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HEALTHCARE VALUE HUB

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HUB WEBINAR: IMPROVING HEALTHCARE VALUE IN RURAL AMERICA

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Welcome and Introduction

Lynn Quincy

Director, Healthcare Value Hub

Housekeeping

- Thank you for joining us today!
- All lines are muted until Q&A
- Technical problems? Use the Chat function in the webinar

Agenda

- **Welcome & Introduction**
  - Lynn Quincy (Altarum, Healthcare Value Hub)
- **Improving Healthcare Value in Rural America**
  - Amanda Hunt (Altarum, Healthcare Value Hub)
  - Charlie Alfero (Southwest Center for Health Innovation)
- **State Rural Health Data**
  - Lynn Quincy (Altarum, Healthcare Value Hub)
- Q & A

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AMANDA HUNT

Policy Analyst

Altarum, Healthcare Value Hub

Rural Areas are Different

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RESEARCH BRIEF NO. 19 | OCTOBER 2017

Improving Healthcare Value in Rural America

In the national discussion about addressing high healthcare costs and improving quality, rural areas have been largely left behind.

Compared to more populated areas, less is known about the quality and cost of care provided in rural settings. Lack of data is due, in part, to the limited participation of rural providers in quality reporting initiatives.[1] Limited resources, low case volumes, a high proportion of vulnerable patients and lack of rural-appropriate quality metrics are all factors that make it difficult for rural providers to participate.[2] Furthermore, efforts to improve rural healthcare value suffer from a dearth of information related to cost. A number of studies compare Medicare expenditures and out-of-pocket costs for rural versus urban populations, but little information is publicly available on the unit prices of services provided to non-elderly adults.

Despite these data gaps, we know enough about rural healthcare delivery to state that healthcare value cannot be achieved with a one-size-fits-all approach. Given the distinctive challenges that rural populations and providers face, strategies to achieve healthcare value must be customized for rural areas. This research brief explains why rural areas are unique, identifies approaches that may have limited utility in rural settings and highlights promising models that improve rural healthcare value.

Although many people associate rural areas with the South, Midwest and West regions of the country, rural populations can be found in nearly every state. Nationally, nearly 13 million people live in rural areas, making rural healthcare value an important consideration for state and federal governments.

SUMMARY

Like many areas of the country, rural communities suffer from inconsistent healthcare value. But in the national discussion about addressing high healthcare costs and improving quality, rural areas have been largely left behind. Due to distinct differences between rural and non-rural settings, strategies to achieve rural healthcare value may have to be customized to reflect the unique challenges faced by rural populations and providers. This brief provides an overview of those challenges, identifies initiatives with limited utility in rural settings, and highlights promising strategies to improve healthcare value in rural America.

What Makes Rural Areas Unique?

Rural populations differ from urban populations in many ways. On average, people living in rural areas are older, poorer and sicker than the general population. They are more likely to smoke and be obese, and live in isolated areas, making it difficult to access needed services like preventative, primary, specialty and emergency care.[3] Because of the relative absence of large employers, people living in small towns are less likely to have employer-sponsored health insurance.[4] Rural residents—particularly those living in states that did not expand Medicaid—are more likely to be uninsured. Not surprisingly, they are also more likely to delay or forgo medical care due to cost.[5] Ultimately, the combination of these factors results in poorer health status and shorter life expectancy among rural populations compared to their urban counterparts.[6]

- 15% of the U.S. population lives in rural areas
- In the national discussion about high healthcare costs and improving quality, rural areas have been largely left behind
- Compared to more populated areas, less is known about the quality and cost of care in rural areas
- Not all strategies will work in rural areas

What is Different About Rural Areas?

- Poorer underlying health status
- Higher rates of uninsurance and public insurance
- Poor health literacy
- Geography and transportation problems
- Gaps in broadband access
- Provider shortages, particularly specialists
- Quality measures not adapted to rural conditions

What Strategies Won't Work in Rural Areas?

Strategies that rely on provider or insurer competition, like:

- Reference pricing
- Consumer price shopping

What Strategies Will Work in Rural Areas?

- Monitoring and addressing provider supply
- Telehealth
- Integrated primary care/care coordination
- Robust, targeted focus on unmet social needs
- Possibly global budgets

Monitoring and Addressing Provider Supply

- Challenges that discourage providers from practicing in rural areas:
  - Too high or too low patient volumes
  - Higher rates of uninsured and publicly insured
  - Lifestyle preferences
- Solutions: loan forgiveness programs; recruit rural students into health professions and provide training in rural areas; and expanded scope of practice laws

Untested but Promising: Missouri's Assistant Physicians

- SB 716/SB 754 established new type of licensed healthcare provider called Assistant Physicians in 2014
- Medical school graduates who passed exams, but did not complete a residency required for certification
- Authorized to practice primary care alongside a licensed physician **in provider shortage areas**
- MO begun accepting applications in 2017 after a 2-year rulemaking period

Telehealth

- Electronic consultation
  - Project ECHO
    - Allows providers to share best practices via weekly teleconference
    - Effectively develops subspecialty expertise among local primary care providers over time
- Telemedicine
  - Connects providers directly to remote patients
  - Increases access to specialists, patient satisfaction and improves health outcomes
  - Potential cost savings

Global Budgets: Pennsylvania Rural Health Model

- Partnership between PA Dept. of Health Innovation and Centers for Medicare & Medicaid Innovation
- Goal: prevent rural hospital closures by providing prospective, fixed payments for PA's rural hospitals
- Based on Maryland's all-payer model
- Currently in pre-implementation phase – implementation will begin in January 2019

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CHARLIE ALFERO

Executive Director

Southwest Center for Health Innovation

Successful Intervention Strategies in Rural Health Care

Quality and Value in the Rural Southwest

Rural Communities briefly

- Rural Communities are diverse.
  - Northeastern Seaboard Definitions of Rural are different than Southeastern, etc.
    - In defining rural areas distance is often less important than community population
  - The Far West, or Mountain-Time, (New Mexico) is often characterized as small communities in large counties, more than an hour from the next community and often further to larger places
    - See railroad and commercial history in the southwest
  - Smaller isolated populations present difficult health care planning and include many inefficiencies
    - Cost Per Person and costs for PC access may be higher in health centers or rural hospitals, but lower overall due to lack tertiary hospitals, available subspecialists, invasive or procedural care and specialized testing.
  - Health Care is often a larger percentage of the local economy due to lack of other economies and population characteristics
    - Healthcare is the fastest growing profession coupled with a demand over the next 10-15 years that greatly outpaces supply
    - 50,000 additional Primary Care Physicians are needed by 2025
    - Subspecialists in training outnumber PC providers 4:1
    - Generally, expensive or specialized health care is the less likely it is to appear in rural areas
    - A PC focused health care system favors a better rural health care system

Integrated Primary Care: Why we need PC physicians at the core

- Sustaining Rural Health Infrastructure
  - Comprehensive Primary Care Services includes Hospital Coverage in Many Rural Areas
  - Minimizing Rural Dependency on Urban-Based Subspecialty Care by Developing Local PC Capacity
- Ensure Access to Family Medicine or Other PC including: OB (C-Sections), Pediatrics, Internal Medicine and Psychiatry
- Support of PAs and NPs
- Part of Core Integrated Primary Care Services Concept
  - Medical, Dental, **Behavioral Health, Patient Support** and Community Health
- Supports Other Rural Health Care: Pharmacy, LTC, DD, Complex Community-Based Senior Care, Therapies, etc.
- Urban Support Systems and Affiliations are Critical but Not Lower Standards of Care
  - Closed Hospitals, TeleMed Dependency for PC or Psychiatry, Dental Therapists

Care Coordination Programs

Patient and Social Support Systems – CHWs are Key

- Clinical Support Services
  - Incidental to the Office Visit – Medical Encounter Required
    - PCMH – Requires medical office visit for payment – drain on medical system resources in shortage environment
    - Volume Based Payment Incentives
    - Shared Savings – HEDIS / Clinical Preventive Services / Reduce Short Term Costs
    - Medical (Vertical) Systems / Referrals Management
- Non-Clinical Support Services
  - Social System Deficit Analysis
  - Facilitated Referrals
    - Other Primary Care – Dental / Behavioral Health
    - Social Referrals and facilitated Access to Non-Clinical Services
  - I-PaCS
- Blended - Most Models
- Informing Community Health

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Community-Based and Rural Pipeline: Development and Training

- Locally trained providers from the community or like the community are more likely to practice in community settings
- 67% of physicians attending medical schools and residencies in their own state will stay compared to 38% if they leave
- SW CHI FORWARD NM – AHEC – Pipeline program works with junior high students through undergraduate education to support health careers choices and local graduate rotations to maintain local connections
- NM PCTC develops local residencies and increases resident applications for family medicine programs in NM
  - State Medicaid Policy Needs to Support GME in Community Settings

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Summary

- Rural is not small urban
  - Urban policies cannot be imposed on rural environments
    - Ie Risk Sharing, Residency Training in Tertiary Hospitals
- Comprehensive / Sustainable Rural Health Systems have a Strong and Stable Primary Care Base that allows other local services to thrive
- Community Health Workers in various roles and with various title create A Comprehensive patient support, care coordination and community health improvement environment
  - Social System Investments are key to a healthy less costly population
- Investments in pipeline and clinical services downstream improves access and outcomes

Southwest chi Center for Health Innovation

Contact

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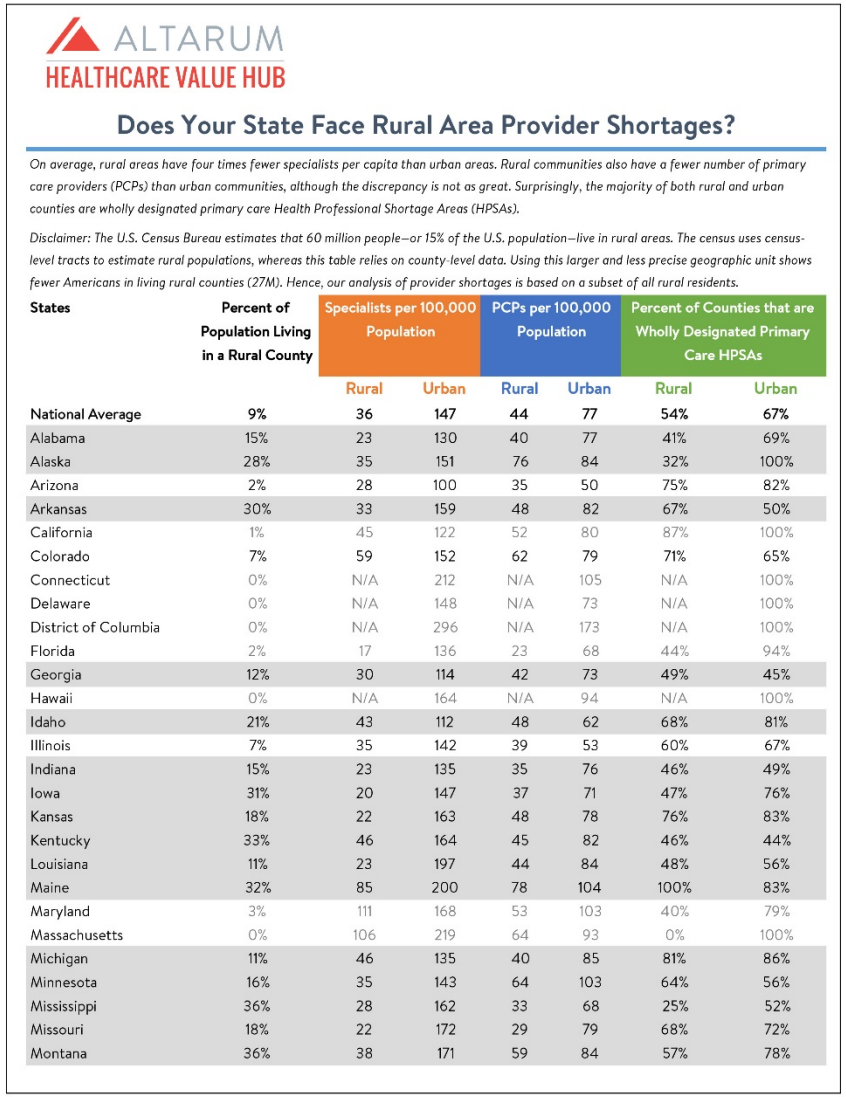
How Rural is Your State?



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Does Your State Face Rural Area Provider Shortages?

On average, rural areas have four times fewer specialists per capita than urban areas. Rural communities also have a fewer number of primary care providers (PCPs) than urban communities, although the discrepancy is not as great. Surprisingly, the majority of both rural and urban counties are wholly designated primary care Health Professional Shortage Areas (HPSAs).

Disclaimer: The U.S. Census Bureau estimates that 60 million people—or 15% of the U.S. population—live in rural areas. The census uses census-level tracts to estimate rural populations, whereas this table relies on county-level data. Using this larger and less precise geographic unit shows fewer Americans in living rural counties (27M). Hence, our analysis of provider shortages is based on a subset of all rural residents.

States	Percent of Population Living in a Rural County	Specialists per 100,000 Population		PCPs per 100,000 Population		Percent of Counties that are Wholly Designated Primary Care HPSAs	
		Rural	Urban	Rural	Urban	Rural	Urban
National Average	9%	36	147	44	77	54%	67%
Alabama	15%	23	130	40	77	41%	69%
Alaska	28%	35	151	76	84	32%	100%
Arizona	2%	28	100	35	50	75%	82%
Arkansas	30%	33	159	48	82	67%	50%
California	1%	45	122	52	80	87%	100%
Colorado	7%	59	152	62	79	71%	65%
Connecticut	0%	N/A	212	N/A	105	N/A	100%
Delaware	0%	N/A	148	N/A	73	N/A	100%
District of Columbia	0%	N/A	296	N/A	173	N/A	100%
Florida	2%	17	136	23	68	44%	94%
Georgia	12%	30	114	42	73	49%	45%
Hawaii	0%	N/A	164	N/A	94	N/A	100%
Idaho	21%	43	112	48	62	68%	81%
Illinois	7%	35	142	39	53	60%	67%
Indiana	15%	23	135	35	76	46%	49%
Iowa	31%	20	147	37	71	47%	76%
Kansas	18%	22	163	48	78	76%	83%
Kentucky	33%	46	164	45	82	46%	44%
Louisiana	11%	23	197	44	84	48%	56%
Maine	32%	85	200	78	104	100%	83%
Maryland	3%	111	168	53	103	40%	79%
Massachusetts	0%	106	219	64	93	0%	100%
Michigan	11%	46	135	40	85	81%	86%
Minnesota	16%	35	143	64	103	64%	56%
Mississippi	36%	28	162	33	68	25%	52%
Missouri	18%	22	172	29	79	68%	72%
Montana	36%	38	171	59	84	57%	78%

- On average, rural areas have four times fewer specialists per capita than urban areas
- Rural areas have fewer PCPs per capita than urban areas but discrepancy is less
- The maldistribution of providers is very state specific (see next table)
- A majority of both rural and urban areas are considered provider shortage areas for primary care

Source: Healthcare Value Hub analysis of HRSA's Area Health Resource File

The maldistribution of providers is very state specific

	Percent of Population Living in a Rural County	Specialists per 100,000 Population		PCPs per 100,000 Population		Percent of Counties that are Wholly Designated Primary Care HPSAs	
		Rural	Urban	Rural	Urban	Rural	Urban
National Average	9%	36	147	44	77	54%	67%
Vermont	46%	133	297	94	149	89%	80%
Oklahoma	21%	21	129	29	62	82%	96%

Questions for our Speakers?

- Use the chat box or to unmute, press *6

- Please do not put us on hold!

Resources

- New Issue Briefs
- State Table
- Webinar slides
- *We'll send an email with links to resources*

www.HealthcareValueHub.org/Rural-Health

Thank you!

- Charlie Aflero, Southwest Center for Health Innovation
- Robert Wood Johnson Foundation

Contact Lynn Quincy at lynn.quincy@Altarum.org or any member of the Hub staff with your follow-up questions.

Join us at our next webinar:

The Value of State Health System Oversight Entities

Friday, Dec. 15, 2 – 3 pm ET

Register at HealthcareValueHub.org/events