Coordinated Community Health Needs Assessments and Population Health

Supporting Population Health Efforts

National Academies of Science Engineering & Medicine

Population Health in Rural America in 2020

June 25, 2020

SAKAKAWEA MEDICAL CENTER

Coal Country Community Health Center

Presentation Agenda

- Community Health Needs Assessment (CHNA)
- CHNA Process
- Using CHNA Information
- Our Organizations
- Our Collaborative Assessment and Planning Activities
- Benefits Realized in Collaboration

Community Health Needs Assessment (CHNA)

- What is a CHNA?
  - A systematic process involving the community to identify health needs and issues through data and information gathering and analysis
- Why is a CHNA done?
  - Provides information to identify and prioritize community health needs
  - Can provide justification for how and where resources should be allocated
- CHNAs conducted by a variety of organizations
  - Critical Access Hospitals – every 3 years as mandated by the ACA
  - Public Health – required for public health accreditation
  - Community Health Centers – HRSA requirement

Community Health Needs Assessment Process

SAKAKAWEA MEDICAL CENTER

Coal Country Community Health Center

Using CHNA findings

- Strategic Planning
  - Individual organization and collective planning
- Develop an Implementation Plan
- Community Health Improvement Plan (CHIP)
  - Partner collaboration with public health
- Population health activities
  - Monitor progress and adjust the plan based on changing needs
- The process realizing the greatest community benefit
  - Coordinated and collaborative assessment and planning
  - Some states aggregate results for state-wide planning
  - Our collaborative CHNA, planning and implementation

Sakakawea Medical Center (SMC)

- 501c3 Not for Profit Corporation
- Located in Hazen, ND
- 13 Bed Critical Access Hospital (CAH)
- Hospital, Hospice, Palliative Care, Basic Care

Coal Country Community Health Center (CCCHC)

- 501c3 Not for Profit Corporation
- Located in Beulah, ND
- Designated as an FQHC in 2003
- 4 Service delivery sites
- Medical, Behavioral Health, Visiting Nurse

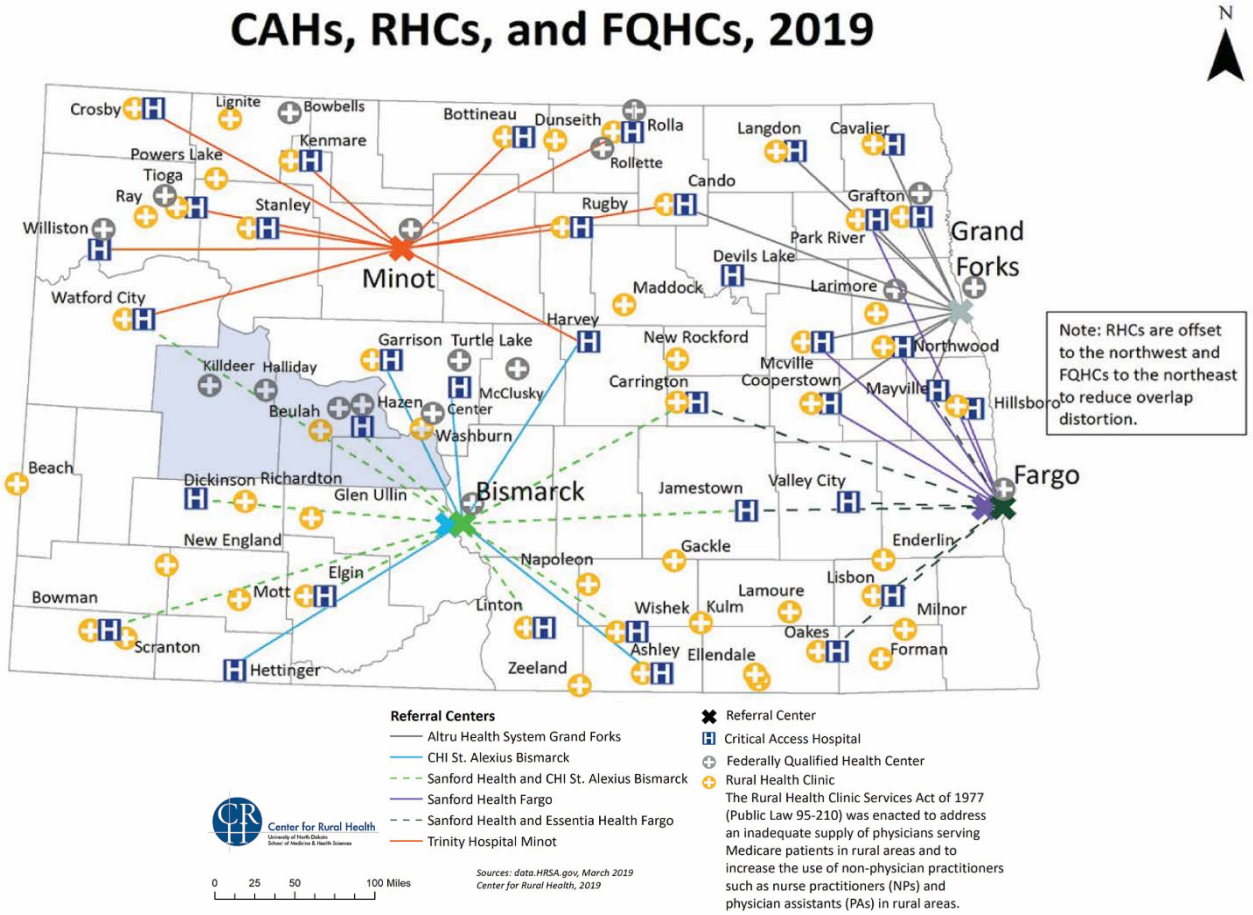
SAKAKAWEA MEDICAL CENTER

Coal Country Community Health Center

SMC & CCCHC Service Area

Service Area – Rural

- West Central North Dakota
- 70 Miles Northwest of Bismarck
- Service area – 4,000 square miles
- Service Area Population – 15,000
- Major Industry – Energy



SAKAKAWEA MEDICAL CENTER

Coal Country Community Health Center

SMC & CCCHC Collaborative Community Health Needs Assessment (CHNA) and Planning

- Evolved from collaborative CAH/CHC Leadership and Governance
- Included multiple community partners
  - Core partners
    - Critical Access Hospital
    - Community Health Center
    - Public Health
    - Skilled Nursing Facility
    - EMS
  - Other participants
    - State and local government, business and industry
    - School administration, community at large

SAKAKAWEA MEDICAL CENTER

Coal Country Community Health Center

Benefits of our Collaborative Process

- Individual and collective implementation and strategic planning
- Collaborative and coordinated Community Health Improvement Plan
- Population Health Committee monitors progress and changing landscape
- Collaborative process aligns efforts and is more effective
- Patient Centered Medical Neighborhood (PCMN) of care
  - Improved financial performance
  - Improved clinical outcomes and quality metrics
  - Enhanced collaborative care
    - Care coordination, transitions of care
- Provides a foundation for additional initiatives

Benefits of our Collaborative Process

- Foundation for additional initiatives
  - CAH and Community Health Center jointly implemented a new EMR
  - Value based care
    - Medicare, Medicaid and Commercial models (ACOs)
  - Patient Family Advisory Council
  - Energy Capital Child Care Cooperative
- Population Health Committee
  - Keeps the activities going and relevant (meets monthly)
- Better able to respond to changing needs such as COVID-19 Pandemic
  - Alignment with planning and processes
- Future collaborative initiatives

Thanks for Listening!

Darrold Bertsch
Sakakawea Medical Center
Coal Country Community Health Center
dbertsch@smcnd.org
Cell 701-880-1440

SAKAKAWEA MEDICAL CENTER

Coal Country Community Health Center

NATIONAL RURAL HEALTH RESOURCE CENTER

June 25, 2020

Supporting Population Health Efforts: Minnesota Integrated Behavioral Health Program

Rhonda Barcus, MS, LPC

Program Manager

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

NATIONAL RURAL HEALTH RESOURCE CENTER

IBH Project Funded By

Office of Rural Health and Primary Care

This project is supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under grant number H54RH00023. The information, conclusions and opinions expressed in this document are those of the authors and no endorsement by FORHP, HRSA or HHS is intended or should be inferred.

NATIONAL
RURAL HEALTH
RESOURCE CENTER

IBH Project Background

Minnesota Flex Program Focus Area: Population Health

Analyzed 59 MN community health needs assessment findings

- Behavioral health (BH) was one of two most frequently cited needs
- Identified need for community partnerships
- Described goals to integrate BH and outreach

Local Public Health (LPH) Department Findings

Aggregated LPH findings identified access to BH services was the top identified need statewide.

What is Integrated Care?

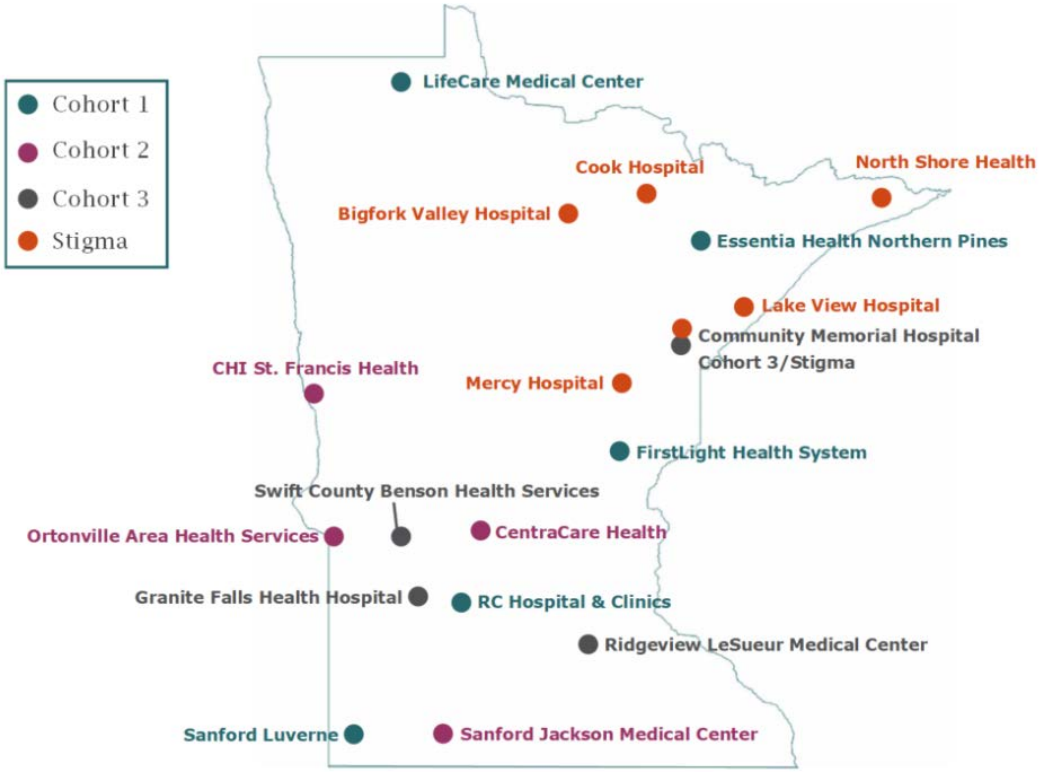
The systematic coordination of general and BH care.

Integrating **mental health**, **substance abuse** and, **primary care** services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs.

Source: SAMSHA

The IBH Project - Toolkit

Explore the Toolkit



- IBH Project Process
  - Readiness Assessment
  - Selection Process
  - Technical Assistance
  - Evaluation of Project Outcomes
  - Lessons Learned
- Hospital & Community Teams
- Promising Practices
- Project Outcomes
- Minnesota IBH Resources

NATIONAL RURAL HEALTH RESOURCE CENTER

Technical Assistance (2015-2019)

- Kick-off workshop
- Community strategic planning event
- Quarterly peer sharing calls
- Quarterly evaluation calls
- Technical assistance calls as needed
- Educational Webinars
- Workshop focused on sustainability practices
- Data collection

IBH Project Process

- Readiness Assessment
- Selection Process
- Technical Assistance
- Evaluation of Project Outcomes
- Lessons Learned

Hospital & Community Teams

Promising Practices

Project Outcomes

Minnesota IBH Resources

Evaluation of Project Outcomes

Recommendation Adoption Progress (RAP) Report

- Conversation focuses on “telling the story”
- Hospital interviews with project teams at regular intervals during implementation
- Hospital to demonstrate ways the project has become embedded in the culture
- RAP interviews are held quarterly which assists to keep the teams focused and motivated

NATIONAL RURAL HEALTH RESOURCE CENTER

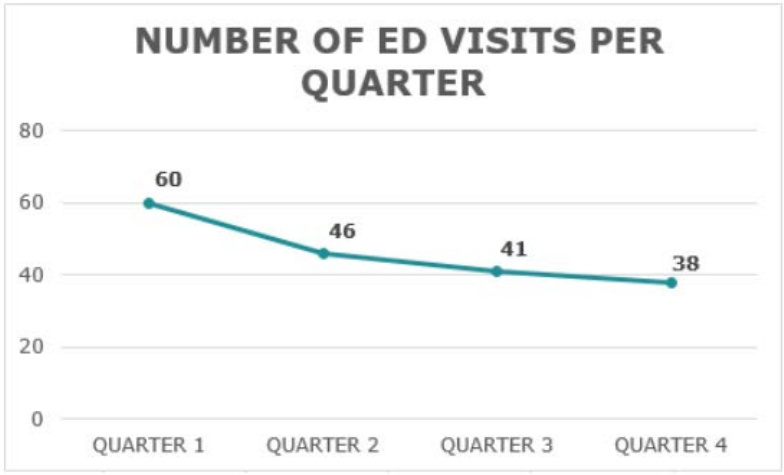
Data Sheet

Measure Area	Pre-Project Values and timeframe	July-Sept 2017 values	Oct-Dec 2017 values	Jan-March 2018 values	April-June 2018 values
Hospital specific utilization of services measure:					
Hospital specific cost of services measure:					
Hospital specific health outcomes measure:					
Hospital specific individual measure:					

NATIONAL RURAL HEALTH RESOURCE CENTER

One Example

- Created a **Roving Therapist** position (Jan 2016)
  - Counsels inmates with depression and anxiety
- Since then:
  - Patients brought to the Emergency Department (ED) from the jail has decreased
  - Inmates seen by the Roving Therapist in the jail have **resulted in ZERO In-Patient Psych transfers**



NATIONAL RURAL HEALTH RESOURCE CENTER

Successful Integration of BH

Measurable Outcomes from MN IBH Project

- Increased access to BH services
- Increased “discharge to home“
- Decreased transfers to inpatient settings
- Decreased cost of transferring ED patients as well as cost of ED visits
- Decreased ED visits and admissions
- Decreased mental health holds
- Decreased Patient Health Questionnaire (PHQ-9) scores at six-month follow-up
- Decreased jail-psychiatric transfers

Promising Practices

Stakeholder Collaboration
Identify and engaging stakeholders and include them in the planning of the project.

Resource Directory
Allows providers and consumers to identify available opportunities to access services.

Universal Release of Information
Includes a list of potential agencies that will support a client's care. See the sample RIO form.

Mobile Crisis Team
The mobile crisis team went directly to a client's home to assess and de-escalate.

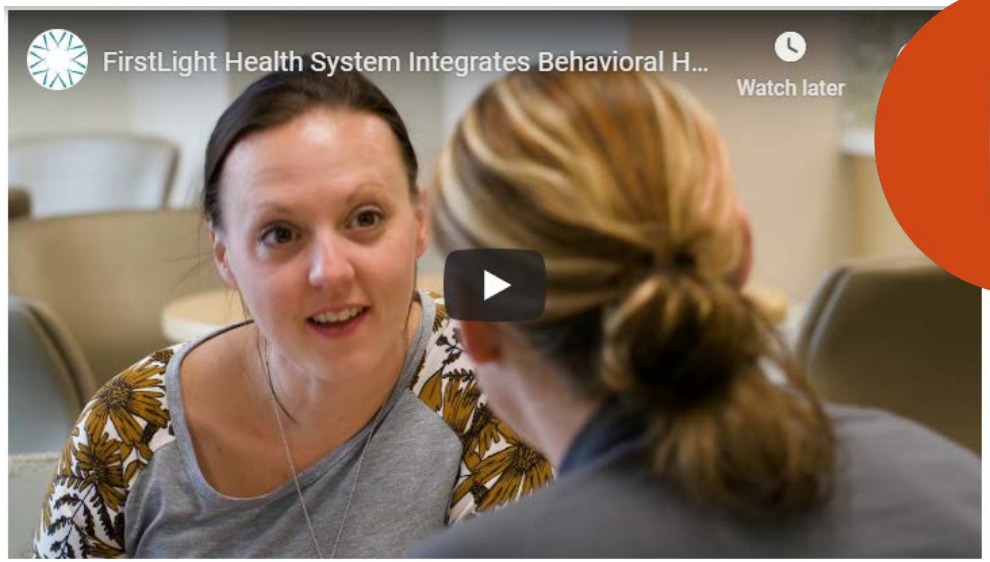
Community Navigator
Provides support and ensures the client follows their treatment plan and/or taking their medication.

Roving Therapist
Available to go where needed and collaborate with other agencies prior to a patient's release.

Client Transport Vehicle
Consider the purchase or donation of a former police vehicle to transport instead of local ambulance.

Implementing the Make It OK Campaign
Use the toolkit on the Make It OK website.

Success Stories



NATIONAL RURAL HEALTH RESOURCE CENTER

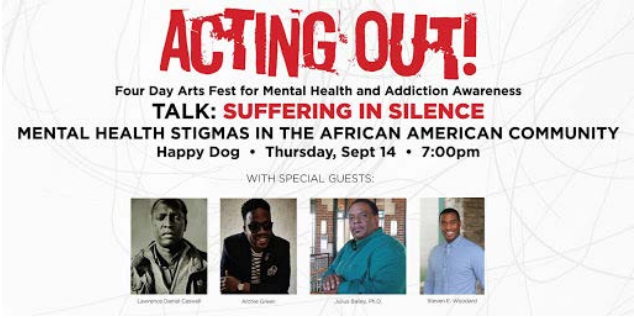
Addressing the #1 Barrier: STIGMA!

Eliminating the societal stigma of mental illness and substance abuse:

- Utilizing the Make It OK Campaign within the hospital and beyond
- Forming a committee of community partners to address the stigma
- Engaging local government, schools, etc.
- Education and Training

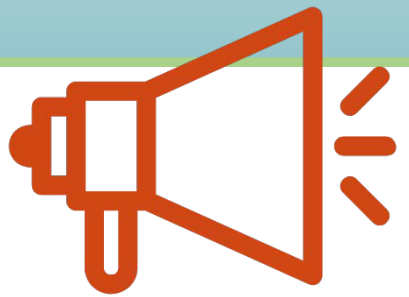
NATIONAL RURAL HEALTH RESOURCE CENTER

Community Event Ideas



NATIONAL RURAL HEALTH RESOURCE CENTER

Campaigns to End Stigma



- Recovery Month Toolkit
  - SAMHSA resources, including addressing stigma
- Makeitok.org
  - Free toolkit, printable collateral, videos, and presentations to implement in your organization
- Changetochill.org
  - Supports school-wide efforts to create a culture of mental well-being for students and staff
  - Provides free trainings, collateral, and presentations
- *Working Through It*™
  - Increase knowledge and awareness of workplace psychological health and safety, improve the ability to respond to mental health issues at work, and turn knowledge into action through practical strategies and tools for employers
  - Free printable resources, research, and reports

NATIONAL
RURAL HEALTH
RESOURCE CENTER

Rhonda Barcus

Program Manager

904-321-7607

rbarcus@ruralcenter.org

Get to know us better:
http://www.ruralcenter.org

Connecting Rural Development, Health and Opportunity

The Role of Rural Development Hubs and Policy

Rural Health in Rural America 2020

Roundtable on Population Health Improvement

June 25, 2020

Katharine Ferguson

Aspen Institute Community Strategies Group

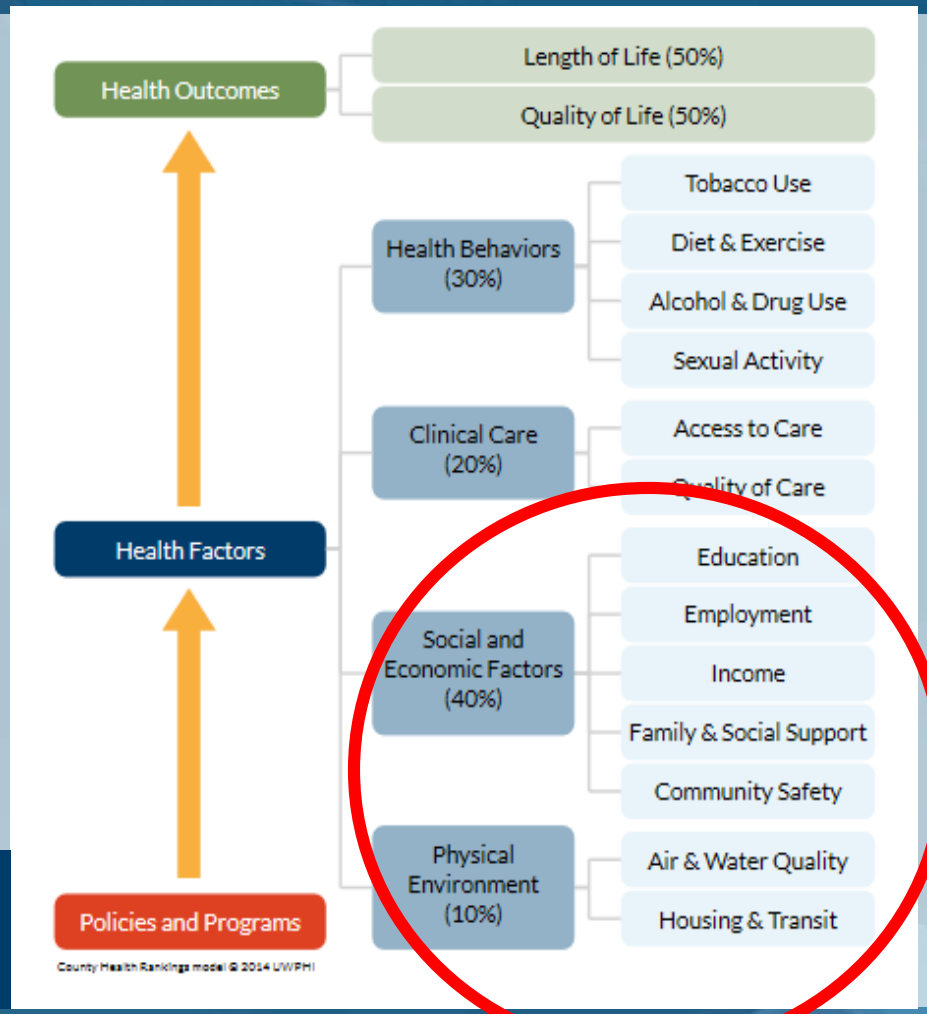
Objectives

1. Make the connection between community and economic development, health equity and opportunity—and why place matters.

2. Explore a *particular type* of regional actor – **Rural Development Hubs** –that are helping build a better rural development ecosystem.

3. Provide background on U.S. rural policy and ideas for how revamping rural policy can help connect development, health and build stronger Hubs.

Community and Economic Development Efforts Influence Health



County Health Rankings & Roadmaps
Building a Culture of Health, County by County

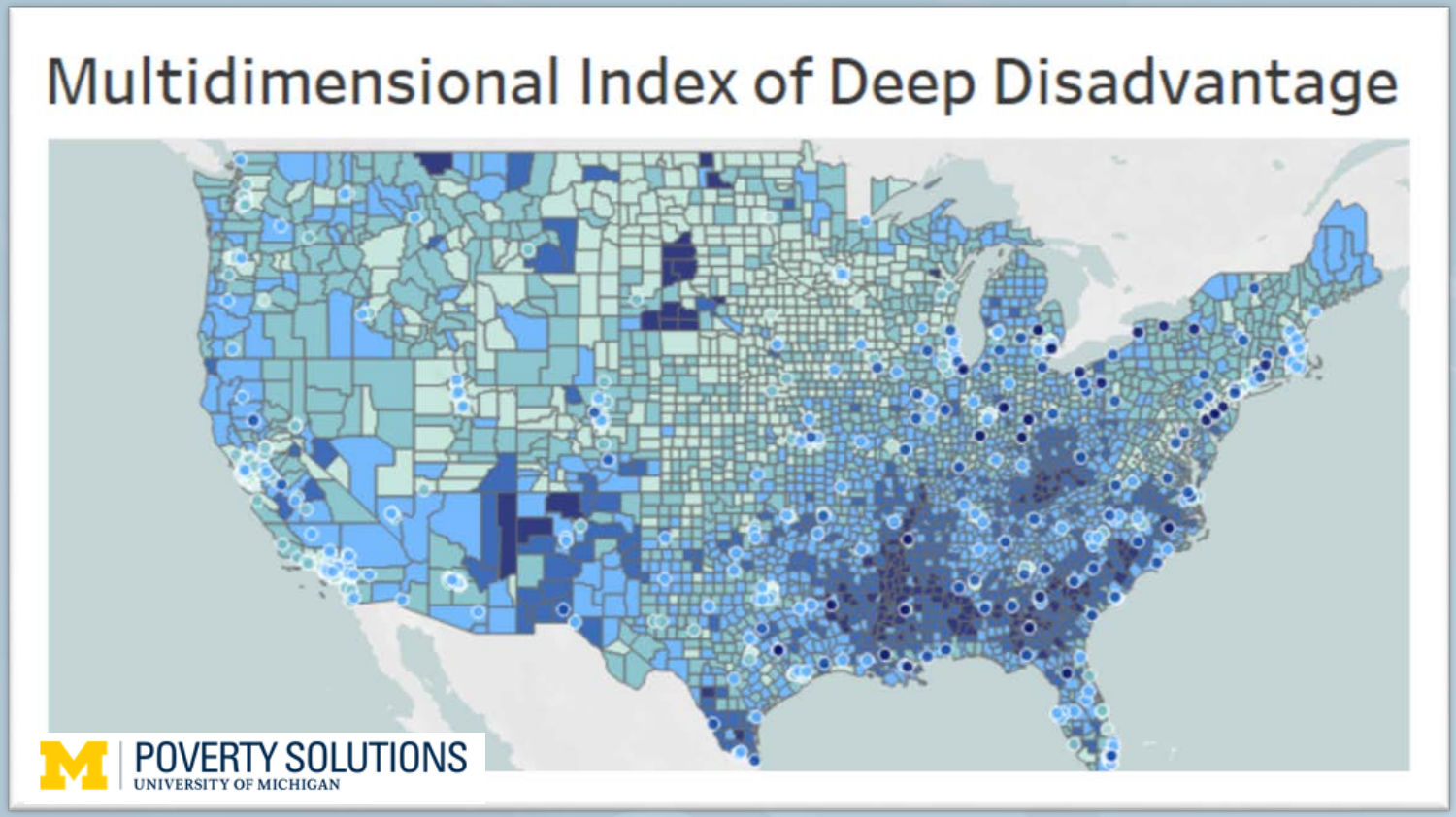
https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

Thinking Beyond Healthcare to Health, Well-Being and Opportunity

- Schools and educators
- Day care providers
- Employers and workforce
- Transportation providers
- Mental health providers
- Social service providers
- Food assistance providers
- Housing availability and affordability
- Safety and security
- Community building
- Recreation opportunities
- The built environment
- The natural environment
- Sense of belonging
- Cultural norms

Place Has Great Bearing on Opportunity

There is a growing awareness beyond public health and academic circles that *place* – meaning where we live – is an important component of health and equity in America.

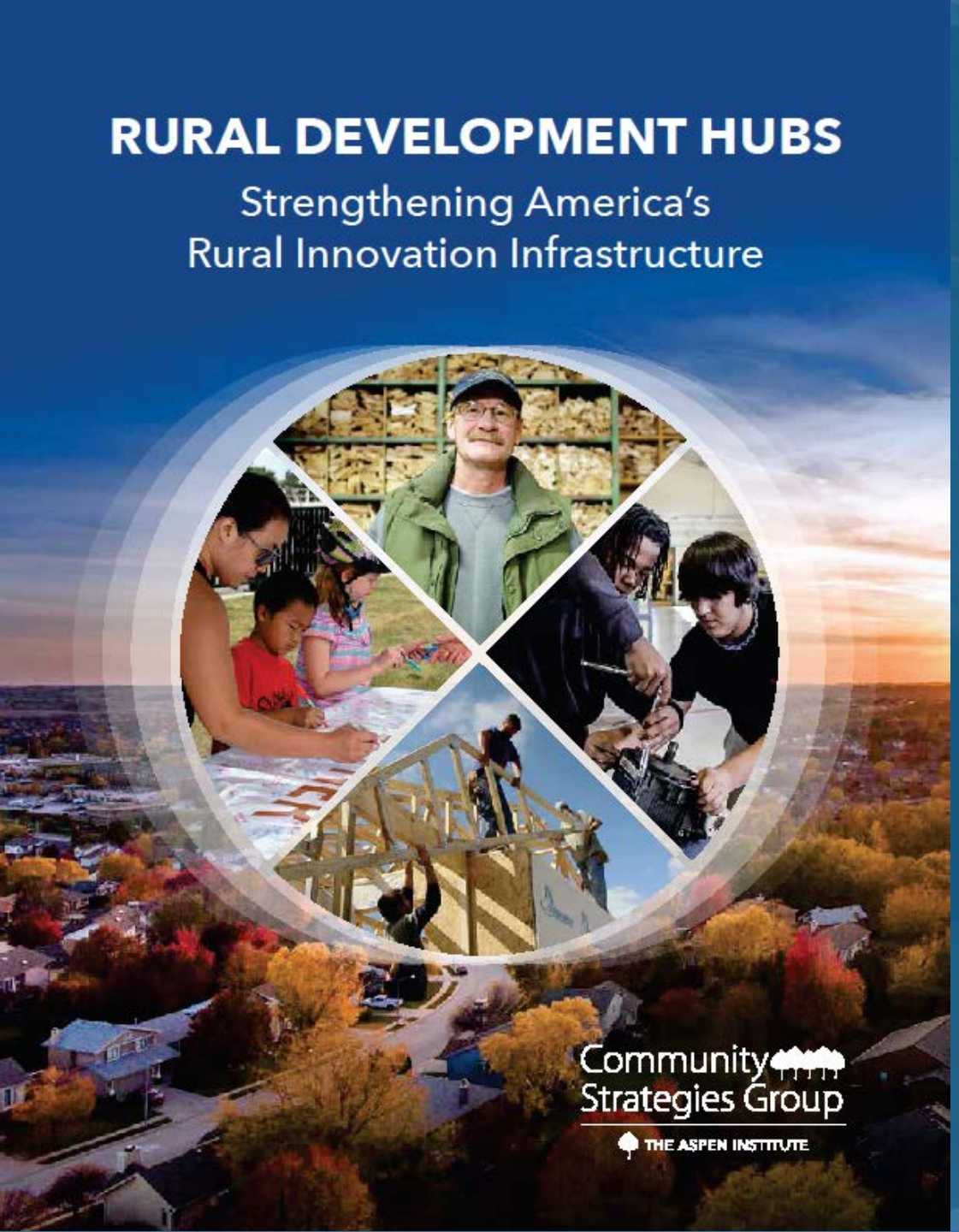


Citation: https://poverty.umich.edu/projects/understanding-communities-of-deep-disadvantage/

Many Important "Development Actors" are Less Visible

Rural and Regional Intermediary Organizations

- Community Development Financial Institutions
- Community Development Credit Unions
- Community Foundations and other kinds of foundations (Health conversion, family, legacy)
- Community Action Associations
- Community colleges
- "unicorn" regional, non-profits organizations
- Value-Chain Coordinators
- Statewide rural organizations
- Social enterprise collaboratives, including cooperatives
- Regional councils of governments



A Rural Development Hub is
a place-rooted organization
working hand-in-glove
with people and organizations
within and across a region
to build inclusive wealth,
increase local capacity,
and create opportunities for
better livelihoods, health and well-being.

Rural Development Hubs: Our Research

- Interviewed leaders in 43 Hubs across the country – representative of varying geography, types of organizations, populations.

- Asked them how they thought about their work, what challenged them and what would help them do more and better.

- Reminder: Hubs can be all kinds of organizations:
  - CDFIs and CDCUs
  - Community Action Agencies
  - Community Foundations – and other kinds of foundations (Family, Health Legacy, Regional)
  - Statewide rural organizations
  - Community colleges
  - Social enterprises/collaboratives
  - Unicorn regional organizations

A Few Rural Development Hubs

We must do economic development differently.
We must make bold moves to shift our economy
away from inequitable extraction of resources
and towards a collective, inclusive vision of the future.

Heidi Khokhar
Rural Development Initiatives
Oregon

An Outcome-Oriented, Wealth-Building Framework for Development

OUTCOME 1

Grow multiple forms of **CAPITAL**

Recognize, invest in and grow the many types of capital – individual, intellectual, social, natural, built, political, cultural and financial – needed to sustain an economy.

OUTCOME 2

Root **OWNERSHIP** in the Region

Create pathways for more local ownership, control and influence over economic drivers and the wealth those drivers generate.

OUTCOME 3

Improve **LIVELIHOODS** for those living on the margins

Strengthen and improve livelihoods – high quality, living-wage work and careers – for all residents, especially those on the economic margins.

The Development Toolbox (*simplified*)

Traditional Development Toolbox

- Marketing a Place or Region
- Resource extraction
  - Timber, coal, oil, etc.
- Business Recruitment
  - Tax credits
  - "investment ready" e.g. industrial park

- Success = growth and jobs (primarily)

Expanded Hub Development Toolbox

- Traditional Development Toolbox

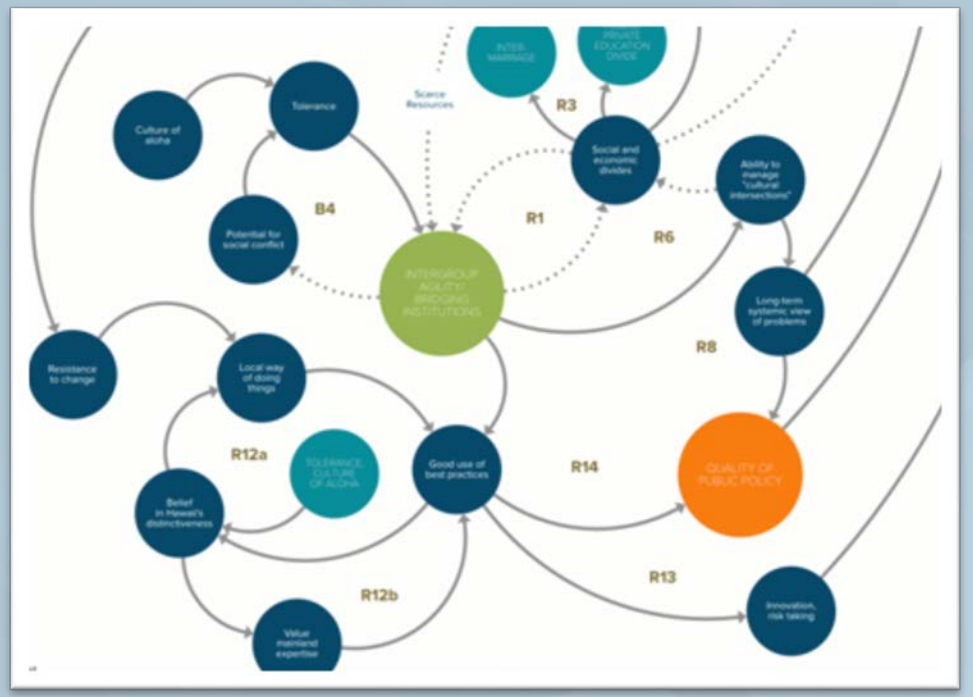
+

- Systems thinking, regional lens
- Broader understanding of 'capital'
- Community engagement + equity focus
- Local ownership

- Success = local wealth built and retained, health, resilience--as well as quality jobs.

RD Hubs are Essential to SDOH Progress

Rural Development Hubs are **essential partners** to progress on social determinants of health in rural regions because RD Hubs **think about the whole system** and **engage a wide-array of non-traditional partners** among different sectors of the community to achieve positive outcomes in a way that is **compatible with the population health.**



Our aim is to create a place at the table
for all parts of the community,
especially those parts that may look different or
have not always been included in the conversation.
Inclusion cannot happen on its own.
It must be an intentional part of any
economic or community development strategy.

Patrick Woodie

NC Rural Center

10 Routes to a Stronger Rural Development Ecosystem

Shift Mindsets	Construct or Revise Systems and Policies	Build Capacity
1. Understand this Truth: Addressing equity nationally requires investments in rural America. 2. Increase America's rural cultural competency. 3. Trust the know-what and know-how of Rural Development Hubs. 4. Reimagine what "impact" means in rural contexts.	5. Detect and eradicate government systems and structures that disadvantage rural America. 6. Design policies and programs with rural implementation in mind.	7. Support analysis and action at the regional level. 8. Boost peer-learning for Hub staff and board leaders. 9. Create pipelines and marketplaces that connect investors to America's rural development. 10. Structure investments and initiatives to strengthen and sustain system-changing organizations.

BONUS: Create a consensus vision and framework for rural community and economic development.

COVID-19 and the Rural Economy

- **Rural economies were the hardest hit by the 2008 recession** and the slowest to recover. By 2017, average rural employment was **still two percent lower** than in 2007.
- **Businesses were hit especially hard**—in the first four years of the recovery, counties under 100,000 lost 17,500 businesses, while economies in counties over one million people added 99,000.
- Existing racial, health and economic **disparities** are being exaggerated.

"I am very concerned about rural America. Especially those who are poor, especially persons of color, especially those who are older…and all of rural, actually. I cannot overstate my concern for rural communities and the lack of health care sites…."

-Rural Practitioner

Citation: https://www.aspeninstitute.org/blog-posts/rural-frontlines-and-covid-19-reporting-from-the-field/

Federal Rural Policy is Outdated

While the pressures and opportunities faced by rural economies have radically changed, the existing federal architecture for rural policy is old—largely dating to the 1860s, 1930s, and 1960s—and designed for a different time.

Principles for Reimagining Federal Policy in the COVID-19 Era

1. Support local ownership and strategies
2. Invest in people and institutions.
3. Increase flexibility and align federal and state funds to meet local needs.
4. Measure and reward outcomes.
5. Embrace a regional mindset.

Citation: https://www.aspeninstitute.org/blog-posts/reimagining-federal-rural-policy/

Four Big Ideas for Modernizing Federal Rural Policy

1. Bring strategy and coherence to US rural policy.
2. Launch the American Challenge Corporation.
3. Expand domestic development finance.
4. Elevate capacity building and evaluation.

https://www.aspeninstitute.org/blog-posts/redesign-required-four-ideas-for-reimagining-federal-rural-policy-in-the-covid-19-era/

Ways to Connect Health & Development Now

1. Adopt asset-based and wealth-building approaches, rather than focusing on deficits.

2. Align development and health strategies, including the required Comprehensive Economic Development Strategies (CEDS) and Community Health Needs Assessments (CHNA).

3. Build partnerships and a shared frameworks and vocabulary among RD Hub leaders and population health leaders.

4. Build momentum for investing in local people, civic institutions, capacity building, and evaluation.

5. Join forces to rewrite the rural narrative to reflect the full diversity and potential of rural people and places.

ECONOMIC DEVELOPMENT

Introducing Thrive Rural

Thrive Rural will work closely with community and economic development, health and civic engagement experts across the nation to create a shared vision and understanding about what it will take to create dynamic, sustainable rural communities where all people can realize their full potential and live healthy lives.

https://www.aspeninstitute.org/blog-posts/redesign-required-four-ideas-for-reimagining-federal-rural-policy-in-the-covid-19-era/

Thank You.

Katharine Ferguson

Katharine.Ferguson@aspeninstitute.org

www.aspencsg.org

For the Hubs report: as.pn/ruralhubs

INNOVATIONS IN SUSTAINING RURAL POPULATION HEALTH.

Karen J. Minyard, Ph.D.

CEO, Georgia Health Policy Center
Andrew Young School of Policy Studies
Georgia State University

Georgia Health Policy Center
Georgia State University | Andrew Young School of Policy Studies

Rural ≠ Monolith

Many sub-groups of rural areas that share historical, cultural, economic, and geographical commonalities

KEY DOMAINS OF RURAL

What is on Our Minds?

- Community Health Workers: Providing Social Support in a Virtual World
- How to Deliver Effective Virtual Trainings and Meetings
- Peer Support Services and Recovery Supports during a Pandemic
- Using Telehealth in New Ways to Meet Emerging Needs
- Data Collection and Evaluation: Adjusting your Approach During a Pandemic
- Working with Schools: Strategies to Support the Community

Innovations

GHPC Sustainability Framework©

Innovation occurs when effectively influencing the flow of funds in your community to drive impact.

Financing innovations involve the application, combination, and creation of financing tools and methods.

Bridging for Health: Improving Community Health Through Innovations in Financing

BLUEPRINT FOR ACTION

CREATING A CULTURE OF HEALTH

How will we do it?

Stewardship

- Purpose
- People
- Structure

Strategy

- Develop a deeper understanding of the issue
- Create a shared vision
- Identify opportunities for greatest impact:
  - Policy
  - Program

How much money do we need?

Annually

Where does it come from?

- Loans
- Investor funds
- Philanthropy
- Public:
  - new taxes/fees
  - redirected/saved
  - federal/state agents

Initially

How do we manage & administer it?

- New or existing not-for-profit
- Coalition
- Public-private partnership
- Joint public agency
- Public agency providers

Financial ROI

Social ROI

Accountability

Financial Instruments

Collaboration & Collective Impact

Innovations in Financing

Health & Health Equity

Evaluation

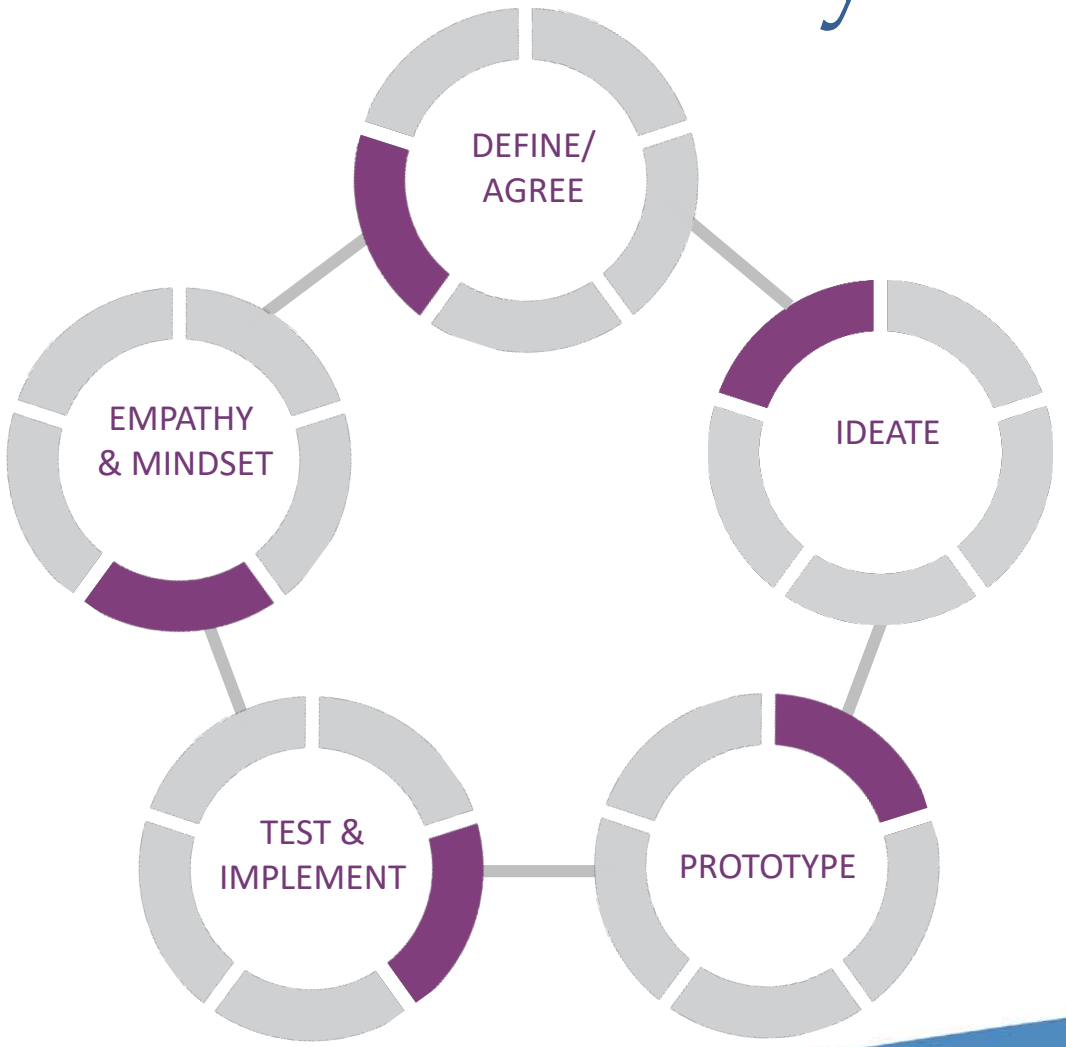
Robert Wood Johnson Foundation

www.ghpc.gsu.edu/bridging

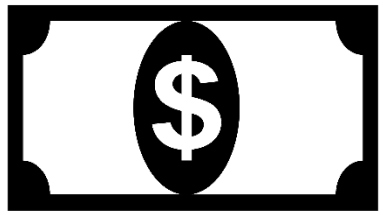
© Georgia Health Policy Center, 2016

Georgia Health Policy Center

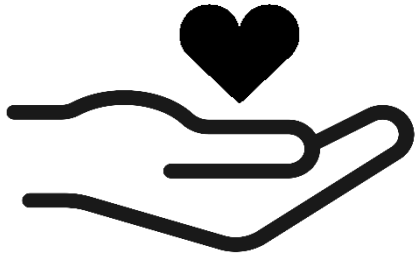
Innovation Cycle



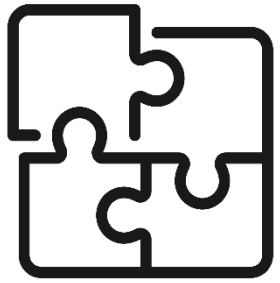
Sources, Uses, and Structure



Sources: Where does the money come from?



Uses: What will funds be used for?



Structure: How do we manage, administer, and provide stewardship for these funds?

Financing

- Fascination with the financing mechanisms is not a substitute for understanding the flow of money in the region.
- Community collaboratives embrace evolutionary rather than revolutionary approaches to financing population health.
- In order for communities to make real progress in developing their pooled community wellness funds, three critical questions must be answered.
- Maintaining a focus on the financing innovation — not program implementation — is critical and often challenging.

Look at the Money – An Exercise

- Review the image shown on the next slide; it represents a common phrase.
- When you know the phrase the image represents, write it down but don't put it in the chat yet.
- Await further instructions.

See the Money

grene geren
ngree eengr
egern

- "See" beyond the obvious
- Macro – system-level
- Micro – program-level
- Some do this naturally ("money whisperers")
- All of us can learn to do with intention and practice

See the Money

grene geren
ngree eengr
egern

Mixed greens

- "See" beyond the obvious
- Macro – system-level
- Micro – program-level
- Some do this naturally ("money whisperers")
- All of us can learn to do with intention and practice

MINDSET CHANGE TO BUILD INNOVATIONS IN FINANCING

Move Thinking Upstream. When focusing on population health, what can we do that will have the highest leverage to improve health and well-being?

Look at the Money. Look at the dollars in the system. Look in unlikely places.

Build Stewardship. Build a culture of collaboration and shared stewardship among a thoughtful group of people from different sectors, inside and outside of health.

Explore the Financing Vehicles. Focus on a broad range of previously known or undiscovered funding vehicles. Innovations may include a combination to meet the local context.

Look for the Intersections. Find the places that health, money, and partners intersect.

Invest Together. Work collectively to make investments in health and well-being.

Repeat. Repeat. Repeat.

Georgia Health Policy Center

Robert Wood Johnson Foundation

THANK YOU!

Contact Information:

Karen J. Minyard, Ph.D.
CEO, Georgia Health Policy Center
kminyard@gsu.edu
Phone: 404-413-0301

Rural Health Policy and Practice toward Value Based Care National Academies

Tim Putnam, DHA, FACHE
Margaret Mary Health
Batesville, IN

Our MISSION

To improve the health of our communities

Our VISION

To be the best health care provider for our communities where people choose to come for services; where physicians choose to practice; and where team members choose to work.

Our VALUES

INNOVATION
We embrace change

COLLABORATION
We work together

ACCOUNTABILITY
We do the right thing

RESPECT
We value everyone

EXCELLENCE
We strive to be the best

2,013
INPATIENT
admissions

494
BABIES
born

176,366
OUTPATIENT
visits

272
PHYSICIANS & PROVIDERS

196
NURSES

782
TEAM MEMBERS

TOP 20 CRITICAL ACCESS HOSPITAL 2019
Overall Winner
NRHA NATIONAL RURAL HEALTH ASSOCIATION

TOP 100 Critical Access **HOSPITAL**
National Rural Health Association

QUALITY RATING
Centers for Medicare/Medicaid Services

Transition to Value Based Care in Small Town America

- Fit to Mission
- Board Education
- Focus on Primary Care
- Coordination with other rural community health systems

Failures and Misconceptions

- It’s not a separate program
- Initially we had a hospital focus
- Not about high-end cost patients
- It really needed to become part of primary/preventative care for everyone

What We Learned

- Partner with hospitals who want to really make a difference
- Use the treasure-trove of data
- Care coordinators
  - Physicians trust the care coordinators and convey that trust to patients
- Annual wellness visits
- Get into the home
  - Address social determinants of health

Then the Pandemic Hit

- Margaret Mary story
  - Friday the 13th
  - Hospital exceeded regular capacity
  - ER patients crashing within hours of arrival
  - Staff contracting COVID-19
- “Knowing” the attributed ACO patients made a difference
- Value of health conditions like diabetes and blood pressure under control
- Trust in the care coordinators

Future

- AWV – prevention is key
- How do we reduce 911 calls
- Partnerships in our community

Rural can lead value-based care

- Relationships
- Mission driven
- Wellness focused

Confronting Rural America's Health Care Crisis: Bipartisan Policy Center Rural Health Task Force Recommendations

Keith J. Mueller, PhD, Task Force Member

Director, Rural Policy Research Center

University of Iowa

Presented in the Roundtable on Population Health,

National Academy of Medicine

June 25, 2020

Acknowledgements

- The Leona M and Harry B Helmsley Charitable Trust provided generous support in funding the work of the Rural Health Task force
- Members of the Honorary Congressional Task force on Rural Health provided special insight: Senator Chuck Grassley (R-IA), Senator Tina Smith (D-MN), Senator Bill Cassidy (R-LA), Senator Angus King (I-ME), Congressman Jodey Arrington (R-TX, and Congressman Xochitl Torres Small (D-NM)

About the Task Force and Process

Task	Support	Process
Task force an array of expertise in rural health delivery, finance, and policy – co-chaired by former U.S. Senators and state Governors	Support from highly capable staff	Process included roundtables with additional experts and stakeholder groups; site visits; and with congressional staff

Essential to Health Care Providers Participation in Population Health

Financial stability: short term

Financial sustainability: long term

Flexibility in using resources, including healthcare workforce

Incentives and flexibility: new models of finance and delivery

Infrastructure support

Financial Stability: Hospitals

- Sequestration relief (accomplished for immediate term, committee would extend through FY 2023)
- Increase critical access hospital payment 3%
- Re-establish CAH necessary provider designation process
- Make designation of Medicare Dependent Hospitals permanent, and adjustment for low volume rural hospitals

Financial Stability: Other Providers

- Payment for rural clinicians reporting data under the Quality Payment Program
- Extend bonus payments for new advanced Alternative Payment Model participants
- Leverage patient engagement incentives to decrease rural bypass and incentivize local care utilization

Financial Stability Long Term

- Grants and loans for capital infrastructure: modify service lines or improve structure or patient safety
- Payment for rural health clinics and expand access to advanced practice clinician services in RHCs
- Increase Medicare-capped reimbursement rate for physician-owned RHCs
- Exclude enrolled accountable care organization beneficiaries when determining regional benchmark in rural areas

Flexible Use of Resources

Clarify	Clarify rules around co-location or shared space agreements that allow rural hospitals to partner with other health care providers
Allow	Allow advanced practice clinicians to work up their state scope of practice in RHCs
Exempt	Exempt rural Medicare beneficiaries from prohibition against same-day services
Remove	Remove regulatory an legislative barriers that prevent non-physician providers from practicing at the top of their license

Incentives and Flexibility

- Establish a process for rural facilities and communities to develop a Hospital Transformation Plan
- New models
  - Rural and Emergency Outpatient Hospital designation
  - Extended Rural Services Program
  - Global budget models
- Decrease qualifying participation thresholds for rural providers in Alternative Payment Models

Infrastructure Support

- Prioritize connecting rural areas with broadband through anchor institutions and direct-to-home services
- Ensure effective implementation of the Broadband Deployment Accuracy and Technological Availability Act
- Use of telehealth services supported by changes in payment, eligible providers, sites of service, and eligible services – all were included in COVID-19 related legislation and regulatory change; now task is extending beyond current pandemic

Additional Recommendations

- Increase number of rural-specific CMMI demonstrations and expedite national expansion of promising models
- Reduce administrative burden for rural providers: use readily available claims data for quality performance
- Improve access to quality maternal care in rural areas (4 specific recommendations)
- Improve utilization of currently available workforce (5 specific recommendations)

Additional Recommendations

- Strengthen the Health Resources and Services Administration rural workforce programs (2 specific recommendations)
- Expand federal rural workforce recruitment and retention initiatives (four specific recommendations)
- Authorize licenses clinicians to provide inter-state services to Medicare beneficiaries
- Direct the Office of the National Coordinator for Health Information Technology to prioritize rural-specific training curricula for the health IT workforce

Necessary Conditions to Address Population Health

- Financially secure delivery system, with predictability
- Payment systems supporting engaging in community-driven population health programming
- Flexibility for how the system is built and how professionals practice and interact
- Flexibility for how patients (persons) interact with a range of providers
- BPC Task Force recommendations are building blocks

For More Information

- The Task Force Report: https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/
- Bipartisan Policy Center health portfolio: https://bipartisanpolicy.org/policy-area/health/
- Rural Policy Research Institute (RUPRI) Health Panel: http://www.rupri.org/areas-of-work/health-policy/

Keith Mueller, PhD

Gerhard Hartman Professor and Head, Department of Health Management & Policy

University of Iowa College of Public Health

Director, RUPRI Center for Rural Health Policy Analysis

145 Riverside Drive, N232A, CPHB

Iowa City, IA 52242

319-384-3832

keith-mueller@uiowa.edu

The University of Iowa RUPRI Rural Policy Research Institute

Indian Health Service

BEN SMITH, DEPUTY DIRECTOR FOR INTERGOVERNMENTAL AFFAIRS

JUNE 25 2020

Indian Health Service: Overview

- The IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives

- Serves members of 574 federally recognized Tribes

- Fiscal Year 2020 budget appropriation is approximately $6 billion

- IHS total staff consists of more than 15,300 employees, including nurses, physicians, pharmacists, sanitarians, physician assistants, and dentists

Promoting Health Care

IHS also promotes health care and protects the public health through other services, including:

- Sanitation construction projects, ranging from complex installation of wastewater treatment systems to simpler things like septic systems for homes without existing or adequate waste treatment.

- Environmental health programs

- Construction of hospitals and health clinics for use by the federal government and its tribal contractors.

IHS System: Three Mechanisms

- Directly

- Contracts with tribes and/or tribal organizations

- Contracts under the Federal Acquisition Regulations with Urban-Indian controlled

Indian Health Care System

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations	School Health Centers	Youth Regional Treatment Centers
IHS	24	50	-	24	11	7
Tribal Health Programs	22	285	127	54	5	5

The IHS also provides funding to 41 urban-centered organizations.

Geographical and Physical Locations

Challenges

Life Expectancy

Health Information Technology

Level of Need Funded

Recruitment & Retention

Facilities & Equipment


INDIAN HEALTH SERVICE
PHS · 1955 ·

The CARES Act

The Congressional Response to COVID-19 for Rural America

Four COVID-19 Response Bills Passed by Congress

- The Coronavirus Preparedness and Response Supplemental Appropriations Act (H.R. 6074)
- The Families First Coronavirus Response Act (H.R. 6201)
- The Coronavirus Aid, Relief, and Economic Security (CARES) Act (S. 3548, vehicle: H.R. 748)
- The Paycheck Protection Program and Health Care Enhancement Act (H.R. 266)

The Coronavirus Preparedness and Response Supplemental Appropriations Act

Provided $7.8 billion in funding to respond to COVID-19

- $61 million for FDA
- $2.2 billion for CDC
  - $950 million for states and localities for core public health functions
- $836 million for the National Institute of Allergy and Infectious Disease
- $3.1 billion for the Public Health and Social Services Emergency Fund
  - $100 million for HRSA for grants under the Health Centers Program.
- $20 million for SBA Disaster Loans

The Families First Coronavirus Response Act

- Provided $3.47 billion in additional funding
  - Significant funding to maintain access to nutrition
  - $1 billion for the Public Health and Social Services Emergency Fund to pay health care providers to cover the costs of COVID-19 testing for the uninsured.
- Provided a temporary 6.2% increase to the federal match for Medicaid
- Expanded access to paid sick leave
- Required that COVID-19 testing and related services be covered without cost sharing

The CARES Act

A $2 trillion bill: The largest stimulus bill in U.S. history

Topline economic provisions:

- Expanded unemployment insurance with $600/week increase in benefits.
- Created the Paycheck Protection Program to help small businesses, including rural health providers
- Provided $1200 recovery rebate to Americans (subject to an income cap)
- $150 billion for states and local governments
- $500 billion for mid-sized and large businesses

CARES Funding for Rural Health Care Providers

- $100 billion for hospitals, physician practices and other health care providers to help cover costs related to COVID-19, including PPE, testing supplies, emergency operations, and lost revenue.
  - HHS set aside $10 billion specifically for rural providers
- Suspension of the 2% Medicare sequester until December 31, 2020.
- 20% Medicare add-on payment for treating COVID-19 patients.
- Expansion of the Medicare Accelerated Payments Program.
- $1.32 billion in grant funding for health centers
- $180 million for HRSA grant programs to strengthen telehealth and rural community health.

Additional CARES Health Provisions

- Reauthorized the "health extenders" through November 30, 2020:
  - Community Health Centers
  - National Health Service Corps
  - Teaching Health Centers operating GME programs
  - Special Diabetes Programs
  - Delay of Medicaid DSH cuts
  - Maintained Medicare reimbursement for rural providers
- Provided immunity from malpractice lawsuits to healthcare professionals who volunteer to provide medical care during the COVID-19 pandemic.
- Authorized the reassignment of National Health Service Corp providers to respond to COVID-19.
- Established a "Ready Reserve Corps" of trained doctors and nurses to respond to the COVID-19 pandemic and future public health emergencies.

CARES Act: Expanding Access to Telehealth

- Increased flexibility for Medicare telehealth services
  - Allowed Federally Qualified Health Centers and Rural Health Clinics to provide telehealth services to Medicare patients in their homes
  - Opened the door to phone-based services
- Expanded HRSA grant programs for telehealth
- Included funding for broadband investment
  - $100m for the Rural Utilities Service Broadband Deployment Pilot Program
  - $25m for Rural Utilities Service distance learning and telemedicine.

The Paycheck Protection Program and Health Care Enhancement Act

Provided $484 billion in additional funding:

- $75 billion for hospitals and other health care providers to support the need for COVID-19 related expenses and lost revenue due to COVID-19.
- $321 billion for the Paycheck Protection Program (PPP)
- $50 billion for the Disaster Loans Program
- $25 billion for testing, including $825 million for community health centers and rural health clinics.

Next Steps: Will there be a fifth COVID-19 response bill?

Republican Priorities:

- Liability protections for businesses, including hospitals and health providers
- Incentives to encourage a safe reopening rather than continued reliance on federal stimulus
- Support for rural hospitals

Democratic Priorities:

- Funding for state and local governments, including an additional FMAP increase
- Additional health care provider relief, including rural hospitals
- National plans for testing and contact tracing and future vaccine distribution
- Improving access to insurance coverage
- Addressing racial and ethnic health disparities
- Support for essential workers, including health care providers