PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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TUESDAY, SEPTEMBER 19, 2023

PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO*
LAWRENCE R. KOSINSKI, MD, MBA
WALTER LIN, MD, MBA
TERRY L. MILLS JR., MD, MMM
SOUJANYA R. PULLURU, MD
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT PRESENT

JOSHUA M. LIAO, MD, MSc

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO),
Office of the Assistant Secretary for
Planning and Evaluation (ASPE)
STEVEN SHEINGOLD, PhD, ASPE

*Present via Webex

A-G-E-N-D-A

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1 P-R-O-C-E-E-D-I-N-G-S

2 9:02 a.m.

3 * CO-CHAIR SINOPOLI: Good morning and
4 welcome back to day 2 of the public meeting of
5 the Physician-Focused Payment Model Technical
6 Advisory Committee, known as PTAC. My name is
7 Angelo Sinopoli. I'm one of the Co-Chairs of
8 PTAC along with Lauran Hardin next to me, here.
9 Yesterday, we began our day with opening
10 remarks from CMS[1] Deputy Administrator and CMMI[2]
11 Director Dr. Liz Fowler, and she offered some
12 context on how our work fits into the
13 Innovation Center's vision. We also had
14 several guest presenters share their ideas on
15 encouraging rural participation in population-
16 based total cost of care models.

17 * **Welcome and Co-Chair Overview -**
18 **Overview of Discussion on**
19 **Encouraging Rural Participation in**
20 **Population-Based TCOC Models Day 2**

21 Today, we have another great lineup
22 of experts for two more listening sessions. We
23 have worked hard to include a variety of
24 perspectives throughout the two-day meeting,

1 Centers for Medicare & Medicaid Services
2 Center for Medicare and Medicaid Innovation

1 including the viewpoints of previous PTAC
2 proposal submitters who addressed relevant
3 issues in their proposed models. Later this
4 afternoon, we'll have a public comment period.
5 As a reminder, public comments will be limited
6 to three minutes each. If you have not
7 registered to give an oral public comment but
8 would like to do so, please email
9 ptacregistration@norc.org. Again, that's PTAC
10 registration at N-O-R-C dot org.
11 Then, the Committee will discuss our
12 comments for the report to the Secretary of
13 Health and Human Services that we will issue on
14 encouraging rural participation in population-
15 based total cost of care models.
16 * **PTAC Member Introductions**
17 Because we might have some new folks
18 online today who weren't able to join
19 yesterday, I'd like the Committee members to
20 please reintroduce themselves today. Share
21 your name, your organization, and if you'd
22 like, you can tell us some experience you may
23 have had with our topic. I will cue each of
24 you as we go around the room.
25 I'll start. I'm Angelo Sinopoli.
26 I'm a pulmonary critical care physician by

1 training, spent many years as a Chief Clinical
2 Officer in a large health system, running a
3 large clinically integrated network with all
4 product lines. Most recently, I'm the Chief
5 Network Officer for UpStream, which is a value-
6 based enablement company for networks and
7 primary care physicians. Lauran?
8 CO-CHAIR HARDIN: Good morning. I'm
9 Lauran Hardin. I'm a nurse by training and
10 Chief Integration Officer for HC2 Strategies.
11 I spent the better part of the last 20 years
12 focused on building care coordination and
13 integration models for underserved populations.
14 Currently working deeply on Medicaid waiver
15 implementation in many rural counties, and am a
16 founding member of the National Center for
17 Complex Health and Social Needs. And when I'm
18 not traveling around working with communities,
19 I live in rural Appalachia, in Kentucky.
20 CO-CHAIR SINOPOLI: And we have at
21 least one PTAC Committee member online. So,
22 Jay, can you introduce yourself?
23 DR. FELDSTEIN: Sure. My name's Jay
24 Feldstein, trained in emergency medicine,
25 practiced emergency medicine for 10 years, and
26 then was in the health insurance world for 15,

1 commercial and governmental plans. And for the
2 last 10 years I've been the President of the
3 Philadelphia College of Osteopathic Medicine,
4 and we've operated a primary care center in
5 rural Pennsylvania. As well as, we've opened a
6 medical school in rural Southwest Georgia,
7 Moultrie, a town of 15,000 people. So, we've
8 got a very vested interest in rural health
9 care.
10 CO-CHAIR SINOPOLI: All right, thank
11 you, Jay. So, I'm going to look to my left and
12 go to Jennifer.
13 DR. WILER: Good morning. I'm
14 Jennifer Wiler. I'm the Chief Quality Officer
15 at UCHealth in the metro area of Denver,
16 working with one of the largest health systems
17 in the Rocky Mountain region. I'm also a
18 tenured professor at the University of Colorado
19 School of Medicine and an emergency physician
20 by training, and I co-founded our Health
21 Systems Care Innovation Center where we partner
22 with digital health companies to grow and scale
23 their solutions. And I was a co-author of an
24 Alternative Payment Model considered and
25 approved and endorsed by this Committee.
26 DR. WALTON: Good morning. Jim

1 Walton. I'm currently serving in a role as a
2 health care consultant, and I just recently
3 retired from a role as a CEO of a large
4 physician IPA[3] in Dallas, Texas, creating an
5 ACO[4] that had multi-payer contracts. Prior to
6 that, I was at Baylor Healthcare System as
7 their Chief Health Equity Officer, and
8 practiced internal medicine in Waxahachie,
9 Texas.
10 DR. KOSINSKI: I'm Larry Kosinski.
11 I'm a gastroenterologist by training. I
12 practiced in the Chicagoland Metropolitan Area
13 for 35 years in clinical practice, retiring in
14 2019. I'm currently the Chief Medical Officer
15 and founder of SonarMD, a company that was
16 developed following a successful proposal here
17 at PTAC back in 2017. For the last 10 years,
18 I've been involved with value-based care,
19 developing full-risk contracts in the
20 gastrointestinal space.
21 DR. LIN: Good morning. I'm Walter
22 Lin, an internist by training. Founder of
23 Generation Clinical Partners. We are an
24 independent medical group in the St. Louis-

3 Independent physician association
4 Accountable Care Organization

1 Southern Illinois area, focused on caring for
2 the frail elderly in senior living, and helping
3 senior living organizations transition into the
4 world of value-based care.
5 DR. BOTSFORD: Good morning. I'm
6 Lindsay Botsford. I'm a family physician in
7 Houston, Texas, and I work with a company
8 called One Medical. I help care for our senior
9 practices as Chair of our ACO REACH[5] entity.
10 So, we care for older adults on Medicare in
11 full-risk, total cost of care contracts.
12 DR. PULLURU: Good morning. Chinni
13 Pulluru. I'm a family physician by trade, 20-
14 plus years in the health care value-based care
15 transformation and clinical operations space.
16 Most recently Chief Clinical Executive of
17 Walmart Health Omnichannel Care, and led their
18 clinical operations. Prior to that, I led
19 DuPage Medical, now Duly, a large multi-
20 specialty group in suburban Illinois. Thank
21 you.
22 DR. MILLS: Good morning. My name
23 is Lee Mills. I'm a family physician. I'm
24 Senior Vice President and Chief Medical Officer
25 for CommunityCare of Oklahoma, where for 30

5 Realizing Equity, Access, and Community Health

1 years we have operated a total cost of care
2 capitated model health plan owned by two
3 providers operating in the Medicare Advantage,
4 commercial, and exchange space. And prior to
5 that, was involved in medical group leadership,
6 coming through a whole variety of CMMI models.
7 Thank you.

8 *** Listening Session 2: Incentives for**
9 **Increasing Rural Providers'**
10 **Participation in Population-Based**
11 **Models**

12 CO-CHAIR SINOPOLI: Great, thank you
13 all. So, with all those introductions we'll
14 move forward to our first listening session of
15 the day, Incentives for Increasing Rural
16 Providers' Participation in Population-Based
17 Models. So, at this time, I'm excited to
18 welcome the experts for our first listening
19 session of the day. We've invited three
20 outside experts to present their thoughts on
21 some financial incentives with potential to
22 improve the management of care transitions.
23 You can find their full biographies posted on
24 the ASPE PTAC website, along with their slides.
25 After all three have presented, our Committee
26 members will have plenty of time to ask

1 questions.

2 Presenting first, we have Dr. Alana

3 Knudson who is the Project Director of the

4 Pennsylvania Rural Health Model Evaluation and

5 Director of NORC Walsh Center for Rural Health

6 and Senior Fellow at NORC at the University of

7 Chicago. Welcome, and please begin, Alana.

8 DR. KNUDSON: Excellent. Thank you

9 so much for inviting me. Next. I always begin

10 my presentations with, why should rural areas

11 matter to you? And I begin this because I

12 think it provides an important context. Rural

13 areas are not only the source of much of our

14 food, drinking water, energy production, and

15 outdoor recreation, but one-in-five Americans,

16 including a disproportionate number of veterans

17 and active-duty military, live in rural

18 communities. Making the study of health needs

19 and challenges of rural Americans essential to

20 us all.

21 And I begin with this to also

22 provide a context about the interdependence

23 that we have between rural and urban providers.

24 It is critical that we address the health needs

25 of rural Americans because they also depend on

26 urban providers, and our rural providers work

1 in great partnership with urban providers. And
2 in order to ensure the economic viability of
3 rural and urban communities, it's important for
4 us to address the needs in our rural
5 communities across the country. Next, please.
6 I'm going to share some lessons
7 learned that we've had with rural participation
8 in some Alternative Payment Models. One of the
9 key lessons that we've learned is that it's
10 very important that we include rural health
11 experts in value-based payment discussions.
12 Not only with CMS and CMMI, but also with
13 private and commercial payers. And this also
14 includes rural finance experts.
15 We have seen numerous times,
16 particularly for Critical Access Hospitals,
17 that participating in some of these models
18 makes it very challenging because of the cost-
19 based reimbursement structure that these, some
20 over 1,300 Critical Access Hospitals across the
21 country operate. And so, it's important to
22 ensure that they have a seat at the table when
23 not only designing but also implementing.
24 It's also critical that we look at
25 aligning rural providers to meet population
26 thresholds, and I think I can take you back

1 years ago when the Medicare ACO beneficiary
2 attestation thresholds were too high and did
3 not allow any rural providers to participate.
4 And that really was the impetus to begin
5 Caravan Health, and recognizing the Medicare
6 beneficiary attestation, for example, is an
7 important piece in looking at how we address
8 those population thresholds.
9 Likewise, we need to look at how
10 rural quality reporting programs are
11 implemented and followed, particularly for
12 small volume providers both in the clinical, as
13 well as in the small hospital space. Many of
14 the different programs are optional in rural,
15 but we need to ensure that our rural providers
16 also have consistent clinical quality metrics
17 so that we are able to monitor over time the
18 quality of care that is being provided.
19 We already know that our rural
20 providers are serving a disproportionate number
21 of vulnerable people in their communities.
22 But, putting a rural provider at financial
23 risk, when many of our rural hospitals in
24 particular are running at small to negative
25 margins, makes participating in these programs
26 particularly risky, and many of them opt not to

1 participate. So, it's important to think about
2 how we can invite innovative ways for rural
3 providers to participate, even given those
4 particular challenges.
5 I think it's also important to
6 recognize that we have some serious innovation
7 fatigue among our rural communities. And I'll
8 give you an example. I worked with a number of
9 frontier hospitals in Montana, those are
10 hospitals serving counties with fewer than six
11 people per square mile. They implemented a
12 community health worker program that was in
13 place for three years. At the conclusion of
14 the program, the grant funding went away, and
15 one of the CEOs shared with me that, although
16 it was an incredibly successful program and the
17 community greatly valued the services that the
18 community health worker provided to the
19 community, because there were insufficient
20 funds locally to continue that community health
21 worker position, the CEO was then hung out to
22 dry, so to speak, because he was no longer
23 meeting a need that the local community felt
24 was valuable.
25 So, many rural providers,
26 particularly those that have been early

1 adopters, where a program has either
2 discontinued or was altered in some way, it may
3 be more difficult to get rural providers to
4 participate in the future. Next slide, please.
5 There are some considerations when
6 we're designing these population-based total
7 cost of care models. And, as I said, it's not
8 only important to encourage and engage our
9 rural providers in the discussion, we also need
10 to bring our community partners together.
11 Particularly for models that rely on our
12 advancing health equity, by addressing the
13 social determinants -- and I like to call them
14 drivers -- of health in the community.
15 It's also critical that we determine
16 success metrics before implementation. Another
17 key example is that, for many rural hospitals,
18 financial viability is their number one success
19 metric. However, many of the value-based
20 payment models don't include financial
21 viability as the number one success model many
22 of these are looking at for cost savings. We
23 need to make sure that the success metrics are
24 aligned.
25 Likewise, it's very important to
26 provide up-front funds, not only to support

1 implementation requirements but also to help
2 our rural providers in developing
3 transformation plans as they move from volume
4 to value. And we've seen this time and time
5 again as part of our Pennsylvania evaluation of
6 the rural health model. That is one of the
7 comments that the participating hospitals
8 shared with us as part of that evaluation. It
9 would have been very helpful for them to have
10 up-front funding to be able to get these care
11 coordination models and requisite resources in
12 place before the model started.
13 Likewise, it's also important to
14 minimize the new and additional staff and
15 financial requirements that some of these
16 models require. As you know, many of our rural
17 providers have limited resources, and so when
18 we require them to provide additional data
19 submissions, that usually requires additional
20 staff. One of the comments that our rural
21 providers have shared with us is, please do not
22 include models that also then require us to
23 recruit additional staff. Frankly, we've had a
24 long-term workforce challenge in many of our
25 rural communities and adding staff,
26 particularly with expertise in data analytics,

1 is a tremendous challenge for them.
2 Likewise, it's really important that
3 there is some type of technical assistance
4 that's provided, not only during the model
5 application but also to support those
6 implementation and ongoing data needs, as well
7 as being able to track progress. Next slide,
8 please.
9 Another consideration for our rural
10 communities is really to look at that continuum
11 of care. Looking at the long-term services and
12 supports, how the public health community and
13 services connect, as well as the role of
14 community-based organizations. One of the
15 greatest pain points that I am hearing in our
16 rural communities right now is with regard to
17 post-acute care. Swing beds are particularly a
18 concern for our rural providers, so thinking
19 about how all of these different types of
20 services align to be able to ensure that the
21 rural residents have access to the care that
22 they need, but also that they are sufficiently
23 reimbursed to ensure that that care can be
24 continued in those communities.
25 Of course, it's very important that
26 we align model implementation and performance

1 expectations across multiple payment systems.
2 Time and time again, rural providers have
3 shared that there are different metrics,
4 different expectations for data reporting, and
5 this is really untenable for a number of our
6 rural providers. So, thinking up front, how we
7 can align these will best serve our rural
8 providers in participating in value-based
9 models?
10 Likewise, ensuring that payers are
11 within the same model design so that they, our
12 rural providers, don't have to try to manage
13 again different types of quality metrics, for
14 example, as well as payment systems. Because,
15 again, with limited staff capacity, this makes
16 it very difficult to actively participate.
17 Next, please.
18 We also recognize that there are
19 challenges with low volumes in performance
20 expectations, particularly with regard to
21 savings. And I'm going to jump down to the
22 fourth bullet. It is critical that we
23 recognize the relative difference between costs
24 directly attributed to patient care, which are
25 variable costs, as compared to cost of
26 infrastructure required to support patient

1 care, regardless of patient volume. Those
2 fixed costs, those are the costs that are
3 required in order to meet conditions of
4 participation.
5 There are also a number of costs for
6 rural providers that are necessary for
7 readiness, such as for emergency medical
8 services, and those need to be factored in.
9 Because, one of the challenges that our rural
10 communities have is that issue of surge, and we
11 definitely saw that during COVID, as well as
12 different types of weather and other natural
13 disasters that our rural providers have
14 responded to.
15 It's also challenging to look at
16 potential avoidable utilization reductions to
17 reduce the overall payer expenditures, because,
18 again, this cost reduction is in the short
19 term, and it doesn't affect those fixed costs
20 that are foundational to be able to meet those
21 conditions of participation. It's also
22 important that, as I mentioned before, that we
23 look at including the recommendations from the
24 2022 National Quality Forum, the MAP[6] Rural
25 Health Workgroup Report, that also provides

6 Measures Application Partnership

1 important quality measures that can be used
2 when we're looking at implementing new models.
3 Last slide, please.
4 It's important, as well, to link
5 financial risk to performance other than cost
6 savings if financial risk is mandated. This is
7 a big issue for many of our rural providers,
8 and it's also a concern not to place essential
9 local services at financial risk, including
10 primary care, public health, and EMS[7]. And
11 again, I'll give you a concrete example. I
12 visited a frontier hospital that had, not only
13 the Rural Health Clinic co-located but also
14 public health, and they had to move public
15 health out of the facility. And, by the way,
16 this is a community of 1,100. The public
17 health had to find a different facility because
18 it played negatively into the cost report. So,
19 again, we do not want to put our essential
20 local health services at financial risk.
21 Also, applying financial risk only
22 to aspects of performance controlled by the
23 model participants is important. Because, one
24 thing that we often see in our rural
25 communities is that, a patient will receive

7 Emergency medical services

1 some type of surgical care or intensive medical
2 care in an urban tertiary, they are released,
3 and they come home and they show up in the ED[8],
4 for example, in a rural community. And it is
5 important not to put those types of care
6 provisions at risk.
7 Also, thinking about models that
8 don't rely on fee-for-service, again, because
9 of that fixed cost, because of the low volume,
10 think about opportunities per member per month,
11 as well as other types of capitation. Also,
12 looking at reducing innovation and alignment
13 barriers through regulatory waivers.
14 Particularly, for example, if you're looking at
15 the Chronic Care Management using, for example,
16 community paramedicine in some of our rural
17 communities.
18 And lastly, I have a number of
19 resources for you at the end of this
20 presentation. We are part of the Rural Health
21 Information Hub Partnership. We develop and
22 design all of the toolkits that are provided to
23 provide support for rural providers as they
24 transition from volume to value. There's also
25 another important slide called, “Am I Rural.”

8 Emergency department

1 And lastly, the Federal Office of Rural Health
2 Policy funds rural health research centers to
3 conduct analyses specific to the implementation
4 of rural programs. Thank you.
5 CO-CHAIR SINOPOLI: Great. Thank
6 you, Alana, that was a great presentation.
7 Next, we'll hear a presentation from Dr. Tom
8 Lee who is the Chief Executive Officer of
9 Galileo. Tom, go ahead.
10 DR. LEE: Thanks for having me. My
11 name is Tom Lee. I'm a primary care internist
12 by training and currently lead an organization
13 called Galileo. It's a new care model really
14 designed to improve the quality and
15 affordability of care for all Americans, but
16 particularly focused on rural and underserved
17 communities. Next slide, please.
18 Just as context, my background, I
19 did my medical training in the rural Northwest,
20 so I have worked in a variety of rural care
21 settings and have used that kind of experience
22 to inform my perspective on how rural care
23 could be reimagined. Most of my career has
24 been focused on entrepreneurial activities,
25 focused on improving the quality and
26 affordability of care. First, at a mobile

1 device company called Epocrates, thinking about
2 point-of-care decision-making on pharmacy
3 information. Then, at One Medical, thinking
4 about how do you innovate on the primary care
5 model, really looking at mostly urban
6 populations? And ultimately, leading to my
7 current journey on building Galileo, which is
8 really looking at how do you serve last mile
9 populations more effectively and efficiently
10 with a higher-quality model? Next slide.
11 Just a bit of background on how we
12 approach care in the rural and underserved
13 communities. At Galileo, we've really tried to
14 look at care in general and break it down into
15 the components that need to be most effectively
16 delivered. Because, you know, care in the
17 primary care setting, particularly in rural
18 environments, is particularly challenging.
19 Putting the resource where it is best fit, with
20 the right skills, is kind of what the goal has
21 been to kind of service rural communities.
22 So, what that means is, we operate a
23 digital-first model of care where appropriate,
24 for populations that can interact with a
25 digital form factor. That includes phone-based
26 and other consultative services, digitally and

1 remotely delivered. And then, we also go to
2 the home as the other first place of care when
3 frail and elderly patients cannot really travel
4 to the office, we really look to meet patients
5 in the home, particularly under -- around
6 complex and capitated frameworks.
7 And then, we operate brick and
8 mortar where needed as the second place of
9 care. So, it's a bit of an inversion of the
10 traditional care model. We wanted to design a
11 care model that could scale much more reliably
12 across rural communities and, almost by
13 definition, be less dependent on brick and
14 mortar to do so. Next slide.
15 We were asked to talk a little bit
16 about some of the challenges related to rural
17 medicine as it relates to infrastructure, but
18 obviously there are many other dimensions and
19 challenges well-described in the presentation
20 and preparatory materials here. But, we'll
21 talk a little bit briefly about our perspective
22 on how we look at some of the infrastructure
23 challenges. Obviously, there's the connectivity
24 lens, but we also think about labor and time
25 matching as an infrastructure-related
26 challenge. Skills matching, facilities

1 capabilities, and payment alignment are all
2 kind of interrelated to the underlying
3 architecture of what creates challenges in,
4 particularly, rural environments. Next slide.
5 How we thought about it at Galileo
6 is really just to start to look at each
7 dimension and solving for, how do you be more
8 effective with more patients more cost
9 efficiently to make the feasibility of
10 operations in low-density markets more
11 possible? So, obviously, connectivity can be
12 an obstacle, but we really look at multi-
13 modality. We're agnostic to the form factor,
14 so yes, cellular and/or broadband access can be
15 limited in some markets and regions, but the
16 landline is also available as are home
17 modalities if and when needed.
18 When we look at the -- next slide,
19 please -- the home modality is particularly
20 challenging, given labor and time matching
21 challenges. And so, whenever we've looked at,
22 how do you operate within low-density markets,
23 it's constantly, how do you get the right
24 supply to the right demand in the most cost-
25 efficient manner, to make the model operate,
26 work within most payment frameworks? This is

1 probably the most challenging aspect, we think,
2 to rural medicine.
3 And I do think that some
4 infrastructure, meaning tech, data, and/or
5 connectivity solutions can help facilitate some
6 of these labor challenges. But, a discipline
7 around matching the appropriate supply to the
8 demand is one of the key aspects that we found
9 to be critical to managing a sustainable
10 practice in rural environments.
11 And then -- next slide, please --
12 the third dimension, which is related to labor
13 and time matching, is skills matching. And
14 obviously, there's a dearth of the right
15 specialists in the right markets for the right
16 communities. And so, what we try to do is
17 leverage remote connectivity, remote skills,
18 and a team-based approach to care that can make
19 what we call, fixed cost, behave more variably
20 so that the expertise can be delivered across a
21 broader geography, where appropriate. So,
22 those are some ways that we've looked at it,
23 specific to these areas.
24 Lastly, on the next slide, we just
25 talk about more broadly ways to think about
26 advancing, kind of, rural health and value-

1 based care innovation across these five
2 dimensions. On workforce, we really think
3 about workforce training, workforce supply, and
4 how do we improve the ability for the workforce
5 to be up-leveled in any given local community,
6 given the challenges.
7 The second is obviously member
8 density. We think about how can partnerships
9 across communities, within communities, further
10 reduce the challenge to member density as a
11 dimension to kind of consider?
12 The third is really looking at, how
13 do you improve the regulatory and reimbursement
14 frameworks to support home-first care? We
15 think that these are important, critical
16 aspects to care, provided that the regulatory
17 and reimbursement flexibility is there. On a
18 related note, the tech enablement, certainly
19 during the pandemic, there were exceptions to
20 payment that facilitated tech-enabled care. We
21 would like to see those continue, particularly
22 as we're looking to innovate into rural
23 communities with more supportive
24 infrastructure.
25 And lastly, the investment.
26 Thinking about facilitating utilities or other

1 data or tech hubs that can help facilitate the
2 up-front investment that might be needed by
3 individual practices or communities that could
4 be supported more centrally. So, those are
5 some dimensions to consider. And thanks for
6 the time.

7 CO-CHAIR SINOPOLI: All right.
8 Fascinating presentation, really appreciate
9 that. So, next, we're excited to have Dr.
10 Randy Pilgrim who is the Enterprise Chief
11 Medical Officer at SCP Health. Welcome, Randy,
12 and go ahead.

13 DR. PILGRIM: Thank you very much.
14 Thank you to the Committee for hosting this,
15 thanks to my colleagues. The next slide will
16 give you an overview of what I want to use for
17 my initial comments here. I was asked to
18 comment on the unique health equity challenges,
19 so I'll briefly touch upon that, because again,
20 we have a very learned audience here today.

21 I want to review the most important
22 measures for social determinants of health, and
23 health-related social needs, and I will spend a
24 little bit of time reviewing examples of prior
25 value-based models that may be applicable and
26 instructive for how we consider rural-based

1 transformation into the value-based world.
2 And particularly, potentially how to
3 approach integrating health equity into value-
4 based transformation as we review those things.
5 And then as my colleagues have already
6 addressed in some fashion, increasing the
7 probability of participation by clinicians in
8 future value-based models. The next slide just
9 is a fundamental slide. Again, I will spend
10 only a little time here.
11 But I do want to point some basic
12 definitions, and an index that I'll use a
13 little later when I share some data. Equity of
14 course is about creating the level playing
15 field where everyone has the opportunity to
16 achieve their full health potential.
17 Disparities arise when there are preventable
18 differences. So, health equity volatiles in
19 value-based transformation really should go at
20 preventing differences that are in fact
21 preventable.
22 The social determinants of health we
23 know well now, and thankfully there are even
24 more data and information that are growing
25 about this. But they can yield to health-
26 related social needs, the unmet or adverse

1 social conditions that do contribute to the
2 poor health, and are frequently arised from
3 those social determinants.
4 And finally, new to some of you
5 perhaps is the Area Deprivation Index, a zip
6 code-based ranking of socioeconomic
7 disadvantage, where a high number is bad or
8 more challenging, a low number is better or
9 less challenging. I'll review that in the
10 data. Next slide. As we know, rural
11 populations often experience disproportionate
12 challenges in health-related social needs.
13 It's well known that health rural
14 communities are 19 to 20 percent, so one out of
15 every five Americans lives in a rural
16 environment. Although variably defined, it is
17 defined often. Lower income, more uninsured,
18 more elderly, more chronic disease. And so, on
19 these two sides of the same slide I have
20 arranged what often are sort of a Maslow's-like
21 hierarchy.
22 If these are the fundamentals that
23 in fact our rural colleagues and citizens
24 experience, then our models must actually get
25 at those things. So, transportation, food, and
26 geographic isolation being the most fundamental

1 challenges. Housing and utilities, and
2 connectivity being the next layer.
3 And you really, until the middle of
4 the triangle, don't even get to clinical care
5 as we would often think about clinical care per
6 se. Most of that is very fundamental, like
7 food, housing, et cetera, and then insurance, I
8 put at the top, is empowering access to care,
9 but itself not delivering the care. It
10 empowers access frequently.
11 Those are the kinds of challenges.
12 So, as we think about integrating health equity
13 into value-based transformation, we have to
14 think about those in terms of priorities, and
15 how those can best be met. The next slide
16 shows that if we are to achieve health equity,
17 proposing here kind of a three-legged stool
18 that equitable access to care is one leg on
19 that stool.
20 Equitable delivery of clinical care
21 is the next leg on the stool. And equitable
22 transitions and continuity. This may be a
23 framework we could consider as we think about
24 transforming into value-based models so that if
25 you don't have access to care, you can't get
26 the delivery of the care. If many have access

1 and that's equitable, the care has to be
2 delivered equitably to various cohorts of the
3 population.
4 And then where a lot of work is, is
5 in the transitions and continuity. So, using
6 this as a framework, on the next slide I do
7 want to review the first two of four models
8 that have given some framework for us to
9 consider how to think about rural models, and
10 again, value-based transformation.
11 The first model, very familiar to
12 one of us sitting here, Dr. Jen Wiler of the
13 Metro Community Provider Network, the Bridges
14 to Care Model. An excellent model that
15 supported post-emergency department patient
16 navigation, utilization, decision-making.
17 Coming back to the emergency department,
18 advanced imaging, et cetera, primary care.
19 And in particular, this model used
20 on-site patient engagement during an emergency
21 department visit for those frequent emergency
22 department patients. That on-site engagement
23 model subsequently dealt with social
24 determinants of health, and interestingly, also
25 substance abuse and mental health patients were
26 included in that model, frequently a challenge

1 that models may not always include.
2 The findings, in very brief, again,
3 Dr. Wiler can detail this like none other. But
4 there was a significant reduction found in
5 post-visit emergency department visits. A
6 significant program savings, and of importance,
7 using the initial ED visit as a real time
8 engagement opportunity is particularly
9 effective. I will get back to that in my final
10 comments before my time is up.
11 But thinking about how we can
12 leverage existing resources in rural
13 communities that programs are already investing
14 in. So, for example, the Rural Emergency
15 Hospitals, the Critical Access Hospitals, and
16 other things are really important in terms of
17 making sure that we have sustainable systems.
18 The second model, very different,
19 but had similar outcomes. The Global Budget
20 Payment Reform System that's in the state of
21 Maryland aligned hospital revenue not with
22 patient volume or services delivered, but with
23 a global budget.
24 What resulted from that was care
25 transformation when hospitals and services, and
26 clinical services in particular were aligned

1 with that; subsequent studies found that repeat
2 visits to the emergency department, admissions
3 from the emergency department, and returns at
4 both three days and nine days were positive
5 findings in subsequent studies done by Dr.
6 Jesse Pines and his colleagues.
7 Lower utilization, ED returns,
8 admission, but also some stable mortality and
9 ICU stays showed that we were probably not
10 adversely affecting the sickest of the sick
11 while we were also trying to impact the volume
12 and services that were delivered. The findings
13 here showed that economic alignment with
14 hospitals can safely reduce total cost while
15 you're working on this.
16 Now again, that sounds self-evident,
17 once you do this, but these are examples of how
18 this has relatively worked well, certainly
19 plenty of challenges about where you set
20 budgets, and what's included or not. But there
21 were opportunities also found to address
22 disparities among the ED returns.
23 So, this was not a highly equitable
24 outcome that we found. We did find
25 opportunities, subsequently I'll talk a little
26 bit about how we might be able to address that.

1 The next slide shows something that Dr. Wiler
2 actually mentioned in her introductory comments
3 as well. I was also a co-author of this, the
4 Acute Unscheduled Care Model, which has been
5 seen by this PTAC back in 2018, approved and
6 recommended.
7 It was the first risk-bearing APM[9]
8 for emergency medicine, and while emergency
9 medicine is frequently seen as a threat or a
10 failure in many APM models, this model looked
11 at how we could actually leverage an existing
12 fixed cost, which my colleagues have already
13 mentioned in prior comments, to reduce
14 hospitalization, foster coordination, and
15 reduce post-ED safety and risk events after an
16 index emergency department visit.
17 The waivers for telehealth, home
18 visits, and transitional care management now
19 being available to the emergency physician in
20 the proposal, including behavioral health
21 patients in mature phases of the plan. Once
22 again, the PTAC looked at this after the
23 rigorous review was recommended, and once
24 again, the value here had more to do with the
25 retrospective evaluation of whether a model

9 Alternative Payment Model

1 like this mathematically should work,
2 economically could work, and practically could
3 be rolled out.
4 The next model on the bottom part of
5 the slide, although the AUCM[10] as proposed to
6 CMS was not in fact implemented yet, the
7 principles of the AUCM model, using the safe
8 discharges, patient navigation, care
9 coordination, and quality measures are being
10 used now. Our group in particular, and there
11 are other groups I know that are looking at
12 this, are using this with commercial plans,
13 with Medicare Advantage, and considering this
14 with Medicaid as well.
15 There are models that are live now,
16 and they include various levels of risk and
17 economic reward, along with quality measures
18 and safety measures. The high patient
19 engagement rates also mirror what the Bridges
20 to Care model found, which is the direct
21 follow-up from the physician group and the
22 hospital after an initial emergency department
23 visit resulted in notably reduced return
24 visits.
25 The patient experience was markedly

10 Acute Unscheduled Care Model

1 improved, and the overall cost was improved.
2 So, we have some reason to think that there are
3 some principles that might be compelling. Some
4 potential models, and learnings, and
5 opportunities.
6 And importantly also, as rural
7 communities struggle most frequently with
8 sustaining models once they're there because of
9 the resource constraints, it's compelling to
10 think about whether we can leverage existing
11 resources in service of other objectives. The
12 next slides will briefly note that when you use
13 existing services, that being the hospitals
14 that exist, and the emergency departments that
15 exist, there are equitable outcomes that might
16 be achievable.
17 These are, on the left-hand side,
18 300 emergency departments in 32 different
19 states showing that there are relative -- using
20 one measure of quality, which is MIPS[11]
21 performance, that's only a single measure,
22 these are six MIPS measures by the way, all
23 aggregated in terms of performance.
24 And as you see, the rural, the small

11 Merit-Based Incentive Payment System

1 practice, the HSSA[12], low-volume, and hospital-
2 based practices had very similar results. We
3 believe that that is because the patients had
4 equitable access, equitable care delivery, and
5 there were simply no barriers in order to get
6 this done, and there was a good amount of data,
7 and feedback to the clinicians that occurred.
8 Similar results happened in hospital
9 medicine after the patients were discharged.
10 So, once again, using hospital-based clinical
11 services may in fact yield opportunities for
12 equitable outcomes. Next slide. Looked at a
13 single area, again, this is just some data that
14 may be worthy of discussion.
15 In 55 emergency departments, of
16 which three-quarters are in rural environments,
17 the Area Deprivation Index was applied, again,
18 a ranking of socioeconomic disadvantage where
19 the deeper blue colors are actually the most
20 deprived, if you will. The scale is from zero
21 to 10, anything over four is indicated in the
22 orange bars.
23 We found that in looking at the
24 primarily rural environments, three-quarters of
25 them, again, of the 55, are rural. The core

12 Health Shortage Service Area

1 measures, MIPS, sepsis bundle, and substance
2 use evaluation outcomes were similar. Once
3 again, there are structures that promote this,
4 and the next slide begins to detail those.
5 As we look at, again, sustaining,
6 there's enough compelling -- there are enough
7 compelling models out there that make us think
8 that we may be able to do something here to
9 engage rural health providers and communities
10 in equitable care. What are the reasons to
11 think that that may actually last?
12 In terms of equitable access, there
13 is an EMTALA[13] requirement that guarantees
14 patients from a federal law standpoint, access
15 to care, assessment of an emergency condition,
16 and stabilization within the resources of the
17 hospital. There's a prudent layperson
18 standard, and there's public reporting of
19 certain measures, including quality measures.
20 So, there are things already in
21 place that would tend to promote that. In
22 terms of equitable delivery, not only
23 established standards of care, but increasingly
24 telemedicine oversight in rural communities,
25 but there is also certification and regulation

13 Emergency Medical Treatment and Labor Act

1 that can apply.

2 Again, the Rural Emergency Hospital
3 setting talked about how to do the
4 certification and regulation standards so that
5 the processes, the outcomes, and the governance
6 are supportive on a longitudinal basis. And
7 finally, where I think the most work is, is the
8 transition and the continuity of care.

9 Increasing screening, HRSN[14] and
10 identification, care coordination, and after
11 care, frequently the issues that have to be
12 funded longitudinally, but with waivers and
13 other access to opportunities. Those may be,
14 again, sustainable. The next slide begins to
15 show one potential framework for inclusion of
16 health equity into value-based models.

17 And the bottom bullets under each of
18 these three legs of the stool that I've
19 repeated now, may be the most important.
20 Actually, on the access to care, not only did
21 you achieve access to care for your population,
22 but was it a representative population of your
23 community, as opposed to a cherry-picked
24 population, or a selective population if you
25 weren't doing the picking, but it was actually

14 Health-related social need

1 picking for you.

2 So, in other words, if you achieve
3 quality measures, or operational measures that
4 are in the middle column, you would actually be
5 paid well if it was an economically at-risk
6 model if you applied those quality and
7 operational measures consistently for all
8 patient groups. You would be paid less well if
9 in fact it was not.

10 So, there are opportunities to sort
11 of risk-adjust the payment, the risk, or the
12 benefit under a model, depending on how well
13 you serve the population itself. Under
14 equitable transitions and continuity,
15 frequently those will be process measures and
16 transition indicators. As I put in parenthesis,
17 very important to align primary care
18 specialists and non-rural resources with those.

19 But oftentimes the kind of
20 integration of health equity into value-based
21 models has to do with whether or not in fact
22 you really did assure the continuity and
23 transitions occurred. And then ultimately the
24 outcomes will follow. Next two slides are my
25 final ones, and that is again, this learned
26 audience knows a unified mission and clear

1 objectives are very key.

2 I do think it is very important of

3 course to establish what clinical objectives we

4 are looking for. Then align an operational

5 model, then align an economic model, and then

6 make sure that the consistent and adaptable

7 model is a result. Consistent meaning the

8 infrastructure, and the outcomes, and the sort

9 of fundamentals are the same.

10 But there's enough adaptability,

11 because as we all know, rural is not rural, is

12 not rural. I personally grew up in Minnesota.

13 The largest town I've ever lived in until

14 recently was 2,500 people, and I spent my

15 entire emergency medicine career practicing in

16 rural environments, and they are all so

17 different.

18 I do however think it's entirely

19 possible to have consistency with a model, but

20 adaptability. Next slide summarizes what I

21 said. Access, delivery, and continuity. The

22 three pillars. Might be, again, compelling to

23 leverage existing structures and mechanisms to

24 achieve health equity objectives.

25 I really think this is a frontier

26 for consideration. The opportunity to use what

1 we have better than we've been using it rather
2 than connect new resource staff, and then find
3 that the resources dwindle over time, as does
4 the program eventually, is a compelling
5 thought. Thank you very much.
6 CO-CHAIR SINOPOLI: Thank you, great
7 presentation. So, now I'd like to open up the
8 discussion to our Committee members for
9 questions. To indicate that you have a comment
10 or question, if you'd flip your name tent up,
11 or if you're on Webex, Jay, just raise your
12 hand in Webex, and I'll ask if there's anybody
13 that has any initial questions they'd like to
14 ask. I can't see, does Jay have his hand up?
15 DR. FELDSTEIN: Yeah, I have my hand
16 up as well.
17 CO-CHAIR SINOPOLI: Okay.
18 DR. FELDSTEIN: Yeah, this question
19 is for Tom. I'm really interested in what
20 you're trying to do. Do you see your company
21 as a standalone solution for rural care, or do
22 you kind of bolt onto existing infrastructure,
23 in certain rural communities, and kind of fill
24 in the gaps, or is it both?
25 DR. LEE: The way we've designed it
26 is both. There are gaps where there aren't any

1 providers, where we fill in gaps in networks to
2 services, regions. And then we intentionally
3 wrap around local providers, and provide
4 infrastructural support and other collaboration
5 with established providers.
6 Definitely in rural communities, we
7 think that the fabric of care needs to be
8 maintained if not supported. So, a lot of what
9 we do is help facilitate handouts,
10 communication, establish [inaudible], and CBOs[15]
11 in any given local community.
12 DR. FELDSTEIN: And about how many
13 markets are you in right now?
14 DR. LEE: Digitally we operate
15 across all 50 states, and that includes just
16 rural care digitally delivered. We do have a
17 home-based presence in four states, soon to be
18 five. Those are particularly in rural
19 communities, but we also can operate in urban
20 communities, but that's the current scale that
21 we're at.
22 DR. FELDSTEIN: Thanks.
23 CO-CHAIR SINOPOLI: So, I'd like to
24 expand on that question a little bit, and maybe
25 ask it of all three of our panel members. So,

15 Community-based organizations

1 we've heard a lot over the last PTAC meetings,
2 public meetings about the need for actual
3 contact with patients, actual physical
4 contacts, and team members, and kind of a
5 multi-modal interaction with patients, and how
6 effective that is.
7 So, obviously in the rural
8 environments, that's much more difficult to do.
9 And so, I'm hearing more about digital
10 intervention, and more about even today,
11 telephonic intervention, virtual intervention,
12 certainly coupled with community health workers
13 and mobile care.
14 But I'm curious as to whether you
15 see that those other interventions are actually
16 working in the rural environments. If they are
17 working, what's the key to the success of those
18 interventions, as opposed to the thought
19 process generally that telephonic care
20 management doesn't really work, and is
21 effective as interventions, or otherwise? So,
22 let's start out with Randy, and we'll work our
23 way through.
24 DR. PILGRIM: Yeah certainly,
25 Angelo. So, we do have some experience in our
26 own group on this, and I'm aware of other

1 groups that are doing the same. Once we
2 establish, I'll use our own experience, just
3 because I know it best. Once we established a
4 24/7 nurse call center for the sole purpose of
5 following up on an initial emergency department
6 visit to ensure continuity, help patients with
7 navigation, connect them with primary care.
8 We found that there was about a 60
9 or 70 percent rate of returning calls from that
10 nurse center. A series of three calls, an
11 escalation, and so forth, just to return the
12 call. Once we appended that with a text
13 message, the initial text of which went out
14 right after the emergency department visit.
15 So patient is typically in the
16 parking lot leaving the emergency department
17 for their ambulatory discharge, that 60 or 70
18 percent raised to 90 percent. So, that was a
19 much different patient engagement result, and
20 then there were other follow-on results that
21 occurred after that.
22 We found that the key was simply
23 getting ahold of and establishing post-
24 emergency department contact with the patient.
25 Texting certainly helped that. We are working
26 also on a web-based interactive site that

actually is diagnosis or follow-up specific for them. So, those results are yet pending.

I think your question is does that work in rural areas? Yes, absolutely it does. We are not in some of the most discrete rural areas if you will, so we're not in Alaska, for example. Where some of the connectivity, and some of the infrastructure there may be more challenging.

But where there are broadband capabilities, Wi-Fi capabilities, and cell phones, we found some very compelling results, and they were much more cost effective.

CO-CHAIR SINOPOLI: Great. Alana, can you comment on that?

DR. KNUDSON: Certainly. We actually did a study looking at the use of telehealth services pre-pandemic and during the pandemic. And one of the interesting pieces on this is that we found that the use of, for example telehealth visits for behavioral health, had a level of continuity over time, especially when we saw increases like in omicron.

We saw those peaks, however, in talking with a lot of rural providers, and

1 looking at the data, the use of, for example,
2 telehealth visits has not sustained, it has not
3 continued to be high in rural communities.
4 That is not the way a lot of the current cohort
5 of older adults in rural communities choose to
6 access care.
7 However, I think as we see our baby
8 boomers continue to age, that are much more
9 digital, they have a greater digital literacy
10 than some of our other older adults, I think we
11 will see that shift. But I will also caution
12 that when we look at, for example, behavioral
13 health, we don't have enough behavioral health
14 providers now.
15 And even with telehealth, and
16 different types of applications, we still have
17 waits for people to be able to access that
18 care. So, I just want to caution that there's a
19 lot of opportunity, but we still need the
20 workforce to be able to provide those services
21 via telehealth.
22 CO-CHAIR SINOPOLI: Great, thank you
23 for that. So, Tom?
24 DR. LEE: So, to maybe address it a
25 little bit, we've found that each modality has
26 a purpose given the context and given the

1 individual. So, our bias has been to use the
2 right modality, and the right moment in time
3 for the right patient. And so, the ideal
4 organization has a range of capabilities so
5 that they can better use their labor in the
6 most effective way.
7 Because of the travel distances
8 required, you have to be more discrete about
9 who is traveling to whom, when, and how. And
10 so, because the digital form factor helps
11 support that relationship in the absence of
12 physical presence, we think that that actually
13 compliments, and augments the providers'
14 effectiveness and efficiency wherever it can be
15 done.
16 It's rarely for us, a playbook of
17 always A, or always B. Because, for example,
18 in the first patient visit we will go to the
19 home by design. That's an inefficient quote
20 unquote visit, but so much is learned, so much
21 trust is built, that then you can form a
22 digital connection thereafter.
23 And then you also better understand
24 the infrastructural limitations of the home to
25 know that a phone-based encounter is probably
26 going to be more effective than a digital-based

1 encounter. So, a lot of this, I think needs to
2 be built into organizational muscles so that
3 they can use the full range of connectivity
4 devices to patients for the right purposes.
5 So that the needs can be better met
6 in a more cost-effective way. So, that's kind
7 of our notes on it.
8 CO-CHAIR SINOPOLI: Perfect, thank
9 you. Lauran?
10 CO-CHAIR HARDIN: All three
11 excellent presentations. I have so many
12 questions for you, but I'll start with one.
13 So, I spend a lot of time in partnering with
14 rural communities, and it's really expanded my
15 perception of who can do care management, who
16 can really deliver services. So, I have been
17 part of designing models that involve ministers
18 as the core person.
19 So, I'm curious, workforce is such a
20 huge issue in rural, what creative roles or
21 disciplines are you seeing set forward as key
22 and also possible to tap into in rural? And
23 are there any policy changes that would
24 facilitate integration of those roles on a
25 broader level?
26 DR. PILGRIM: I'll start. Our

1 experience has been a surprising amount of -- a
2 surprising contributor, out of proportion to
3 what we ever thought to the ultimate outcomes
4 that we're looking for, or to interval
5 outcomes, has been simple navigation and way
6 finding. We typically use nurses, occasionally
7 nurse practitioners or PAs[16].
8 Very frequently, not at the clinical
9 license level, but to do those kinds of things
10 increasingly, we're finding that that's simply
11 not necessary. In fact, we're not even sure we
12 need an LPN[17] at times to do that kind of basic
13 way finding, navigation, appointment
14 achievement, and satisfaction.
15 So, it may be important from a
16 policy standpoint to consider whether or not
17 there are compensable actions that support
18 ultimate continuity and transitions of care
19 that do not require a clinical license of any
20 kind. Again, we've been very surprised at how
21 simply the first, second, or third step with a
22 patient is all you need.
23 And as we try to not become their
24 entire health care service provider, but

16 Physician assistants
17 Licensed practical nurse

transition to the correct one, navigation and way finding has been huge.

DR. LEE: Maybe the analog for us, I agree with Randy's comments in that area, what we have been investing in is local rural markets because of the lack of available skilled talent in all the markets, we've really focused on hiring local talent from local communities to build relationships with patients, and sort of as a way finder and navigator.

So, a community health worker, but in a much more kind of advanced context. That's how we've looked at labor opportunities for local markets. And the beauty is, obviously, they're from the local community, and really understand the nuances naturally. So, agree, reimbursement architectures to support that framework are always helpful.

DR. KNUDSON: I would also add that community health workers are really critical in rural and in tribal communities because of that connection, and that trust factor that I think is really important, especially as we're looking at advancing health equity, that is foundational. But I will also counter that

1 with the challenges of getting those different
2 people reimbursed.
3 And I am at a rural meeting today
4 sponsored by the National World Health
5 Association, and that is the exact discussion
6 that we're having. Community health workers
7 are not always reimbursable, and yet they are
8 really key in making those important
9 connections.
10 CO-CHAIR HARDIN: Thank you.
11 CO-CHAIR SINOPOLI: Chinni?
12 DR. PULLURU: Thank you to the panel
13 for the really thoughtful dialogue. My
14 question is regarding something that Tom had
15 mentioned, and it's to Tom, as well as the
16 other panelists. Tom, you had mentioned in
17 your presentation a decrease of sort of the
18 regulatory infrastructure, or regulations that
19 now govern certain parts of care delivery.
20 Yesterday, it was brought up,
21 obviously some of the regulations around
22 telehealth, in person requirement, as well as
23 some of the other things. Can you give us more
24 details on your thought processes around this?
25 Because given the construct of sort of the
26 Committee, and our recommendation, this seems

1 like it's something that is something we can
2 take on.
3 DR. LEE: Yeah, it's probably beyond
4 my expertise to give the specifics. I think
5 the general lay of the land, and I'm happy to
6 refer to our counsel, who probably has a much
7 more specific lane of conversation around each
8 state. So, it's obviously programmatic, state-
9 based, but they generally fall into two areas.
10 One is about labor and workforce, so
11 what services are reimbursable in what settings
12 by whom? So, a lot of that has to do with kind
13 of what labor and workforce can be deployed
14 into kind of which setting. The second would
15 be reimbursement, and reimbursement
16 flexibility, particularly around digital
17 modalities. So, I think those would be the two
18 general areas.
19 And then I would probably just defer
20 to my senior team to kind of comment more
21 specifically.
22 DR. PULLURU: Thank you. Randy?
23 DR. PILGRIM: Yeah, it's a good
24 question. I mean, the whole idea of
25 telemedicine was to bring a clinician to the
26 patient. I think anything that supports that,

1 and has the right sort of framework around it
2 so that it's not promoting misuse, or even
3 abuse of clinical care, is a good thing.
4 So, anything that we can do, as
5 COVID has shown us, as the extension of
6 telehealth capabilities has also been provided
7 for through 2024, those things are generally
8 good. Once again, I'm actually quite surprised
9 at how at times the clinical objectives of the
10 telehealth visit are not always as concrete.
11 Some people just know they just want
12 to see a doctor, and this is one way to do
13 that. And if it's entirely patient-driven,
14 which I'm a very big supporter of, but if it's
15 entirely patient-driven, sometimes the ultimate
16 objective gets lost in the setting of
17 longitudinal care and ultimate health outcomes.
18 So, I'm a big fan of bringing
19 clinicians to patients wherever it can possibly
20 be done, but also aware that there have to be
21 certain guidelines around the utilization, so
22 that in fact you don't just get a lot of care
23 delivered, but no ultimate outcomes for that
24 care.
25 DR. KNUDSON: I would add, one place
26 in rural that's really important to look at

1 some of the regulatory, particularly face-to-
2 face, and that is with regard to hospice care.
3 Having telehealth be used instead of face-to-
4 face, especially in the later stages of hospice
5 care, is an important addition.
6 You don't want to take vulnerable
7 patients out of the home if you don't have to,
8 and many providers are not able to go to the
9 home. So, that telehealth visit really
10 supports not only the patient, but also that
11 family.
12 DR. PULLURU: Thank you, Alana, that
13 was really --.
14 CO-CHAIR SINOPOLI: Thank you. Jim?
15 DR. WALTON: Thank you for your
16 comments. Randy, I was struck by some of your
17 comments. I was going to kind of just do some
18 reflection. When I was practicing in a rural
19 area, one of the things that seemed to be
20 recurring a lot was the emergency department at
21 my local hospital served as a reservoir, so to
22 speak, or an opportunity to decant patient
23 overflow when we were overwhelmed.
24 We would often tell the patients in
25 the middle of the day, please go to the
26 emergency room, because we already had so many

1 patients to take care of we couldn't possibly
2 work them in, even though we had an open
3 schedule. And what I think that I'm reflecting
4 on, and that also happened at night right, when
5 we were on call taking care of folks.
6 And so, one of the things that I was struck by
7 your data, which was the amount of equity of
8 care delivery that took place once the patients
9 got to the emergency room. And I really think
10 that that was a very helpful piece of work to
11 illustrate that. But one of the things that
12 kind of comes to my mind around this idea of a
13 value-based model, kind of if we move forward
14 with the next idea of incorporating equity in a
15 real time way, is
16 do you see emergency department activity, and
17 actors, and reimbursement for emergency
18 department activity connected to primary care?
19 So that there is a combined responsibility for
20 chronic disease outcomes, and completion of
21 preventive care services that we know, by
22 evidence, reduces the downstream demand for
23 health care, and also will reduce morbidity and
24 mortality.
25 So, in a future value-based model,
26 would you see emergency department physicians

1 and primary care doctors being, if you will, an
2 integrated team, particularly in the rural
3 areas? And being accountable for the way they
4 receive payment rewards, being accountable for
5 not only measuring the community's health
6 disparities, but also being accountable for
7 moving them, or closing them, or shrinking them
8 together by some kind of concerted activity?
9 And I think Tom, I'd like to hear
10 your response to that too, from what you're
11 doing with Galileo. But I think this really
12 kind of, you stimulated me with your comments,
13 so I just thought we would explore this a
14 little bit.
15 DR. PILGRIM: Yeah, listen, I really
16 appreciate that. I would have a couple of
17 thoughts to your comments and question. First
18 of all, I do not think the current
19 reimbursement environment, and the realities of
20 how we are paid in emergency medicine is
21 aligned well. I do not think that at all. I do
22 think that there is every possibility that in
23 fact we can change that.
24 The emergency department being sort
25 of, in some sense a safety net, a backstop, a
26 failsafe of sorts, it's very difficult to take

1 a failsafe, and a back stop, and turn that into
2 an opportunity that actually does what you were
3 talking about, which is align around health
4 disparities, and prevent them where
5 preventable, and make sure that you have the
6 chronic care.
7 And ultimately the utilization of
8 the system is right sized. Our current system
9 does not support that well. There are systems
10 that do that, in concept and in theory. The
11 AUCM model was one of those. And I think it is
12 harmonizable with other existing systems,
13 rather than it being stand alone.
14 So, I really liked your comment
15 about making sure that the primary care and
16 appropriate specialty care is aligned with the
17 emergency department. I absolutely believe
18 it's possible. It will take change from the
19 current system. The current system does not do
20 that well. It may also take, and this will be
21 an edgy comment, but it may also take some
22 revision of the requirement under EMTALA, which
23 is a very high standard of assessment.
24 With a requirement of near
25 perfection to identify a potential emergency
26 medical condition, that chews up a lot of

1 resources to meet that standard when in fact
2 you don't always have to meet that standard in
3 order to make sure that the longitudinal care
4 for the patient is appropriate and aligned with
5 primary care.
6 So, I think there is work to be done
7 here on this, and particularly in rural areas,
8 we need to make sure that we don't trip
9 ourselves up with existing structures, but at
10 the same time leverage what's already there.
11 DR. LEE: Yeah, just briefly. You
12 know, obviously, this primary care ED access is
13 an important access in a lot of communities in
14 general, and I agree the reimbursement
15 alignment is challenging. I think it's a noble
16 goal. I think organizationally, and
17 financially, I think it could be complicated,
18 given the just inherent natures of the
19 different types of services in the
20 organizational infrastructures.
21 But I think if you could solve that,
22 it would be interesting. The way we've looked
23 at it is at the end of the day, people and
24 individuals choose to go down the path of least
25 resistance, all things being equal, and so the
26 ED in general can be the easiest place for most

1 people.

2 And so, I think coming up with some
3 alternatives, creating some financial alignment
4 for those alternatives, I think can also kind
5 of redirect patients to the appropriate
6 resource first. Those can be done digitally,
7 and through phone-based services, and, or other
8 ways to support the infrastructure of better
9 places of care.

10 So, I think I always look at kind of
11 path of least resistance, and how do you kind
12 of change those incentives and architectures to
13 better support the right flows and dynamics. I
14 do think communication between those groups is
15 still critical regardless. And so, I think
16 something needs to kind of help facilitate
17 that.

18 Certainly, the information for
19 whenever go into a community is pretty low, in
20 terms of ADTs[18] and otherwise. It does take a
21 lot of effort to wire those up. And so that's
22 another opportunity for better communication
23 between those two important provider types I
24 think as well.

18 Admission, discharge, and transfers

1 CO-CHAIR SINOPOLI: Perfect, thank
2 you. Larry?
3 DR. KOSINSKI: Thank you, Angelo.
4 This was a very sophisticated set of
5 presentations. I really enjoyed all three. And
6 I jotted down a number of the statements that
7 each of you had made, and I love Alana's
8 comment about utilization reduction only
9 affects variable cost. I thought that struck
10 me. Tom, I love the fact that you flipped, and
11 had digital first, and brick and mortar last.
12 And that you want to make fixed
13 costs act more variably. I love that comment as
14 well. And Randy, rural is not rural, is not
15 rural, you got me with that, and I love your
16 focus on access. My question to the three of
17 you is we've learned in previous PTAC sessions
18 on different meeting dates that we need to have
19 a proactive primary care model.
20 I heard a lot of reactive from the
21 three of you. What are each of the three of
22 you doing to proactively reach out to this
23 population that may not even realize that they
24 need care?
25 DR. LEE: I can maybe start. We
26 participate in risk-based arrangements, and so

1 we take accountability for populations. So, I
2 think that just the mere concept of
3 accountability helps, and then you have to look
4 at payment alignment and operational alignment
5 to do so. We’ve designed pop-up services, or
6 what we call proactive services by design,
7 because it accomplishes multiple goals.
8 Engagement with patients,
9 preventative care, chronic care, quality of
10 care, but also builds trust so that when we're
11 doing the transactional reactive care we have
12 better context, and better nature of how to
13 service the individual patient. So, we think
14 proactive care is an important component to
15 population-based care in general.
16 And a lot of the capitated, and, or
17 quality programs help foster that alignment.
18 That being said, it is very hard to do this
19 work on a scaled basis if you're in a very busy
20 primary care practice. And so, that unwinding
21 of time to find more time to play offense in
22 the general community I think is quite
23 challenging.
24 And so, there needs to be a tech and
25 data infrastructure to know which cohorts have
26 which gaps. There needs to be a reasonably

1 scalable labor force to build, engage, close
2 those gaps. And then what I call the
3 appropriate clinical connectivity of the
4 primary care team so that there's alignment
5 with a primary care plan, not what I call kind
6 of two different teams operating in very
7 different environments with different
8 objectives.
9 So, I think those are the challenges
10 to it, but I think those are kind of some of
11 the elements that we face in our operations.
12 DR. PILGRIM: I'll mention something next.
13 Another great question, I really think that
14 articulates the various roles that health care
15 entities in a community play. In the emergency
16 department we've been classically doing
17 absolutely nothing about reaching out to the
18 population. In fact, it's one of the things
19 that has held us back from participating in
20 value-based models over years, and years, and
21 years,
22 has been our population is actually whoever
23 comes to see us. It's 100 percent unscheduled,
24 100 percent patient-driven, where the patient
25 or someone on their behalf comes to seek their
26 care. So, that's held us back as opposed to a

1 roster-based mechanism where a primary care may
2 get a list, here is your patients, take care of
3 them, allowing them the opportunity to reach
4 out ahead of time.
5 In trying to bridge that, however,
6 there is actually an answer to, are you doing
7 anything? In some of the models that I
8 mentioned in my presentation, the outreach
9 after an initial emergency department visit,
10 because that's now our population. You came to
11 me, now I can reach out after you.
12 Interestingly, that outreach becomes
13 the outreach prior to the next visit. So, it's
14 after the first one, but it's prior to the next
15 one. That's where we found most of our
16 opportunity, and mainly, not to replace primary
17 care, but to connect them with primary care,
18 which of course requires that there be primary
19 care to connect them with.
20 But most of that outreach,
21 amazingly, even though it's after the first
22 event, has been effective. I think there's
23 opportunity there, but it still does leave a
24 gap, Larry, that I think you point out very
25 nicely, which is what if no one ever does come?
26 Have we seen about their health care, and let

1 alone equitable care in the process of that?
2 I think that's a gap that we need to
3 think about very carefully in rural areas
4 especially.
5 DR. KNUDSON: And I guess I also go
6 back to finance drives function. And when
7 you're looking at primary care and what people
8 are reimbursed to do, I often talk about
9 windshield time in rural. Because similar to
10 Randy, I grew up in a community of 434 people.
11 Trying to get care out in some of those areas
12 requires actual windshield time if you're going
13 to go to these homes.
14 So, that is also an issue. But I
15 just want to take you to two demonstrations
16 that we have in progress right now. The
17 Pennsylvania Rural Health Model is a model that
18 funds hospitals. And hospitals work with
19 communities, but the interesting part is that
20 primary care is foundational to all of the work
21 that we do, and all of the outreach in being
22 able to advance population health outcomes.
23 So, we need to have models, and
24 payment systems aligned so that hospitals, and
25 primary care, and ED, everybody is aligned, and
26 going along the same path. If we have a

1 different value structure, or a different
2 incentive for the hospital than we have for
3 providers, we are going to have a misalignment.
4 Likewise, when you look at Maryland
5 and the total cost of care, it's always
6 important to remember there is an all-payer
7 rate that is foundational to the success of
8 that model. And so, it helps to be able to
9 align not only incentives, but payment. And
10 so, as we're thinking about this, think about
11 how payment needs to be aligned not only across
12 hospitals, EDs, primary care, behavioral
13 health, the whole continuum. But also think
14 about the alignment across payers.
15 CO-CHAIR SINOPOLI: Great, thank
16 you. Lauran, are you next? Or Chinni next?
17 Okay.
18 DR. PULLURU: Thank you to the team.
19 Alana, and then Tom, as well as Randy, adding
20 on to the construct of payment reform, how do
21 you see differences in attribution, and changes
22 that could potentially happen given that
23 there's low density in rural areas to
24 attribution? What are your thoughts around how
25 that could be changed?
26 DR. KNUDSON: Well, the Rural

1 Emergency Hospital designation that began
2 January 1st of this year provides up-front
3 funding for these rural hospitals. And I think
4 if we start thinking about rural hospitals from
5 the standpoint, or rural providers, if you
6 will, from the standpoint that we look at, for
7 example, police, fire, different requirements
8 that we need to maintain our rural communities.
9 I think we need to also think about
10 having those essential services be available.
11 And looking beyond - volume-based is piecemeal,
12 so that creates a lot of trouble for those low
13 volumes, that's what we're talking about.
14 Those low volumes are really challenging. When
15 we get into value-based, even when you look at
16 global budgeting for a value-based payment
17 model, you are also always starting at the
18 basis of the history of what was sought using
19 volume.
20 And so, when we're thinking about
21 new payment, what if we think about it in a
22 structure where you have a base payment for
23 rural hospitals that provides incentives and
24 accountability to address population health
25 metrics? And not just rural hospitals, but
26 rural providers. I talk about rural providers

1 more holistically.
2 As I said, it needs to be hospitals,
3 primary care, and also those community partners
4 as a unit. Because in a rural community, these
5 types of efforts are blurred, and we were just
6 speaking before about ED services. I can't
7 tell you how many rural providers share with me
8 that their ED is the safety net for mental
9 health problems.
10 People show up at the ED because
11 there's nowhere else to go. And the only place
12 that some of our rural providers have to
13 provide care for these folks is either through
14 the hospital, or they send them back to the
15 county jail, or the local jail facility. So,
16 there's a lot of intricacies that need to be
17 thought through.
18 And if we had, for example, some
19 kind of a grant program, or an up-front payment
20 for these rural hospitals that address the
21 population health needs, that would better suit
22 the low-volume facilities.
23 DR. PULLURU: Tom?
24 DR. LEE: Yeah, so, I'll give my,
25 again, naive lens, given that the regulatory,
26 financial, technical constraints are beyond my

1 pay grade. But in general, for me the concept
2 is, in these low-density markets, is there a
3 concept of a regional utility that can kind of
4 float above the PCP[19] groups, and or local
5 hospital, that can kind of centralize, and
6 share some of these functions more globally?
7 Similar to an IPA, but perhaps with
8 a slightly different business intent or
9 organizational intent. To me, it allows you to
10 overcome these sub-scale issues with a common
11 mission purpose that kind of floats outside the
12 organization, per se. To me, that's one way to
13 start to think about it, so that there's
14 alignment.
15 Because there aren't that many
16 options to aggregate in a local market. You
17 kind of have to build this consortium together,
18 and then there's a lot of shared functions that
19 are needed by this community. If you think
20 back in the days it was the RHIO[20], but it's RIO
21 with broader services kind of concept. So,
22 that's how I think about it.
23 We're trying to just innovate on our
24 own individually, sub-scale, and that creates

19 Primary care provider
20 Regional Health Information Organization

1 challenges for us. But when you really look at
2 how do you foster with the communities, my
3 guess is something that kind of helps
4 facilitate aggregation at some level.
5 DR. PULLURU: Randy?
6 DR. PILGRIM: Yeah, look, if this
7 group could solve the accountability quandary,
8 and the attribution quandary in particular, I
9 would love that. I know that's a very thorny
10 thing to do. Couple of thoughts just to add to
11 this. I think of attribution a couple of ways.
12 One is accountability for care that is
13 delivered once care has been contacted.
14 So, the patient comes to me, I've
15 delivered something, I should have an
16 attribution piece of that assigned to me
17 because I did something with the patient.
18 There may be also attribution in terms of
19 accountability for a population whether or not
20 they came to see me as a clinician.
21 And so, I think being very clear,
22 when I have approached this in the past,
23 including my brief actuarial background, we've
24 really been tripped up a lot about attribution
25 with respect to a clinical event, as opposed to
26 attribution with respect to a population for

1 which I am accountable. I think there's a real
2 need for clarity around that.
3 I know in brief comments here I'll
4 not be able to do this, but I will say the
5 accountability for outcomes can occur, and be
6 attributed to an accountable group,
7 particularly a clinical group whether or not
8 they see the patient or not. There are some
9 patients that self-treat, and do fine, and the
10 outcomes that we're looking for even for some
11 conditions are okay.
12 However, if I ever touch that
13 patient, they do come to me for care, I elect
14 to deliver care, the attribution in some
15 fashion or another should attach in fact to me.
16 And again, the intricacies of working all that
17 out, and across attributional complexities in
18 systems are pretty daunting at times.
19 Sometimes I have found though, that
20 again, as the earlier comment was, aligning
21 primary care and acute care around attribution,
22 something in that direction is highly
23 important, and there is very little of that to
24 my knowledge, scalably being done right now.
25 So, I would really encourage the group's
26 thinking around combining acute care with

1 longitudinal care and combining the attribution
2 scheme around those things. Again, more
3 detail, happy to talk offline if desired.
4 DR. PULLURU: Thank you.
5 CO-CHAIR SINOPOLI: Okay, Lauran?
6 CO-CHAIR HARDIN: This is a bit of a
7 follow-on question from your conversation
8 there. So, one of the things that's emerged
9 the deeper we get into the needs of rural,
10 along that theme of what's most helpful in
11 looking at this as an all-payer approach,
12 really taking into consideration the standby
13 costs, and the need for capacity building.
14 So, one thing I've started to see across the
15 country, it's emerging a lot related to the
16 Medicaid waivers, but it applies in this
17 context related to rural, is an interest, and a
18 cry for hubs, and we've heard that from other
19 presenters. So, a way to bring a community
20 together, whether that's on a county level, or
21 a regional rural level to concentrate and share
22 some of those standby costs
23 to look at co-location, facilitate community
24 partnerships, to build the response system for
25 health-related social needs. And also, some of
26 that is also bringing forward a central way to

1 address the need for technical assistance,
2 quality assurance, data analytics, grants. So,
3 I wonder if you are seeing that as well.
4 And any successful models emerging,
5 or recommendations related to payment for that.
6 And Alana, you are starting to address that
7 with the base payment for the rural hospitals
8 as a hub.
9 DR. KNUDSON: We are seeing some
10 hospitals coming together, for example in
11 Texas, they have the clinically integrated
12 network, and I believe they're up to 23
13 hospitals in Texas that is part of that, and I
14 can share more information regarding that
15 group. But we also are seeing it not just in
16 hospitals and clinics, but we are also seeing
17 it in some long-term care.
18 Because of the issues with staffing
19 and pulling together resources at a regional
20 level so that there is a way to share those
21 types of resources, as well as to anticipate
22 staffing shortages. And, as we know, CNAs[21] and
23 other nursing, and frankly staffing across the
24 board in many of our rural nursing homes is at
25 a critical level.

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21 Certified nursing assistants

1 DR. PILGRIM: I'll go next Tom. If
2 you have thoughts. I think one of the most
3 vexing things, besides attribution, is the
4 expensive nature of hospital-based acute care.
5 And so, your question about the funding of
6 standby capacity capability, responsiveness,
7 that's expensive. It's just expensive, that's
8 one of the biggest downsides of trying to
9 utilize something that's already inherently
10 expensive in order to accomplish other health
11 care or outcome objectives.
12 However, the opportunity is it's
13 already there, and it's already being paid for
14 in some fashion or another. So, as we've
15 talked in other comments about modifying what
16 you're paying for, I think there is opportunity
17 to your comment. Again, I appreciate this, not
18 just to use hospital-based whatever form they
19 are, critical access facilities, Rural
20 Emergency Hospitals, or existing full acute
21 care hospitals, and their emergency
22 departments, or their ancillary services.
23 There's a lot of money there, and a
24 lot of that money has to be spent, particularly
25 in the workforce deprived areas that Alana was
26 talking about. You've got to respect that, and

1 you have to not invade that, otherwise you will
2 get upside down with that objective. But I do
3 think there is opportunity to be more clear
4 about what those standby costs and capabilities
5 are for.
6 And to expand them in service of the
7 equity objectives we've talked about, and the
8 fuller community perspectives. I think
9 clarity, and as Alana said earlier, I agree
10 with this entirely, the functions will follow
11 what the funding is for. And as long as that
12 actually is thoughtfully done, I think there's
13 opportunity there to leverage things that we
14 have.
15 DR. LEE: Yeah, maybe just one minor
16 add-on to Randy's comments, which agreed. I
17 don't know specific examples of the hub zone
18 otherwise, but I think the tension here, a
19 little bit to Randy's comment about rural is
20 rural, is rural. A common framework would be
21 helpful for these, but perhaps not a
22 prescriptive program design allowing
23 communities to shape the elements of them,
24 shape the anchoring of them, the standards of
25 them, that might facilitate a more scalable,
26 and customized, localized hub framework without

1 being too prescriptive. Again, easier said
2 than done, but I do think that because of the
3 nuances in any rural community, making sure
4 that it's not overly prescriptive I think will
5 help facilitate engagement and design at a
6 local level.
7 DR. KNUDSON: And if I could just
8 add one comment to that as well, it's really
9 important to have some kind of a glide path, or
10 some way to provide a place of convening to
11 determine how that hub is going to work.
12 Because the trust and the ability for these
13 local entities to work takes time, and it takes
14 dedicated staff.
15 It doesn't just happen. So, really
16 thinking about what is that structure, and how
17 is that structure coming together, and how is
18 it funded?
19 CO-CHAIR HARDIN: Thank you.
20 CO-CHAIR SINOPOLI: All right,
21 Walter?
22 DR. LIN: Thank you to our experts
23 for just fascinating presentations. It's been a
24 really informative session for me. My question
25 is primarily for Tom. It is a really
26 innovative model that you've created through

1 Galileo, and I wanted to just raise a few
2 questions based upon your comments, and some of
3 the supplemental information in the slides that
4 you've given us.
5 So, in terms of reimbursement, you
6 mentioned that you have risk-based
7 reimbursement that is working right now, that
8 provides what seems like really great rural
9 health care. I'd love to understand kind of
10 what reimbursement model that Galileo uses to
11 support its operations, one. Two, one of your
12 slides at the end there talks about high acuity
13 member management.
14 And it just made me wonder if
15 Galileo focuses on a certain sub-segment of the
16 rural population that are more high acuity, or
17 is this model applicable to all members in
18 rural settings across the board? And three,
19 one of your slides mentioned the impact of the
20 model, which you document as 46 percent fewer
21 specialty visits.
22 We've heard from prior sessions,
23 just the dearth of specialists in rural areas,
24 and I just kind of wanted to unpack that a
25 little bit. Whether this kind of model with
26 much fewer specialty visits is something that

1 works really well from a patient quality
2 perspective.
3 Is this something that we can use to
4 think about in terms of maybe substituting more
5 intensive primary care for specialty visits
6 given the difficulty of obtaining specialty
7 expertise in some of these areas?
8 DR. LEE: Yeah, happy to maybe
9 clarify a bit. So, the current form factor of
10 medicine in almost any context is an office-
11 based synchronous encounter. And so, there
12 you're blending general knowledge, specialty
13 knowledge, a bunch of other intangibles into
14 one form factor.
15 With Galileo we've tried to be more
16 discrete about what form factor is needed for
17 what type of care, for what type of patient in
18 the appropriate context. And so, by doing so
19 we have changed the framework a bit to
20 knowledge-based care, and what we call
21 translationally-based care. So, knowledge-
22 based care is what we all grow and learn as
23 clinicians about.
24 What we're trying to do there is
25 improve the quality of the knowledge, the
26 quality of the decision-making, the breadth of

1 the interdisciplinary nature of the decision,
2 what we call a multi-specialty lens to any
3 decision through a digital form factor. That
4 allows us to be more unit price efficient,
5 because the time for a provider to solve any
6 clinical situation is more effective, and
7 efficient.
8 Provider satisfaction is higher too.
9 They're not spending all their time collecting
10 information and repeating a bunch of
11 information. So, the unit price is lower,
12 which allows us to operate within most fee-for-
13 service environments, and or risk-based
14 environments with a preference towards risk on
15 our side.
16 The corollary to that is by spending
17 more efficient care on the digital side for the
18 stuff that can be accessed digitally, we then
19 have more time to invest in complex care, home-
20 based care, what we call the people intensive
21 side of care, where that interaction is much
22 more labor intensive.
23 So, we're bifurcating into more
24 efficient care and more intense care against
25 the cohorts needed. And so we, in any rural
26 population, can service a low complexity

1 individual to a high complexity individual.
2 And then with respect to specialty care, a lot
3 of specialty care is knowledge-based.

4 And so, that knowledge can be
5 adjudicated digitally, or sometimes in the
6 situation where there's not a mobile app, a
7 phone-based consultation. And then the
8 physical nature of specialty care and or
9 primary care is then typically allocated to the
10 office. So, the use of resources better
11 allocated to where the cap ex is.

12 And so, therefore we think that not
13 only improves the quality, but the
14 affordability of the care in general, and
15 obviously under a value-based arrangement, the
16 alignment is there as well. It's a lot, but
17 hopefully that helps clarify.

18 DR. LIN: It does, thank you.

19 CO-CHAIR SINOPOLI: So, we only have
20 five minutes. I'm going to end with one kind
21 of broad question. So, as we have listened
22 over the last two days, and with the research
23 that PTAC has been provided, and what's been
24 constantly in our face is that these rural and
25 or frontier markets consist of much older
26 patients, sicker patients.

1 The geographies have less primary
2 care doctors, significantly less specialty
3 providers, less health care resources, less
4 community resources, a historical poor coding
5 activity by the physicians. And actually
6 because of all that, we wonder how can a
7 practice even survive in that kind of
8 environment, and have been actually been shared
9 with us some practices that have failed because
10 of participating in Alternative Payment Models
11 that stress their practice.
12 So, my question to you all, if you
13 know, is so how are practices surviving in
14 these rural and frontier geographies with all
15 of that against their success? And of the
16 ones, are you seeing practices fail, are you
17 seeing them being unwilling to participate in
18 APMs?
19 And if they're participating in APMs
20 and being successful, what's different about
21 those practices that will allow them to be
22 successful in an ACO or an APM that
23 distinguishes them from others? If you've had
24 that exposure, or can answer that. So, I'll
25 start with Alana.
26 DR. KNUDSON: I think those that are

1 successful are more willing to take risk, and
2 they're also innovative, and they draw on their
3 strengths. And I'll give you a great example.
4 We worked with the Maryland Health Care
5 Commission on a rural health problem that they
6 had with Chestertown, Chestertown was about to
7 close.
8 We worked with them, and identified
9 the strengths of that community. It has a high
10 proportion of older adults. They were
11 committed to ensuring that there was access in
12 their community, and providers, and the
13 community worked together. And I think a lot
14 of the success of the providers that are able
15 to continue in value-based care models are
16 because they have aligned with their community,
17 and got buy-in.
18 People are not bypassing, they are
19 staying local. And that is critical to any of
20 these rural providers being able to be
21 successful, having that community buy-in.
22 CO-CHAIR SINOPOLI: Great --
23 DR. PILGRIM: I'll add --
24 CO-CHAIR SINOPOLI: Go ahead, Randy.
25 DR. PILGRIM: Yeah, sorry. I'll
26 add, I do think a progressive mindset when

1 we've seen success is definitely helpful. But
2 a real reason to invest in the community for
3 either the clinicians or their staff are both,
4 as well as aligning as Alana just mentioned,
5 those are keys to when people have succeeded.
6 When things have failed, what we
7 have found is we've looked at the communities,
8 and again as I mentioned, 62 percent of our 300
9 emergency departments are in rural and
10 underserved communities. So, we see a lot of
11 what happens in communities when they fail, and
12 a lot of times the practices do not have
13 natively the capital to invest.
14 Or at least affordable capital to
15 invest in order to get themselves to a place
16 where they can utilize telemedicine, texting
17 capabilities, or other functionalities that are
18 required, that support them and expand their
19 capabilities. So, access to capital is a key.
20 And another thing is a reasonable
21 backstop to any risk-bearing arrangement.
22 Sometimes there are unreasonable backstops,
23 which are really sort of nothing. And then
24 people really don't want to invest, and they
25 have capability, and they're already there.
26 So, again, you can't take all risk away out of

1 risk-bearing value-based programs.

2 But reasonable backstops that are
3 considerate of the kinds of risks that are
4 actually being encountered by practices are
5 important.

6 CO-CHAIR SINOPOLI: Thank you. Tom?

7 DR. LEE: Yeah. My observations
8 have been interacting with a broad range of
9 provider groups across rural and urban
10 environments, is the ones that are surviving
11 tend to have leaders who are rooted in the
12 community and are more operationally and
13 financially savvy than the average primary care
14 provider.

15 I think the average primary care
16 provider is not financially and operationally
17 savvy just based on the nature of our training
18 and who we are as people. And so, I think the
19 vast majority of providers are struggling, and
20 the ones that are rooted are figuring out a way
21 to survive, but I think it's challenging.

22 The reimbursement, or ability to
23 potentially uplift these practices I think
24 needs to be facilitated, not necessarily just
25 done through reimbursement. Only in the sense
26 that reimbursement is a bit of air, but I think

1 the structures are really the challenging
2 aspects to most of these practices.
3 And I think the operational savvy to
4 do so can be challenging regardless of
5 reimbursement. So, I think reimbursement is,
6 in my mind, just air to a suffocating provider,
7 but doesn't allow them to truly innovate. So,
8 I think a combination of air and or structures
9 to plug into, I think could be a helpful
10 formula to think about to lift the average
11 struggling provider in the community.
12 CO-CHAIR SINOPOLI: Great insight,
13 thank you for that. So, I appreciate the
14 panelists’ time. As Larry said, you've been a
15 very sophisticated group, and have given us a
16 lot of information and things to think about.
17 We'll have another listening session this
18 afternoon at 10:50. And so, for now we're going
19 to adjourn at 10:40 for a short 10-minute break
20 until we come back. So, thank you all.
21 (Whereupon, the above-entitled
22 matter went off the record at 10:41 a.m. and
23 resumed at 10:52 a.m.)
24 *** Listening Session 3: Successful**
25 **Interventions and Models for**
26 **Encouraging Value-Based**

Transformation in Rural Areas

CO-CHAIR HARDIN: Welcome back.

I'm Lauran Hardin, Co-Chair of PTAC, and very excited to welcome you to this session where we've invited four experts who have real world experience in innovative approaches to facilitate value-based transformation in rural environments.

At this time, I'd like to ask our presenters to go ahead and turn on your videos, if you haven't. All four, after all four have presented, our Committee members will have plenty of time to ask questions.

The full biographies of our panelists can be found on the ASPE PTAC website, along with other materials for today's meeting.

So, I'll briefly introduce our guests. First, we have Dr. David Herman, who is Chief Executive Officer at Essentia Health. Welcome back, David. Please go ahead.

DR. HERMAN: Thank you very, very much. And I really appreciate PTAC having these sessions. I learn a lot more than I'm sure than of the content that I provide where others are learning from me.

1 As you can see, there's a great body
2 of knowledge and a lot of committed people that
3 want this to work. Next slide, please.
4 Just a little bit of background. At
5 Essentia Health our mission is we are called to
6 make a healthy difference in people's lives.
7 And I'll think you'll note from that, it's not
8 about whether they're in our clinics or in our
9 hospitals, but it also includes the
10 communities.
11 There's the resources that we have.
12 I do recognize that we are likely more
13 resourced-rich than a lot of small practices,
14 yet our commitment is to rural health. Next
15 slide, please.
16 What I'd like to share today is that
17 we've been on a value-based care journey since
18 2016 in our organization. But I'd like to talk
19 a little bit about some of the things you've
20 already heard a lot of detail on: the unique
21 challenges of providing care in the rural
22 communities and how we embarked on that value-
23 based care, what we've learned along the way,
24 and then most importantly, how these models
25 serve as a pathway to the future of rural
26 health care and gaining better health outcomes

1 for the rural communities that we're all
2 privileged to serve. Next slide, please.
3 You've heard ad infinitum about the
4 rural health care challenges. This is our
5 service area in Minnesota. And I'm going to
6 show some other slides that back this up.
7 Lower household incomes; much older; less
8 education; certainly more health concerns.
9 The distance to care, particularly
10 in northern Minnesota is very, very great. And
11 these communities and the people that reside
12 within these communities are relatively
13 resource-poor. There are many food deserts.
14 There's unreliable, if existing, broadband
15 connectivity. The provider practices that exist
16 in these rural communities are smaller. And
17 there certainly is a lack of specialty services
18 either within the community or within an hour's
19 drive away. Next slide, please.
20 As you can see, in this brown is
21 significantly below median state income for the
22 state of Minnesota. And as you can see, the
23 small town rural and isolated rural, the area
24 that we're privileged to serve, certainly has
25 its disproportionate share of those below the
26 median state income. Next slide, please.

1 Health insurance is another thing
2 that many of our communities and our patients
3 struggle with. As you can see, a large
4 proportion of Minnesota patients in rural areas
5 are on Medicare, medical assistance,
6 MinnesotaCare, or other supported programs.
7 And I can tell you that when you
8 look at employer-sponsored plans and it says
9 rural, they're at 39.4 percent. We at Essentia
10 Health are right around 23 percent on that.
11 And to outline, the challenges with
12 that, Minnesota has not re-based its Medicaid
13 compensation since 2017. And the world that we
14 live in, particularly since 2020, has had
15 significant inflation in everything that we use
16 to serve these patients. Next slide, please.
17 Travel to care, significantly
18 different. 85 minutes for mental health. 38
19 minutes, on average, for maternity and neonatal
20 care. Other med-surgical care, 60 minutes.
21 So, it's a long ways away.
22 Telehealth certainly helps, can provide and
23 close some of those gaps. But still, when a
24 person needs to travel, particularly when
25 they're aged, it's not just them that needs to
26 get in the car but generally their son and

1 their daughter. The opportunity costs, as well
2 as the time and travel costs, are tremendous.
3 Next slide, please.
4 So, really what it took for us to
5 get started on this was an organizational
6 commitment to the work. We decided in 2016 is
7 that if we were going to be taking care of the
8 communities that we're privileged to care for,
9 we had to focus on the quality of their care
10 and their outcomes rather than just on the
11 volume of the care that we provided.
12 In order to do that well, we had to
13 have an emphasis on prevention and wellness.
14 Because the distances are so far,
15 keeping someone healthy within their community
16 is a great benefit to the patients and the
17 communities.
18 In order to make sure that we're
19 doing well with our patients, coordination and
20 integration of care is tremendously important.
21 Showing up at the wrong clinic at the wrong
22 time after a two-and-a-half hour drive is not
23 serving our patients well.
24 Also, and I don't know if any of you
25 have tried to navigate the health care system
26 within the last several years, but even for the

1 best of us, even when we're feeling well, it's
2 incredibly complex and confusing.
3 In order to do this, we had to
4 transform our organization. We couldn't just
5 remodel around the edges. And that
6 transformation had to be clinician-driven. And
7 I'm very proud of my colleagues that have
8 helped navigate our way through that. Next
9 slide, please.
10 So, our approach -- and I wanted to
11 do this. I had my colleagues put pictures of
12 some of our buildings in there to remind you
13 that this is not about the buildings, this is
14 not about capital spent for patients to go,
15 this is how we care for our patients on a day-
16 to-day basis.
17 The first thing we needed to do is
18 identify the patients, not just the ones that
19 are "attributed to us," but everyone in the
20 communities we're privileged to serve.
21 Then we needed to determine what
22 their care needs were. And I'll talk a little
23 bit more about that in just as second.
24 We need to manage their chronic
25 illnesses and provide their care needs in a
26 proactive and coordinated way.

1 One of the things we think about is
2 that everybody should have a mother or a
3 grandmother that you can call when you have a
4 health question and get pragmatic advice that
5 you can use on a moment's notice. We want
6 utilization to be appropriate. That also
7 drives lower health care spending.
8 There's also tremendous health-
9 related social factors within our communities,
10 things that we can do on a day-to-day basis in
11 partnership with community partners that can
12 really make a difference in the health outcomes
13 of the people we're privileged to serve.
14 And then we want to be a bridge
15 organization and provide partnerships with
16 government, private payers, and the community
17 organizations to make sure that we're being
18 good stewards not just of Essentia health
19 funds, but the funds in the community, and the
20 funds that are provided to us by government and
21 other entities. Next slide, please.
22 We first started with community
23 level priorities. Every hospital does a
24 community health needs assessment and
25 implementation plan. But what do you do after
26 you do that?

1 We decided that in order to make
2 progress, we need to strategically invest in
3 community projects. Whether that's dollars or
4 expertise depends upon the project.
5 We need to be fully engaged in these
6 community coalitions. They have resources and
7 knowledge that we do not have as a health care
8 organization.
9 And then sometimes it takes an
10 organization to kick, get these things kick-
11 started. And what we want to be able to do is
12 implement and then evaluate for success those
13 strategies that have been defined within those
14 implementation plans.
15 And then work together to create
16 community conditions, not just health care
17 conditions, that empower all of us in our
18 communities to realize our optimal health.
19 Next slide, please.
20 So, our approach is what we call the
21 three A's: analytics, then action, and
22 accountability. And what we strive to do in
23 each one of these communities is create a model
24 of care delivery that is as standard as
25 possible and, yet, as unique as necessary to
26 meet the needs of our patients and communities.

1 That infrastructure can certainly be common.
2 But even communities that are as close as 20
3 miles apart often have very different and
4 disparate needs to maintain health outcomes
5 within their communities. Next slide, please.
6 What we use our analytics for is,
7 first, risk stratification. Who needs
8 resources now and who needs them a little bit
9 later.
10 The evaluation and utilization
11 patterns. Which one of our patients aren't
12 seeing us often enough or seeing us too often
13 but in the wrong ways. Through that, identify
14 the care gap identification and design to close
15 those. And then referral management. Not just
16 telling a patient you need to see a
17 cardiologist, but to be able to cultivate that
18 and curate that and get those patients and
19 their care connected. Next slide, please.
20 Then that comes to action. We need
21 alternative care delivery models, such as
22 virtual care, remote monitoring, home EMS
23 services. Improving those transitions of care
24 to make sure that the patient does not fall
25 through a care gap that we may have. Addressing
26 those social factors that influence health and

1 well-being at home and within their community.
2 Closing their care gaps. And then, of course,
3 chronic illness management.
4 I'm proud to say that we're one of
5 the best organizations in the country for lack
6 of readmissions after an admission for
7 congestive heart failure, as an example. And
8 it's because of the system that we've built
9 about the patient. Next slide, please.
10 Accountability. We all know what
11 we're responsible for, yet we hold ourselves
12 accountable for that. We establish goals
13 through our governance structure, all the way
14 up to the board.
15 We provide oversight coaching on
16 performance to make sure people are doing the
17 things that they need to do, and helping them
18 redesign those care models literally on the
19 fly.
20 We have transparency. We share
21 quality data across our organization. Any of
22 our providers if they want to know how they're
23 doing on their quality, they can click it. If
24 they want to know how anyone else in our
25 organization is doing on our quality measures,
26 they have access to that information very

1 easily as well. We track that progress.
2 And then we just don't wait till the
3 end of the year or the end of a quarter. We
4 have ongoing improvement strategies. If we're
5 not meeting our goals, if we're not closing
6 those gaps, what are we going to be doing
7 differently tomorrow than we're doing today to
8 be better as an organization to better serve
9 our patients and communities? Next slide,
10 please.
11 All that starts for us addressing
12 the needs of our communities because that's
13 where health starts. We want to at the
14 individual level address immediate, non-medical
15 needs of a patient. I'll talk about that in
16 just a second.
17 That organizational part, develop
18 those partnerships to tackle those needs beyond
19 the medical setting.
20 And then, in our community,
21 collaborate with community members and local
22 stakeholders to identify the needs and then
23 close those gaps.
24 There are skills that the
25 communities have that we will never have as an
26 organization that can lead to better health for

1 the people we're privileged to serve. Next
2 slide, please.
3 One of the things we've used to
4 address the needs of our community is each one
5 of our primary care patients at each visit,
6 because their status can change, completes a
7 five-question screening in MyChart. Our
8 Community Care Associate then follows up with
9 that. And then we make community referrals and
10 partnerships to make sure that we can close
11 those gaps, not just identify them. Next
12 slide, please.
13 Last year we did 185,000 screenings,
14 identified 20,000 patients who identified at
15 least one need. We had 10 Community Care
16 Associates who have worked with the patients.
17 We made 12,000 referrals, and 20 percent of
18 those patients with a social need are connected
19 with a new resource at that time of the visit
20 to help them maintain their wellness and their
21 health. Next slide, please.
22 We use a tool called "Resourceful"
23 that's immediately available within our EPIC,
24 our EHR[22]. We then have a public site also
25 where community members can access this as well

22 Electronic health record

1 to make those connections when our community
2 partners find that they need a resource that
3 they may not have. Next slide, please.
4 As you can see on this map, we have
5 664 programs. It's a living thing: things roll
6 in, things roll out. And it works across our
7 entire service area. Next slide, please.
8 We have been very successful in
9 Medicare Shared Savings and the Minnesota
10 Integrated Health Partnership. You can see the
11 numbers there. Nearly 40 percent of our
12 revenue flows through value-based programs.
13 And about 80 percent of those value-
14 based contracts have downside risk. We are
15 willing to take upside and downside risk
16 because that helps us drive our ability through
17 these programs. Next slide, please.
18 The lessons that we've learned.
19 First of all, commitment as an organization is
20 crucial. We've heard a lot over the last 20
21 years about having one foot on the dock and one
22 foot in the boat. I believe unless you jump
23 right in the water and get wet, and make a
24 commitment, you really can't do this as an
25 organization.
26 It requires design infrastructure to

1 support it. Just asking our colleagues and
2 clinicians to do better every day does not meet
3 our patients' needs. We need to know what our
4 patients need and the community needs, and then
5 work together to close those gaps in care.
6 I do believe that organizational
7 strategies can be different whether you're
8 capacity-limited versus the demand-limited as
9 an organization.
10 Our organization is capacity-
11 limited. So, when someone says, what am I
12 going to do with my excess capacity when we
13 take better care of patients? We do not have
14 excess capacity. There is another person that
15 needs to get in for health care. That may be
16 different than other organizations,
17 particularly in very rural areas where they may
18 be demand-limited.
19 And then building the systems within
20 your organization and the partnerships with the
21 community that make the right thing to do the
22 easiest thing to do. Next slide, please.
23 Thank you very much. Look forward
24 to the conversation.
25 CO-CHAIR HARDIN: Thank you so much,
26 David. And thanks for returning again. Your

1 presentation was very helpful.
2 Next, I'd like to welcome Dr. Ami
3 Bhatt, who is Chief Innovation Officer at the
4 American College of Cardiology and an Associate
5 Professor at Harvard Medical School. Please go
6 ahead, Ami.
7 DR. BHATT: Thank you so much for
8 having me.
9 So, I just wanted to echo a few
10 things that David started with. I think the
11 first is the organization's commitment to doing
12 its work is really important. And so I just
13 want to start by saying at the American College
14 of Cardiology, we have a value-based care forum
15 where we really get together. Clinician does
16 not silo from all the other institutions that
17 are relevant in making this happen.
18 And so, I will refer you to an
19 American Heart Association Journal article --
20 and I can maybe include that in the chat later
21 so they can take a look at -- that came out
22 that really puts together all of our thoughts
23 about where we start from, what the key things
24 to look at are, and where we might end up.
25 Today specifically I've been tasked
26 to talk about interventions and models for

1 value-based transformation in rural areas. And
2 so, even though a lot of the work can be echoed
3 in that paper, I'm taking a slightly different
4 take on it to help share it with you. Next
5 slide.
6 Is it too loud in the background
7 here by the way? Are we okay? It's okay.
8 Okay.
9 I want to start with just two key
10 things. When we talk about rural care for
11 cardiovascular care, this is often what we see.
12 Procedure rates are lower in rural
13 hospitals, for the Critical Access Hospitals.
14 Here you see in the top chart acute
15 myocardial infarction, or heart attack, in blue
16 are rural hospitals. In red are urban
17 hospitals. And we see decreased rates of
18 cardiac catheterization, intervention or
19 placement of stent, or coronary artery bypass
20 grafting.
21 And then similarly, we also see in
22 stroke care our decreased rates in ischemic
23 thrombolysis or intravascular therapy. Next
24 slide.
25 We also see mortality is higher in
26 rural hospitals. And this is across the board,

1 whether it's heart attack, heart failure, or
2 ischemic stroke in the top panel, or acute MI[23],
3 heart failure, and ischemic stroke at 90 days
4 in the bottom panel. Next slide.
5 The point I'd like to make today is
6 I think we have to really differentiate chronic
7 from acute care when we talk about how are we
8 going to make progress in the initial stages of
9 value-based models that include cardiovascular
10 care. And for that, root cause is essential in
11 improving Critical Access Hospital outcomes.
12 So, similar to what David was
13 saying, we need to move into the communities
14 where these people live in order to be able to
15 catch these diseases far earlier than we're
16 currently catching them. And that's inherently
17 the root of our problem in cardiovascular
18 disease outcomes.
19 It is possible -- I'll only talk
20 about this once and not again -- to strengthen
21 our telehealth and our transfer networks for
22 the acute care between rural and non-rural
23 hospitals. Especially in stroke care, the use
24 of telestroke care has been incredibly helpful
25 in really changing our ability to medically

23 Myocardial infraction

1 treat stroke patients.
2 However, for purposes of this
3 discussion I think I want to concentrate on the
4 other side, which is we do think about how we
5 will provide more care. We have a workforce
6 shortage in rural areas in cardiovascular,
7 across the board but clearly in cardiovascular.
8 And we often talk about whether we
9 need to implement community-based or hospital-
10 focused telehealth. And I'll say I think we
11 need to move even earlier than that because our
12 quality in certain efforts that are centered on
13 improving telehealth based out of the brick-
14 and-mortar institutions are still not as
15 successful as we see with behavioral health and
16 other fields where we're implementing home-
17 based telecare.
18 And the real incentives for staying
19 close to home are clear: our population in
20 cardiovascular disease overlaps with a large
21 majority of the mental health population. So,
22 in fact those studies are studying our patients
23 a large majority of the time.
24 Lastly, I want to point out that
25 Medicare Advantage does already demonstrate
26 differences in preventive versus acute care

1 when it comes to cardiovascular disease. Now,
2 I recognize that Medicare Advantage versus the
3 rest of Medicare may be a select population,
4 but we are seeing that value-based efforts
5 already are showing differences both at 30, 90
6 days, but even at 365 days. Next slide.
7 So, how do we approach this? I
8 think one of the most important things is to
9 build up rural cardiovascular care
10 infrastructure. There are some excellent
11 groups that are already working on this.
12 But first is rural-oriented design.
13 We are really focused at the ACC[24] on expansion
14 of the team. I'm currently in New York City
15 for the UN General Assembly 2023 meeting where
16 we're talking about workforce shortage. And I
17 only bring that up because our approach
18 globally is really very similar to our approach
19 when we think about rural underserved areas in
20 the U.S., which is that team, yes, will include
21 physicians, it can include allied
22 practitioners, nurse practitioners, or
23 physician assistants. So, we have to lean on
24 the out team, we have to lean on pharmacists.

24 American College of Cardiology

1 And oftentimes, community health
2 workers are really a key part of our answer to
3 be able to provide care all the way down to the
4 communities where people live, especially rural
5 areas. And so, we're really kind of just
6 thinking about what does the expansion of the
7 team look like?
8 Also, what does payment for the
9 expansion of the team look like? Right? How
10 does that change payment models is important.
11 The second that we've focused on in
12 our value-based care forum that we have at the
13 American College of Cardiology and Heart Health
14 started with atrial fibrillation as a single
15 diagnosis that we could then care for. We're
16 not going to have a single diagnosis in a
17 single episode. We're actually seeing it over
18 the life of a diagnosis. What happens to these
19 patients?
20 And from that we're learning that
21 disease-based closed loop programs may actually
22 be the way for us to be able to achieve value-
23 based care.
24 The other two areas this would be
25 relevant in are heart failure and hypertension,
26 times where we can help educate the community,

1 we can diagnose earlier. We can then implement
2 care in the communities where people live, and
3 then take those patients when we realize that
4 they need further care and get them to the
5 right person at the right time.
6 There needs to be a unique blend of
7 community-based care, telemedicine, and then
8 larger practices. I think we have to recognize
9 that we can't say it's going to be 20 percent
10 telemedicine and 80 percent in-person, and
11 everybody is going to do that.
12 And so, I think a little bit of
13 loosening of the reins on this is the
14 percentage we do on any given practice is
15 important. I say that only because as we build
16 practices, oftentimes we say, well, how much
17 are you going to do this? And the answer is we
18 really don't know. So, we need the flexibility
19 to know when we're going to be using
20 telemedicine, when we're using digital health
21 or remote monitoring for cardiovascular
22 disease, and when we need people to be seen in
23 person, either in the homes where they live or
24 in the local institution.
25 One of the collaborations that we
26 have had for the past several years is with a

1 group called Dispatch Health. And that's been
2 a great example for us in starting to learn
3 about how to get to the communities, to
4 patients' homes. And what kind of care can we
5 provide there that the patient understands and
6 feels safe, and that we do as well.
7 One of the key things that we really
8 focus on is ensuring that by having cost-saving
9 care or care in areas that may have less access
10 to specific types of testing, although
11 increasing what we can get through the home,
12 we're not actually decreasing the quality of
13 that care. And so, really starting to think
14 about what are the metrics and what is the
15 balance between cost and quality, and it is an
16 important part of work. And partnering with
17 some of these organizations helps us study
18 that.
19 And then, lastly, we really want
20 high-impact, low-complexity digital health.
21 You are hearing about, and I'm going to bring
22 it up, AI[25], and ChatGPT, and clinical decision-
23 making. And the more complicated we get with
24 the digital health interventions, the harder
25 it's going to be for us to be able to build the

25 Artificial intelligence

1 infrastructure upon which that can then grow.
2 So, we really are still focused on
3 lower complexity digital health to reach the
4 areas we need to reach to establish that
5 infrastructure. At the same time, you'll hear
6 organizations studying the more complex parts
7 of AI and digital health. However, we can't
8 think about starting with that first
9 necessarily.
10 I can answer more questions about
11 that later. Next slide.
12 So, what are the advantages? There
13 are a couple advantages to cardiology in terms
14 of taking care of rural populations.
15 So, the first is we know the patient
16 volume in rural health is lower in general.
17 And this is the problem with the shutting of
18 hospitals, it's simply that we have lower
19 volume.
20 However, our cardiovascular risk
21 factors in disease are quite prevalent. So,
22 you can really fairly say that if we're talking
23 about doing population-based care together
24 between subspecialties and primary care,
25 cardiovascular disease is going to overlap,
26 overlap at least 60 to 80 percent of the time,

1 depending on which age group we're looking at.
2 So, for us that's a great
3 opportunity to study together and not set
4 cardiovascular separate from primary care.
5 Second, we know we are human and
6 finance resource-limited. However, for
7 cardiology we're pretty good at remote
8 monitoring services. And that's a great force
9 multiplier.
10 So, if we really only have one
11 physician to be able to look over an area, we
12 can set up those remote monitoring systems, and
13 set up the alerts to get us the right care at
14 the right time. We can actually force-multiply
15 the workforce that we currently have because
16 remote monitoring is so well established in our
17 field.
18 We have a way to link compensation
19 to non-cost saving metrics as well. The last
20 time I spoke with PTAC I know that I brought
21 this up as well. But achieving what we call
22 guideline directed medical therapy for almost
23 any cardiovascular disease, we have very clear
24 algorithms and goals for these are the
25 medications, these are the therapies that
26 people should receive.

1 We are also clearly not meeting that
2 goal, guideline directed medical therapy goal
3 in the United States right now, especially in
4 rural and, actually, inner-city as well.
5 And so, I think linking compensation
6 to those non-cost saving metrics and what part
7 of the population achieves guideline directed
8 medical therapy, because we know that guideline
9 directed medical therapy will turn into better
10 outcomes, morbidity, and mortality. Could be a
11 near term mechanism for us to start to test and
12 build infrastructure.
13 And, lastly, and I mentioned this
14 earlier, we need to incentivize team-based
15 care. And we need some innovative local
16 community health roles. The more time we spend
17 thinking about global, the more we think about
18 how relevant what we're doing there is to rural
19 America. And really thinking about who are the
20 community health workers that we could up-
21 skill, educate, who may be providing primary
22 care right now or urgent care right now, but
23 could really help us provide cardiovascular
24 care at the same time, and create a novel
25 mechanism of team-based care. Next slide.
26 This is my favorite digital health

1 paradigm. Rural health fits it perfectly. We
2 have chronic management, which is the bulk of
3 what cardiovascular disease is. And that
4 partnership with primary care needs to happen.
5 It's patient-centric. It reduces low-value
6 specialist care. And when we have a workforce
7 shortage, that's really important.
8 It helps us identify rising risk in
9 the community so that we can identify illness
10 and then manage it either locally in their
11 homes, out of primary care, or coming to a
12 specialty practice. And it really does enable
13 us to take those patients who require
14 intervention that I started with on the first
15 slide who are having worse outcomes and worse
16 mortality in the Critical Access Hospitals, and
17 instead be able to get them specialty care in
18 the appropriate place where they belong.
19 And some of those patients will do
20 excellently at the Critical Access Hospital.
21 And we can identify those who may not. But we
22 can only do that if we're doing digital health
23 and we're measuring these patients earlier on.
24 Next slide.
25 I'm going to end with the patients.
26 What are we working on at the ACC? So, we are

1 really thinking about how do we take education,
2 which is what the American College of
3 Cardiology produces, and revise it to make it
4 relevant to rural team caregivers and patients.
5 How do we do that? What does that look like?
6 Partnering with other programs, with other
7 tests.
8 The second is accepting use of
9 blended care and not be fixed in what that
10 looks like. Use phone, use video in addition
11 to being seen in person. And accept that
12 those, again, those ratios can change from day
13 to day, and that's okay.
14 Realize our patients' potential by
15 making digital interfaces easier to engage with
16 for self-monitoring. We need to start thinking
17 about the systems that allow self-monitoring,
18 and how we can really make those digital
19 interfaces as easy as the rest of the digital
20 world.
21 And we can't say rural America
22 doesn't have digital interaction. They, in
23 fact, have quite a bit. But the people who are
24 interacting with them have entire fields and
25 teams who are building how easy it is to use
26 those interfaces. And we're not doing that

1 just yet. And I think that's a priority for us
2 in terms of innovation at the ACC.
3 We do need to match rural needs with
4 the interventions that are offered. So, I
5 think what we refer to as case mapping, which
6 is which are the areas that have the ability to
7 have good connectivity, and have high
8 hypertension. Those are the areas where remote
9 blood pressure monitoring programs make sense.
10 But if we have areas that don't have
11 good connectivity and we just can't do the
12 square peg/round hole, we should think about
13 who the community-based health care groups are
14 and design different tools for those areas.
15 So, I think the one-size-fits-all,
16 we need to do even better than that.
17 And then, lastly, and this is a new
18 area that we're working in but I wanted to
19 share with everybody is to start to lead
20 registries and trials. We do a lot of this in
21 cardiology. But, generally, it comes from us.
22 We have a registry. A clinician
23 puts the data in. We run a trial. And rather,
24 using some of the novel registry mechanisms
25 that are actually patients able to get onto a
26 cell phone and sign up, or get onto a web.

1 Again, it requires some connectivity, but
2 minimal. And sign up themselves to be part of
3 a registry.
4 And so, the patient-led registries
5 are an area we have great interest in because
6 our patients are motivated. They want the
7 care. And they're being developed in a way
8 that's already addressing a user interface that
9 we're trying to think about, and turning our
10 clinical work to do something that is with a
11 good user interface for the patient.
12 And so, these registries are really
13 being stated as, hey, patients, go ahead and
14 sign up for this.
15 What happens next? When a patient
16 signs up, they give permission for us to be
17 able to then extract their digital health
18 records from the EHR, whether it's a local one
19 or a large conglomerate, and then be able to
20 help analyze that data, set up remote
21 monitoring systems for them.
22 And so, having patient registries,
23 and I would say, you know, it's hard to say
24 rural patient registry, it's a very large and
25 amorphous idea, but other specific disease
26 processes where we want to really be able to

1 engage patients to enroll themselves. And then
2 their clinicians will come along and be onboard
3 as well.
4 So, I think that's a real
5 interesting area. I'm happy to talk more about
6 that later.
7 I think that might be my last slide.
8 Okay.
9 Thank you so much. And apologies
10 again for the background noise.
11 CO-CHAIR HARDIN: Thank you so much,
12 Ami. That was very interesting.
13 Next, we'd like to welcome Thad
14 Shunkwiler who is an Associate Professor at the
15 Department of Health Science, and Director of
16 the Center for Rural Behavioral Health at the
17 College of Allied Health and Nursing at
18 Minnesota State University, Mankato.
19 Welcome, Thad. Please go ahead.
20 MR. SHUNKWILER: Good morning. Thank
21 you, everyone, for having me join this, this
22 webinar today to share a little bit about my
23 professional expertise and, honestly, my
24 personal passion.
25 I'm a bit of an odd outlier, given
26 some of the topics we've had so far, in that my

1 presentation is exclusively focused on
2 behavioral health, and really about the
3 workforce. And I think it is important to have
4 that conversation because it doesn't matter how
5 you pay for care if there are -- if there's no
6 one to provide the care is how I've always
7 framed that conversation.
8 And so, I just want to spend about
9 10 minutes to talk about some of the challenges
10 and opportunities, and how we're going to move
11 forward in solving some of these issues within
12 rural behavioral health. Next slide.
13 Now, all of us are aware there are
14 multitudes of challenges going on across health
15 care in various capacities. But none that is
16 getting the attention that mental health and
17 behavioral health is having. You know, the
18 attention that our media is focusing in on some
19 of these issues, as well as some of our
20 decision makers and policy makers at the state
21 and federal levels, they are, they are zeroing
22 in on what's going on with people.
23 And rightfully so. People are
24 unwell. We are seeing rates of mental
25 unwellness and emotional distress that we
26 historically have never seen before. And so,

1 these challenges are very real and impact every
2 facet of what we do, whether we're a CEO of an
3 entire system or a cardiologist, I mean, all of
4 us are impacted professionally, and many of us
5 personally by these challenges.
6 The story that's often missed when
7 we're having these conversations is about the
8 treatment gap. And what I mean by that is
9 there are more people who need services than
10 the providers who can provide it. And so, we
11 kind of refer to this as the treatment gap.
12 Next slide.
13 The challenge with that treatment
14 gap, among many, is that it's not
15 geographically equitable. The rural, rural
16 America has a huge gap of behavioral health
17 services.
18 And this graphic here kind of really
19 outlines it. It's from HRSA[26]. It's the Health
20 Professional Shortage Areas [HPSAs] for mental
21 health.
22 And everywhere that it's a dark is
23 a, is an HPSA for mental health. And so, you
24 can see pretty much the entire country, other
25 than the highly-concentrated metropolitan

26 Health Resources and Services Administration

1 areas, qualifies as a Mental Health
2 Professional Shortage Area.
3 In Minnesota, where I am from, 80
4 percent of our counties qualify as an HPSA.
5 South Dakota, our neighbors to the
6 west, 100 percent of their counties are Mental
7 Health Professional Shortage Areas.
8 So, this issue, this treatment gap
9 that we talk about, it's important to recognize
10 that it is, it is impacting our rural
11 communities at a much higher rate than our
12 metropolitan counterparts. Next slide. One
13 more I think. I think we skipped over a
14 couple. Okay. Oh, never mind, we've got it
15 right here.
16 The issue as a professor, we're
17 always kind of couched as being the doom and
18 gloom folks. And I'm going to be a little bit
19 doom and gloom before we get to some of our
20 opportunities.
21 This problem is getting worse. We
22 are seeing unprecedented increasing demand for
23 behavioral health services. For those of you
24 in the room who are providers, you're probably
25 seeing this from across your desk.
26 Here in Minnesota, our state

1 association just did a survey of the community
2 mental health clinics. And we have 70,000
3 children on waiting lists in Minnesota for
4 mental health services. And it's not getting
5 any better. All the underlying metrics show us
6 that things are getting worse, as far as
7 people's emotional well-being.
8 On top of that we're seeing an
9 unprecedented provider exodus from behavioral
10 health care, in part due to retirements. I
11 think the professional on its own, particularly
12 in rural communities, our providers tend to be
13 a little bit older.
14 In Minnesota, for example, over half
15 of our behavioral health professionals in
16 Minnesota are 55 years of age or older. And
17 that's a problem because we're not graduating
18 students going into these programs at the rate
19 in which people are retiring simply just
20 reaching that age.
21 The other, the other issue that is
22 facing health care across the board but is
23 really impacting behavioral health is burnout.
24 And folks who are leaving their careers, or
25 reducing their hours worked, or going to a
26 cash-only payment structure to reduce some of

1 the administrative burden, we're seeing a lot
2 of our providers burning out and leaving the
3 field or reducing their capacity to treat
4 patients.
5 And so those two things combined
6 just really kind of highlight just how -- I
7 mean, we're in a crisis. And it's going to get
8 considerably worse if we, if we don't act.
9 Next slide.
10 Now, HRSA would have us believe that
11 we're going to have everything that we need in
12 the next three years. This is the infamous
13 2020 projection report that told us that we
14 would have two social workers for every job
15 here by 2030.
16 And I can tell you, that's the
17 furthest thing from the truth on the ground in
18 what's going on. I mean, there are substantial
19 vacancy rates across health care, but mental
20 health care often has the highest. At least in
21 Minnesota, one out of every four positions in
22 Minnesota is vacant according to Department of
23 Economic Development data.
24 So, the HRSA projections are wrong.
25 And the other thing they didn't take into
26 account is the next slide.

1 One of the conversations we're also
2 not having when we're thinking about the future
3 of the workforce is where is the pipeline going
4 to come from?
5 The well-known issue within higher
6 education and but less known everywhere else is
7 that we are about to fall off an enrollment
8 cliff. But there are going to be fewer high
9 school graduates across this country going into
10 college. That's not taking into account
11 economic factors and other factors that may
12 dissuade someone from obtaining higher
13 education. This is simply there are not enough
14 kids graduating high school that will be
15 eligible.
16 So, when we think about the future
17 pipeline, we are going to have to do more with
18 even less. Next slide.
19 So, I'd like to give just a couple
20 solutions to some of the issues that were
21 raised by the GAO[27]'s report to Congress about
22 the behavioral health workforce. And so, if
23 you've not read that report, basically Congress
24 asked them to say what are the barriers to
25 growing the behavioral health workforce?

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27 Government Accountability Office

1 And so, they really looked at both
2 the recruitment and retention side of things.
3 And I won't go through each of these bullet
4 points individually.
5 But a couple of things that I think
6 that are important to highlight when we're
7 thinking about workforce:
8 One is, obviously, the financial
9 commitment that students make to get an
10 advanced degree, whether that be a master's
11 degree, or a doctoral degree, or in medicine, a
12 medical degree. And we have great student loan
13 repayment programs, National Health Service
14 Corps, state-level programs.
15 And what we have found through our
16 work at the Center for Rural Behavioral Health
17 is that we should really take that model and
18 flip it over. And we should really invest in
19 grants and scholarships on the front end to
20 incentivize and recruit more people into this
21 profession. It doesn't cost us as taxpayers
22 anymore, it's just taking that repayment plan
23 and putting it on the front end.
24 The other piece around the academic
25 pipeline issues, it's important for us to
26 recruit. For rural health care in general, the

1 literature is very clear: if you want a health
2 care workforce in rural communities, you have
3 to grow it yourself. The transplant model is
4 ineffective, doesn't work at the same rate that
5 if you were to invest in growing that pipeline
6 organically in those communities that is shown,
7 that is shown to work.
8 In addition to that, we have to
9 increase the training capacity of our rural
10 institutions. Research is very clear, students
11 tend to practice, at least within behavioral
12 health, within a kind of geographical catchment
13 area of where they trained. And so, how do we
14 increase the training capacities of our
15 programming?
16 In Minnesota we wrote a paper this
17 spring for our legislature that they asked us
18 why don't we have more behavioral health
19 professionals?
20 And what we found through our work
21 is that in Minnesota we turn away 100 qualified
22 students every year who want to pursue an
23 advanced degree in behavioral health because of
24 training capacity limitations. So, at a time
25 when we're having unprecedented demand for
26 services and workforce shortages, how are we

1 turning away kids who want to do this, and are
2 qualified to do it, but we just don't have the
3 seats in our courses for them?
4 So, how do we solve some of those
5 challenges? Next slide.
6 And with retaining I think, you
7 know, the great work that you're all doing
8 around reimbursement rates, Alternative Payment
9 Models, those things, that work has to
10 continue. I think it's the oldest story within
11 mental health is that we're not paid enough.
12 Which is true. But, you know, how are we going
13 to innovate and solve some of those challenges
14 around that?
15 The last piece about burnout, right,
16 some of the exodus of our providers to burnout,
17 I think it's important for us as an industry to
18 shift from a self-care model to a system-care
19 model. Stop putting the responsibility on the
20 individual, and then they own some of that, but
21 ultimately as a system, how are we going to
22 attack this burnout issue more holistically
23 across the board? Next slide.
24 We can go ahead. Oh, go back a
25 couple more. One more. Thank you. Now we'll
26 go ahead.

1 When we think about the -- yeah,
2 we'll go to the slide that says,
3 "Opportunities: Data Driven Policy Solutions."
4 I think it's two slides from this forward,
5 please. There we go.
6 So, how do we, how do we solve this
7 issue? I think it's important for us to lean
8 on the data.
9 I think when we talk about mental
10 health, there's a lot of personal feelings,
11 there's a lot of emotion when it comes to it.
12 We should really let the data drive the
13 conversation on how we solve this, particularly
14 when it comes to things like policy. And so,
15 how do we enact policy that builds workforce
16 capacity, both for the professionals, the
17 licensed providers like myself, but also our
18 para-professional colleagues?
19 How do we increase their roles? And
20 how do we, as Ami talked about, pay for those
21 individuals to be part of that care team?
22 Expand APMs that improve access to
23 care. Prioritize upstream intervention. I
24 think I just want to share just one piece about
25 what I mean by that.
26 There's a phenomenon happening

1 across the country, and it happens in your
2 settings I'm sure, that our EDs are full of
3 people with mental health challenges and
4 nowhere else to go. In Minnesota it's a, it's
5 a crisis, particularly with our young people,
6 our children and adolescents who are sitting in
7 emergency departments sometimes for days,
8 weeks, and in some cases months before they can
9 go and receive appropriate care.
10 When the legislature talks about how
11 we solve this problem, their solution is build
12 more hospital beds, or open up more beds. And
13 I think, how silly. Right? Like, why don't we
14 go upstream and prevent them from having to
15 walk into the doors of the EDs in the first
16 place?
17 We have 7,000 kids on a waiting
18 list. Some of those kids aren't going to get
19 care, many of those kids won't get care, and
20 they are going to end up in the ED because we
21 are not upstream intervening on some of those
22 challenges.
23 And the last piece I think is
24 important is prevention. The best treatment is
25 always preventing it. And we don't often think
26 about mental health prevention and building

1 resilience. And how do we kind of adopt a
2 model, a system? How to we pay for that to
3 really incentivize some of those preventative
4 practices so that we don't need the demand
5 which we're seeing? Because we will never out-
6 supply this and dig ourselves out of this hole.
7 Next slide.
8 The last thing I just want to
9 highlight is some of the great work that we're
10 doing here in southern Minnesota on this issue.
11 The Center for Rural Behavioral
12 Health is an academic research center that is
13 trying to solve this issue for Minnesota and,
14 frankly, across this country. We're one of the
15 few academic research centers in the United
16 States that is exclusively focused on rural
17 behavioral health. And we're hoping that what
18 we're learning from our faculty and our
19 research team can really, hopefully, solve some
20 of the challenges that we have spent the last
21 few minutes discussing.
22 So, thank you so much for having me.
23 And I look forward to the question-and-answer
24 series.
25 CO-CHAIR HARDIN: Thank you so much,
26 Thad. That was very interesting.

1 And, lastly, we have Dr. Susan
2 Stone, who is President of Frontier Nursing
3 University.
4 Welcome, Susan. And please go
5 ahead. And we can't hear your sound.
6 DR. STONE: Okay, sorry.
7 CO-CHAIR HARDIN: There we go.
8 DR. STONE: Just a little bit more
9 about myself.
10 I spent the first half of my career
11 working in rural areas in Upstate New York --
12 Little Falls, New York; Herkimer, New York;
13 Cooperstown, New York -- and then later moved
14 on to Kentucky where I developed a practice in
15 southeastern Kentucky at a tiny rural hospital
16 with Frontier Nursing Service.
17 In listening to the other
18 presentations today, it's very inspiring and
19 hopeful that we can make some differences in
20 rural health care. But I did, when we talk
21 about prevention, I wanted to share this little
22 story that somebody told me just last week that
23 has been kind of stuck in my brain.
24 Picture a river and there are health
25 care providers, and EMTs[28], and everybody's

28 Emergency medical technicians

1 standing around the river. And there's babies
2 coming down the river. And everybody's pulling
3 the babies out, and doing resuscitation, and
4 doing all kind of health care with them.
5 When somebody looks up and says,
6 hey, maybe we better go upstream and find out
7 who's throwing the babies in the river in the
8 first place.
9 And I think that's what we really
10 have to think about when we're talking about
11 social determinants of health. What are we
12 doing upstream to cause these significant
13 problems that we're having?
14 So, next slide, please.
15 So, what are the social determinants
16 of health? You know, you all know. I've heard
17 it today and yesterday, too. And I cited to a
18 couple of presentations.
19 But they're "the conditions in the
20 environment where people are born, live, learn,
21 work, play, worship, and age that affect a wide
22 range of health, functioning, and quality-of-
23 life outcomes and risks."
24 So, rural persons, as we know, we've
25 heard that today, David Herman was very
26 eloquent in his delineating this, but they

1 include poverty, lack of literacy including
2 health literacy, access to safe and affordable
3 transportation, access to safe homes,
4 environmental health such as water quality,
5 access to healthy and affordable food, and
6 access to health care services.
7 We're at our wits end over this data
8 on maternal deaths, with all the work that
9 we've been doing, the CDC[29] reports that
10 maternal deaths nearly doubled over the last
11 three years. So, our maternal mortality rate
12 rising. In rural communities, where maternal
13 mortality is almost double what it is in urban
14 areas, really struggle to access lifesaving
15 maternal health care. And this is a good
16 example of the struggles. Next slide.
17 So, we're going to go quickly
18 through these slides. But just you can see in
19 the rural areas, people are older. Next.
20 People are more likely not to have a high
21 school education. Next. People are more
22 likely to have, to report four or more chronic
23 conditions in a rural area. Next. And they're
24 more likely to use the emergency department for
25 their visits, and indicating a lack of primary

29 Centers for Disease Control and Prevention

1 health care providers. Next slide. They are
2 poor. They have less income to deal with every
3 year. Next slide.
4 Okay. So, I love this, this diagram
5 put out by the CDC. Social determinants of
6 health are really complex issues. And it's
7 going to take all of our resources to really
8 address them. Health care providers cannot
9 address all of these issues. It's a team
10 approach.
11 But it does take policy and laws.
12 We have to be collecting data and surveillance.
13 And then we have to evaluate that data. We
14 have to find out what strategies work and what
15 don't work. We have to build our evidence.
16 Partnerships are absolutely critical
17 in order to solve some of our rural health
18 issues.
19 And we have to involve the
20 communities because we cannot create solutions
21 for communities without involving them in what
22 are their issues and what are we doing.
23 The infrastructure and capacity,
24 we've heard about that. Not having internet,
25 not -- I mean, just think about saying, okay,
26 now we're all going to use electronic medical

1 records. In a tiny Critical Access Hospital
2 with very few resources, you know, IT
3 resources, things like that, these kinds of
4 things are a struggle. How are we helping to
5 make that happen?
6 And one of our most important issues
7 is equity. We have to pay attention to equity.
8 We know that there's crisis in our health care
9 system. We can absolutely see that in the
10 outcomes.
11 Again, I refer back to maternal
12 mortality where women of color are three times
13 more likely to die of childbirth and related
14 issues than a white woman is in our country.
15 So, there's a very complex issue.
16 I like this diagram. I think I'm
17 going to put it on my desk so I remind myself
18 every day that we have to look at everything.
19 Next slide, please.
20 So, you know, there's different
21 kinds of rural areas. The Census Bureau said
22 if it's not urban, it's rural. And the
23 National Rural Health Association basically
24 says, well, we have to have definitions
25 specific to the purposes of the programs, for
26 the programs that are being used. And these

1 are referred to as programmatic designations.
2 But the bottom line is really that
3 not all rural areas of communities have the
4 same challenges.
5 It's important to do a community
6 assessment to identify the major issues in
7 designing programs for rural communities.
8 When I worked in Herkimer, New York,
9 honestly a little bit similar to Hyden,
10 Kentucky, in many ways, but on the other hand
11 the resources were different. We could drive
12 an hour and be in Albany, or drive an hour the
13 other way and be in Syracuse. Where down in
14 Hyden, it was more than two-and-a-half hours to
15 the university setting health care system.
16 So, even the mountains of Hyden were
17 a challenge because they would not do
18 helicopter transfers unless the weather was
19 perfect. We had too many bad outcomes. You
20 know, we actually had two helicopter crashes
21 with very bad results.
22 So, you can just see, like, that
23 even though they're similar, they're very
24 different, and the challenges can be very
25 different. And we have to pay attention to
26 that. Next slide.

1 So, how are we currently addressing
2 some of these? There's lots of programs like
3 the comprehensive asthma home assessments and
4 education.
5 Some Federally Qualified Health
6 Centers even provide legal assistance, you
7 know, to help with housing, and immigration,
8 and financial security.
9 It's important -- I think that David
10 did mention this, too. I was very impressed
11 with your presentation, David. So, but
12 creating web-based systems that identify
13 community resources, and the referrals that are
14 made to those resources, and the outcomes of
15 the referrals, if we could do that
16 electronically, it would help so much.
17 Offering telehealth services when
18 appropriate is very helpful in a rural setting.
19 And hiring community health workers,
20 this is a very important issue. You know, if
21 we can't go in and do the home visits ourself
22 and be out there in the community, we have to
23 have health workers that are out there
24 assisting with patient contact, education,
25 facilitating partnerships, making those
26 referrals happen.

1 And I think that we need to invest
2 in a lot more community health workers to
3 assist us in their work. Next slide.
4 So, promising models that improve
5 outcomes. Again, technology systems that allow
6 health care providers to screen for social
7 needs and identify resources in those
8 communities, if the resources are there.
9 That's another issue.
10 Connecting these systems to the
11 medical record would allow tracking of outcomes
12 and better coordination. And this is so
13 important because, you know, just telling
14 someone they need to go to WIC[30] isn't, just
15 isn't enough.
16 This would also help us to determine
17 what works. And it's really important for us
18 to grow the evidence of what works.
19 The Medicare Shared Savings Program
20 "Pathways to Success" does allow the
21 organization of Accountable Care Organizations.
22 And the outcomes to date have showed comparable
23 or better outcomes with decreased costs with
24 the ACO compared to the traditional physician
25 fee-for-service practices. And I'll talk about

30 Women, Infants, and Children

1 that more in a minute.

2 So, partnering with doulas also to
3 give information and support to pregnant women.

4 Recruiting nurse-midwives to provide
5 first -- provide first-line comprehensive
6 maternity care that does address the social
7 determinants of health.

8 And in our university, which is a
9 kind of unique university, we only educate
10 advanced practice nurses and nurse-midwives:
11 family nurse practitioners, psychiatric mental
12 health nurse practitioners, women's health care
13 nurse practitioners. It is done through
14 distance. We've been doing this for 30 years
15 now.

16 And so, our students come to campus
17 only twice during their educational program and
18 spend some days with us. It's very interactive
19 educational online. And we are recruiting from
20 the rural and underserved areas. 22 percent of
21 our students do live in rural areas right now.
22 And over 60 percent live in rural and
23 underserved areas overall.

24 So, we are educating these nurses to
25 be nurse practitioners and nurse-midwives to
26 stay in their communities and work in their

1 communities. We use community, we use their
2 community as the classroom. So, they have to
3 learn more about the community, what the
4 resources are, you know, what the needs are in
5 that community.
6 And we have evidence to show, one,
7 they have very high board pass rates. I know
8 people are suspicious about distance education.
9 But I promise you it works, with 30 years of
10 evidence to show it.
11 They do stay, largely stay in their
12 communities. And a report from employers are
13 that they are ready to practice when they hit
14 the ground.
15 So, this is a way of getting more
16 providers, nurse practitioners, and nurse-
17 midwives at least, and I'm sure it would work
18 for other types of commissions, to be able to
19 stay in their community and become educated and
20 serve their home community.
21 Next, community concordant care.
22 You've probably heard of racial concordant
23 care. We know that racial concordant care
24 improves outcomes. Well, community concordant
25 care does too.
26 It's important for us to put

1 providers in the community who know the
2 community, are part of the community, and know
3 the challenges of those communities.
4 When I used to work in Hyden and the
5 National Health Service Board would send
6 scholars, so they would pay for them to get rid
7 of their student loans, and then send us a
8 graduate from Long Island to live in Hyden,
9 Kentucky, and provide care.
10 They rarely lasted very long. It
11 was very difficult for them to really
12 understand that whole community and live in a
13 community with no, no movie theaters, the
14 restaurants are DQ[31], and, you know, the nearest
15 mall is two hours away.
16 So, you know, that is important,
17 too, community concordant care. And we can do
18 that also by having more doulas, more community
19 health workers who really know the community
20 and can help us to make bridges.
21 Next slide, please.
22 So, the hub and spoke model relies
23 where larger hospitals partner with smaller
24 hospitals that are at risk of closure, is
25 really positive. Similar models in which

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31 Dairy Queen

1 hospitals either develop clinics in places
2 where they are most needed, and partner with
3 existing clinics staffed by nurse practitioners
4 or nurse-midwives.
5 These clinics can effectively bring
6 primary health care closer to those who need
7 it.
8 So, I mentioned the one in Texas
9 because I read about it, and it looked really
10 good.
11 I worked at the one in Bassett
12 Healthcare. And I worked at the one at Mary
13 Breckinridge Hospital.
14 Bassett Healthcare, pretty well-
15 resourced, 13 Rural Health Clinics all run by
16 nurse practitioners. The nurse-midwives
17 visited weekly to provide care to maternity
18 patients in those areas.
19 And then, of course, if there was
20 any medical issue that needed a physician's
21 attention, they would come into the hospital.
22 So, that worked really, really well.
23 And it still works really well today.
24 Mary Breckinridge is a little bit
25 different. A tiny Critical Access Hospital.
26 Average daily census was about 17. And there

1 were six Rural Health Clinics. A faculty
2 practice of nurse practitioners and nurse-
3 midwives ran the Rural Health Clinics and also
4 had a small maternity practice within the
5 hospital.
6 They had a physician who provided
7 collaboration care on an ongoing basis. And
8 that physician spent time in the Rural Health
9 Clinic that was at the hospital, so could deal
10 with more high-risk cases and cases that needed
11 a physician's care and attention.
12 That really worked well, too. I
13 think those types of practices are really
14 hopeful for rural hospitals, for rural
15 communities. Next slide.
16 So, the Alternative Payment Model
17 really helps tremendously. So, when I worked
18 in places where everybody got paid a salary
19 and, basically, it didn't matter how many
20 patients you saw, I mean, the physicians might
21 get bonuses at the end of the year if they did
22 extraordinary things, and that was great. That
23 was really great.
24 But this allowed providers to build
25 a team, to relax, and not feel as if you had to
26 see XX number of patients for hour. Fee-for-

1 service can incentivize a provider to see more
2 patients with a decrease in time spent with
3 each patient.
4 I remember sitting in meetings and
5 watching them review how many patients. And
6 the business people would say, Look, Dr. So-
7 and-So saw 40 patients the other day. Yay.
8 But what can you really do when
9 you're seeing 40 patients in a day?
10 So, I really do support Alternative
11 Payment Models and not fee-for-service models.
12 Also, we had situations where
13 obstetricians felt they had to do the births
14 because otherwise we would not get reimbursed
15 if the nurse-midwife did the birth.
16 So, those kinds of things happen and
17 should be thought about.
18 If an APM is thoughtfully developed
19 with provider input, the result can be a system
20 that facilitates team-based care, innovations
21 in methods to delivery health care, and
22 collaboration with APRNs[32], PAs, and other
23 allied health professionals. Next slide,
24 please.
25 Okay. It's important when we're

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32 Advanced practice registered nurses

1 talking about quality of care and measuring the
2 quality of care, with rural patients they're
3 sicker, and so you have to be careful that
4 you're not comparing things that are really due
5 to one group of patients being sicker than
6 another group or patients.
7 Traditional risk assessments focus
8 on medical complexity, such as we see with the
9 Hierarchical Condition Category. We need to
10 add to the assessment of social risk factor
11 adjustment. For example, we could measure
12 differences in smoking, history of drug use,
13 education, income, employment, social support,
14 and community resources.
15 We need to operationalize these
16 social risk factor assessments so that it can
17 compare clinician performance and patient
18 outcomes that are attributable to differences
19 in the quality of care. Said by Milbank. And
20 I just think that's well said. Next slide.
21 Okay. This is my last slide.
22 So, we have to think about the
23 heterogeneity of rural areas. And this has
24 particular implications for health care
25 performance measurement.
26 Variations in geography, population

1 density, availability of health care services,
2 and other factors make modifications for
3 different areas necessary. There is also the
4 possibility of not having enough patients to
5 have a valid result.
6 Now, this was important, too, we see
7 in, for example, down in Hyden where the nurse
8 practitioner out in the Rural Health Clinic
9 might see 11 patients in a day. She is seen as
10 less productive than -- it was a she -- than
11 the physician who is working in the Rural
12 Health Clinic and had as many patients to see
13 in the hospital Rural Health Clinic.
14 But is it still important to do
15 those 11 visits? And how many minutes do we
16 need in the visit to provide care that includes
17 the social determinants of health? We can't do
18 all five-minute maternity visits where all you
19 do is check the blood pressure, check the heart
20 rate, and say, How are you doing? And measure
21 the belly. We have to have some time if we're
22 going to provide that kind of care that
23 addresses social determinants of health.
24 So, the National Quality Forum has
25 developed a core set of "Rural Relevant
26 Measures." They did so in 2018, and updated it

1 in 2022. Which can be helpful in addressing
2 these issues.
3 So, in summary, rural persons
4 struggle more with the social determinants of
5 health than our urban population. And this is
6 clear in their health are outcomes.
7 And it takes a variety of approaches
8 to address these issues as defined by the CDC
9 in all of those things that we have to take
10 into consideration.
11 Not all rural communities have the
12 same challenges, so programs have to have the
13 flexibility in application to be effective.
14 And we have to operationalize social
15 risk factor assessment in order to measure
16 what's working and what's not as we move
17 forward in helping our rural population be
18 healthier.
19 So, thank you very much.
20 CO-CHAIR HARDIN: Thank you so much,
21 Susan.
22 At this time we're going to turn to
23 our Committee members for questions. And as
24 usual, if you have a question, please flip your
25 name tag up, name tent up, or raise your hand.
26 And, let's see who would like to

1 start with questions. Larry?
2 DR. KOSINSKI: Thank you everybody,
3 for your great presentations.
4 My question's going to be for David.
5 I was very impressed with your passion for what
6 you're doing there in rural Minnesota.
7 And you made the statement that 40,
8 I think it was 40 percent of your revenue was
9 coming from value-based contracts. That's
10 impressive.
11 So, how does that filter down to
12 your providers? That's at the entity level;
13 that's where the revenue's coming in.
14 So how do you incentivize for your
15 providers, specifically your specialists?
16 DR. HERMAN: Well, that's a very good
17 question. So, we don't treat any of our
18 patients differently than we do our value-based
19 care patients. So, we take the infrastructure
20 that we have underneath that and provide it to
21 everybody along the way.
22 We are not, I think this gets to a
23 point that I tried to make, is that we are not
24 capacity, we are capacity constrained, not
25 demand constrained.
26 So, if as an example, someone

1 doesn't need hip surgery, the orthopedist
2 although they are paid by RVU[33], knows that if
3 that patient doesn't need it, I can have that
4 time for another patient that does need it.
5 So that's one of those things where
6 if you're capacity constrained, or demand
7 constrained. So, we are capacity constrained
8 with that.
9 We used to provide incentives for
10 quality of care. It was the least happy thing
11 that I've experienced in the organization.
12 So what we did is we said we're not
13 paying for quality care anymore. What we're
14 doing is we're designing standard work to make
15 sure that quality care is delivered.
16 Minnesota has what they call the
17 Minnesota Community Measures, where every
18 health care system is measured on more than 20
19 different metrics.
20 We are number one in the state,
21 because we've designed that standard work to
22 make the right thing to do, the easy thing to
23 do.
24 So, we are very transparent. I can
25 look at my measures. A colleague can look at

33 Relative Value Unit

1 his or her measures, and can look at my
2 measures.
3 And so, we pay basically some people
4 are on salary. Some people are on
5 productivity. But we measure the quality in
6 everybody's practice and make the right thing
7 to do, the easy thing to do.
8 Our providers are busy enough, and
9 that's, was one of the, there are you know,
10 very few silver linings to some of the clouds
11 over rural health care.
12 But being relatively understaffed by
13 specialty, means that someone isn't well-
14 incented to provide care that's not necessary.
15 Let's get that care back to the
16 primary care provider, and let's reserve my
17 high-level specialty care for the patients that
18 really need.
19 CO-CHAIR HARDIN: Jay, please go for
20 it.
21 DR. FELDSTEIN: So, this is a combo
22 question for both David and Ami.
23 We know the leading cause of death
24 is cardiovascular disease. And, the greatest
25 discrepancy in the death rates between urban
26 and rural populations, is cardiovascular

1 disease, which is both due to chronic disease,
2 and acute events, which Ami, you just showed in
3 terms of the mortality of acute events.
4 You don't want to have your acute MI
5 in a rural hospital without an interventional
6 cardiologist. Let's cut to the chase.
7 So, how do you address that in
8 balance, in rural settings? You know, because
9 a small community hospital cannot support an
10 interventional-based cardiologist.
11 And quite frankly, you don't want to
12 go to someone who's doing 10 stents a year.
13 You want somebody who is doing 10 stents a
14 week.
15 So, how do you balance that so you
16 can actually make an impact on the acute event
17 death rate, as well as putting the things into
18 place you know, for chronic care and
19 prevention, you know, which will prevent people
20 from dying from CHF[34] when they're 80 years old?
21 DR. BHATT: Yes, , I'll go first and
22 then David will say something brilliant and my
23 whole mind will be blown.
24 It is a real problem. We have to
25 accept that some of those ratios of mortality

34 Congestive heart failure

1 being worse in a rural hospital, will continue
2 to be higher as we move to getting the systems
3 ready to recognize those patients at risk
4 earlier in their diagnosis.
5 And so the key is not how are we
6 going, I think we've been going about it a lot
7 of like, how are we going to staff those
8 Critical Access Hospitals? How are we going to
9 reassure?
10 We can't staff them with those
11 people. Now, are we working on things like
12 virtual half practice, so that people get more
13 numbers under their belts for those areas in
14 the meantime? Absolutely.
15 However, I think we have to really
16 be proactive about who is the highest risk
17 before we lose the opportunity.
18 How do we find them? And we smile
19 but it's actually doable. With the right
20 systems, we can find the rising risk.
21 And those are the people where, you
22 know, if we know you have diabetes, why are you
23 not on a statin? Give me a good reason, right?
24 If we know that you have
25 hypertension, have we talked to you and taught
26 your family the symptoms of stroke? The answer

1 is likely no.
2 And so, I think those populations,
3 we really need to have an active effort for
4 both patient education, and then getting people
5 to get on to guideline directed medical
6 therapy.
7 And, you kind of can't do it by just
8 instructing I think, one person in the primary
9 care rural area after another.
10 We can do a lot of education, but we
11 can automate some of this. If you're on this
12 dose and you have this diagnosis, unless
13 someone's arguing, you've got to go to the next
14 step.
15 By the way, the doctor or nurse can
16 overlook that and say hey no, actually there's
17 a really good reason.
18 But the majority of time, we're
19 going to have to start opting out of guideline-
20 directed therapy, rather than opting in, to be
21 able to get there.
22 But I kind of, I know what you're
23 saying. I'm going to answer you the best I
24 can, and that's what I can do.
25 For stroke, I will change my answer,
26 which is when I look at those ischemic stroke

1 rates, it reminds me at least here in the
2 Northeast, Lee Strong was my mentor.
3 And he started telestroke. And we
4 saved millions of lives. And millions of
5 dollars.
6 So I think telestroke is a little
7 different. But doing an interventional catch,
8 we got to catch them and really control them
9 better, in that rising risk phase.
10 David, what can I do better?
11 DR. HERMAN: I think you covered a
12 lot of that, but I will start out that when you
13 live in a rural area, you make choices
14 regarding quality of life.
15 And you go into it I think, with
16 your eyes wide open recognizing that I may live
17 in Ely, Minnesota, where I don't have a
18 cardiologist within seven minutes, but I like
19 living in Ely, Minnesota, and it contributes to
20 the quality of my life.
21 The other part of it is prevention.
22 And so, that's where it gets to the Minnesota
23 Community Measures.
24 More than 80 percent of like, over
25 20,000 of our patients who have hypertension,
26 are well controlled. We have built processes

1 to make sure they're seen.
2 It doesn't just require the primary
3 care provider, but we have pharmacists that are
4 involved in that step therapy that's driven by
5 protocols, that goes to that.
6 So, the primary thing is prevention.
7 But then you do connect all of the, your local
8 EDs with the mother ship, to make sure that you
9 have recognition.
10 Because one of the things is someone
11 comes in. We make sure that we can get the
12 enzymes even in our smallest hospitals, all
13 that forward, and get that going.
14 And then, design your system the
15 best you can to get to those areas where they
16 can get the intervention.
17 But the most important thing is that
18 prevention, and then that recognition. And,
19 you have to design your system around that.
20 I think the same thing happens with
21 maternity care. There's been 56 hospitals
22 since the first of February across the United
23 States, that have reduced some sort of care
24 within their hospital. The vast majority of
25 that has been labor and delivery care.
26 Just because you can't provide that

1 quality of care, science will tell you for
2 fewer than 200 patients, but then how do you
3 design that system to support those people
4 within the small communities without labor and
5 delivery services?
6 So, it's really about design. But I
7 think what Ami brought out is you can't leave
8 it to chance.
9 You can't say, just because you live
10 there, you have to take a lower standard of
11 care. Here's the standard of care that we can
12 provide in this community, and we're going to
13 provide it each and every time reliably.
14 And that requires designing it,
15 staffing it, and requiring the standard work.
16 DR. FELDSTEIN: Thank you.
17 CO-CHAIR HARDIN: So, in many of our
18 presentations we've heard in the last two days,
19 about the importance of community
20 collaboration.
21 Sort of hub structures, bridging
22 organizations like you talked about, David,
23 that are really helping to bridge the gap in
24 resources, reduce costs by sharing some of the
25 infrastructure.
26 And also, address some of the

1 workforce issues.
2 So, I wondered if each of you could
3 talk a little bit about what coordinating hub-
4 type structures you're seeing in the markets
5 you're in.
6 And, what recommendations you might
7 have for financing or facilitating, future
8 development of that. And any of you can start.
9 DR. HERMAN: I'll jump in. I think
10 the first requirement for any health care
11 provider, or any health care system, is
12 humility.
13 When you reach out and you talk with
14 community partners, health care systems, we
15 have a tendency to want to do things our way.
16 Okay, we want a medicalize
17 everything. And the community has a tremendous
18 amount of knowledge.
19 So, unless we bring humility to the
20 table, we probably can't come to the solutions
21 that we need to come to.
22 Another one we need to do is to find
23 out, what we've done in our health care system
24 when I came, we were giving money everywhere.
25 If you were the Duluth Community
26 Garden, you could get money from Essentia

1 Health. And I know that gardening is probably
2 good to your health, for your health, but we're
3 not funding those anymore.
4 We have strict criteria that allow
5 us to say, here's the limited amount of
6 resources that we have. Here's what we're
7 going to fund in these communities because
8 number one, it will have an impact on the
9 health of the community.
10 Number two, it will have an impact
11 on our partners and they'll be able to do
12 better work. And then, we will learn from it
13 and be able to spread that to further
14 communities.
15 There's a lot of other stuff that we
16 could sit down and talk about, but our
17 challenge was the humility.
18 No, we're Essentia Health, we want
19 to do it our way. And I think you need to step
20 back from that and have the right people in
21 your organization, that are having the
22 conversations with the community partners.
23 CO-CHAIR HARDIN: Any of our other
24 panelists like to comment?
25 DR. STONE: I will speak to the
26 bridging.

1 So, Mary Breckinridge Hospital,
2 which was a small, is a small Critical Access
3 Hospital, was really suffering financially, and
4 resource-wise.
5 I mentioned that things like just
6 the technology, the leadership, all of the
7 things that need to be in place in order to run
8 a hospital.
9 And, it almost failed. But
10 Appalachia Regional Healthcare ended up taking
11 over Mary Breckinridge Hospital.
12 I would say that Frontier Nursing
13 Service sold the hospital to them, but that
14 would be, I think almost was paid to take the
15 hospital.
16 But, the bottom line is that that
17 happened 10 years ago. And, Mary Breckinridge
18 Hospital is still operating in that community.
19 And it's so much stronger. There
20 was so much resistance from the community to
21 allow that to happen, because they felt that
22 was their hospital.
23 And, as well as the people within
24 the hospital. But those partnerships are
25 really strong and can be extremely helpful,
26 allowing that sharing of those resources such

1 as technology, and leadership, and all of those
2 things across the system.
3 So, it's just one small example of
4 the importance of, in collaborations for even
5 keeping a small hospital within a community.
6 DR. BHATT: So --
7 (Simultaneous speaking.)
8 MR. SHUNKWILER: And I'll just add a
9 little bit to that -- oh, go ahead, Ami.
10 DR. BHATT: No, no, go ahead, go
11 ahead, Thad. I'll go after you.
12 MR. SHUNKWILER: Yes, I was just
13 going to add the, you know, from that workforce
14 perspective, I'm blown away at the number of
15 times I'm in committees, or meetings around the
16 health care workforce.
17 And, there's nobody representing the
18 university systems. There's nobody
19 representing the training institutions in those
20 conversations.
21 And so we've been very deliberate
22 about how do we, how do we connect the training
23 institutions to the provider organizations in
24 the community, to make sure that there is that
25 pipeline, and we start developing those
26 relations early on.

1 With the Center for Rural Behavioral
2 Health, we were very intentional about finding
3 community-based partners to really support our
4 mission.
5 And, we have brought some unusual
6 suspects to the table. We receive funding from
7 ag lending banks, from the Minnesota Pork
8 Association, provided funding.
9 And, really what it's about is they
10 all are invested, they're all vested in the
11 outcome of ensuring behavioral health access in
12 those communities.
13 So, it does really take a convening
14 to really bring these resources together. But
15 I think it's paramount to make sure higher
16 education is at the table.
17 DR. BHATT: I love that. I think
18 that's essential.
19 I think I agree with everyone so I
20 won't say it again. The only thing I'll add is
21 specifically, if we're thinking about systems
22 where we're saying disease management.
23 Randy mentioned hypertension
24 earlier. I mentioned atrial fibrillation being
25 an area that we worked at.
26 Really clearly defining what is the

1 continuum of shared accountability. So I'm not
2 talking so much about the location of care.
3 But who is the person providing the care, and
4 what can they do?
5 So if you have a new diagnosis and
6 you need a work-up, that should generally be
7 done in the primary care/cardiology realm.
8 But if you need rhythm control,
9 which requires a specific set of medications
10 that others may not be as familiar with, that
11 is when we then say you need to see electro-
12 physiology.
13 If your symptoms are mild, you can
14 be here. If your symptoms are severe. And we
15 really broke it down into what are all the
16 things that can go into this one diagnosis'
17 management at a time?
18 And where should it live? And then
19 get buy-in from both the patients, and their
20 caregivers, in addition to the clinical
21 caregivers, that like, this is how our system
22 is going to work.
23 It's a lot of work. However, once
24 created, it's actually somewhat reproducible
25 because the disease is not that different.
26 You know, there are certain

1 variations you can have, but once you learn
2 where you're going to go for this variation.
3 So, I think a continuum of shared
4 accountability for whatever diagnosis,
5 explaining it, understanding it, educating to
6 it if it's community health workers.
7 I would say that's probably the one
8 other thing about infrastructure, that's really
9 important.
10 And we don't think of it as
11 infrastructure, but in fact, that understanding
12 is the infrastructure that helps us.
13 And probably why, you know, people
14 like my colleagues here are all so successful.
15 CO-CHAIR HARDIN: So helpful.
16 Team, community members, or
17 Committee members and community members, any
18 additional questions?
19 Larry?
20 DR. KOSINSKI: You know me, I can't
21 help but ask questions. I actually have two.
22 One follow-up for David, and one for Ami.
23 My follow-up for David is, of that
24 40 percent of your revenue, how much of that is
25 coming from commercial, other than, you
26 mentioned the public funding? But is any of

1 that from commercial?
2 DR. HERMAN: Yes, a lot of it is from
3 commercial, as a matter of fact. Although the
4 vast majority is from public programs.
5 Mostly from public programs because
6 they have the data. Insurance companies aren't
7 very good at having data, other than claims
8 data.
9 We have a very strong partnership
10 with Medica here in the state of Minnesota, and
11 in North Dakota.
12 And, we actually share the bottom
13 line on a variety of different programs and
14 services that they provide to employers.
15 So, our big challenge has been
16 expanding that within the commercial realm by
17 developing those partnerships with the payers,
18 where we call it joint accountability model,
19 where we're going to work together, decide what
20 each of us is accountable for within this. And
21 then work together and then share the bottom
22 line.
23 If we do something and that product
24 that they have loses money, we lose money, as
25 well. If we put together a product and it
26 makes money, we all make money together.

1 I think that's the best way to do,
2 but it requires a lot of different
3 conversations. All of us in our conversations
4 with payers have something in our brain stem
5 from the last 30 years of negotiating with
6 payers, that makes it win/lose.
7 And it requires a lot of a CEO's
8 time, and a lot of leadership time, to call
9 time out, say this is about building
10 relationships, and taking care of our patients,
11 rather than winning on a particular point.
12 DR. KOSINSKI: Okay, great. Now for
13 you, Ami.
14 I could see, I can imagine the
15 remote monitoring for rhythm disturbances will
16 lend itself very well to a remote capture.
17 How have you moved beyond that?
18 What other, what are your target conditions
19 where you've had success outside of the rhythm
20 space?
21 DR. BHATT: Yes, so blood pressure's
22 been another one which I know primary care has
23 done well also.
24 But remote blood pressure
25 monitoring, we've also been doing remote
26 cholesterol monitoring.

1 So those blood pressure programs
2 that I'm talking about, we started really
3 thinking about how do we, we are starting a
4 driving urgency for LDL[35] screening throughout
5 the country.
6 Which is a real, large, now funded
7 play to get everybody to at least get that
8 done. Now whether or not you think of LDL as
9 the cure-all to, you know, preventing
10 cardiovascular disease is not on the table
11 right now.
12 It's simply that we need to be
13 checking something, so we're going to take the,
14 the base.
15 And so, hypertension is a very well
16 established one. Heart failure has pockets,
17 because heart failure requires a real hub and
18 spoke model, with heart failure doc present
19 there.
20 However, heart failure preserved
21 ejection fraction, these are people who have
22 the heart failure symptoms but actually don't
23 have weak heart muscle.
24 That is probably the next area that
25 we can grow out of for remote monitoring, based

35 Low-density lipoprotein

1 on what we're learning from hypertension, what
2 we're learning based on weight scales.
3 Similar to what David said, but I'll
4 say two things. So a-fib, heart failure,
5 hypertension, and cholesterol screening, main
6 areas of interest for us.
7 As we're working on that, one of the
8 things we're doing from the innovation side,
9 and so I put that hat on for a second, is
10 really partnering with the monitoring companies
11 that we think are doing it right.
12 That are willing to work with us to
13 fit into the existing workflow, or make a
14 reasonable workflow for clinicians and teams to
15 be able to use them.
16 And so, to really similar to what
17 David was saying, be there at the table with
18 them and say, you know, our name is with you.
19 Your success is with us.
20 We have a small LLC that actually
21 puts in minimal actually not of dollars because
22 we are a nonprofit, but some dollars and
23 invests in some of those companies saying, we
24 really believe your success is going to be our
25 clinicians’ and patients' success.
26 And so, I think you do need to show

1 these remote monitoring tech companies, we
2 can't have a million of you.
3 We're going to need to narrow down
4 the ones who can achieve success, or the ones
5 who are going to be willing to work with the
6 clinicians, rather than saying our square peg,
7 your round hole, but let's develop it together.
8 So, hopefully there will be more
9 things. But a-fib, heart failure, hypertension
10 right now, and moving towards LDL screening.
11 CO-CHAIR HARDIN: David, I see you
12 have your hand raised. Please go ahead.
13 DR. HERMAN: Yes. Ami put a question
14 in the chat that said, this is great but
15 culture change is hard. How long before the
16 progression to value-based care did the
17 messaging start?
18 I believe the culture change is the
19 only thing that makes this work, because
20 culture is what's very durable in your
21 organization. That's what makes it so hard to
22 change.
23 Ed Stein, who wrote a book on you
24 know, corporate or organizational culture, is a
25 good friend of mine.
26 And what he used to say is that

1 culture is the behaviors that are successful
2 within an organization.
3 So it's not what you say your
4 culture is, it's what someone can come in and
5 observe these are the behaviors that are
6 successful.
7 So what we did is we said okay,
8 we're going to make sure that these behaviors
9 are successful in our organization. We're
10 going to design our organization around those
11 behaviors that align with value-based care.
12 We're going to reward people that do that by
13 just attention, and thank you's.
14 We had someone that raised their
15 hand at one of our leadership things that says,
16 you know, why did we fire somebody in this
17 organization that has 200 outstanding charts,
18 and we don't do anything for the person that
19 has 200 patients that should be on a statin,
20 that aren't?
21 And, it really changed the culture
22 of our organization. You have to measure and
23 reinforce, and support the right behaviors.
24 And then that will change the culture.
25 And then that will make it very
26 durable, that keeps people from tipping you off

1 this value-based care journey, sometimes when
2 it's very difficult, and sometimes when it just
3 is a very fair thing to do with the patient
4 that sits across from you.
5 CO-CHAIR HARDIN: That's great.
6 DR. BHATT: I love to hear that
7 because as we really start thinking about
8 quality measures, and accreditation based on
9 quality measures, Centers of Excellence for
10 Diseases, we're basing it all on we're going to
11 do the same quality, no matter how you're
12 getting paid right now.
13 And then we will hope that the
14 culture will change enough from fee-for-
15 service.
16 I mean, we have so many procedures
17 that there are, you know, parts of
18 cardiovascular care that are more preventive.
19 And those people will get on value-
20 based care. And then there are those who you
21 know, got into it to do procedures and are paid
22 for them.
23 And, I understand where they come
24 from. They have a mortgage, and their kids'
25 college depends on that. But I think we can
26 get there in a way where everybody is

copacetic. Thanks, David.

CO-CHAIR HARDIN: I'm going to shift to a really heavy question. So, David, we have a question for you.

If single-sided risk and/or double-sided risk is a realistic goal for the typical rural provider, and, what would the glide path be in order to prepare and encourage more rural providers to participate in APMs and accept risk?

DR. HERMAN: So, the first question I would ask is that does it require accepting risk to change behavior?

Because what you're talking about really is changing behavior. And you're using risk either single-sided or double-sided risk, as an incentive to change that behavior.

So, I would ask the question, what are the behaviors that you really want to change, and what is the best way to do that?

We are happy to take upside and downside risk, because we made the commitment and built the infrastructure to support it.

And, we like taking that risk because we do well in it. It spurs our quality, and we go on.

1 There may be other providers as was
2 mentioned, they may not have the numbers. They
3 may not you know, one patient can tip a small
4 practice from being very successful, to being
5 regarded as a failure in a particular
6 statistic.
7 So, what I would say is, what
8 mechanisms, what toolkit of mechanisms, can we
9 have that incent the right behaviors in a
10 particular practice?
11 I think we've heard from every one
12 of us today that what we've said is, you know,
13 a standard is possible, but as unique as
14 necessary.
15 You can certainly, there aren't an
16 infinite number of classifications of rural
17 health care providers.
18 But there's certainly enough to say,
19 how do we incent the behaviors that we want in
20 a particular practice, so their patients get
21 better care, and that that practice is
22 sustainable?
23 And I don't know if that's an answer
24 to your question or not, but that's my
25 philosophy on it.
26 CO-CHAIR HARDIN: Great, very, very

1 helpful.
2 Any other advice about the glide
3 path to get there?
4 DR. HERMAN: I would say you have to
5 measure the glide path. And, we actually use
6 the term glide path for every one of our
7 quality measures within our organization.
8 So you can pull up the dashboard,
9 and using hypertension as an example. And if
10 we're not making it, we have you know, 124
11 people that are not meeting their goal on
12 hypertension.
13 The key to it is to start to measure
14 it within your practice. Making the outcomes
15 of your patients, and making the processes that
16 you have within your practice to get those
17 outcomes transparent, is the best way to start.
18 It is very challenging for small
19 practices to build that level of analytics. I
20 think there could be a toolkit that you could
21 put and have a lot of different practices
22 share, rather than have them to develop it on
23 their own.
24 But until you get that transparency
25 agreement on what your goals are, and the
26 transparency of where you are along the

1 journey, I think you're not planning for
2 success, you're just hoping for success.
3 CO-CHAIR HARDIN: Thank you, David.
4 Jim, please --
5 (Simultaneous speaking.)
6 DR. BHATT: So maybe I'm just going
7 to add to that for one second, if it's okay.
8 We have atherosclerotic
9 cardiovascular disease risk score, ASCVD risk
10 score, and it's based on blood pressure, LDL,
11 et cetera.
12 And we've created in a way that in
13 most people's electronic health records, one
14 can actually just have those fields pulled.
15 And, it will give you the percent
16 likelihood that your patient will have a heart
17 attack in the next 10 years, which is what we
18 use to determine taking a statin.
19 But we can also use it now to say,
20 but if your blood pressure comes down this
21 much, then this risk will go down.
22 If your LDL comes down this much.
23 And so we've started to use it more as a
24 teaching tool for the patient.
25 Dieticians, nutritionists can use it
26 as well. Our pharmacists are using it. And

1 so, I think those kind of tools are helpful to
2 people.
3 Eventually, once we roll out those
4 tools, so, I think what David's saying is
5 right. The next step needs to be now you know
6 how to use the tool, now we are going to
7 measure our use of the tool.
8 That's still scary for clinicians,
9 but I think it has to be that next step.
10 DR. HERMAN: And what we do every
11 year is we, at the end of the year, we
12 translate it into actual lives saved.
13 So, if we are you know, at 85
14 percent on colon cancer screening, that
15 translates to this many lives saved.
16 Hypertension, statins, all the other
17 stuff that, breast cancer screening,
18 mammograms, we transfer that, we translate that
19 to lives saved.
20 And I think that really helps us get
21 alignment within the organization, that our
22 mission is, we are called to make a healthy
23 difference in people's lives.
24 And, this is the healthy difference.
25 These are the people that will you know, see
26 their grandchildren's graduation, or their

1 daughter getting married.
2 And really translate that into
3 impacts on lives, rather than just statistics
4 on a dashboard.
5 CO-CHAIR HARDIN: So helpful.
6 We're right at time for public
7 comment but Jim, do you have a fast question,
8 or?
9 Okay, we want to thank our
10 presenters so much. This was really valuable
11 dialogue, and just encourage you to stay on if
12 you'd like to continue to hear the conversation
13 today.
14 * **Public Comment Period**
15 So, we do have a public comment.
16 There's one person that signed up to give
17 public comment.
18 And I want to open it up to
19 Elizabeth Foster, from Columbia Gorge
20 Coordinated Care Organization, an Oregon CCO.
21 And, Elizabeth, please go ahead.
22 DR. FOSTER: Can you hear me okay?
23 CO-CHAIR HARDIN: We can hear you
24 perfectly.
25 DR. FOSTER: Excellent.
26 Good afternoon. My name is Dr.

1 Elizabeth Foster, and I'm a rural family
2 physician, and a founding member of the
3 Columbia Gorge Health Council, the public
4 partner of our rural coordinated care
5 organization.
6 We are addressing rural health
7 disparities with community health workers. We
8 need payment reform to support clinically
9 effective cost saving care to address health
10 disparities in rural parts of Oregon.
11 Community health workers, CHWs, are
12 system navigators, health educators, patient
13 advocates.
14 They connect patients with resources
15 and services. They help patients and family
16 members understand and advocate for their own
17 health care needs.
18 Often bilingual and bi-cultural,
19 CHWs are trusted to provide patient-centered
20 care for racially and culturally diverse
21 patients, and families.
22 Oregon has a long history of
23 incorporating CHWs in clinical and community
24 settings since the late 1980s, targeting
25 diabetes education, migrant farm worker
26 outreach, perinatal care, access to housing,

1 and now support for frail, older adults.
2 Clinic-based community health
3 workers. Connected care for older adults is a
4 pilot that uses community health workers, and
5 evidence-based age-friendly protocols to
6 provide improved care for frail, older adults
7 in rural areas.
8 Currently being tested in the
9 Columbia River Gorge, the clinic-based pilot is
10 conservatively projected to result in a return
11 on investment of 5.15 over three years.
12 Our community-based CHW program has
13 also demonstrated medical cost savings.
14 Community health workers provide effective
15 interventions that save public funds, reduce
16 health care costs, decrease hospital days,
17 increase use of primary care and behavioral
18 health services, provide fragile older adults
19 with access to resources, improve patient and
20 clinician satisfaction, and save money.
21 The projected return for investment
22 on the connected care for older adults CHW
23 pilot is over five times in three years.
24 Problem. Community health worker
25 services are not currently reimbursed at viable
26 rates, or at all.

1 Current billing mechanisms do not
2 support community health worker travel, home
3 visits, coordination of care, outreach,
4 connecting patients with community services, et
5 cetera.
6 They are currently funded through
7 unsustainable, unstable grant cycles and local
8 investment.
9 Solution. Add a wrap payment to
10 cover CHW services at FQHCs[36], RHCs[37], and
11 community-based hubs.
12 Wrap payments are used for cost-
13 based reimbursement for RHCs and FQHCs. They
14 cover actual costs, and are paid as a block fee
15 to cover the differences between Medicare and
16 Medicaid payments, and actual costs of visits.
17 Because the scope and breadth of
18 care a community health worker performs varies
19 a lot, and much of the work is not done in the
20 visit, the wrap payment could be tied to panel
21 size, PMPM[38] payments, with expectations that
22 delivery of evidence-based services are
23 available to those who are empaneled and
24 capitated.

36 Federally Qualified Health Centers
37 Rural Health Clinics
38 Per member per month

1 Number two, currently private
2 insurers are not required to pay for CHWs as
3 essential services. Action. Require private
4 insurers to cover CHW services.
5 We are available to share our
6 evidence-based program and cost savings
7 information with you.
8 Thank you for your time.
9 CO-CHAIR HARDIN: Thank you so much,
10 Dr. Foster. Amy, are there any other public
11 commenters?
12 Okay, hearing none, this is the end
13 of the public comments.
14 * **Committee Discussion**
15 And now the Committee members and I
16 are going to discuss what we've learned
17 yesterday and today from our guest presenters,
18 panel discussions, and background materials.
19 PTAC will submit a report to the
20 Secretary of HHS[39] with our comments and
21 recommendations, based on the public meeting.
22 Members, you have a document on
23 potential topics of discussion and deliberation
24 tucked into your binder, to help guide the
25 conversation.

39 Health and Human Services

1 If you have a comment or question,
2 please flip your name tent up, or raise your
3 hand in WebEx.
4 And we'll be discussing this until
5 about 12:15.
6 Who would like to start?
7 DR. FELDSTEIN: All right, I'll make
8 it easy, Lauran, and I'll start since nobody
9 wants to start.
10 CO-CHAIR HARDIN: Thank you, Jay.
11 DR. FELDSTEIN: I started yesterday.
12 I'll start today.
13 You know, another great set of
14 panels. I think again, you know, kind of
15 reiterating yesterday about the ecosystem
16 between you know, hospitals and primary care.
17 I think it got sharper and focused
18 today with some of our presenters in terms of
19 the hospital.
20 The emergency department often
21 sometimes they're staffed by organizations.
22 They're not hospital employees. A lot of ED
23 staffing is outsourced to private enterprises.
24 They all have to be aligned for
25 rural health care, from my perspective, for
26 survival. In addition, whatever payment

1 methodologies and Alternative Payment Models,
2 and total cost of care, it really does have to
3 be across all payers.
4 Because the Medicare population, or
5 the Medicaid population alone, is not enough to
6 support them on an ongoing basis.
7 So, we really have to be cognizant
8 of that. You know, we can talk about up-front
9 costs, up-front costs all we want.
10 But where are those dollars, where's
11 the money going to come from? And you know,
12 it's not just enough for CMS.
13 This needs to happen at the state
14 level, and the local level. You know,
15 everybody's got to come together if we're
16 really serious you know, as Jim alluded to
17 yesterday, we need a moonshot if we're really
18 going to have, make an impact on rural health
19 care.
20 CO-CHAIR HARDIN: So helpful. Thank
21 you, Jay.
22 So, what I'd like to do is go around
23 the room and just capture what additional
24 insights or things, should we emphasize or call
25 out as a result of this meeting?
26 Lee, would you kick us off? Thank

1 you.

2 DR. MILLS: Yes, it's all still
3 gelling, I think.

4 But I was really struck by many of
5 David's comments about Essentia, and how they
6 are pretty deeply connected to their community,
7 and doing deep learning about what the
8 community needs to truly be effective, and
9 change health metrics.

10 But then not, but then being very
11 specific in building the culture where doing as
12 he said several times, doing the, you know, the
13 right thing to do is the easy thing to do.

14 So he's building the systems that
15 deliver that outcome reliably, which was fairly
16 striking.

17 A lot of times I think, in standard
18 practice, it's more haphazard that the right
19 thing happens to do when all the forces align
20 randomly. And, we can't count on that moving
21 forward.

22 I was also struck by the statement
23 that until you have transparency of data and
24 concrete action, you're just open for success,
25 not planning for success.

26 And, I think that can be applied to

1 a wide variety of learnings from this meeting.
2 CO-CHAIR HARDIN: That's great, thank
3 you. Chinni?
4 DR. PULLURU: Building on, great day,
5 building on some of the themes from yesterday.
6 What I have written down is something that was
7 said in this panel, which standard is possible,
8 unique is necessary.
9 And so, I do think going back to
10 rural archetypes, and how we differentiate and
11 create both standardization and some level of
12 uniqueness, is important.
13 I was struck by something that Tom
14 Lee said, which is you know, one of the things
15 that is necessary in implementation, is
16 unwinding of time to find more time to play
17 offensively, to play offense. I'm sorry, play
18 offense.
19 And so, I think that you know, it's
20 really important to look at how the time
21 expectations of the primary care physician, and
22 other providers, is handled in reimbursement.
23 That is important.
24 And from today, one of the things
25 that struck me across the board was, the
26 importance, and I think this has been said many

1 times before, of data.
2 And data infrastructure. And the
3 ability to re-stratify on the front end.
4 While this is important, I think
5 everywhere in value-based care, it seems to be
6 the largest opportunity and gap, that exists in
7 rural areas that they don't have the tools and
8 enablement in order to be able to actually
9 actualize even the basics, right. And so,
10 that's very important.
11 And so, that struck me as a theme
12 from today was really across the board, you
13 know, how do we get that resource proactively,
14 so people can actually start the process?
15 And lastly, from our public
16 commenter I wanted to sort of also double-click
17 on you know, paying for, having sort of you
18 know, having private insurers, as well as CMS,
19 pay for wrap-around payments for CHWs.
20 But also, all allied health
21 professionals in a way that, I think that's the
22 challenge is to do that in a way to maintain
23 budget neutrality, but really frigure out how
24 that team-based payment can work.
25 So, we bring, so it behooves people
26 to actually bring those allied professionals

1 under the tent.
2 CO-CHAIR HARDIN: Very helpful,
3 Chinni. Lindsay?
4 DR. BOTSFORD: Yes, thanks for the
5 conversation.
6 I mean, I think the theme that came
7 through almost every presentation is that it's
8 hard to think about cost savings, as we think
9 about applying that lens to rural providers and
10 hospitals, when right now financial viability
11 or existence, is the primary concern.
12 I think a couple themes resonate.
13 Whether it's a proposal for a hub and spoke
14 model, or using AHCs[40] to provide support to
15 rural areas or rural hospitals, figuring out a
16 way we leverage resources and don't expect
17 rural hospitals and providers to get out of
18 this on their own, needs to be part of the
19 solution.
20 We heard the theme of upright, up-
21 front funds on multiple occasions. But I also
22 found today the concept of you know, it doesn't
23 necessarily have to be more money, but what do
24 we pay rural hospitals to do.
25 And if we provide stable funding to

40 Accountable Health Communities

1 do different things, could we influence the
2 problem of volume needing to drive
3 sustainability?
4 We heard again today the need for
5 all-payer alignment, and I think even some
6 tinges of where can, where can state
7 involvement in terms of promoting the amount of
8 primary care spend, or aligning on quality
9 measures for state problem -- programs.
10 How could that also decrease some of
11 that administrative burden that our, our rural
12 providers feel intensely?
13 A couple themes around flexibility.
14 I think I heard that flexibility for a home-
15 based, or alternative sites of care can be
16 especially important for rural communities.
17 And flexibility in telehealth space,
18 particularly in things like hospice care, or
19 other at-risk models.
20 If we're paying you for outcomes,
21 let's not worry as much about how you are
22 delivering that, or where you are delivering
23 that.
24 And then the last thing that Chinni
25 highlighted is, you know, what are those
26 compensable actions that don't require a

1 clinical license, that drive value either on
2 non-medical drivers of health, or improving
3 health-related social needs?
4 Where are those people, whether they
5 be community health workers, or actions that we
6 would expect a rural provider to, to have for
7 our patients that currently don't have a way to
8 get reimbursed?
9 And, that cost plus reimbursement
10 isn't enough to be able to make those people
11 exist in communities. I'll end there.
12 CO-CHAIR HARDIN: Thank you, Lindsay.
13 Walter?
14 DR. LIN: First, I just wanted to
15 thank the hard work of the PCDT[41], ASPE, NORC
16 staff, for just another outstanding public
17 session. It's been really informative.
18 And as I've listened through these
19 past two days of superb experts kind of sharing
20 their insights and wisdom, I was reminded of
21 the famous opening line of a Charles Dickens
22 novel.
23 It was the best of times, it was the
24 worst of times, it was the age of wisdom, it
25 was the age of foolishness, it was the epoch of

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1 belief, it was the epoch of incredulity.

2 And, I really do think we have a
3 tale of two health systems in America. One
4 urban, which we're so familiar with; and one
5 that's often not so much in the news and the
6 limelight, the rural health system.

7 And in many ways, these two health
8 systems are quite unique and face different
9 issues.

10 I ended my comment yesterday with
11 the idea that I think the task before us as a
12 Committee is to help suggest or recommend
13 payment model redesign, to support innovation
14 and team-based care delivery models tailored to
15 rural health.

16 And just to kind of dissect that a
17 bit further, you know, I, this idea of team-
18 based delivery models tailored to rural health,
19 is something that I think I'm all the more
20 convinced is important after our experts today.

21 The idea that maybe we can address
22 some of the shortages of resources in rural
23 health through telehealth, that leverages more
24 intensive primary care to decrease the need for
25 specialist care.

26 The idea that we can use non-

1 licensed health care workers to leverage the
2 presence of primary care resources in rural
3 America, I think is really fascinating.
4 And, maybe through kind of the
5 better utilization of non-health care
6 resources, or primary care resources, we can
7 create more specialist capacity, more primary
8 care capacity, and address some of the problems
9 that we've heard about these past couple days.
10 So, this whole idea of innovating
11 care delivery models I think is important, and
12 I really appreciate it also the comment of Dr.
13 Foster around community health workers.
14 I think it speaks to that concept of
15 creating more effective FTEs[42] of licensed
16 professionals, through the use of team-based
17 care. And hope that that's something that we
18 can encourage CMMI to explore.
19 CO-CHAIR HARDIN: Thank you, Walter.
20 Larry?
21 DR. KOSINSKI: We heard a lot of
22 common themes. We certainly I think Alana said
23 it well, that finance drives function.
24 And, we need to, if we want value-
25 based care, we have to pay for value-based

42 Full-time employees

1 care. We have to figure out a way of doing it.
2 One of the other comments she made
3 that stuck with me and I wrote down, is that
4 the providers are suffering innovation fatigue.
5 And, I think it stems from the fact
6 that we haven't done the moonshot. As Jim
7 mentioned yesterday, we've been tweaking, and
8 tweaking, and tweaking around the edges.
9 And the providers are tired of it.
10 And I think we need to tighten our timelines.
11 We need to be bolder in what we're doing.
12 Because the tweaking is just going to continue
13 to alienate them.
14 This Committee has come up with a
15 model. And we said earlier, we reported to the
16 Secretary last year that the model should be
17 high-touch proactive care. Team-based, high-
18 touch proactive care.
19 Well, if that's the model, then
20 let's push it and figure out how it should be
21 paid for.
22 I think our provider entities are
23 screaming for it. And they're waiting for us
24 to act.
25 This goes to the heart of why this
26 Committee exists. This Committee exists to

1 allow the groundswell of innovation from the
2 provider community, to actually reach an
3 implementable crescendo.
4 I think we're seeing that, but
5 somebody needs to take it over the other, other
6 side before the wrong entities prevail in the
7 market.
8 If we want the right things done, we
9 have to be bold and push the right things.
10 Those are my takeaways from today.
11 And yesterday.
12 CO-CHAIR HARDIN: Thank you, Larry.
13 Jim?
14 DR. WALTON: I would prefer not to
15 have to follow that. That was brilliant.
16 Number one, I feel privileged to be
17 here to, for the last six or nine months
18 sitting with the Committee, and learning so
19 much about how this, how this works.
20 And, I'm really grateful that there
21 was a theme that was decided to listen around
22 rural health care providers, and their
23 participation in total cost of care, value-
24 based arrangements.
25 And I really appreciate the fact
26 that citizens get a chance to you know, both

1 talk at, from their homes and then people like
2 us get to come here and to hang out with people
3 that are, dedicated their lives, the staff, to
4 dedicate their lives, their careers, to doing
5 something that really can promote scale.
6 When we asked our, when we've asked
7 ourselves this question about rural health
8 providers, we are then as providers if you
9 will, representing what we think we heard from
10 our colleagues.
11 And one of the things that I take
12 away from our meeting, in addition to what
13 you're saying, Larry, is this sense of urgency,
14 but that I got an impression that I think can
15 be proven with a little bit more research.
16 That there's probably unintended,
17 unmeasured, health disparities existing in
18 rural America because of value-based care.
19 And, it may be getting worse.
20 I feel like that's what I heard from
21 the SMEs[43]. And, I think that's the subtext, is
22 they're feeling something from the patients.
23 And they're feeling something about
24 themselves. And they're feeling something
25 about their infrastructure. And the perceived

43 Subject matter experts

1 threat.
2 And Larry, I think you're spot on,
3 is that there are market forces that are more
4 than willing to respond to that vulnerability.
5 And so, so as a consequence, I think
6 what I in addition to what everybody
7 brilliantly said, I think one of the things
8 that we've not explored well enough is this
9 idea that there are agencies and departments in
10 the government, who are, who have funding, and
11 people, and talent, and programs that touch
12 health. And health care.
13 And they could be arrayed and
14 coordinated in a way, to help the providers on
15 the frontline in rural America.
16 And help them help the patients, and
17 their families, to reduce the inequality that
18 exists in the United States.
19 And as we said yesterday, this is a
20 bipartisan opportunity because it speaks to the
21 very heart. And oftentimes, we talk about the
22 rural areas of the heartland of our country.
23 And someone, one of our speakers
24 yesterday said food, fiber, and fuel. You
25 know, these, this is the bedrock of our
26 country.

1 And oftentimes, you know, in rural
2 America, we can see some of the, I think we can
3 see some of the issues that they confront often
4 like we would see a developing country. Or a
5 country who is challenged, a whole nation
6 that's challenged.
7 And it's quite possible that we
8 could actually approach the problem in rural
9 America, as you might approach a developing
10 country's problem of developing their
11 infrastructure, and developing their human
12 capital, and their economic development.
13 And I think that that plays to both
14 the red and the blue in us. You know, or the
15 American-ness in us, right, that we're all
16 Americans.
17 And we all are very, very deeply
18 concerned if there are both providers and
19 patients experiencing avoidable morbidity and
20 mortality as an unintended consequence of a
21 well-meaning model, or policy.
22 And so, I would call us to think
23 through this idea of can we organize in a way,
24 can we, PTAC, recommend something that's
25 unique, that we would organize?
26 Or agencies and departments whose

1 activities can be identified and can be said,
2 that's a health-related activity that deals
3 with labor and the need for behavioral health
4 workers, our community health workers.
5 There's a communication and
6 infrastructure area, or transportation, or
7 food, or public health, or payment, you know,
8 Medicaid and Medicare payments.
9 And of course, anti-trust. We know
10 about consolidations.
11 So, I think there's this opportunity
12 for us as a Committee to report and ask for the
13 Secretary to consider a project that would kind
14 of reimagine kind of how we would help our
15 rural providers and their patients, but
16 arraying the entire federal structure that we
17 have, that touches health.
18 So, I'll leave it there.
19 CO-CHAIR HARDIN: Thank you, Jim.
20 Jen?
21 DR. WILER: I, too, want to give my
22 gratitude to the numerous people who
23 contributed to making really exceptional,
24 valuable last two days.
25 There were four things that in
26 addition to all the previous comments and our

1 comments yesterday, that I heard that I'd like
2 to note.
3 The first is that moving from volume
4 to value has no place in our rural community
5 construct when we think about our value-based
6 care delivery models and payment models. It
7 just doesn't work.
8 We heard a lot around you know, the
9 challenge around low volume. And, I'm
10 convinced after these last two days that just
11 aggregation of patients for attribution, or
12 being able to apply a risk methodology, is the
13 wrong approach.
14 And what we heard is, or a question
15 was asked that I thought was a really important
16 or thought provoking one, is risk necessary to
17 change behaviors?
18 And I think the answer in this
19 situation again after these two days, I think
20 the answer is no.
21 What we heard is that you know,
22 financial viability is the number one success
23 factor.
24 And so, thinking about how to create
25 a sustainable workforce and delivery network
26 that touches our rural patients, and props up

1 our delivery system providers, including our
2 various forms of acute care hospitals, seems
3 important. It's part of critical
4 infrastructure.
5 And when our rural providers are
6 already in a practice environment that is by
7 nature at risk, delivering care to our
8 vulnerable patients who are not healthy, not
9 only is it a call to us around the fragility
10 and the fact that it's breaking, but I think we
11 need to be laser-focused on how to create
12 maintenance and sustainability.
13 Because I think point number two,
14 what I heard early on the session yesterday and
15 then again today. I think we all agree that
16 the first principle is to be home first. Which
17 means community first.
18 And in order to do that, there's a
19 cost of availability, much like our utilities
20 that we've talked about before.
21 And I thought lots of good
22 conversation that I won't replicate here, but
23 we heard that most of the cost of, from a
24 delivery perspective, is fixed in these
25 communities.
26 And so really, we need to pivot our

1 thinking around leveraging this fixed cost to
2 be more effective, and to be more efficient.
3 And we have these payment structures
4 that it sounds like are preventing us from
5 being able, being able to do that. And
6 leverage some of those assets that are already
7 in those communities.
8 The last thing I heard dovetails on
9 what I think Jim is raising, and that's I think
10 it's become clear we have to double down on
11 public-private partnerships.
12 And that in these communities,
13 conveners are really critical. If that's from
14 portfolio management and seeking funding, and
15 implementing funding through grants, or
16 operationally, you know, project managing, how
17 to do that implementation, there's a need for
18 that within at least the provider community.
19 So, my last point is, it sounds to
20 me like a community-based ACO program, which
21 CMMI has already started thinking about, and
22 implementing.
23 But I think really getting
24 sophisticated and understanding what a
25 community-based ACO looks like, with regards to
26 funding and unique partnerships.

1 With regards to this idea of fixed
2 costs and utilities. With regards to unique, I
3 don't even think community health workers are
4 no longer innovative. They're critical
5 infrastructure.
6 So there might be an innovative care
7 model, but that asset is one that's no longer
8 innovative.
9 And there's a real opportunity for
10 us to think about how to keep care at home.
11 And when appropriate, an escalation to an
12 interventional cardiologist, not in the acute
13 care phase, but right in the diagnostic phase.
14 But what are those things that can
15 be kept closer to home with the resources that
16 exist? Thank you.
17 CO-CHAIR HARDIN: Thank you so much,
18 Jen. Angelo?
19 CO-CHAIR SINOPOLI: Yes, thank you.
20 So again, just like everybody else
21 I'll start out by commending this team, the
22 PTAC Committees and all of our support from
23 ASPE and NORC, and others that have
24 participated in this.
25 And particularly to our panelists
26 who clearly dedicated a lot of time to putting

1 their presentations together, have years of
2 experience that they brought to the table.
3 And a lot of their discussion, I
4 think has been eye-opening to me, and I suspect
5 a lot of people around the table.
6 We had a good discussion yesterday
7 after yesterday's meetings, and I just want to
8 kind of rapidly highlight a couple of those
9 that.
10 And what we heard is lack of capital
11 investment. We heard a lack of community
12 resources, and a lack of ability to
13 partnership, or organize as community
14 resources.
15 We heard a lack of definition of
16 rural and the recognition of the different
17 archetypes of rural.
18 We heard that VBC[44] just doesn't work
19 in the rural community. We heard that the
20 quality measure dysfunction that we experience
21 even in the urban areas, is magnified in the
22 rural areas.
23 We heard the lack of data. And we
24 heard that this is a public emergency. And so,
25 and we talk about it only being 15 percent.

44 Value-based care

1 It's 15 percent. It's 15 percent of all the
2 people in the United States, of which no other
3 area has the capacity to absorb those 15
4 percent.
5 And so, I just want to emphasize
6 those things. And what it really says to me,
7 is that the rural components emphasize the fact
8 that we don't really have a health care system.
9 We still have fragmented care,
10 fragmented programs, et cetera. And so I am
11 looking forward to that day when we actually
12 can develop a system where maybe we need a
13 rural ACO, but wouldn't it be nice if we had a
14 health care system that alleviated the need to
15 have a rural ACO?
16 That actually all the systems were
17 integrated. That we supported the rural
18 hospitals. Connected them to the urban and
19 academic medical centers.
20 That the specialists in those areas
21 were connected to the rural primary care
22 physicians and specialists.
23 And that we work to create true
24 integration. And that's what we talk about.
25 We have a model that we've talked about as the
26 model.

1 What we've not talked about is how
2 does that get operationalized and integrated
3 across all geographies in the United States?
4 And I think that's where we need a thought
5 process around.
6 And then the last thing I'll mention
7 is, you know, even in my previous work going
8 back to a lot of what Jim talked about.
9 There's a huge amount of resources
10 in state agencies, and governor cabinet
11 resources that deal with health care day in and
12 day out.
13 And those things are not coordinated
14 with all the other health care resources that
15 are available in the health care system. And
16 they should be.
17 And so, lots of opportunity. All
18 this is fixable. Somebody's got to step up and
19 make a decision that we're going to pull all
20 this together, so.
21 * **Closing Remarks**
22 CO-CHAIR HARDIN: Thank you so much,
23 Angelo. Audrey, or any of the staff have any
24 questions or comments?
25 I want to thank all of our esteemed
26 presenters and also our wonderful experts on

1 the Committee itself, for your active
2 engagement. Really important comments.
3 And really key themes. We've
4 explored a lot of facets regarding and
5 encouraging rural provider participation, and
6 population-based total cost of care models.
7 And, I think we will continue to
8 gather information on our theme through our
9 Request for Input on our topic.
10 We'll be posting that on the ASPE
11 PTAC website, and sending it out through the
12 PTAC Listserv.
13 You can offer your input on our
14 questions by October 20th.
15 The Committee will work to issue a
16 report to the Secretary with our
17 recommendations from this public meeting.
18 * **Adjourn**
19 And with that, the meeting is
20 adjourned. Thank you.
21 (Whereupon, the above-entitled
22 matter went off the record at 12:57 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 09-19-23

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Court Reporter