



## The Future of Rural Health

### Why Rural Health is Different

Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Economic factors, cultural and social differences, educational differences, lack of recognition by legislators and the sheer isolation of living in remote rural areas all conspire to impede rural Americans in their struggle to lead a normal, healthy life. Some of these factors, and some of their effects, are listed below.

- Only about ten percent of physicians practice in rural America despite the fact that nearly one-fifth of the population lives in these areas.<sup>1</sup>
- Rural residents are less likely to have employer-provided health care coverage or prescription drug coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts.<sup>2</sup>
- Rural residents tend to be poorer. On the average, per capita income is \$7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. The disparity in incomes is even greater for minorities living in rural areas. Nearly 22% of rural children live in poverty.<sup>3</sup>
- People who live in rural America rely more heavily on the federal Food Stamp Program, according to The Carsey Institute at the University of New Hampshire. The Institute's analysis found that while 22 percent of Americans lived in rural areas in 2001, a full 31 percent of the nation's food stamp beneficiaries lived there. In all, 4.6 million rural residents received food stamp benefits in 2001, the analysis found.<sup>4</sup>
- The Health Resources and Services Administration reports that 65% of all Health Professional Shortage Areas are in rural areas.<sup>5</sup>
- 60% of Dental Health Professional Areas are located in rural areas.<sup>6</sup>
- 55% of Mental Health Professional Shortage Areas are located in rural areas.<sup>7</sup>
- Abuse of alcohol and tobacco is a significant problem among rural youth. The rate of DUI arrests is significantly greater in non-urban counties. Forty percent of

<sup>1</sup>van Dis J. MSJAMA. Where we live: health care in rural vs urban America. JAMA. 2002 Jan 2;287(1):108.

<sup>2</sup>HHS Press Release, May 4, 2009. <http://www.hhs.gov/news/press/2009pres/05/20090504a.html>

<sup>3</sup>O'Hare, William. The Forgotten Fifth: Child Poverty in Rural America  
<http://www.carseyinstitute.unh.edu/publications/Report-OHare-ForgottenFifth.pdf>

<sup>4</sup>Carsey Policy Institute Policy Brief No. 1, Fall 2005  
[http://www.carseyinstitute.unh.edu/publications/PB\\_foodstamps\\_05.pdf](http://www.carseyinstitute.unh.edu/publications/PB_foodstamps_05.pdf)

<sup>5</sup>Health Resources and Services Administration, Designated Health Professional Shortage Areas (HPSA) Statistics -  
[http://ersrs.hrsa.gov/ReportServer?/HGDW\\_Reports/BCD\\_HPSA/BCD\\_HPSA\\_SCR50\\_Smry&rs:Format=HTML3.2](http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2)

<sup>6</sup>Ibid.

<sup>7</sup>Ibid.

rural 12th graders reported using alcohol while driving compared to 25% of their urban counterparts. Rural eighth graders are twice as likely to smoke cigarettes (26.1% versus 12.7% in large metro areas)<sup>8</sup> and in rural areas, the rate of smokeless tobacco usage is 8.1% versus 1.5% in large urban areas.<sup>9</sup>

- Anywhere from 57 to 90 percent of first responders in rural areas are volunteers.<sup>10</sup>
- Hypertension was also higher in rural than urban areas (101.3 per 1,000 individuals in MSAs and 128.8 per 1,000 individuals in non-MSAs.)<sup>11</sup>
- The suicide rate in rural areas is significantly higher than in urban areas, particularly among adult men and children. The suicide rate among rural women is escalating rapidly and is approaching that of men.<sup>12</sup>
- Medicare payments to rural hospitals and physicians are dramatically less than those to their urban counterparts for equivalent services. This correlates closely with the fact that at least 393 rural hospitals closed from 1980-2000.<sup>13</sup>
- Medicare patients with acute myocardial infarction (AMI) who were treated in rural hospitals were less likely than those treated in urban hospitals to receive recommended treatments and had significantly higher adjusted 30-day post AMI death rates from all causes than those in urban hospitals.<sup>14</sup>
- Rural residents have greater transportation difficulties reaching health care providers, often travelling great distances to reach a doctor or hospital.<sup>15</sup>
- Death and serious injury accidents account for 60 percent of total rural accidents versus only 48 percent of urban. One reason for this increased rate of morbidity and mortality is that in rural areas, prolonged delays can occur between a crash, the call for EMS, and the arrival of an EMS provider. Many of these delays are related to increased travel distances in rural areas and personnel distribution across the response area. National average response times from motor vehicle accident to EMS arrival in rural areas were 18 minutes, or eight minutes greater than in urban areas.<sup>16</sup>

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<sup>8</sup> Rural Healthy People 2010—*"Healthy People 2010: A Companion Document for Rural Areas,"* is a project funded with grant support from the federal Office of Rural Health Policy. The full document is available for download at the following site: <http://www.srph.tamushsc.edu/rhp2010/>

<sup>9</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), Results from the 2010 National Survey on Drug Use and Health: Detailed Tables, <http://www.samhsa.gov/data/NSDUH/2k10ResultsTables/NSDUHTables2010R/PDF/Cover.pdf>.

<sup>10</sup> Rural Healthy People 2010

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7653/91-cbo-037.pdf>;

[http://www.shepscenter.unc.edu/rural/pubs/finding\\_brief/fb73.pdf](http://www.shepscenter.unc.edu/rural/pubs/finding_brief/fb73.pdf)

<sup>14</sup> WWAMI Rural Health Research Center study, funded by the Federal Office of Rural Health Policy, described in: Baldwin L-M, MacLehouse RF, Hart LG, Beaver SK, Every N, Chan L: Quality of care for acute myocardial infarction in rural and urban U.S. hospitals. *Journal of Rural Health* 2004;20(2):99-108.

<sup>15</sup> [http://www.medpac.gov/documents/Jun12\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun12_EntireReport.pdf)

<sup>16</sup> Rural Healthy People 2010

## The Status of the Current Rural Health System

Our health care system is undergoing dramatic changes. Providers have become increasingly aware that the current rural safety net programs are not structured for success in this new environment. While it is critically important to sustain the rural safety net providers such as Rural Health Clinic, Federally Qualified Health Center, Critical Access Hospital, Medicare Dependent Hospital, Sole Community Hospital, physicians and other rural programs and providers during this time of change and uncertainty, it is equally important to outline a meaningful phased and non-destructive transition strategy that successfully links today's payment and patient care delivery structures to the health care systems of the future.

Current federal licensure and certification processes create barriers to comprehensive patient care, increase costs and may be unsustainable in rural communities. Constrained by these financial and regulatory silos, frontier and rural providers are finding it difficult to live with one foot mired in historic restrictions while determining how best to interface with new models of care. Rural health care is currently less expensive per beneficiary, as noted in the analysis of data from the Centers for Medicare and Medicaid Services.<sup>17</sup> Yet there is limited ability to participate in innovative approaches when current rural payment models leave little room for necessary investment.

Congress has recognized the economic disadvantage in rural health care by establishing programs and policies to ensure and protect access to a broad range of health care services for the elderly and others living in rural America. In an effort to maintain access to care, Congress has devised specific payment methodologies for different types of rural providers. Each of these specific payment scenarios come with special provider designations and is governed by its own unique and separate infrastructure and regulatory requirements. A provider's payments are premised on its maintenance of multiple and separate infrastructure requirements. Therefore the form of rural health delivery today follows finance and regulatory requirements.

A regulatory checklist – as opposed to a community's unique needs or a patient's unique needs - dictates how a provider will allocate its limited financial and human resources. Rural delivery systems, therefore, are fragmented and inefficient. There are few incentives and little value assigned to enhanced efficiency or improved health outcomes. A community's providers have little or no incentive to collaborate for the delivery of patient-centered care. Instead, the system is provider-centric, driven by a volume-based payment model.

New models for value-based reimbursement currently being developed such as accountable care organizations, bundled payments, and value-based purchasing may not translate well in rural markets, given rural providers' unique regulatory confines and

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<sup>17</sup> Rural Relevance Under Healthcare Reform, iVantage Health Analytics, Inc., April 25, 2012

low population density. Also, lower patient volumes make it difficult, if not impossible, for rural providers to bear risk as these models demand.<sup>18,19</sup>

It is important to recognize that, historically, rural health care systems have been financially fragile, and many still have small operating margins, making it difficult for them to participate in innovative efforts intended to stimulate fundamental redesign of the delivery system.<sup>20</sup> This financial fragility remains true according to a study completed in 2012 that indicates that more than half of the country's hospitals are rural and of those Medicare Dependent Hospitals (MDH), rural Prospective Payment System (PPS) hospitals and Critical Access Hospitals (CAH) were the worst at controlling expenses relative to revenues, generating cash flow from patient care services, avoiding financial distress from negative margins, and being able to service debt.<sup>21</sup>

Rural providers now must design and implement alternatives to the urban-centric payment models that maintain local access while achieving improved quality, improved outcomes and enhanced efficiency with lower costs.

### Environment for Change:

Certain provisions of The Patient Protection and Affordable Care Act offer the opportunity to correct the inequities in the rural health delivery system caused by categorical certification and payment models.

Opportunities are emerging in public policy and the private sector to change the organization, financing, and delivery of rural health care services. What might appear to be threats to rural health care, such as challenges to current special payments or new administrative requirements, may instead be opportunities to update and improve outdated and unsustainable service configurations.<sup>22</sup>

Regardless of the specific form rural value-based payment models eventually may take, there are key relationships and resources that must be present in a community for it to survive and thrive through the transition period to the future.

The term community in the context of rural health should not be thought of as a specific and precise geographic unit. Within the body of the North Carolina Rural Health Plan the term "cluster of communities" comes to fruition.<sup>23</sup> Although as stated in the North Carolina document "there is no specific definition of a "cluster of communities", it may

<sup>18</sup> Anticipating the Rural Impact of Medicare Value-Based Purchasing, RUPRI Rural Health Panel, April 2012

<sup>19</sup> Comment Letter from The Rural Wisconsin Health Cooperative to Dr. Donald Berwick, CMS administrator regarding CMS-1345- Accountable Care Organizations & Medicare Shared Savings Program, June 6, 2011

<sup>20</sup> Quality Through Collaboration: The Future of Rural Health Care, Institute of Medicine, 2005

<sup>21</sup> A Snapshot of the Financial State of Rural Hospitals, North Carolina Rural Health Research & Policy Analysis Center, August 2012

<sup>22</sup> The High Performance Rural Health Care System of the Future, RUPRI Health Panel, September 2, 2011

<sup>23</sup> Fundamental Rural Community Health Building Blocks – North Carolina Rural Health Plan June 2012. This document was prepared in coordination with the State Offices of Rural Health of North Carolina, Pennsylvania, Maine and Virginia

initially be thought of as communities within the primary service area of a rural hospital. However, primary service area definitions are not precise and the grouped communities may change with consideration of specific services.<sup>24</sup> Within this context, the rural community used to define rural health systems of the future may be more like a large scale “medical neighborhood” as described by the Agency for Healthcare Research and Quality (AHRQ).<sup>25</sup> As used in the AHRQ white paper the medical neighborhood is conceptualized as a Patient Centered Medical Home (PCMH) and the constellation of other clinicians providing health care services to patients within it, along with community and social service organizations and State and local public health agencies. AHRQ goes on to say that the neighborhood is not necessarily a geographic construct but instead a set of relationships revolving around the patient and his or her PCMH, based on the patient’s health care needs.

Therefore in the rural health perspective, community may be a relatively well defined, local geographic area constituting the service area of an existing rural hospital or it may be a larger, non-contiguous “area” or population group with similar characteristics, interests and commonalities. This difference will be especially apparent when considering a more densely populated rural area in a southeastern state compared to a frontier area in a western state. Consequently one type of delivery and payment system will not fit all rural areas in the United States.

Every effort should be made to create a community environment needed for future success and sustainability. These environmental elements may include at least the following:

1. Regulatory environment that supports fundamental, patient-centered community services appropriate to clusters of rural communities
2. Financial incentives for improved health, lower costs and improved systems of care
3. Strong and well-respected local leadership
4. Broad base of provider groups, knowledgeable of current and future patient-centered health delivery and payment systems, significantly vested in the process. Special consideration for providers actively opposed to participating in community health systems
5. Willingness to acknowledge and address local limitations and build working relationships with providers in other communities through networking
6. Willingness to develop and operate under a local governance structure (not necessarily a new “entity”) that engages and empowers local stakeholders
7. Skilled outside facilitators and other well-developed technical assistance
8. Access to and use of reliable epidemiological and financial data
9. Adequate financial resources to support planning and implementation phases
10. Adequate financial incentives to drive collaboration and integration (or at least removal of disincentives driving systems in the opposite direction)

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<sup>24</sup> Ibid.

<sup>25</sup> Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms – White Paper, Agency for Healthcare Research and quality,

11. Agreed-upon measures of success and reward for achieving specific goals relating to improving population health, decreased cost and commitment to ongoing-improvement.

A health *care* system is a collection of individual providers each focused on providing specific services in their specific setting. A *health* system is built by a community to maximize resources for keeping people healthy. It is patient-centered and comprehensive in scope, making available services from pre-natal care to death. It focuses on comprehensive wellness and support services, not merely treating illness. Although rural communities face the reality that not all services can or should be provided locally, this fact does not diminish the need for these services to be reasonably accessible to all rural residents.

Clusters<sup>26</sup> of rural communities have the primary responsibility for determining workable models for rural health improvement and the scope of services to be delivered locally, within obtainable resources. Nonetheless, in many instances, local communities cannot independently address all of their challenges, share strategies and responsibilities that are necessary to provide local services.

Priorities for the development of clinical services and other health improvement strategies may vary significantly among communities. Better community-specific needs assessments will support clearer local priority setting. In some cases, there are multiple service alternatives; in others, reasonable alternatives are not readily apparent. The definition of what is clinically appropriate and affordable in rural locations keeps changing with advancements in knowledge and technology and the associated changes in the costs of services.<sup>27</sup> The National Rural Health Association (NRHA) supports multidisciplinary community engagement to identify and address local and regional needs.

While consensus around the future challenge is clear, the method(s) of reaching the ultimate goal is more elusive. Yet consistent themes are prevalent:

- The ability to adapt current systems to allow payment for preventive health measures and care coordination is central to future success.
- Hospitals and physicians/clinics are characterized as a focal point, looking beyond bricks and mortar to their role as a physical or virtual hub of service delivery.

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<sup>26</sup> NC Rural Health Plan - Fundamental Rural Community Health Building Blocks— North Carolina Rural Health Plan June 2012: There is no specific definition of a “cluster of communities”. It will initially be helpful to think in terms of the communities within the primary service area of a rural hospital. However, primary service area definitions are not precise and the grouped communities may change with consideration of specific services. When some services are considered, shared strategies may include joint planning and service development involving two or more adjacent “clusters,” or groups of communities. None of the planning discussions indicated that community-based planning groups should be rigidly fixed. Additional discussions of access standards, e.g., travel times to a provider or time-to-appointment standards may help in sharpening planning.

<sup>27</sup> NC Rural Health Plan



- Flexibility is essential. Whether outlining incremental change through transitional approaches to current frontier and rural programs, or transformational models designed to capitalize on the primary care foundation of rural health delivery, all require the ability to maneuver.
- Perhaps most importantly, the need for transitional support cannot be over emphasized, noting rural payment and delivery policies must “**preserve what we have until we have clarity of where we are going.**”

While we examine the potential future delivery and payment policies, the need to sustain the present rural health infrastructure as we prepare for the future cannot be overstated. If current rural hospitals are forced to close during this transition period, the rural safety net infrastructure will deteriorate, thereby depriving local residents, especially vulnerable populations, of crucial access to health care services.<sup>28,29</sup> The redevelopment of providers in these affected rural areas may be nearly impossible considering the difficulty of recruiting physicians to some of these communities.<sup>30</sup> The closure of a rural hospital can contribute to the closure of other businesses or lack of new business coming to the community.<sup>31</sup> In addition the closure of the sole hospital in a community reduces per capita income and increases unemployment.<sup>32</sup>

## Core Concepts and Principles of Rural Health Services

As our health care system undergoes vast changes in payment models, the creation of insurance marketplaces and advances in public coverage, rural health systems will need to develop a flexible model that accounts for the varying needs of rural communities and their residents. Complicating matters further, there is no “one size fits all” model for rural health systems.

Keeping in mind the worthwhile goals stated in the Triple Aim<sup>33</sup> better care, better health and lower costs; there are certain foundational concepts that must be present for rural delivery systems of the future. Some of these over-arching concepts include:

- Community involvement and investment: acknowledging the variances between rural communities and thus encouraging the use of “place-based policies” in which a health system is tailored to the needs of each individual community, ideally with high levels of community ownership of the system.

<sup>28</sup> Reif SS, DesHarnais S, Bernard S. Community Perceptions of the Effects of Rural Hospital Closure on Access to Care. *The Journal of Health*, 1999, 15-2: 202-209

<sup>29</sup> CAH/FLEX National Tracking Project, Vol 3, Number 2, 2003

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> Holmes GM, Slifkin RT, Randolph RK, Poley S. The Effect of Rural Hospital Closures on Community Economic Health, *Health Services Research* 41:2, April 2006

<sup>33</sup> Donald M. Berwick, Thomas W. Nolan and John Whittington. “The Triple Aim: Care, Health, and Cost”. *Health Affairs*. May 2008 vol. 27 no. 3 759-769.

- Form follows finance: regardless of the type system, providers will conform to “how the money flows”. Innovative models of care delivery and providers will be an outcome associated with changes in reimbursement practices.
- Importance of compiling and reporting “best practices”: an organized method by which providers can share models that produce desired results on patient care and financial sustainability
- Balance present concerns with future needs: recognizing the need to provide a transition strategy from current dysfunctional systems of care to seamless patient-centered care
- Appropriate relationship of rural to urban health care systems: appropriate incentives to encourage rural providers and urban systems to collaborate to provide seamless, non-duplicative patient care services

There are no universal solutions to difficult rural health challenges. Notably, there are substantial variations of actual and perceived needs, resources, and organizational capacity among communities. These variations are paralleled by significant differences in both overall health status and chronic disease morbidity across rural regions. Health status is also affected by many social determinants of health including factors such as age, employment, educational levels, race, ethnic factors, the extent of “rurality,” seasonality, the availability of transportation, community history, and associated cultures and attitudes.

The broad goal of rural health advocates should be to improve the health of rural people. There is recognition that good health is determined by more than just access to acute health services. Prevention, health improvement strategies, and social determinants of health are profoundly important. Without recognizing that the population segments are diverse and without addressing those conditions that drive disparities, realistic expectations and strategies for long-term improvement in health cannot be sufficiently defined, let alone achieved. Health related costs cannot be managed, let alone minimized.

Although many factors other than health services are fundamental to good health, there is also recognition there is a need to provide the right services (evidence based and including prevention and public health services), to the right people, in the right places (as locally as possible), at the right times, efficiently, and at reasonable costs.

Several categories of services and relationships constitute fundamental or foundational building blocks that must be in place if there is to be long-term progress toward assuring strong, healthy, rural communities.<sup>34</sup> The following construct can support discussions of an extraordinarily complex set of variables, as well as the tradeoffs that must be considered as communities try to advance “health,” not just the treatment of disease, in an era of significant resource challenges.

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<sup>34</sup> This outline reflects the synthesis of examples from the National Institute of Medicine’s report “Quality Through Collaboration, The Future of Rural Health” and the “Fundamental of Rural Health.” It borrows heavily from sections of the North Carolina, Virginia and Maine Rural Health Plans, It was originally based on the work of the Maine Rural Health Association and input from the Pennsylvania Office of Rural Health.



These foundational resources are not a limit on services that *could* be provided, but serve as a basis for services that *should* be provided. This core set of integrated parts defines long-term service and systems development goals, not current conditions. There are clearly gaps between realities and aspirations.

It is easy to say that rural residents should have ready access to all of the identified services and referral linkages to more specialized providers and facilities. However, in many cases neither the local capacity nor the referral resources and linkages are adequate. To state that all identified resources should just “be there” is overly simplistic. This does not mean we should lower our sights. It does mean that in rural areas, priority should be given to putting in place the identified building blocks and securing the resources necessary for their sustainability.

### Primary Care

Primary care is currently and should remain at the core of rural health care systems. NRHA has defined primary care as: comprehensive health services at the point at which people enter the health care system that includes diagnosis, prevention, treatment, and management.<sup>35</sup> According to the NRHA document, the entire spectrum of healthcare is divided into four components: tertiary, secondary and subspecialty care, comprehensive primary care and social determinants/community health. The primary care component is further divided into three parts: care coordination, comprehensive primary care and community/family health. Primary care is practiced in four environments: primary medical, family support and coordination, behavioral health and oral health. Prevention, diagnosis, treatment and management take place in all of these four primary care environments.

Considering the comprehensive primary care component, a set of core concepts and common, guiding principles should be considered important for rural delivery and payment systems.

1. The system must be patient-centered and oriented to providing quality care using best practices
2. Communities differ: frontier solutions will be different from those of more densely populated rural areas
3. Local determination of how best to address local needs: communities have primary responsibility for addressing needs, securing resources and stewardship of those resources
4. Access to a full range of services for all populations - prevention, (physical, oral health, mental health/behavioral health) – primary care, home care, extended care-long term care, acute care, rehabilitation, public health, emergency and pharmacy
5. Core set of services provided at the community level or through arrangement(s) with regional providers based upon need and capacity

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<sup>35</sup> Definition of Primary Care, National Rural Health Association, January 2012

6. Health information technology is a critical component, including health information exchanges
7. Expansion of telehealth is essential: including not only inpatient and outpatient care but also patient monitoring, home care management, etc.
8. Development and stability of skilled healthcare workforce is necessary: physicians, mid-levels and all healthcare technicians including administrative and infrastructure personnel i.e. HIT, financial, human resource staff, etc.
9. Development of new community health workers: community paramedics, health coaches, care coordinators, patient navigators, etc.
10. Allow all providers to practice 'at the top of their license' and skill level
11. The system must be affordable and accessible to rural citizens
12. Focus on developing community health rather than continuing to 'fix problems'
13. Patient and population education is an integral part of system

Although primary medical care cannot be overemphasized, other services should be reasonably accessible to all rural residents. Some of those include:

### Basic Mental Health Services

People in rural areas often experience problems with access to behavioral health services for both mental health disorders and substance abuse and a combination of both as in co-occurring disorders. There are an inadequate number of providers in rural areas and stigma regarding obtaining behavioral health treatment continues to exist. Both of these factors often prevent people from accessing needed behavioral health services.

Integrating primary care and behavioral health increases access to behavioral health care for people in rural areas. When behavioral health services are provided in the same health care setting as primary care services, people are more likely to take advantage of the behavioral health services. Resources should be provided to encourage integrated care and to increase the number of behavioral health providers (Licensed Clinical Social Workers and Ph.D. Psychologists) practicing in primary care settings.

- Crisis intervention, diagnosis, primary outpatient treatment (including medication management), prevention, and referral, including services for adults, children, adolescents and families<sup>36</sup>
- Referral mechanisms to specialists and inpatient mental health services in other communities with referrals back to local community outpatient providers<sup>37</sup>

### Basic Substance Abuse Services (Alcohol and Drugs)<sup>38</sup>

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<sup>36</sup> Fundamental Rural Community Health Building Blocks – North Carolina Rural Health Plan June 2012

<sup>37</sup> Ibid.

<sup>38</sup> Ibid.

- Crisis intervention, detoxification, diagnosis, primary outpatient treatment, prevention, and referral, including services for adults, children, adolescents and families
- There is a need for well-developed referral mechanisms to inpatient substance abuse providers in other communities with referrals back to local community outpatient providers

#### Basic Oral Health Services<sup>39, 40</sup>

- Preventive dental services including prophylaxis, appropriate use of fluoride, dental sealants, screening for oral disease (e.g., cancer) and oral health education (e.g., including nutrition counseling)
- Basic restorative treatment (i.e., repair of cavities)
- Referral mechanisms to access more specialized treatment services (e.g., orthodontics, other restorative care, oral surgery, prosthodontics [e.g., crowns and bridges])

#### Emergency/Urgent Care Services<sup>41</sup>

- Mobile emergency medical services for trauma and for the care of other time sensitive illnesses and injuries (ambulance services including air ambulance services, emergency medical technicians, paramedics and communications systems)
- The integration of all systems for time-sensitive illnesses and injuries (Trauma, Stroke, STEMI / Cardiac, pediatrics, Burns, OB and other emergencies)
- Hospital emergency departments (including an appropriate scope of immediately available medical/surgical/mental health/substance abuse services, as well as triage and referral, and telehealth/teletrauma linkages)
- Clinical education programs for all emergency service providers
- Automatic external defibrillator programs

Emergency care must be available in the form of highly trained EMS/paramedic personnel. Response times are critical in rural areas. Community crews should be empowered to care for emergency situations until they can transport patients to the nearest emergency center. Consideration should be given to using funds currently used to subsidize under-utilized hospital emergency rooms to fund community-based emergency crews (i.e. community paramedic program).

Emergency and non-emergency transportation is critical to developing and maintaining continuums of care among communities. As part of its decision whether to offer a service locally or make arrangements with another community to provide that service, a community must consider the cost, availability and reliability of transportation.

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<sup>39</sup> Ibid.

<sup>40</sup> Rural America's Oral Health Care Needs, National Rural Health Association, February 2013

<sup>41</sup> Fundamental Rural Community Health Building Blocks – North Carolina Rural Health Plan June 2012

## Surgery and Obstetrics

Access to surgical and obstetrical services is fundamental to strong, rural and non-rural, community health systems. While not “primary care,” these services are integral to comprehensive primary health care, to which timely access is essential. Primary care providers are often unwilling to practice in a location without surgical backup.<sup>42</sup> There are many rural hospitals that cannot provide surgical or obstetric services, even though local providers must assure access for routine and emergency surgery and routine obstetric services. Timely access to surgical services is secured for patients in many ways. Some small hospitals use referrals to regional hospitals; others bring the surgeon to the rural setting. The future of robotic surgery may also provide access for patients. However, the addition of a general surgeon to a local rural hospital staff can be very beneficial to the medical staff in provision of medical care. Workforce decisions about general surgery services will require an understanding of “time to access” for trauma and critical surgery services. Additionally, the provision of obstetrical care can be enhanced, or even dictated by the presence or availability of a general surgeon to help with complicated operative obstetrics.

## Pharmacy and Medication Services<sup>43</sup>

- Financial and geographic access to prescription drugs as well as associated adverse risk screening and consumer education related to the appropriate use of medications
- Support for hospitals inpatient programs

## Eye Care and Audiology Services<sup>44</sup>

- Ophthalmology (also above as a physician specialty)
- Optometry and Optical Services
- Audiology services: the diagnosis and treatment of hearing disorders and the rehabilitation of people with hearing impairments

## Public Health

There are numerous community health and public health issues in rural areas, which must not only be part of a comprehensive vision and health strategy but must also be better integrated with the practices of medicine and dentistry in order to improve rural health status. These issues do not fit within, but overlap, the previous categories of services.<sup>45</sup> Public health involves identifying and addressing social determinants of health through community-focused, health promotion and illness prevention, and

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<sup>42</sup> The Crisis in Rural General Surgery, WWAMI Rural Health Research Center Policy Brief, Doescher MP, Lyng DC, Skillman SM, April 2009

<sup>43</sup> Fundamental Rural Community Health Building Blocks – North Carolina Rural Health Plan June 2012

<sup>44</sup> Ibid.

<sup>45</sup> Ibid.

educational initiatives. The content of public health services includes data collection and analyses (assessments), personal health (e.g., maternal and child health, family planning), environmental health (e.g., food protection, sanitation) and health promotion and disease prevention (e.g., health education and public awareness, special services for at-risk populations, immunizations, surveillance of communicable diseases).

Food access is an important aspect of frontier and rural health. Public health organizations should include plans to address deficits in access to fresh fruits and vegetables and other healthy food products to enhance the overall wellness and health of the population.

#### Education, Prevention, Health Literacy, and Cultural Competency<sup>46</sup>

- Community health education, as well as patient and family health education, that addresses health promotion, prevention and disease-specific treatment needs
- Screening programs and appropriate follow-up linkages to treatment when necessary
- Immunizations

#### Inpatient Acute Care

Whether or not inpatient services should be included in a community health system has traditionally been a community decision and in many places currently, the decision of a corporate entity not local to the community. Regardless of ownership issues, the financing and investment in community inpatient structures should be considered within the context of a limited amount of resources and the most appropriate placement of those resources to reduce costs and improve health and health systems. If hospitals were paid globally based on historical utilization and costs on a per capita basis, incentives for providing unnecessary or cost ineffective services would be reduced. Over time, the population of a cluster of rural communities, utilization patterns and available financial and human resources may not sustain traditional inpatient hospital services. Arrangements must be made with referral hospitals to provide the care needed by community residents.

Non-traditional inpatient services, e.g., Emergency Medical Service linked, extended observation services, and Frontier Extended Stay-type clinics may provide a reasonable alternative for many communities.

#### Outpatient Diagnostic, Treatment, Rehabilitative and Therapeutic Services

Transitional services before and after inpatient admissions must be available in the local community to support primary care services, the continued treatment of chronic conditions and rehabilitation. Some of these include

- Outpatient diagnostic imaging and laboratory

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<sup>46</sup> Ibid.

- Physical, speech and occupational therapy
- Respiratory therapy
- Outpatient surgery
- Oncology and other follow up services

### In-home Care and Monitoring

Home health and hospice services, including visiting nurse and person care-type services should be provided.

Adequate levels of support and monitoring services to avoid institutional care settings should be provided. These services may be provided by leveraging other resources, e.g., community paramedic model or provided through more traditional home health and hospice services.

Rural PACE (Program of All-Inclusive Care for the Elderly) models should be considered as a means of reducing the need for inpatient long term care and community development in support of an aging population.

Integration with non-medical system services such as senior citizens centers as wellness centers, meals on wheels, etc. should be considered in a comprehensive local care collaboration model.

### Long-term Institutional Care

Long-term care, including skilled nursing (SNF) care, nursing facility (NF) care and assisted living (AL) care, must be evaluated in communities to determine the level of institutional long-term care to support. Many rural communities with a small hospital use the swing bed services in the hospital for long-term care while others have distinct-part nursing home units. The community should be involved in the decision of “right-sizing” the long-term care and end-of-life needs of their community.

### Transportation Services

Public transportation in many rural communities is non-existent or very limited. This factor limits the ability of residents without their own transportation, primarily the elderly and poor, to access even basic primary health care unless it is available in the home. Communities should evaluate non-emergency transportation services for health care and determine how best to meet the needs of their residents while providing reasonable access to core services.

### Proximity Criteria

In view of the differing aspects of rural communities and the need for more regionalization, distance and mileage should not be the only determinate to define service areas. Distance and mileage criteria currently present in certain regulatory and



certification requirements create situations leading to the inefficient delivery and cost of rural health services. Rather than stipulating specific mileage criteria that attempt to define specific service areas and may not adequately portray local travel, cultural or other barriers, the new system should include incentives to encourage collaboration of providers in a given community.

## **Other Concerns Unique to Rural Health**

### Health Care System Integration

Today, almost every health care provider is in a network of some kind, whether it is a more formal ownership or contractual arrangement or some sort of loose affiliation. Rural health care providers struggle to function effectively without a supporting network, which almost always involves a relationship with an urban care center. Health system integration includes a wide variety of arrangements including affiliations, mergers, acquisitions, and other types of networks that make up health care system development.

The pace of health care system integration is accelerating, but vertical integration has become more common than more patient-friendly horizontal integration. Additionally, many models of business consolidation do not correspond to clinical integration, in which patients' 24/7 access to necessary care must remain a priority. In rural health care, "networking" is generally perceived as a positive, cooperative process, whereas "ownership" and "consolidation" are usually understood as more negative, exploitative relationships. However, these simple conceptions are not always true. The reflexive fear in rural communities is that an outside provider moving in implies a loss of jobs or services. It is sometimes difficult to quantify what a local rural provider does well and defend to larger systems why that service should be maintained or enhanced in the rural area. Dependent rural "spokes" often fear the pullout of the central "hub" and the accompanying loss of resources which might result in disruptions or collapse of the rural safety net—strategic selection of facilities into existing larger networks does not often align with patients' needs. The patients for whom extended travel is costly and dangerous are dependent on local care—and are sometimes the most unattractive to regional providers.

To ensure access to health services in rural America, communities should be focused on sustaining local access, not local independence—sometimes a reduced level of locally provided inpatient or specialty care may work for a community. Local providers and communities should be brought into the consolidation process early to discuss the goals of consolidation and prospectively assess health care challenges rather than make important decisions hurriedly with consideration of only short-term concerns. Community involvement and ownership is critical in this step. Additionally, every consolidation proposal should be examined on its own merits—place-based and patient-centered solutions are good, even when part of a larger system.

## Workforce and Education – Rural Training and Infrastructure

Regardless of any attention to need determination and health service planning, services cannot be delivered if they cannot be staffed. Workforce development strategies must be flexible but consistent with staffing the fundamental services addressed above. The strategies must consider the full range of possible providers, as well as variation in settings where services can be provided. It is also critical to keep in mind that the need for staff is determined by the structure and efficiency of delivery systems. Some workforce demands can be reduced by improving the systems of care.

Physician-level services are a keystone of comprehensive rural care and there are persistent rural physician shortages. At the same time, there are documented shortages of other essential health professionals such as registered nurses, mental health professionals, dentists, pharmacists, public health professionals, and allied health professionals in rural America.<sup>47</sup> Allied health professionals include occupational therapists, physical therapists, radiation therapists, respiratory therapists, pharmacy technicians, radiation technicians, respiratory technicians, dental hygienists, speech pathologists, laboratory technicians, laboratory technologists and nursing/medical assistants.

In addition, a new patient-centered workforce will be needed to help manage and coordinate seamless care of patients in the health care systems of the future. These include community paramedics, health coaches, care coordinators, patient navigators, and community health workers.

Further, skilled administrative and other personnel who do not provide direct patient care are key to an effective rural health system. These core personnel are often overlooked in the overall plan to ensure vibrant rural health services. Administrative, health information, financial and operational support staff should not be overlooked in the development of training and career paths that support rural and frontier services.

Developing specific strategies to train a broad range of health professionals supporting a community appropriate range of services as described earlier is essential to ensuring access to care in rural and frontier America. There are few financial incentives supporting rural-based health professions training and there are often financial disincentives for rural hospitals, clinics and health care professionals to become involved in such training. In addition, on the issue of primary care, we return once again to the principle of “form follows finance” —fewer medical students choose to go into rural primary care because it simply does not pay as well as being a specialist in an urban area. In addition, rural areas are not as attractive to many health care professionals of all disciplines because of the different culture, long hours, long distances and other factors that make rural unique. Access to sub-specialty care is also a problem for these reasons.

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<sup>47</sup> Health Care Workforce Distribution and Shortage Issues in Rural America, National Rural Health Association, January 2012.

Studies show that physician trainees are more apt to work in rural and primary care settings if they:<sup>4849</sup>

- have a significant rural experience in childhood, are from lower income families and are from minority populations
- receive training in rural sites early in their education
- have extended educational experiences in rural sites.

Institutions delivering health care professions education are mostly located in urban centers. In the recent past, programs at these institutions have been developed to target admission for students with a rural background. However, these students are then required to relocate to urban areas to receive the vast majority of their education.

This urban focus of training has not proven conducive to building an adequate rural workforce. Many students from rural communities become acculturated to urban living and, as a result do not return to work in rural settings. Part of the “urbanization” of students is to disconnect from the community and family support that is an integral part of rural culture. In addition, urban-based training is often not easily accessible to individuals who, for a variety of reasons, are “place-bound” in rural communities – those who frequently have the closest ties to and knowledge of the needs and culture of those communities. Finally, urban-based training seldom includes a strong focus on building rural-specific knowledge and the special skills needed to practice effectively in rural communities.

Some health career schools have been more successful graduating students that select primary care training and residency programs and ultimately rural practice. These schools utilize rural training sites for students to receive ever increasing portions of their education in rural health care settings. There is a wide variety of solutions to increasing rural exposure, but there are some common elements contributing to the success in the various programs. The solutions include

- Admission programs that target students most likely to work in rural areas
- Fostering rural culture and de-stigmatize rural background during education
- Creating a health careers culture that values comprehensive primary care provision
- Early and continuous rural educational experiences
- Frequent or prolonged educational experiences in rural settings
- Capacity building and financial support of Graduate Student and Residency training in rural settings – Rural Training Tracks and Residency Programs
- Financial incentives for primary care choice and rural practice
- Tele-health support of rural training and access to specialty consultation services

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<sup>48</sup> Phillips RL Jr, Dodoo MS, Petterson S, et al. Specialty and geographic distribution of the physician workforce: what influences medical student & resident choices? Washington, DC: Robert Graham Center, 2009.

<sup>49</sup> Rabinowitz HK et al. “Medical School Rural Programs: A Comparison With International Medical Graduates in Addressing State-Level Rural Family Physician and Primary Care Supply,” *Academic Medicine* 2012;87:488–492.

Training students in rural sites is an absolute requirement if there is any hope of addressing workforce shortages in rural health care. The future of rural health hinges on this pivotal point.

Currently, there are no direct financial incentives for rural sites to provide educational experiences for students. Direct funding strategies for health professions student and medical resident education in rural settings must be an integral part of the vision for a comprehensive sustainable rural health delivery system. Programs and policies need to be developed to address the disincentives to educating the future rural health care workforce. Funding and administrative support for implementing successful strategies including Rural Training Tracks, rural-based Teaching Community Health Centers and Rural Health Clinics, and rural-focused Title VII and VIII grant programs must be robust and consistent. Such support should also be available to test and implement innovative collaborations including rural hospitals, Community Health Centers, Rural Health Clinics, and health care professionals that develop rural-based centers of excellence training a variety of health care professionals for effective rural practice.

In addition to increasing the rural health care workforce, rural-based student education can provide other benefits for rural communities and health systems. Students energize the health care system. Clinical teachers are stimulated to keep current. Engaging students from multiple professions can be very effective in fostering the development of collaborative inter-professional teams that will be required for future practice models including the patient centered medical home. One innovation would be to identify high utilization patients with increased health care needs and offer them care in an integrated setting. Early studies show that these patients benefit from the multi-faceted team care that can be provided in such an environment. Students function and learn well in these settings and can provide the extended time with patients needed for success. The expected result would be a decrease in emergency department visits, reductions in redundant or dangerous prescriptive practices and a decrease in hospital admissions for patients with chronic diseases - all leading to lower costs and the promise of improved health.

Local and regional educational institutions will likely be challenged to accommodate the training required to meet the continuing need for health professionals in rural America. However, with significant investment and attention to comprehensive rural training we can assure there are sufficient numbers of trained professionals available as part of a vibrant and effective rural health infrastructure.

### **The Role of Electronic Technologies**

The future of rural providers is unequivocally tied to the evolution of electronic technologies that will sustain and expand local access to services, improve quality, and provide clinical and managerial data that will support informed decision-making. Electronic technologies are transforming rural delivery systems and this trend will accelerate. Multiple components of the delivery and referral systems are becoming electronically connected (e.g., electronic medical or health records, and networked data

systems ) and technologically supported (e.g., by eICUs systems, remote EKG reading, PACS, teletrauma, telestroke care and other EMS supportive systems, video-supported pharmacy systems, telebehavioral health, telemedicine access to specialty services (e.g., oncology and dermatology), practice-supportive hand-held technologies and home-based care systems among others.

The availability of data is expanding logarithmically. There will be a need to greatly advance the ability to analyze and to then use the information obtained. The advancement in information bases will greatly reshape the future of health care delivery and other strategies to optimally influence the health of populations.

While providers agree that data is one of the most valuable parts of their organizations and will shape the future of health care, infrastructural, regulatory, and financial barriers make Health Information Technology adoption and implementation difficult in rural areas. Gaps in adoption of electronic medical records (EMR) and health information technology (HIT) between urban and rural providers are already apparent and will likely continue to grow.

The development and expansion of telemedicine presents both a challenge and an opportunity for rural health systems as they try to determine the appropriate role of telemedicine and what payment structures can be leveraged to achieve that outcome. Currently, the distribution of risk in the delivery of care falls disproportionately on rural providers and remains a poor fit for fee-for-service due to a lack of payment for physicians, licensure issues, and an insufficient business case.

Historically, what is envisioned in policy and what is decided by federal or state administrations has been profoundly disconnected from what actually occurs in the rural providers. While infrastructure and broadband access is still a problem for rural facilities, the greater challenge is to encourage rural providers to embrace EMR. Rural hospitals lag behind urban institutions in nearly every measure of meaningful use.<sup>50</sup> The United States Government Accountability Office documented that acute care hospitals were more than 2 times more likely than critical access hospitals to have been awarded an incentive payment that documents the attestation of meaningful use.<sup>51</sup>

As more rural providers incorporate HIT systems into their practices and hospitals, information technology should take on a more meaningful role than a replacement for paper records. Using the EMR to improve integration across the care continuum, a rural health system must focus on making the primary care provider the central focus while determining the appropriate role of data sharing across providers in navigating Health Insurance Portability and Accountability Act regulations.

Implementation of telemedicine and HIT should be married processes because the most

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<sup>50</sup> McCullough J, Casey M, Moscovice I, Burlew M. Meaningful Use of Health Information Technology by Rural Hospitals. *Journal of Rural Health* 27(2011) 329-337

<sup>51</sup> Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011, GAO-12-778R, July 26, 2012. <http://www.gao.gov/products/GAO-12-778R>

significant use for rural HIT is telemedicine, which allows rural patients and providers access to greater resources at little geographic inconvenience. Part of making HIT work in rural settings will be engaging patients and their families to help them understand how HIT benefits them by creating new access points for patients through 24-hour nurses' hotlines, consulting with specialists remotely, etc.

For HIT to become a sustained investment in rural health systems, an evidence base for the value of the technology must demonstrate that telemedicine can make resource use (e.g. avoided transfers) more efficient. Making the business case for telemedicine is critical for its adoption, and thus payment policy should be a major focus.

### **Innovative Approaches to Improving Access, Quality and Cost**

The federal government has supported a variety of programs addressing this tri-partite goal. Several are specifically designed to engage rural providers and communities and address the unique needs of rural America. Most recently, Accountable Care Organizations have been given incentives from CMS to include both Federally Qualified Health Centers and Rural Health Clinics within their provider mix and advanced payment mechanism strategies have been added for small rural provider capacities to lessen capital needs. Several CMS Innovation grants have been awarded to rural communities as parts of regional or multi-state initiatives designed to impact rural communities. The results of these special projects can provide valuable information on how rural communities which are parts of larger collaboratives can become engaged in future health care systems. Additionally, the Health Resources and Services Administration has supported several special projects targeting rural communities to address a variety of infrastructure needs such as Health Information Technology, Workforce Development, Rural Health Network Development, and Quality Improvement Processes.

Perhaps the most successful innovative rural health model supported by the federal government has been the Critical Access Hospital (CAH) and Rural Health Clinic programs which have been implemented in virtually every state with rural populations, maintaining access to local hospital and primary care service capacities. Future pathways to change for rural communities can be guided by the concepts demonstrated in these national programs, which are keys to successful implementation. Specifically, the CAH program was designed, tested and funded at the state/rural community level; adjusted and expanded to a multi-state demonstration project, adjusted once again, and then implemented nationally.

In 1988, the Montana Hospital Research and Education Foundation designed a demonstration of a type of hospital called a Medical Assistance Facility (MAF) that received cost-based reimbursement from Medicare. MAFs were isolated, limited-service hospitals that could admit patients for no more than a four-day length of stay. In 1989, Congress authorized the Rural Primary Care Hospital (RPCH) program, a second demonstration program whereby small, rural hospitals would receive cost-based payments from Medicare. In 1997, the Balanced Budget Act of 1997 merged the MAF and RPCH programs into a new category of hospitals called the Critical Access



Hospital. CAHs received cost-based inpatient and outpatient payments from Medicare. Numerous adjustments have been made since that time and as of September 30, 2012 there are 1,330 CAHs in the nation<sup>52</sup>.

This process took nine years to develop a national model and approximately ten additional years to reach “full” implementation, including resources of both grant funds and technical assistance. Evidence of success was first gathered at the local/state level, then multi-state level and then ultimately at the national level.

Health services innovation models currently being tested on a large scale have track records of success which have been prerequisites for funding on a larger scale. A challenge for rural communities is that most of those models have not been tested in rural communities, with the exception of those sponsored primarily by large urban/suburban systems. Therefore innovation has been hampered in rural communities due to the lack of rural evidence based models originating with rural providers. Exceptions appear to be the targeted models of the patient centered medical homes and care management that have been initiated by some rural providers.

A major lesson learned is that wide scale innovation in rural communities should be preceded by multi-site projects defined and tested during a “beta” phase at the local level. Unfortunately, rural innovation projects tend to include small numbers of patients, which severely limits statistical validation. On a more positive note, rural communities, due to their smaller scale in terms of number of service providers, represent communities which may aggressively address the development of integrated systems of care and innovative projects that address total costs of care.

Given these considerations and the far-reaching positive effects of the CAH program, consideration and replication of key features such as local design and multi-level testing, commitment of significant developmental resources over a minimum of five years, and current expressed willingness of the rural communities to test new models warrant attention and deliberation. An important new feature that needs to be introduced and emphasized is the importance of significant improvements in tri-partite (access, quality and cost) metrics as determinants of the best pathways to change for rural communities and providers.

The best specific pathway to such change is unclear. Financial pressures, exerted through various reimbursement mechanisms faced by both urban and rural health care providers, are the major stimulus for change, yet few innovative reimbursement models have been embraced by rural communities. Those that have been proposed by rural communities themselves range from transformational models with restructuring as their core objective to targeted transitional approaches which are designed to revise or redirect specific health care program or reimbursement policies without major restructuring of rural delivery systems. None have been implemented and tested on tri-partite impacts in rural communities, yet represent rural-based initiatives with support at

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<sup>52</sup> Flex Monitoring Team, January 10, 2013, <http://www.flexmonitoring.org/cahlistRA.cgi>

the community/provider level, reflective of the diversity of rural health care community environments.

Both transitional and transformational models are outlined in the subsequent section of this report, but as noted, none is preeminent as THE model with the most potential for successful implementation. As a result, perhaps a simpler prescription for change exists: a flexible framework which does not add yet another silo to the alphabet soup of current programs, but instead reaffirms the underpinnings and intent of the rural safety net. Such a model would be one that builds upon the existing rural provider foundation without risking the disintegration of the current delivery of core services. One alternative might be a fast-track rural health care innovation challenge grant demonstration, available to willing providers of all types, under a common set of ground rules, guidelines and measures such as:

- Based upon community needs identified through the assessment process already required of many hospitals and public health departments, augmented significantly to define the communities' most critically needed programs by the entire (not just underserved) community and a financial plan reflective of the respective model through which such services can be strengthened and maintained
- Reimbursed through expanded payments to providers, through an approved organization of their own planning and design
- Built upon evidence-based practices and designed to test the relevance of urban evidence-based practices
- Measured through proven, relevant benchmarks of quality and financial/operational efficiency, comparable to those already required of FQHC's, established by the Office of Rural Health Policy and others
- Incentivized through shared downstream savings, projected utilizing CMS' Innovation Center model, and gauged by per-beneficiary cost.

### **Incentivizing New Models of Care**

These so-called Transitional Models of Care emphasize targeted approaches to change, emphasizing adjustments in specific reimbursement mechanisms or federal policies or procedures. The commonalities are the intent to strengthen rural providers and systems of care through targeted waivers or modifications to existing regulations and payment mechanisms. Below is a broad breakdown of potential options, each designed to assure core services without unnecessary duplication:

1. Expansion of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) programs, in communities without or in close collaboration with a local hospital, allowing for services beyond the traditional scope of service of

- a primary care provider including respiratory therapy, physical therapy, home health, etc. to be appropriately monitored and reimbursed.
2. Transition of some CAH, rural PPS hospitals, and RHCs, already operating under community governance structures, to fast track to the FQHC look-a-like model with or without Frontier Extended Stay Clinic options as appropriate.
  3. Increased subcontracting with RHCs and CAHs by FQHCs to provide care to the uninsured
  4. Waiver or modification of CAH cost allocation regulations, allowing investment in integrated community services including a broad range of primary care activities including prevention, wellness and care coordination activities without negatively impacting cost-based reimbursement on inpatient, outpatient or swing bed services.
  5. Broaden the interpretation of FQHC new access point service areas for frontier communities to include non-contiguous communities as a way to improve efficiency by spreading overhead and centralizing administrative and support functions.
  6. Increase RHC and FQHC cost limits to include a reasonable factor for increased cost associated with Health Information Technology, the Patient Centered Medical Home model of care and other care coordination and chronic disease management practices.
  7. Recognize community paramedic services as covered services with appropriate payments.<sup>53</sup>
  8. Improve coverage criteria, ease licensing restrictions and improve payments for telehealth services to enable more usage.<sup>54, 55, 56</sup>
  9. Provide SCH and MDH a reasonable payment add-on, above base year hospital-specific rates, for allowable investment in Health Information Technology, care coordination and chronic disease management.
  10. Improve the Frontier Extended Stay Clinic (FESC) modeled in the demonstration project by:<sup>57</sup>
    - Removing or reduce the 75 mile restriction
    - Providing a start-up funding mechanism

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<sup>53</sup> Principles for Community Paramedicine Program, National Rural Health Association, September 2012

<sup>54</sup> Telehealth Reimbursement, National Rural Health Association, May 2010

<sup>55</sup> Telehealth Provider Credentialing, National Rural Health Association, May 2010

<sup>56</sup> Streamlining Telemedicine Licensure to Improve Rural Health, National Rural Health Association, February 2013

<sup>57</sup> RUPRI, Frontier Extended Stay Clinic Evaluation, 2013

- Providing alternative payment mechanisms for additional services and make recommended changes to demonstration project payments
  - Allowing providers to practice at their optimal level of licensure, education and experience.
  - Pending improvements, FESC should be made available on fast-track certification to other clinics or CAH that wish to convert.
11. Investigate the opportunity of rapidly expanding the Program of All-Inclusive Care for the Elderly (PACE) programs in rural areas to accommodate all-inclusive care to the elderly.
  12. Reevaluate all rural payment programs to assure reasonable payments for low-volumes created by sparsely populated communities that create significant “stand-by” costs based on regulatory requirements.
  13. Accelerate the expansion of school-based health centers that are necessary to promote health and wellness in school age youth.
  14. Provide incentives to rural providers that demonstrate “downstream savings” through changes in the patient delivery system.
  15. Develop a demonstration project for frontier communities served by CAHs, RHCs, or FQHCs to test the importance of a "special payment to maintain access" referenced in the MEDPAC Report of June 2012.

The bottom line: A strong and comprehensive primary care system should be incentivized either through further development of existing categories of Medicare certification and adjustments to existing payment structure as described above or through a new definition of comprehensive rural health services in order to create health system efficiencies, reduce costs and focus on improve health. This could also include flexibility through targeted waivers or modifications to existing regulations and payment mechanisms, supporting investment in key care management strategies and improved operating efficiency leading to greater value for patients and the payment system.

## Transforming Existing Models of Care

While some advocate incremental transition, others believe the current system must be truly transformed if we are to achieve the goals of health reform.

Transformational options identified include:

1. Care Collaboration Model outlining a rural ACO-like organization responsible for patient-centered care and shared responsibility, built around assessing community need and design specific intervention strategies based on utilization, cost and health outcomes goals, eliminating the concept of risk in small populations by focusing on outcomes based incentives.

2. Intermediate Health Center model bridging historic Critical Access Hospital requirements with Patient Centered Medical Home or other integrated or comprehensive primary care goals.
3. Virtual Community Health Center, replacing bricks and mortar with comprehensive primary care focused systems including care coordination and chronic disease quality measurement through Health Information Exchange.
4. Commercial payer engagement in transition to new payment systems, forming regional “accountable care-like organizations” to secure rural providers including at least physicians and rural hospitals a seat at the table.
5. The National Organization of State Offices of Rural Health Rural Integrated Service System, defining tiered levels of minimum service expectations in communities without a hospital, with a CAH, and with an acute care hospital. The model seeks a financing model designed to achieve health reform goals at no greater cost than historically expended through re-allocation of resources.
6. Demonstration of rural Accountable Care Organization, identifying the potential of ACO’s to stabilize or destabilize the existing rural safety net.<sup>58</sup>

The bottom line: **new models of care are applicable, but only if the unique challenges of rural health delivery are understood and respected.**

## Conclusion

It is clear rural providers provide solid value, under today’s programs and structures.<sup>59</sup> In addition, rural providers are a significant driver of the economic fabric of their community. It is equally clear the current rural health safety net must be sustained as the transition/transformation under health reform is developed. To move forward successfully, a bridge between the foundations of today and the systems of tomorrow is necessary. The flexibility to construct that bridge, in keeping with community need and local determination, can best serve those who choose to live and work in rural areas across our nation.


The list of “Transitional Strategies” was identified so that, if adopted, would help insure flexibility to rural providers through targeted waivers or modifications to existing law and regulations.

Policy makers are currently moving forward with implementation of health reform. In response, there are a number of Transformational Models of Care around the country

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<sup>58</sup> Rural Hospital Participation in the Medicare Shared Savings Program, National Rural Health Association, February 2013

<sup>59</sup> Rural Relevance Under Healthcare Reform, iVantage Health Analytics, Inc., April 25, 2012



designed to achieve the goals of health reform while understanding and respecting the unique challenges of rural health care delivery.

NRHA believes the current system must be truly transformed if we are to achieve the goals of health reform in rural America. NRHA will analyze these Transitional Models of Care and others yet to be identified to better understand how they are addressing the unique needs and circumstances of rural communities and providers. From that effort, NRHA will develop a fast-track demonstration project that recognizes community needs, builds on the existing rural provider foundation and maintains the rural health safety net. This demonstration project, if funding can be obtained, will help create a bridge between the rural system of today and the health reformed system of tomorrow.

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