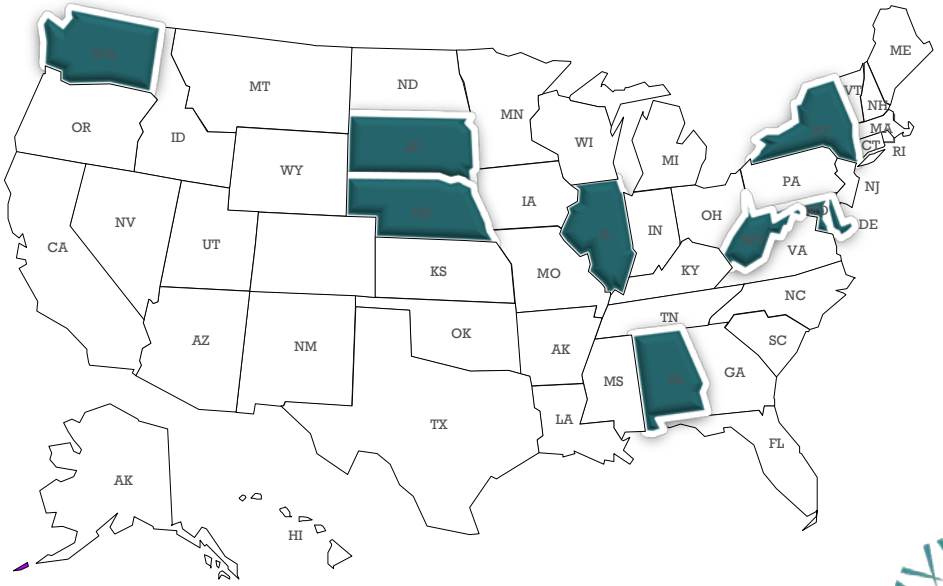
SHIP Technical Assistance (TA) Webinar
May 2, 2019

Program Overview

- September 2015- August 2018
- Support the development or expansion of formal rural health networks that focus on care coordination activities targeting three chronic conditions in rural communities.
- Up to $200,000 per Budget Period
- 8 Grantees



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Program Grantee Overview

State	Grantee	Core Areas	*Counties	*Patients Served
AL	Tombigbee Health Care Authority	Outreach, Transitional Care, Diabetes Education	2	79
IL	Gibson Area Hospital & Health Services	Health Education, CHW, SDoH, EHR Interoperability	7	126
MD	County of Worcester	CHW, Health Insurance Enrollment, EHR Enhancement, SDoH	1	94
NE	South East Rural Physicians Alliance	Care Management, Diabetes Education, Transition of Care, Workforce Enhancement	17	8034
NY	Chautauqua County Health Network, Inc	Systems Capacity Development, Disease Management, Contract Negotiation	3	297
SD	Avera St. Mary's	Cultural Competency, Telehealth, Pharmacy Assistance, Diabetes Education	13	53
WA	Critical Access Hospital Network (CAHN)	Health System Redesign, Value Based System Transformation, Workforce Enhancement	3	23
WV	Williamson Health and Wellness Center	CHW, Telehealth, Transitional Care, 3rd Party Payer Engagement, Cost Savings Data	7	130
			53	**8836**

** Numbers reflect Year 3 Counties and Patients Served*

RURAL HEALTH RESOURCE CENTER

WA Spotlight: Care Coordination in Rural Hospitals

Jac Davies, MS, MPH

NORTHWEST RURAL HEALTH NETWORK

May 2nd, 2019

Acknowledgements

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G07RH28863, Rural Health Care Coordination Network Partnership, for $800,000 over three years (25% from nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

We also are grateful to the Empire Health Foundation for their support of our region's efforts to expand care coordination services in rural communities.

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Northwest Rural Health Network

The Northwest Rural Health Network (NWRHN) is a nonprofit, multi-county network of rural health systems in eastern Washington state that have come together to share resources, promote operational efficiencies, and improve health care services for member hospitals and the rural communities they serve.

Formed in 2002 as the Critical Access Hospital Network, the organization has grown to 15 members across ten counties.

Rural Health Care Coordination Network Partnership Program (RHCCNP)

Goal

- Promote the delivery of coordinated care for vulnerable populations (seniors, low income and minority) diagnosed with diabetes, congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) in four rural health systems in eastern Washington.

Method

- Implement a Health Home intensive care coordination program for enrollees in a Molina Medicaid Managed Care plan. Highly structured program for high-risk/high-need individuals including regular meetings with care coordinator, home visits and data registry.

Public/Private Partnership

NWRHN Members

- Four independent non-competitive rural health systems in three counties, all sharing a common referral pattern to urban tertiary care centers in Spokane, WA
- Overall network structure for project coordination and evaluation

Molina

- Largest Medicaid Managed Care Organization (MMCO) in region with established Health Home program including a payment model for reimbursing care coordinators

Empire Health Foundation

- Regional philanthropy with an interest in healthy aging for rural residents

HRSA Office of Rural Health Programs

- Funding agency and promoter of collaboration with philanthropies to address rural health issues

Need

Rural communities with older and sicker residents

Low income populations

Limited local resources

- Lack of housing and transportation
- In three of four communities lack of social services

Limited care coordination capacity and experience in three of four communities

While all four health systems consist of CAHs and RHCs, they and their communities vary in size which affects ability to hire as well as their overall capacity

Activities

Recruiting and hiring care coordinators

Training in Health Home model and use of required IT platform

Training of primary care teams

Promoting program and recruiting patients

For enrolled patients

- Intake assessment
- Creation and tracking of Health Action Plan
- Regular contact with care coordinator (including home visits)
- Assistance getting connected to health and community services

For care coordinator

- Regular contact with MMCO
- Communication with care team

Outcomes

- Successful implementation in all four systems, although three systems with limited prior care coordination experience struggled to integrate the model into their primary care programs
- Lessons learned by Molina and WA state policy makers on how to adapt the Health Home program for rural providers and how to support rural health systems in implementation
- New capacity with staff at each site trained in care coordination and working within primary care teams
- New model available for sustainable care coordination programs through MCO payments for Health Homes work

Lessons Learned

Three of the four health systems added care coordination responsibilities to nursing responsibilities.

- Staff did not have experience in dealing with many social determinant issues (housing, lack of food, etc) and found the work to be extra challenging.
- In small rural health systems with limited staff, care coordination sometimes took a back seat to nursing.

The model was most successful in the health system that was able to hire social workers for the care coordination role and to fully integrate that position into the primary care team.

> "A person's basic needs like safe housing with water and electricity have to be met before you can start addressing their health needs." - Nursing Director

Lessons Learned Continued

In smaller communities with limited social services, care coordination programs will struggle. Care coordinators become frustrated when patients have problems for which there are no local solutions (such as lack of adequate housing).

To build a successful care coordination program, health systems need to look outside the clinic walls and partner with other agencies that can address those social service needs.

Smaller health system with limited capacity may need to find social service agencies to provide care coordination services but integrate those activities into primary care in the same way that behavioral health agencies are starting to integrate their programs into primary care.

Thank You!

Jac Davies -- jdavies@nwrhn.org

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SD Spotlight: Care Coordination in Rural Hospitals

Marnie Burke, MPA, BSN, RN, CPHQ

Director of Quality, Safety & Risk Management

May 2, 2019

HRSA Coordinated Care Grant 2015-2018

PROGRAM GOAL

To teach individuals with Diabetes as well as those at high-risk of getting Diabetes, how to manage and improve their health.

This program follows established Indian Health Services standards of care for the treatment of Diabetes.

COMPLETING THE CIRCLE

The Completing the Circle program will assist patients diagnosed with Type 2 Diabetes.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G07RH28860, Rural Health Care Coordination Network Partnership for $505,828. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

PARTICIPATING LOCATIONS

AVERA MEDICAL GROUP PIERRE
AVERA MEDICAL GROUP CHAMBERLAIN
AVERA MEDICAL GROUP MILLER
AVERA MEDICAL GROUP GREGORY
AVERA MEDICAL GROUP WINNER
SOUTH DAKOTA URBAN INDIAN HEALTH

COMPLETING THE CIRCLE

A Diabetes education program for patients and their families

A Partnership between:

South Dakota
Urban Indian Health

Avera

VILAS PHARMACIES & HEALTHCARE STORES

NATIONAL RURAL HEALTH RESOURCE CENTER

Completing the Circle

Project served patients in 13 central SD counties
6 Clinic Locations

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Strategies for Success

Patient Population:

- 18 year or older
- Type II Diabetic
- 40 unique patients enrolled

Support Staff:

- Primary Care Provider (PCP) /Clinic Staff
- RN Case Manager (RNCM)
- Coordinated Care Specialist
- Master's Prepared Social Worker
- Certified Diabetic Educator (CDE)

Initial Educational Components:

- 3 education sessions with CDE
- Grocery Store Tour (local) with CDE
- Cooking Kitchen with CDE

Program Components:

- Monthly patient contact/touch base with RNCM, Social Worker and/or CDE
- Clinical data monitoring by Care Specialist
- PCP appointment adherence by Care Specialist

Completing the Circle Final Outcomes

Access to Care :

- **29 Patient Educational Sessions with AveraNow**

Utilization:

- **50% Reduction in Inpatient Admissions**
- **46% Reduction in Emergency Department Visits**

Clinical Outcomes:

- **2 Point Decrease in HgbA1C Values**
- **34% Improvement in Dilated Eye Exam**
- **65% Improvement in Diabetic Foot Exam**

Community Care Coordination Resources for SHIP

Salamatu Barrie

Federal Office of Rural Health Policy
SHIP Program Officer

Care Coordination Resources

- 2015-2018 Cohort: Grantee Directory
- RHIHub's Rural Care Coordination Toolkit
- NRHC's Community Care Coordination & Chronic Care Management
- Stratis Health Coordination of Care Resources
- GHPC's Care Coordination Resource Guide

NATIONAL RURAL HEALTH RESOURCE CENTER

Contact

For additional information regarding the resources highlighted contact:

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Questions?