Responsive Rural Health Delivery Systems

Introduction

For decades, rural health care delivery systems have dealt with many challenges including low volumes, aging populations, poverty, health disparities, difficulties with provider recruitment, and limited capital constraining necessary investments. Today, a new set of challenges have emerged with the passage of the Patient Protection and Affordable Care Act (ACA). As the ACA aims to improve healthcare outcomes and lower costs, they will transition the current volume-based payment system to alternative payment models that tie payment to quality performance and value for 30 percent of Medicare by 2016, and 50 percent by 2018.[i] The ACA's value-oriented payment reforms are designed to improve quality and reduce waste. Among these reforms is pay-for-performance, which awards bonuses to facilities and providers who meet goals for quality and efficiency. In contrast, the current fee-for-service system compensates hospitals and physicians based on the volume of procedures and tests ordered or performed for patients. There is little financial incentive to reduce hospitalizations or the number of procedures; coordinate patient care after discharge; or prevent illness and improve community health, particularly for rural hospitals paid by cost-based reimbursement.

Some rural health care providers are also often ill-equipped to respond to public and private quality reporting requirements and improvement imperatives. Many rural hospitals and physician practices do not have the necessary health information systems, data analytics, staff, and the requisite patient-centered focus needed to implement quality improvement programs effectively. Rural health systems typically lack the capacity to pursue population health strategies such as clinical care management and community health improvement strategies. Notwithstanding, stakes have never been higher for rural providers to operate successfully within value-based payment criteria, while simultaneously establishing new care model designs and capabilities needed to manage the health of their rural patient populations.

This paper will discuss elements of a responsive rural health delivery system that moves beyond the comfortable "hold harmless" approaches to "hold accountable" models. Together, these elements aim to yield a better return on public investment, measurably improve health outcomes, and further the ACA's framework of the Triple Aim providing better care, improving health and lowering costs, a framework developed by the Institute for Healthcare Improvement (IHI).[ii]

Current Landscape

The ACA undeniably increased access to health care services. Since 2010, health insurance marketplaces implemented under the ACA have enrolled 16.4 million Americans for health

insurance coverage, intensifying demand for health services, especially in rural counties where 77 percent are designated federal Health Professional Shortage Areas (HPSAs) for primary care, mental health and dental services.[iiiiv] Limited provider availability is compounded by rural economics, demographics, lack of transportation, and disparate health status.[v] Rural communities have less economic opportunity, higher uninsured rates, and lower incomes than their urban counterparts, which lead to a greater number of rural persons relying on public insurance. Furthermore, rural populations report a higher prevalence of chronic conditions related to an aging demographic. Due to the poorer and older population mix commonly found in rural areas, the reimbursements to rural health providers are disproportionately affected by public payer policies. This landscape compels vulnerable rural health systems to reconsider service delivery models that leverage hospital and community resources, improve care coordination and transitions between care settings, minimize duplicative efforts, and align strategic direction across local level sectors to improve population health and address upstream determinants of health (e.g., low income, inadequate housing, limited transportation options, food insecurity, and low educational attainment).

The ACA set into motion an expeditious goal to tie provider payments to alternative payment models but still exclude rural providers by not requiring them to meet the same rigorous quality benchmarks as their urban counterparts. A recent report issued by the National Quality Forum's Rural Health Committee recognizes exclusion policies such as this as harmful and made the following recommendation: "Make participation in Centers for Medicare and Medicaid Services (CMS) quality measurement and quality improvement programs is mandatory for all rural providers".[vi] The Committee further supports the recommendation by arguing that rural providers will financially benefit from systems that accurately document and measure their performance. Yet, rural health policy and payment systems are not aligned with the Triple Aim. Cost-based reimbursement, for example, does not incentivize value-based models that invest less in technology-intensive medical services and more in health promotion, care coordination, improved clinical care quality, enhanced patient safety and experience, and better population health at lower per capita costs. Paradoxically, rural providers are, by nature, well positioned to achieve high value care. Rural health care systems are smaller and nimble in making the kind of change necessary to succeed in the current environment. New delivery arrangements may be pursued more easily among local clinical, behavior, and public health providers who know and trust one another. Together, they share a collective interest in improving their community's well-being.

Essential Elements of an Accountable Rural Health System

Accountable rural health systems are predicated on a robust primary care base that integrates medical, dental, and behavioral health care; human services; community health; and other services affecting rural quality of life.[vii] The Rural Policy Research Institute's Rural Health Panel

identified five important components to a high performance rural health care system. These include:

1. Affordable
   A high performance rural health care system should be affordable to all members with the costs not being so much as to impoverish those who need to access the system. To ensure no disparities in affordability arise, health care costs should be equitably shared across individuals in rural communities.
2. Accessible
   Closely linked to affordability, accessibility to primary care, EMS services, and public health is at the foundation of a high performance rural health care system.
3. Community focused
   A disproportionate number of rural residents have chronic health conditions, are elderly, and lack health insurance coverage. Through the ACA, more rural residents have access to preventative and screening services that stem the impact of these community-wide chronic conditions. Wellness, personal responsibility, and public health are tenets of a high performing rural health delivery system.
4. High quality
   Quality health services leads to an efficient delivery system and is integral to high performance. Payments tied to quality make the high performance rural health delivery system sustainable by incentivizing efficiency and penalizing volume-dependent waste.
5. Patient centered
   A high performance rural health delivery system centers the care team on the patient to eliminate gaps in health care, especially in times of transitioning the patient between providers.

Challenges unique to the rural condition exist in achieving a high-performing rural health care delivery system. These challenges include:

- Statutory exclusions
  The ACA and CMS aim to meet alternative payment goals that require participation in a variety of efforts to tie payment to quality. Many rural providers and facilities are currently excluded from participation due to their low volume falling short of attribution requirements. As well intended as this allowance is, mandatory participation, through a scale-up onboarding process, would improve long-term outcomes of a rural health care delivery system.
- Lack of rurally relevant measures:
  As rural providers and facilities payments are mandatorily tied to quality measures, it is paramount that these quality measures reflect and are sensitive to patient population treated in rural areas: i.e. low volumes of more at-risk patients more often covered through Medicare and Medicaid payers than urban populations.
- Limited resources to make needed value-based transitions:
  It needs to be recognized that many rural providers and facilities do not have the same resources available to make all the changes demanded by a high performing rural health care delivery system. These include electronic information systems and operating budgets to support care coordination activities. Grants and technical assistance should be available to these providers and facilities during this time of transition.

- Workforce shortage, both number and type:
  A widespread challenge for rural health care facilities is recruiting and retaining health care professionals. This limits the rural health care workforce by both volume of professionals available and expertise of health care professionals.

Policy recommendations

This brief presents policy recommendations of an accountable, high-performing, responsive rural health delivery system that align with the Rural Policy Research Institute.

1. **Affordable**: A responsive rural health delivery system recognizes the impact that factors outside the health care system have on health. Eighty percent of health is determined by physical environment, health behaviors and socio-economic factors.[viii] The rural health system is affordable in that it prioritizes prevention and wellness (physical, oral health, mental health/behavioral health) as a foundation of its service delivery model which leads to more efficient systems promoting cost saving measures for the long term. An affordable system recognizes that good health in turn enhances quality of life; improves workforce productivity; increases the capacity for learning; strengthens families and communities; supports sustainable communities; and contributes to poverty reduction.

2. **Accessible**: A responsive rural health delivery system has an accessible primary care system that is incentivized to create health system efficiencies, reduce costs and focus on improving health. The primary care providers are part of a network of providers focused around organized care principles that prioritize care coordination functions resulting in high-quality care outcomes. Further, it has the capacity to meet the needs of high-risk patient populations through a comprehensive care management infrastructure.

3. **Community focused**: A responsive rural health delivery system recognizes that impacting the health of a community requires collaborative efforts across many sectors at the local level. This includes clinical and behavioral health providers, public health, education, local businesses, and community-based organizations. Together, they can solidify their infrastructure by using local population health indicators to establish health priorities and align their strategic directions across agencies. Rural communities develop, support and sustain community practice transformation, such as Patient Centered Medical Home and primary care and behavioral services integration. Further, they create opportunity to test alternative payment models designed specifically to stabilize and strengthen the rural health care system as a whole.

4. **High quality**: The ultimate goal underlying health care performance measurement is to improve health care outcomes. The capacity to measure quality improvement should be a fundamental component of any responsive rural health delivery system. This includes the development and acquisition of appropriately scaled quality-enhancing knowledge, skills, and health information technology (HIT). Resources such as (1) appropriately trained and dedicated staff, (2) accurate and timely data, including clear and actionable performance reports, (3) basic and ongoing educational opportunities, (4) sustainable quality improvement processes with measureable metrics of success that are relevant to rural settings, and (5) an organizational culture of continuous performance improvement are all critical components of

a strategy to "improve clinical quality."

5. **Patient-centered**:
   Size and agility of rural health systems can be advantageous in meeting new health care demands and alternative payment models. Responsive rural health systems that are patient-centered with the capacity to manage population health will be well-positioned to succeed in ACA reforms. In a patient-centered care model, providers commit to care coordination and redesigning delivery of health care to ensure high-quality, evidence-based health care is delivered, errors are minimized, and unnecessary care eliminated. The care coordination extends past the episode of care to a whole-person approach with overreaching goals of health advocacy, safer medical systems, and greater patient involvement in decision-making about treatment options.

Summary and Conclusion

The ACA and alternative payment models create unprecedented opportunities to develop sustainable rural health care systems designed to meet the health needs of local populations. A responsive rural health care delivery system is achievable. Yet, rapid change requires preserving access to essential health care services while transitioning to value-based models of care, otherwise rural communities may suffer. Continued evaluation of policy considerations and of newly executed rural demonstrations that redesign the local rural health care system are needed to identify and replicate successful and effective models of care while mitigating unintended consequences.

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