CMS Innovation Center Person-Centered Listening Session: Improving Care Experience, Outcomes, & Equity in Rural Communities
November 20, 2024

>>Alexis Malfesi, CMS: Hello, everyone, and thank you for joining us, for today's listening session focused on improving care in rural communities. Before we get started, I have a few administrative items to address. If we could go to the next slide, please.

First, this session will be recorded. All participants will be muted, besides those providing verbal comments. Second, closed captioning is available on the bottom of your screen. Third, we ask that you submit comments via Q&A on the bottom of your screen. And please note that your comment may be read aloud, unless you indicate not to share. We will be monitoring the Q&A and answering questions, time permitting. Last, we'll be noting all feedback we received during this listening session, and we encourage you to stay connected with us after today. Next slide, please.

Before we dive in, I want to give a brief overview of the agenda for today's session. We will begin with opening remarks from Dr. Liz Fowler, the Deputy Administrator and Director of the CMS Innovation Center. Then, Dr. Purva Rawal, Chief Strategy Officer of the CMS Innovation Center, will provide a recap of the 2024 Rural Health Hackathons, including a summary of themes emerging from what we heard from the hackathon participants, and what the Center is doing with that information to chart a path forward to drive rural health transformation. Then, Dr. Rawal and Kate Davidson, Director of the Learning and Diffusion Group, will facilitate a discussion with Alyssa Meller of the National Rural Health Resource Center, Patti Banks, of Ely-Bloomenson Community Hospital, Brea Burke from Healing Hands Health Center, and Dawn Alley of IMPaCT Care. Finally, we will finish with a few final remarks from leadership where they will close out the session.

Again, thank you all for joining us today. I am now going to turn it over to Dr. Fowler to formally welcome you to today's event. Next slide, please.

>>Dr. Liz Fowler, CMS: Oops trying to get my camera situated.

Thanks so much, Alexis, and good afternoon. And thanks to all the advocates, experts, and stakeholders for joining us today. It's your dedication to improving rural health care that's truly commendable. And we really value your participation in today's session on Improving Care Experiences, Outcomes, and Equity in Rural Communities.

Over 60 million Americans currently live in areas identified as rural, tribal, frontier, or geographically isolated. And through the Center's experience implementing models and demonstrations in rural areas, and through feedback we've received directly from those living and providing care in rural communities, we know there are many challenges that negatively affect clinical outcomes, access to care and the overall care experience. And these challenges touch on issues such as limited availability to providers, long travel distances to sites of care, and difficulties accessing technologies that can support care delivery. We'll talk about those challenges in today's session, but our goal is to spend much of the time exploring innovative ideas for solutions to these challenges.

As Alexis mentioned, we hosted recent rural hackathons that generated new ideas to tackle key challenges in rural healthcare, and those solutions are focused on improving clinical outcomes, increasing access and enhancing the care experience through cross-government and cross-industry partnerships. We were thrilled to receive over 500 applications to participate in the hackathons, from

individuals representing organizations across all sectors of rural health care, including providers, health plans, nonprofits, policy organizations, tech companies and academics. This response really highlights the collective commitment to enhancing rural healthcare.

So today we'll share exciting ideas generated from those events, and discuss potential challenges, and then gather your insights with a particular focus on how to better address the needs of beneficiaries living in rural areas, and enhance their experience with care. I'm joined today by colleagues and members of the team, as Alexis indicated, who helped lead the rural hackathons, and who are eager to share what we learned, and hear your thoughts. Next slide.

As many of you are familiar already with the Innovation Center, with the Innovation Center and what we do, I'm just going to give a very brief overview before diving in. So, we were established in 2010, as part of the Affordable Care Act, to test new payment and delivery models that have the potential to improve quality for Medicare and Medicaid beneficiaries or lower program spending. In 2021, we laid out a new vision for a healthcare system that achieves equitable outcomes through high-quality, affordable, person-centered care. And supporting that vision are five strategic objectives.

First, we are committed to driving accountable care that promotes delivery of whole-person, integrated care, with accountability for costs and quality. Within this objective, we set a bold goal of having 100% of traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships with a provider who's responsible for helping quarterback their care. Over half of our traditional Medicare beneficiaries are in accountable care relationships, and we're making progress on that goal.

Second, we're focused on advancing health equity. We embed equity into our models by including screenings for social drivers of health, engaging safety net providers, and asking participants to develop health equity plans. Our goal with these actions is to increase the diversity of beneficiaries and providers in our models, with a particular focus on supporting more safety net provider participation.

Third, we're focused on supporting innovation that enables the delivery of person-centered, integrated care. And we provide tools, data, resources, and flexibilities through our models to our model participants, to support delivery of care that's consistent with people's goals and preferences. And we also support knowledge sharing and peer-to-peer learning collaboration.

Fourth, we're focused on affordability by addressing health care, prices and reducing duplicative or unnecessary care. And that means addressing out-of-pocket costs for patients as well as Medicare and Medicaid program costs. One recent example is the $35/month insulin model that became part of the Inflation Reduction Act, and is now a permanent part of the Medicare program.

And then finally, we partner with beneficiaries, providers, other payers and key stakeholders on transformation activities. Next slide, please.

As part of our last objective on partnering to achieve system transformation, we're aiming to develop closer engagement with beneficiaries to make sure we're meeting their needs. We are aiming to re-center the patient experience in our work and do a better job communicating what we do at the Innovation Center and at CMS, and the value of our work directly to beneficiaries. We made a commitment to solicit more balanced feedback during our model development process, and especially

in the early stages, including from the patient perspective. And this includes expanding our measurement and evaluation strategy to consider patient and caregiver experiences and outcomes, engaging with patient organizations and consumer organizations to provide feedback and input on our models, highlighting benefits of value-based care directly to patients, and holding listening sessions like this one on important topics, like rural healthcare, that really do matter to patients. Next slide, please.

Today, our focus is on how we can improve the healthcare experiences and outcomes for people in rural communities. To help inform that conversation, I want to share the rural health care framework that we've developed at CMS. This framework is designed to guide CMS's approach to implementing innovative solutions, to the challenges that keep beneficiaries in rural areas from experiencing better health outcomes and experiences of care. The framework focuses on six priorities over the next five years.

Number 1: Apply a community informed geographic lens to CMS programs and policies. Priority 2: Increase the collection and use of standardized data. Priority 3: Strengthen and support providers and healthcare professionals in rural communities. Fourth: Optimize medical and communications technology. Fifth: Expand access to comprehensive care coverage, benefits, services and supports. And then, finally, Priority 6 is: Drive innovation and value-based care in rural, tribal and geographically isolated communities, which is an area of particular focus for the CMS Innovation Center.

Examples under Priority 6 are the Innovation in Behavioral Health and the Transforming Maternal Health Models. Both of these models include design elements specifically meant to improve healthcare and advance health equity across diverse geographies, including rural areas. So, we've done work to address the unique needs of beneficiaries, but there's much more that we can do.

To get us started and really kick things off, I'm going to turn things over to Dr. Purva Rawal. And she's going to provide more detail on how the Innovation Center plans to continue to improve rural health care and experience based on what we've learned from this year's 2024 Innovation Center Rural Health Hackathon. Next slide. Please.

>>Dr. Purva Rawal, CMS: Thank you, Liz for your leadership, and to everyone that is joining us this afternoon. These listening sessions, as Liz said, are an important way for us to share the work we're doing with all of you. But, more importantly, to ensure that the needs of patients and communities are informing the Innovation Center's work. Next slide, please.

As some of you may know, the Innovation Center convened three rural hackathons in August of this year. They were in-person, collaborative sessions to generate actionable ideas for supporting health system transformation in rural areas. We held the hackathons, as you can see here in Bozeman, Montana; Dallas, Texas; and Wilson, North Carolina.

We were inspired to convene these hackathons by recent trips that Dr. Fowler, Kate Davidson, who will be following me, and other CMS leaders, took to Arkansas. And on that trip, on those trips, it became clear that people, providers, and leaders in rural communities understood the challenges facing rural health. But it wasn't clear what the solutions for addressing those challenges could be.

And across the three hackathons, we convened a diverse group of almost 140 rural health experts, including patients, advocates, and community-based provider participants. And across all these events

we received over 30 in-person and over 60 virtual submissions with ideas to address significant challenges impacting rural healthcare that could improve clinical outcomes, that can increase access to care, and improve the care experience for both rural patients and providers. The sessions convened dedicated experts that brought forward creative solutions and gave us the opportunity to source local ideas. Next slide, please.

During the hackathons, participants shared insights relating to three areas of focus that you see here. The first is care delivery, the second is access to care, and the third, very importantly, is workforce. I'm going to highlight a few of the ideas that centered on how to better engage with and care for the unique needs of rural patients and providers within each of these three focus areas.

So for care delivery, hackathon attendees, advocated for co-building and co-owning programs with community members to tailor support to local needs. Hackathon participants also suggested establishing things like a central care manager, who for each patient, captures their care needs across different sources and reports back to a primary care provider. Hackathon attendees also suggested facilitating collaboration across different provider types and incentivizing screenings and referrals for needed services and care. And lastly in care delivery, participants encouraged CMS to collect input from rural and frontier providers to inform specific quality measures and model features. So, for instance, benchmarking, attribution, minimum or maximum payments in models. So they also gave us ideas on and suggestions for some of the technical payment aspects of our work as well, that really better match rural and frontier providers' capacities.

In the second category, for access to care, several hackathon attendees discussed creating team-based mobile sites of care that can support community and/or home-based care for rural patients, many of whom might be harder to reach, or may have to travel greater distances to access care. Some participants also called for expanded virtual care flexibilities, and guidance and resources for health professionals delivering at-home care.

We also heard several attendees suggest creating mechanisms to enable trusted community members and institutions. So, for instance, church volunteers, community health workers, who we are going to hear from today, to help patients navigate clinical and non-clinical services, or services to address health-related social needs. And finally, many participants called for improving specialty care access by increasing the distribution and reach of health facilities, including through the use of tools and mechanisms like eConsults.

And then the last category was workforce, which is a big one, and we've received a lot of ideas here and share a couple with you. To grow the rural workforce, hackathon participants suggested training local community members for clinical and non-clinical roles by providing additional rural focus training and career development. We also heard suggestions to provide funding and regulatory flexibilities that allow staff to practice at their maximum scope of practice, and for non-clinical workers to receive payment for their ,for their services ,as well. And then several participants actually called for national training programs to address the knowledge gaps among the existing healthcare workforce.

For a full summary of the themes, and many of the insights that we heard over the three rural hackathons, we encourage you to read the report that we released at, that the Innovation Center released on November 12th, titled *Reimagining Rural Health Themes Concepts and Next Steps from the CMS Innovation Center Hackathon Series.* And the link should be in the chat. Now next slide, please.

In recent years the Innovation Center has tested ideas to address rural health challenges and opportunities through previous and ongoing models. So, including through the Community Health Access and Rural Transformation, or the CHART Model, the Pennsylvania Rural Health Model, or the PARHM Model, and congressionally mandated Rural Community Hospital Demonstrations, and congressionally mandated demonstrations such as the Rural Community Hospital Demonstration and the Frontier Community Health Integration Project.

And while progress has been made, there are persistent healthcare barriers and challenges in rural communities that the Innovation Center seeks to address through future models or initiatives. And the hackathons were a great way for us to generate new and novel ideas from people on the ground. So to move, in moving forward, some of the places the Innovation Center is looking to explore, include improving coordinated care by iterating on our accountable care organization, or ACO, models to make it easier for rural providers to participate in value-based care models, and for us to be able to reach the goal that Liz talked about around 100% of our Medicare fee-for-service beneficiaries being in accountable care relationships.

So, for example, the Innovation Center is looking to explore, you know, potentially tracks or targeted policies to increase rural and safety net provider participation in models, so that they're better able to meet the needs of the patients that they're serving. The Innovation Center could also look for ways to improve the meaningful engagement of specialty care providers in primary care and to strengthen relationships between ACOs and community-based organizations to address health-related social needs.

The CMMI, the Innovation Center can also focus on increasing access to team-based care through payment flexibilities and waivers. Examples of the waiver flexibilities could include waivers to pay for services across a broader, non-traditional care team, allowing for more inclusive and comprehensive care delivery, or waivers for services to be provided by a licensed care provider outside of a formal care setting such as in home or in community centers.

The CMS Innovation Centers will continue to improve quality for rural health residents by developing pathways, also for rural and tribal healthcare providers to participate in our models. So for instance, recently, we established a working group with advisors from the Tribal Technical Advisory Group at CMS to identify ways to align Innovation Center models with tribal health programs and the needs of American Indian people.

The hackathons clearly generated creative ideas and excitement, and we are looking forward to exploring new ideas, to reimagine rural health. I'm now going to pass it over to my colleague, Kate Davidson, for some final opening remarks before we kick off today's panel discussion. Next slide, please.

>>Jake Mathwich, SEA: Hey, Kate, you might be on mute. Just want to double check.

>>Kate Davidson, CMS: Thank you, Jake, sorry about that. Hi, everyone. I'm Kate Davidson, the Director for the Learning and Diffusion Group at the CMS Innovation Center. And I appreciate the opening remarks from Alexis and Liz and Purva.

Before we get started with our discussion panel, I wanted to highlight a couple of our active models that we were designing, currently in the primary care space, that are designed also to address some of

the rural health services issues that we've outlined through the hackathon report. The Making Care Primary Model, or MCP, provides a pathway for primary care providers to engage in value-based care to bring accountable care to more patients in rural health areas. It focuses on additional payment, data, and learning support opportunities, specifically for rural providers. The Kidney Care Choices Model, or KCC, is designed to help healthcare providers reduce the cost and improve the quality of care for patients with late-stage chronic kidney disease and end stage renal disease. It seeks to delay the need for dialysis and encourage kidney transplantation. The ACO Realizing Equity Access and Community Health, or the ACO REACH Model, provides novel tools and resources for healthcare providers to work together in an accountable care organization to improve the quality of care for people with traditional Medicare.

All these models represent innovative approaches to improving healthcare delivery in rural and underserved communities by using generally supervised auxiliary staff or post discharge home healthcare and care management visits. Even though these models have different focuses and payment methodologies, they operate together to enhance care coordination, reduce healthcare costs and improve patient outcomes.

The Transforming Maternal Health Model, or TMaH, is designed to focus exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program, or CHIP. It requires State Medicaid Agencies to cover the full range of doula services and promote team-based care in rural communities. Participating states also have the flexibility in the methods that they use to pay for doula services, allowing for tailored approaches to meet local needs.

The ACO Primary Care Flex, or ACO PC Flex Model, increases funding for primary care and accountable care organizations to empower participants to use more innovative, person-centered care approaches. In particular, the model aims to support federally qualified health centers, or FQHCs, and rural health clinics, or RHCs, by addressing structural differences in their payment system.

And, lastly, the Transforming Episode Accountable Model, or TEAM, seeks to improve the coordination of items and services paid through Medicare fee-for-service. It includes payment incentives specifically targeted to rural providers. It offers no downside risk for up to three years for rural safety net hospitals, providing financial stability and encouraging participation.

These models collectively aim to improve care coordination, enhance payment systems, and support rural health providers in delivering accountable care. Their focus is on creating sustainable, high-quality care, solutions that address the unique challenges faced by rural healthcare providers and their patients. Thank you. Next slide, please.

I'm going to shift gears in a second and speak with our panel of experts, including community representatives and advocates, on a couple of key priority areas for the Center. We're really thrilled to welcome today Alyssa Meller, who is the Chief Operating Officer of the National Rural Health Resource Center, Patti Banks, who is the CEO of the Ely-Bloomenson Community Hospital, Brea Burke, the Community Health Manager at Healing Hands Health Center, and Dawn Alley, Head of Scale of IMPaCT Care will close out with some reflections and insights.

But before we dive in, we want to open a poll to hear from you guys. And you can see here in the chat, the poll is open. We're using a platform that will allow you to participate in answering this poll question

to share your feedback and thoughts and insights using your phone or computer browser. The responses to the poll questions will be anonymous.

You can see here that our question is: “What is the most significant challenge for patients to access healthcare in rural areas?” If you can respond in one word or connect your responses with an underscore, that would be really helpful. And I will give you guys a second to answer. That looks like transportation is a big one that's across the board. Distance, provider and workforce shortages, lack of specialty care. Transportation is still hitting home, lack of financial resources, access to care.

So many great thoughts here, and this is definitely echoing what we heard from the field when we're out learning through the hackathons that Purva talked through. This is fantastic. Thank you so much. We will, we actually at the Innovation Center we take all of this information and track it and make sure that we are using it to inform our model design work. So, this is really, really helpful to us, thank you so much. And with that I'm going to start to close out the poll. Broadband, behavioral health, I see, patient navigation and cost. Okay, I'm going to take the time now to kick us off to our next discussion. So, if we could go to the next slide, please.

I'm going to hand it over to you, Alyssa. I was wondering if you could tell us a little bit about yourself as well as your organization, and I know you've worked really closely with Patti at the Ely-Bloomenson Community Hospital. Could you tell us a little bit about the work that you guys have done together? What are some of the biggest barriers to successful transitions between settings of care, for example, things like hospital-to-home that are affecting rural communities?

>>Alyssa Meller, National Rural Health Resource Center: Great. Thank you, Kate, and I appreciate being here today. As Kate mentioned, I'm the Chief Operating Officer with the National Rural Health Resource Center. I've been with our organization nearly 11 years. Prior to joining The Center, we also call our organization The Center. So, I've worked for a large managed care Medicaid and Medicaid payer in Minnesota, where I managed, you know, a dual eligible, special needs plan as well, too.

So, the National Rural Health Resource Center is the nation's leading technical assistance and knowledge center focused on all things rural health. We directly support rural hospitals, clinics, community health centers, state offices of rural health and other rural health organizations with information, tools, resources, really designed to help sustain access to quality health services in rural communities. And so, our organization has worked with Patti Banks and the Ely-Bloomenson Community Hospital for many years in many different areas. But most recently, we worked with them through our Path to Value program, where that program really works with rural hospitals to refine or create a person-centered care coordination plan. In addition to that, where they're firming up, you know, looking at their target population making sure that's specific, we introduce the importance of outreaching and engaging with those community partners, other providers, to really connect the person of that target population that they're working on with the resources, the next level of care or service through their care coordination, or transitions of care process. Before I kind of go into some of those barriers, I'll have Patti introduce herself and where she's calling from. Patti.

>>Patti Banks, Ely-Bloomenson Community Hospital: Sure, thanks. Alyssa. Yes, I am currently, you know, here in Ely we are located just to kind of put it a little bit in perspective is, we are literally at the end of the road in northeastern Minnesota. You could actually cross into Canada about 15 miles from here if you decided to paddle in or go over, you know, via water.

So anyways, yes, we have worked with the National Rural Health Center on, on a number of projects, and most recently it was the Minnesota Path to Values. Our target population was substance use and abuse disorders and mental health challenges. As a critical access hospital oftentimes, we are the first point of care in many situations, but especially when individuals go into crisis with these types of issues that they're experiencing. And we really learned to create the trust in the patient so that we could allow them to access the level of care that they needed. But distance oftentimes was our primary hurdle that we came across as we worked through this project.

>>Alyssa Meller, National Rural Health Resource Center: Yeah, thanks, Patti. And I think you know, Kate, going back to your question about some of the biggest barriers or challenges, and that the poll that you did prior to introduction, really keyed in on a couple of areas that came to mind when I was asked to prep for this question, but I'll go in a little bit deeper.

So, the two areas that we have found not only through our work here with our organization and our rural communities, and my work back with the dual eligible plan was exactly transportation. That did not surprise me, that that came up as the largest that kind of that number one area. And then also that next level of care being available locally, or the distance that Patti referred to as well, too. And so, when I talk about like transportation from a rural community's perspective, many people in our rural communities do not have access to personal or reliable transportation, not just to bring them to the hospital, and when they're discharged, but for that, follow-up care as well, too.

So, and then the other, the other transportation area that we have found, too, in our rural areas is that when that higher-skilled or more acute person is needed transport to that next level of care, like an inpatient setting local EMS is often tasked with that, so the ambulance service as well. And so, thinking about that, and the miles between that those inpatient beds, or wherever they may be going, are taking that ambulance out of service. So, if an emergency comes up, so that really is a challenge for those rural communities, along with the Medicaid or Medicare reimbursement rate. So, if the type of transport does qualify for Medicare or Medicaid coverage, it isn't enough for those pickup and drop off miles, and the time that's spent as well, that as well.

>>Patti Banks, Ely-Bloomenson Community Hospital: And then oftentimes, if I can just interject, oftentimes when their needs are met outside of the community, then the next barrier is bringing them back, you know, into the community. Because oftentimes, you know, of course, they want to return home and then having the resources available to help them successfully transition, you know, back to being at home and keep them, keep them healthy in their home.

>>Alyssa Meller, National Rural Health Resource Center: Great, thank you. No, that that's a great, great point. And I think the other area that that I wanted to talk a little bit more about that Patti will talk about with their solutions, or what they're working through in Ely, is that that next service or level of care setting being available. So, thinking that about when a person is being discharged from the hospital or the rural emergency hospital, sometimes that service or that inpatient unit is not available. So, thinking that from a perspective of a person being discharged that needs home health services, you know, the first question is, is there a home health agency in the community or nearby that is there? The second is, do they have the capacity to take on another referral? They too, are very short staffed from a workforce standpoint. And so, they're usually at max capacity as well.

And I think that's something that's critical that that I know that Patti's probably worked through with theirs, and then I've worked in my dual eligible plan, is sometimes people do not meet the Medicare

level of skilled care needed, and so Medicare coverage does not often cover. And so when we're thinking about that you know, and our panelists upcoming with Brea and Dawn will talk more about the community health workers. But when we're thinking about some of those skills, home health aides, personal care attendant, community health workers, care coordinators, help support particularly those non-traditional healthcare providers, often aren't a covered Medicare or Medicaid service unless they're partnered with a skilled level of care as well, too. So, thinking about that challenge, that they don't quite need that skilled level, but they need some type of service so that they can transition back home safely, and for lesser cost of being in an emergency room or inpatient as well.

I think the other at the point that I don't think is a surprise, particularly when you're talking about behavioral health, substance misuse treatment, is that there aren't inpatient beds available locally, or if they are, they're filled. So, they are looking broader out outside of that service area many, many miles, hundreds of miles or hours away. And then that circles us back to that transportation issue that Patti and I spoke about already is, how do you get them there? How do you get them home and support them back in their home?

>>Kate Davidson, CMS: That's incredibly helpful. Thank you both Alyssa and Patti. I think some of the things that you hit on number one are very similar to the themes that we heard during the hackathons, specifically around access to care, workforce. We heard so much about transportation. I think the things that Alyssa, that I really appreciate about what you said, too, are very concrete things that I think that Medicare can think about in terms of how our models might have flexibilities, that within our portfolio of models, around transportation, around levels of care, that could be supportive of building access. I also think that it's really important to just also note that organizations like yours, Alyssa, that are building on existing resources that already, that exist in communities, and that are working hand in hand with existing organizations like Patti's is really important as well. And we heard that firsthand that that you guys understand the issues, and that, you know, we really need to be partnering with local organizations to better address the challenges in in those communities.

So, I'm going to hand it back over to Purva, and we'll come back around to you guys hopefully, we'll have some time at the end for some Q&A, because, you guys I know have so much to share. But really appreciate you being here today going to go through our second poll and then get to a couple of other speakers. Purva.

>>Dr. Purva Rawal, CMS: Thanks, Kate. Next slide.

Great. Once again, please join our Poll Everywhere activity. You can either scan the QR code on the screen, and if you already did that for the first poll, this question should automatically load, but the link is also in the chat.

So, hoping you can select a response to the following: “Which community health services do you find the most difficult to effectively provide for rural communities?” Preventive care and screenings, coordination with social supports, hospital-based care, behavioral health care, health education and outreach, home-based care and support. And there's also another category where we'll be capturing any text or written responses as well. So, I'll give you all a minute to respond.

Okay, it looks like behavioral health care might be at the at the top in terms of the most difficult service to effectively provide in rural communities. And Alyssa and Patti, you both mentioned behavioral health

barriers and challenges in your remarks as well in the opener. But preventive care and screenings and home-based care and support as well. Thank you for your responses. And again, we'll take a look at the written responses or text responses in the "other" category as well. Next slide, please.

And then we're going to go to one more poll. So please select a response to our final polling question: "What is the most significant need for community health workers to better support rural communities?" And this will be a great transition to our second panel. More training, certification and or education, increased funding, coverage, reimbursement and resources, better integration with healthcare providers, enhanced communication tools and technology, or, again an "other" category, where we'll look at the text and responses as well.

It looks like the responses are slowing so well, oh, not quite yet. It looks like the top one is increased funding, coverage, reimbursement and resources to better support community health workers. And again, Alyssa, you spoke about that just a few minutes ago. Just the reimbursement structures aren't always there and stable enough to support community health workers and other non-traditional care providers. But also, integration and enhance communication tools and technology. But the overwhelming one is increased funding coverage and reimbursement.

So, thank you all for your response. Now we'll get back to our discussion hopefully that tees up our discussion next with Brea and Dawn. So, we can go to the next slide.

Great, I think we're going to start with Brea first. Brea, thank you again for joining us today. And Dawn, it's great to have both of you. I was going to start with Brea. Brea, I was hoping you could talk a little bit about some of the unique needs that you see in the community that you work in, and how some of those unique needs have impacted. How you, you know, deliver care and work with people in your community.

>>Breanna Burke, Healing Hands Health Center: Absolutely. Thank you so much, Purva, as she said, my name is Brea. I'm a community health worker. I'm actually the Community Health Manager at Healing Hands Health, and we serve all of northeast Tennessee and southwest Virginia. We're right on the line. So a big, large area right here in the middle of the Appalachian Mountains. So we do serve a ton of rural areas where we are. And really, I was not shocked to see what the polls were saying, I think that's going to ring true throughout probably the rest of this, the rest of the day, honestly. But I think some of the unique needs that we notice is, of course, lack of transportation being at the top, being that we are such a rural location, and our area surrounding us is very rural. Having transportation to and from doctor's appointments, follow up care, to the emergency room, things of that nature is very is very hard to come by. And we do have some transportation that's within like 10 minutes of some of our smaller towns or bigger towns. Bristol's considered a city. It's a very small city, but they do have transportation within the city limits. But anything outside of that is very difficult. And how that's really kind of impacted our care. Well, actually, I wanted to also touch on the fact that digital literacy, coupled with transportation, is also one of the things that we struggle with in our most rural areas.

So how that's really impacted us is our clients, of course, are not able to get here because of transportation issues. And when we do find transportation in our area most of the time they have them anywhere from 35 to 40 minutes late for their appointments. So then, we're having to wait and try to fit people in. But then, not having the, the literacy, as far as digital literacy goes, to utilize telehealth appointments and things of that nature has been very difficult. So community health

workers, our team have been going into people's homes teaching them how to use telehealth as well as partnering with, this is something I'm very proud of in our area, trying to partner with churches to see if they're willing to go and pick people up and bring them into their appointments, bring them into to do just the basic things, go to dental appointments, checkups, just doing all of the things they need to do in that area as well as getting them to the, the grocery store, so they can pick up their food to live a healthy life. So there's a lot of things that we have to do a little differently because we serve rural areas. But I think that that being the biggest one.

So of course, being an impact CHW means that we get to know our clients where they are and learn about the things in their life that has shaped them into who they are, and we get to work on what's most important to the clients to get them to the happiest and healthiest versions of themselves possible. That is our goal ultimately but getting them the transportation they need to get the help they need, and also educating them on how to utilize telehealth, what that looks like. It's not always the best, there's lots of times they need to be in the office, but for follow up care sometimes telehealth is so important for them to be able to get the continuing care that they need.

>>Dr. Purva Rawal, CMS: Thank you. I was just really struck by how you can have a sort of common problem, like transportation that cuts across a lot of rural communities, and then you can have solutions like virtual care or telehealth. But I think the piece that you're really drawing attention to you called it you know, digital literacy is like, you can have the solutions, but people need education and support to be able to effectively use them if you really want to actually address access. So I was hoping to ask you one more question before we turn to Dawn, if that's okay with you. How do you and your organization reach members of your community? And then, what's worked well and what could others maybe, maybe learn from, from you?

>>Breanna Burke, Healing Hands Health Center: Absolutely. So there's lots of things that we do to kind of reach the community. We host health fairs, we do resource fairs, and we try to go to, we don't just keep them right here at our clinic in Bristol. We try to go to the different areas, the more rural areas, making sure that if they have like a little farmers market or something that we set up there, and that we make it well known by tapping into maybe social media. But not only that, a lot of people in the rural areas still don't utilize social media as much. So we have really still tried to tap into like the local newspapers, because that's still really big in some of our rural areas. They really love their newspapers. So, tapping into that as well and advertising, hey, we're going to be here these days, this is what we're going to be doing. And we use what we call a social determinants of health screening form, and that kind of helps us understand what their needs are, as far as food, housing, transportation. What do they need that's outside of the box, that's not inside the walls of the clinic? What are they going to need, and how can the community health workers help get to know them and start working on those needs?

And then, as far as what I think, people can learn from us. I think that the one thing that we've learned the most is serving the community is not to put ourselves in a box and to make sure that we are understanding the needs of our client. So just because the referring physician or the referring organization may say, this is why I want you to work with that client, that doesn't mean as a CHW that's what we're going to be working on with that client. When we get to know them and get to know their story and who they are, it's really important that we work on what's most important to that specific client. So if they are talking to me, and they're like, if the physician says, hey, this person's noncompliant, they're not taking any of their medication as prescribed, they're not doing any of the things, but then I get to their home, and I am talking to them, and they're talking to me about being

dyslexic. And you know I've got all these medications I'm supposed to take, but sometimes it gets difficult. Then I can say, well, show me your process, show me how you are taking your medications. What does that look like for you? And then I find out that they have all their medications in one big bottle, and they just dump them out and pick out the different kinds and take them once a day, when they have sleeping pills in there, and they have diabetes medication they need to be taken two or three times a day. So then I can then learn, okay, you're not noncompliant. You actually are not able to comply. So I can help you with that. I can figure out how to get you connected to a pharmacist, how to get you connected to your nurse when you're going into your appointments, or when you're having those telehealth visits, and we can get you an organizer and help you organize your medications day by day/morning/evening, or morning/afternoon/evening. We can do that for you, and we can help you be able to comply. So next time you go to the doctor it's not going to be, oh, you're not compliant. It's going to be, oh, my goodness! You just needed assistance on figuring out how to comply to a doctor.

So I think if I could teach anybody anything, it's to listen to your patients. Listen to the clients. Listen to what they need most. Get to know them, love on them, be very compassionate, just be patient and really work on what's most important to them. I think that that's probably the best thing that you can learn from the model that we're using at this time.

>>Dr. Purva Rawal, CMS: Brea, if we didn't have 16 minutes left in the webinar, we could end right there. I feel like, because you just really captured the essence of, I think you know the term we use the term person-centered, or people-centered care, and I think you captured the essence of it because you talked about, you know, the importance of listening to someone's story, and how that you know what you described is like the ability then to problem solve with them. And it's really empowering when you're able to do that. And when honestly, we have payment, healthcare payment systems and deliver.

>>Kate Davidson, CMS: I think we might have lost Purva, but I think I can jump in where she left off, and oh, there you are.

>>Dr. Purva Rawal, CMS: Sorry having Zoom issues. So my apologies. I think we're going to.

>>Kate Davidson, CMS: I was commenting because I think Dawn's smile said it all, as Brea was talking. It obviously resonated with you, Dawn, about the person-centered care and about loving on people and hearing their stories and wondering if we could pivot to you to tell us a little bit about what you guys are doing at IMPaCT, and the work that you're doing with CHWs. If you don't mind sharing a little bit about your role and the work that's happening there.

>>Dawn Alley, IMPaCT Care: Of course. Thank you. Brea is a hard act to follow, but I'm going to do my best. I'm Dawn Alley, I'm Head of Scale at IMPaCT Care where it's my privilege to work every day on working to expand access to evidence-based community health worker programs, like those Brea just described. We support more than 70 community health worker employers across 20 plus states to implement CHW programs, to transform lives, serve communities, and create healthcare savings. One of those CHW employers is Healing Hands in Tennessee, where Brea is one of our Community Advisory Board members. And I think the first thing that folks need to know is that CHW programs can work in rural areas. I think, unfortunately, there's often a misconception that CHW programs are somehow more effective or feasible in urban areas. But I would argue that CHW programs are, if anything, even more necessary given the workforce shortage and access issues we've been hearing about today. And we've successfully supported CHW programs in rural areas ranging from Northern

California to Texas to Appalachia. One of the findings that we're most proud of comes from a PCORI evaluation of the CHW Program at Ballad Health in Tennessee, which found that patients receiving the IMPaCT structured community health worker intervention had 29% fewer hospital admissions at 9 months. And so, you know, when we look at how to generate results like that, one of the things we found is really important is zeroing in on which program design elements are mission critical, no matter where CHWs are working or who they're supporting and which can really flex to adapt to the local area and the unique needs of rural areas. So I wanted to quickly highlight two necessary ingredients.

The first is, and most important really is the people. You just heard this from Brea. But community health workers come from the communities they serve, and they bring traits like empathy, problem solving, and reliability to their work to generate trusting relationships with people who often have had to live with a fragmented system and really have almost an expectation of falling through the cracks. It's just hard to overstate how important getting the right people is. Hiring the right people, it doubles engagement, it's foundational to effectiveness, and it reduces operational costs because it reduces turnover. And what we found in working with rural CHW providers is that you can't just post an Indeed ad for CHWs. Folks don't even know necessarily what a CHW is. So you need to use different strategies for recruitment to try to identify those folks, like Brea, who do good without being asked. And you may need to think differently about what we mean by community. It may not be that I live in the same zip code as the people that I serve but having that background of rural lived experience. So the number one thing that's really important everywhere is getting the right people.

And the second is that structured, person-centered workflow that starts with what's important to patients. And you heard that from Brea, and then makes weekly contact to make progress on the patient's goals. And that is so important again, because we're often serving clients who have been let down and are really experiencing the worst fragmentation of the healthcare system. That said, neither the initial nor the weekly contact has to be in person. It's ideal if you can do in person contact at least once a month. But that can happen in a clinic visit or at a Lowe’s garden center. It doesn't have to be that you're driving all over rural communities to do every meeting at home. So again, there are things that we want, that we know from the evidence, we want to apply across the board, and then last where we can flex to meet the needs of the community.

In closing, I did want to emphasize that again, that this work is even more important in rural communities, and share a really quick personal story that I think illustrates this point. So my Aunt Margaret is a dually eligible beneficiary in rural Indiana who had a stroke and getting to her neurologist, requires an hour and a half of travel that is logistically complicated, and an exhausting ordeal for her. And we've heard today about the challenges of transportation. For her first appointment after discharge home, she was able to get transportation. She made that trek only to get to her appointment and be told that it had actually been canceled and rescheduled, and somewhere in the transition from nursing home to home none of this information had made it to the people who needed to know that. This shouldn't be the way things work, but too often it is, and CHW programs are really designed to counter that dysfunction.

So IMPaCT CHWs, as part of a standard workflow, prior to a provider appointment they call to confirm the appointment so that you don't show up and do all that work, and then find that you can't see the provider. They also talk with the client about any barriers that might keep them from getting to the appointment, what questions they have from the provider, and even offer to accompany the client to the appointment. And this is just one of those things that's great for everybody. From a systems

perspective, we see greater follow up after hospitalization and a 12% improvement in primary care engagement. From a provider perspective, it means lower no-show rates, and hopefully, from a patient perspective, we prevent people from having experiences like my aunt had.

I want to very quickly also note that the biggest item in the poll was around reimbursement challenges, and I think there is a huge opportunity for more education around the Community Health Integration codes that became a Medicare Part B covered service just this year. There's a tremendous opportunity for CHWs services for the Medicare population to be paid where they haven't been in the past, and there's growing coverage in Medicaid as well, although we still have a long way to go there.

>>Kate Davidson, CMS: Thank you so much, Dawn. I thank you again. I just want to thank everyone, all of our panelists today for your responses, but also for the great work that you're doing in communities, and also for giving us really concrete feedback about the things that we at CMS might be able to do. I think one thing that under Liz and Purva's leadership that has really been driven home is that payment is an enabler for care transformation, and the flexibilities that we have at the Innovation Center really are designed to make it possible for those folks that are working in communities to be innovative and to change their care delivery practices to meet their community needs and to meet their patient needs.

We've heard some questions in the chat, and I think you know you named payment as one of the things that emerged from the as an issue that emerged from the polls. And and that is absolutely true, but I think one of the other issues that emerged was transportation. And there was a very concrete question, I think, in the chat about what can we do about transportation? I think one of the things, and Dawn this will resonate with you, especially given your role previously at the Innovation Center is, you know we've tested models in the past that maybe, as standalones, haven't been effective at reducing costs or improving quality. But we have seen that they do have promise. And so one of the things that comes to mind in my mind is the waivers and the flexibility that we've built into the ET3 Model, which was a model that was specifically designed to change the way that we're delivering care for emergency services. And so I think that we're taking a much more refined look at some of the ways that we might be able to scale some of the waivers that we have in some of the previous models and think about how we might be able to apply those in models for specific geographic areas. And so I just wanted to make sure that folks knew that while there were things that you know that we might be able to try and think about building on from previous models that we've tested in the past as well.

Purva, I don't know if you have any thoughts. And, Patti, I saw you came on camera again. I don't know if you had any, if you or Alyssa had any thoughts that you wanted to drive home from the discussion as well.

>>Patti Banks, Ely-Bloomenson Community Hospital: No I just, I wanted to kind of tag in just a little bit on what all the other panelists talked about and what we have learned as we have been taking on these projects with the Rural Health Center. And really, looking at innovative, you know, approaches, changes within how we take care of our communities. And I agree, I think waivers from a reimbursement perspective to work with different ways that when something is working, how do we sustain what is working, you know? How do we continue to be able to, to do this good work? We have been able to in our community look at things like food insecurities, childcare, transportation. Those are all issues that we find come into play when helping us to be able to be a good provider of quality services and making sure that that access is still available. And we have to, we found that by default we, we tend to take the lead on these, but it is important if we want to continue to maintain that access. So it does take collaboration. And I think a lot of conversations, and one-size-fits-all isn't always

reasonable if that makes sense. So I just kind of wanted to add that. So I do appreciate all the work and the ability to be able to let our voices be heard in this complex area. So.

>>Kate Davidson, CMS: Patti, I could not agree more. When we set out to do the hackathons, we started with three questions, and those questions were: What are we doing that we need to stop doing that is preventing good care in communities? What are we doing, or what is already happening, that we should be scaling, and that we should continue to help to grow and foster and disseminate? And then what's a totally new idea that we haven't thought of yet that we could think about exploring? And so I think you just drove that home, that innovation is already happening. How do we enable that? How do we foster that growth. Alyssa, did you have anything to add?

>>Alyssa Meller, National Rural Health Resource Center: I just wanted to say one thing because I think it supports what Brea and Dawn and Patti said to that, those models are innovative and creative. They're built from kind of that community up on what works within that community. And that type of thinking and planning takes time. And I and we, as I mentioned, are a technical assistance provider and a nonprofit one. But I think what as you're thinking, in testing and looking at new models to support that you should think about incorporating the requirement of having a neutral technical assistance tech provider in them that can help those communities, those hospitals communities plan. So, really acknowledge, because what we found is that rural communities we have this mindset we don't have, we don't have, but at the end of the day they have so much more than what they know about. Just by bringing them to the table to help plan and create and create a priority plan that's specific to their needs. So, I think that that infrastructure upfront is needed. And we're finding that this is what Patti talked about sustaining it post by allowing that thinking, talking about roles and responsibility, a shared commitment across all community organizations create that sustainability path because they see the outcomes. They see the joy that's coming from their community, that they want to keep working together after the technical assistance is done. So, I just wanted to put that little plug in there as well.

>>Dr. Purva Rawal, CMS: Thank you, Alyssa, and thanks, Patti. Dawn, did you have anything else?

>>Dawn Alley, IMPaCT Care: I would just plus one to Alyssa's great comments just now. I think sometimes there is also a kind of reinvention of the wheel that can happen. And at this point we know enough about how to plan and implement programs like this that we shouldn't be building the plane as we're flying it, we should be saying, what are the objectives? What are the strengths of this community? Where do we want to focus? What needles do we want to move right? And so just think, it's really important to have that support and infrastructure.

>>Dr. Purva Rawal, CMS: And what I love about what some of what you brought to the discussion today Dawn was like the data and the evidence. So, you know, here we're by speaking to you all we're able to bring some of these stories to life and help people understand what these terms mean and what this looks like right when we're talking about person-centered care. And I was really struck by, you know, this discussion, even just in the last hour, being able to talk about common needs like transportation. But each person and community has a unique story and a unique set of challenges, but importantly, a unique set of strengths. And what we need is flexibility in our payment systems, flexibility in who is delivering care where they are able to deliver care to really get to that goal of a more person-centered health system. We've made some progress. But, like you said Dawn, we know how to do this better, and we can get there faster together hopefully.

So, I'm going to actually go ahead and close this out. We have a minute left, and I just really on behalf of Liz and Kate and everyone at the Innovation Center want to thank everyone on this call for joining today's listening session. It was incredibly productive. And we are really looking forward to future dialogue as well. As Kate said at the top, we'll be synthesizing today's conversation, gathering key insights and feedback.

Please participate in the survey for today's event. That is in the chat window. And take note of some of the actions to continue engagement and learn more about value-based care and what the Innovation Center is doing. You can sign up to receive regular email updates. You can visit our webpage and follow us on Twitter.

So, this concludes today's listening session. Again, thank you all for joining, and hope you have a great rest of your day.

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