Reflections from the Rural Health Listening Tour: Challenges and Opportunities

Prepared for the Rural Health Innovation Steering Committee

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December 15, 2018

Funding for this project was provided by the Office of Rural Health in the Nebraska Department of Health and Human Services.

Background

The recent changes in the rural health care system has magnified some of the traditional challenges and created new ones. However, these changes are also creating new opportunities to strengthen and transform the rural health system. To address these challenges and take advantage of the opportunities, key rural health leaders from the Nebraska Rural Health Association and the Rural Health Advisory Commission began discussing some of the major rural health issues in Nebraska. Based on these discussions, the Rural Health Innovation Steering Committee was formed in August 2017. This initial committee included representatives from the Nebraska Rural Health Association, the Rural Health Advisory Commission, the Nebraska Medical Association, the Nebraska Hospital Association, the Rural Futures Institute, and the University of Nebraska Medical Center, and three hospital administrators. After a short time, the Nebraska Office of Rural Health and the Nebraska Health Care Association were added to the group.

During the four meetings that were held, several new ideas emerged, but there was not a consensus on the strategies for moving forward. As a result, the committee decided that a wider environmental scan should be conducted, including more input from a variety of rural practitioners and community members. With funding from the Office of Rural Health, five listening sessions were organized by the Nebraska Rural Health Association during August of 2018. The purpose of the sessions was:

- To understand the state of rural health in Nebraska
- To identify some of the major challenges facing rural providers and communities
- To determine the readiness for change
- To gain input on short-term and long-term strategies

The listening sessions, which were held in Auburn, York, Lexington, Norfolk, and Grant, were attended by about 100 people, including hospital administrators, chief financial officers, local health departments, insurers, and others.

This report is divided into four sections. The first section provides an overview of the current state of rural health in Nebraska. It includes a discussion of some of the major strengths and key challenges facing the rural health care system. The second section assesses the readiness for change among rural health leaders and key stakeholders. The third section presents future trends related to health care delivery models, reimbursement, care coordination, and new technology. The final section explores the elements of a new delivery model and short-term and long-term strategies that will help to strengthen and transform the rural health system.

The State of Rural Health in Nebraska

The rural health system in Nebraska has been evaluated on both a regional and state level (Bipartisan Policy Center, 2017 and Office of Rural Health, 2016). Since these reports taken together provide a comprehensive analysis of both the strengths and weaknesses of the rural

system, this report will mainly highlight the issues that were discussed during the listening tour. However, it should be emphasized that these reports have all concluded that while the rural health system continues to be very resilient, the long-term survival of the system and its ability to meet the needs of future patients and improve health outcomes depends on making a series of strategic changes.

Major Strengths of the System

One of the strengths of the rural health system is the large number of rural health professionals who are committed to providing high quality health care services. Another strength is that many rural health leaders are visionary and exploring new models of care. For example, there are several rural physician clinics, both independent and hospital-based, that have joined accountable care organizations (ACOs) and/or become patient-centered medical homes (PCMHs). Some health care providers are also working closely with other health organizations such as community mental health centers, rural dentists, long-term care services, and local health departments to improve care coordination and patient outcomes. In addition to stronger collaborative partnerships, most rural health care organizations are focused on high quality patient-centric care and operational efficiency. Many have emphasized improving work processes (e.g., streamlining hospital admissions and discharges), reducing waste by applying lean management techniques, and enhancing the patient experience as evidenced by relatively high patient satisfactions scores. Another strength is that rural health organizations are both agile, adaptable, and resourceful. In comparison to their large urban counterparts, rural organizations are quite flexible and can shift course more quickly. For example, rural clinics are more likely to allow physician assistants and nurse practitioners to provide care closer to their full scope of practice. Other examples include the effective use of telemedicine and sharing resources such as mobile CT scanners and MRIs.

Major Challenges

Many of the challenges facing the rural health care system are related to the demographic and socioeconomic status of the population. The population is not only small but also spread out over a large geographic area. In addition, the population is declining and growing older in most areas. The net result is a smaller volume of services and a less healthy population. These problems are magnified by relatively low-incomes and less adequate health insurance coverage. Furthermore, rural populations tend to be less healthy than urban populations for several conditions and risk factors. Although the mortality rates for some conditions (e.g., cancer) tend to be lower for rural populations as compared to their urban counterparts, the rates were higher for heart disease, unintentional injuries overall, and motor vehicle crashes. Rural populations were also less likely to have had their cholesterol checked in the past five years, screened for colon and breast cancer, and visited a dentist in the past year. They were more likely to be obese, use smokeless tobacco, and report their health as fair or poor (Nebraska Department of Health and Human Services, 2016).

During the listening tour, several major challenges were discussed. These issues are examined under (1) Workforce shortages, (2) Survival of rural hospitals, (3) Regulatory burdens, (4) Fragmented rural health system, and (5) Other concerns.

- **Workforce Shortages** – The shortage of health professionals has been a significant problem for many years. These shortages include virtually all types of health professionals, including physicians, dentists, behavioral health practitioners, nurses, physical therapists, lab technicians, and many others. The inadequate supply of health professionals has limited access to health care services as well as the number of services that can be provided.

  During the listening sessions, participants identified several reasons for these shortages, including lower reimbursement and a higher workload. Additionally, many younger professionals who are interested in moving to rural areas were unable to find acceptable daycare services to meet the needs of their family. The shortage of adequate housing was also mentioned as a factor for not practicing in a small community.

  Another issue that limits the supply of health care workers is related affordable health insurance coverage. Many employers in rural areas, including hospitals and clinics, have found that it is difficult to purchase health insurance coverage for their employees because they are simply too expensive. Unfortunately, most of the policies that are more affordable often provide inadequate coverage.

  A major problem in some areas is the lack of obstetrical services. These "obstetrical deserts" have become larger because fewer family practice physicians now provide obstetrical care. As a result, some women are forced to drive an hour or more to deliver a baby and is likely to limit the frequency of their prenatal care visits.

  Unfortunately, this problem is likely to become more severe as older physicians retire. In 2015, almost 40 percent of family practice physicians were over 55 years of age. The retirement factor coupled with a higher workload and in some cases lower compensation will make it more difficult to recruit an adequate number of health practitioners to rural areas. Given these challenges, new strategies such as more team-based care and a greater use of technology such as telehealth services need to be implemented.

- **Survival of Rural Hospitals** – Although only one small hospital in Nebraska has closed its doors in the past four years, several critical access hospitals (CAHs) are experiencing severe financial pressures. In 2007, only 4 CAHs had a negative margin and 5 had margins between zero and two percent. By 2016, nine CAHs had negative margins and 16 had margins between zero and two percent. There are many reasons for the declining profitability of CAHs, including the negative financial impact of sequestration

and bad debt policies. According to a recent study, the average one-year loss due to sequestration for each rural hospital was $150,000 and it was estimated at $64,000 for bad debt (Michael Topchik, 2018). In addition, many rural hospitals are located in geographic areas that have a small and declining populations, a high proportion of Medicare and Medicaid patients which have lower reimbursement rates, and high levels of uncompensated care which is directly related to a higher number of uninsured and underinsured patients. Other factors may include a lack of consistent physician coverage and located in a non-expansion Medicaid state (G. Mark Holmes, Brystana Kaufman, and George Pink, 2017).

During the listening sessions, participants also mentioned the negative impact of high deductible insurance plans, the reduction in swing bed usage due to bundled payments in some urban and regional hospitals, and the decreasing revenue associated with value-based plans such as ACOs, particularly if the hospital does not own the clinic. In addition, the proposed changes in some key federal policies such as the 340B medication assistance program could significantly reduce revenue for some hospitals.

Many hospitals and physician clinics are moving upstream and focusing on Population Health (keeping people healthy instead of waiting for them to become sick or injured). They are also partnering with other organizations such as behavioral health organizations, local health departments, and long-term care organizations to improve the coordination of care. Although the reimbursement system is in the process of transitioning from an emphasis on volume of services to the value of services provided, this transition is far from complete. As a result, many rural health providers are not appropriately reimbursed for their population health efforts.

- **Regulatory Burdens** – Although many laws and regulations have been created to protect the health and safety of patients and in some cases to control costs, often these regulations negatively impact the operational efficiency of the hospital and/or are out dated or should be modified to reflect the changes in the health care environment. For example, all small hospitals in Nebraska now have operational electronic medical records (EMRs), but some of them cannot meet the federal meaningful use standards. During the listening sessions, participants agreed that EMRs were essential to high quality patient care, but meeting the federal requirements was very costly, especially for small hospitals. To meet these requirements continual upgrades were needed, resulting in higher costs, lower revenue, low staff morale, and no appreciable improvement in patient care. If a hospital and/or clinic has a working EMR, it has been quite cumbersome and time-consuming to access information through the Nebraska Health Information Initiative.

  To improve care coordination and encourage partnerships between hospitals, physicians, long-term care facilities, and other providers, the HIPAA and Stark laws

needed to be modified. Effective care coordination requires health care providers to share confidential patient information, but these laws have created barriers to information sharing.

As previously mentioned, recent efforts by CMS and pharmaceutical companies to eliminate or significantly change the 340B program would be very detrimental to many CAHs in Nebraska and even force some of them to close their doors.

Regulatory and reimbursement policies related to the provision of home health and hospice services have limited the availability of these services in rural areas. For example, home health services are very costly to provide because of relatively low reimbursement rates and high operational costs. However, the home health fee schedule established by CMS is set very low and only allows providers in a high -volume market with a high concentration of patients to earn a small profit. In rural and frontier areas, where the volume of patients is low and operational costs are higher because of the longer travel distances to see patients access to these services is severely limite

To improve access to home health services for rural patients, CMS should adjust the fee schedule to reflect the lower volume of patients and higher operational costs. Access could also be improved by allowing reimbursement for home health telehealth visits. These changes would lead to an improvement in health outcomes and a reduction in long-term cost for Medicare.

- **Fragmented Health Care System** – During the listening sessions, there was considerable discussion about why the fragmentation of health care services resulted in major gaps in services. While the patient referral and coordination process between rural hospitals and physicians and urban hospitals and physician specialists is generally effective, this process does not work nearly as well for other types of services. For example, major problems occur if a patient has a physical health problem and behavioral health issues. In a recent survey of primary care physician clinics in Nebraska, only 37 percent of the PCMH clinics and 22 percent of the non-PCMH clinics had access to behavioral health professionals that can provide immediate care for clients who present for a behavioral health condition (David Palm, et al., 2017). These care coordination challenges are linked to the inadequate supply of behavioral health professionals, a lack of data sharing capabilities, and reimbursement issues. However, this problem is also related to the fact that the behavioral and physical health systems have operated as separate systems of care. Although the new delivery models such as ACOs and PCMHs are working toward better care coordination models, progress has been relatively slow.

  EMS Services – EMS services play a vital role in transporting patients to both urban and rural hospitals, but these services are generally not closely connected to small hospitals

nor to other EMS units. A single county often has several ambulance services (e.g., eight in Thayer County with an estimated population of only 5,045 in 2015). Additionally, there is no central, regional or, in many cases, local control of volunteer EMS agencies, which makes it difficult to establish uniform policies and to link these units to other parts of the rural health care system.

Public Health - Many local health departments are forming strong linkages with a few primary care clinics in their jurisdiction. These linkages involve sharing patients through the implementation of the National Diabetes Prevention Program, worksite wellness programs, and home visitation programs. These departments also assist nonprofit hospitals in developing their Community Health Needs Assessments and implementation plans. These plans can be used to identify local community health needs and help to better target resources to address these needs.

Dental Health – Studies have shown a strong association between oral health infections and several chronic illnesses such as heart disease, diabetes, and cancer. Despite this association, access to dental services for low-income children and adults, older populations residing in long-term care facilities, and individuals with mental or physical disabilities often have difficulty accessing oral health services. Many of these access challenges stem from an inadequate supply of dentists, lack of insurance coverage, and a limited number of dentists who participate in the Medicaid program. As a result, these population groups tend to have poorer health status and are more likely to receive treatment in a hospital emergency room. A recent study in Nebraska found that during the period 2011-2013 the average and total hospital room expenditures were estimated at $934 and $9.3 million respectively (Rampa, et al., 2017).

Readiness for Change

During the five listening sessions held across the state, there was a strong consensus that the rural health system must change to meet the health needs in rural communities. However, there was not a consensus about how the system should change. Major concerns were expressed with regard to the survival of small hospitals and that changes in the rural health system needed to be led by rural leaders. It was recognized that rural areas in Nebraska are highly diverse culturally, economically, and socially so some flexibility is needed in the design and application of new models. In addition, it should be a bottom up and not a top-down approach in which an urban model is modified to address rural needs.

Two major changes were discussed at the listening sessions, including adopting a global budgeting model and building regional networks of care.

Global Budgeting

A global budget is a fixed amount that is set in advance for inpatient and outpatient hospital-based services. Overall, there was general understanding the concept and intent of global budgeting because this type of model is currently being implemented in Maryland and Pennsylvania. In the Pennsylvania model, there are two key components. First, for each year, an all-payer global budget is prospectively set for each participating hospital. The budget is primarily based the hospital's historical net revenue for inpatient and outpatient services from all participating payers. Each of the participating payers will then pay the hospitals for all inpatient and outpatient services based on the payer's respective portion of the global budget. The second component involves developing a health care delivery transformation plan. This plan will describe how the health care system will be redesigned and transformed, including a description of the improvements that will be made in quality and preventive care, a mechanism for obtaining support and continuous feedback from stakeholders in the community, and how this redesigned system will tailor the services to meet the needs of the community (Centers for Medicare and Medicaid Services, 2017).

Based on the discussion during the listening sessions, the following recommendations were made:

- Although the operational details of the Pennsylvania model and its applicability to Nebraska were not well understood, it should be closely monitored to determine the success factors, lessons learned, and opportunities for Nebraska.
- If a decision is made to move forward, the model should be pilot-tested in a few sites to determine the feasibility of implementing it in Nebraska. In comparison with Pennsylvania, there are more CAHs in Nebraska and the population density varies considerably.

Regionalization of Services

Compared to global budgeting, there appeared to be more interest in building regional networks that would involve physician clinics, local health departments and other partners (e.g., behavioral health, long-term care, EMS, and dental health). The focus of the network would be to improve care coordination, reduce health care costs, and improve individual and population health outcomes. To achieve these goals, some type of capitated reimbursement system would need to be negotiated with public and private payers (e.g., Medicaid, Blue Cross Blue Shield of Nebraska, and United Health Care).

There are several advantages of a regional model. First, if some form of capitated reimbursement is part of the regional model, it would increase the volume of patients and reduce the overall risk to each provider. Second, it would allow providers to negotiate with payers as one entity rather than as individual providers. Third, depending on the size of the region, it may allow CAHs to participate in bundling programs. Fourth, in most rural areas it will

be easier to coordinate care because more services will be available (e.g., behavioral health, social services, and public health). Fifth, it would provide an opportunity to share staff and other resources and perhaps lead to more cross training of licensed and unlicensed staff. In addition, it could provide greater opportunities to collaborate with area colleges and universities on workforce training programs. Finally, it would create a larger pool of employees to purchase a less expensive and more comprehensive employee health insurance plan.

Before any type of regional model could be implemented, various legal issues related to sharing services among governmental entities (i.e., counties and districts) will need to be resolved. As with global budgeting, education will need to be provided to boards and the community in order to show the benefits of partnering with their neighbor "competitor". For example, there are several lessons that could be learned from the mandatory school consolidation of a few years ago.

Recommendations to Improve Nebraska's Rural Health System

Although the listening sessions covered a wide range of topics, the recommendations were organized into the following categories: (1) Workforce, (2) Rural hospital survival, and (3) Rural health system transformation.

(1) Workforce – To overcome workforce shortages, many policies and programs have been implemented. Most of the successful workforce programs have attempted to improve the recruitment of students from rural areas, provide financial incentives for them to practice in rural areas, expose them to rural practice during their medical school training and residency programs, and reduce the feeling of isolation.

- Continue to support and expand the state and federal loan repayment programs.
- Continue the Rural Training Tracks, the Rural health Opportunities Program (RHOP), and other programs that expose health professionals to rural practice opportunities.
- Expand interdisciplinary and team training opportunities in Nebraska's medical schools to focus on individual treatment needs and address and improve population health outcomes. This team training should involve, students in medicine, dentistry, pharmacy, behavioral health, public health, nursing, and others.
- Encourage the use of and evaluate the effectiveness of new types of health workers (e.g., community health workers, community paramedics, and public health dental hygienists).
- Provide technical assistance to rural communities on the best practices for recruitment and retention.
- Expand the use of telehealth services by expanding broadband access and increasing reimbursement for these services.

(2) Rural Hospital Survival – Many rural hospitals in Nebraska are struggling financially and eventually may be forced to close or reduce the number of services offered. While it is not possible to address the myriad of factors that have contributed to this problem (e.g., small and declining population base), there are changes that could help level the playing field.

- Eliminate the 2 percent cut under sequestration for CAHs and increase the level of uncompensated care that can be included under cost-based reimbursement under federal policy.
- Create options for alternative delivery models (e.g., replacing inpatient care with emergency and outpatient services and use telehealth to connect with other CAHs and specialty services.
- Use state and federal funds to plan for and implement pilot projects to test the efficiency and effectiveness of these models.
- Provide targeted technical assistance to improve the operational efficiency of CAHs (e.g., strategic planning, board roles, and revenue cycle management).
- Provide education and training to hospital staff and board members about potential new roles for hospitals such as becoming "anchors of wellness" for population health.
- Provide new funding streams to allow all CAHs to submit EHR data with the Nebraska Health Information Initiative (NeHII).
- Revise the federal regulations related to EHR requirements to be more CAH friendly.

(3) Rural Health System Transformation – There was a strong consensus that it is critical to strengthen and transform the rural health system to meet the immediate and future health needs of rural communities. In this transformation, it is essential to stabilize the rural health system which includes an adequate supply of health professionals that work as a team, financially viable hospitals, long-term care institutions, and other treatment facilities, a more coordinated system of care, a shared information system, and achieving the goals of the Triple Aim (improved and population health outcomes, high quality individual care, and lower costs). These changes will require new models of care that are developed from the bottom up and understanding that a single model will not fit every community. However, high quality affordable services should be available and accessible to everyone within a region. Of course, this does not mean that all or most services will be available in every or most communities. Building this new system will require great leadership, careful planning with diverse stakeholders, new payment and delivery models, and additional resources.

Short-term Recommendations

- The Rural Health Innovation Steering Committee (RHISC) should expand its membership to include representatives from behavioral health, oral health, EMS, public health, and

public and private insurers to develop a transformation model(s). A potential draft model is presented in Appendix.

- Once a new model(s) is developed, the RHISC should obtain input from the state Medicaid agency and other key stakeholders from across the state.
- A new leadership development program should be designed and implemented to assist hospital boards, community leaders, and local government officials in understanding the factors that are driving the changes in the health care delivery system. This program should include the current and future reimbursement systems and the impact of new delivery system models such as ACOs and PCMHs.
- A public information campaign should be developed to help Nebraskans to understand the current environment and the future of rural health care in the state.
- In addition to developing a new Nebraska rural model, the RHISC should continue to monitor and assess the Pennsylvania global budget model, other innovative models implemented across the nation, and state and federal legislation.

Long-term Recommendations

- After a consensus is reached on a Nebraska rural health model, the RHISC should identify communities and regions that would be interested in becoming a pilot model site.
- Once the sites have been identified, a planning grant should be written to a private foundation (e.g., Helmsley or the Robert Wood Johnson Foundation) or a network grant from the Federal Office of Rural Health Policy to test and evaluate the model.
- If it appears the model can be successfully implemented, an innovation grant should be submitted to the Centers for Medicare and Medicaid.

Conclusion

The listening tour participants discussed a wide array of issues, challenges, and opportunities. There was a clear message that the rural health system needs to be strengthen and transformed, but there was not a consensus about what these changes should be. However, the new system must be developed by rural leaders and stakeholders from the bottom up. It should address workforce shortages and increase practice flexibility. It should also address the financial crisis facing many small CAHs and identify new roles for these organizations. To reduce fragmentation, capacity needs to be expanded in areas such as care coordination, telehealth, transportation, and home monitoring. Finally, new collaborative partnerships among both clinical providers and community partners should be formed to address the high priority community health needs and minimize the gaps in care.

Appendix

During the listening sessions, several components of a Nebraska rural health innovation model were discussed. In this Appendix, some future trends and basic assumptions about the future rural health care delivery system and reimbursement will be explored. It will also describe the major components of the model, the gaps that currently exist, and a plan for moving forward.

Future Trends

Many changes are already occurring in the health care system and these changes are likely to have a significant impact on how health care services are delivered and reimbursed in rural areas. Although it is always difficult to predict the impact, these changes should considered in the development of a Nebraska rural health innovation model (NRHIM). Some of the current trends that may have a future impact future include:

- The Triple Aim (lower health care costs, better population health outcomes, and improved quality of care for patients) will continue to drive health policy and influence the way health care services are delivered and reimbursed.
- Health care expenditures will continue to exceed increases in inflation and will influence future health policies.
- New clinical care delivery models such as ACOs and PCMHs will become more widespread and evolve over time.
- Reimbursement of health care services will continue to move from volume-based fee-for-service to value-based reimbursement. These reimbursement options will emphasize capitation, global budgeting, and bundled payments and include quality goals and targets.
- Although some form of cost-based reimbursement for CAHs is likely to remain, inpatient utilization will continue to decline causing financial distress for many small rural hospitals.
- There will be a greater emphasis on care coordination, the social determinants of health and preventive care, and improvements in population health outcomes.
- Improving care coordination will require stronger collaborative partnerships between hospitals, physicians, and many other health care organizations such as behavioral health, oral health, long-term care, public health, and EMS units.
- Disruption in the health care sector will continue, leading to more mergers and consolidation, more retail care for minor treatments, and greater transparency of prices and costs.
- Greater investments will be made in leadership development, team-based care, and strategies to change the culture of organizations.
- Many new technological innovations have the potential to have a positive impact on the quality of health care services and the experience of patients. Some of these

innovations will include, telehealth, electronic patient monitoring, patient engagement portals, and sharing patient information through EHRs.

- There will be a greater emphasis on chronic care management, behavioral health, and elder care.

Essential Components of the NRHIM

The major goal of the NRHIM is to provide high quality, affordable health care services and improve both individual and population health outcomes. To achieve this goal, it is essential to develop both clinical and non-clinical leaders, build a competent interdisciplinary workforce composed of health professionals and community workers, collaborate and share information across the continuum, establish quality, cost, access, and health outcome measures and targets, and evaluate the efficiency and effectiveness of the model.

Ideally, this new model would be developed by a diverse group of rural stakeholders using a regional approach. Although it may be more complicated and challenging to reach a consensus on key decisions, a regional approach has several advantages such as a larger volume of patients, greater availability of health care services, and more capacity to invest in and use new technology.

A regional approach would also provide a greater opportunity to build the capacity that is necessary to improve care coordination, focus more on preventive care, and address the social determinants of health. This shift in focus will require designing a health care system that not only provides high quality treatment and positive individual patient experiences but also the flexibility to address all of the factors, including the social determinants of health, that influence the health of people in rural communities. In this model, strong collaborative partnerships must be developed between hospitals and physician clinics and other essential health care providers such as behavioral health, oral health, elder care, and EMS as well as community-based organizations such as local health departments, cooperative extension, and community action agencies.

A regional approach would also assure a larger volume of patients which would reduce the uncertainties that are associated with capitated payment systems. As alternative payment models such as those associated with ACOs, PCMHs, bundled payments and global budgets become more mainstream, it is likely that rural health providers will be required to assume some financial risk in the future. Capitated payments also provide an incentive to improve individual and population health outcomes. For example, local health departments employing community health workers could screen patients on the social determinants of health (e.g., adequacy of housing, food insecurity, transportation issues, or lack of health insurance coverage).

With a regional approach, it would be more feasible to address some broader strategic issues such as obstetrical deserts, behavioral and oral health issues, and build capacity for care

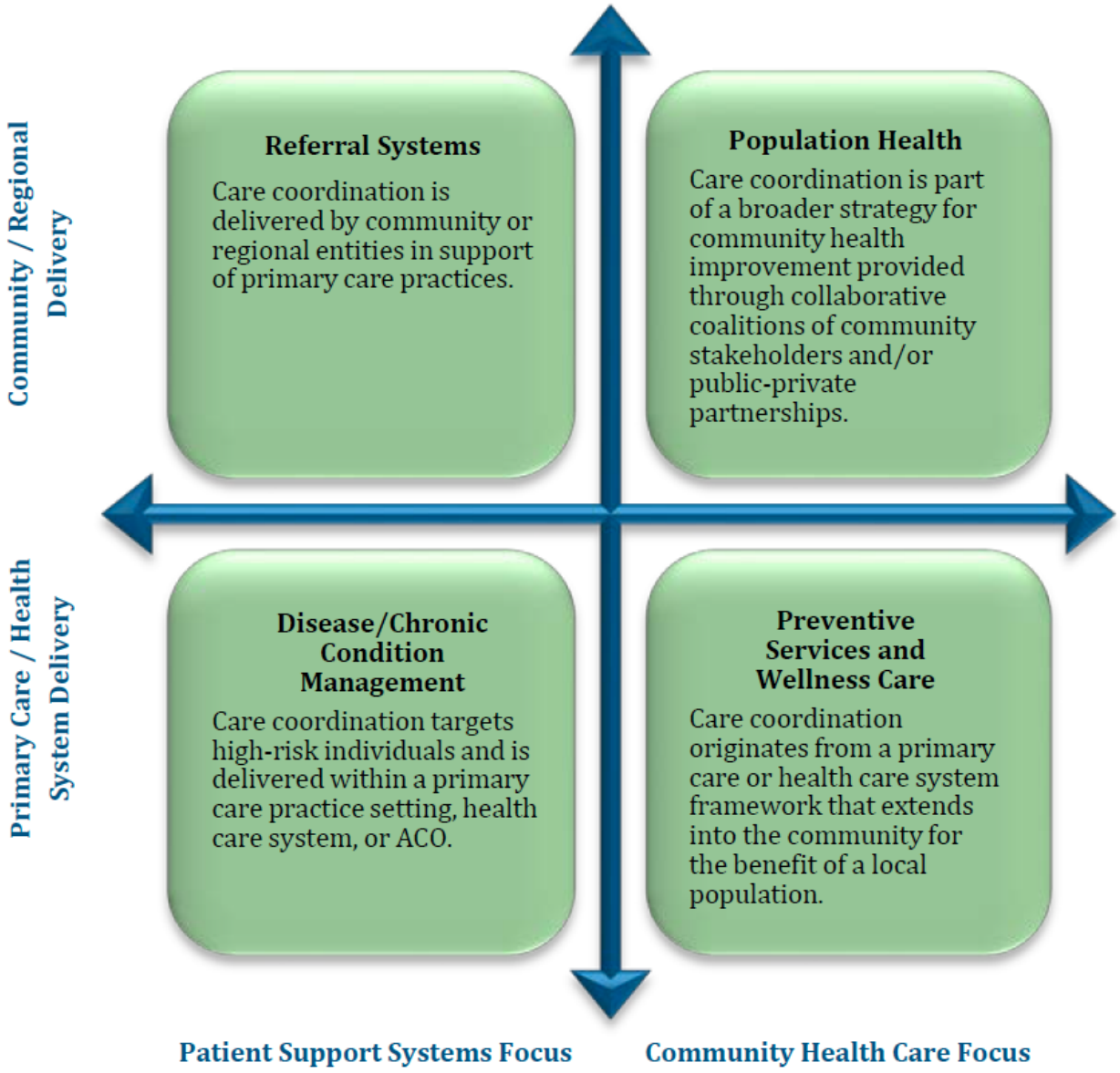
coordination, virtual care, transportation, and other social needs. For example, CMS is proposing to reimburse health care providers for a patient's housing and social needs (Maria Castellucci, 2018). In addition, new technologies such as home care monitoring and telehealth services are more likely to have lower costs per unit with a larger volume of patients.

Recently, the Rural Health Policy Institute (RUPRI) developed a conceptual model to help rural communities think about how to move toward a more integrated rural health system (Mueller, et al., 2018). This model which is shown below uses a team-based coordinated care approach that includes primary care, behavioral health, oral health, and other clinical services as well as community-based and social services. Of course, inpatient care and referrals to physician subspecialists and hospital specialty services located regional or urban centers would also need to be taken into consideration. However, in this model health care becomes more proactive and shifts from a major emphasis on treatment to improvements in care coordination, population health, and prevention and wellness.

Payment Reform

A successful transition from treatment to prevention and wellness will require payment reform. Many new payment models have been tested and implemented. Several states, including Oregon, Minnesota, and Vermont, have received large CMS innovation grants and it appears that these new models have saved money and improved health outcomes. New payment models associated with ACOs and PCMHs have helped shift the focus of reimbursement from volume to value. CMS and private insurers are also experimenting with risk capitation, global budgeting, and bundled payment approaches. While these new payment reforms appear to be saving money and improving quality, there is not conclusive evidence and some key questions remain unanswered. For example, can these savings be sustained over time, how will these savings be shared with and among health care providers, and how will these savings be shared with the community partners. Although many difficult payment issues have not been resolved, there are also opportunities for Nebraska to design an innovative delivery and payment model that would transform its rural health system and improve health outcomes.

Figure 1. Community Health and Care Coordination Models by Primary Focus (x-axis) and Delivery Domain (y-axis)



Source: Keith Mueller, Charlie Alfero, Andrew Colburn, Jennifer Lundblad, A. Clinton MacKinney, Timothy McBride, and Erin Mobley, "Primary Care: The Foundation for a High-Performance Rural Health Care System," Rural Policy Research Institute, July 2018.

Any major payment reform in Nebraska must involve the state Medicaid agency and key private insurers. The new Medicaid waiver rules now provide states with more flexibility and some private insurers have expressed interest in testing new models.

Role of CAH Hospitals

Although the emerging health system will have a greater focus on primary care and prevention, CAH hospitals will have an important role in this transformation process. Inpatient treatment will remain an important function, but it is very likely that admissions will continue to decline in the next few years. However, CAHs can play an important role in the care coordination of patients with chronic illnesses and palliative care/advanced illness management. This care coordination could involve helping patients navigate various stops in the health system (e.g., physicians, pharmacists, elder care, and home care), as well as community-based services such as community mental health centers and local health departments. CAHs can also coordinate and manage new technologies, including telehealth, electronic patient monitoring, and other virtual technologies.

Regardless of whether a CAH is a nonprofit hospital, all CAHs should work closely with their local health department to organize a coalition of key stakeholders, develop a vision for the future, identify the highest priority health needs, and formulate strategies and implementation plans to address these needs. By working with local health departments and other community partners, resources can be better aligned and targeted to meet community needs.

Finally, it is important to understand that improving population health cannot be the sole responsibility of one organization. It requires collective action and the involvement of many community partners. To be successful, communities must have creative leaders, a clear vision, a consensus on the priority issues, a roadmap for implementation, and a performance assessment plan.

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