Podcast Episode79

Are rural health disparities being widened by bundled payments?

Featuring Donna Kurek.

When healthcare quality management expert Donna Kurek made the switch to a more rural hospital system, she realized that there exists a whole different set of social determinants to consider in Appalachia, especially in the context of bundled payments. This reimbursement system can impact more complex patients negatively, especially in the presence of comorbidities such as diabetes and obesity, both of which disproportionately impact rural populations. In today's podcast she discusses Appalachian health disparities, the contrast between urban and rural environments, and reflects on how the bundled payment system has made the role of the coordinated care team even more crucial. She shares insights into the role health literacy plays in improving health decisions and outcomes, and she explores valid concerns from advocates that some patients may be excluded from elective surgery in ways that could be considered inequitable. With podcast host Eileen Body.

All views and opinions are the participants own.

Eileen: Welcome to the Health Disparities Podcast. A program of the Movement is Life Caucus. I'm Eileen Bodie. I've been a member of the Caucus for 10 years, and I'm delighted to be hosting a conversation today with Donna Kurek, who is Director of Quality and Patient Safety for OrthoVirginia. Welcome to the Health Disparities Podcast, Donna.

Donna: Thank you, Eileen. I am very happy to be here with you today.

Eileen: Your nursing experience, you've got 30 plus years of nursing experience and includes working for many years at a hospital with an urban population. Now you've transitioned to a role into a rural setting. What contrast have you seen between an urban area and a rural area?

Donna: Eileen, this is actually an exciting question for me to answer because it really has expanded my life and has created a big impact on me, especially when it comes to Movement is Life and the work we are doing. So, I worked in an urban environment for over 20 years. I took care of patients with health disparities, but it was not our normal population and social determinants of health had not been an integral part of our care plan back then. We knew what we were told by patients, or if we were asked specific questions, occasionally, we would have a patient who had extra needs or learning needs or socioeconomic needs. But again, it wasn't the norm. And then, when I went to the rural community hospital, which was only 20 miles away from my previous hospital, I had no idea, as I had not been exposed until then, of the barriers that the patients faced. There were increased socioeconomic issues. Patients weren't able to obtain or manage their prescriptions. Knowledge deficits in patients is a large factor. They didn't understand their discharge instructions, or they may not have been able to read or write. And patients in the community

had poorly managed chronic conditions like diabetes. And I remember when I first started in the Quality Department, I was shocked by the length of stay of patients who had elective joint replacement surgery. And I first thought, wow, this hospital is behind the times. We really need to fix this. And then I sat and had a meeting with the Joint Replacement Coordinator to discuss this and what she told me was very eye-opening. The length of stay was not longer because the facility was not up to date in the current processes and protocols, it was because their patient population had different needs. And many of those patients traveled forty-five minutes to two hours to come from their rural farmland to have surgery. The lack of medical care in their areas, as well as lack of knowledge of their health, contributed to these differences in care. And then, I have never been exposed to those in the past. This was the greatest, again, eye-opening experience for me in my nursing career. I realized that I had a unique opportunity to create change, to help this patient population improve their health. And this is what Movement is Life about, right? It is not only about improving musculoskeletal health, but it is about creating awareness and educating everyone about the disparities that exist in our communities across the country.

Eileen: Now you are overseeing care for people in rural Appalachia now in some coal mining towns, can you talk about some of the health challenges that are commonly experienced by your patients?

Donna: Virginia is part of the central Appalachian region, which includes West Virginia, Kentucky, and Tennessee as well. And in the central region, there's a wide gap in life expectancy. The Central Appalachian region leads all other regions in deaths related to diseases such as heart disease, cancer, lung disease, and diabetes. There was a study that was conducted on comparing residents of Appalachian County, Virginia versus other counties in Virginia, and the health perception was significantly worse in residents within communities in the Appalachian counties at a whopping 30.5% compared to non-Appalachian County residents at 17.4%. So, we definitely have a different perception and responsiveness or effect of our health care in our Appalachian counties.

And other disparities that strongly affect the Central Appalachian region are diabetes prevalence, opioid prescription rates are very high and there's a higher incidence of smoking. And most importantly, that I've found there are 5% fewer grocery stores compared to other counties in the state, which creates food deserts in many of these areas. So access to care is also limited as well as the availability of not only primary care services but specialty care as well.

Eileen: In terms of health equity in general, what gets you fired up?

Donna: Eileen, honestly, for me, it is about assumptions and lack of awareness. In many areas of healthcare, there are assumptions about what people need and what people can or cannot do. Judgments are often placed. Patients are often treated in a one size fits all mentality. We treat patients in an across the board fashion. We have to begin to treat each patient similar no matter their gender, race, or socioeconomic status. In healthcare, we say we shouldn't treat patients differently. We should treat everyone the same, but people are different. And what we need to do is treat our patients individually based on their specific needs.

Eileen: But what's wrong with our healthcare system right now?

Donna: Our health care is lacking providers and community resources. There are many urgent care centers and emergency care centers that are denying care to Medicaid patients. Thus far, there are over 118 rural hospitals that have closed. Hospitals across the country are facing financial losses. There is an estimate of 450 rural hospitals at financial risk. The safety-net hospitals are steadily closing. Primary care clinics are closing and primary care is our first level of healthcare in our communities. This creates an even bigger burden on our access to healthcare for all our patients. Rural communities are already faced with patients who have to travel sometimes hours to receive medical care. These closings also do not affect just rural America. That happens to our inner cities where most of our safety

hospitals are located. Also, disparities are not specific to those who have Medicaid. They also exist in private commercial insured patients in the Medicare system and also in the veterans' administration and care has often become based on the finance of what is happening and care is determined by clinical status and physical location rather than patient needs.

Eileen: Okay, well, what's of specific interest to you?

Donna: Eileen, I am passionate about working on health literacy and education. In my nursing experience, I have had multiple roles. I oversee patient care management. I have taught preoperative education classes for joint and spine patients. And I am passionate about educating patients and making sure they are actively able to manage their care both before and after surgery. Literacy is not just about reading and writing. It is about being able to comprehend the instructions and implement these practices into everyday life. We have to ensure that the patients in our community have the appropriate resources so that they can function to better health.

Eileen: You've moved from an urban area to a rural area. So what are the health disparities that you're aware of now? What are you concerned about?

Donna: I think for me, I'm most concerned with and aware of the obesity epidemic. Educating and providing resources to our communities on obesity and managing weight leads to the improvement of so many other chronic conditions. If we could start here by managing obesity, then we can work to improve the Vicious Cycle and start getting people to move and to have active participation in their life. And which will then improve the obesity, decrease their weight and then help improve other conditions.

Eileen: Is obesity a factor in the sort of skewing the bundled payments?

Donna: It can be. There's a lot of differences of opinion and controversy on how BMI affects patients in the bundle. There are many providers and institutions that will turn patients away because of their BMI. But another key component of a bundled payment is providing quality of care to all patients, right? So, if we limit patients based on their BMI, then we're not actually helping the patient to improve their quality of life. We are focusing just on the cost-effectiveness. So, the key really to have a successful program is to work with the patients to manage their weight, instead of having a restriction of not having surgery. Having a, maybe not now, but later mentality rather than a not at all mentality when it comes to the BMI's. Okay. And by not now, I mean that we take the opportunity to tell the patient or work with our patients to get the proper weight resources that they need. Find what's in their community that can help them. There are

low-cost or no-cost programs that are beneficial to patients for weight reduction. Get them in front of the appropriate physicians. And now, that's also a challenge in our rural communities. So, they may not have that access to care or these additional resource services. So, what we really need to do is first take a good assessment of these patients, find out what their needs are, then determine a good plan of action rather than restricting them.

Eileen: Movement is Life is very concerned about bundled payments having a negative impact on certain patient groups. It seems that more complex patients and those patients with fewer resources may struggle to get a good care plan in place for something like a total knee replacement. Do you find that to be true?

Donna: Yes, I do believe that's true. And this kind of ties into the question we just talked about, about BMI and skewing data and also related to obesity. Many providers, payers, and institutions participating in bundled programs are imposing these strict criteria on patients having surgery. The main criteria are the BMI's and management of A1C levels in diabetic patients. Smoking is another key factor. Operating on patients with these risk factors does increase the patient's risk of having complications. And then there is a strong emphasis place on surgical outcomes. This often puts increased burdens on surgeons to meet specific standards. So, many

people with fewer resources or with limited access to health providers may not have the ability to effectively manage their care. There are knowledge deficits that are a major concern. And what often happens is patients will be turned away from the surgery. Patients are often told to seek care elsewhere by another surgeon. So is the bundle really working? If patients are being turned away because of these restrictions and we limit their care, then we are missing the key component of one of the goals of bundling, which is providing high quality of care to our patients. So how do we balance risks with limiting patients from having surgery and that's through patient optimization. And that's where a care management program, which I oversee, comes into strong play. Optimization is essential for all patients but has a larger impact on patients with health disparities. It has been my experience, to be successful in a bundle program primarily for elective procedures, is to have a care coordination team who is a resource to each patient. Their care managers work to assess risks, they identify strategies, they identify community resources that align with the patient's individual needs. And then it helps to develop a pre-surgery plan of care that includes discharge planning. So, if a patient is not at the appropriate weight resource or needs to be only provided to the patient, a careful needs assessment must occur, which identifies the ability of how a patient can achieve their goals. The care management team can identify community resources that offer free or reduced-cost services as we talked about. The care managers can arrange for patients

for appointments for medical care or assisting patients in not only accessing care but also getting to these appointments. CMS has a bundle called BPCIA. It's a bundle payment care initiative, and in that program, there are also waivers that are allowed for certain care services. So, the care management teams can actually arrange for free transportation for patients to get to their therapy appointments or for follow-up care. There are waivers for services like nutrition, like Meals on Wheels. So, when communities that do not have access to care quickly or locally, or may not have support systems at home, a proper care management team can work to have these waivers and services in place ahead of time, which decreases the concerns for the patient. It's actually providing high-quality care, and it's allowing us to not restrict these patients from having surgery. So, careful planning is the key.

Eileen: It sounds like you've given a lot to this, you know, care, management team. How successful it is down there? How is it working with your patients?

Donna: We are seeing an increased amount of patients that are going straight home from the hospital. One of our focuses is to heal at home. By keeping a patient out of higher-cost care, which like services like inpatient rehab centers or skilled nursing facilities and getting them into the home, we're decreasing their risk of complications by being out of their environments.

So, part of the bundle payment care initiative is as we mentioned to decrease costs but provide a high quality of care for our patients. And what I've found is that patients are often being sent to higher cost facilities like inpatient rehab utilizations, or skilled nursing facilities, primarily for reasons that are unnecessary. For example, if a patient goes to an inpatient rehab center because they just want to, or their family member works there, but they have a large support system at home. The best goal or to provide the highest quality of care for patients is actually to get them to their home environment. So, what we do in our case management program and what is successful there is that we are very engaged in providing services to get that patient in their home environment immediately from surgery. When we do that, we're successful because it decreases those unnecessary costs to the higher level of care settings. So, that's a benefit to Medicare, right, and the bundle. But in addition, we're decreasing our risk of complications to our patients, especially with the flu season and the higher alerts for other viruses that are around, surgical site infections, or just exasperation of their comorbid conditions. So, by having these waivers and a controlled care management team that puts the patient first, we provide these resources in the home and the patients recover better and quicker, and they're much more satisfied and can return to optimal health with less complications.

Eileen: Do you think you need care management teams to better affect the social determinants of health care?

Donna: Yes, I would agree. Based off my current work with having a care management team, especially where we're implementing bundle programs for value-based care, where we have rural communities that have limited access to care and gender and socioeconomic disparities, having the resources in place to provide oversight of care through whether it's community resource care management, whether it's care management that comes from the primary care services or the specialty services, or from the hospitals, we need to have more direct impact on our patients from start to finish when it comes to surgery or managing other care. I think, again, the challenge goes back to in these areas, we do have the limited resources of our medical doctors. So, therefore, we're also going to have shortages and less opportunities in nursing care services and other ancillary services such as social workers or case managers that are available local or able to provide these services. So, that would be a future goal is to work to increase the availability of community resources to our patients to be able to be managed appropriately.

Eileen: What are some of the social determinants that you have witnessed and need to understand in order to deal with patient care in rural Virginia?

Donna: There's such a wide gap in life expectancy. Looking in our Northern Virginia communities where we have a more wealthy population, it's a more urban environment, higher socioeconomic state, we have an average age of life expectancy of up to 91 years in the higher wealthy communities. And then we compare that to our coal countries in Southwest Virginia, who live to an average of 66. That is a dramatic change in life expectancy from one side of the state to the other. And one of the biggest impacts is housing. Thirteen percent of households spend more than half of their income on housing, which leaves little for other necessities. In Petersburg city, which is about 30 miles south of our major city Richmond, has a 26% poor health rate than any other Virginia County, primarily affecting African Americans and Hispanics. And the main factors that influence these disparities are access to care, education, employment, and family and social support. One strong, positive with Virginia, they have developed a plan for wellbeing that has been put into place for all of the counties across the state that sets goals and strategies for communities to make measurable changes to improve health in these counties.

Eileen: What are some of the changes that you want to effect in order to improve health care delivery to your patients?

Donna: This takes me back to the discussion about care management. We need to start by increasing risk and social assessments of patients to help people better understand what their individual needs are, and to not only prepare them for surgery but for their postoperative discharge and care, as well as their long-term health. And most joint replacement patients attend a joint replacement preoperative class and receive educational materials. Patients are encouraged to review this information prior to surgery and contact the office or the hospital or whatever resource with any questions they have. Every organization I feel should work to have a health literacy plan to ensure patients receive the level of care and understanding equally. Now, the CDC does offer a guide called Simply Put. I have used this guide to develop educational materials for patients that are appropriate for all reading levels. Discharge information for patients should be more visual. We should be bulleting and highlighting information rather than writing long texts. This is very important not only for patients that may have a limited ability to read but for their understanding and comprehension. The design and layout need to be more visual and less text and mixed with pictures. And we need to make sure all education materials go through a readability tool so that we can ensure that the people receiving this information can actually understand it. The size of the font and text also makes a key difference and when it comes to understanding. So, it's just not being about being able to read the information. It's about being able to understand their plan of care and

be able to incorporate it into their everyday life. So, the education materials provided to patients are just a small step. We need to make sure that our patients actually comprehend the material and put it into action.

So, patients should not be excluded from care because of health illiteracy, which can be a factor. And this starts by having effective communication with patients from the providers' offices, as well as the care management team, and that involves asking the difficult questions. Many times we don't get to the level to ask a patient if they're able to read information or understand the information. And then we have to assess their health care needs and then establish that effective education plan. So, again, having a care management team that has the time to focus on individualizing a plan of care for a patient is beneficial for all disparities and primarily the health literacy as well.

Eileen: Donna, thank you so much. Our discussion has been very informative and I appreciate everything you've been able to tell us.

Donna: Thank you, Eileen. I'm very excited to have been here today.

Eileen: Thank you our listeners for joining us in this episode of the Health Disparities Podcast. We hope you found it interesting. Please remember to subscribe on iTunes or you can sign up on our website to receive

notifications of new episodes. I'm Eileen Bodie and I thank you for your time today.

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