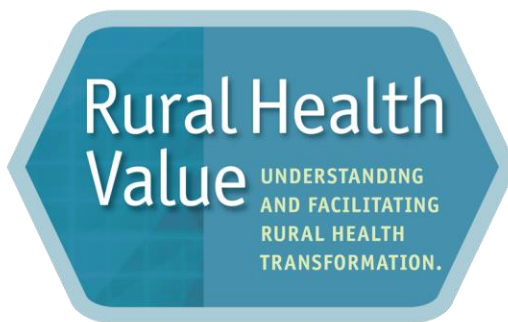

Rural Health Value Summit: Driving Value Through Community-Based Partnerships

EXECUTIVE SUMMARY

In June 2023, the Rural Health Value team hosted a virtual summit highlighting the efforts of four rural communities around the United States. A hospital representative and community partner from each community spoke about their efforts to screen for health-related social needs and address social determinants of health, including any efforts involving financial incentives, such as value-based payment models.

The experiences shared by the community representatives highlighted several opportunities for policymakers, payers, and health system leaders for building and supporting social needs infrastructure in rural communities:

Opportunity 1. Value-based payment models are still emerging, particularly in rural areas. Leverage opportunities to **support the design of value-based funding mechanisms** that include a focus on addressing health-related social needs and test them in rural communities.

Opportunity 2. The four communities highlighted cross-sector collaborations, with hospitals assuming different roles across their examples. **Help health leaders see the myriad of ways they can contribute**—beyond contributing financial resources or their 'usual' way of operating—to help unlock innovative partnerships. In addition, **equip leaders with the skills required to collaborate** (e.g., building trust, communicating value across sectors, aligning around a shared purpose, sharing power, etc.) to advance the state of cross-sector, social needs partnerships in rural areas around the country.

Opportunity 3. The community representatives highlighted a number of ways that **technology has played an essential role** in screening and addressing social needs. Examples of how they leveraged technology include EHRs, text messaging patients, and utilizing payor data sets. **Provide mechanisms to support sharing and scaling these practices which can lead to broader adoption.**

Opportunity 4. Community leaders voiced significant workforce constraints, whether in recruiting Community Health Workers (CHWs) or staffing community hospitals and social services. As social needs became more integrated with care settings, the futures of the two sectors become interdependent in important ways. **Leverage policy opportunities to help ensure attention is given to building and supporting the social needs infrastructure in a region.**

Possible next steps include additional convening of cross-sector rural leaders to explore the opportunities generated by the discussion and design and experiment with payment models that connect value-based payments with community-based organizations.

RURAL HEALTH VALUE SUMMIT: DRIVING VALUE THROUGH COMMUNITY-BASED PARTNERSHIPS

Rural Health Value is a national initiative funded since 2012 by the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) with the RUPRI Center for Rural Health Policy Analysis (RUPRI Center) and Stratis Health.

As part of a cooperative agreement, the Rural Health Value team hosted a virtual summit designed to bring community and health care leaders together in a small group discussion to share and explore insights, innovations, successes, and challenges in rural health work, specifically related to the intersection of rural providers and communities; value-based care and payment models; and the social determinants of health (SDOH). Health care and community leaders were invited to speak to:

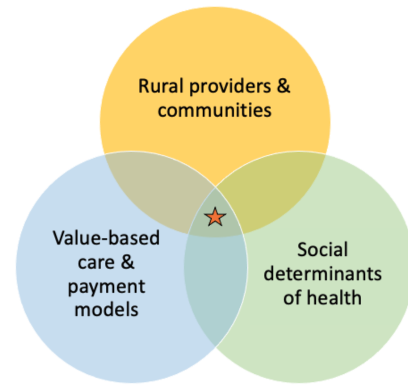

Figure 1. Intersecting interests explored through the Rural Health Value Summit.

- Health-related social needs screening and referral processes
- The design and structure of collaborative activities between health care and community-based organizations
- Partnerships and financial incentives, particularly between health care and community-based organizations

Criteria for selection. In deciding which communities to invite, the Rural Health Value team analyzed data from the 2021 social determinants of health supplement to an American Hospital Association survey. This supplement focused on hospital partnerships with outside organizations to support community members' social needs, as well as the number of social needs addressed through organizational programs and strategies. That analysis resulted in a list of potential hospitals to invite based upon their engagement with partners and internal efforts to address social needs. The list was reviewed with considerations to geographical representation from across the country and hospital 'type' (i.e., prospective payment, critical access). Invitations were extended to leaders in Iowa, Oklahoma, Michigan, and South Carolina. Representatives from Oklahoma recommended system partners in Rogers, Arkansas, who the team then also invited. Leaders from Arkansas, Michigan and South Carolina agreed to participate. In addition, members of Rural Health Value team reached out to contacts in their networks, with a focus on rural hospitals with innovative practices around SDOH and value-based payment. This generated invitations to leaders in Minnesota and Oregon and from this outreach, Oregon agreed to participate. All communities had hospital and community partner representatives participate.[1]

Format of the Summit. The Summit, which was held virtually, invited each community to spend fifteen minutes sharing their experiences at the intersection of rural providers and communities; value-based care and payments models; and health-related social need screening. A short discussion and Q&A period followed.

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[1] In Arkansas, the initial invitation was accepted by leaders at Mercy Health in Rogers; after some discussion they requested to bring leaders from their health system headquarters in St. Louis, Missouri who they felt were best positioned to speak to elements of their community partnership strategy which spanned the Mercy Health system.

COMMUNITY PROFILES

Arkansas

The Arkansas team was comprised of two leaders from Mercy Health Northwest Arkansas—based in Rogers, Arkansas—and two executive leaders from the Mercy Health, a large Catholic health system (of which Mercy Health Northwest Arkansas is a member)

Figure 2. Figure showing estimated impact of Mercy's health equity efforts.

The Mercy Health representatives shared their experiences in addressing health-related social needs by leveraging technology, cultivating a social needs partnership with the health plan Humana, and scaling up their efforts through innovative outreach. Mercy Health's strategy focuses not just on screening for health-related social needs, but also helping address them; their current focus is on addressing needs around access to care, transportation, medication adherence, and food security. Mercy's activities are currently funded primarily from the Mercy Health operational budget; the goal, however, is to demonstrate and capture savings from value-based contracts that are then reinvested to address social needs.

Mercy has leveraged their electronic health record (EHR) platform to better meet patients' social needs in two key ways. First, they standardized health-related social needs screening across care settings, integrating the screening into EHRs. When social needs are uncovered, patients are assigned a Community Health Worker (CHW) who helps connect them to local social service providers. Second, they automated referrals to CHWs in the EHR; this previously relied on a manual referral process which was, at best, unreliable and, at worst, did not happen. To help ensure ongoing communication across the system, the referral is noted as closed in the EHR once the CHW has contacted the patient.

As they began their social needs screening process, Mercy staff discovered they lacked good data to guide their work. However, the health payor, Humana, had more reliable data, and staff from the two organizations partnered to better address patients' health-related social needs and understand the impact of those needs on utilization, admissions, and re-admissions. In addition, Mercy was able to align their activities with those of Humana so they could access Humana's Care Managers and unlock additional benefits for their patients, including patient subsidies for social needs expenses like food, medications, and utilities.

Lastly, in scaling their efforts, Mercy began having CHWs "cold call" patients to share information on available programs and connect them with services. This effort was largely unsuccessful, so Mercy switched to mass text outreach, which increased both the percentage of patients reached and patients connected to social services by 10%.

Michigan

The Michigan group was comprised of two community leaders: a medical director and family physician in Northwest Michigan, and the Executive Director of Community Connections, a certified Pathways Community HUB located in the region. Both representatives are part of the Northern Michigan Community Health Innovation Region (NMCHIR), which was one of five pilots in the state funded with Center for Medicaid & Medicare Innovation (CMMI) State Innovation Model (SIM) funding, and the only rural site.

The Michigan team described how, in designing their response to the region's social needs, their focus has been on ensuring that if a health-related social need is uncovered that there are services available to address it, and that care providers are made aware of any activity or follow-up.
The region uses the Pathways Community HUB model, which offers a universal program where certified CHWs provide health navigation services. Called Community Connections, the region's HUB model is supported by 34 CHWs, housed in six local public health departments across the 31-county region. Patients are screened and CHWs coordinate care for those with identified social needs (i.e., transportation, food security, mental health, adult education, etc.).

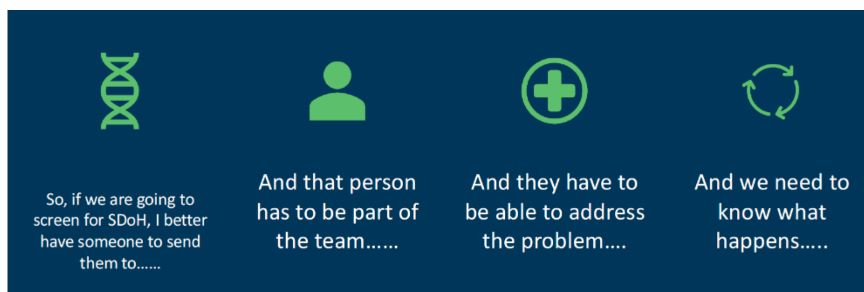

Figure 3. Ideal referral process from Michigan.

Community Connections also works to ensure that community voice and priority needs are integrated into local Community Health Needs Assessment and improvement processes so that investment decisions are informed by the unmet needs and perspectives of community members.

Despite the fact that NMCHIR has been able to demonstrate $1.21 in medical cost savings for every $1 of health navigation services, funding sustainability has been a challenge for the organization. Originally financed by funds from the region's SIM, that funding has ended, and the organization must seek new funding through grants and advocacy efforts.

The Michigan team spoke of two main barriers to their work: instability in funding requiring they engage in resource-intensive fundraising activities and impacting their ability to scale, and limited numbers of certified CHWs in the region, restricting their ability to serve greater numbers of patients.

Oregon

The team from Oregon consisted of the CEO of Samaritan Lebanon Community Hospital and a community leader of Partners for Health, a cross-sector health collaboration focused on addressing the region's social needs across three counties in western Oregon

The Oregon representatives spoke of their innovative efforts through the Coast to the Cascades Community Wellness Network (CCCWN), which was formed in 2010 with HRSA grant funding. This network brought together diverse community members including law enforcement, education, local nonprofits, care organizations. and more, in a collaborative partnership to improve the health and wellness of the region.

Figure 5. Membership of the Cascades Community Wellness Network

Samaritan saw significant value in convening the network and began the partnership by inventorying the care and social service infrastructure in the region and generating a Memorandum of Understanding (MOU), which was signed by all network members. The MOU stated the group's focus and outlined the roles and responsibilities of members. Central to the group's operations was the agreement that if the network agreed to a focus, members would take it back to their home organization and strive to get organizational support as needed.

Samaritan's leaders sensed the network would lend the region a competitive advantage in securing grant funds to support the region. Since its inception they have generated over $1 million in grant funding every year to support the health of the region. Keys to the network's success include members' ability to unite around a common vision, frequent communication and troubleshooting to ensure alignment across the membership.

The network's focus has varied over the years and has included people experiencing homelessness or unstable housing, food insecurity, opioid use disorder, and those with dental care needs. Recently, one of the network's coalitions, Partners for Health, began hosting an annual health summit where regional providers come together to learn about services they each offer and cultivate relationships and connections to better serve the residents of the area.

The biggest barrier to the work, as indicated by the team, is rural workforce development, which impacts Samaritan's ability to provide care and the region's ability to meet social needs.

South Carolina

Two representatives from McLeod Health-Cheraw spoke of their health system's efforts to address social determinants in the northeast region of South Carolina: the Assistant Director of Access Health at McLeod Health, and a family physician and medical director of McLeod's family medicine rural residency program.

Figure 6. McLeod Health Community Partners

In 2022, McLeod secured HRSA funding to create a family medicine rural residency program. Leaders felt fortunate to have the opportunity to design the program from scratch, embedding community connection at the core. The program's curriculum requires the family medicine residents to spend significant time at community sites, gaining first-hand experience of the abundance, as well as the challenges, that rural health care offers.

McLeod Health's recent transition of their EHR platform to Epic has enabled them to integrate social needs screening into care settings. Importantly, McLeod's leaders saw the transition as an opportunity to ensure that not only were the screenings integrated into EHRs, but that all the system's procedures and workflows supported the screening process. As part of their implementation plan, they consulted people across the organization—coders, providers, social workers, and others—identified gaps in knowledge and workflow, and created an improvement plan to address those gaps one by one so activities were integrated and worked towards a common goal.

Lastly, McLeod leverages the power of regional partnerships to address social needs, such as those with philanthropy, various health and wellness initiatives, and free clinics. Staff emphasized their focus on ensuring coalition work is collaborative and integrated.

OPPORTUNITIES REVEALED THROUGH THE DISCUSSION

All of the community representatives detailed innovative and committed action to address health-related social needs in their communities. It is clear they are passionate and dedicated to the work, and that the residents of their regions benefit because of their efforts. The experiences shared by the community representatives highlighted several opportunities for policymakers, payers, and health system leaders to build and support infrastructure to address social determinants of health in rural communities:

Opportunity 1. Sustainable financing for activities to address health-related social needs was a challenge mentioned by all participants and to-date there is limited connection between activities focused on addressing health related social needs and social determinants of health with value-based payment models. Participation in value-based payment models, particularly in rural areas, is still emerging; ensuring those models support social needs referral processes, such as those detailed by the community representatives, is a clear opportunity. The recent announcement of the CMS Medicare Physician Fee Schedule Proposed Rule proposes coding and payment changes for community health integration and SDOH risk assessment, including services provided by CHWs specifically. There are clear opportunities for payors and other system leaders to **support the design of value-based funding mechanisms that include a focus on addressing health-related social needs and test them in rural communities.**

Opportunity 2. Hospitals are positioned to play different roles in different contexts (e.g., neutral convener, backbone, bridge builder, technology resource, etc.). Oftentimes leaders in a region can get locked into roles they have played for years and do not envision all the ways they could contribute to regional partnerships. Sharing these various roles can **help health leaders see the myriad of ways they can contribute**—beyond contributing financial resources or their 'usual' way of operating—and help unlock innovative partnerships. Second, **equipping leaders with the skills required to collaborate** (e.g., building trust, communicating value across sectors, aligning around a shared purpose, sharing power, etc.) could advance the state of cross-sector, social needs partnerships in rural areas around the country.

Opportunity 3. The community representatives highlighted a number of ways that technology has played an essential role in screening and addressing social needs. Examples of how they leveraged technology include EHR integration, text messaging patients, and utilizing payor data sets. **Provide mechanisms to support sharing and scaling these practices which can lead to broader adoption.** It is important to note that technology is not a panacea to address social needs. Collaboration—built on trust, shared value propositions, and shared interests—must lead, with technology in an assistive role.

Opportunity 4. Community leaders voiced significant workforce constraints, whether in recruiting CHWs or staffing community hospitals and social services. As social needs became more integrated with care settings, the futures of the two sectors become interdependent in important ways. There are opportunities to **ensure attention is given to building and supporting the social needs infrastructure in a region**. This could include assisting health providers in inventorying their community's social needs infrastructure, prioritizing a set of social needs to focus on, building bridges between health and social service providers, and more.

POSSIBLE NEXT STEPS

Convene cross-sector leaders to explore the opportunities generated by the discussion. Opportunities to explore these questions in a more focused manner, with a broader contingent of cross-sector leaders could be beneficial in deepening understanding, designing experiments, and generating insights that could unlock new approaches, and help identify policy solutions to address key challenges.

Design and experiment with payment models that connect value-based payments with community-based organizations. Grant funding is often unreliable and will not sustain the innovative efforts by groups like those spotlighted at the Summit. Creating opportunities to increase alignment of value-based payment models and addressing health-related social needs and social determinants of health—either directly or through operational investments and strategy—could advance this work in important ways. There are also opportunities to develop new payment models that incorporate community-based organizations in value-based financial incentives such as shared savings.

The Rural Health Value team is grateful to the following individuals who generously shared their experiences and insights as part of the Rural Health Value Summit. Thank you for all you do to better the lives of the people in your community.

Arkansas

- *Dr. Lisa Low, Medical Director for Community Health, Mercy Hospital Northwest Arkansas*
- *Corina Huston, Community Health Worker, Mercy Hospital Northwest Arkansas*
- *Cindy Rydberg, Executive Director Mercy Population Health, MercyHealth*
- *Rocco Gonzalez, Community Health, Access and Informatics Director, MercyHealth*

Michigan

- *Jenifer Murray, Executive Director, Community Connections*
- *Dr. Jim Whelan Medical Director of Northern Michigan Care Partners and Munson CIN*

Oregon

- *Marty Cahill, CEO, Samaritan Lebanon Community Hospital*
- *Dr. Jeannie Davis, Assistant Director of Population Health Science, Western University Medical School*

South Carolina

- *Dr. Susan Robins, Family Physician & Program Director, McLeod Family Medicine Rural Residency Program*
- *Lorene Godbold, LMSW, Assistant Director of Access Health Pee Dee, McLeod Health*

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