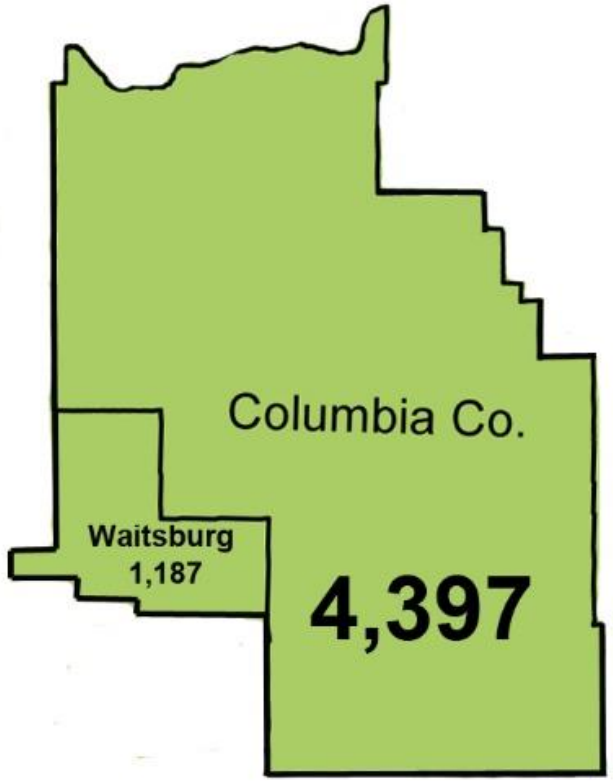
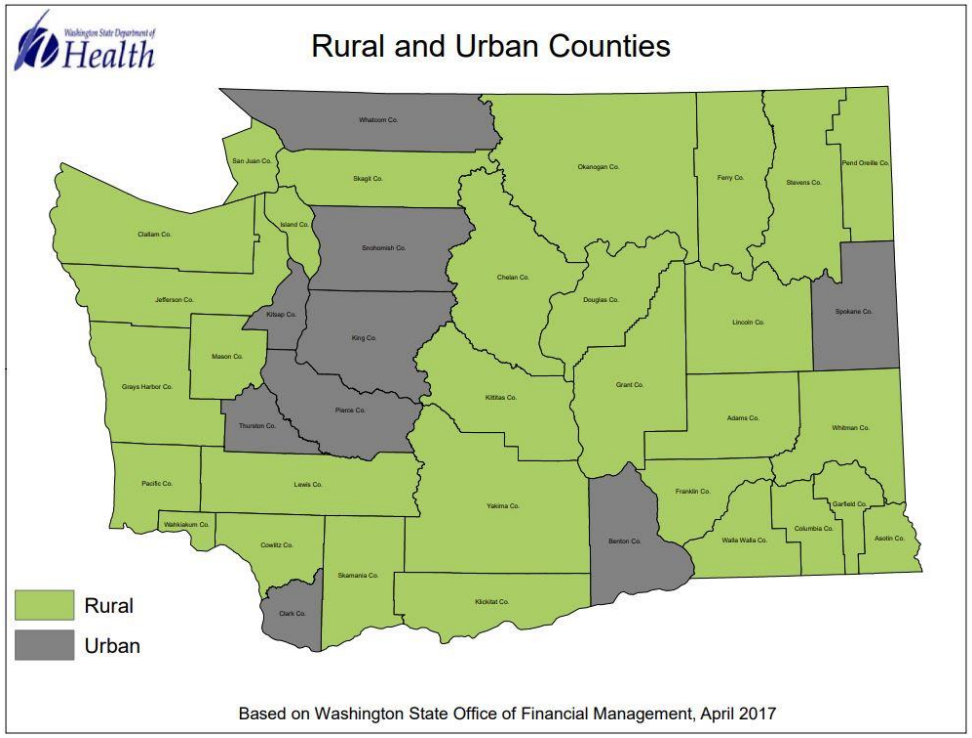
Aligning innovative services with existing and transformative funding streams in a rural community.





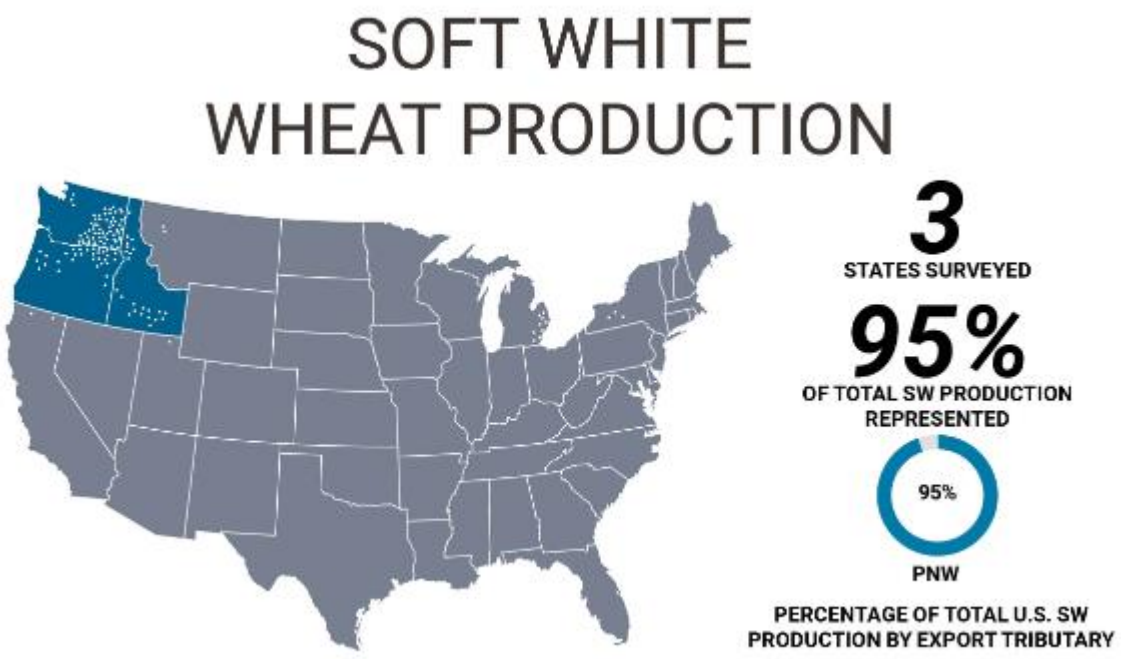
Rural is broadly defined

What rural SE Washington looks like

Why we need health care in rural areas

- Rural is where we vacation and recreate
- Much of the State's agricultural industry exists in rural areas
- New energy frontiers are being built in rural environments
- Interstate and State Routes carry us through rural areas

Healthcare in rural Washington is of National interest



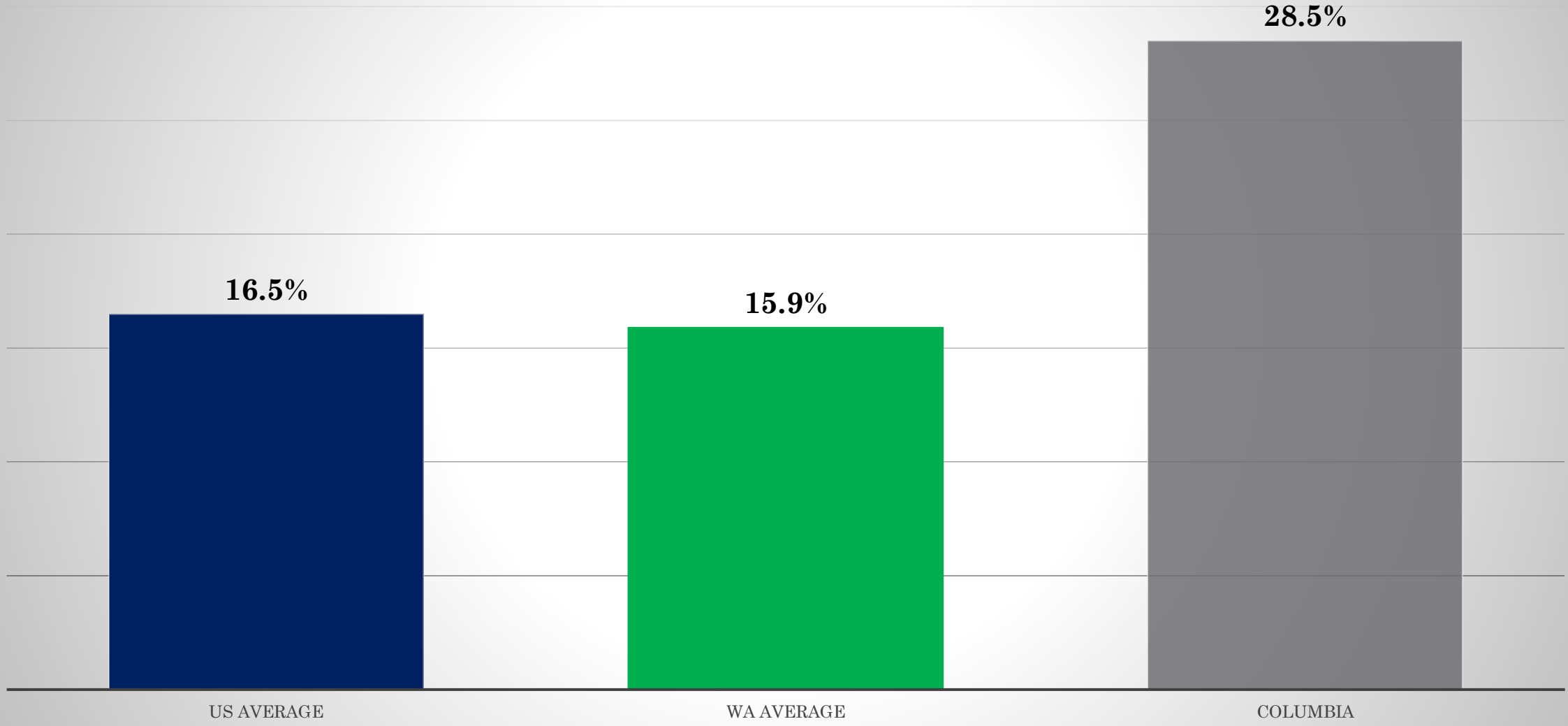
- Washington State ranks 5th in the Nation for wheat production (2020/21)
- 60% of Washington's wheat comes from Southeast Washington
- 46% of the Nations soft, white wheat is produced in Washington State

A new kind of crop

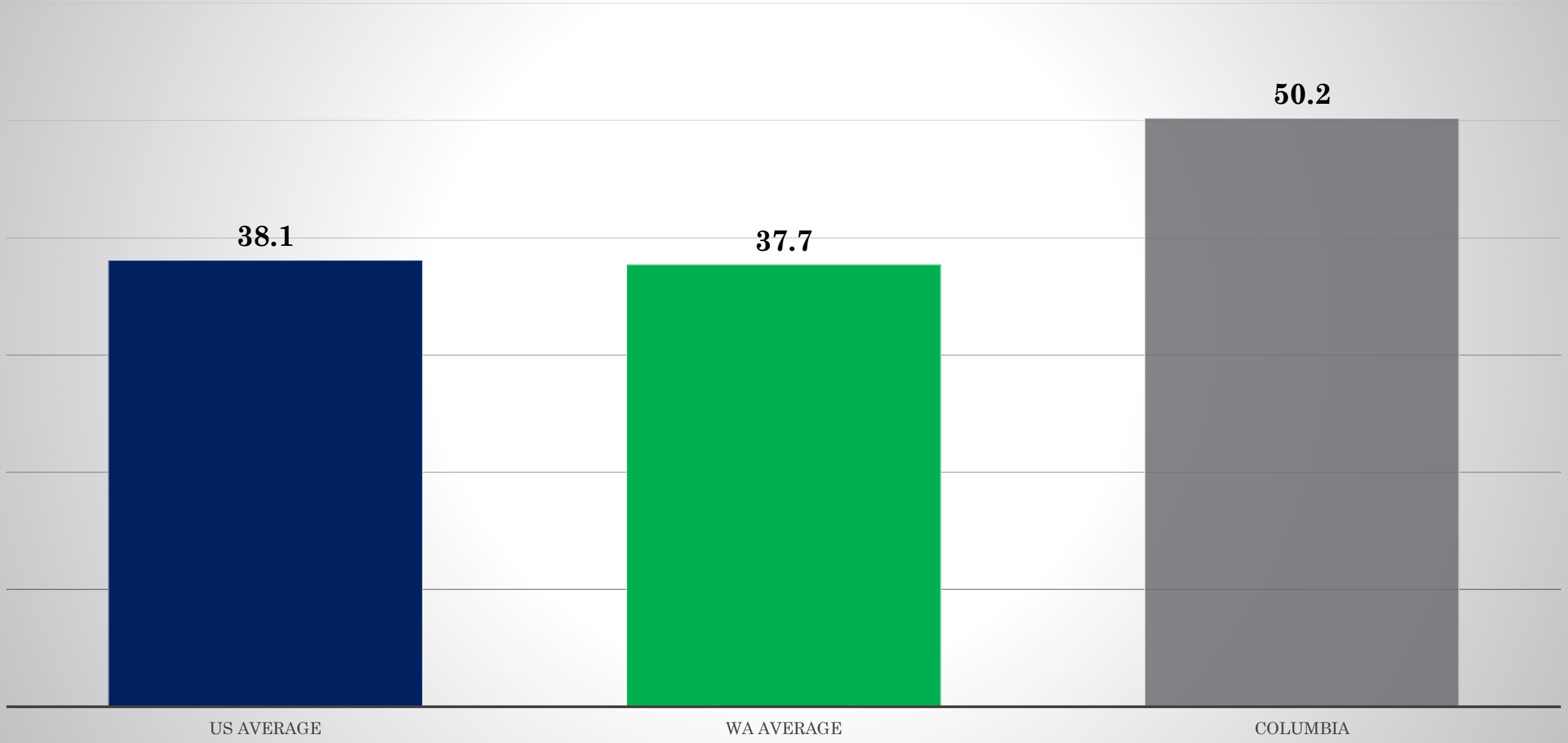
56% of Washington's wind energy is produced in Southeast WA

26% is generated in Columbia County

Percentage of Population over 65

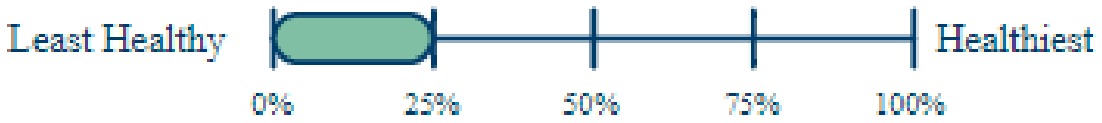


Median Age

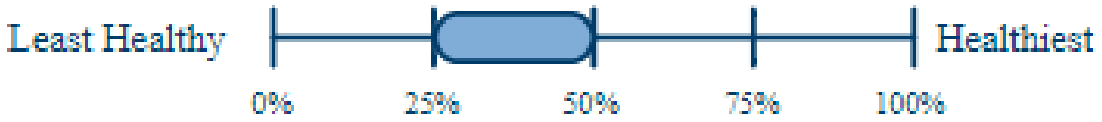


Health Outcomes & Health Factors

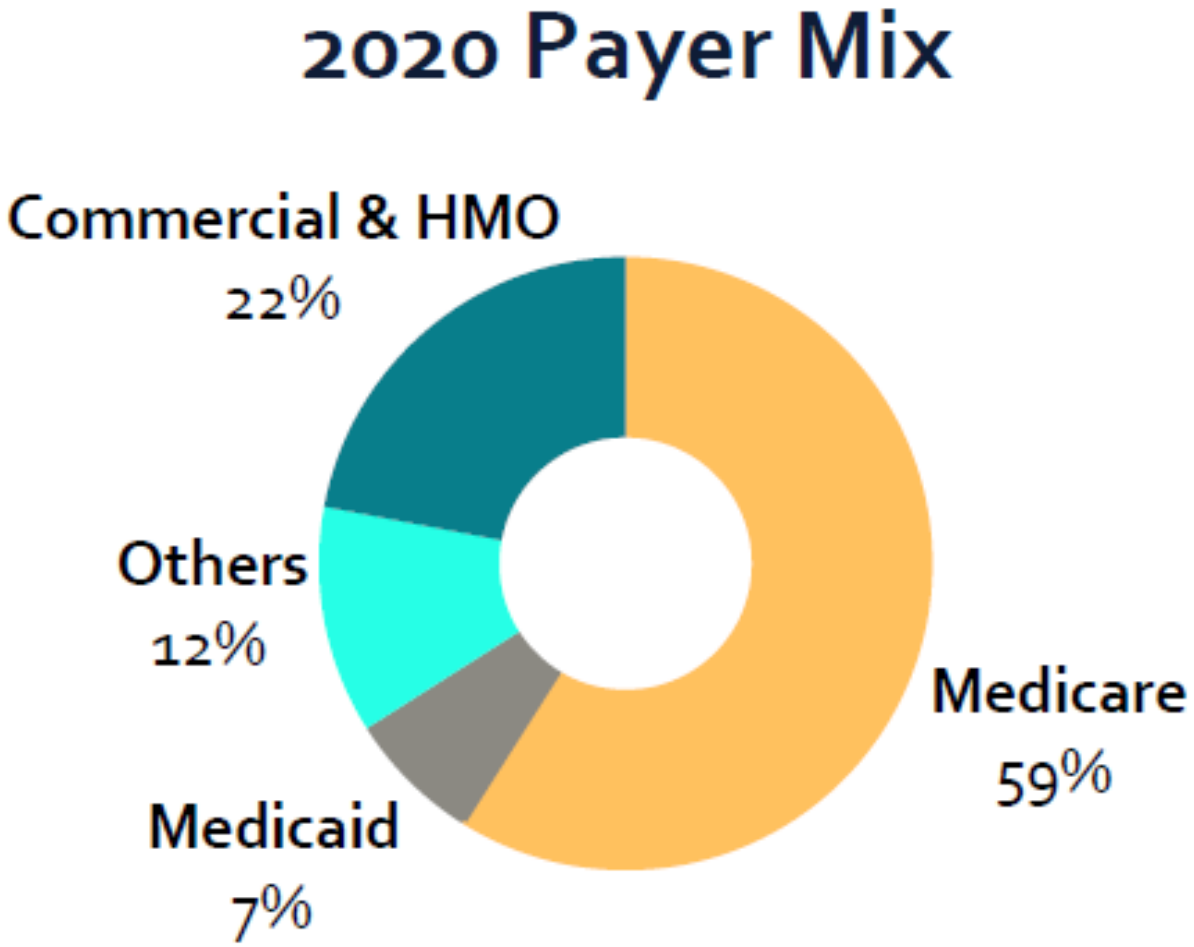
Columbia (CL)



Columbia County is ranked among the least healthy counties in Washington State for Health Outcomes



The County is ranked in the lower middle range of the Washington counties for Health Factors


2020 Payer Mix
Commercial & HMO
22%
Others
12%
Medicaid
7%
Medicare
59%

Our Payers

How do we build systems that care for the whole person?

- Primary Care
- Behavioral Health
- Dental Care
- Chronic Care Management
- Collaborative Care
- Palliative Care
- Community Health Workers
- Community Partners
- Hospital Based Services
- Long Term Care Providers

Complex patient panels

Some patients require behavioral health interventions for chronic disease management

60% of our Palliative Care patients also have a behavioral health diagnoses

63% of Chronic Care Management patients have a co-occurring, behavioral health diagnosis

Case Studies

Case 1

- 53-year-old female with need for dental work and medical comorbidities. She is established in our clinic system. She has history of diabetes type 2, COPD, past smoker, ADHD, anxiety and shoulder and back pain.
- Services Used by this patient
  - Dental
  - Transportation
  - Behavioral Health
  - Primary Care
- Patient presented with Leukoplakia often associated with mouth cancer that would have gone unnoticed if not for the integrated care team including dental services

Case 1 Continued

- Leukoplakia lesions are concerning when a medical or dental provider discover them, because in many cases, it is an indicator of cancer. Traditionally, the patient would be referred to an oral surgeon for biopsy, but this patient is Molina/Medicaid making it challenging to find an oral surgeon willing to accept the patient.
- The patient would have experienced transportation challenges that would have necessitated the use of our transport services.
- Primary care providers do punch biopsies but generally not in the mouth. The primary care providers discussed the process with the dental provider, and the dentist felt comfortable performing the procedure.
- Patient’s tongue was anesthetized, the biopsy was performed, and the sample sent out for analysis.

Case 1 Funding

- DSHS will pay an encounter rate for dental services out of the Rural Health Clinic
- The Washington State Legislature awarded a grant to pay for a significant portion of the dental building in the amount of $350,000
- HRSA provided a two-year grant to support dental operations @ $86,000 per year
- Funding sources for transportation include: The department is an allowable expense on the cost report. Patients show up for appointments decreasing no call/no show appointments, and a recent grant awarded will provide a set rate per mile up to $30,000

Case 2

- Female patient in her early 50’s. Patient with socioeconomic distress, substance use issues severe diabetes, diabetic wounds and with history of toe amputations.
- Services used by the patient:
  - Palliative care
  - Chronic Care Management
  - Primary Care
  - Transportation
  - Wound Care
- Our care helped her wounds heal, she was stable, off substances and participating much better in her care, we transferred her from Palliative Care to Chronic Care Management after about 1 year.

Case 2 Continued

- Patient did well with Chronic Care Management program being able to call the nurse with any needs between her visits and that support helped her stay stable.
- Patient ended up having a surgery with healing of the incision a concern and mobility compromise which showed a need for Palliative Care to step in again with wound care, dressing changes, mobility and transportation support.
- Palliative Care in the home continued until her incision healed, she was again able to drive and get to appointments on her own. She then transferred back to the Chronic Care Management Team.

Case 2 Funding

- Our Rural Health Clinics are in a Home Health shortage area
- Nurse home visits are paid at our Medical encounter rate for the clinic in which the nurse is based
- Wound care services are performed at the outpatient wound care clinic which is a hospital-based service with a standard fee schedule and traditional payment methodologies
- Transportation uses the funding mechanisms from the previous slide, but also ensures patient compliance with wound care treatments positively impacting total cost of care for the beneficiary contributing to shared savings potential

Case 3

- Early 80's male with heart failure and Shortness of breath. He had been referred to Palliative Care by his PCP but was hesitant to have anyone in the home due to family hoarding issues.
- Services Used by the Patient
  - Primary Care
  - Chronic Care Management
  - Partners Improving Patient Health (Multi-agency partnership)
  - Emergency Department
  - Acute Care
  - Hospice
- RN helped to keep his chart updated with medication changes, assist in communication with his heart provider, and support for his symptoms and care. Although he still preferred to not have home visits, the RN met with him in clinic and on the phone and was able to educate him about his condition.

Case 3 Continued

- One day he called about worsening shortness of breath (SOB) and feeling poorly, he was very resistant about going to the ED, but the PIPH RN could hear how much more SOB he was and had him agree to call EMS.
- He was admitted to Dayton General Hospital with COVID, which on top of his existing disease was a terrible change. The entire Health System team tried to improve his status, but they supported his wishes and in time discharged him home with Hospice.
- The PIPH and CCM RN's were able to prepare family, arrange help to clear some of the hoard to support him moving home, and the transition to Hospice took place.

Case 3 Funding

- The Partners for Improving Health (PIPH) is a 5-year, HRSA grant funded, multiagency partnership. The grant funds are $250,000 per year.
- Palliative care and Chronic Care Management, nurse home visits are paid at our Medical encounter rate for the clinic in which the nurse is based
- ED and Acute Care services are covered by standard fee schedule and daily rates from Medicare
- Hospice is one of the PIPH partners, but by providing the patient and family education regarding disease state and prognosis, combined with a warm handoff to hospice, we can reduce cost of care while improving quality of life for the patient at end stage disease

Notes on Funding

- 340 B revenue is crucial in allowing us to pursue lines of service that do not have direct charge components
- Several years of financial contributions from Greater Health Now, formerly Greater Columbia Accountable Community of Health have supported transportation, behavioral health integration, and population health infrastructure
- Local Health Improvement Networks (LHIN) such as the Southeast Washington Alliance for Health has contributed multiple grants in support of population health efforts. Including support for our transportation services

Program sustainability

Programs built around specific individuals or provider types have sustainability risks.

- What happens when the perfect person for the role leaves.
- The burnout rate for behavioral health providers needs to be considered.

Financial sustainability is challenging when revenues are tied to grant cycles or programs that have a finite funding period

Wicked Question

Given the recent news that Washington State hospitals have lost $1.7 billion in the first half of 2022, should health care organizations wait for Federal, State, or private insurers to create reimbursement streams in support of transformation efforts, or should we redesign our service delivery and then pursue or create funding streams to fill in the financial gaps?