

The Rural Health Care Coordination Network Partnership Program: Critical Access Hospital Network of Eastern Washington

This practice brief is part of a series developed by the NORC Walsh Center for Rural Health Analysis and the University of Minnesota Rural Health Research Center to highlight findings from the Evaluation of the Rural Health Care Coordination Network Partnership Program. The Federal Office of Rural Health Policy provided funding support for the program and its evaluation.

RURAL HEALTH CARE COORDINATION NETWORK PARTNERSHIP PROGRAM

Over 50 million people live in rural areas in the United States and are at higher risk for developing chronic illnesses than their urban peers.¹⁻³ The increasing prevalence of chronic disease in rural areas and the high cost of health care in the U.S. are intensifying the demand for high-quality, high-value services that effectively meet this population's physical and behavioral health needs.

Despite certain barriers (e.g., incompatible electronic health record systems across providers), redesigning health care systems in order to better coordinate patients' care is important.⁴ Individuals with complex health conditions often require care from both primary care and specialty providers, and may be unsure how to access or navigate these services. In addition, providers may not always communicate with each other regarding test results, treatment plans, and other aspects of a patient's care.

In response to these concerns, the Federal Office of Rural Health Policy (FORHP) developed the Rural Health Care Coordination Network Partnership Program (Care Coordination Program). Under this program, eight grantees received funding to support the development or expansion of formal rural health networks that focus on coordinating care for three chronic conditions: type 2 diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Grantees are encouraged to develop innovative approaches, demonstrate improved health outcomes, and employ evidence-based care coordination strategies that address the prevalence and management of at least one of the three chronic conditions. The three-year grant program began in September 2015.

The NORC Walsh Center for Rural Health Analysis (NORC), in partnership with the University of Minnesota Rural Health Research Center, is contracted by FORHP to serve as the Care

Coordination Program's external evaluator. The evaluation focuses on the implementation, impact, context, and sustainability of the Care Coordination Program. Key grantee-specific findings to date will be shared in a series of practice briefs. The focus of this brief is the Care Coordination Program developed by the Critical Access Hospital Network (CAHN) of Eastern Washington¹.

Grantee Program Area Served

- *Located in three counties in western Washington.*
- *Compared to the Washington state averages, the area population is older, less educated, and more likely to live in poverty.*
- *Population reports high rates of diabetes, heart disease, smoking, obesity, high cholesterol, and high blood pressure.*

GRANTEE BACKGROUND

The CAHN was established in 2002 with funding from members and the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) Rural Network Grant Program and continued support from the state's Rural Hospital Flexibility Program, also funded by FORHP. The CAHN is an integrated network of 15 hospitals and 24 rural health clinics in eastern Washington that collaborate to achieve administrative, operational, and clinical efficiencies. Initially focused on unifying Health Information Technology (HIT) efforts, the CAHN expanded over time to address collective contracting, workforce issues, performance improvement, and market shifts from volume-based to value-based payment models. When the Rural Health Care Coordination Network Partnership Program grant (Care Coordination grant) opportunity was announced by FORHP in January 2015, the CAHN expanded existing efforts and relationships to implement a promising care coordination program for rural settings.

¹ Since this site visit, the CAHN has become the Northwest Rural Health Network.

State Context and Key Partnerships

Washington's Health Home program provides a roadmap for the CAHN's care coordination program. Initiated in 2013 under a Medicaid State Plan Amendment, the program supports a range of services intended to improve the integration and quality of care for high-cost, high-risk Medicaid beneficiaries. Under the state program, Managed Care Organizations (MCOs) operate as Health Home Leads, contracting with local entities such as Care Coordination Organizations (CCOs) to provide services at the local level. These care coordination services include, but are not limited to, assisting with identifying and meeting patient-directed goals, coordinating medical care, and managing referrals to community and social support services. Health Home Leads are responsible for overseeing a network of CCOs and carrying out key administrative functions, such as reporting to the state on financial, health status, and performance outcome metrics, and paying CCOs based on the services they provide.

The CAHN and Molina Healthcare (Molina), the largest Medicaid MCO in the state and a Health Home Lead, previously worked together to use claims data to better target network services for Medicaid patients. Expanding on this collaboration and leveraging both the Health Home program and care coordination grant funding from FORHP, the CAHN assisted four rural health systems from the CAHN network in contracting with Molina as CCOs. Under these contracts, the health systems provide care coordination services to eligible Molina members and are reimbursed on a per-member, per-month (PMPM) basis. The Health Home PMPM reimbursement structure uses three payment tiers driven by the level of patient need: 1) initial engagement and action planning; 2) intensive care coordination; and 3) low-level care coordination. The tier level assigned to each patient is intended to reflect the overall frequency of engagement and activation level of the patient and/or their caregivers.

Private Funder Engagement

While the Health Home program provides a service and reimbursement structure for the CAHN's care coordination program, CAHN leadership was aware that it would take time for the program to become sustainable. FORHP strongly encouraged care coordination grant applicants to augment their grant proposal submissions with commitments from private foundations. The CAHN was also awarded a three-year grant from the Empire Health Foundation (EHF), a philanthropy in eastern Washington. EHF is committed to supporting rural health issues,

particularly the impact of health services on the ability of older adults to age safely in their homes, a strong fit for care coordination. EHF funds were secured by the CAHN to partially support the costs of a grant director and the analysis of program data, allowing the majority of the FORHP funding to be directed toward the initial salary for care coordinators (CCs) at the four health systems.

In June 2017, program evaluators from the NORC Walsh Center for Rural Health Analysis, contracted by FORHP, conducted a two-day site visit to learn how the CAHN implemented its program. This brief presents an overview of what was learned regarding program structure, impact, and challenges.

HOW IS THE PROGRAM STRUCTURED?

Target Population

To be eligible to receive services provided under CAHN's program, Medicaid patients must select Molina as their MCO and meet the state's eligibility criteria—have at least two chronic conditions or one chronic condition and the risk of developing another, and have a high score on the state's Predictive Risk Intelligence System (PRISM) index. Eligible patients are referred to the program in two ways: (1) from primary care providers (PCPs), who identify individuals who would benefit from care coordination; and (2) from Molina, based on patients' claims data.

Partners and Approach

Four CAHN health system members contracted as CCOs under Molina (the Health Home Lead). These health systems provide services to communities in Adams, Lincoln, and Pend Oreille counties in Eastern Washington.

When a patient enrolls in the program, the CC develops a Health Action Plan (HAP), which includes several health status assessments (e.g., Body Mass Index and depression screening) and the Patient Activation Measure (PAM). PAM is an evidence-based tool used to assess a patient's knowledge, skill, and confidence for managing his or her health condition. This information is used by the CC and patient to prioritize care. The Health Home program requires three HAP submittals per year (baseline, four months, and eight months) for each patient. Molina supports the four CAHN health systems' HAP monitoring by producing monthly dashboards of completed HAPs and progress-to-date for patient-defined goals. HAPs are usually completed during home visits or at the clinic.

Following the initial HAP completion, CCs meet with enrolled patients at least once a month and provide services based on each patient's care plan (See Care Coordinator Services below).

Care Coordinator Services

- Health promotion and education
- Transitional care and follow-up
- Individual and family support
- Referral to community and social services

WHAT IS THE PROGRAM'S IMPACT?

Enhancements in Care

By July 2017, the program had provided care coordination to 26 eligible patients. CCs reported that patients ranged in age and often had multiple co-occurring issues, including substance-use disorders and other behavioral health challenges. The most frequently cited physical health issues were type 2 diabetes and chronic obstructive pulmonary disorder (COPD).

While it is too early for the CAHN to provide health outcomes at the patient level, providers and care coordinators provided anecdotal evidence of early success. One provider described how a health system's CC successfully reached out to a woman living in an RV in a remote area. The woman suffered from multiple physical and behavioral health issues and was frequently a no-show to provider appointments. The CC helped her find a new place to live with improved access to important quality-of-life amenities, such as a functioning shower. The provider reported that the woman now regularly keeps her appointments and is able to focus on her health needs in a way that she could not before. The provider further highlighted how the CC, with her unique perspective on patients' lives informed by home visits, has been valuable in helping him understand barriers to patients' compliance with treatment plans.

"[The Care Coordinator] made a huge impact in [the patient's] life and in my life as provider."
-Physician Assistant

Improved Capacity to Offer Care Coordination

Care Coordination Structure

While provider engagement varies across the four health systems, providers are learning the advantages of having CCs who can help address barriers to patient health. The CAHN determined that a tight integration of the care coordinator into

the primary care team is the most effective model. This integration allows for optimum communication between the care coordinator and the provider, which results in enhanced patient engagement and improved information flow.

Training

All CCs are required to participate in a two-day training course for the Health Home program. The core curriculum covers information on high-risk patient outreach, inappropriate emergency department utilization reduction, missed appointment reduction, and the fundamentals of population health management. Molina has additional care coordination webinars available; however, those classes tend to address issues in urban settings. Based on feedback from the CCs regarding a need for training on the theories and activities essential to care coordination, the CAHN developed an additional training series with FORHP collaboration to provide more foundational information on care coordination. This training included a focus on how to provide ongoing support and link patients with community services.

Readiness for Value-Based Payment Models

All four health systems completed the contracting process to become CCOs for Molina. This contract was the first value-based contract that any of the health systems had entered into with an MCO, and provides an opportunity to test whether the payments are sufficient to sustain these efforts in a rural setting. The CAHN reported that its goal is to use this experience, including knowledge about the infrastructure necessary for providing, tracking, and billing services, to approach other Medicaid MCOs in the future. Establishing a care coordination program is also increasing each health system's capacity to obtain Patient-Centered Medical Home (PCMH) recognition, which improves the RHCs' ability to negotiate contracts and participate in future value-based payment programs.

WHAT CHALLENGES HAS THE PROGRAM FACED AND WHAT LESSONS HAVE BEEN LEARNED?

Time Required for Building Program

While becoming a CCO for Molina enabled the health systems to receive reimbursement for care coordination services, the CAHN reported that it took longer than expected to establish CCO contracts. Molina's processes had to be adapted to better fit the structure of rural primary care practices, which are generally less well-resourced than their

urban counterparts. The CAHN reported that the health systems are now in a better position to help other rural primary care providers enroll in the Health Home program.

The CAHN also reported that each of the four participating health systems began at a different stage in the implementation of care coordination. For the RHC with care coordination experience, adopting the new state Health Home model meant additional training, new policies and workflows, and adapting to a more structured care coordination approach. For the RHCs with no experience, implementing the Health Home model meant establishing the program from the ground up.

Staffing

Under the original Health Home model, CCs must be clinical or non-clinical professionals, such as registered nurses (RNs), advanced registered nurse practitioners (ARNPs), psychiatric ARNPs, social workers, mental health social workers, chemical dependency professionals, or counselors. Health systems reported difficulty finding CCs who held appropriate clinical credentials in their areas. Three of the four health systems used registered nurses from within their organizations to provide the care coordination services. These health systems reported that this was a strain on their workforce, and expressed concern over not having the resources to share nurse time with the care coordination program. Administrators advocated for using medical assistants (MAs) as CCs. They reasoned that MAs are easier to hire in rural settings and often have fewer demands on their time than RNs. In October 2017, grant leadership reported that Washington's Department of Health and Social Services and Health Care Authority approved the use of MAs as CCs based, in part, to the experience of the four rural health systems in this project. Health system administrators also noted rural workforce shortages as a barrier to adequately staffing and implementing the program.

Two health systems experienced more CC turnover than they were expecting. The CAHN highlighted the importance of hiring individuals with home-visit experience and an understanding of the social determinants of health. The health system experiencing the most success with the Health Home model had a CC with a strong social work background. Yet, while nurses must shift from a clinical perspective to a more community-based approach when providing care coordination, they bring deep expertise in disease management.

State-Wide Model to Rural Settings

The Health Home model, developed in urban settings, includes a structured set of required services and a defined reimbursement amount. This model requires a robust infrastructure to support all related processes and activities; rural CCs have had to adapt the model to the resources and services available in their areas. For example, home visits are a required part of the Health Home program; visits in rural settings require significantly more time and effort than home visits in urban settings. Reimbursement rates are the same for urban and rural CCs and do not take into account the additional "windshield" time that rural CCs require. Molina is advocating for the state to modify reimbursement rates for rural CCs to help address these differences.

Unintended consequences of the Health Home model in rural areas, such as a reduction in hospital revenue, may also pose challenges. Care coordination is intended to decrease avoidable hospital admissions and Emergency Department visits; the CAHN noted that reductions in hospital and ED utilization may jeopardize the financial viability of a Critical Access Hospital, particularly when there is no shared savings program that benefits a hospital's revenue.

Adapting the model to rural settings also has consequences for program-level sustainability. According to Molina, the number of patients eligible for the program in each rural health system is small, ranging from 10 to 55 patients. Molina has calculated that a caseload of 50 to 60 enrollees is needed to sustain one full-time CC. At Molina's recommendation, the CCs started slowly, in order to develop familiarity with the model. As of July 2017, the number of eligible patients enrolled at each clinic ranged from 0 to 23. The CAHN, Molina, and the CCs all expressed concern about building a large enough caseload to sustain a full-time CC. While Molina is the dominant MCO in the area, the Molina representative recommended that health systems consider joining other Health Home Leads or other initiatives, such as the Accountable Communities of Health (ACH) program that is a regional community-based care coordination program under the state's Medicaid demonstration project. Most small rural health systems do not have the financial resources to initiate a program and cover all costs unless caseloads are fully developed, particularly because there can be delays in receiving reimbursement from the state. The FORHP grant funding and philanthropy funds have made program

implementation possible for the four CAHN health systems.

Tracking and Utilizing Data

While the Molina information technology (IT) system will eventually provide valuable metrics for tracking program progress, CCs reported that the system can be difficult to use. Incorporating the system into existing workflows and cross-referencing between the Molina system and existing electronic health records has been a challenge. For example, one CC reported having to “double document” so that information was accessible to both Molina and health system providers. In addition, internet connectivity is required to access the Molina IT system, which is often a challenge in remote, rural home-visit settings; Molina is developing an application to alleviate this issue. Given the delays in implementation and enrollment, the CAHN will begin analyzing clinical and care coordination measures by the end of 2017.

Evolving Market Forces

There are a large number of practice transformation activities and initiatives in Washington promoting the transition from volume-based to value-based payment models. The CAHN reported that most members are currently participating in the Health

Home program and also in Accountable Care Organizations or initiatives to transform clinical practices. In addition, a community-based care coordination program called Pathways will be implemented as part of the state Medicaid demonstration project work across the region in 2018. While these initiatives are intended to target different populations, staffs must coordinate and align program activities and requirements. Such alignments can be a burden on rural health systems with limited resources. The CAHN reported that based on its experience with the Care Coordination grant, it has worked with the Washington Department of Health to convene a working group to coordinate practice transformation efforts underway in the state. The CAHN also plans to create tools to support rural health systems that participate in multiple value-based payment programs that require program-specific data reporting.

CONCLUSION

The CAHN has successfully navigated a number of challenges through its support implementing the Health Homes program in rural eastern Washington. These experiences highlight unique opportunities and challenges that may help other rural providers and networks as they move forward in collaborating

with Medicaid MCOs and other payers in new, value-based delivery and payment models.

REFERENCES

1. Downey, L.H. (2013). Rural Populations and Health: Determinants, Disparities, and Solutions [book review]. Preventing Chronic Disease; 10:130097. Available at: http://www.cdc.gov/pcd/issues/2013/13_0097.htm
2. Dallas, M.E. (2012). COPD Deaths Highest in Rural, Poor Areas: CDC. HealthDay News. Available at: <http://consumer.healthday.com/diseases-and-conditions-information-37/misc-diseases-and-conditions-news-203/copd-deaths-highest-in-rural-poor-areas-cdc-669692.html>
3. American College of Chest Physicians. (2012). Poverty, rural living linked to increased COPD mortality in the US. Science Daily. Available at: <http://www.sciencedaily.com/releases/2012/10/121022080655.htm>

For More Information:

FORHP Care Coordination Grant Funding Announcement:

<https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx?id=e3af9abe-a716-4a40-be96-b8273fac43f6>

Washington State Department of Social and Health Services' Health Home Program Page:

<https://www.dshs.wa.gov/altsa/washington-health-home-program>

Rural Health Information Hub Rural Care Coordination Toolkit:

<https://www.ruralhealthinfo.org/community-health/care-coordination>

Rural Health Information Hub Articles and Video Highlighting Philanthropic Partnership:

<https://www.ruralhealthinfo.org/rural-monitor/care-coordination-partnership/>

<https://www.ruralhealthinfo.org/rural-monitor/rural-health-philanthropy-partnership/>

<https://www.youtube.com/watch?v=tQN1ta1MOVs&feature=youtu.be>

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