Slide 1

Slide 2

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

Slide 3

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

Slide 4

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

Slide 5

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

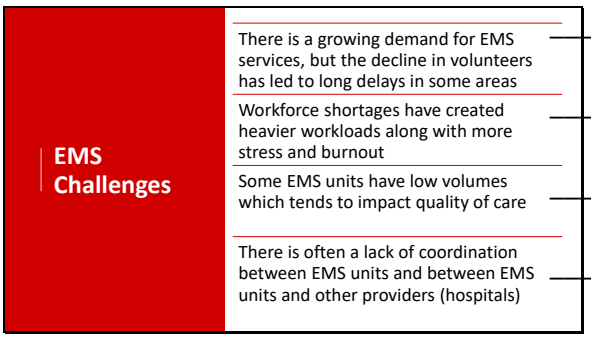
https://flic.kr/p/a2MoRt

Slide 9

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**

Slide 10



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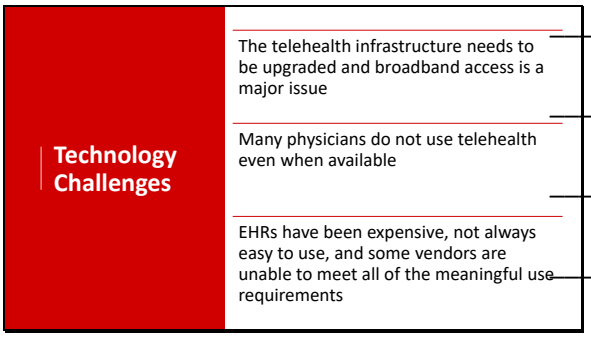

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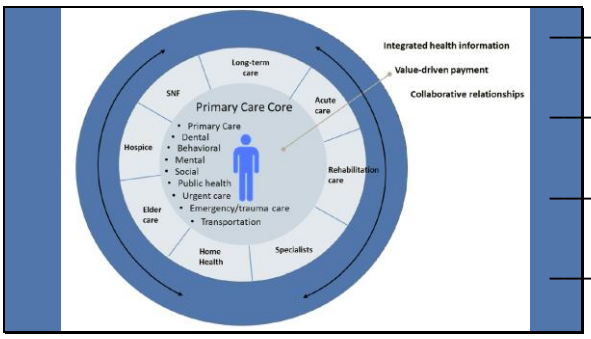

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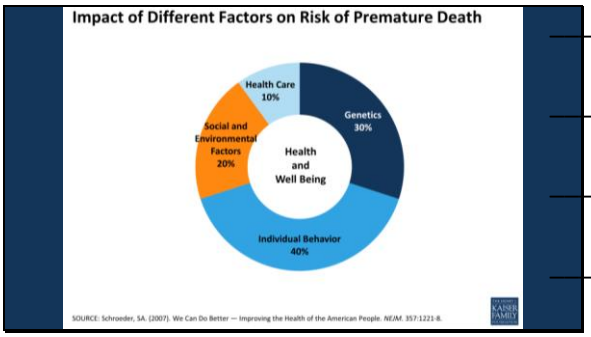

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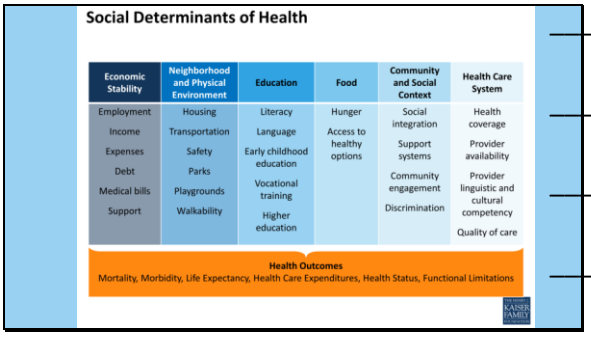

Slide 16

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

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

Diabetes	Heart Disease	Lower Back and Neck Pain	Hypertension Treatment	Falls	Depressive Disorders
$101 Billion	$88 Billion	$88 Billion	$84 Billion	$76 Billion	71 Billion

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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

	PCMH		Non-PCMH	
	No.	%	No.	%
1. Each patient has the opportunity to select his/her primary care physician. The primary care physician is responsible for providing or arranging for all health care services.	56	95%	46	68%
2. Each member of the interdisciplinary team has clear roles and responsibilities and is involved in the development of each patient's treatment plan.	49	83%	28	41%
3. The clinic can demonstrate that the patient, and when appropriate the family, is involved in goal setting and in making decisions about his/her treatment plan.	50	85%	30	44%
4. The clinic provides written materials at the appropriate literacy level that explain the essential features of a PCMH.	35	59%	13	19%
5. The clinic has a formal approach for obtaining feedback from patients and families and uses this information to make improvements.	40	68%	19	28%
6. EHR data is used to identify patients' needs and electronically track their progress based on their treatment plan.	45	76%	29	43%
7. The clinic receives reports on readmissions and ER visits within 24 hours and acts on these reports.	47	80%	29	43%
8. The clinic analyzes claims data on cost and quality to identify care gaps.	42	71%	14	21%
9. The clinic uses systematic methods to analyze quality measures.	51	86%	28	41%
10. The clinic uses quality measures to make practice improvements.	58	91%	40	59%

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Highest Priorities among the Nonprofit Small Rural Hospitals in Nebraska

Specific Area	% of Hospitals
Behavioral health/mental health/substance abuse/suicide	76.5%
Obesity/overweight/physical activity	73.5%
Chronic disease prevention and screening (diabetes, hypertension, heart disease & stroke)	32.4%
Access to care	32.4%
Cancer	29.4%
Violence and injury prevention	8.8%
Aging issues (arthritis, hearing, etc.)	8.8%
Family issues/parenting support	8.8%
Maternal and child health/prenatal care	8.8%
Breast feeding	2.9%
Aging of primary care providers	2.9%
Increase number of visiting specialists	2.9%
Age of nursing home facilities	2.9%

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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

Slide 24

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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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

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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

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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

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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

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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

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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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