The Rural Health Care Coordination Network Partnership Program: Williamson Health and Wellness Center

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

RURAL HEALTH CARE COORDINATION NETWORK PARTNERSHIP PROGRAM

Over 50 million people live in rural areas in the United States and are at higher risk for developing chronic illnesses than their urban peers.[1-3] The increasing prevalence of chronic diseases in rural areas coupled with the high cost of health care contribute to the need for high-quality, cost-effective coordinated services that meet physical and behavioral health needs.

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

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

The NORC Walsh Center for Rural Health Analysis (NORC), in partnership with the University of Minnesota Rural Health Research Center, is contracted by FORHP to serve as the Care Coordination Program's external evaluator. The evaluation focuses on the implementation, impact, context, and sustainability of the Care Coordination Program. The focus of this brief is the care coordination program developed by the Williamson Health and Wellness Center based in Williamson, West Virginia.

Grantee Program Area Served

- *The region comprises the heart of Central Appalachia along the southwest West Virginia and eastern Kentucky borders.*
- *The population is primarily White and has disproportionately low income, high rates of unemployment, and low educational attainment.*
- *There is a deep culture of pride regarding the area's long history of coal mining.*

GRANTEE BACKGROUND

The care coordination program discussed in this brief has its roots in a 2012 Center for Medicare and Medicaid Services (CMS) Innovation Award. Under that award, Duke University established the Southeastern Diabetes Initiative (SEDI), which utilized Community Health Workers (CHWs) to improve the quality of care and reduce health care costs for Medicare and Medicaid beneficiaries diagnosed with type 2 diabetes in Durham County, NC, Cabarrus County, NC, Quitman County, MS, and Mingo County, WV. Williamson Health and Wellness Center, Inc. (WHWC) provided oversight for the SEDI project in WV as the lead partner and fiscal agent of the Central Appalachian Health Alliance (CAHA).

Upon completion of the three-year award, the SEDI project demonstrated significant improvement in health and reduced health care expenditures among its participants. The health improvements included a decrease in HbA1c levels (average 2 percent), a decrease in uncontrolled hypertension, and an increase in chronic disease self-management.

Expanding what was begun under the SEDI program, WHWC and CAHA used the Care Coordination Program funding to include patients with congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD). A central

goal was to build a business case to third-party payers for reimbursing CHWs' work as part of a care coordination team by showing that enrolled patients experience improved health outcomes and lower health care costs by reducing emergency department visits and hospital admissions.

Additional Funding

WHWC received additional private funding from a network of local philanthropies. WHWC uses this funding to augment the FORHP grant funds to enhance its internal evaluation capabilities. The funds support robust data collection and analysis to make the business case for third-party payers that the CHW care coordination program is cost-effective. Efforts to collect and analyze data include working with Dr. Richard Crespo at Marshall University, West Virginia University, and the Duke University research team to examine program-related cost-savings.

HOW IS THE PROGRAM STRUCTURED?

Target Population

According to the Appalachian Regional Commission, residents of the region face multiple health challenges. Appalachia has some of the highest mortality rates in the nation. Leading causes of death, include heart disease, COPD, and diabetes. In addition, access to specialty physicians in Central Appalachia is considerably less than in the nation as a whole. WHWC reports that residents are extremely isolated and travel up to four hours one-way to get to the closest urban center with, specialty providers, tertiary hospitals and other health care resources.

As a result of these disparities, WHWC enrolled individuals with diabetes, COPD, or congestive heart failure (CHF) into their care coordination program.

Partners and Approach

CAHA is a formal network of health care stakeholders in the region with the shared goal of strengthening collaboration in the regional health care system for community health improvement.

WHWC, a Federally Qualified Health Center (FQHC), has a long history of implementing innovative community health programs in the region, and serves as the fiscal agent and lead partner for the network. Additional partners include: 16 local primary care providers, a Critical Access Hospital, social service providers, multiple private foundations, third-party payers, three universities, and the National Area Health Education Center Organization.

Care Coordination Program funding was used to expand a CHW clinical team based at WHWC primary care. The team is comprised of Community Health Workers, a registered nurse (RN), and a mid-level primary care practitioner (Nurse Practitioner). Enrolled patients are offered an initial assessment, weekly home visits for a period up to six months, and care transition upon leaving the program. Network members established a Referral Network to refer patients with diabetes, CHF, and COPD who could benefit from care coordination into the program. In addition, the local hospital committed to integrating CHWs into the hospital discharge planning process for patients who are being discharged and have a diagnosis of diabetes, CHF, and/or COPD.

"I probably owe my life to him, to tell you the truth"
-Patient 1

"[The CHW] helped keep me on track. It is the most valuable program that I have ever been involved with."
-Patient 2

Upon referral to the program, the RN and Nurse Practitioner conducts an initial home visit to administer screening and assessment tools, and develop a care treatment plan. The patient is assigned to a CHW for weekly home visits. The role of the CHWs is to link patients with community services and to address medication adherence, chronic disease self-management, healthy eating, and active living goals. CHWs also measure blood pressure and pulse. Weekly care conferences are held by the clinical team (CHWs, RN, and Nurse Practitioner) to discuss patient status and goals, and coordinate with other specialty providers. As a valuable part of the broader care team, the CHWs keep providers up-to-date on a patient's status based on their weekly visits. Key problems and medication adjustments are communicated by either the RN or Nurse Practitioner to the patient's primary care provider for input.

WHAT IS THE PROGRAM'S IMPACT?

Key Model Components

- Team = Community Health Workers (CHWs), a registered nurse (RN), and a Nurse Practitioner.
- CHWs conduct weekly home visits.
- Team holds weekly huddle meetings to discuss patient status and care.

Improvement in Patient Health

While project data to demonstrate improved health among patients is forthcoming from the WHWC,

multiple patients shared that dramatic heath and quality of life improvements have been made due to program involvement. Patients described the value of feeling 'accountable' to the CHWs, who regularly ask about behaviors, such as blood sugar testing and medication adherence, which help patients achieve their goals. Patients also described losing weight, feeling better, and increasing their physical activity. They valued the face-to-face contact with the CHWs and noted the benefit of having a person available to answer their health-related questions.

Provider Buy-In

The care coordination teams reported that most providers were very easy to engage and were appreciative that the CHWs were available to help with their complex patients. One hospital nurse attributed improved care transitions to the program. The nurse confers with the CHWs to assess enrolled patients' supports at home and ensures that the correct follow-up appointments are scheduled. She reported that this coordination results in fewer hospital readmissions because patients have the medical and social resources needed to stay out of the hospital.

Improved Capacity to Offer Care Coordination

The Care Coordination Program expanded the work begun with SEDI funding to include adults with Congestive Heart Failure (CHF) and COPD. Further efforts to extend the program to additional locations is described in the following section.

Public-Private Partnerships- Expanding Research and Service Capacity

Multiple philanthropic organizations contributed to WHWC's efforts, including Claude Worthington Benedum Foundation, Sisters Health, Highmark, Logan, McDonough, and Bernard Shaw Foundations. WHWC is using philanthropic funding to strengthen the evaluation of cost savings associated with the program for Medicaid and private payers. Philanthropic funding has also been used to help support data collection and analysis efforts at West Virginia University, which has been integral in developing systems to collect data for both grant reporting requirements and cost analyses.

In addition, Marshall University Research Corp. and Dr. Crespo received funding from the Appalachian Regional Commission POWER and the Merck Foundation to spread the CHW care coordination model to 17 locations across Ohio, Kentucky, and West Virginia. WHWC serves as Technical Assistance for these additional CHW sites and has formalized a training for CHWs. These sites use WHWC's care coordination program structure and materials (e.g., intake forms) for their own programs. Fidelity to the model is maintained through site visits and check-in calls. In addition, WHWC has partnered with the National Area Health Education Center Organization to become a rotation site for health profession trainees -- an activity that increases awareness of the model.

The expanded evaluation capability and reach helps to establish the business case for this model as a cost-effective intervention in the region.

Making a Business Case

WHWC has an ambitious plan for building a business case for CHW care coordination payments with payers. Network partners meet quarterly with insurance providers, including all of the Medicaid Managed Care Organizations in the region, as part of an internal payer advisory committee.

WHWC is using public and private funding to leverage the initial data collection efforts under SEDI, current efforts under the Care Coordination Program, and expanded efforts as more communities to adopt the CHW care coordination model to build and analyze a dataset of almost seven years of program activity. WHWC aims to collect and analyze cost data for enrollees associated with inpatient, outpatient, ambulatory, and home health care for one year prior to enrollment, and compare costs and health care utilization 6 months and 12 month after enrollment. This data will be used to calculate a return on investment (ROI) to sustain program expansion within rural communities. As of February 2019, three Managed Care Organizations (MCOs) have signed on to work with CHW sites. Signed MOUs will govern the sharing of actuarial data to establish a payment model. This data sharing represents a big step forward in establishing a business case for WHWC's care coordination model.

WHWC is actively working to determine the best payment model for this program and has made considerable progress towards the goal of securing third-party reimbursements from insurers. In collaboration with the Claude Worthington Benedum Foundation, WHWC is exploring a Pay for Success Model.

In addition, WHWC has become a part of Aledade Accountable Care Organization (ACO) and is rewarded for improved health outcomes achieved through the CHW Care Coordination project. Through the ACO, WHWC has gained access to

cost data for Medicare patients and is working to identify a cohort of Medicare patients served by the WHWC care coordination program.

Sustainability

WHWC leadership has a strong commitment to the CHW care coordination program. A 2018 HRSA Rural Healthcare Partnership Funding award will support continued services for individuals at risk of heart disease. In addition, WHWC is working towards Diabetes Health Home certification with the WV Medicaid office, which would support diabetes-related care management activities with a $51/month reimbursement for Medicaid patients. These additional funding streams will help sustain the program while WHWC continues to expand their reach and evaluate their outcomes in an effort to demonstrate program-related savings to payers.

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

Making a Business Case

Grantee leadership described two key lessons learned regarding engaging third-party payers. The first lesson is that you should onboard payers from day one of the program. Engaging payers early on helps them determine the value of the work and provides opportunities to explore innovative payment models. The second lesson is to use federal funding as impact investment funds. The WHWC program demonstrated cost savings – some third-party payers observed the cost savings for patients enrolled before the evaluation findings are complete. Awardee leadership thought they needed to “sell” the program, but some third-party payers already see the value in it and are discussing reimbursement strategies to continue the CHW program.

Data

Sharing Cost Data

Data sharing with private payers, Medicaid, and Medicare for the purpose of cost savings analysis is a long standing challenge. If data are available, there is often a significant time lag between when it was collected and its availability. WHWC has been working to smooth the flow of data from private payers through the WHWC Advisory Team quarterly meetings. They have also worked to better understand how to access the federal Centers for Medicare & Medicaid Services (CMS) data and data through participation in an ACO.

Internal Data

Staff also highlighted the challenge of having to report requirements for the Care Coordination Program grant and other programs that do not align. WHWC care coordination team members have worked together to identify ways to align data collection efforts and ease the burden of multiple report requirements.

Patient Engagement

The care coordination team described their relationships with patients as being a ‘two-way street’. The intake process includes a discussion about what services the team will provide and expectations for patient involvement. The team reported dis-enrolling a very small number of patients for noncompliance, such as frequently missing appointments with CHWs.

CONCLUSION

WHWC offers a replicable care coordination model that demonstrates measureable improvements in health outcomes and decreased health care costs. The role of CHWs in crucial to this model’s success - the CHWs provide a consistent and regular link between the patient and his/her care team. This program highlights unique opportunities and challenges that may help other rural providers and networks as they aim to create a similar CHW-based care coordination program and develop a business case to secure reimbursement for care coordination services.

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For More Information:

Williamson Health and Wellness Center:
https://www.williamsonhealthwellness.com/

FORHP Care Coordination Grant Funding Announcement:
https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx?id=e3af9abe-a716-4a40-be96-b8273fac43f6

Rural Health Information Hub Rural Care Coordination Toolkit:
https://www.ruralhealthinfo.org/community-health/care-coordination

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