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# Rural Health Convening



## Intermountain Healthcare

Convening Proceedings Report | August 2019

By Laura Summers, Senior Health Care Analyst  
Kem C. Gardner Policy Institute





Dr. Marc Harrison welcomes participants to the 2019 Rural Health Convening held in Midway, UT.

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# Introduction

On June 24–25, 2019, Intermountain Healthcare hosted the 2019 Rural Health Convening in Midway, Utah. The convening brought together leaders from the Centers for Medicare & Medicaid Services (CMS) and rural healthcare providers from the Mountain West.<sup>1</sup>

The convening created a platform for discussing the optimal future of rural healthcare in the Mountain West and established a foundation for future collaborative efforts to improve the health and wellbeing of rural communities.

This report summarizes the convening's presentations and discussions, outlines key observations, and poses next steps for consideration. The purpose of the report is to help policy and healthcare leaders better understand and make informed decisions about improving rural healthcare.

## The convening focused on strategies and innovations for:

- Addressing the future of rural healthcare delivery
- Payment model innovation
- Resourcing and staffing transformation
- Stakeholder engagement and collaboration

## Convening Speakers



**Adam Boehler**  
Senior Advisor to the Secretary of Health and Human Services (HHS)  
Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and Director of the Center for Medicare and Medicaid Innovation (the Innovation Center)



**Marc Harrison, MD**  
President and Chief Executive Officer  
Intermountain Healthcare



**Mikelle Moore**  
Senior Vice President and Chief  
Community Health Officer  
Intermountain Healthcare



**Rob Allen**  
Chief Operating Officer  
Intermountain Healthcare



**Eric Cragun**  
Government Products Partner,  
Population Health  
Intermountain Healthcare



**Dan Liljenquist**  
Senior Vice President and  
Chief Strategy Officer  
Intermountain Healthcare

# Rural Health Challenges

Rural healthcare is at risk. Not only do rural residents tend to be older, sicker, and poorer, but 44 percent of rural hospitals are operating at a loss and 21 percent are at high risk of closing.<sup>2</sup>

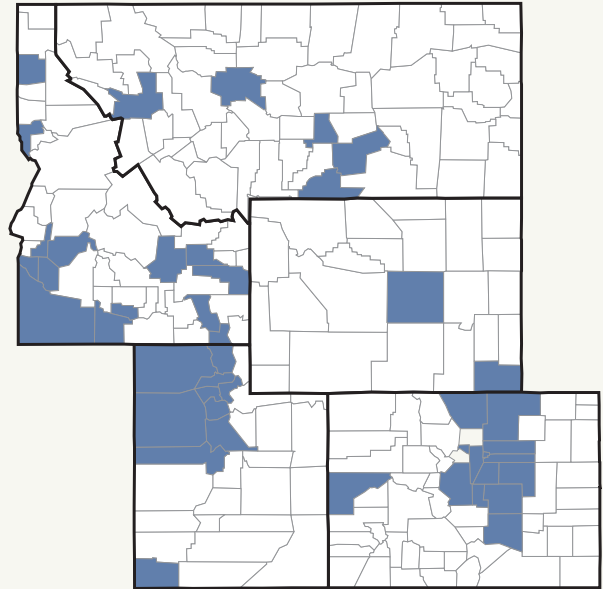
Healthcare is a critical part of rural economies and hospitals are often a community's largest employer.

## Rural Health in the Mountain West

There are 136 Critical Access Hospitals (CAHs) and 215 Rural Health Clinics (RHCs) in the Mountain West.<sup>9</sup>

- CAHs are rural hospitals with 25 or fewer inpatient beds, and are least 15–35 miles from another hospital or designated as a “necessary provider.”
- RHCs must be located in a non-urban region that is a designated health professional shortage area or medically underserved area.

Unlike the rest of the country, the Mountain West has not experienced many rural hospital closures since 2010.<sup>10</sup> However, the area still struggles with high poverty rates, high uninsured rates, and provider shortages.



**Figure 1: Mountain West Rural, Health, and Social Statistics by State**

Key Statistic	Utah	Idaho	Wyoming	Colorado	Montana
Average Population Density (# People/ Sq. Mile for Rural Counties)	6.9	14.9	4.7	10.2	5.4
% Pop. (Rural Counties)	11%	35%	70%	14%	65%
Avg. Sq. Miles (Rural Counties)	3.1k	1.9k	4.3k	1.7k	2.7k
PCP/100k Population and State Rank (All Counties)	64.7 (49 <sup>th</sup> )	73.1 (46 <sup>th</sup> )	77.4 (43 <sup>rd</sup> )	94.2 (21 <sup>st</sup> )	86.6 (29 <sup>th</sup> )
Suicide Rate/100k Population and State Rank (All Counties)	22.7 (6 <sup>th</sup> )	23.2 (5 <sup>th</sup> )	26.9 (3 <sup>rd</sup> )	20.3 (10 <sup>th</sup> )	28.9 (1 <sup>st</sup> )
Percent of Metro v. Non-metro Population Living Below Poverty	9.4% v. 12.1%	12.0% v. 13.8%	10.3% v. 11.1%	10.0% v. 12.8%	11.9% v. 13.2%
Metro v. Non-metro Uninsured Rate for Population Ages 18–64	11.4% v. 14.7%	13.9% v. 18.1%	15.1% v. 17.0%	9.8% v. 13.4%	10.8% v. 12.8%
Expanded Medicaid	Yes*	Yes	No	Yes	Yes
Percent of Metro v. Non-metro Population Without a High School Diploma	8.1% v. 9.6%	8.5% v. 12.3%	7.3% v. 7.2%	8.6% v. 10.3%	6.6% v. 7.2%

\*Expanded to 100 percent of the federal poverty level.

Note: Data is 2017 or earlier if latest year available. PCP = primary care physician.

Sources: Cragun, E. (2019 June 24). Pennsylvania Model and CMS Rural Initiatives. Presented at the 2019 Rural Health Convening, Midway, UT. Rural Health Information Hub. Centers for Disease Control and Prevention.

# Improving Rural Health

## **Existing Federal and State Initiatives**

The 2019 Rural Health Convening kicked off with providing examples of federal and state initiatives to improve rural health. While solutions developed for the Mountain West will need to be tailored to address the region's specific needs and challenges, these examples provide points of consideration and highlight areas where CMS has given support and flexibility in delivery system and payment reform. Additional information on these examples is detailed in the convening pre-read materials.

## **CMS Rural Initiatives**

Eric Cragun, Government Products Partner, Population Health at Intermountain Healthcare, highlighted current delivery system and payment reform models supported by CMS that promote rural participation. Examples include:

- Medicare Shared Savings Program (MSSP) and Next Gen ACO models, which financially support rural ACO participation through the ACO Investment Model (AIM).
- Comprehensive Primary Care Plus (CPC+), which covers a large rural footprint (467 rural practices participated in the first round).
- Practice Transformation Networks, which are peer-based learning networks designed to coach, mentor, and assist clinicians obtain core competencies for practice transformation.<sup>3</sup> Provider networks have to commit to serving rural and underserved populations to participate.

The objective of these models is to help rural providers take full accountability for the cost of care by shifting from fee-for-service payment arrangements to outcome- or value-based healthcare. The concept of value-based healthcare is one in which providers are paid for the value, or outcomes, of care provided, rather than the volume of services. Value-based payments are structured to

reward providers for keeping patients healthy at the lowest cost possible rather than incentivize over-utilizing services. Examples of value-based payment models include bundled payments, upside-only shared savings, downside risk sharing, capitation, and global payments.

It can be more difficult for rural providers to shift to value-based healthcare given limited financial resources, smaller patient populations, increased severity of patients' needs, and limited access to technology and data sharing capabilities. As a result, rural providers often need more time, additional financial support, and flexibility in payment model reform. For example, they may need to use a different set of outcome-based metrics than their urban counterparts to successfully scale value-based payments. Rural payment model reform may also need to account for a different set of health and social service stakeholders than urban areas given the close-knit structure of rural communities.

## **Regional and State-Specific CMMI Innovation Models**

Eric highlighted several rural-focused regional and state delivery and payment models that are supported by the Center for Medicare & Medicaid Innovation (the Innovation Center).<sup>4</sup> The Pennsylvania Rural Health Model, for example, provides participating rural hospitals with a global budget for inpatient and outpatient hospital services. While moving to a global budget could lower hospitals' overall revenue, it is expected to increase their operating margins. The global budget is determined from a "baseline of net patient revenue plus any planned prospective adjustments plus any corrections for unplanned market shifts and minus any potentially avoidable utilization. Any savings generated remain in the budget based on scale."<sup>5</sup>

The goal of transitioning to a global budget is to promote greater flexibility in the services hospitals provide and increase focus on providing services that improve population health. In Pennsylvania, a hospital care delivery transformation program

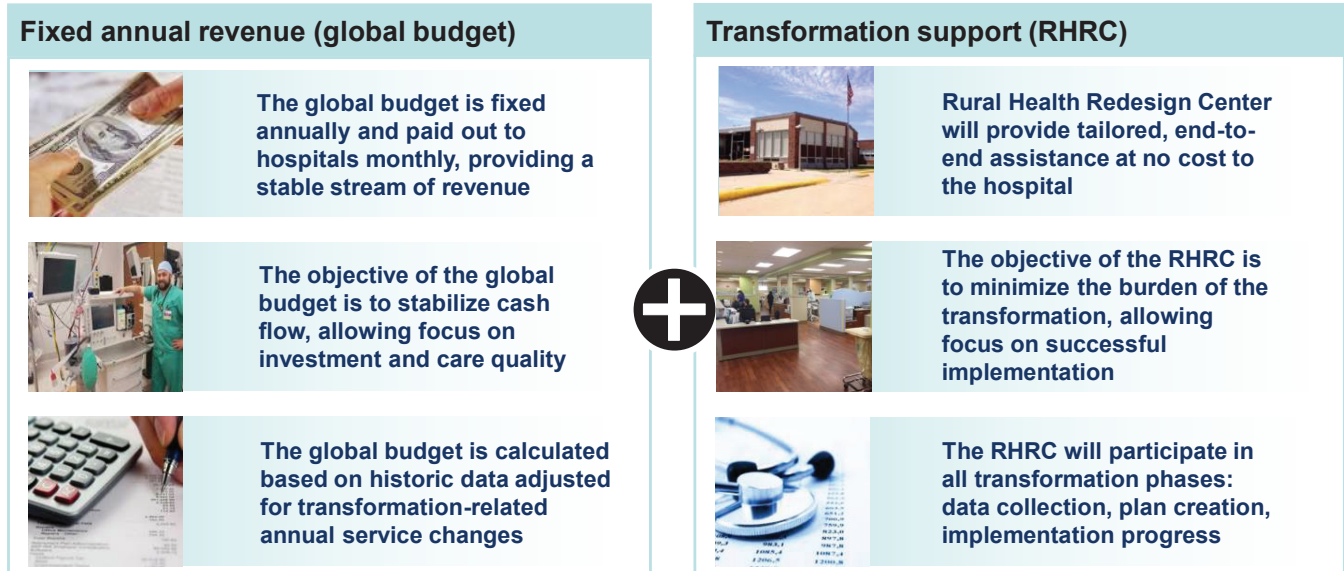
*"We look for models that are as simple as possible, that provide as much data as possible, and models that hold people accountable. We're happy to invest ourselves and drive people to outcome-based care, but we also demand sustainability and accountability. What you'll see out of us [CMS] are big building blocks. We like to set the table. We don't make the mistake of thinking that we are providing the care. The model has to give you [providers] the fabric to come up with new interventions."*

Adam Boehler, Senior Advisor to the HHS Secretary, Deputy Administrator of CMS, and Director of the Innovation Center

Figure 2: The Pennsylvania Rural Health Model

# Rural Health

The global budget and the Rural Health Redesign Center are the two pillars of the model.



**In addition, pilot candidates can expect infrastructure support**



Source: Hughes, L. (n.d.). Rural Health in Pennsylvania. Pennsylvania Department of Health PowerPoint. Included in 2019 Rural Health Convening pre-read materials (2019 June 24-25).

operated by the Rural Health Redesign Center (a public-private partnership) supports participating hospitals:

- Increase access to primary and specialty services.
- Reduce deaths related to substance use disorder (SUD) and improve access to opioid treatment.
- Improve chronic disease management and preventive screenings of cancer, cardiovascular disease, and obesity/diabetes.
- Build partnerships with other providers through care coordination and referral patterns to promote population health.
- If appropriate, reduce excess beds, change service delivery lines, or transition to an outpatient center.

The program launched in January 2017 and will conclude in 2024. While the effectiveness of the program is still being evaluated, participating hospitals are expected to save the federal Medicare budget \$35 million.

# Future of Care Delivery

## What should the future of care delivery look like in the Mountain West?

To better understand what the future of care delivery should look like in the rural Mountain West, Intermountain Healthcare invited three panelists to share their perspectives and lead

a discussion on how best to build a high-value healthcare delivery infrastructure in rural communities.



**Sandy Morse**  
Director, Regional  
Nursing, Billings Clinic

*“We need to facilitate connections across rural communities and to other communities that have a greater range and depth of healthcare resources, including ensuring that there are financial structures and incentives in place to support those connections.”*

Sandy specifically focused on achieving key connections through nursing system reform, including investing in nursing leadership development. She also provided several examples of how the Billings Clinic improved healthcare delivery in Montana and northern Wyoming. One example is the creation of a post-acute care program with a mission to get “care closer to home.” The program includes (1) education to local hospitals on best practices in care delivery; (2) a dedicated phone line to answer care questions from care managers and specialty providers such as respiratory therapists; and (3) streamlined and standardized equipment across facilities. Results show this program is helping patients access better care and return home faster. Another example is the development of a transfer center, which is a critical access hospital with a dedicated physician who answers calls from hospitals requesting transfers. The transfer center improves care management and helps people remain local for their medical care.



**Keith Gnagey**  
CEO, Board Chair  
Emeritus  
Teton Valley Health

*“We need to get creative to provide services in place.”*

Keith shared the story of how some Teton Valley Health patients were driving an hour and half to the nearest town to get pediatric Tylenol. In response, Teton Valley Health bought a vending machine and stocked the machine with the 20 items most likely to be needed in the middle of the night. At a higher level, Teton Valley Health developed strategies to bring specialists and subspecialists to their valley by partnering with larger hospitals to offer telehealth services and employing visiting specialists on a rotating basis.

Keith also noted that there are advantages to living in rural areas. He talked about how Teton Valley Health was able to make progress on the opioid epidemic because their community is so small that they could get everyone involved (e.g., criminal justice, drug court, the VA, etc.). They developed a program that requires patients receiving opioids for non-acute medical conditions to be under the care of a pain management specialist, have a psychological evaluation, submit urine analyses, and sign a contract. This program and other collaborative efforts resulted in a 20 percent reduction in prescription opioids. His example highlights how coordination in small rural areas can lead to big impacts that may not be possible in larger cities.



**Alan Pruhs**  
Executive Director  
Association for Utah  
Community Health  
(AUCH)

*“As healthcare shifts to value, we must collaborate.”*

Alan noted that collaboration includes improving the ability to share data across providers and care teams. AUCH is currently developing a clinically integrated network of health centers across Utah. This network will allow centers to more easily share resources and improve analytics and reporting.

AUCH is engaged in several other collaborative efforts as well. One example is embedding behavioral health consults in primary care physician visits to reduce the stigma associated with receiving mental health or SUD services. AUCH also worked with Utah’s Pharmacy Board to allow Green River (a small rural town in Utah) to have a local pharmacy technician dispense medication. This technician operates under the supervision of a pharmacist located in a nearby rural town that participates in a telepharmacy program.

Key themes that emerged from the discussion include:

**Healthcare delivery model design and infrastructure has to reflect community needs.**

Every community is different. Improving rural health requires listening to and understanding what each community needs, including needs that extend beyond the walls of traditional medical care. These needs are commonly referred to as social determinants of health, or the conditions in which people are born, live, learn, work, play, and worship that affect their health risks and outcomes.<sup>6</sup> Research shows that non-medical factors, such as a person's living and working conditions, social environment, economic situation, and healthy behaviors, account for up to 60 percent of their health outcomes, while genetics and the healthcare system comprise the remaining 40 percent.<sup>7</sup>

**Partnerships and communication are critical to building dynamic solutions—innovate and share.**

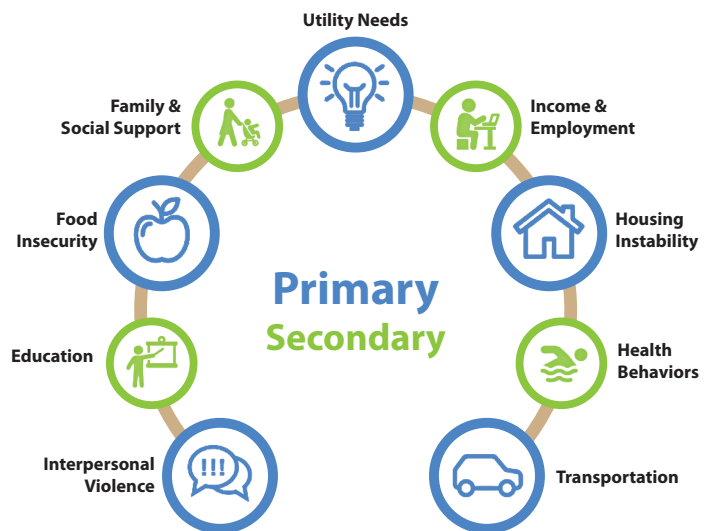
Understanding and addressing a community's needs related to health issues, access, and availability is best done at the social center of the community, which may be places like the grocery store. One discussion group suggested building partnerships with non-traditional players such as Associated Food Stores—a grocery wholesaler in the Mountain West that supports grocery stores in eight states.

Partnerships with traditional players, such as school systems, payers, hospitals, provider groups, dentists, etc., also need to be strengthened and maintained. Having a well-connected and collaborative community is key to improving the health and wellness of rural areas. These partnerships not only help promote integrated care, but also help avoid the unnecessary duplication of services.

**Ambulatory, preventive, and community care are rural health's competitive advantages**

Rural hospitals and healthcare providers have a unique advantage in addressing and promoting ambulatory, preventive, and community care. These areas should be supported and enhanced—and in a way that protects rural economies. For example, it is important to consider more than just consolidation or outsourcing when looking at healthcare delivery reform given that many rural hospitals and providers are key economic drivers.

**Figure 3: Social Determinants of Health**



Source: Intermountain Healthcare.

**Strong, trusting connections should be developed and facilitated across rural and urban communities.**

For rural health to maximize its areas of competitive advantage (ambulatory, preventive, and community care), connections with urban hospitals and providers should be developed and strengthened. Increasing the use and reimbursement of telehealth and telementoring (peer-to-peer consultation), exploring shared staffing models, and improving data sharing can help build and sustain rural health systems. However, this may require improving basic infrastructure in some rural areas, such as increasing access to transportation and broadband internet.

**Consider economies of scale when promoting payment reform.**

Many rural hospitals and providers do not have the resources to take on payment model reform without additional financial supports and incentives. Rural payment reform should occur at an appropriate pace while taking into account and leveraging the discussion themes highlighted above.

*"I've solved more problems in the egg section of the grocery store than in the office."*



# Payment Model Innovation

## **How should rural healthcare services be reimbursed?**

Intermountain Healthcare invited Adam Boehler, Senior Advisor to the HHS Secretary, Deputy Administrator of CMS, and Director of the Innovation Center, and Rob Allen, Intermountain's Chief Operating Officer (COO), to participate in

a fireside chat about how to improve rural healthcare delivery through innovative payment models. Convening participants then had an opportunity to engage in a question and answer session with Brede Eschliman and Rivka Friedman from CMS.



### **Adam Boehler**

Senior Advisor to the HHS Secretary, Deputy Administrator of CMS, and Director of the Innovation Center

The Innovation Center is engaged in further development of a rural-specific approach to promoting healthcare cost accountability—and it acknowledges that sustainability is a critical ingredient of this approach. The effort goes beyond direct contracting or primary care-focused efforts. Rural payment reform has to take into account the whole community, not just the medical side, because the two are so intertwined.

*“One of our jobs is to let more flowers bloom. If we give you accountability, you pick the population, and you’re on the hook. We give you the flexibility, and you do it.”*

### **Rob Allen**

COO, Intermountain Healthcare

In one rural community, 35 percent of the patient population was driving 85 miles or more for hospital services. To address this and other access issues, Intermountain committed to supporting rural health by promoting telehealth services. This allows patients to receive care close to home, reduces transportation needs, creates opportunity for rural hospitals to retain patients and revenue in their areas, and supports and sustains the local workforce and economy.

*“You can reduce healthcare costs per person by keeping people at home.”*



Director Adam Boehler provides comments on payment and delivery system models focused on improving rural health.



2019 Rural Health Convening participants discuss payment model innovation.

Key themes that emerged from the question and answer session include:

***Base services offered by rural providers will vary by region.***

A key part of the discussion focused on what base services rural hospitals should be required to provide. Participants noted that it is important to determine required base services while balancing what people in the community want and what services a hospital can reasonably provide due to resource and financial constraints. Some convening participants, for example, felt that it is impractical for some hospitals to provide certain services, like OB/GYN, due to a small number of patients.

***The goals of payment reform should include improved quality, sustainability, and accountability.***

Payment reform should incentivize healthcare providers to provide high-quality care at the lowest possible cost. It should hold providers accountable for their treatment decisions, but promote reform in a sustainable way that reflects the needs of the different patient populations being served.

***The focus on payment reform needs to shift beyond hospitals to include “upstream” partners and leverage unique community resources.***

Transportation, food, housing, and other social determinants of health are critical components of rural payment reform. Director Boehler noted that if the U.S. healthcare system was developed today, it would not make sense to silo the different departments that oversee health and social services such as Medicaid, housing, and food stamps. Addressing social determinants of health not only saves the healthcare system money, but provides people with a better quality of life. That said, the question the industry is currently trying to address is how to scale existing demonstrations.

*“The problem with outcome measures is that there is an asterisk on the numbers. There should be more of a focus on wellness. Don’t focus on treatment, focus on prevention. The more we do on prevention, the more we’re going to take down costs.”*



2019 Rural Health Convening participants discuss the future of rural healthcare delivery.

***Payment reform models should maximize local flexibility.***

Effective payment models are not one-size-fits-all. They need to be flexible in ways that allow rural areas to best meet their community needs. For example, it was suggested that rural hospitals and other healthcare providers be able to determine and define the outcome metrics used to measure success in payment models. It was noted that typical outcome measures focus on the quantity of services received such as the number of emergency room visits or the number of people receiving a colonoscopy or mammography. However, these type of services can be high or low in rural areas relative to urban areas, which may result in rural providers receiving negative ratings. It was also suggested that risk-adjustment should account for distance to care given distance can negatively impact rural patients' ability to access treatment.

Director Boehler noted that flexibility in payment model reform can be provided through waivers that allow for non-traditional, "upstream," or social determinant of health-related outcome measures. These type of outcome measures are currently being developed and tested, including by CMS' Integrated Care for Kids model.<sup>8</sup>

***Multi-payer payment reform is necessary for complete system transformation.***

Payment reform cannot be limited to hospitals and primary care providers. Specialists, community health centers, and other non-traditional providers need to be involved. Payers are the other critical player in payment reform. Medicare, Medicaid, and commercial insurance need to be committed to new reimbursement models.

It was recommended that the Mountain West consider a small pilot project focused on reforming payment for a specific condition (e.g., dialysis). Engaging in this type of targeted reform at the regional level could help test how to get all of the necessary players on board and determine the best model before expanding it to more populations and conditions.

*"Don't test me on services I only provide three times a year."*

# Resourcing and Staffing Transformation

## **How are people and technology best leveraged in rural healthcare delivery?**

To explore how people and technology can best be leveraged in rural healthcare delivery, convening participants broke into

four groups. Key healthcare leaders from across the Mountain West led these discussion groups.

## Resource and Staffing Transformation Discussion Group Leaders

### TECHNOLOGY



**Jim Sheets**  
Vice President  
Outreach Services Development  
Intermountain Healthcare

### DATA



**Patt Richesin**  
President  
Kootenai Care Network

### EXPERTISE



**Dr. Rhonda Robinson Beale**  
Chief Medical Affairs Officer  
Blue Cross of Idaho Foundation  
for Health, Inc.

### STAFFING



**Rita Osborn**  
Director  
Utah Center for Rural Health

Key themes that emerged from the discussion groups include:

### ***Existing non-healthcare technology can be leveraged to help patients and providers.***

UBER and Lyft's rideshare technologies are being used to provide medical transportation. Amazon's delivery network is touted as a possible way to provide direct food assistance and better address food insecurity. Participants also mentioned using drones to deliver medication and leveraging social media accounts to increase the sharing of healthcare information and education.

### ***Most data and management tools currently used by rural providers are inadequate to support the transformation to value-based care.***

Participants agreed that preset electronic medical record (EMR) templates currently used by many rural health providers are inadequate for payment and delivery system reform. It was also noted that some rural patient populations might be too small for population-based payment reform. Overcoming this challenge may require aggregating data across similar counties determined by patient profiles or health conditions.

### ***Telehealth and telementoring capabilities should expand.***

Telehealth, telementoring, and other virtual platforms are critical to improving rural healthcare and driving delivery system reform. These platforms allow healthcare information, education, and consultation to flow directly to consumers, from consumers to providers (e.g., in-home monitoring), from urban providers to rural providers, and from specialty providers to primary care providers. Appropriate reimbursement models need to be in place to increase the use and sustainability of these models.

*"We have an opportunity to lead out on [developing data interoperability] rather than being forced by the market to do it. We have the bandwidth and ability to do this now before we are in crisis."*

## Key Themes from Resource and Staffing Transformation Discussion Groups:

- Leverage existing technology
- Improve data and management tools
- Expand telehealth and telementoring
- Use data in care transformations
- Address health care provider shortages
- Leverage technology, partnerships, and communication



Patt Richesin leads a discussion on leveraging data in rural healthcare delivery transformation.

### ***Data is necessary to facilitate care transformation.***

Many rural providers don't have access to sophisticated systems that can understand and produce the necessary data for payment and delivery system reform. Support for improving data access, exchange, and interoperability is an important component of constructing closed-loop referrals and a regional payment model.

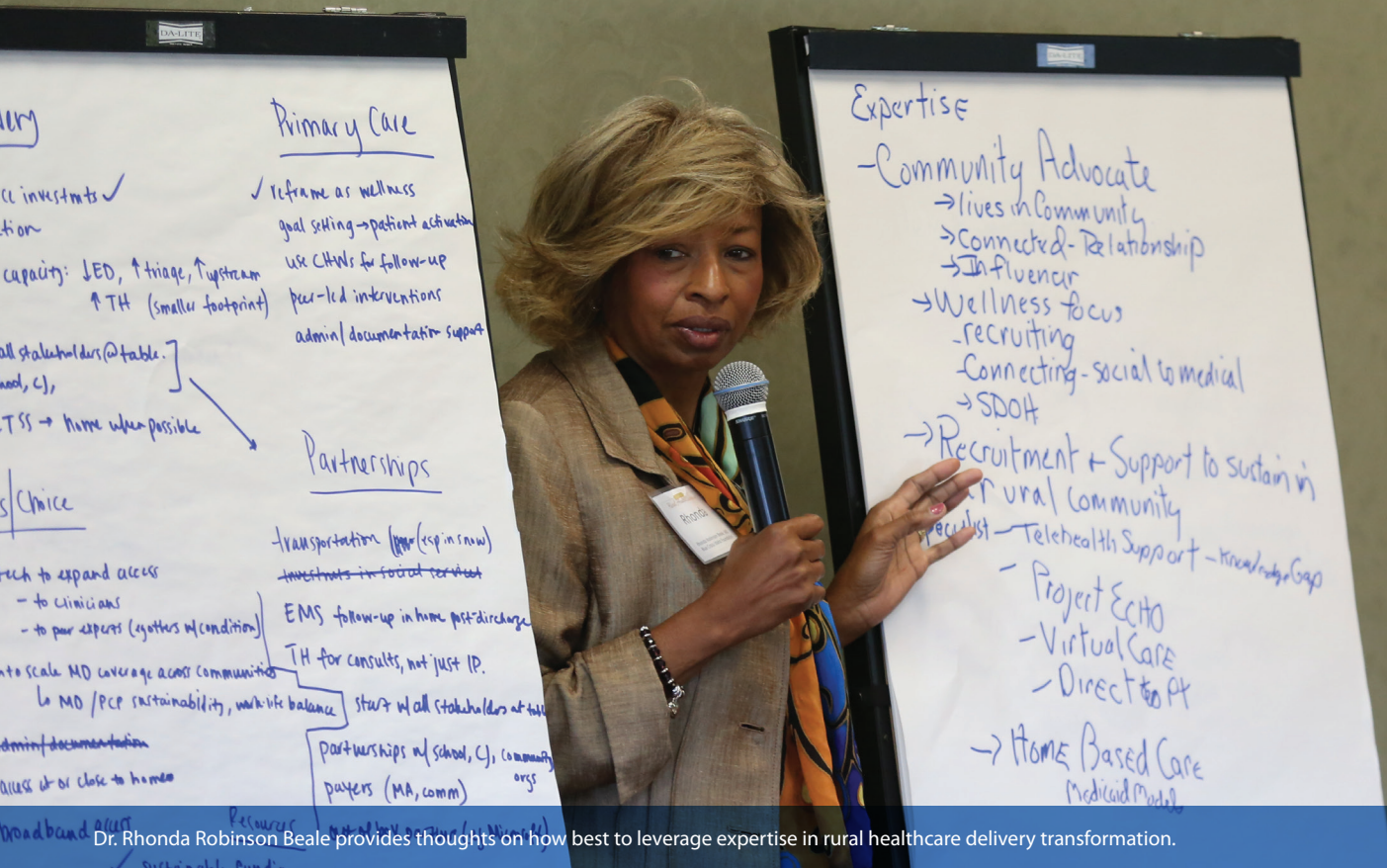
### ***Many rural areas suffer from a severe shortage of healthcare providers.***

Key points in this discussion included (1) physician burnout; (2) nursing shortages; (3) the need for providers who reflect the cultural and linguistic differences of the area; (4) the importance of "growing your own" and encouraging people who leave the area to obtain a healthcare degree to return to the area; and (5) improved training for talented physician and medical assistants.

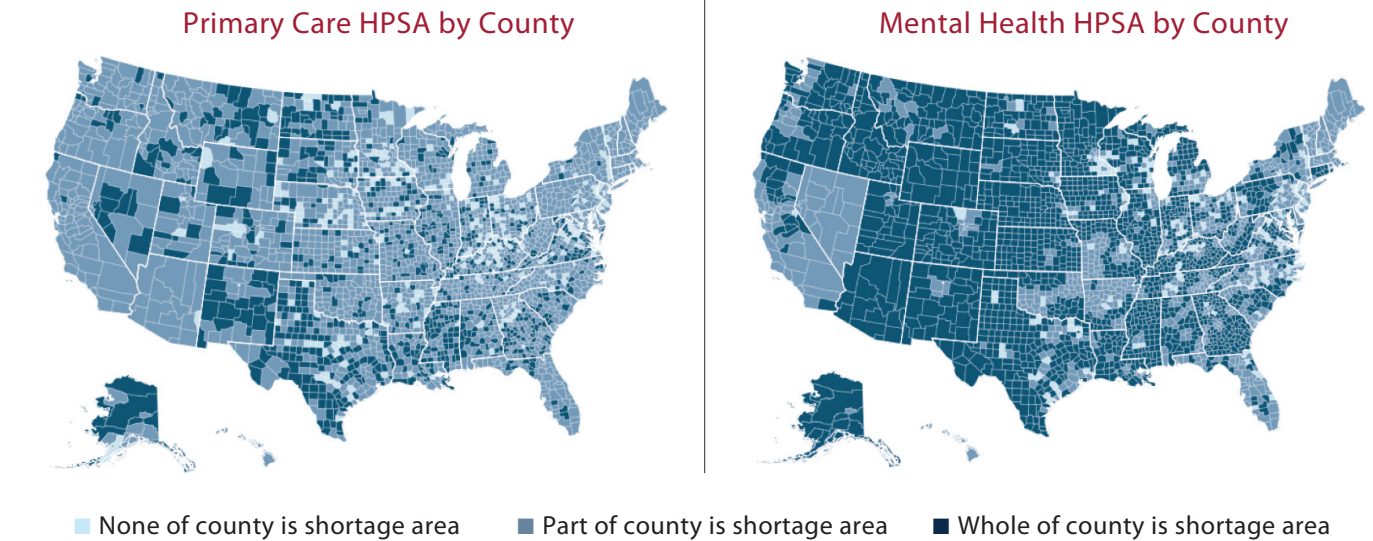
### ***Technology, partnerships, and communication are critical to all areas of resourcing and staffing transformation.***

Many rural areas experience gaps in medical and administrative knowledge (e.g., finance, HIPAA compliance, IT systems, data analysts, etc.) due to workforce shortages and a difficulty in attracting appropriately trained professionals to live in the area. While financial incentives such as loan repayment or relocation bonuses are effective strategies, finding a sustainable way to overcome these gaps in the long run requires creative solutions that leverage technology, urban partners, and improved communication and collaboration between systems.

*"Rural providers might not have access to necessary data, information, and tools to know what their future state should look like in order to innovate."*



Dr. Rhonda Robinson Beale provides thoughts on how best to leverage expertise in rural healthcare delivery transformation.



Source: Rural Health Information Hub. (2017 September). Healthcare Access in Rural Communities Chart Gallery. From Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care. (2019 February). American Hospital Association.

# Stakeholder Engagement and Collaboration

## **How can we better utilize federal, state, and community partners and resources?**

A goal of the 2019 Rural Health Convening was to establish a foundation for leaders in the Mountain West to collaborate on improving healthcare for the people and communities they serve. To build this foundation, the convening closed with a discussion of how policy and healthcare leaders can better utilize federal, state, and community partners and resource to improve rural health.

Dan Liljenquist, Senior Vice President and Chief Strategy Officer for Intermountain Healthcare, outlined four fundamentals for effective stakeholder engagement and collaboration:

- 1. Define the problem.**
- 2. Create urgency** by socializing the issue relentlessly.
- 3. Know your non-negotiables.**
- 4. Think differently to do things in a new way**, including looking for new allies and local partnerships.

Dan particularly stressed the importance of looking for new allies and local partnerships. He believes the key to system reform is thinking outside the box in terms potential supporters. For example, when advocating for Medicaid managed care in Utah, Dan sought the support of some members of the education community. He felt they would be important allies and support the concept of a capitated payment given education and Medicaid compete for limited state dollars.

Dan and Director Boehler provided examples of how these fundamentals of effective stakeholder engagement and collaboration could be used when promoting rural health payment reform. Dan stressed how important it is to help local leaders and partners understand what could happen if action is not taken. Director Boehler outlined the points he would demand and concede in negotiations: (1) he would demand regulatory relief; and (2) he would concede a slow transition to new payment models.

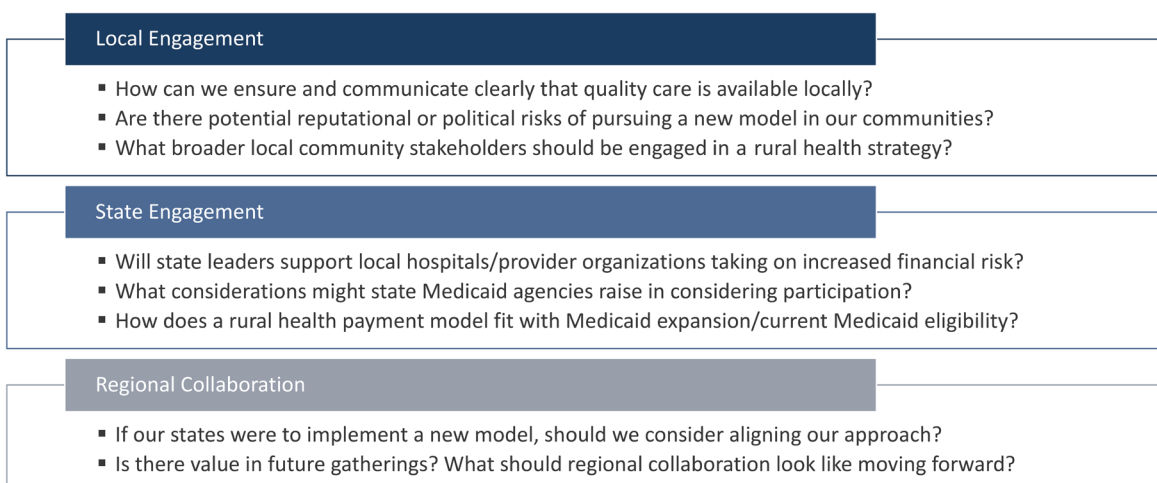
Figure 5 provides a question-based framework participants can use as they think through future stakeholder engagement and collaboration processes.

*“We cannot get to where we need to be through hospital-only focused reform. We need local partnerships. If you’re not talking about population health payment, then you’re only talking about a subdivision of the revenue streams you would need to move further upstream.”*

Dan Liljenquist, Senior Vice President and Chief Strategy Officer, Intermountain Healthcare

**Figure 5:**

## **Working Together to Advance Rural Health** Designing Stakeholder Engagement and Collaboration



Source: Liljenquist, D. (2019 June 25). Stakeholder Engagement & Collaboration. Presented at the 2019 Rural Health Convening, Midway, UT.

## Next Steps

Mikelle Moore, Senior Vice President and Chief Community Health Officer at Intermountain Healthcare, closed the stakeholder engagement and collaboration session by asking participants what is needed to bring other healthcare and social service providers to the table given the need for local partnerships and broader stakeholder engagement. It was suggested that to engage necessary stakeholders, both the problem and measures of success need to be clearly defined.

Dan posed the question of who can best serve as the convening body for rural communities. It was recommended that that groups that cross state and county lines, like a CMS Quality Improvement Organization (QIO), may be well suited to serve this role given state and county boundaries are irrelevant in many rural areas. Dan also suggested identifying an organization to serve as the financial driver of reform. This organization would be responsible for taking on and promoting risk-bearing arrangements.

Director Boehler outlined three areas the Innovation Center is currently seeking input on related to rural healthcare payment and delivery system reform. These areas could serve as the base for future collaborative efforts or convenings.

- 1. *Should the Innovation Center push capitation or full-risk payment reform in rural areas?*** Director Boehler posed the question of whether capitation or full risk-sharing was something rural providers could take on. He noted the Innovation Center didn't want to expand these types of payment models across all rural regions if providers weren't ready. However, he also noted that providers willing to take on more risk are typically granted more flexibility from CMS.



Mikelle Moore provides concluding remarks and outlines next steps.

- 2. *What outcome-based measures are most effective for rural health?*** Director Boehler indicated he was looking for measures that can be tracked close to real-time. He noted that using outcome-based measures creates accountability for providers engaged in delivery system and payment reform.
- 3. *What services are provided and reimbursed in rural areas today that shouldn't be?*** Director Boehler asked participants to think about what critical services they provide today, but are not getting paid for providing. He also asked participants to think about the services they shouldn't have to provide to make a living.

## Conclusion

The 2019 Rural Health Convening had three objectives:

1. Provide perspective on the optimal future state of rural healthcare in the Mountain West.
2. Establish the foundation for collaborative efforts to improve rural healthcare in the Mountain West.
3. Enable providers and stakeholders to have a voice in shaping federal and state policy.

Participants agreed that the Mountain West has unique rural characteristics that create both challenges and opportunities for healthcare delivery system and payment reform. There was also agreement that continued convenings, like the 2019 Rural Health Convening, would improve collaboration across the Mountain West and help ensure better healthcare in its rural regions.

Intermountain looks forward to hosting future convenings on the important issue of rural health and creating meaningful and sustainable reform.



# List of Attendees

Intermountain Healthcare would like to thank the 2019 Rural Health convening participants for attending the event and for their valuable contributions to the discussion.

**Marc Harrison, MD**

President & Chief Executive Officer  
Intermountain Healthcare

**Mikelle Moore**

SVP & Chief Community Health Officer  
Intermountain Healthcare

**Adam Boehler**

Senior Advisor to the Secretary of  
Health and Human Services;  
Deputy Administrator of the Centers for  
Medicare & Medicaid Services;  
Director of the Innovation Center

**Robert (Rob) W. Allen**

Chief Operating Officer  
Intermountain Healthcare

**Samantha W. Ball, PhD**

Research Associate  
Kem C. Gardner Policy Institute  
University of Utah

**Scott D. Barlow, MBA**

Chief Executive Officer  
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## Endnotes

- 1 The Mountain West includes Colorado, Idaho, Montana, Utah, and Wyoming.
- 2 Moore, M. (2019 June 24). Welcome and Overview of Objectives. Presented at the 2019 Rural Health Convening, Midway, UT.
- 3 Cragun, E. (2019 June 24). Pennsylvania Model and CMS Rural Initiatives. Presented at the 2019 Rural Health Convening, Midway, UT.
- 4 Other examples include the Frontier Community Health Integration Project (FCHIP), the Maryland Total Cost of Care (TCOC) model, and the Vermont All-Payer ACO model.
- 5 Hughes, L. (n.d.). Rural Health in Pennsylvania. Pennsylvania Department of Health PowerPoint. Included in 2019 Rural Health Convening preread materials (2019 June 24-25).
- 6 Social Determinants of Health. (2018, July 25). Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-ofhealth>.
- 7 HealthyPeople.gov, Office of Disease Prevention and Health Promotion. Adapted from James Rubin, TAVHealth. Leavitt, M., DeSalvo, K. (2017 September 23). Guest Commentary: Value-based care's success hinges on attention to social determinants. *Modern Healthcare*. Retrieved from <http://www.modernhealthcare.com/article/20170923/NEWS/170929957>.
- 8 The Integrated Care for Kids (InCK) model will help prevent and treat behavioral and mental health conditions in children. Mental and behavioral health issues in children are often a symptom of instability in another part of their lives. The InCK model provides a full set of crisis services to handle the needs of kids and their families when mental and behavioral health challenges arise.
- 9 Cragun, E. (2019 June 24). Pennsylvania Model and CMS Rural Initiatives. Presented at the 2019 Rural Health Convening, Midway, UT.
- 10 Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care. (2019 February). American Hospital Association

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# Intermountain Healthcare

*Intermountain Healthcare's mission is*  
Helping people live the healthiest lives possible.®

*Its mission reflects Intermountain's expanding role  
as it focuses even more strongly on prevention  
and wellness, and strives to improve the  
health of those who live in Intermountain  
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Thanks to the Kem C. Gardner Policy Institute for preparing this convening proceedings report and gathering additional demographic and economic research on the Mountain West.