Healthcare Value in Rural America: Challenges and Opportunities

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RURAL
URBAN


15% OF ALL AMERICANS LIVE IN RURAL AREAS
Rural Americans are at greater risk of death from 5 leading causes than urban Americans
• Heart Disease
• Cancer
• Unintentional Injury
• Chronic Lower Respiratory Disease
• Stroke

Rural Disparities
see: www.ruralhealthresearch.org

- Rural populations are older, poorer and sicker
- Higher
  - Death rates for children and young adults
  - Smoking, obesity, inactivity
  - Rates of disability and suicide
  - Rates of preventable hospitalizations
  - Numbers of children living in poverty
  - Rates of uninsurance and food insecurity
- Lower
  - Household income
  - Number of healthcare and mental health providers

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Nearest Town 13 km
Health Care 300 km

Barriers to Care

- Less health care coverage
- Less choice and competition in insurance market
- Healthcare workforce shortages
- Distance and transportation
- Privacy concerns
- Poorer health literacy

Policy Response

- Focus on access to care
  - Funding support to retain rural hospitals and providers
  - Funding to recruit rural providers – loan repayment, tax credits
  - Enhanced reimbursements
  - Telehealth, broadband access
  - Changes to scope of practice
- Quantity has eclipsed quality and value

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Quantity vs Quality Conundrum

- Insufficient provider volumes to cover high fixed costs
  - Paying more can maintain provider numbers
  - Should we pay more for low quality care?
- Greater volume/experience can enhance quality for certain medical procedures
  - How do you maintain critical infrastructure, staff, training with low volume?

Challenges to Healthcare Value

- Workforce shortages
- Lack of choice/competition in providers and insurers
- Greater proportion of public payers and uninsured
- Low volume makes the challenge of measuring and rewarding quality even more difficult
- Limited data

Opportunities

- Better regional cooperation and strategic resource allocation
- Tying quality to some of the payment enhancements already in place
- Greater efficiency in care delivery and investments in non-physician workforce
- Care coordination
- Focus on social determinants
- Telehealth

The Eastern Oregon Coordinated Care Story: An Example of Regional Cooperation and Strategic Resource Allocation

Quick Facts About EOCCO

- **EOCCO serves 12 rural and frontier counties**

- **Land Area: approximately 50,000 sq. miles**
  - 52% of land area of State of Orego
  - Equal to the size of NY
  - Larger than land area of 19 states

- **Population: 194,592**
  - 5% of Oregon's population
  - 1/3 the population of WY (least populous State)

EOCCO Service Area and Common Cities and Towns

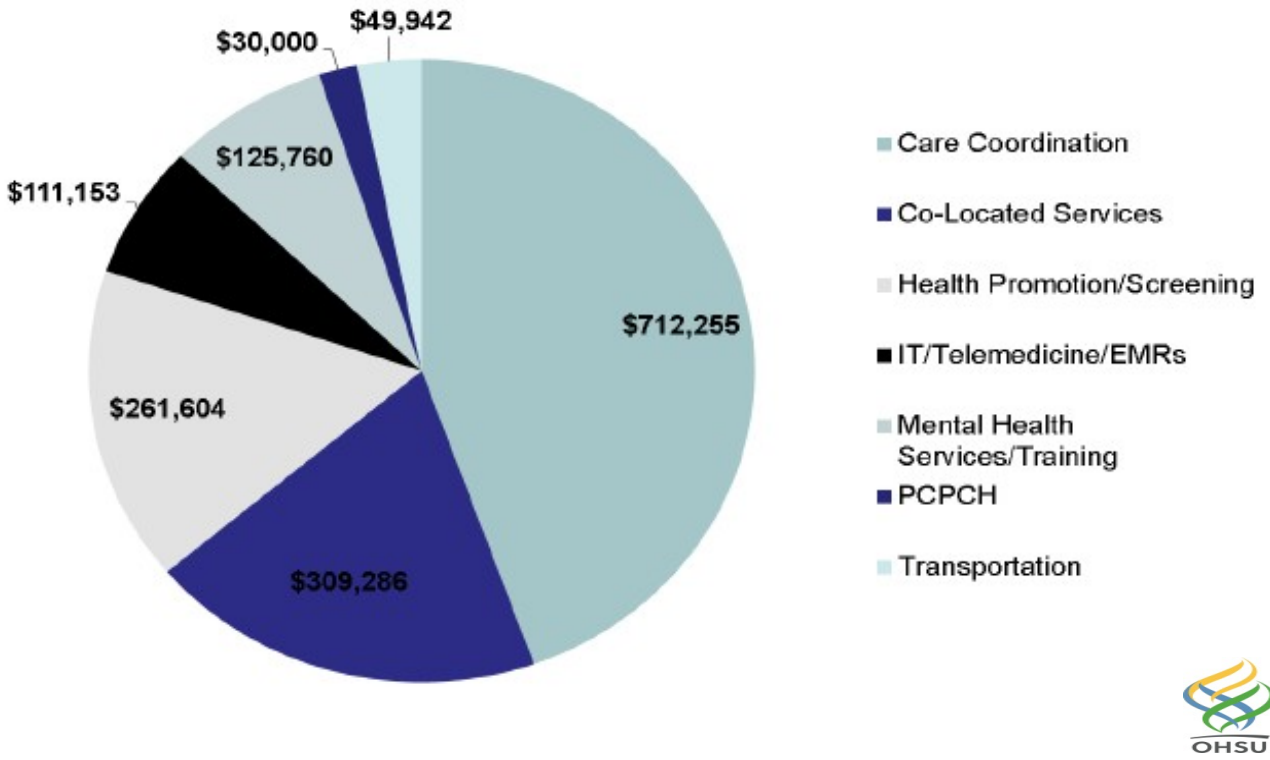
Reinvestments in the Community

- Transformation grants
- Technology investments – EHRs, collection of quality data
- Shared savings/Alternate Payment Methodology (APM)
- Patient Centered Primary Care Home investments
- Quality measure fund reinvestments
- Community capacity building including developing a cadre of community health workers

Transformation Grants

- $1.6 Million distributed
- 52 letters of intent
- 36 grant applications received
- 23 projects funded
- At least one grant awarded in each of our 12 counties

2014 Transformation Grants



Umatilla County

- The “ConneXions” project developed a workforce of CHWs to meet behavioral health needs of patients in physical health care settings and to coordinate across agencies

- Outcomes:
  - Return ED visits reduced 8%
  - Multi-organization care team established, bedside assessments in ED, universal community referral process created
  - 900 referrals
  - Active caseload of over 500 patients
  - Received “Excellence in Innovation Award” from the Federal Office of Rural Health Policy

Project is expanding, savings now sustaining CHW’s

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Malheur County

- Embedded a nurse care coordinator and behavioral health specialist in hospital and primary care clinic for patients with complex conditions and behavioral health needs to reduce ED use and improve access to care

- Outcomes:
  - Connected 550 patients to resources (mental health, primary care, housing, medication assistance, and educational services)
  - For 183 patients targeted for ED care coordination intervention saw 63% decline in ED visits and 50% decline in inpatient visits

Project is expanded in 2016 by adding a Qualified Mental Health Professional to the ED, savings helping with community supports

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