A Plan for Transforming Rural Health in Nebraska

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Outline of presentation

- Major forces of change impacting the rural health system
- Purpose of the plan
- Major health needs and challenges
- The elements of a high performance rural health system
- Major policy recommendations

Major Forces of Change Impacting Rural Health

Continued workforce shortages hinder access
New payment and delivery models (PCMHs and ACOs) that emphasize value over volume
Proposed federal legislation would create greater financial barriers and reduce revenue
Consolidation can create new opportunities or produce an adverse impact
New technology (e.g., telehealth) provides new opportunities but is not a panacea
Purpose of the Plan and Methods

Purpose: Provide a blueprint for improving health of rural populations and making delivery system more accessible, coordinated, and sustainable.

Reviewed data and information on health status and access barriers.

Conducted 5 focus group interviews with over 40 people asking about major challenges and potential solutions.

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Major Rural Health Needs and Challenges

- Declining and older population; continuing outmigration of younger workers
- Falling farm and ranch prices have negatively impacted the economy
- Good and bad news on health indicators:
  - Higher mortality rates for heart disease, unintentional injuries, and motor vehicle crashes
  - Lower mortality rates for cancer overall, lung cancer, and chronic lung disease

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Major Health Needs Continued

- Based on the 2011-2014 results from the BRFSS survey, rural residents were:
  - Less likely to have cholesterol checked in past 5 years
  - Less likely to be screened for colon and breast cancer
  - More likely to use smokeless tobacco
  - More likely to be obese
  - Less likely to have visited the dentist in the past year
  - Many of these challenges reflect shortages of health professionals and affordability of insurance coverage
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**Challenges Identified in the Focus Group Interviews**

- Significant shortages of health professionals; PAs and NPs are the exception
- Shortages of physicians will be magnified because of retirement and younger physicians working fewer hours
- There are serious behavioral health issues: acute workforce shortages, uncoordinated care, and limited translational services
- The lack of insurance coverage for dental services has increased hospital ER use

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**Hospital operating margins have trended downward:**

- Declining population and low inpatient volumes
- Sequestration of Medicare payments
- Higher costs (investment in EHRs)
- Changing regulations (% of bad debt allowed)
- Shift to value-based purchasing (ACOs)
- More high deductible plans have increased uncompensated care

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**Hospital Challenges Continued ...**

- Workforce shortages lead to higher salaries
- Payer mix – reliance on Medicare funding
- Outmigration of patients
- Lack of Medicaid expansion
- Net Result: Most CAH margins are dropping and closure for some is a distinct possibility
EMS Challenges

There is a growing demand for EMS services, but the decline in volunteers has led to long delays in some areas.

Workforce shortages have created heavier workloads along with more stress and burnout.

Some EMS units have low volumes which tends to impact quality of care.

There is often a lack of coordination between EMS units and between EMS units and other providers (hospitals).

Technology Challenges

The telehealth infrastructure needs to be upgraded and broadband access is a major issue.

Many physicians do not use telehealth even when available.

EHRs have been expensive, not always easy to use, and some vendors are unable to meet all of the meaningful use requirements.

Strengthening and Transforming the Rural Health System?

Develop an integrated system that has a shared goal of improving patient and population health outcomes.

Integration means the linkage of programs and activities and not necessarily a single organization.

Form a diverse coalition to identify and prioritize health needs.

Think beyond medical care and focus on ALL determinants of health.
**Reducing Preventable Deaths**

The CDC reported that as a percentage of all deaths:

- 30% of heart disease deaths are preventable
- 15% of cancer deaths
- 43% of unintentional injuries
- 36% of chronic lower respiratory disease
- 28% of strokes

**U. S. Spending by Disease Condition (2016 JAMA Study)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>$101 Billion</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>$88 Billion</td>
</tr>
<tr>
<td>Lower Back and Neck Pain</td>
<td>$88 Billion</td>
</tr>
<tr>
<td>Hypertension Treatment</td>
<td>$84 Billion</td>
</tr>
<tr>
<td>Falls</td>
<td>$76 Billion</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>$71 Billion</td>
</tr>
</tbody>
</table>

**Key Elements of an Integration Model**

- Great leadership and a shared vision among the stakeholders
- A competent interdisciplinary workforce
- The ability to share information
- Continuous evaluation of performance outcomes
- Collaboration and linkages across the continuum
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Applicability of the Model to Nebraska

- Using a conservative estimate, the number of physician clinics that are PCMHs or members of an ACO is over 150.
- All LHDs and nonprofit hospitals have developed CHNAs, set priorities, and created implementation plans.
- Effective linkages already exist between LHDs, physician clinics, and CAHs.

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Comparison of Levels of Patient Communication and Data Usage between PCMH Clinics and Non-PCMH Clinics, Nebraska, 2017

<table>
<thead>
<tr>
<th>Specific Area</th>
<th>PCMH No.</th>
<th>PCMH %</th>
<th>Non-PCMH No.</th>
<th>Non-PCMH %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Each patient has the opportunity to select his/her primary care physician.</td>
<td>56</td>
<td>95%</td>
<td>46</td>
<td>68%</td>
</tr>
<tr>
<td>The primary care physician is responsible for providing or arranging for all health care services.</td>
<td>49</td>
<td>83%</td>
<td>28</td>
<td>41%</td>
</tr>
<tr>
<td>2. Each member of the interdisciplinary team has clear roles and responsibilities and is involved in goal setting and making decisions about the patient's treatment plans.</td>
<td>50</td>
<td>85%</td>
<td>30</td>
<td>44%</td>
</tr>
<tr>
<td>3. The clinic can demonstrate that the patient, and when appropriate the family, is involved in goal setting and making decisions about the patient's treatment plans.</td>
<td>35</td>
<td>59%</td>
<td>13</td>
<td>19%</td>
</tr>
<tr>
<td>4. The clinic provides written materials at the appropriate literacy level that explain the essential features of a PCMH.</td>
<td>40</td>
<td>68%</td>
<td>19</td>
<td>28%</td>
</tr>
<tr>
<td>5. The clinic has a formal approach for obtaining feedback from patients and families and uses this information to make improvements.</td>
<td>45</td>
<td>76%</td>
<td>29</td>
<td>43%</td>
</tr>
<tr>
<td>6. The clinic uses systematic methods to analyze quality measures.</td>
<td>47</td>
<td>80%</td>
<td>29</td>
<td>43%</td>
</tr>
<tr>
<td>7. The clinic uses quality measures to make practice improvements.</td>
<td>42</td>
<td>71%</td>
<td>14</td>
<td>21%</td>
</tr>
<tr>
<td>8. The clinic analyzes claims data on cost and quality to identify care gaps.</td>
<td>51</td>
<td>86%</td>
<td>28</td>
<td>41%</td>
</tr>
<tr>
<td>9. The clinic analyzes claims data on cost and quality to identify care gaps.</td>
<td>58</td>
<td>91%</td>
<td>40</td>
<td>59%</td>
</tr>
</tbody>
</table>

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Highest Priorities among the Nonprofit Small Rural Hospitals in Nebraska

<table>
<thead>
<tr>
<th>Specific Area</th>
<th>% of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral/mental health/substance abuse/suicide</td>
<td>76.5%</td>
</tr>
<tr>
<td>Obesity/overweight/physical activity</td>
<td>73.5%</td>
</tr>
<tr>
<td>Diabetes prevention and screeninganken, hypertension, heart disease &amp; stroke</td>
<td>32.4%</td>
</tr>
<tr>
<td>Access to care</td>
<td>32.4%</td>
</tr>
<tr>
<td>Violence and injury prevention</td>
<td>29.4%</td>
</tr>
<tr>
<td>Aging issues (alzheimer's, hearing, etc.)</td>
<td>8.8%</td>
</tr>
<tr>
<td>Family issues/parenting support</td>
<td>8.8%</td>
</tr>
<tr>
<td>Maternal and child health/parenteral care</td>
<td>8.8%</td>
</tr>
<tr>
<td>Home health</td>
<td>8.8%</td>
</tr>
<tr>
<td>Aging of primary care providers</td>
<td>2.9%</td>
</tr>
<tr>
<td>Increase number of visiting specialists</td>
<td>2.9%</td>
</tr>
<tr>
<td>Rural/remote homes/hospitals</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
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**Linkages between LHDs and Physician Clinics**

- Screening and education programs for diabetes and hypertension
- Work site wellness programs
- Cancer screening promotional campaigns
- Home visitation programs
- Helping patients enroll in Medicaid or insurance exchanges
- Medication assistance programs
- Analysis of EHR data
- Coordination of immunization programs

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**Policy Changes**

- Workforce
- Hospitals
- EMS
- Delivery system reform
- Funding

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**Maintaining and Building the Workforce**

- Expand funding for health professional incentive programs
- Continue RHOP and Rural Training Track Programs
- Incorporate more interdisciplinary team training in rural and urban sites
- Train and use new health workers (community paramedics, CHWs, and dental therapists)
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**Workforce Continued**

- Expand the use of telehealth and remote patient monitoring
- Connect specialists with primary care physicians for specific diseases (e.g., ECHO program)
- Think about sharing staff more regionally

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**Redesigning Hospitals Functions**

- Continue to provide high quality treatment
- Promote and help manage new technology (remote patient monitoring, managing the flow of patients with other providers such as long-term care)
- Become an active player in community planning and implementing population health programs
- If possible, move some community benefit funding from treatment to population health initiatives

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**ADVANCING HEALTH IN AMERICA THE PATH FORWARD**

- Our vision: A society of healthy communities where all individuals reach their highest potential for health
- Our commitment:
  - Patient-focused care
  - Healthy communities
  - Health behavior interventions
  - Working across the community
  - People-centered care
  - Management and sustainability

- Our role: The work of the future - Hospitals, Health systems, and Health organizations that are
  - Driving forward the mission to advance health in America
  - Helping our communities beyond the four walls of the hospital
  - Creating new models of care, services and collaborations
EMS
- Investigate potential of employing EMS volunteers
- Fund pilot projects that encourage collaboration between large and small ambulance units
- Convene a task force of EMS leaders to:
  - Develop performance measures for all units
  - Identify an organization (county government) that is responsible for performance
  - Examine training options for EMS volunteers
  - Assess impact of consolidating ambulance services

Delivery System Reform – State Level
- Develop legislation to allow an alternative CAH model where only outpatient and ER care are provided
- Provide incentives to encourage all primary care clinics to become PCMHs and/or join an ACO
- Develop a core set of standard metrics to measure cost, access, and quality for PCMHs
- Require or strongly encourage all hospitals and physician clinics to submit patient information to the Nebraska Health Information Initiative

Delivery System Reform Continued ...
- Convene a task force to assess the barriers to using telehealth more effectively (e.g., expanding broadband) and strategies for overcoming these barriers
- Establish a high level Center for Health Improvement to monitor changes in health outcomes, the quality of care, access to care, and the cost of care and make appropriate recommendations
Funding

- Expand funding for the workforce incentive programs
- Provide new funds for pilot projects that improve care coordination between primary care/CAHs and behavioral health, dental health, EMS, and public health
- Seek grants to conduct research and evaluate innovative practice models, future workforce needs, and best practices to improve health outcomes

Funding Continued

**Require:** nonprofit hospitals to invest at least 10% of their total community benefit funds into the Community Health Initiatives category

**Work:** with private and public insurers to allow providers to share the savings from reduced ER use, unnecessary hospital admissions, and meeting selected quality measures

**Seek:** grant funds to support physician clinics in converting to a PCMH and/or an ACO

Final Thoughts

- Transformation will not happen overnight and there is no one solution for every community
- Community resources and readiness to change vary widely so...
- Many transformation policies and activities require little or no new funding (community planning, alternative hospital models, using community health workers, etc.)
- Some new funding is essential to maintain access and build the rural health system
- Moving from a treatment emphasis to a population/community health need and outcome focus requires a new way of thinking and strong collaborative partnerships
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