Rural Health System Value-Based Care Innovators Roundtable: Strategies and Insights

October 2022

PURPOSE

The Rural Health Value (RHV) team convened the Rural Health System Value-Based Care (VBC) Innovators Roundtable to (1) better understand health system perspectives and experiences related to participation and support of their system's rural hospitals and clinics in value-based care and payment, and to (2) translate insights into strategies for health systems, rural hospitals, and rural clinics to advance adoption of VBC.

PROCESS

The RHV team identified a convenience sample of five health systems that include a substantial proportion of rural hospitals and clinics and actively support transition to VBC. Participating health systems included Ballad Health, Bryan Health, Essentia Health, MaineHealth, and UnityPoint Health. Collectively, these systems deliver care in 11 states in the Midwest, South, and Northeast regions of the U.S. The number of rural hospitals affiliated with each health system ranged from 11 to 24. Each health system had at least five years of value-based contracting experience.

System leaders were invited to participate in a process that included the following:

- *Initial group convening* to introduce group members to each other and this project.
- *Semi-structured interviews* with individual system leaders or leadership teams using a 12-question interview instrument designed by the RHV team and shared with interviewees in advance. The 90-minute interviews explored topics such as organizational structure, governance and decision-making, operations, data and communication, value-based contracts (with payers and clinicians), and social determinants of health (SDOH). Interview questions are appended.
- *Findings synthesis* by the RHV team into a set of themes and lessons learned.
- *Follow-up reconvening* of the participating system leaders to refine and confirm the themes and lessons learned and strategize how the project information could assist other health systems to advance adoption of rural VBC.

FINDINGS

The RHV team found considerable variation in value-based care and payment approaches among the systems. Nonetheless, common tensions and opportunities existed. Based on the interview instrument and the RHV team synthesis, six categories of interview responses emerged and are discussed below. VBC activity was generally described in the context of the Accountable Care Organization (ACO) payment model. While ACOs were the primary type of value-based payment referenced by the interviewees, they were not the sole type of payment model; others included pay for performance, shared savings, and alternative payment models. For ease of discussion, ACO is used as a global reference for the payment model in the remainder of this report.

1. Organizational Structure

The ACO was used as an organizing structure that in some cases existed as an independent entity and in other cases was housed within the system, for example, as a population health services line. When housed within the system, the ACO still operated relatively independently, with its own provider network and payer contracting. ACO participants generally included a mix of affiliated and independent facilities and providers across their rural service areas. Health systems found that tightly affiliated rural members (e.g., through ownership) were better aligned and VBC activity was more easily implemented than among loosely affiliated or independent members due to the former having established clinical integration and contractual relationships. Criteria used by health systems to evaluate a rural hospital's or clinic's participation in their ACO included factors such as quality scores, electronic health record (EHR) use, and board engagement. ACO membership in some systems required annual dues or management fees. Some ACOs included additional types of rural participation such as skilled nursing facilities, community health workers, and other community-based organizations with population health management roles.

- *Rural Insight* – Rural affiliates were increasingly seen by health system leaders as an important extension of the system, delivering patient-centered care in their local communities and consequently gaining health system leadership respect. Health system leaders reported that rural affiliates were eager to have more information that would help them improve the quality of care that they deliver locally.

2. Governance and Decision-Making

Organizational structure tended to drive governance; for example, all of the health systems had rural affiliates owned by the health system, while some also had independent rural sites participating in their value-based care and payment efforts. Decision-making authority varied among the health systems. One system took four years to formally affiliate and fully integrate all of their rural sites into VBC and emphasized that alignment of governance and communication was key to their success. Health system leaders indicated that their rural affiliates wanted a voice at the table to make sure that decisions were fair and balanced, and they collaborated for that purpose. They also acknowledged that rural primary care quality scores impact health system ACO performance measures and that critical access hospitals (CAHs) are essential rural healthcare providers.

In some systems, the health system board of directors served as the ACO board of directors. In other systems, the ACO had a separate and independent board of directors. Most systems emphasized the

importance of both administrative and clinical professional input, and most ACO leadership groups included a mix of clinical and administrative leaders. In one case, each affiliated organization chief executive officer (CEO) and chief medical officer (CMO) dyad had a single vote on the board.

Some health system ACOs included additional advisory groups that informed strategic decision-making. One health system had an ACO committee that made recommendations to an ACO council, another had regional governance groups, and yet another had an affinity group of rural hospital CEOs. One system involved market leaders in ACO decision-making through monthly payer and strategy meetings.

The health systems varied in the balance of central versus local decision-making. They noted that central decision-making was more efficient, but local decision-making was more sensitive to frontline issues. Most interviewees acknowledged the tension of balancing centralized governance efficiency and local input from their rural affiliates.

- *Rural Insight* – By including rural voices in ACO governance and decision-making to inform VBC program design, health systems addressed the challenges of balancing quality performance, ensuring rural access to care, and succeeding financially.

3. Operations

All health systems emphasized the operational importance of an integrated EHR supported by broadband connectivity for their rural affiliates. This, in and of itself, can be a challenge for rural sites. In fact, one health system described broadband connectivity as a SDOH in rural communities. That said, rural participation in the ACO through the health system means that the rural sites can leverage the technology and tools of a larger system and the health system benefits from a single integrated EHR.

The EHR serves not only as a clinical record, but also as a communication platform with quality dashboards, decision support tools, pharmacy information, and more. Clinical huddles and operations meetings were discussed by health system leaders as common tools for understanding issues, barriers, and challenges of their rural affiliates. One system used daily huddles to support the adaptive changes in human behavior that are needed to fully leverage the EHR and other technology. Operational alignment and information sharing require trusting relationships with members and independent facilities in rural as well as other areas.

One health system actively managed referrals through EHR prompts and other processes designed to guide referrals in-system and discourage referrals outside of the system. Furthermore, the health system guided in-system referrals to venues that were most cost effective. For example, a CAH might wish to discharge a patient to their in-house swing bed program, but the ACO would prefer to treat the patient in a skilled nursing facility to provide care more cost effectively. The referral guidance process can be challenging due to clinician desire for autonomy and because individual clinicians and facilities may still be paid (or services accounted for) based on service volumes.

Health system interviewees highlighted other important operational success factors such as facilitating physician buy-in through change focused on patient and community, developing team-based care, allowing “top of license” work, and recognizing that patients are attributed to primary care physicians, not CAHs or health systems. One system reported that the most engaged CAHs were those that had at least one key physician leader who is engaged and motivated to learn alongside the hospital partners how best to navigate the work of VBC. Several systems reflected on the importance of viewing their

entire system as a continuum of care and also acknowledged that such a health system viewpoint was in tension with local affiliates wanting to provide care in their own communities. Care transitions were noted to be a persistent challenge that requires ongoing attention and more comprehensive solutions than discharge follow-up phone calls. One system interviewee noted that about 50 percent of their patient attribution was rural, and that they were starting to consider their rural sites as a distinct group of affiliates with their own footprints, including different benchmarking methodologies, operations, and cultures.

- *Rural Insight* – One interviewee commented on the future of VBC based on operational observations: "Clinical care variation, including in rural, suggests that VBC is not a race to the bottom." Where there is clinical care variation, there are multiple opportunities for performance improvement.

4. Data and Communication

The small number of patients in rural facilities makes it difficult to design incentives dependent on statistically significant improvement that may be difficult to achieve That said, data are central to VBC success, and data analysis begins with an integrated EHR that includes quality dashboards and allows clinicians and staff to share information, assess performance, and manage patient panels. Though health system interviewees commented on the difficulty of getting claims data from non-Medicare payers, one health system used a population health platform that integrates EHR and claims data to better understand the full continuum of care for all patients and manage clinical care, cost, and utilization concurrently. Data were shared broadly among the ACO participating providers in the interest of reducing total cost of care, facilitating buy-in for ACO goals, and holding members accountable for those goals. Traditional care metrics like readmissions and hospital-acquired conditions are measured, and Healthcare Effectiveness Data and Information Set (HEDIS) and/or Medicare Shared Savings Program measures may be used for consistency.

One system used a quality report ("the heat map") to distill dozens of quality metrics down to a top 10 and then reported unblinded performance on the top 10 metrics to each member organization. A centralized value oversight committee reviews system performance, and each rural affiliate selects a limited number of measures from the top 10 for focused performance improvement at the local site. Another system provided data to rural sites by clinician, by region, and by employed versus independent physician status. Recognizing the importance of a communication strategy to support data-driven performance improvement, one health system used performance data to identify and hold face-to-face "value-based conversations" with local clinicians and leaders in rural as well as urban communities.

The health system leaders reported that multiple metrics, varying by payer and plan, were difficult to manage. Thus, all health systems prioritized certain measures for presentation and improvement attention. For instance, one system had dashboards for each VBC contract that included inpatient and outpatient utilization and spending, outflow, emergency department utilization, and referrals. Actionable information from the dashboards was shared with their rural sites. Although not available yet, one system hoped for an eventual outcome measure of "productive lives," or years of potential life lost (YPLL). YPLL is a variation on the quality-adjusted life years (QALY) concept.

- *Rural Insight* – Despite the low volume of patients served in rural facilities, data are key to driving quality and efficiency of care. Allowing rural leaders to select locally relevant

performance measures fosters trust and prioritizes quality improvement to the most pressing issues.

5. Contracts

Health systems maintained a variety of value-based payment (VBP) contracts (ACO and other types) with payers and affiliate providers. One system is signing only VBP contracts with payers and no longer accepting exclusively fee-for-service contracts (for plans with greater than 10,000 enrollees). Another health system suggested that payers were moving too quickly into VBC before the health system's affiliates could adequately transition away from historic payment systems and associated care processes.

Rural affiliates were not uniformly included in contract negotiations, and most systems acknowledged that the misalignment of incentives between large health systems and their rural affiliates was a significant impediment to collaboration within VBC. One system's solution has been to allow these rural hospitals to join the ACO and give them the discretion to select the contracts in which they wished to participate. This approach has been helpful to keep everyone engaged as VBC and payor strategies evolve.

Even in VBP contracts, payment may still be based on a fee-for-service platform, such as in the Medicare Shared Savings Program or pay-for-performance plans. Yet, one system representative pointedly noted that "everything changed when we assumed down-side risk" (i.e., accepting both the opportunity for receiving shared savings as well as the risk of financial loss), suggesting that leadership attention (in investments and operations) changed dramatically after accepting down-side risk.

Distribution of VBC investment and VBP shared savings varied across the health systems. Some retained all savings at the system level, while others shared savings based on the number of covered lives and quality performance. Some physicians continued to be paid fee-for-service, but one interviewee stated that performance incentives need to flow directly to those primary care teams that manage a patient panel to reward improved quality and lower cost.

Since hospital payment remains primarily fee-for-service, health systems acknowledged the challenge of paying hospitals adequately when effective VBC often reduces hospital utilization. Yet, all interviewees acknowledged that managing care differently for different payment contracts was extremely difficult, if not ethically questionable. Thus, all health systems agreed that best care and lowest cost should guide patient care.

- *Rural Insight* – VBP contracts are both a motivator and a tool through which health systems "learn-by-action" as they experiment with how to most effectively engage and reward rural affiliates in value-based care.

6. Social Determinants of Health (SDOH)

Attention to SDOH is a component of VBC for all health systems because it demonstrates a patient-centered approach to care, and also because it leads to better health outcomes. For instance, to provide discharge instructions in a way that may actually prevent a readmission, it is important to know if a patient has transportation to their follow-up appointment and can afford to pay for their medications. Some health systems were engaged in a contractual partnership with a social needs referral vendor such as UniteUs or FindHelp and used software, data warehouse, and analytic tools to gather information and

make closed-loop referrals to appropriate community-based organizations. Some had functionality built into their EHRs to assess for social risk factors and then make referrals through a vendor. SDOH screening generally focused on transportation, food, and economic security. Referrals often involved partnerships with organizations that are tailored to local rural needs and supports, such as social services, food shelves, schools, and the YWCA/YMCA.

Health systems also used care managers, utilization nurses, or community engagement specialists to help manage SDOH assessments and social needs referrals. One system developed an accountable care community of 300 organizations with a focus on such goals as getting children kindergarten-ready or working to ensure that students graduate from high school. This organization launched a program to allow anyone access to a common social-based network and they were reviewing referrals in the health record to ensure services were received. Not every health system was familiar with Z-codes to document social need, and those that were familiar with Z-codes used them minimally.

- *Rural Insight* – In rural communities, social needs referrals can be both simpler due to closer ties among partners and more complicated due to a shortage of resources.

SUMMARY

All health system leader interviewees were engaged and positive about the future of VBC. They described a variety of "tensions," or "growing pains," inherent in the transformation from fee-for-service to value-based care and payment. They also identified multiple opportunities. The tensions and opportunities highlighted below represent a combination of what the RHV team heard from the health systems as well as the RHV team's observations about the interviews and responses.

Tensions:

- Decision-making must account for both the efficiency of centralized decision-making and the importance of local input.
- Performance data selected for discussion and improvement must be both manageable and comprehensive.
- Differing urban and rural priorities, such as considering CAHs as an integral system component or a high-cost service site, must be accounted for.
- Investment both in facilities ("bricks and mortar") and in primary care infrastructure (e.g., compensation systems, team development initiatives, care coordination processes, and prevention and disease management systems) must be balanced.
- System policies and clinical care with both fee-for-service and value-based payment revenue must be managed equitably.
- The accounting of future revenue generation through reduced utilization and spending must consider that accounting policies and practices traditionally used by hospitals more readily apply to fee-for-service.
- Shared savings must be distributed equitably between individuals or organizations that invest in VBC and those that deliver VBC.
- Both independent provider autonomy and health system goal achievement must be considered and balanced.

- Hospital solvency must be ensured when VBC requires hospital volume reductions to reduce cost.

Opportunities:

- Frontline care teams should be paid for VBC. Value-based payments should not be restricted to healthcare organizations.
- VBC processes are evolving and are most evident in "robust" primary care practices.
- Referral management (including referrals to skilled nursing facilities) is critical to cost control, and health system VBP approaches must account for the importance of long-term care swing beds to the viability of many CAHs.
- Managing to a preset budget (e.g., a medical loss ratio or historic cost) is much more challenging than forecasting and managing units of service.
- As enrolled patients rather than delivered services become the currency of VBC, actuaries are needed in the Finance Department.
- Once leaders understand the opportunities of VBC, they do not want to return to non-risk-based contracts.
- Rural affiliates can be seen as extension of, and connected to, the system – bringing enrolled patients along with mutual respect and empathy.
- Data are central to success (EHR and claims data must be refined to be actionable).
- Leaders cannot communicate enough.

Overall, the findings from the VBC Innovators Roundtable demonstrate that there is no single model of health system ACO design, structure, and function that best addresses how rural health providers should be integrated into a health system VBC strategy. This fact may be viewed as a frustration for some rural partners, but an opportunity for others. Value-based care and management is challenging work, especially for rural hospitals with limited resources. Therefore, it is imperative that health systems that include rural hospitals and clinics devote time and effort to develop the areas which emerged in this project (organizational structure, governance, operations, data management, communication, contracts, and SDOH) to support rural hospital and clinic success in VBC, which ultimately enables rural healthcare organizations to do the right things for their communities. VBC is a better way to care for patients and increases accountability for meaningfully improving health. Ultimately, VBC is about "doing the most good for the most people." (John Findley, Bryan Health)

APPENDIX

Rural Health Value Roundtable – Health System Interview Questions

1. How does the type of rural affiliation (e.g., merger or management contract) impact the system's ability to advance value-based care?
2. How did value-based care and payment influence rural affiliation decisions and negotiations?
3. What system characteristics and operations will help the system's rural affiliates succeed in value-based care contracts?
4. What is the role of rural-based leaders, formal and informal, in value-based care strategic planning and operational decision-making?
5. Please describe the system's current value-based payment contracts.
6. How are value-based care implementation costs and value-based care payments distributed between the system and individual rural affiliates?
7. How does the system measure the success of value-based care (across the system, and/or at individual affiliates)?
8. How does the system address social determinants of health and/or health equity in value-based care efforts?
9. What community partnerships have advanced the system's value-based care efforts?
10. What are the challenges to value-based care sustainability?
11. What has been surprising about the system's value-based care experience?
12. What advice is needed for other health systems implementing value-based care in rural communities?

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