Delta Region Community Health Systems Development (DRCHSD) Program

Forecasting The Future

National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

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National Rural Health Resource Center

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/DEI

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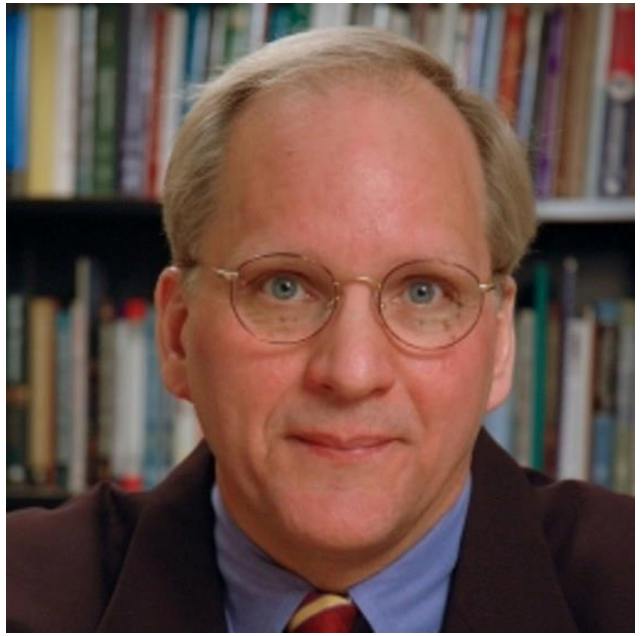
Today's Speaker / Moderator:



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Forecasting the Future: Challenges and Opportunities to Improve Rural Health Care

John Gale, MS

Delta Region Community Health Systems Development Program
January 11, 2024

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

Maine
Rural Health
Research Center

Learning Objectives

- Explore the challenges impacting rural delivery systems and describe the potential impacts on hospitals, clinics, and communities
- Discuss strategies to mitigate the impact of these challenges
  - Re-imagine rural hospitals
  - Workforce – team-based care, new staffing patterns
  - Clinical transformation and re-alignment of services
  - Cultivate a patient-centered culture
  - Focus on comprehensive primary care
  - Community engagement, partnerships, and self-determination
- Building a foundation to transform local delivery systems and prepare for the future

Forecasts for the Healthcare Operating Environment

- The system-wide shift from volume to value will accelerate as employers and insurers drive lower reimbursement and increased risk sharing with hospitals and medical groups
- Health costs, affordability, and equitable access are major issues
- The regulatory environment for hospitals will be more challenging
- Major change in the structure/financing of U.S. health system is unlikely
- The environment for large, national health insurers, major private equity sponsors and national retailers is more positive

Challenges Impacting Rural Delivery Systems

- Current
  - Increases in the pace of mergers and acquisitions
  - Loss of essential services – obstetrical care, chemotherapy, specialty care
  - Declining need for inpatient hospital care
  - Increased competition by non-hospital providers (urgent care centers)
  - Growth of value-based payment, Medicare Advantage, and managed care
- Evolving
  - An increased focus on containing healthcare costs
  - Demand for health equity
  - Evolution of “retail” and “technology” healthcare competitors
  - Continued transition of care from hospitals to the community and homes

The Crumbling Foundation of Rural Health

- COVID-19 has the exposed cracks in rural health systems
  - Increased risk of hospital, clinic, and EMS closures
  - Loss of services
  - Low investment in public health
  - Maldistribution of the rural workforce and services
  - Payment policies ill-suited to low-volume rural providers
  - Rural communities have fewer resources to respond to emergencies
  - Limited collaboration between providers
  - Failure of our market-driven system that favors urban delivery systems
  - Policy environment that does not support a systems approach to health delivery

Weaknesses of our Market-Based System

- Inhibits coordination
- Promotes wasteful competition
- Distributes services inefficiently
- Shifts planning from local to corporate levels
- Fee-for-service payment policies:
  - Fail to address rural providers' high fixed costs, inadequate cash reserves, and high reliance on non-emergent care revenues
  - Discourage delivery of high-value, low-margin services such as primary care, chronic care, behavioral health, public health, and prevention
- U.S. healthcare costs are higher and outcomes worse than other industrial countries

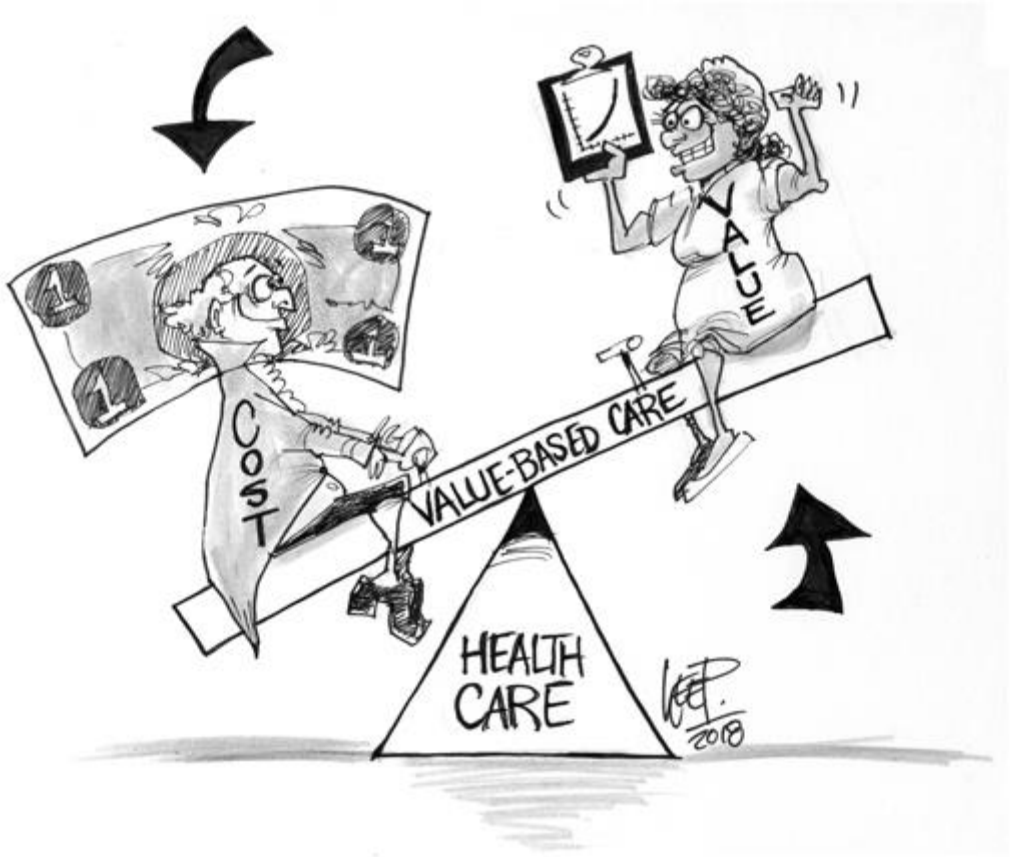
Source: Pat Bagley, Salt Lake Tribune, July 5, 2022

Patient Bypass

- 76% of patients in rural counties with a local hospital bypassed the hospital to obtain care (35% suburban and 23% urban)
- 68% of rural patients with lower acuity conditions that could be addressed at their local hospitals bypassed their local hospital
- Bypass patterns suggest:
  - Tension between the desire to save hospitals and local responsibilities
  - Need for realistic expectations about the role of hospitals – emphasize enhanced primary care, chronic care, swing beds, and long-term care
  - Over-emphasis on inpatient beds
  - A lack of understanding of the needs and use patterns of rural residents
  - Time for honest conversations between community leaders and hospital leaders

Weakness of Current Payment Policies

- To sustain low-volume rural providers, Medicare provides enhanced reimbursement to rural providers
- These programs rely on fee-for-service payment methods ill suited to small rural providers by failing to:
  - Mitigate the impact of Medicare sequestration and bad debt cuts
  - Low Medicaid and commercial reimbursement
  - Lower dependence on inpatient care
  - Declining rural populations
- Enhanced payment policies conflict with efforts to control costs (e.g., Medicare Advantage plans, Medicaid managed care)



Source: MediAxiom Blog, Value-based Care: Is it Working?, June 7, 2018. https://www.medaxiom.com/blog/value-based-care-is-it-working/

Policy Context for Supporting Vulnerable Rural Hospitals

- Concerns about rural hospital closures are not new
  - 1965 implementation of Medicare and Medicaid triggered regulatory challenges
  - Initial efforts to address regulatory issues date back to a 1973 DHEW report that first raised the issue of the limited-service hospital
- State and federal support programs have been developed in response to waves of rural hospital closures – MAF, EACH/RPCH, CAH
  - Most focus on enhanced reimbursement and regulatory relief in exchange for reductions in beds and lengths of stay
  - EACH/RPCH and CAH enhanced networking expectations

More Recent Policy Interventions

- States continue to experiment with support programs/alternative models
  - Georgia Rural Hospital Stabilization Program – hub and spoke model
  - Kansas Primary Health Center Model
  - Oregon's Community Care Organizations
  - Alaska Health Care Transformation Project
- Federal experiments with payment and delivery system models
  - Pennsylvania Rural Hospital Model
  - Vermont's All-Payer ACO Model
  - CHART, AHEAD
  - Frontier Extended Stay Clinics
  - Frontier Community Health Integration Program
- Rural Emergency Hospitals

Re-Imagining Rural Hospitals

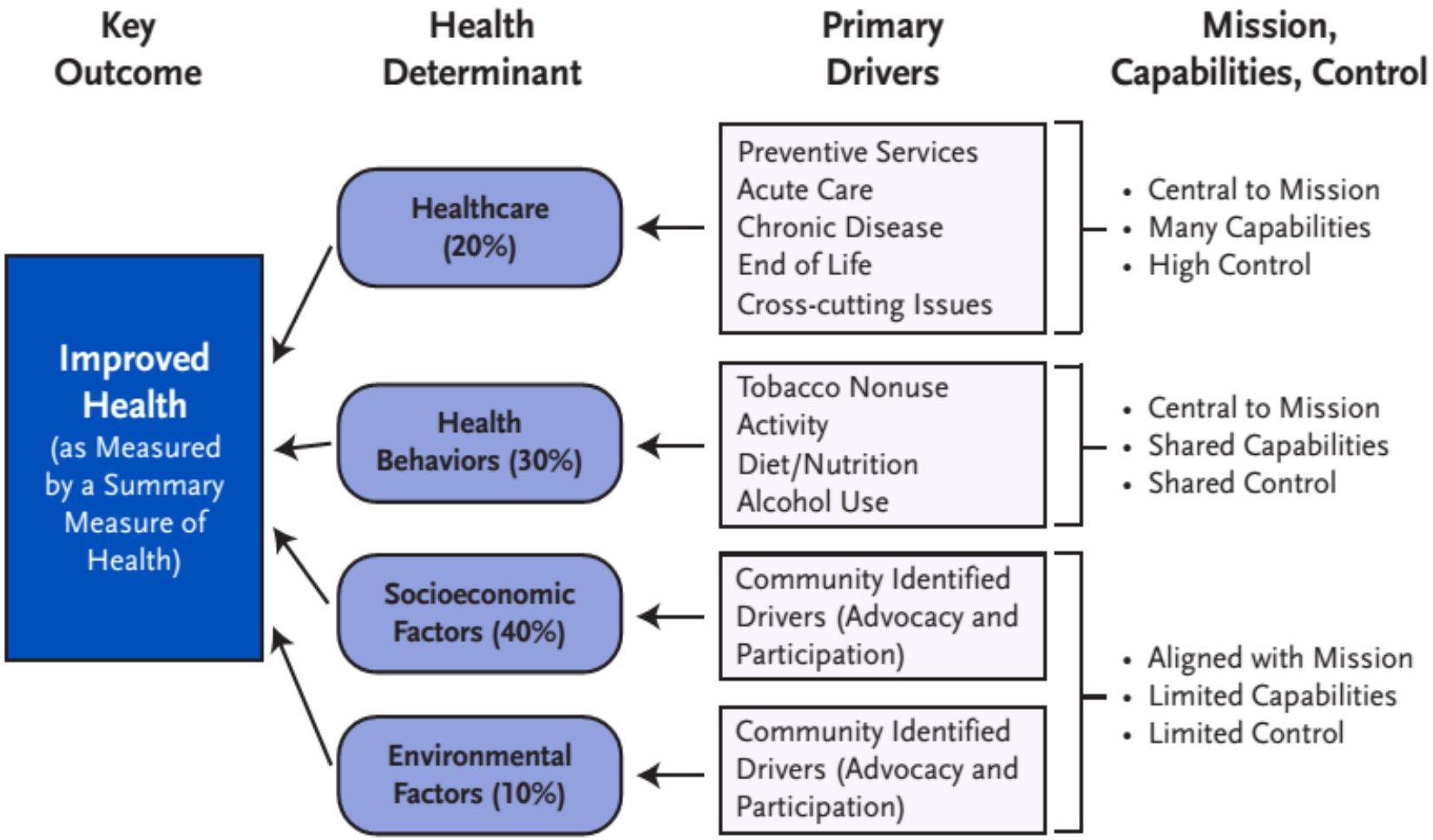
Context for Re-Imagining Rural Hospitals

- Changing delivery landscape –more services can be provided in home, ambulatory, or virtual settings
  - Estimates suggest we will have 1.6 times the number of inpatient beds needed in 2030 and that many of these beds will be of the wrong type
- CAHs are the foundations of local delivery systems and economies
  - Support the role of CAHs as “anchor institutions” and hubs of local systems of care - Hub and spoke models in Ontario and Georgia
- Create *Rural Community Health Improvement Systems* - partnerships of rural hospitals and providers based on the Accountable Communities for Health model
- Re-visit service mix to focus on outpatient and ambulatory care, long term care and support services, chronic care management within larger integrated systems of care

Hospital-Level Strategies

- Develop strategies that align with evolving trends
  - Develop a patient-centered culture
  - Enhance primary care capacity through development of rural health clinics
  - Expand high-value services–behavioral health, chronic care mg, wellness, prevention
  - Explore long-term care services and supports
  - Implement efforts to manage costs
  - Collaborate with other providers to avoid duplication of services and efficiently provide specialty services – obstetrical care, specialty care
  - Redirect community benefit and accountability efforts to address social determinants of need and health equity issues
  - Expand use of telehealth and technology
  - Consider expanded primary care and urgent care hours to meet patient needs
  - Develop a health equity strategy

Health Partners Drivers Program



Source: Kindig, D. A., & Isham, G. (2014). Population health improvement: A community health business model that engages partners in all sectors. Frontiers of Health Services Management, 30(4), 3-20.

Emphasize Comprehensive Primary Care

- David Johnson (January 2022)
  - "Americans do not receive the vital primary care, health promotion, behavioral health and care management services they require to sustain their well-being"
  - "More of the same crisis-care delivery will yield more of the same dismal health outcomes"
- Basu, et al (2019)
  - Every 10 additional primary care physicians per 100,000 people was associated with a 51.5 day increase in life expectancy from 2005 to 2015, compared to a 19.2 day increase for 10 additional specialists
- Primary care is necessary to achieve the quintuple aims of health care – enhanced patient experience, better outcomes, lower costs, improved clinician satisfaction, and improved health equity

Strategies to Build Comprehensive Primary Care

- Build Comprehensive Primary Care Services
  - Primary care, wellness and prevention, mental health and substance use, chronic care management, oral health, public health
- Expand services
  - Utilize Rural Health Clinics and other ambulatory services– develop additional sites and expand range of services
  - Focus on population health and social determinants of health
  - Align with hospital accountability requirements - community benefit, community health needs assessment, and implementation requirements
  - Partner with health systems and local providers to expand key services

Health Equity Strategies for Rural Providers

- Growing demands will require rural providers to develop health equity improvement strategies
- Key – focus on issues within provider control
- Strategies for hospitals to consider
  - Examine and modify hiring strategies and policies to ensure a representative workforce and a supportive work environment
  - Work with providers and staff to develop “cultural humility” and recognize the impact of their cultural biases on patient care
  - Develop community benefit and service strategies to address the needs of the vulnerable residents in their communities
  - Recruit members from vulnerable populations to serve as a “bridge” to understand and address their needs

Examples of Rural Health Clinic (RHC) Mental Health Services

- Regional Medical Center (RMC), Manchester, IA
  - RMC has 5 RHCs that provide an expanded array of primary care and mental health services primary care in rural Iowa
- Weeks Medical Center (WMC), Lancaster, NH
  - WMC has four RHCs providing comprehensive primary care, mental health, and substance use services throughout the Lakes Region. The mental health program was described as the fastest growing department in the WMC system
- Ozarks Community Hospital (OCH), Gravette, AR
  - OCH operates 12 RHCs and two other clinics in rural Arkansas, Arkansas, and Oklahoma that serve primarily Medicare and Medicaid patients. Most of its 12 RHCs provide comprehensive primary care as well as mental health services

Examples of a CAH-Based Mental Health Services

- Nor-Lea General Hospital
  - Created Heritage Program for Senior Adults in 2003
  - Provides O/P mental health services to seniors
  - Staff-psychiatrist, therapists, RN, and MH technicians
  - Services: individual and/or family therapy and group therapy, both focus and process
  - Van is available to transport clients to the hospital for services
- Essentia Health St. Mary's
  - Collaborative Care Mgt of Depression in Primary Care
  - Priority need identified in CHNA
  - Team approach- behavioral health specialist, psychiatric nurse practitioner, care coordinator
  - Coalition of EH-St. Mary's and community mental health professionals
  - Community outreach and education

Examples of a CAH-Based Oral Health Program

- Waldo County General Hospital,
  - Board stretch goal–create dental program in 2013 to serve safety net clients
  - Staffing: Dental hygienist, employed dentist, private dentists. dental assistant, receptionist, Access-to-Care coordinator, CarePartners staff
  - 700 individual patients, $203 average cost per visit, most had no dental care in 10
  - Funding: hospital funds, grants, fundraising, in-kind contributions, patient co-pays, some Medicaid
  - Reduced ED use – 20% of ed visits for 18-49 year olds for dental pain / no safety net program in county/$100,000 in uncompensated care annually
  - Improve patients' overall health, employability, and personal well-being.
  - Dentist shared with program in Knox County
  - Planning/advisory board: Board members, private dentists; public health hygienists; physicians; denturists

Examples of a CAH-Based Wellness and Prevention Services

- New Ulm Medical Center
  - Heart of New Ulm Project applied evidence-based practices
  - Reduce # of heart attacks over 10 years
  - Collaborates with Minneapolis Heart Institute Foundation, local employers, providers
  - Results: Improvements in consumption of fruits and vegetables, taking daily aspirin, participation in exercise
- Redington Fairview General Hospital
  - Redington Fairview houses the Greater Somerset Public Health Collaborative
  - Developed community-based employee wellness program for very small businesses
  - Small businesses can offer workplace wellness activities that would not normally be economically feasible for groups their size (cost is $2.00 annually per employee)
  - Developed other programs with grant funding

Workforce Issues -Primary Care and Behavioral Health

Primary Care Workforce Challenges

- Rural areas face a chronic shortage of primary care services due to an insufficient supply of new primary-care physicians, an aging workforce, and a maldistribution of physicians across urban and rural areas
  - In 2017, the GAO estimated shortages of more than 20,000 primary-care physicians in rural areas by 2025
  - In 2020, the Association of American Medical Colleges estimated that the primary care gap could widen to 55,200 in the US by 2033 (Estimates do not reflect lower levels of care received by rural populations)
  - To achieve health equity and reach population health goals for body weight, blood pressure, cholesterol, blood glucose, and smoking, the AAMC estimated that an additional 10,130 primary-care physicians are needed in rural areas
  - Growth of nurse practitioners and physician assistants can potentially offset physician shortages but are inequitably distributed across urban and rural areas

Behavioral Health Workforce Challenges

- Rural communities have some of the largest need for behavioral health care providers and the lowest availability
- 60% of rural Americans live in a mental Health Professional Shortage Areas
- 90% of psychologists and psychiatrists and 80% of social workers practice exclusively in metropolitan areas
- Rural behavioral health providers tend to be generalists and address a wide range of issues
- Rural residents rely on primary care for behavioral health services
- They also must travel longer and have fewer choices of providers

Addressing Workforce Shortages

- Key – better use scarce resources
- Expanding the use of team-based care
  - Asprius Keweenaw Hospital – implemented a successful team nursing model utilizing nurse interns, nursing technicians, licensed practical nurses, and certified nursing assistants to mitigate nursing shortages
- Explore new staffing types – community health workers
- Use telehealth, AI, and evidence-based clinical guidelines to expand access to care, transform clinical paradigms, and improve provider productivity
  - Forward in Los Angeles, CA - uses artificial intelligence and predictive analytics to reduce payroll costs and create better outcomes for patients. Uses AI to follow what doctors do, step-by-step.
  - Use telehealth technology to improve productivity and reduce the emphasis on 15-minute visits, particularly for chronic care management

Community Engagement and Collaboration

Community Engagement and Ownership

- Implement community engagement tools to assist communities in taking control of their health systems
  - Reducing loss of community input and control
  - Reducing bypass behavior
  - Improve population health and health equity
- Informed Community Self-Determination Model was developed to engage residents in making informed decisions about their EMS systems through:
  - Assessment of the reality and adequacy of the current EMS system (response, operational, and financial characteristics as well as clinical level and performance)
  - Alternative models and cost impact (what levels of services and response capacity, outside of the box alternatives, costs of each alternative)
  - Decision makers forum (broad interests, reports from meetings, straw poll)
  - Choose operating model and commit to funding (designate follow up reporting)

SourceSource: Hospital Research Education Trust, Managing Population Health, The Role of the Hospital, AHA, 2012

Example of Community Leadership

- Mt. Ascutney Hospital and Health Center
- Create partnerships, give away credit, promote open communication, decentralized control
  - Partnering to support community health infrastructure
  - Addressed fragmented/decentralized services
  - 14 health promotion programs implemented; trust improved
  - Challenges–skepticism over control/management
  - Mission-promote community health/wellness
  - Activities funded over time by different grants
  - Key factors-assessment/evaluation, community health metrics
  - Clear, consistent dedication to mission

Regionalization of Services

- Regionalizing high-cost services complements local/state health planning
- Rural hospitals compete in “medical arms races” for specialty and diagnostic services, resulting in duplication and inefficient resource use
- Regionalization involves “rightsizing” health systems by organizing delivery of essential services locally and high-cost services regionally
- The loss of rural obstetrical (OB) services suggest an opportunity to regionalize OB care by:
  - Providing pre/postnatal services locally
  - Performing deliveries at designated regional hospitals
  - Provide supportive services to care for children and families during deliveries
  - Provide transportation to delivery hospitals

100% Community: A Community Engagement Tool

- 100% Community: Ensuring 10 Vital Services for Surviving and Thriving (Ortega Courtney and Capello), focused on developing the following services
  - Food
  - Housing
  - Medical and Dental Care
  - Behavioral Health Care
  - Transportation
  - Parent Supports
  - Early Childhood Learning
  - Community Schools
  - Youth Mentoring
  - Job Training

Ongoing Financial Concerns and Closure Risks

- The risk of closure remains high
  - 450 rural hospitals are estimated to be at risk for closure and 200 are at high risk
  - Since 2005, 179 rural hospitals have closed
- Turmoil and change are consistent themes due to COVID-19
- Hospitals and communities will need time and support to rebuild and stabilize
- Reimbursement changes are needed but may not be sufficient to stabilize rural hospitals and health systems without supporting interventions
- Concerns exist about the ability of rural providers to effectively participate in the CHART demonstration and to transition to Rural Emergency Hospitals

Opportunities to Support Rural Hospitals and Health Systems

- Payment reform that uncouples payment from FFS, covers fixed costs, supports population health, and funds the provision of essential services
- Models of care that deliver essential services and are appropriate for different rural communities
- Technology is a critical element, particularly for remote and isolated areas
- Health planning and regionalization are needed to offset the flaws in our market-based system
- Community engagement to support planning for local delivery systems and to encourage ongoing financial support/utilization of services
- Regulatory relief to reduce burden and encourage integration of services

Closing Thoughts

- Tools and resources are needed to assist rural communities in taking responsibility for the effective operation of their health systems
- Government and philanthropy can fund development of these resources
- States should explore opportunities for statewide and regional planning
- New delivery system models that emphasize comprehensive primary care as well as long-term care and supports
- New payment models must recognize the needs of low-volume providers
- Leadership and innovation are critical
- Telehealth and technology are essential to support rural systems of care
- Rural hospitals can begin to move their systems in the right direction by focusing on reducing health costs, improving affordability, enhancing patient centeredness, and providing equitable access

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