The Rural Context for Health Policy: An Advocate’s View

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Presentation Outline

1. RWHC’s Perspective on Advocacy
2. Bird’s Eye View of Rural Health
3. Health > Health Care
4. Challenges & Opportunities
5. Health Insurance ≠ Access
6. Health Care = Jobs
7. Critical Access Hospitals Here to Stay
8. Bottom Line Principles
1. RWHC’s Perspective on Advocacy

- Advocacy is working for a desired future.
- It can be on behalf of self, a few others, the state, nation or world.
- It may be done alone or with others.
- It may be in public or private sectors or both.
- Rural is bipartisan issue.

Founded in 1979, RWHC is a statewide collaborative of 40 rural hospitals with a twin mission of advocacy and shared services in support of keeping local care local.

Rural Advocacy Needed On Many Issues

- Federal and market places reform that works for rural.
- Fair Medicare and Medicaid payments to rural providers.
- Federal and State regulations that recognize rural realities.
- Retain property tax exemption for nonprofit hospitals.
- Solve growing shortage of rural physicians and providers.
- Bring rural voice to regional provider networks & payers.
- Bring a rural voice into the quality improvement movement.
- Continue push for workplace and community wellness.
- Strong link between economic development and rural health.
Rural Advocacy Challenges Not New (1 of 2)

1970s: Federally funded planners proposed a massive consolidation of rural hospitals in Wisconsin; that plan was blocked and RWHC’s role as an advocate was born.

1980s: Growth of health plans with closed provider networks were seen as threat; RWHC started a rural based plan and later federal anti-trust protection.

1980-90s: Medicare radically changed how they paid hospitals and 100’s of rural hospitals closed; in response, RWHC and others championed Medicare’s Critical Access Hospital program that provides critical support to most of our members today.

Rural Advocacy Challenges Not New (2 of 2)

• 1990s: Growth in the shortage of physicians working in rural Wisconsin led to the Wisconsin Academy of Rural Medicine, RWHC’s Wisconsin Collaborative for Rural Graduate Medical Education and a major rural expansion by the Medical College of Wisconsin.

• 2000s: The National Institute of Medicine highlighted major gaps in American health care quality—RWHC helps lead call for rural relevant metrics.

• 2010s: That providers will be paid not for volume but for value has led RWHC to focus on services preparing for the new era of Accountable Care Organizations.
However, in recent years, the majority of the enrollment in PFFS plans has shifted to PPO plans in rural areas. The ACA created quality-based bonus payments for MA plans with ratings of 4.0 stars or higher. Using this rating level as a dividing line, a higher proportion of urban MA enrollees (36.0% compared to 31.6% in rural areas) are enrolled in an MA plan that receives a bonus payment. However, nearly all MA enrollees both in rural areas (91.9%) and in urban areas (94.4%) are in plans with a quality rating of 3.0 stars or higher (Figure 2), qualifying them for bonus payments under the current demonstration program. Nearly one-half (49.8%) of rural HMO enrollment is in a plan with a 4.0-star or higher rating, while only 24.7% of rural PPO enrollment is in such a plan. The majority (73.6%) of rural PPO enrollment is in plans with an average quality rating of 3 or 3.5 stars. Many rural Medicare beneficiaries have limited access to MA plans and in some areas do not have an HMO option available to them, leaving them with PPO plans as their only option.

Figure 2. Percentage of Plans and Enrollment by MA Plan Star Rating and Location, 2012

The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine (Figure 3). MA beneficiaries in southern and some central midwestern rural areas are, in general, enrolled in MA plans with lower quality ratings (4.0% in urban areas vs. 11.7% in rural areas) (Figure 3). Wisconsin’s Snap Shot as a National Leader

- **13 CAHs in iVantage top 100** CAH List (2013)
- Relatively **high overall quality** in national studies
- Relatively **low rate of uninsured**
- Relatively **low Medicare costs**
- Relatively **strong physician/hospital cooperation**
- Relatively **more stable provider finances**
- **Robust adoption of HIT**, especially with EHR
- **Supportive tort environment**
- **Many early adopters of population health**
2. Bird’s Eye View of Rural Health

_There is an Ongoing Need for Rural “Myth” Busting_ 

- Rural residents **don’t care about local care.**
- Rural folks are **naturally healthy, need less.**
- Rural health care **costs less** than urban care.
- Or rural health care is **inordinately expensive.**
- Rural **quality is lower; urban is better.**
- Rural hospitals are just **band-aid stations.**
- Rural hospitals are **poorly managed and governed.**

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National Rural Health Snapshot – 2010 (1 of 2)

<table>
<thead>
<tr>
<th>Access to Health Services</th>
<th>Rural % population</th>
<th>Non-Rural % population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>No form of health coverage (age 18 - 64 years)</td>
<td>20.6</td>
<td>17.8</td>
<td>21.2%</td>
</tr>
<tr>
<td>Needed to see doctor but could not because of cost - past year</td>
<td>15.6</td>
<td>13.6</td>
<td>14.7%</td>
</tr>
<tr>
<td>No personal doctor</td>
<td>18.1</td>
<td>19.3</td>
<td>-6.2%</td>
</tr>
<tr>
<td>No dental care in previous year</td>
<td>35.6</td>
<td>28.3</td>
<td>25.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Behavior/Risk Factors</th>
<th>Rural % population</th>
<th>Non-Rural % population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Smoker</td>
<td>22.0</td>
<td>17.8</td>
<td>23.6%</td>
</tr>
<tr>
<td>Obese (Body Mass Index ≥30)</td>
<td>30.5</td>
<td>25.9</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

[www.shepscenter.unc.edu/rural/snapshot.html](http://www.shepscenter.unc.edu/rural/snapshot.html)
National Rural Health Snapshot – 2010 (2 of 2)

Age - Adjusted Mortality

<table>
<thead>
<tr>
<th></th>
<th>Rural per 100,000 population</th>
<th>Non-Rural per 100,000 population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>All - cause</td>
<td>493.8</td>
<td>923.1</td>
<td>8.6%</td>
</tr>
<tr>
<td>Infant (age&lt;1)</td>
<td>755.0</td>
<td>600.9</td>
<td>9.3%</td>
</tr>
<tr>
<td>Diseases of the heart</td>
<td>249.4</td>
<td>230.2</td>
<td>8.3%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>27.6</td>
<td>24.6</td>
<td>12.2%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td>49.0</td>
<td>42.2</td>
<td>16.1%</td>
</tr>
<tr>
<td>Unintentional Injuries (including motor vehicle traffic)</td>
<td>51.9</td>
<td>34.7</td>
<td>49.6%</td>
</tr>
<tr>
<td>Suicide</td>
<td>13.4</td>
<td>10.3</td>
<td>30.1%</td>
</tr>
</tbody>
</table>

www.shepscenter.unc.edu/rural/snapshot.html

Rural Health Typically Does More With Less

- “The people served by rural hospitals are more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer than residents of urban areas.”
- Yet overall, the average cost per Medicare beneficiary is 3.7 percent lower in rural communities than in urban ones, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.”

“Implications of Proposed Changes to Rural Hospital Payment Designations Policy Brief,” by The National Advisory Committee on Rural Health and Human Services, December, 2012
3. Health > Health Care

It’s no longer just about what we do during a physician visit or hospital stay but also how we keep a population healthy.

“We must help all reach highest potential for health and reverse the trend of avoidable illness.”*


Factors that Affect Health

Source: Centers for Disease Control and Prevention
The Rural Context for Health Policy: An Advocate’s View
Tim Size, RWHC for the Wisconsin Academy of Rural Medicine, 2/27/13

HEALTH OUTCOMES

MORTALITY (LENGTH OF LIFE): 50%
MORBIDITY (QUALITY OF LIFE): 50%

HEALTH BEHAVIORS (30%)
Diet & exercise
Alcohol use
Sexual activity
Access to care
Quality of care

CLINICAL CARE (20%)
Education
Employment
Income
Family & social support
Community safety

SOCIAL & ECONOMIC FACTORS (40%)
Environmental quality
Built environment

PHYSICAL ENVIRONMENT (10%)

Rural

HEALTH FACTORS

POLICIES & PROGRAMS

HEALTH FACTORS

POLICIES & PROGRAMS

County Health Rankings model © 2012 UWPHI

Tobacco use

www.countyhealthrankings.org

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2013 Wisconsin County Health Rankings (Outcomes)

MORTALITY (LENGTH OF LIFE): 50%
MORBIDITY (QUALITY OF LIFE): 50%

HEALTH BEHAVIORS (30%)
- Tobacco use
- Diet & exercise
- Alcohol use
- Sexual activity

CLINICAL CARE (20%)
- Access to care
- Quality of care

SOCIAL & ECONOMIC FACTORS (40%)
- Education
- Employment
- Income
- Family & social support
- Community safety

PHYSICAL ENVIRONMENT (10%)
- Environmental quality
- Built environment

County Health Rankings model © 2012 UWPHI
Where Bars Trump Grocery Stores

http://flowingdata.com/

http://flowingdata.com/
What the County Rankings are Teaching Us

- **Where you live matters** to your health.
- There are **many factors that influence health**.
- Improving health is **everyone’s responsibility** and together we need to find solutions.
- **All sectors need each other’s participation** and expertise to make progress.
- While **personal responsibility is important**, it must also be linked to a larger discussion about how **policy change can make healthy choices easier**.

Source: Karen Timberlake, Director UW Population Health Institute

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4. Challenges & Opportunities

Rural Health is the alignment of forces driving reform to **improve individual health care, the health of populations and lower costs** (the “Triple Aim” originated at the Institute for Healthcare Improvement).
Population Health Key Focus of Reform

In Traditional Practices
- Most MDs, providers are involved in treating illness and acute problems
- Providers are accustomed to dealing with patients who present seeking care

In An Accountable Care Organization
- Attention must shift to the management of all patients in a practice across the entire spectrum of health.
- Successful practices will transform to meet the needs of less-active, disengaged, or disadvantaged current or prospective patients.

Shift from Volume to Value

Current State
- Cost: Reduction Viewed as Discrete Projects
- Quality: Public Relations/Liability Issue
- Physicians: Drive Volume
- Collaboration: Limited Amount Required for Financial Success
- Financial Risk: Revolves Around Cost, Position

Future State
- Cost: Continuous Process Improvement
- Quality: Drives Reimbursement
- Physicians: Drive Value
- Collaboration: Clinical and Finance Staff Must Work Together
- Financial Risk: Revolves Around Utilization of Services Across Continuum

Healthcare Financial Management Association
Questions Rural Providers Needs to Ask

1. How do we provide local patient-centered care that is team based and outcome focused?

2. How do we collaborate with regional organizations to emphasize value of care over volume of care?

3. How do we partner with others locally and regionally to foster healthy communities?

4. How do we adapt urban-based federal models to the unique characteristics of our rural communities?

Accountable Care Organization 101 (1 of 2)

- **ACOs** are volunteer groups of doctors, hospitals, and other health care providers giving coordinated quality care to Medicare patients.

- Goal of coordinated care is to ensure that patients, especially the chronically ill, get right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

- **When an ACO succeeds** in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for Medicare.

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/
Accountable Care Organization 101 (2 of 2)

- Medicare offers 3 ACO programs: (1) Medicare Shared Savings Program—a program for Medicare fee-for-service program providers, (2) Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program. (3) Pioneer ACO Model—a program designed for early adopters of coordinated care.
- Participating in an ACO is voluntary for providers.
- Fee-for-service Medicare patients maintain all their rights, including right to choose their providers.

Reform*: Paying for Value

- Assessment based on patient experience, care quality, and delivery efficiency.
- Health care value, not simply service volume, will drive payment.
- Rural health care systems will be organized around a robust primary care base.
- The focus will be on care in the community, supported by the hospital–anchored in primary care.

*Reform with or without "Obamacare" or Medicare ACOs
"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11
Reform: Collaborating to Integrate Services

- Collaborative providers will deliver the continuum of care seamlessly to patients.
- Rural providers will collaborate locally for improved health outcomes and better financial performance.
- Rural providers will collaborate vertically to ensure timely access to services not available locally.
- Urban systems will collaborate with rural health systems to meet performance and financial goals.

-Reform with or without "Obamacare" or Medicare ACOs
"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

Reform: Information Used to Manage Care

- Patients engaged in their own care plans (patient responsibility promoted by the system) and patient needs met (better care).
- Seamless transfer of clinical and administrative information among providers.
- Health information readily available in rural places and understandable to individual patients.
- Transparency of health care cost and quality information, access to proactive disease management and prevention assistance.

-Reform with or without "Obamacare" or Medicare ACOs
"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11
Reform: Healthy People / Healthy Communities

- Providers and patients will connect to community health resources to improve individual health.
- Providers and the community will “go upstream” to address factors that influence population health.
- In concert with clinical quality and efficiency metrics, rural communities will employ metrics that assess these more global outcomes.
- Rural providers and their communities will partner in creating healthier communities.

*Reform with or without “Obamacare” or Medicare ACOs
“The High Performance Rural Health Care System of the Future,” RUPRI Health Panel, 9/2/11

5. Healthcare Coverage ≠ Access

Workforce shortages hit rural first, harder and longer:

Currently
Primary Care, Dental,
Mental Health,
Pharmacy & EMS

Coming Our Way
General Surgery & Nursing
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PROJECTED NEED FOR PHYSICIANS

“By 2020, our nation will face a serious shortage of both primary care and specialist physicians. The shortfall will be most severe on vulnerable and underserved populations. Unless we act now, America will face a shortage of more than 90,000 doctors in 10 years.”

-- Association of American Medical Colleges
June 2010

“Wisconsin will need to add 100 new physicians annually to avoid an expected shortfall of 2,000 by 2030. The need is most urgent in primary care, general surgery and psychiatry – in both rural and underserved urban areas.”

-- Wisconsin Hospital Association
November 2011

“If students complete both their medical education and residency training in Wisconsin, nearly 70% will remain in the state to practice medicine.”

-- AAMC State Physician Workforce Data Book
December 2011

Worst Shortages: Mental Health & Dentistry

* The green shaded areas denote federally-designated rural and urban locations where there are significant shortages of primary care physicians

6. Health Care = Jobs

Rural health is about rural health and health care but it is also about the whole community, especially jobs & vice versa.

Rural Health is an Export “Commodity”

• People often know that business relocation decisions are influenced by the cost and quality of health care available locally.

• But more importantly, rural health has the same economic impact as export commodities like milk, soybeans or rural manufactured goods because of its own ability to bring dollars and jobs into the community.
Jobs in All Sectors Depend on Rural Health

• Rural insurance premiums and taxes only come back to the community and create jobs if there are local health care providers there (and people use them) to attract those dollars.

• For every 2 rural health jobs created (or lost), the number of other community jobs increase (or decrease) by 1+ jobs.

• The rural economy is very dependent on where its health care dollars are spent.

7. Critical Access Hospitals Here to Stay

Most rural hospitals are CAHs, a distinct Medicare provider type with a cost based payment method. CAHs basically same as PPS, except have 25 bed max. and average 96 hr. LOS max.
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Rural Hospitals Widespread but Small % $

Percent Hospitals by Type

- RRC: 4.1%
- Rural PPS: 8.4%
- SCH/RRC: 2.5%
- SCH: 6.5%
- CAH, 27.3%
- Urban FFS: 46.1%

Percent Medicare Payment by Hospital Type

- Rural PPS: 2.9%
- MDH: 4.0%
- SCH/RRC: 3.1%
- SCH: 2.9%
- CAH: 2.2%

North Carolina Health Research Policy Analysis Center, 8/12

Rural Hospitals: Backbone of Rural Health

1,327 CAHs as of 6/30/12

North Carolina Health Research Policy Analysis Center, 8/12
Rural Hospitals Have a Lot to Brag About

- Rural hospital performance on CMS Process of Care measures is on par with urban hospitals.
- Rural hospital performance on CMS Outcomes measures is better than urban hospitals.
- Rural hospital performance on HCAHPS inpatient experience survey measures is better than urban hospitals.
- Rural hospital performance on price and cost efficiency measures is better than urban hospitals.
- While, Medicare spent $2.2 billion less in 2010 on rural beneficiaries—3.7% less than average urban beneficiary.

“Rural Relevance Under Healthcare Reform”
(based on Medicare Shared Savings Data Files) 1/23/12
http://www.ivantagehealth.com/

8. Bottom Line: Vision Matters

“I knew I was going to take the wrong train, so I left early.” (Yogi Berra)
Follow Your Passion

RWHC Eye On Health

“Get over the Doc Welby thing, what you do makes a lot more difference to your health than what I do.”

Health > Health Care

RWHC Eye On Health

“Get over the Doc Welby thing, what you do makes a lot more difference to your health than what I do.”
Cooperate In Order to Successfully Compete

Rural Health Resources

- **RWHC Web**: [www.RWHC.com](http://www.RWHC.com)
- Free **RWHC Eye on Health e-newsletter**; email [office@rwhc.com](mailto:office@rwhc.com) with “subscribe” on subject line.
- **Wisconsin Office of Rural Health**: [http://WORH.org](http://www.worh.org)
- **County Health Rankings & Roadmaps**: [www2.countyhealthrankings.org](http://www2.countyhealthrankings.org)
- **Nation Rural Health Resource Center**: [www.ruralcenter.org](http://www.ruralcenter.org)
- **Rural Assistance Center** at [www.raonline.org/](http://www.raonline.org/) is an incredible federally supported information resource.
- **The Health Workforce Information Center**: [www.healthworkforceinfo.org/](http://www.healthworkforceinfo.org/)