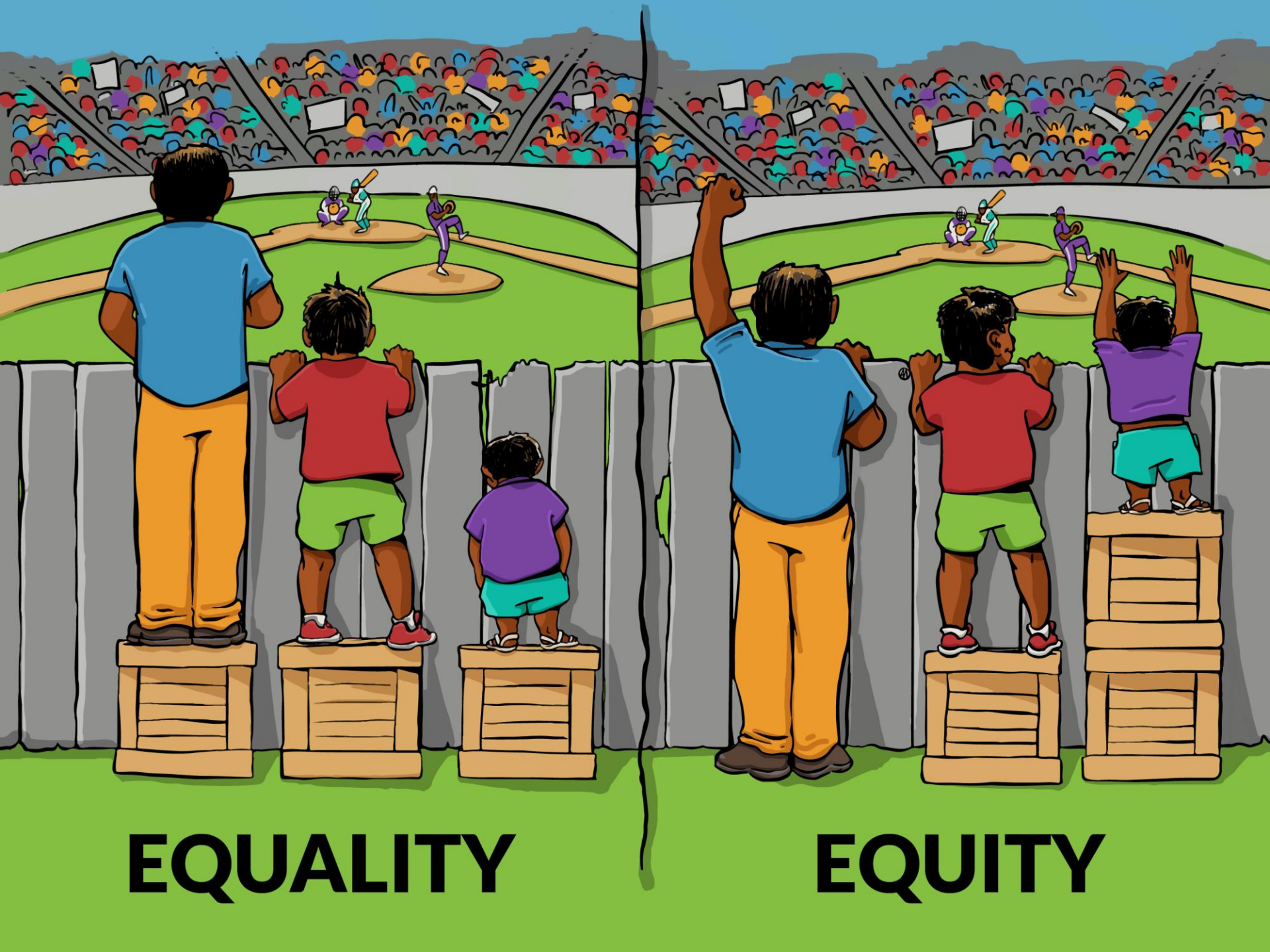
- Increased focus on prevention, wellness, and chronic disease management leads to improved performance on quality measures.
- Why? US needs to provide better care, improve health, and lower costs.
- Moving from a “sick care” system to a “well care” system.
- “Volume to value” less reliance on fee-for-service and more on care and payment associated with outcomes and performance.
- 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.

Systemic Change –Some say Transformative Change

- **Change is constant – our needs and values influence policy, policy drives change.**
  - **US health system is confusing – mix of public and private providers and payers.**
  - **US health system is intimidating and even scary- access, insurance, language.**
  - **US health system seemingly has conflicting values-rights vs. privilege, equality or equity, responsibility, who pays?**
  - **What is the role of public health policy? Ask –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, disparities, – movement to health equity.**


EQUALITY
EQUITY

Systemic Change –Some say Transformative Change

- **Affordable Care Act – profound policy change. Most significant since Medicare/Medicaid.**
  - **Shift to population health and health equity- Triple Aim influence. Health system pivot to primary care.**
  - **Increase access points, expand coverage, and modify delivery system and payment – Private insurance changes, Marketplace (Public), Medicaid Expansion.**
  - **Experimentation in delivery and payment models – CMMI – range of models – Medicare as the driver.**
  - **<u>Theory: If we actually improve health and adjust the system to well care and not just sick care we produce better outcomes and lower costs.</u>**
  - **Renewed awareness of equity can lead to <u>*better health and better care for ALL.*</u>**

- **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 - RRHVN**

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 since 2018 but number of people covered increased – consolidation. Actually a tick up to 483 ACO in 2022 with 11 million Americans in an ACO. (700,000 in Signify Health, includes ND).**
- **1/3 (35%) of all US CAHs in an 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 dropped out.**

Systemic Change –Some say Transformative Change

- **Value-Based care –** use of care management and coordination, annual wellness visit, community health services, motivational interviewing, population health principles, SDOH, and health equity are engrained in the system of care.

- **Philosophy** is focus on prevention, wellness, and chronic disease management.

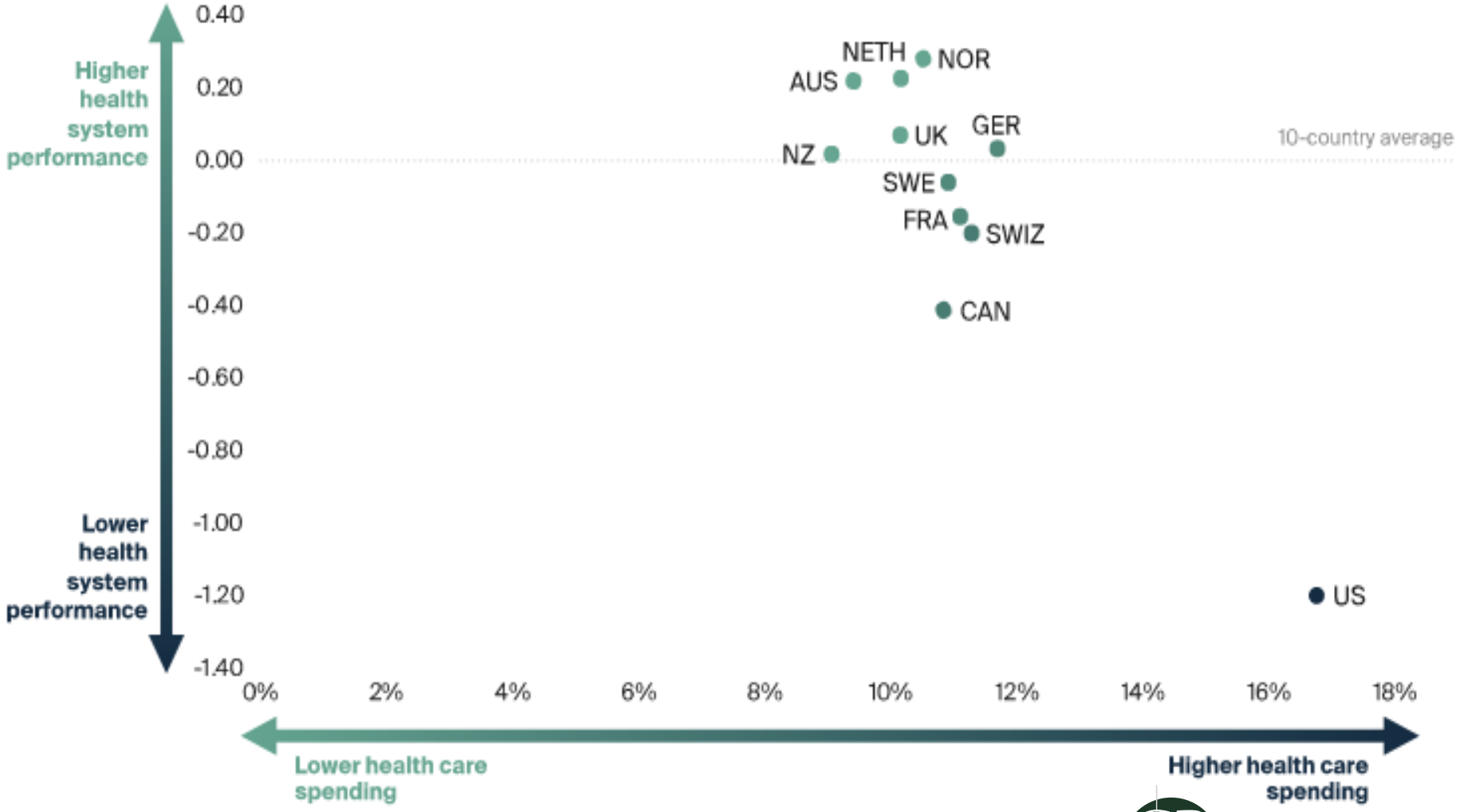
- **Community engagement is crucial.**
  - Formal networks, informal coalitions, individual partners in community.
  - Shared priorities and shared work that involve many partners – population health creates the need for a range of groups-aging, transportation, park district, school, economic development – focus on health of the community.
  - Align and leverage resources/efforts to address patient needs (need community partners)– avoid duplication – maximize impact.

- **Access to care is still the focus but recognize that it is impacted by an array of issues – SDOH, health disparity, health equity.**

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, $7,400; Neth, $6,700; France, $6,100; Canada, $5,900; Auz $5,600; United Kingdom, $5,400; and Japan, $4,700. (2022 data). (Source Commonwealth Fund)
- **18% of US GDP** – Germany, 12%; Canada, 11%, FR, 11%, AU, 10%, 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 infant mortality.
  - US has highest rate of avoidable and treatable conditions.
  - US has one of the highest suicide rates.
  - 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?

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.

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 ☺).

Factors Contributing to Health

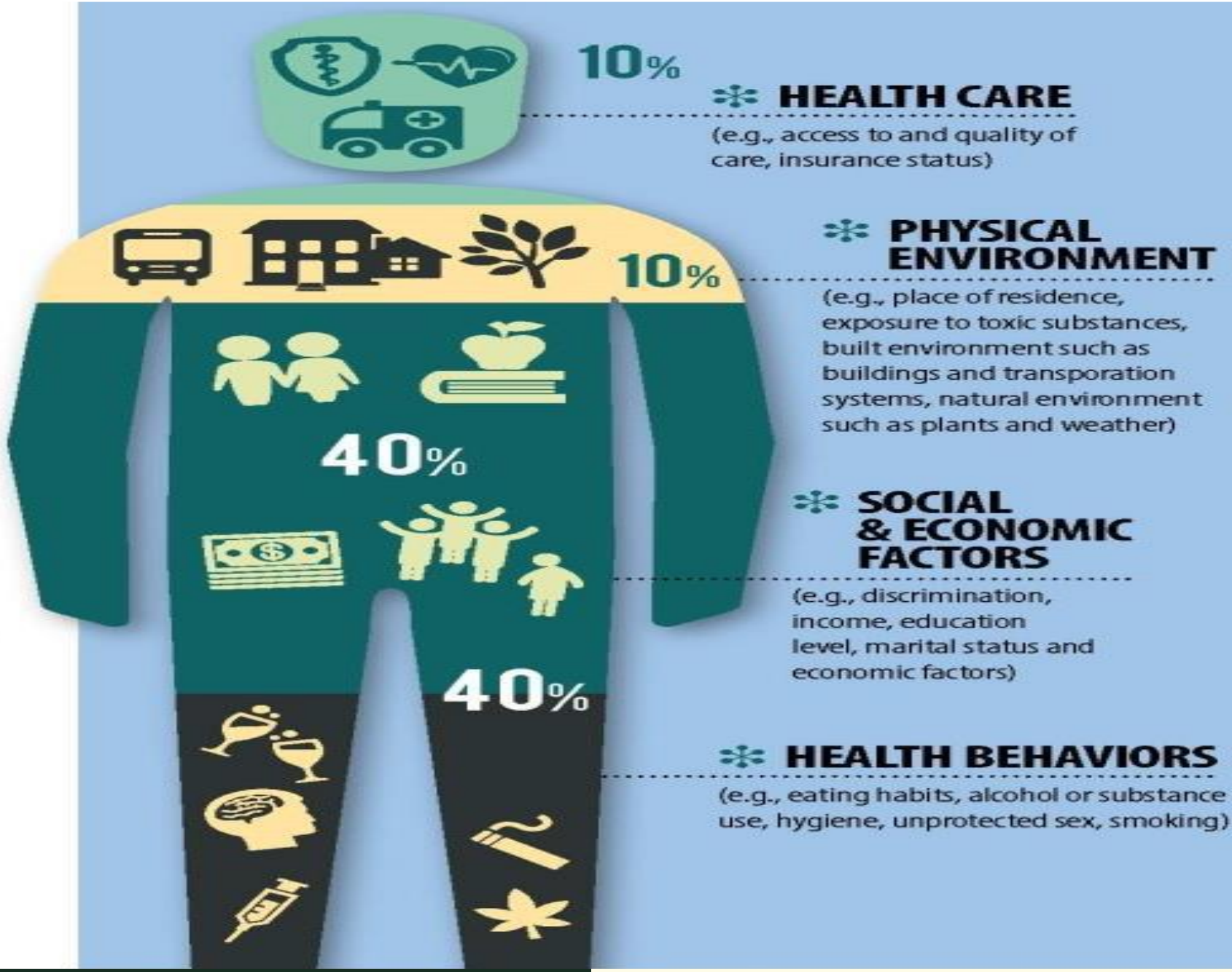
Outside Health Care System	Related to the Health Care System	
Societal Factors	**Care Delivery**	**Regulatory Environment**
• Food Safety • Health food availability • Housing conditions • Neighborhood violence • Open space and parks/recreation availability • Genetic inheritance • Disease prevalence •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

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

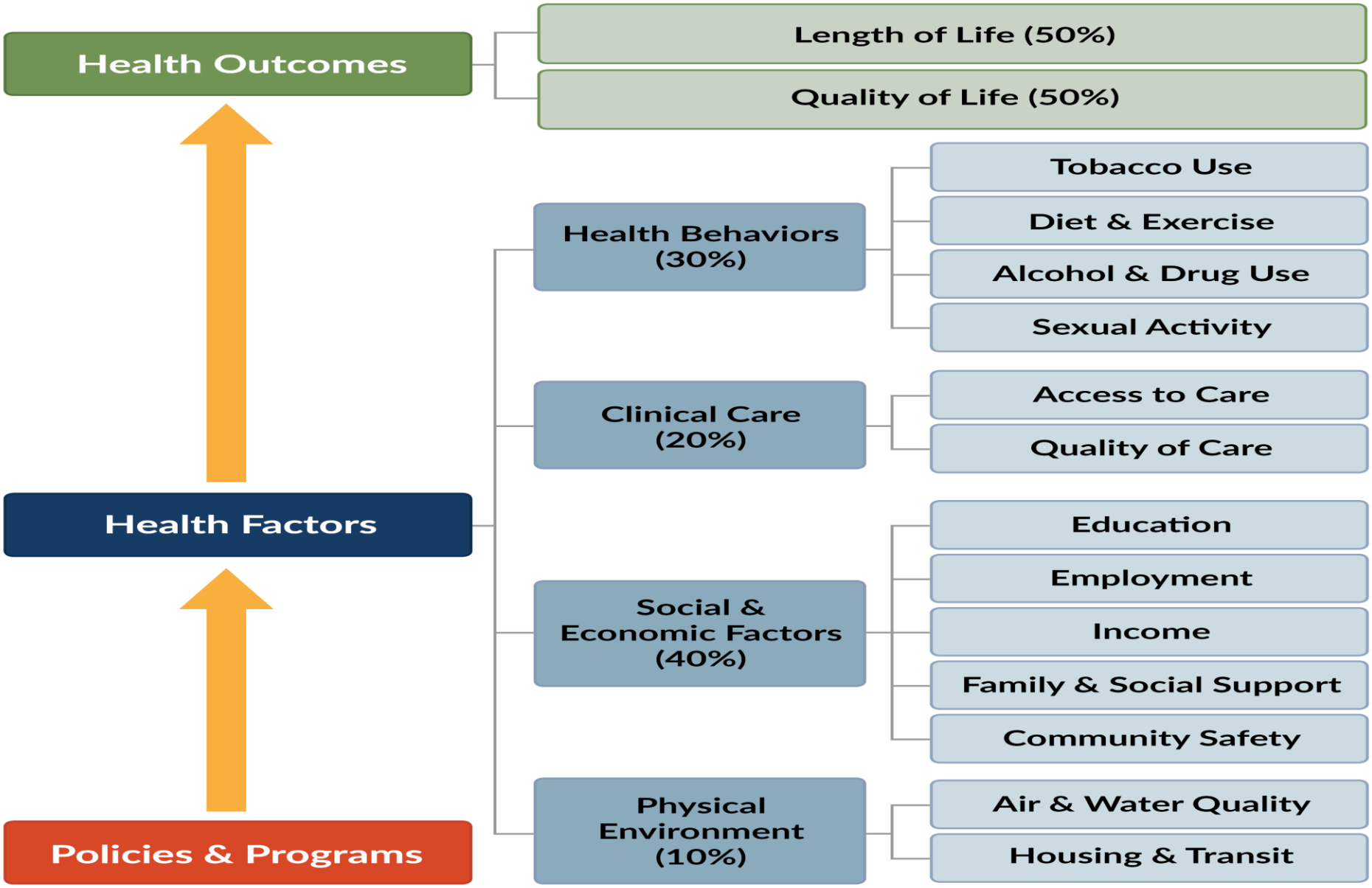
Social Determinants

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)

County Health Rankings Model



SDOH Toolkit

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Rural Health Information Hub

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IN THIS TOOLKIT

Modules

- 1: Introduction
- 2: Program Models
- 3: Program Clearinghouse
- 4: Implementation
- 5: Evaluation
- 6: Sustainability
- 7: Dissemination

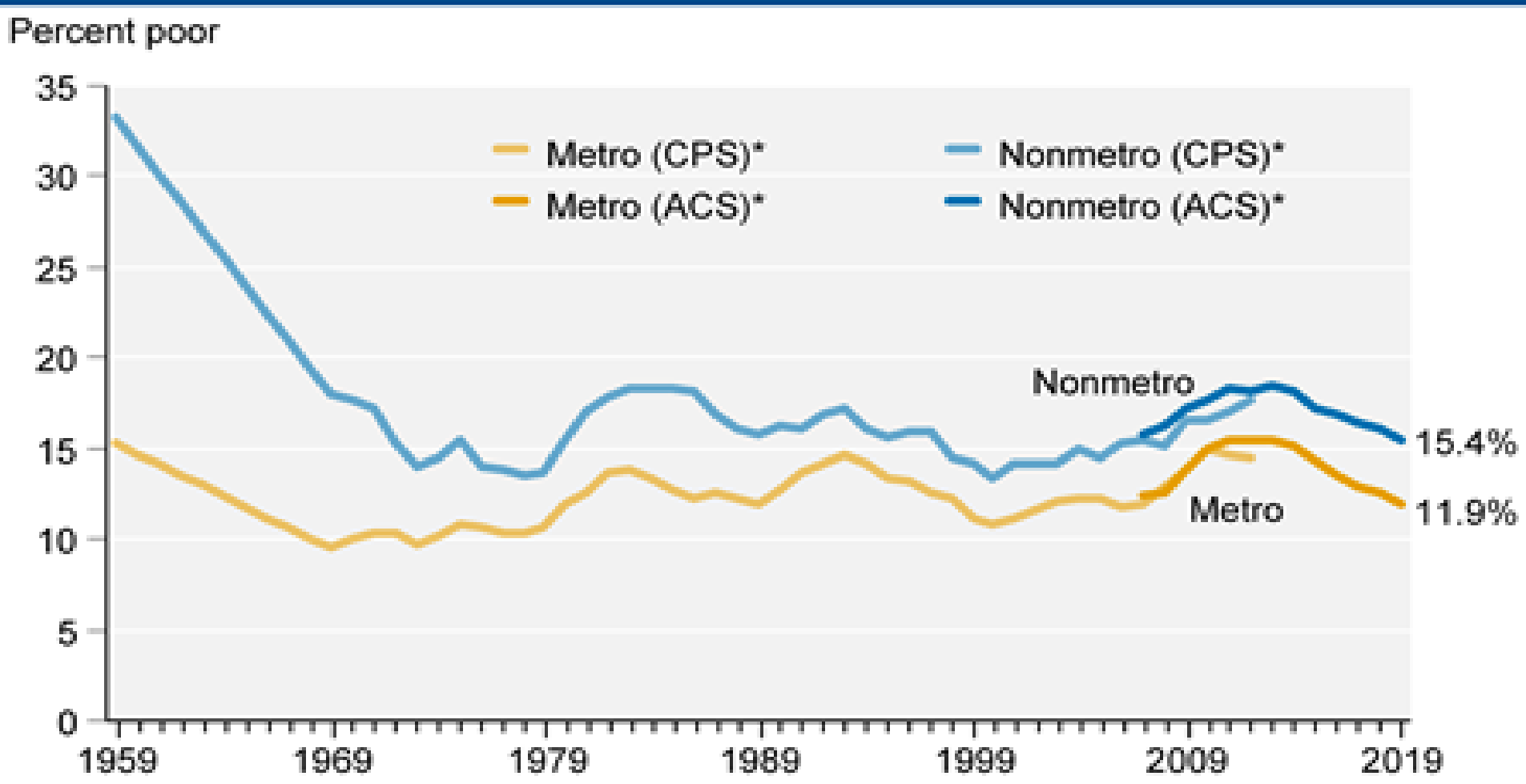
About This Toolkit

Rural Health > Tools for Success > Evidence-based Toolkits > Social Determinants of Health in Rural Communities Toolkit

Social Determinants of Health in Rural Communities Toolkit

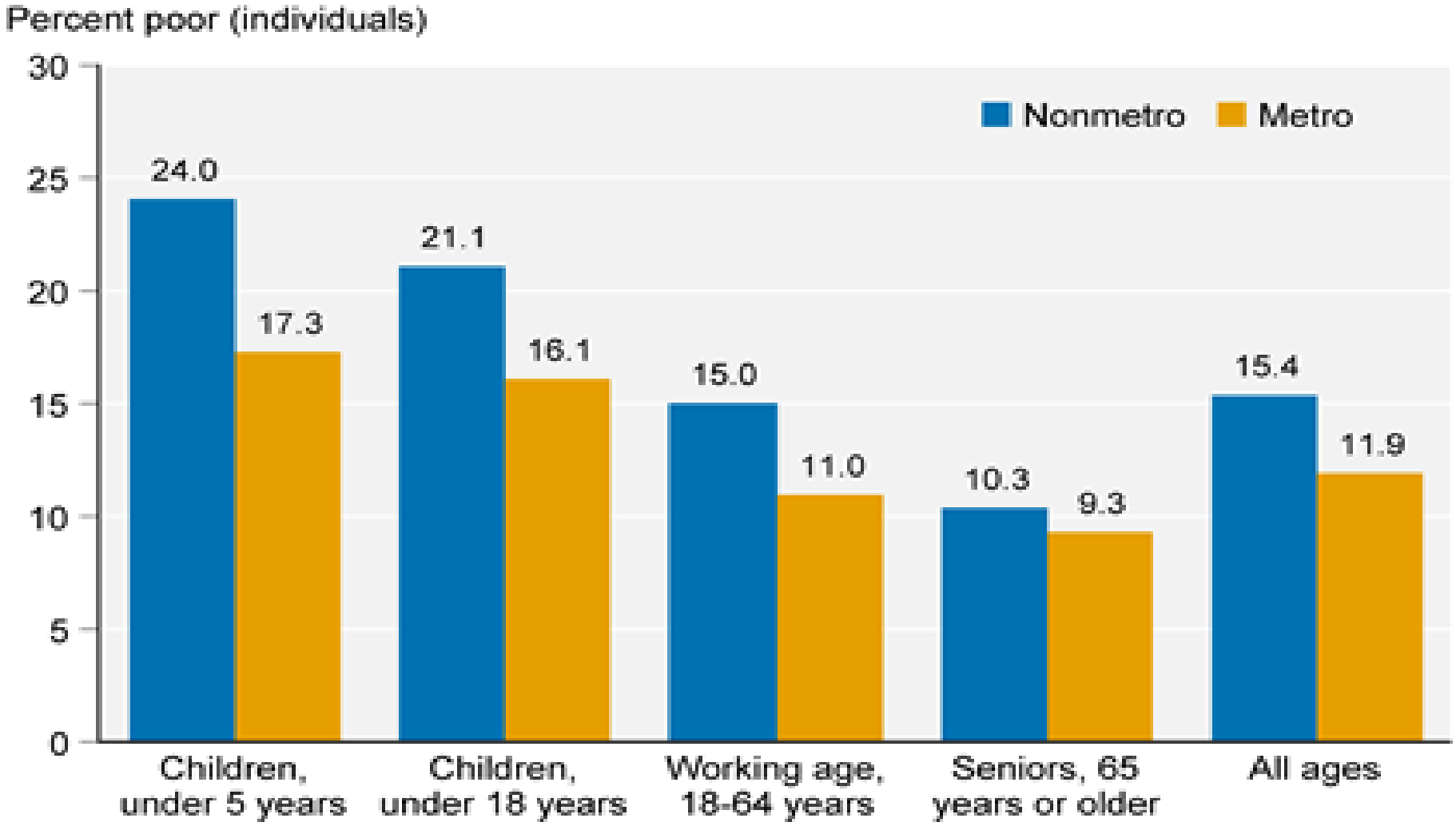
Health Disparities – What do the numbers say?

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.

Poverty rates by age group and metro/nonmetro residence, 2019



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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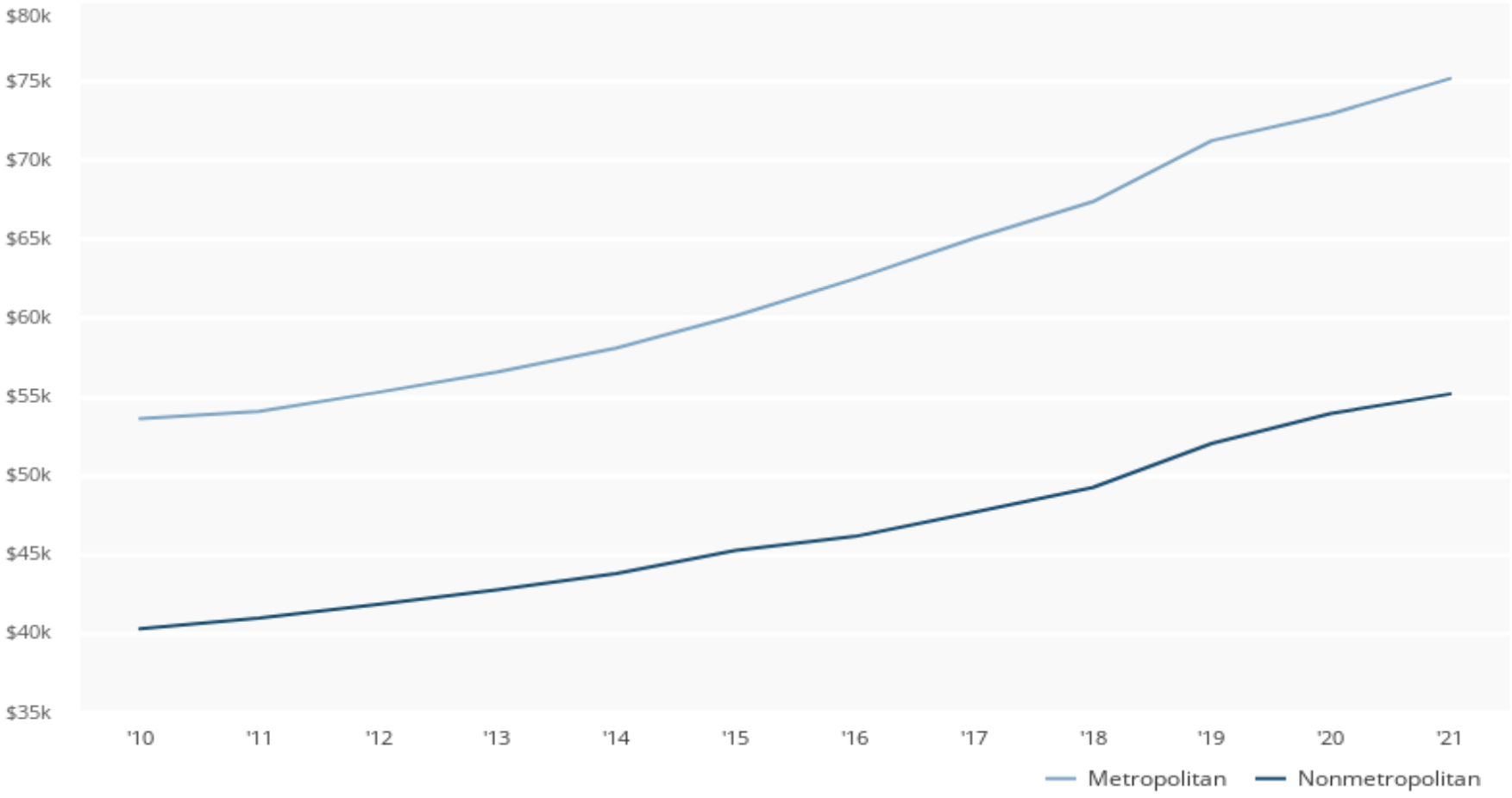
Average Median Household Income for Metro and Nonmetro Counties, 2010-2021



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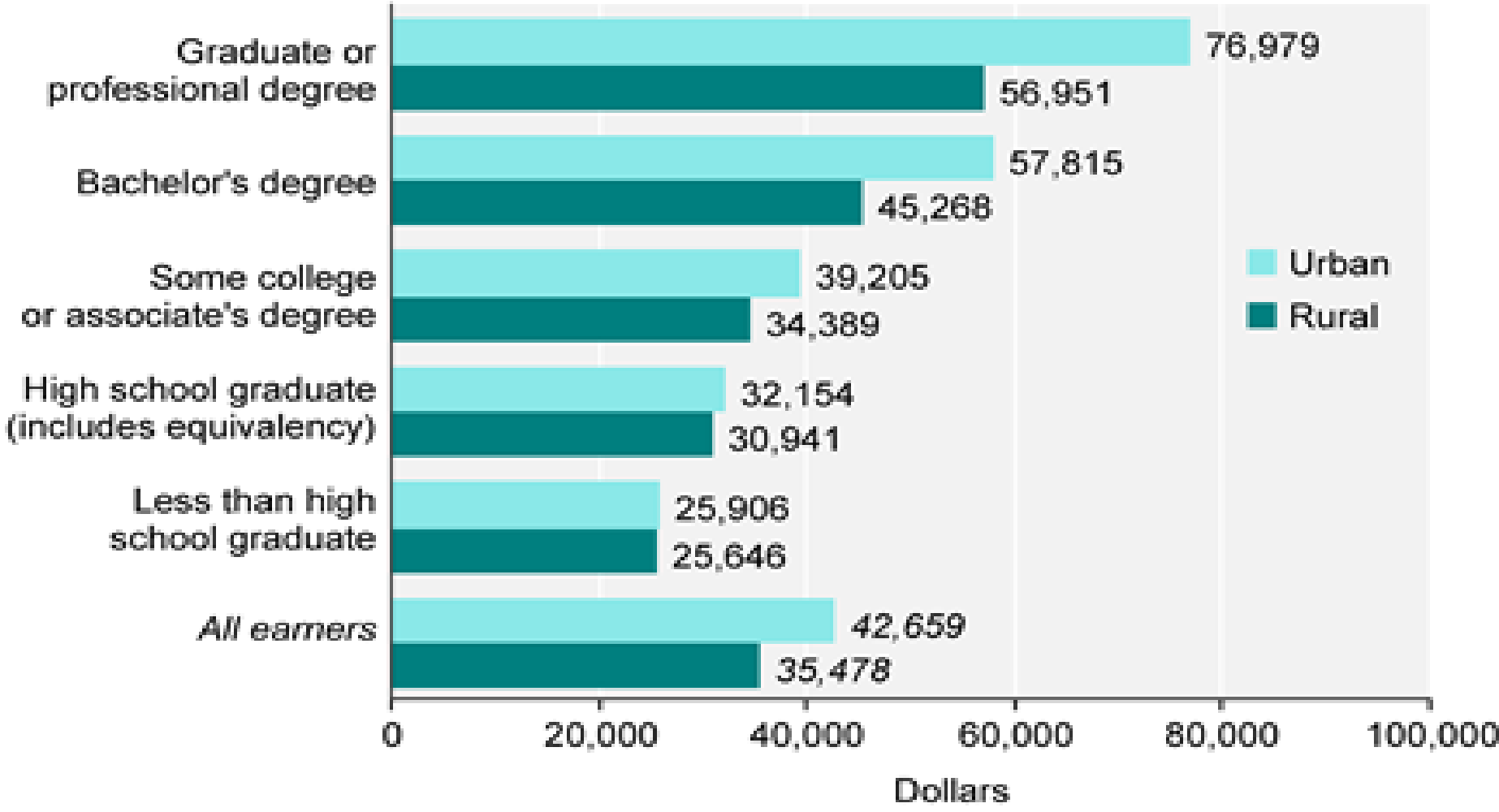
Note: Metro and nonmetro averages are calculated by weighting county median household income by ACS 5-year estimates of total households.

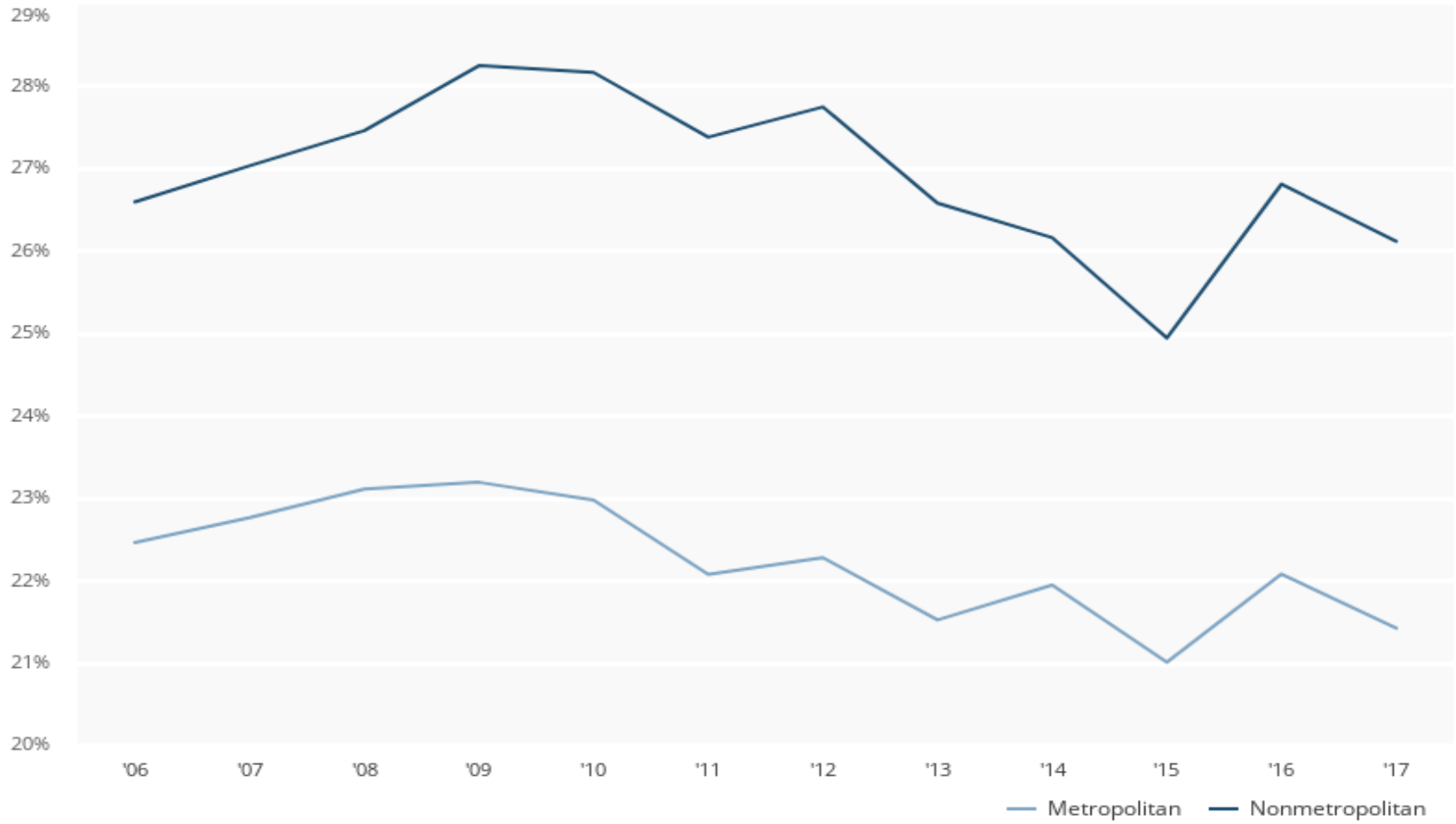
Source: US Census Small Area Income and Poverty Estimates, 2010-2021.

U.S. median earnings in rural and urban areas by educational attainment, 2019



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.

Leisure-time Physical Inactivity for Metro and Nonmetro Counties, 2006-2017



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Source: CDC Diabetes County Data Indicators, 2006-2017.

SDOH and Health Disparity: Rural LGBTQ+ Population

- 15-20 percent of LGBTQ+ population is rural, about 3-3.8 million. (R=62 m)
- About 10% of youth nationally identify as LGBTQ+ (LGBTIQA+ or Canada has LGBTQ2) and same for rural youth
- Live rural for the same reasons as others – rural way of life, nature, slower pace.
- Social and political landscape makes lives more vulnerable to discrimination.
- 23 states have strong laws against discrimination based on sexual orientation and gender identification. (Eastern and west coast but also MN and IA).
- 19 states have no explicit protection against such discrimination. (mainly south but MT and SD too.
- ND a bit nebulous as state law does not explicitly note this but Human Rights Commission does

(Source: Where We Call Home: LGBT People in Rural America, April 2019, Movement Advancement Project and Nondiscrimination Laws, MAP https://www.lgbtmap.org/equality-maps/non_discrimination_laws)

SDOH and Health Disparity: Rural LGBTQ+ Population

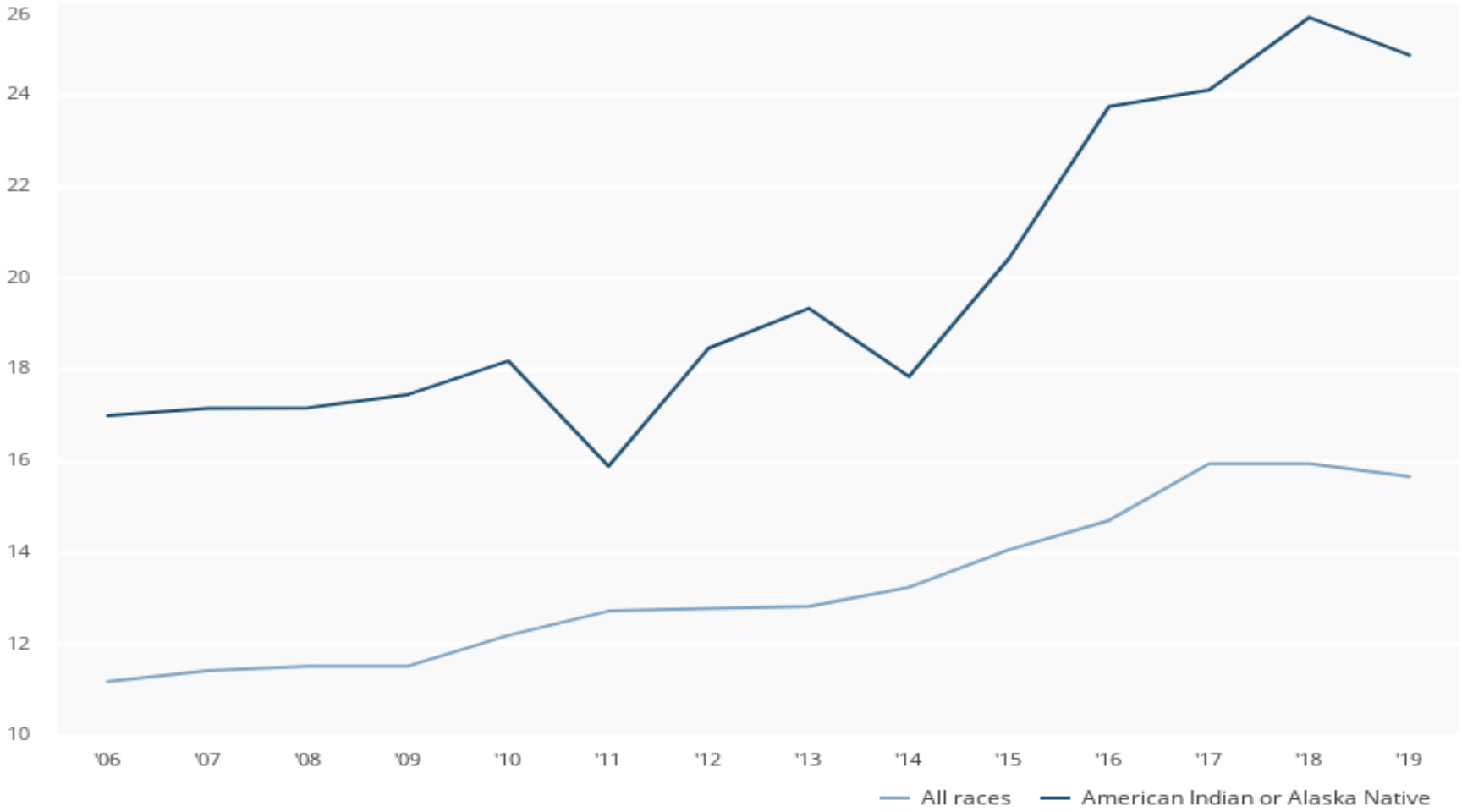
- 53% of LGBTQ+ pop live in a state that prohibits housing discrimination for the pop.
- 17% live in a state that interprets sex discrimination laws to cover sexual orientation/Gender Identity.
- 29 % of LGBTQ+ population lives in states that do not prohibit housing discrimination based on sexual orientation or gender identity (including 2% of LGBTQ population living in states that preempt local nondiscrimination laws).
- Challenges
  - Increased visibility
  - Ripple effects
  - Fewer alternatives in the face of discrimination
  - Less support structure
  - Family, Faith, and Community

(Sources: Where We Call Home: LGBT People in Rural America, April 2019, Movement Advancement Project and Nondiscrimination Laws, MAP https://www.lgbtmap.org/equality-maps/non_discrimination_laws)

SDOH and Health Disparity: Rural American Indian and Alaska Natives

- **Rural American Indian/Alaska Native (AI/AN) populations experience both personal and community disadvantages**. In 2016, rural AI/AN were:
  - More likely to live in poverty (29%) than their rural white peers (10%).
  - More likely to live in counties falling into the highest quartile in the US for the proportion of households in poverty (61% or rural AI/AN rural residents versus 46% of rural white residents).
  - More likely to live in persistent poverty counties (37%) of rural AI/AN versus 9% of rural white residents).
  - Rural AI/AN adults were much more likely to live in counties where > 16% of the population lacked health insurance (55% versus 19%).
  - Rural AI/AN age adjusted mortality rates were higher than those of white residents.
  - Prevalence of self reported poor/fair health was 23% for AI/AN versus 16% for white residents.
  - Higher obesity – 35% vs. 31%.
  - (Source: *Rural and Minority Health Research Center, University of South Carolina, July 2019).*

American Indian/Alaska Native Age-Adjusted Suicide Rates, Ages 15-34, 2006-2019



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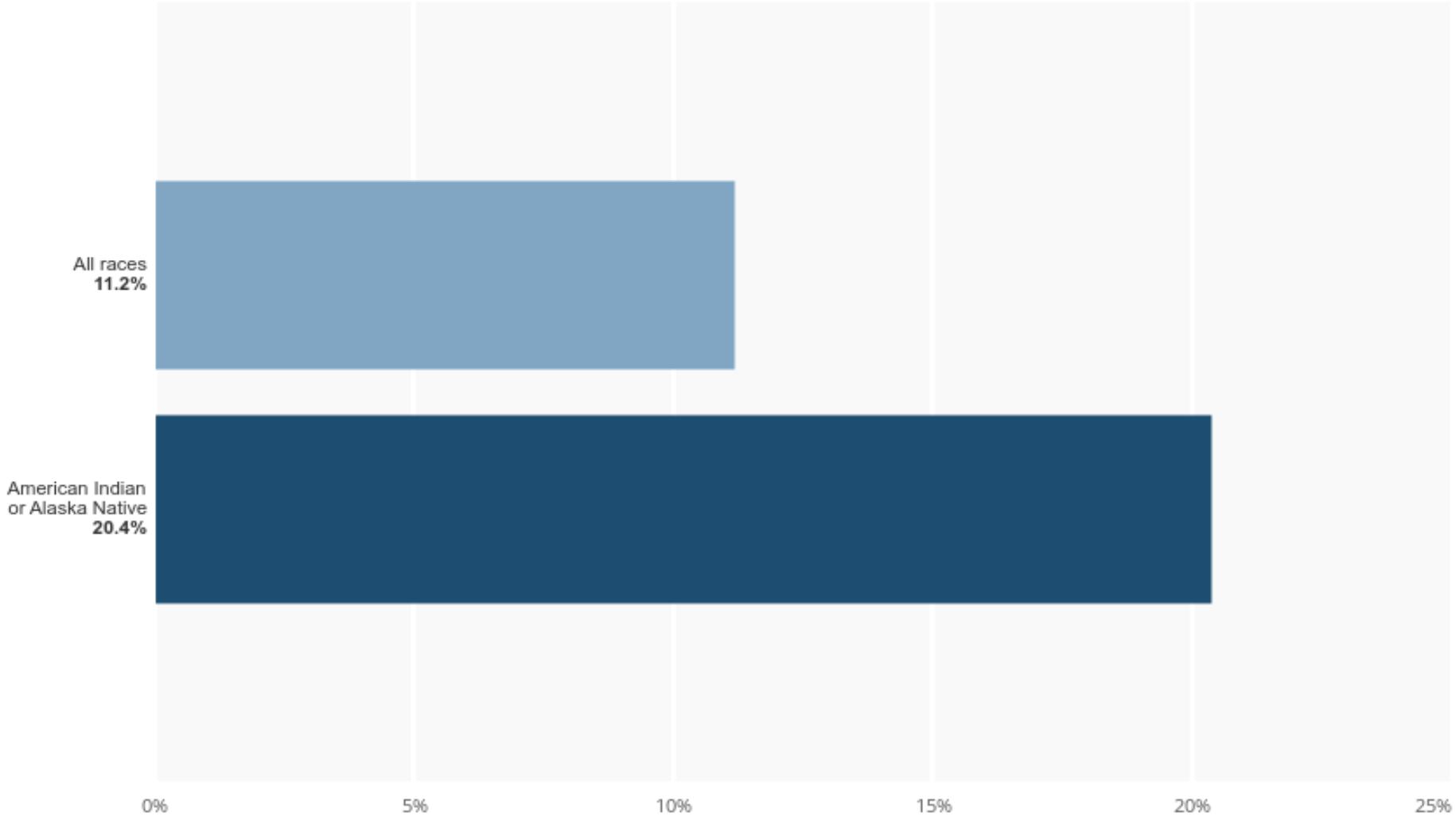
Source: CDC WISQARS, 2006-2019.

American Indian/Alaska Native Respondent-Assessed Fair-Poor Health Status, 2019



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Source: Health, United States, 2020 — National Center for Health Statistics.

SDOH and Health Disparity: Rural Housing Challenges

Some of the key housing concerns that impact health include:

- Plumbing and wastewater systems (or lack thereof), which can impact water quality and contribute to illness.
- Heating and cooling methods, which impact indoor air quality and safety, for example through the use of kerosene heaters.
- Lack of smoke alarms, carbon dioxide, and carbon monoxide detectors.
- Weatherization needs and energy costs, which impact whether a house can be maintained at a temperature healthy to its inhabitants.
- Safety concerns such as lead-based paint, mold, and pests.
- Overcrowding, which can spread communicable disease and also negatively influences issues such as substance abuse and domestic violence.
- Rural minorities are twice as likely as non-Hispanic whites to live in **substandard housing**.
- Rural renters are more likely to live in substandard housing and to experience multiple housing problems related to affordability, quality deficiencies, and crowding, compared to rural homeowners.

(Source: Rural Health Information Hub -RHI Hub)

SDOH and Health Disparity: Rural Transportation Challenges

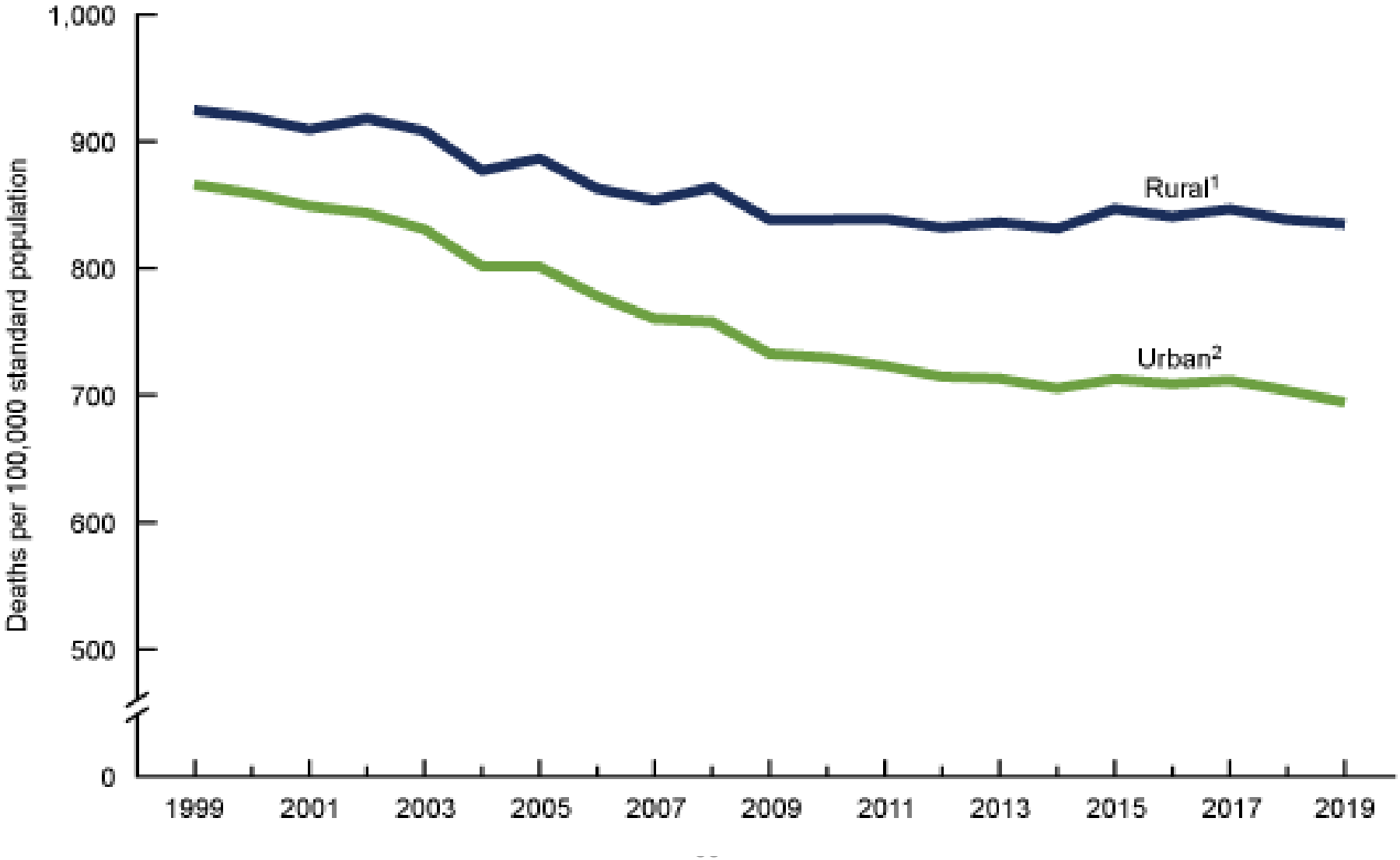
- **University of Minnesota Rural Health Research Center-** Key Informant interviews from 50 states (2017)

- **Issues**
  - Infrastructure
  - Geography
  - Funding
  - Accessibility
  - Political Support

Rural Mortality

- Cause-specific mortality is often higher in rural counties than urban counties
- Risk factors contribute to high mortality rates in rural areas
  - Smoking
  - Obesity
  - Physical inactivity
- High mortality rates and risk factors are a reflection of the physical and social environment in which people live and work

Age-adjusted death rates, by urban-rural classification: United States, 1999–2019



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

How do rural ND communities respond to SDOH issues?

Rural ND Addressing Community Health (CHNA)

- **Obesity and physical activity**
  - Community farmer's market
  - Pilot wellness programs with hospital staff
  - Monthly cooking classes
  - 12 week weight management program
  - Community run and/or walk
  - Support new community walking paths
  - Community access to school fitness center
  - CDM monitor program
  - Target fitness and exercise to elderly (stretching and movement)
  - Step competitions (pedometers)

Rural ND Addressing Community Health

- **Mental health**
  - Hire mental health nursing specialist in the hospital
  - Explore regional mental health shared service program
  - Develop mental health screenings in schools
  - Connect to "Behavioral Health Bridge" at UNDSMHS and UNDCONPD https://ruralhealth.und.edu/projects/behavioral-health-bridge
  - Support groups
  - Work with university MSW, counseling and psychology programs for student interns
  - Tele-mental health

Rural ND Addressing Community Health (CHNA)

- **Not Enough Jobs with Livable Wages**
  - Promote jobs in healthcare as they tend to provide high paying jobs. Jobs.net website lists all jobs by North Dakota community
  - Create a liaison between hospital and area economic or jobs development corporation to promote economic impact of healthcare jobs. North Dakota CAHs have an average economic impact of over $7 million (larger CAHs it is higher) and contribute about 220 jobs to the community
  - Start a local scholarship for health education with understanding recipient returns to the community for service for a specified period of time
  - NDSU Extension
  - Focused community dialogue on job gro

Rural ND Addressing Community Health (CHNA)

- **Child Daycare Services**
  - Offer incentives in the form of subsidies for licensed home daycare providers and/or subsidies to employees
  - Promote Child Care Aware of North Dakota as resource to find local child care centers
  - Offer extended Clinic hours, in evenings and weekends, for working parents
  - Offer hospital supported day care for healthcare employees
  - Securing grant funds to support a new community day care -10 families. (one CAH in 2022)

Where is North Dakota in this Discussion on Health Value?

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

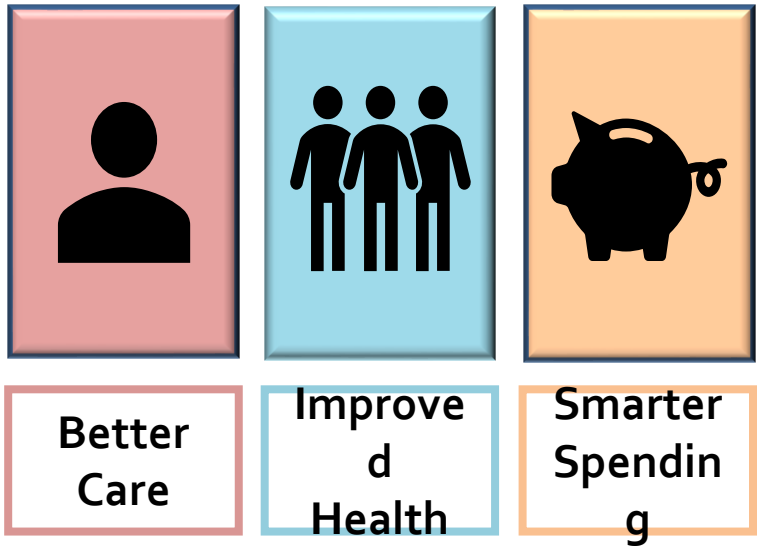
- **North Dakota Rural Health Value (ND RHV)**
  - CDC Health Equity funds –CRH over $3 million -5 projects (NA, Capital Improvement, Workforce, BH via Project ECHO, and Rural Health Value)
  - ND RHV – U of. IA, Stratis Health, HealthPoint Health – 1 year project.
  - 5 CAHs intensive, all 37 overview, 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.
  - 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.



ND Rural Health Value 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

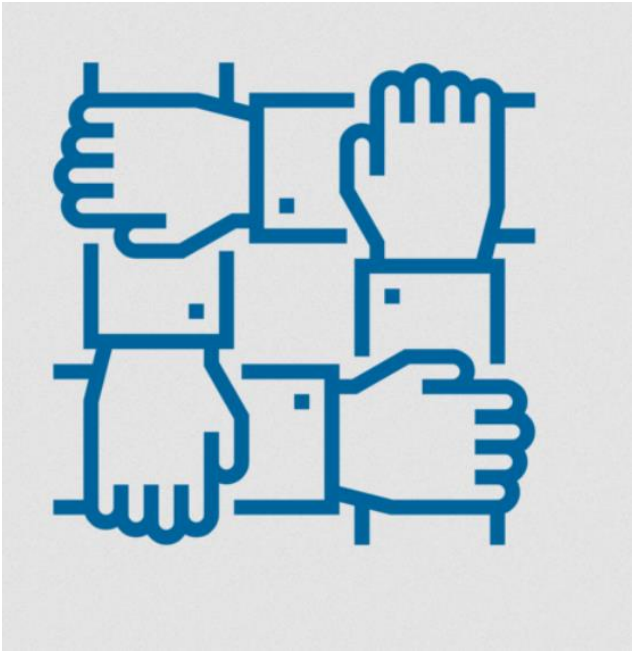
From Now Until When

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



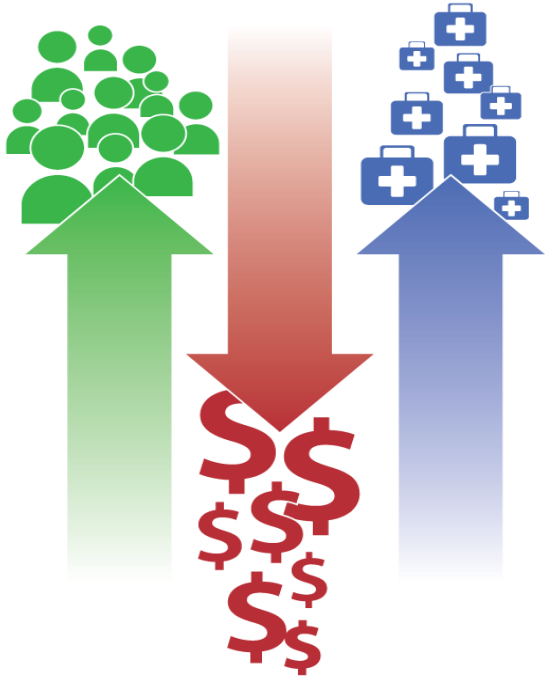
Value-Based *Payment*

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



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.

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.

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. Possibly Signify Health Medicare Shared Savings ACO. Also commercial.

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Per Ostmo, MPA, Program Director
Tel: (701) 777-6522 • per.ostmo@UND.edu

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Contact us for more information!

Center for Rural Health
UND School of Medicine and Health Sciences
1301 N. Columbia Road, Stop 9037
Grand Forks, North Dakota 58202-9037
Brad Gibbens (brad.gibbens@und.edu)
701.777.2569 (desk)
701.777.3848 (CRH Main #)
ruralhealth.und.edu


welcome to
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