



Rural Health Care



A Strategic Plan for Washington State

2nd Edition • Winter 2012

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Preface

This is a time of extraordinary and rapid change in health care financing and delivery. Driven by health care reform, a great increase in demand for services is expected in rural health systems while federal and state policy makers are seriously considering cutting significant funding that keeps them alive.

Rural health systems stabilize emergency patients before they are transferred to tertiary facilities, and they offer an array of other services that are critical to providing a continuum of primary care and population health services, while keeping patients close to their families and social support. Many of the services delivered in rural communities are already creatively delivered, with efficiency, on a tight budget. Special payment programs for rural services have only stabilized them in the past, not enhanced them with extra money. Rural providers are finding solutions every day for the problems that exist in their local communities, and collectively at the state and national level. Destroying that momentum would be disastrous not only for rural communities, but for state and national reform efforts as well.

The authors of this plan understand the urgency of the challenges faced by rural health leadership. If the rural health care system is dismantled by state and federal budget cuts, none of the plans presented here will be implemented. Rural communities will have to rebuild an entire system of care from the ground up if they are denied the resources that have been allocated to support rural health care in the past. Funding cuts to rural communities may lead to major losses of health services or even total facility and clinic closures. This could devastate communities with reduced access to care, job loss, and markedly reduced ability to recruit providers and families to grow the community and support other local infrastructure.

In the short term, rural communities must put steps in place to spend available funds in the best way for the community to maintain essential services. These services include:

- Local public health
- Emergency medical services
- Primary care
- Connection to a regional system of care

Rural communities and rural health advocates must actively participate in policy discussions to educate decision makers on how to stabilize health care systems to safeguard the health of rural communities. Local leaders have a critical role in voicing community needs at the local, regional, state, and national levels.

While addressing the current crisis, a parallel focus on a long-term strategic plan is also vital. This Rural Strategic Plan was developed to explore ways to transform the rural health care system and is intended to match in scale the challenges that rural communities face. Fundamentally, it is not about short-term reactions to immediate threats. However, a delicate balance is required in maintaining a system of necessary services while transforming it, especially as the economic environment for health care changes rapidly. If funding cuts are held back long enough to implement what is in this plan, we can achieve a better future state. This plan is about full-scale transformation of our approach to rural health care, to assure long-term viability for rural health care systems.

Executive Summary

This is an updated edition of a document that lays out a path for rural health care by framing the transformational issues that affect health care for rural communities. Long term strategies for addressing transformational issues to promote healthy communities were defined early in this work, in 2007, enduring even as the social and economic environment has changed.

Rural communities around the state of Washington are socially, politically, economically, and geographically diverse from urban communities and from each other. This plan outlines the differences as well as the similarities between communities. Each community in rural Washington can use it as a guide in its own planning process. This plan defines strategies that can be implemented at the individual local level as well as at the state policy level.

Implementation of this plan calls on local health leaders to:

1. **Join together** through local, state and national networks to strongly advocate for adequate resources to support the rural health care delivery system;
2. **Increase** representation from all community sectors - schools, businesses, farming, hospitals, physicians and other health care providers - when speaking with policy makers about the full impact of health care cuts to rural communities;
3. **Strengthen** local and state leadership and enhance collaborative efforts by working together in different, creative ways across the broad spectrum of services;
4. **Advocate** for federal and state policies and financial support to maintain necessary rural health infrastructure for defined core services appropriate for each community;
5. **Prepare** communities for health care reform by designing solutions for future system sustainability;
6. **Develop** creative strategies and programs to assure adequate numbers and mix of health professional skills to meet current and future community health needs.

Model for the Rural Health Care Strategic Plan of WA State

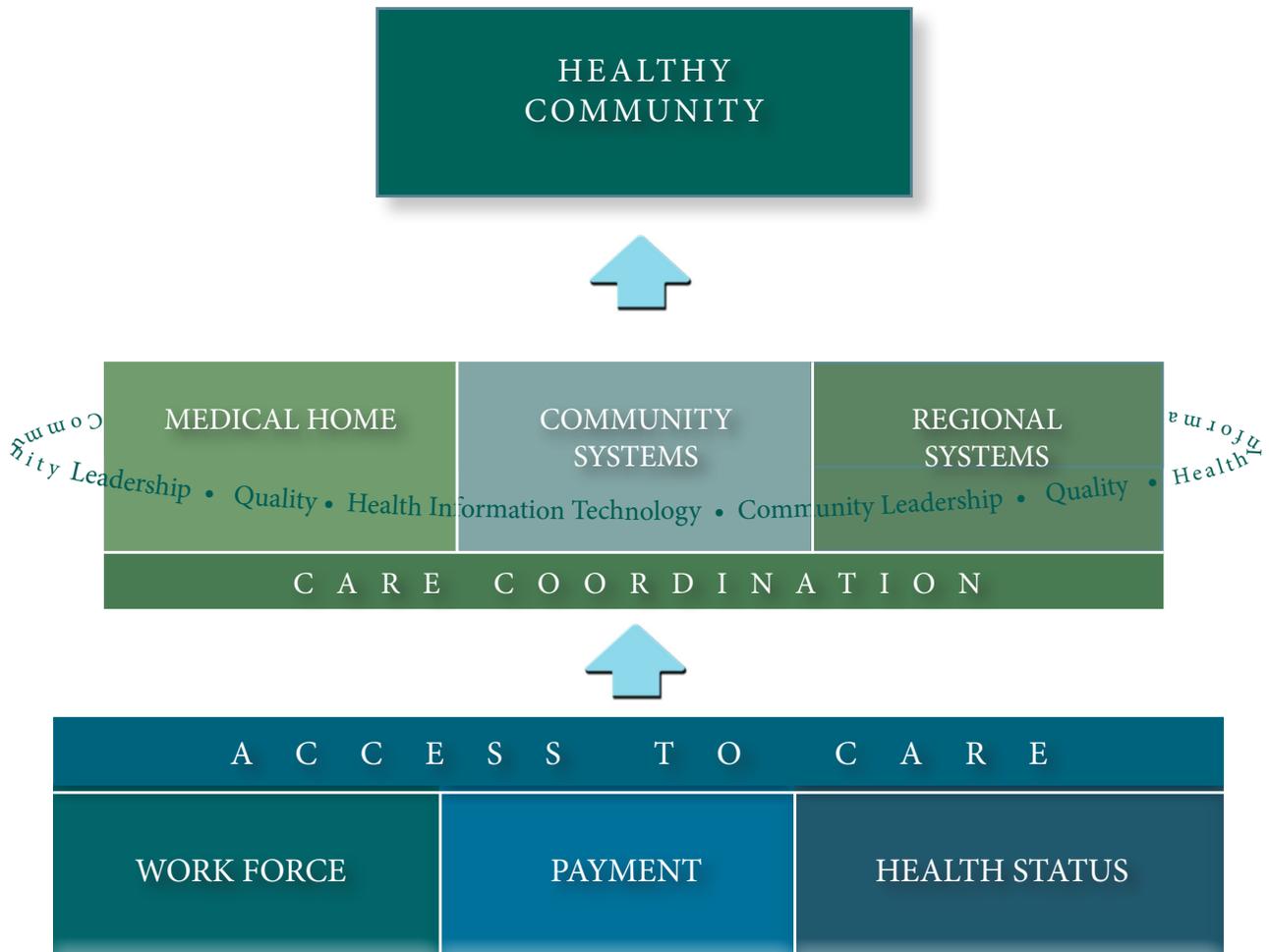
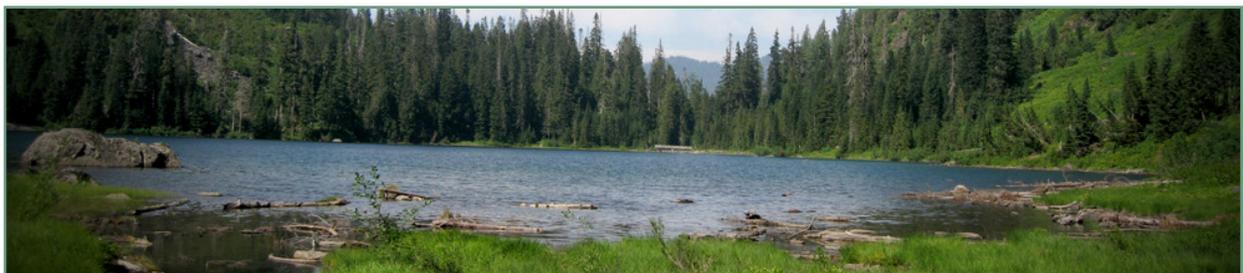


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Vision

We envision a strong, reliable, publicly accountable health care system for rural Washington that ensures those who need care receive the right care at the right time in the right place. The system will provide personal and population health services responsive to the unique needs of each community. The system will provide a medical home for all people in the local community and will provide planned access to the full continuum of care — including physical, oral, and behavioral health services — through regional systems that formally link primary and specialty services. The system will produce high quality outcomes, promote healthy communities, and merit the confidence of the community. The leadership to create and support a better rural health care system will come from communities and providers working together.

Guiding Principles

Principles to Achieve This Vision

1. The rural health care system will be community-centric while recognizing the essential role of providers in achieving community health. Rural health care will take advantage of the inherent strengths of rural communities including close integration of health care providers in the community with the local hospital, community resources, community leadership, and community self-reliance.
2. The rural health care system will actively promote personal and family health in homes, schools, workplaces, and in the community at large.
3. The rural health care system will provide services as close to the community as possible whenever they can be delivered safely, effectively, and in a timely manner at a high level of quality.
4. As the centerpiece of the rural health care system, the role of primary care will be broadened to become “medical homes” providing access to comprehensive, patient-centered primary care, health information, health promotion, chronic care management, and coordination of primary and specialty services to ensure seamless integration of care.
5. Formally-structured relationships and integrated information systems will link primary and specialty care providers in each region to assure rural residents seamless access to care across the full range of services.
6. The rural health care system will be sufficiently financed to assure access to appropriate care, promote continuous improvement, and support the principles outlined here.
7. Payment methods and formal linkages between primary and specialty care providers will align incentives while supporting the medical home model and care coordination within regional systems.



Principles to Achieve This Vision

8. Investments in prevention and health promotion will address physical, oral, and mental health and reflect both the short term and long term payoffs of health promotion.
9. The rural health care system will develop, attract, and retain an adequate supply of well-trained providers; advance new provider roles; provide professional development opportunities locally; and employ organizational structures that attract providers and promote good care.
10. Community health assessment and evidence-based care protocols will drive the planning of care, decisions about services, performance measurement, and accountability for care provided both in the local community and through formal linkages with other providers in each regional system.
11. Responsibility and accountability for community health will be shared by community leaders, health care providers, public health, and the community at large.
12. Community leaders, employers, providers, and payers will work together to ensure private and public health care coverage and access to care for all members of the community.
13. Rural health care leaders will assume an active voice in seeking public policies that support a strong, reliable, publicly accountable rural health care system consistent with these principles.
14. Quality health care available locally will continue to be essential to the social and economic integrity and vitality of rural communities.



Background

INTRODUCTION

Why are we planning for health?

This plan was developed out of a need for an organized statewide plan that would look at how to provide better care, anticipate limitations in resources, outline models for the future, and define the roles of rural provider organizations in health care delivery.

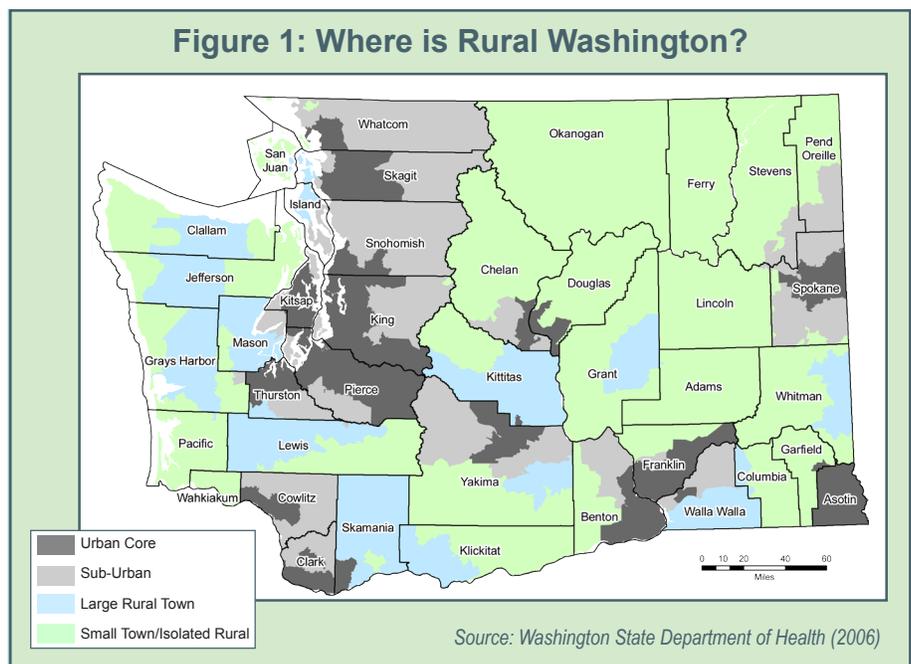
Rural health care providers face a number of challenges including increasing chronic illness, an aging population, high poverty rates, low education levels, substantial numbers of uninsured persons and high dependence on public insurance. While rural areas are often attractive places to live, they can be physically isolated by mountains, water, and inaccessible roadways in severe weather. Some challenges they face in addition to population health status and environmental isolation include a shortage of care providers and access to capital to expand services and update existing equipment and buildings.

Despite these challenges, rural communities are highly motivated to form relationships with each other and urban communities to maintain the highest level of access to care for their communities, use new information technology, try new models of care, and continue to achieve a high level of quality.

There is often a disconnect between those who are creating health care policy and regulations, and those who are providing care and working in rural communities. This plan attempts to bridge that gap and provide a realistic look at rural communities, and to recommend strategies to achieve a long term vision for the future.

Where is Rural Washington?

Rural Washington's geographic boundaries have been defined by census data, although rurality can be defined in different ways depending on community. The map in Figure 1 gives a general overview of what is considered rural.

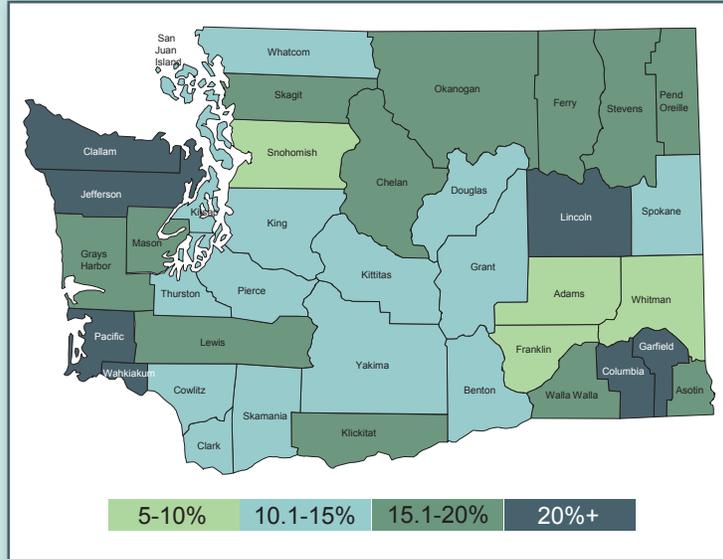


Background

Who lives in rural Washington?

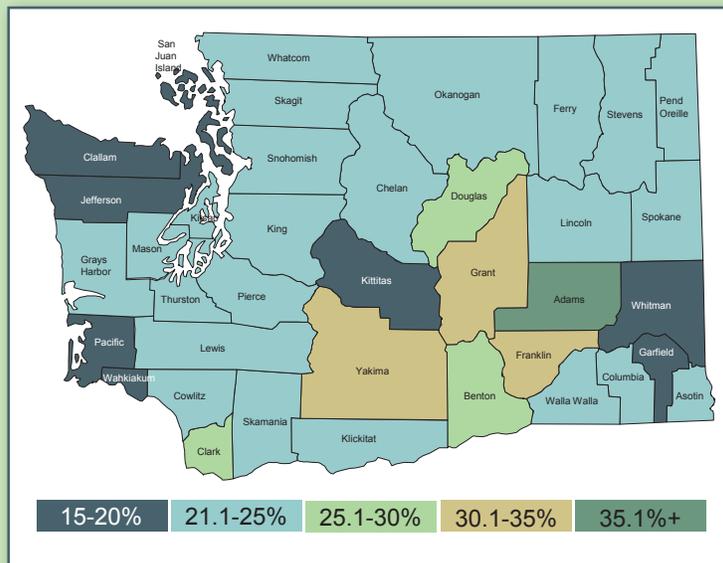
Rural Washington is both older and younger than urban Washington and is diversifying culturally more quickly than urban Washington.

Figure 2: Percent of Population Age 65 and Over



Source: US Census Data: <http://quickfacts.census.gov/qfd/index.html>

Figure 3: Percent of Population Under Age 18



Source: US Census Data: <http://quickfacts.census.gov/>

Background

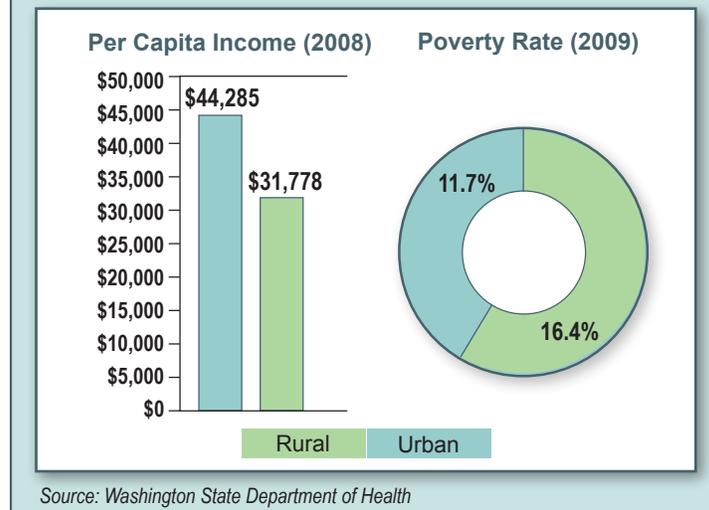
**Table 1. Increasing Minority Population Over Time
— Counties Ranked by Percent Minority,
2000 & 2010**

	2000		2010	
	Non Hispanic White Race	Total Minority	Non Hispanic White Race	Total Minority
Washington	79.40	20.60	74.81	25.19
Franklin	47.94	52.06	32.65	67.35
Adams	51.33	48.67	40.40	59.60
Yakima	56.88	43.12	47.64	52.36
Grant	66.01	33.99	56.82	43.18
Okanogan	72.01	27.99	66.42	33.58
King	73.94	26.06	68.50	31.50
Chelan	77.83	22.17	69.67	30.33
Douglas	77.52	22.48	70.94	29.51
Pierce	76.54	23.46	72.50	27.50
Walla Walla	79.26	20.74	73.09	26.91
Ferry	76.16	23.84	73.24	26.76

Source: Washington State Office of Financial Management (<http://www.ofm.wa.gov/pop/race/10estimates/summary.asp>)

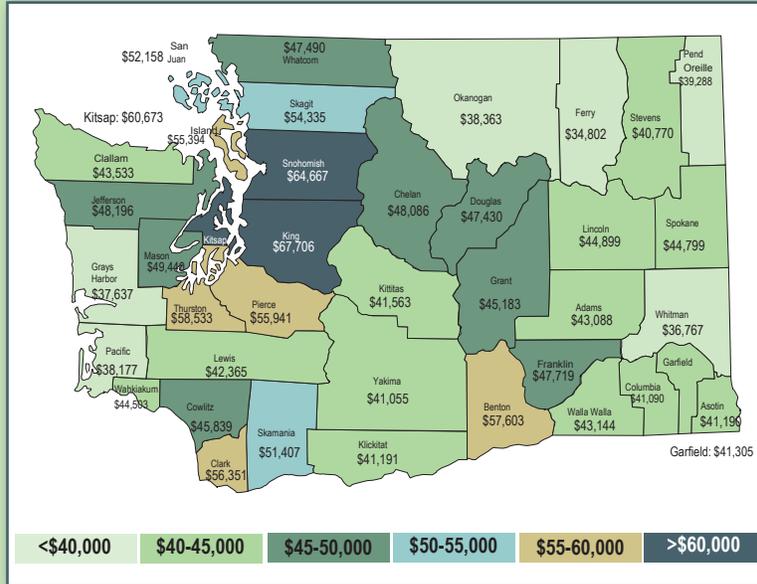
In the current economy, which has hit everyone hard, the poverty rate in rural Washington compared with urban Washington is much higher on average, coupled with lower education, fewer opportunities for higher paying jobs, and lower median household incomes for rural communities.

**Figure 4: Rural and Urban Economics
2008 & 2009**



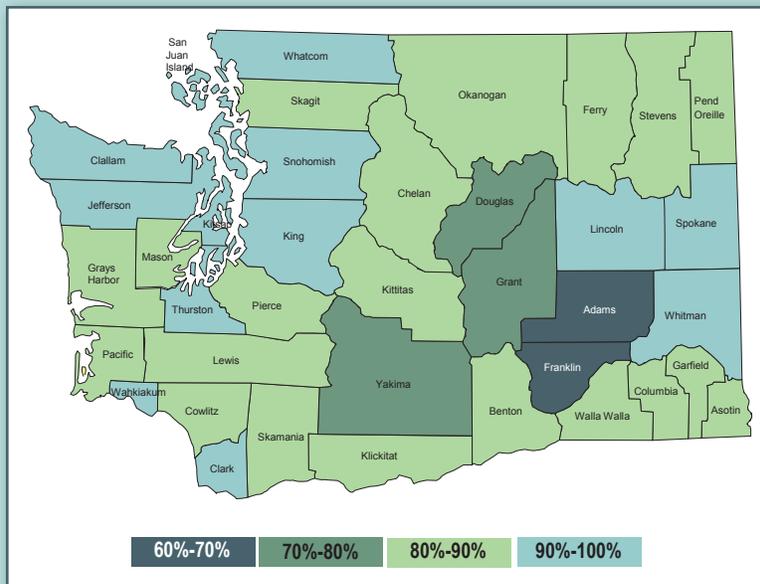
Background

Figure 5: Median Household Income, 2009



Source: US Census Data: <http://quickfacts.census.gov/>

Figure 6: Percent of High School Graduates Age 25 and Higher, 2005-2009



Source: US Census Data: <http://quickfacts.census.gov/>

Background

As far as immediate health risks are concerned, adults who live in large rural, small rural, and isolated areas have consistently higher percentages for obesity and smoking when compared to urban areas throughout the years, from 2006 to 2010. Rates for three of the top ten causes of death: heart disease, unintentional injury, and self harm, in Washington State are higher in rural communities, and access to care is limited in terms of those with health insurance and with primary care providers.

Table 2. Age-adjusted percentages for adults who are current smokers in Washington State by year and rural/urban classification				
Year	Current Smokers			
	Urban	Large Rural	Small Rural	Isolated
2006	16.6	17.8	19.5	19.9
2007	16.3	18.3	17.6	19.6
2008	14.9	18.5	18.3	21.9
2009	14.8	15.1	17.2	16.2
2010	14.6	17.5	18.4	19.7

Source: Behavioral Risk Factor Surveillance System (BRFSS).
Accessed at: <http://www.cdc.gov/brfss/>

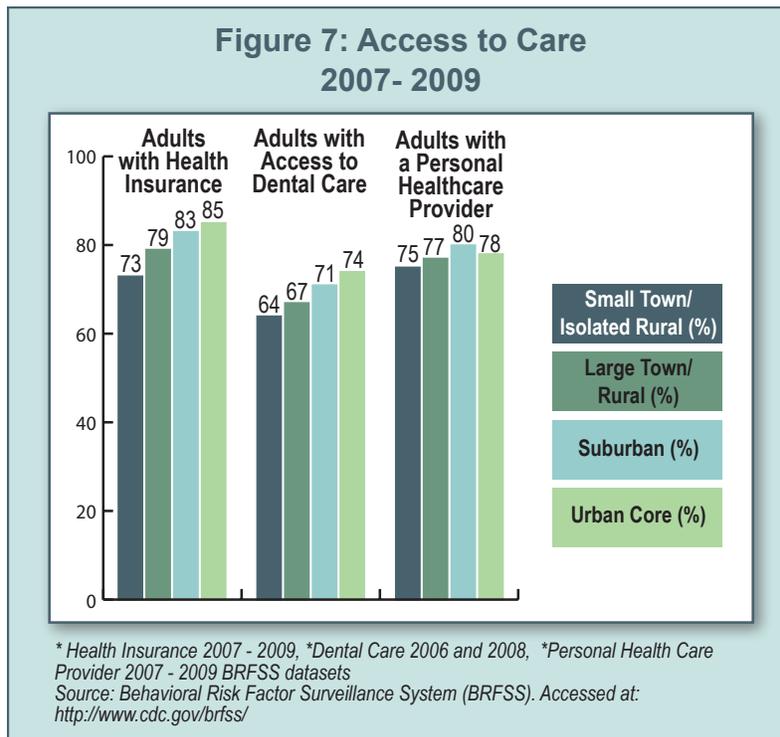
Table 3. Age-adjusted percentages for obese adults in Washington State by year and rural/urban classification				
Year	Obese			
	Urban	Large Rural	Small Rural	Isolated
2006	23.4	27.5	28.2	27.4
2007	25.2	29.4	29.3	24.7
2008	25.4	30.1	26.5	30.2
2009	26.4	29.9	27.5	28.1
2010	25.4	27.8	28.6	28.2

Source: Behavioral Risk Factor Surveillance System (BRFSS).
Accessed at: <http://www.cdc.gov/brfss/>

Background

Table 4. Mortality Rates Per 100,000 people, 2007-2009			
Cause of Death	Small Town/ Isolated Rural (CI)	Large Town/ Rural (CI)	Urban (CI)
Heart Disease	120 (115,126)	119 (114,124)	106 (104,107)
Unintentional Injury or Accident	58 (54,63)	46 (43,50)	35 (34,36)
Intentional Self-Harm (Suicide)	16 (14,19)	15 (13,17)	12 (11,13)

*Note: Heart Disease, Accident, and Suicide are for 2007-2009 from Death Certificate datasets, *CI are lower and upper confidence intervals
Source: Washington State Department of Health



Background

This is not a coincidence. People with fewer resources are more likely to experience stress and associated health problems, and how they access services depends on how they are able to pay for them. Rural communities have a complex set of circumstances to take into account when planning for community health.

Clearly, there is not one plan or one answer to solve every community's needs. However, the Rural Strategic Planning Committee recognizes that ensuring that all rural residents have access to quality health services is essential to addressing health status disparities (see box) and promoting equity across the state's diverse population groups.

CURRENT INFRASTRUCTURE

Health Care Delivery System

One goal of this plan is to help rural providers and health care systems understand how they can contribute to community health and develop a common vision for reform. A strong health care delivery system that works together to address health disparities is the first step in improving access to care. The following is a basic description of health care facilities and that exist in rural Washington or support health care in rural Washington. Each community has some combination of local services while regional and statewide organizations support statewide population-based rural health. Local organization types are listed below. More information, including a list of regional and statewide organizations can be found at www.waruralhealth.org.

A. Clinics

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) work together with their local rural hospital to provide a comprehensive and functional health care system for the community. These clinics and health centers are both defined and funded through Federal legislation and differ in the scope of services they provide, their funding mechanisms and their governance structure. In addition, health services are also provided by Tribal Clinics and a growing number of free clinics.

What are Health Status Disparities?

- **Economics:** People with fewer resources are more likely to experience newborn health problems, chronic disease, infectious disease, and disabilities.
- **Education:** People with higher quality education are more likely to get better jobs with higher income, live in neighborhoods that are safer and closer to more nutritious food sources with better schools for their children.
- **Environment:** Air, water, and soil quality; housing, transportation, stores, parks, and libraries; social support affect daily choices people make such as walking instead of driving, eating nutritious food, and social activities.
- **Ethnicity:** Structural discrimination, policies that affect opportunities and resources, and social friction can increase stress on the body, which in turn increases vulnerability to disease.

Background

Rural Health Clinics (RHC)

Established by Congress in 1977, RHCs are certified by CMS/Medicare to provide increased access to primary care services in rural areas. A key provision is that the clinics utilize physician assistants, nurse practitioners, or certified nurse midwives at least fifty percent of the time the clinic is open. CMS reimbursement is on an annual cost based basis regardless of which provider provides the service (MD or PA/NP). Medicaid is mandated to provide reimbursement on a similar basis. A RHC may be a for-profit or non-profit organization and may be owned by a local hospital or be independent. Some of the largest RHCs also provide specialty services. There are currently 133 RHCs operating in Washington.

Federally Qualified Health Centers (FQHC)

FQHCs are designated under the 1996 Health Centers Consolidation Act (Section 330 of the Public Health Service Act) as Community Health Centers who serve low income and underserved populations to include: migrant, homeless, and school based populations, and public housing residents. FQHCs provide a scope of services to include: primary medical, dental, and mental health, case management and enabling services. Services are provided on a discount fee schedule and no one is refused services based upon inability to pay. FQHCs receive federal funds for operations, with limited capital grants to support infrastructure, access to 340B drugs, malpractice coverage under the Federal Tort Claims Act and cost based reimbursement for their Medicaid patients.

There are currently 26 FQHC organizations operating over 160 delivery sites (both rural and urban WA). FQHCs must be governed by a board of directors and have 51% consumer representation. FQHC Look-alike designation requires an entity to meet all requirements of the FQHCs but these entities do not receive a federal 330 grant. FQHC look-alikes receive cost based reimbursement for services provided to Medicaid clients.

Free Clinics

Free clinics are private, non-profit, community or faith-based organizations that provide health services through the use of volunteer health professionals or in partnerships with other health providers. There are 39 free clinics providing services across the state. 11 of these are in rural communities.

Tribal Clinics

There are 29 federally recognized tribes in Washington State. Health services to American Indians and Alaska Natives are offered in both urban and rural areas of the state. Services range from basic health care to advanced, and often include integrated behavioral health services. Many tribal clinics are functioning as FQHCs and all are qualified as FQHC look-alikes. Funding streams are varied and include Indian Health Service, Medicaid, Medicare, commercial insurance, and private pay. Many tribal clinics are starting to see non-natives in addition to native populations in their clinics.

Background

B. Hospitals

Ready access to emergency care at all hours is critical to a well-functioning medical care delivery system. In most of rural Washington, Critical Access Hospitals (CAHs) are the main point of entry for emergency care. Rural hospitals vary in size and services they provide, but all provide 24 hour coverage. Additionally, many operate rural health clinics and nursing homes.

Critical Access Hospitals

There are 38 CAHs in WA State. They range in size from very small “frontier” hospitals to larger hospitals that can support specialty activity. The smallest hospitals serve populations of less than 8,000 residents and are typically unable to support obstetrics, surgery, or anesthesia. While the inpatient volumes may be limited to less than one patient per day, the CAH designation is vital to maintaining the presence of health care in the community. The largest CAHs in Washington have population bases large enough to support significant specialty activity. This means in most cases they have the volume to keep at least two practitioners busy in each specialty and can provide on-call coverage. Their primary care complement is also more likely to include pediatricians and internists as well as family practitioners.

Sole Community Hospitals

There are 3 designated sole community hospitals in WA State. They do not fit the criteria of Critical Access designation, but are still rural hospitals who serve much of the same population as Critical Access Hospitals. Most Sole Community Hospitals provide specialty care in addition to primary care services, and operate as the backbone of care services in the community.

C. Local Governmental Agencies

Public Hospital Districts (PHDs)

There are 56 PHDs in Washington State. 42 of these operate hospitals, while the others operate emergency services, clinics, and other local health care provisions. Under Washington law, localities may form PHDs for the purpose of “delivering health to their communities... Hospital districts are authorized not only to operate a hospital, but to deliver any service to help people stay healthy-physically, socially and mentally.” The majority of Washington’s rural hospitals are structured as PHDs and governed by boards. These governing boards are elected by the citizens served by the hospital district.

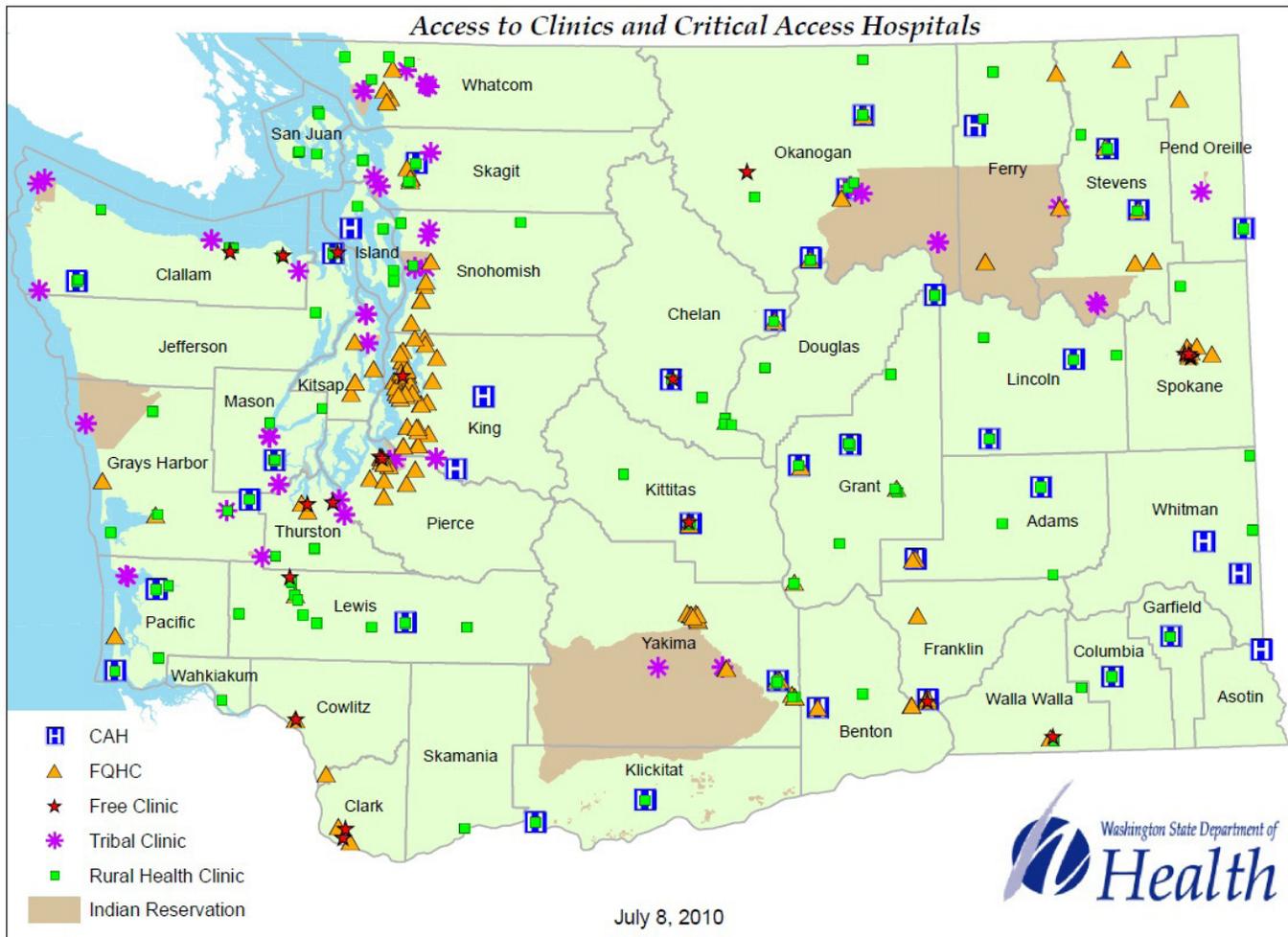
Local Health Jurisdictions (LHJs)

There are 35 LHJs serving 39 counties in Washington. Local Health Jurisdictions are responsible for population health, the part of the health care system that seeks to understand the underlying determinates of health, and use this knowledge to prevent disease and injury and improve overall community health. Local Health Jurisdictions, as governmental agencies, are tasked with a long list of duties mandated by statute, such as the protection of food and drinking water safety, proper disposal of hazardous wastes, and a wide range of communicable disease control responsibilities. In addition, LHJ’s carry out locally defined priorities, such as health care access, public health nurse home visiting, and nutrition support programs.

Background

Emergency Medical Services (EMS)

EMS are operated in each community differently. Some are paid for by local taxes while others are paid for by local hospitals. Some are shared by more than one community. They are critical to stabilizing patients in emergency situations and providing transportation to local hospitals or tertiary facilities.



FINANCE AND PAYMENT

Reimbursement and Special Programs

The Critical Access Hospital (CAH) program and other enhanced payment programs have prevented the closure of a number of rural hospitals and stabilized the financial situation of many others. While these programs are critical to the survival of the CAHs, they still do not cover all of the costs of the rural hospitals. Even with cost based reimbursement for Medicare and Medicaid patients, revenues still fall short of expenses.

Background

Across the health care system, the cost of caring for Medicare and Medicaid patients is subsidized by revenues from other sources, including privately insured patients. This system as a whole does not work, particularly in rural communities since privately insured patients, on average, only account for about 27% of the insured patients of rural hospitals.

Though currently Medicare and Medicaid pay respectively 101 and 100 percent of allowed costs to CAHs, some services such as hospital-based physician services, ambulance services, and charity care, are not allowable costs. In many rural communities, there is little to no public transportation to get to medical services, only to be further complicated when ambulance services are not an allowable cost.

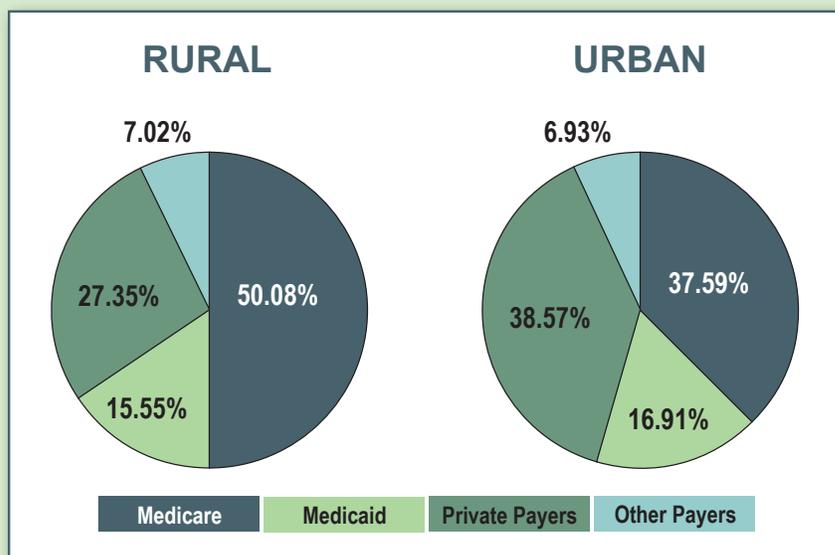
In addition, Medicare advantage programs are not mandated to pay at cost basis. Consequently, the effective payment to cost ratio of those two programs remains below 100 percent. Other health services, like home health, hospice, and nursing home care services, are not reimbursed on a cost basis and are increasingly difficult for rural hospitals to support. Medicare overhead cost allocation methods tend to over allocate costs to hospital-

based nursing homes, further contributing to the financial instability of the sponsoring hospital.

Rural providers face several regulatory hurdles to access enhanced payment programs. In order to qualify for enhanced payment under the Health Professional Shortage Areas program, 60% of the Medicare claims of each physician have to be for primary care services. The difficulty to qualify arises when most physicians in rural areas also provide specialist services for lack of specialists.

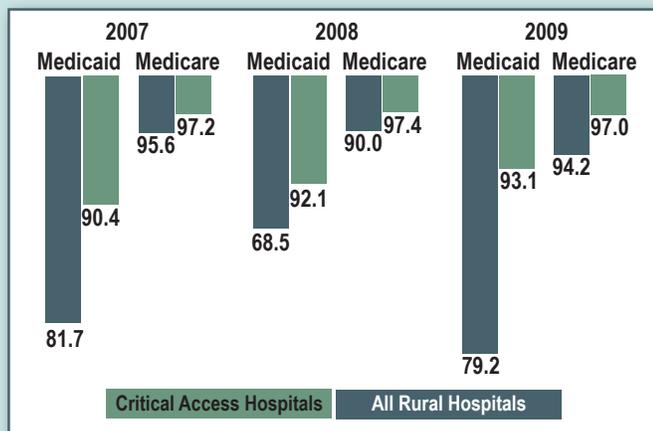
Despite the number of payment shortfalls, cost-based reimbursement and enhanced payment programs have maintained the rural safety net and brought rural communities a long way in assuring access to care.

Figure 8: Percent of Gross Revenue by Payer Type, 2010



Source: CHARS - Analyzed by Washington State Hospital Association

Figure 9: Effective Payment to Cost Ratio 2007 - 2009



Source: Washington State Hospital Association

Background

**Table 5.
Summary Table of Payment Programs**

	Medicare	Medicaid
Critical Access Hospitals (CAH)	101% of some hospital inpatient and outpatient services reasonable costs	100% of some hospital inpatient and outpatient services reasonable costs
Sole Community Hospitals (SCH)	Higher of either the standard hospital inpatient PPS rate or payment based on hospitals costs in a base year adjusted for inflation and case-mix	N/A
Medicare-Dependent Hospital (MDH)	Higher of either the rate based on 25% hospital inpatient PPS rate and 75% historical cost or payment based on hospitals' costs in a base year adjusted for inflation and case-mix	N/A
Free Standing Rural Health Clinics (RHC)	All-inclusive per visit rate based on reasonable costs, with a cap, below cost, and subject to productivity targets	All-inclusive rate based on Medicare cost reports in a base year adjusted for inflation and case-mix for direct payment Medicaid patients or Medicaid FFS plus "premium" (PMPM payment) to bring rates up to RHC Medicaid direct payment rates for Medicaid managed care (Healthy Options)
Provider-based RHC	Cost-based reimbursement, with no cap and no productivity constraints if hospital has fewer than 50 beds. Costs pooled with hospital.	Same as for free-standing RHCs
Federally Qualified Health Centers (FQHC)	Same as free-standing RHCs, though FQHCs have significantly higher caps. FQHCs funded under section 330 of the Public Health Service (PHS) Act also receive grants to care for the uninsured and migrant populations that they are mandated to serve and receive free malpractice insurance coverage.	

Background

HEALTH PROVIDER WORK FORCE

One of the greatest threats to the availability of health care in rural areas is the supply of health care providers. This is complicated by the growing diversity in communities and the need for providers who understand cultural, language, and age differences, and chronic disease complications. There is a shortage of all types of care providers in many parts of the state. All counties in rural Washington are considered health professional shortage areas in primary care and dental care. All but one of Washington's rural counties has a behavioral health professional shortage¹.

Rural areas have always struggled to attract health care professionals. The high cost of medical education and low provider reimbursement rates for Medicare and Medicaid patients, lack of exposure to rural medicine during training, as well as professional isolation, are barriers to medical students choosing to focus on rural care. Even with community building efforts and enhancement of professional collegiality, rural providers are faced with medical school debt and may not be able to afford to practice in a rural community if there is lower patient volume and higher numbers of patients with Medicare and Medicaid insurance.

Federal and state rural provider loan repayment and scholarship programs exist, however these programs are not a long term solution. The government programs are limited to certain provider types and are targeted to the areas of greatest need. There is also a retention rate problem with providers in rural areas who have paid off their obligation. It is critical to not only keep loan repayment options available, but also to address the retention of providers once they are practicing in a rural community.

The already existing shortages will be exacerbated in the coming decade with the aging population and retirement of boomer-generation providers.

Health Professional Shortage Area and Medically Underserved Area/Population (HPSA & MUA/P)

HPSA is a federal designation for an area having a shortage of primary medical care, dental or behavioral health providers. It may be an urban or rural area, population group or medical or other public facility.

MUA/P: A medically underserved area is a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. A medically underserved population can include groups of persons who face economic, cultural or linguistic barriers to health care.

These designations help define federal funding priorities.
(<http://bhpr.hrsa.gov/shortage/>)

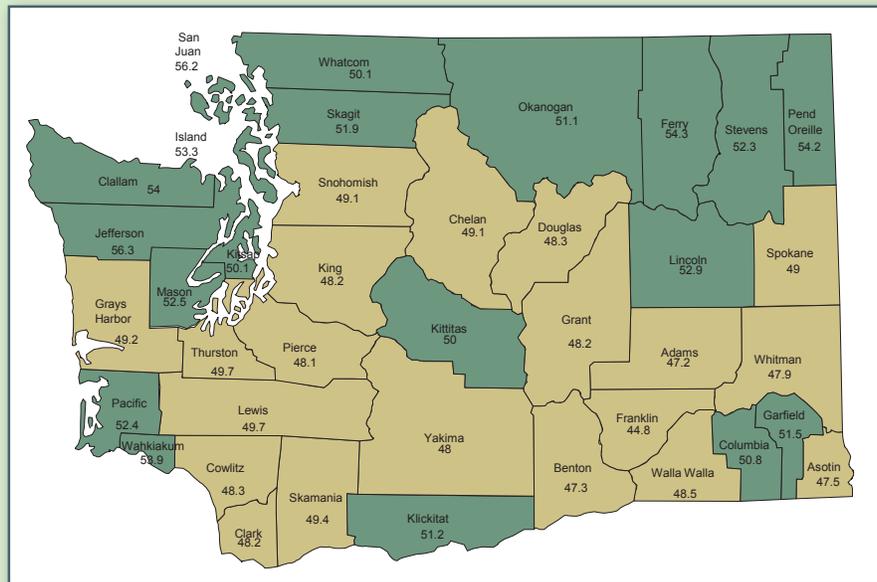
¹www.doh.wa.gov/hsqa/ocrh/HPSA/hpsa1.htm

Background

Nursing Work Force

Maintaining an adequate supply of nurses in rural Washington is also difficult. The nursing workforce is rapidly aging with the average age between 47 and 56 among registered nurses.

Figure 10: Average Age of RNs by County, 2011



Data Source: University of Washington, Center for Health Workforce Studies

*Includes licensed RNs age 18-75

**The data come from the Dept of Health RN Licensing File. This does not indicate whether or not the RN is working, or working in nursing, only indicates active license or not.

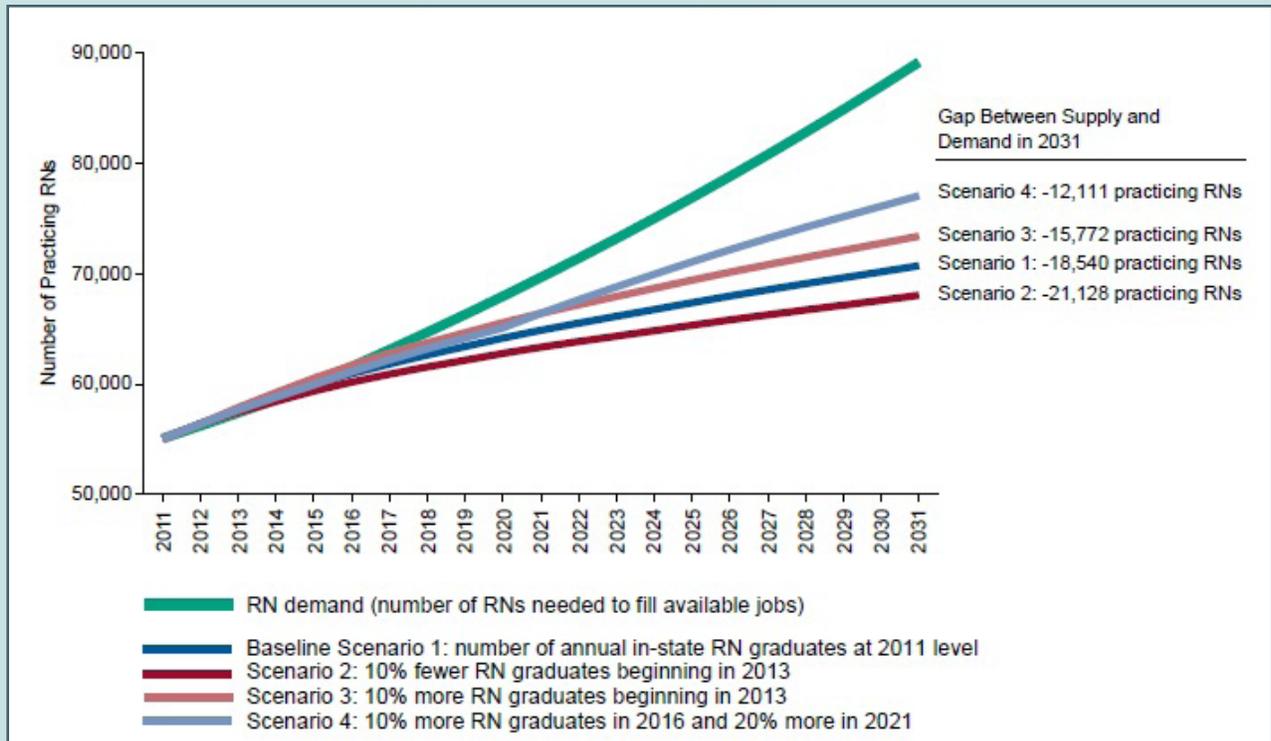
Recent trends show that the nursing shortage will increase again by 2031². Barriers to maintaining an adequate nursing work force include:

- Inadequate number of nursing education programs in rural areas;
- Increasing specialization within the nursing profession;
- Career changes and burnout.

²Skillman, S., Andrilla, H., Tieman, L., McCook, A. *Washington State Registered Nurse Supply and Demand Projections: 2011-2031*. Policy Brief. December 2011. Accessible at: http://depts.washington.edu/uwrhrc/uploads/CHWS_FR134_PB.pdf.

Background

Figure 11: Estimated Washington State RN Supply and Demand, 2011 - 2031



Source: University of Washington, Center for Health Work Force Studies

Challenges Ahead

Rural communities have populations with unique needs from each other and from urban areas. With the requirements of federal health reform, there will be many more newly insured Americans in 2014. There is a good chance that many of these people will seek primary care providers in order to address previously unmet medical needs. When a rapid increase in demand for services meets the diminishing supply of rural primary care providers, a reduction in access to health care is inevitable.

FEDERAL HEALTH REFORM

Thrown into the mix of the social and economic situation in rural communities is a set of national reform guidelines and requirements. Since the first edition of this strategic plan was published in 2009, federal health reform legislation has become law. Health reform legislation attempts to address health disparities and encourage efficiencies. Reform is necessary to improve the health of the population, enhance the care experience for patients and make care more affordable--the Institute for Health Care Improvement's Triple Aim.

Background

National reform requirements, for the most part, are not prescriptive, and much of the implementation has been left to states. Rural communities in Washington are likely to see:

- Increase in the insured population due to increasing the age limit to 26 for dependents, increased eligibility for Medicaid, and subsidies available to purchase health insurance through insurance exchanges.
- Increase in payments for primary care.
- Incentives to collaborate with community partners.

CHALLENGES IN WASHINGTON STATE

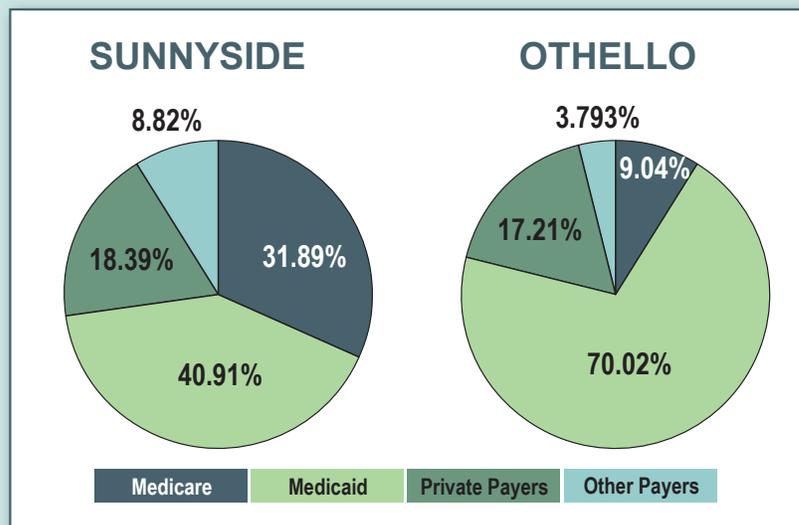
National health reform proposes significant changes to the payment system that should increase access to quality care in rural communities. However, the changes are interdependent and rely on individual states to make these changes. In the past, state and federal programs, such as the CAH program, have filled a budget gap to allow rural health care systems to remain viable. Communities are seriously concerned that the rural system will not sustain itself in the face of need for services and cuts to funding in order to bridge the gap to the newer system of care that reform of the health care system envisions.

Although many policy makers understand the negative impacts that funding cuts to rural communities will have, Washington State is in financial straits, and rural communities could bear the brunt of a series of destructive cuts to public payment programs.

Some rural communities are disproportionately affected by across the board cuts. For example, communities such as Othello and Sunnyside, which serve up to 70% Medicaid patients in their hospitals will have significantly reduced resources.

Eliminating Basic Health would adversely affect CAHs and rural FQHCs. FQHCs already see 35% of uninsured patients. More uncompensated care would force them to cut services. It is not elective surgery that will diminish in rural areas when budget cuts are made. People living in rural Washington will have significantly reduced access to primary and urgent care.

Figure 12: Percent of Gross Revenue by Payer Type, 2010



Source: CHARS - Analyzed by Washington State Hospital Association

Background

The health service industry also contributes significantly to the economic vitality of communities. There are nearly 8000 full time positions (FTEs)⁴ in Critical Access Hospitals alone, which is under-representative of the number of people employed by rural health systems in Washington. In a time of economic depression, health services are not only critical to the people they directly serve, but to the economic vitality of communities where they are located.

⁴Source: CHARS – Analyzed by Washington State Hospital Association

Strategic Plan

The flexibility for communities to have different health care infrastructure in rural and urban settings is essential. Despite variation amongst Washington's rural communities, nationally recognized essential services have been identified by rural policy experts to assure the provision of adequate health care.⁵

These essential services include:

- Local Public Health
- Emergency Medical Services
- Primary Care
- Connection to a Regional System of Care

To assure or even maintain these essential services in the face of today's challenges, this Rural Strategic Plan recommends that the following elements are necessary:

- Community Leadership and Civic Engagement
- Adequate Financing
- Adequate Supply of Providers
- Health Information Technology
- Quality Improvement Capabilities
- Long Term Strategic Planning

A long term vision and principles for creating healthy communities are detailed on pages 1-3 of this document. These were defined early in this work, in 2007, enduring even as the social and economic environments have changed, and they are foundational to moving together toward a coordinated, cost-effective and population focused rural health care system.

ESSENTIAL SERVICES

Local Public Health

Local health jurisdictions have primary responsibility for services related to population health. Core services such as food and drinking water safety, public health nursing, and communicable disease control protect the public's health and safety. Given their broad scope of work and leadership capabilities, the Washington State Department of Health and local health jurisdictions launched an initiative called the Agenda for Change⁶, a framework for redefining local public health and its services in an era of declining public resources. The Agenda for Change sets shared principles and decision considerations for policy, program, and funding decisions while engaging others in the health care system in rethinking their roles in disease prevention and health promotion. The work

⁵RUPRI Health Panel. (2011). The High Performance Rural Healthcare System of the Future. Available at: http://www.rupri.org/Forms/HealthPanel_FutureSystem_October2011.pdf.

⁶Washington State Public Health Agenda for Change (2010). Accessed at <http://www.doh.wa.gov/hip/doc/catalog/a4c/a4c.pdf>.

Strategic Plan

focuses on three key areas: communicable disease and other health threats, healthy communities and environments, and partnering with the health care system. Much of the content of the Agenda for Change is relevant to rural health systems. Rural health leaders are encouraged to learn more about the Agenda for Change work and consult its evaluation guidelines when considering cuts to programs and funding.

Washington State Core Public Health Functions, 2007⁷

1. Community health assessment.
2. Communication to the public and key stakeholders.
3. Community involvement.
4. Monitoring and reporting threats to the public's health.
5. Planning for and responding to public health emergencies.
6. Prevention and education.
7. Helping communities address gaps in critical health services.
8. Program planning and evaluation.
9. Financial and management systems.
10. Human resource systems and services support the public health work force.
11. Information systems support the public health mission and staff.
12. Leadership and governance bodies set organizational policies and direction to assure accountability.

⁷Washington State Department of Health

Strategic Plan

Strategies

Local health leaders should consider:

1. Collaborating in identifying the roles and skills of public health and medical providers in rural communities. Understand:
 - Their separate functions;
 - What they can teach each other to provide the best care for the population.
2. Consulting the state Public Health Agenda for Change to align with statewide strategies when making decisions about programs and funding.

Statewide rural health leaders should consider:

1. Supporting the work of local health jurisdictions in pursuing community health priorities.

EMERGENCY MEDICAL SERVICES

As identified on page 13, emergency medical services are available in varying capacities in rural communities. Each community has an individual approach to supporting and managing EMS, while Washington State as a whole has an integrated approach to standardizing procedures and promoting quality improvement activities. The integrated approach was built to prevent death, disability, and nursing home placements due to heart attack, stroke, and cardiac arrest.⁸

Strategies

Local health leaders should consider:

1. Striving to achieve statewide best practices.

Statewide rural health leaders should consider:

1. Promoting statewide participation in the Washington State Emergency Cardiac and Stroke System to ensure that all patients with symptom onset of heart attack, stroke, and cardiac arrest in rural Washington are treated at a tertiary facility in less than 120 minutes.
2. Expanding the current Washington State Cardiac, Stroke and Trauma system to share data for improvement across the continuum of Dispatch, EMS, Critical Access Hospital and Tertiary Hospitals to other diseases.

⁸Washington State Department of Health Emergency Cardiac and Stroke System.<http://www.doh.wa.gov/hsqa/hdsp/default.htm>. Accessed November 28, 2011.

PRIMARY CARE: THE MEDICAL HOME MODEL

The medical home is an approach to organizing primary care whereby patients have an ongoing relationship with a primary care provider and caregiver team which collectively take responsibility for providing and coordinating all of the patient's health care needs. The medical home offers comprehensive, patient-centered primary care, enhanced access, health promotion, chronic care management, and coordination of primary and specialty services. The medical home ensures that patients who need care receive the right care at the right time in the right place. It provides a strong base for connection to a regional system of care.

Integration of Behavioral Health

In 2011, the National Committee for Quality Assurance (NCQA) revised its criteria for primary care practices to obtain medical home status by specifically addressing the integration of behavioral health services into the care coordination activities of a medical home. The concept of patient centeredness and focus on the whole person implies that mental health and substance abuse issues are part of the medical home's approach. Prior to the revision of the NCQA standards, the Affordable Care Act (ACA) supported the integration of behavioral health into general medical services, especially at the primary care level.

Health Home Model⁹

The cornerstone of the ACA approach to improve quality and reduce costs is the concept of a health home. A health home is a medical home that specializes in the integration of health services, coordination of care and health promotion for patients with two or more chronic diseases, including behavioral health. Health homes require comprehensive care management capabilities and coordination with community and support services. Washington State's governor, Christine Gregoire, endorsed the concept of a health home in her proposal to reform the state's health delivery system by requesting authority to require all people covered by Medicaid to be enrolled in a health home.¹⁰

Federally Qualified Health Centers (FQHCs)

FQHCs provide mental illness diagnosis and treatment through social work services, thus they are well positioned to take advantage of health home incentives aimed at expanding the concept of a medical home to that of a health home. For instance, the Centers for Medicare and Medicaid Services, in part as a result of the ACA increased funding for FQHCs, launched an initiative – the FQHC Advanced Primary Care Practice project. This aims to demonstrate how the medical home model can improve the quality of care, lower cost, and attain better community health outcomes.

⁹Note: Despite changes in terminology, medical home is still widely used and will be used for the purpose of this plan. Medical home in this plan is inclusive of the health home concepts."

¹⁰Washington State Proposal Addendum: Health Innovation for Washington. Washington State Health Care Authority web site. <http://hrsa.dshs.wa.gov/Reports/pdf/WASStateProposalFinalAddendums.pdf>. Accessed September 9, 2011

Strategic Plan

Transformation to the Medical Home Model

While most primary care providers embrace the principles of the medical home model and recognize the model's potential to contain costs, transformation of primary care practices to medical homes is a major undertaking that requires extensive staff time and financial resources. Criteria include:

- Ensuring patients 24/7 continuous access via phone, email, or in-person visits;
- Defining roles and tasks among care team members and training them in the medical home concepts;
- Linking with or referring patients to community resources and specialists;
- Implementing payment systems that reimburse for care coordination activities;
- Adopting evidence-based care protocols that encompass both primary and specialty services;
- Using panel data and registries to contact, educate, and track patients by disease and risk status, or community and family needs;
- Choosing and implementing a formal model for quality improvement;
- Encouraging patients to expand their role in decision-making and self-management; and
- Most importantly, strong, visionary and persistent leadership.

Despite the implementation challenges, this Rural Strategic Plan considers medical and health homes central to the health care delivery overhaul, providing an opportunity to strengthen the rural health safety net.

¹¹Source: National Patient Centered Primary Care Collaborative. Accessed at: <http://www.pcpcc.net/node/14>

Principles of the Medical Home, 2007¹¹

Personal care provider* — each patient has an ongoing relationship with a personal care provider trained to provide first contact, continuous and comprehensive care.

Provider directed medical practice — the personal care provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation — the personal care provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

Quality and safety are the focus of the medical home.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

***Note:** In some rural areas, nurse practitioners and other qualified providers are the primary care providers, so the rural medical home model will not only use physicians as primary medical home providers and team leaders, but other qualified providers as well.

Case Study - Mark Reed Health Care District: A stepped approach to a small rural health clinic's transformation into a medical home

Mark Reed Health Care District is moving toward a medical home, but it has not been easy. To facilitate the transformation of its primary care practice into a medical home, Mark Reed has opted for a stepped approach.

The first goal was to ensure continuity of care for all patients and to promote care coordination among their staff and outside specialists. They designed each patient care team around a team leader, a physician or nurse practitioner, and a medical assistant who often is the first contact the patients have. Clinic hours were expanded. Open slots for same day appointments are now integrated into the clinic. Since it is a small community practice, reception staff and the referral coordinator know all the patients and are encouraged to take ownership of the patients' needs that they can help with, such as follow-up appointments. They also have two nurse care coordinators who support the care teams and whose role is to keep patients healthy, answer patients' phone and email queries, and empower patients to be in charge of their own health.

Care coordination with specialists and hospitalists is facilitated when patients are in the emergency room of Mark Reed because sharing of medical records is almost instantaneous. Communication between care providers has been greatly enhanced by the use of an electronic medical records (EMR) system. Additionally, specialists' notes, pharmacy and home health orders requests are automatically routed to the EMR, and attached to the patient's chart. If patients are admitted to another regional emergency room, Mark Reed primary care providers rely on electronic notification and will stay involved throughout the patient's stay by visiting the patient and communicating with the admitting hospitalist when needed. There is only one exception to achieving care coordination along the full continuum of care: when a patient moves to a nursing home. There are not any nursing homes in the local community, so that coordination has not happened yet.

The major hurdle Mark Reed Health Care District has identified is the lack of payment for team member interaction and care coordination. According to one of their physicians, "how will we be able to maintain two care coordinators, who manage patients' needs, triage incoming calls, and administer vaccination programs, if they are not revenue centers? In fact, 90% of their role is to keep patients healthy enough and out of our office and 10% is to get people in need of care in our office." For small practices like Mark Reed, the potential of the medical home model is well understood and embraced, but financial constraints may deter full implementation.

Future steps for Mark Reed Health Care District will involve the expansion of the functionalities of the EMR system, namely: the use of registries to manage patients' health needs; the use of flags to notify care team members of needed interventions prior to provider face-to-face visits; performance management through metrics and reporting; and integration of customer feedback into the quality improvement process. Mark Reed is also training their care professionals in teamwork skills, in an effort to boost patient experience and their quality improvement cycle.

Strategic Plan

Strategies

Local health leaders should consider:

1. Advocating for the development of community health teams to coordinate the care needs of persons with chronic conditions and work with providers interested in becoming a medical home.
2. Participating in learning collaboratives offered to primary care practices interested in integrating the elements of the medical home model into their practices and disseminate local “findings”.

Statewide rural health leaders should consider:

1. Promoting communication strategies that inform and mobilize consumers, communities, government entities, health plans, public purchasers, providers and other interested parties about the medical home model.
2. Identifying tools available to enable rural provider organizations to:
 - assess their stage of readiness to transition toward becoming a medical home;
 - identify the types of technical assistance they need to move forward;
 - take steps to transition toward the medical home model.
3. Advocating for payment reforms that support the transformation to a medical home by:
 - recognizing the cost of currently non-reimbursable care coordination activities and the extra time to provide care management services;
 - recognizing the case mix of the patient population and the cost of providing care to populations with lower health status due to social, economic, behavioral and environmental factors;
 - providing enhanced payment that recognizes the level of medical home attained and achievement of quality improvement measures appropriate to the rural setting; and
 - considering strategies to share cost savings achieved through care management.

CONNECTION TO A REGIONAL SYSTEM OF CARE

Health care culture is shifting away from individualism to consolidation and collaboration. Partnering on some level is critical for the survival of many health care providers. The availability of specialty care in rural settings is limited. Access to specialty services requires that care is effectively and efficiently coordinated across the care continuum. Since the first edition of this plan, regional systems have developed throughout the state. They vary according to demographics, distance, and provider resources across communities. Examples include a group of rural hospitals

Strategic Plan

working together to secure an urban tertiary center as an affiliate, a local health department and hospital working together, federally qualified health centers and local hospitals developing a network of care, and community based providers affiliating with local hospitals. For detailed information on these examples, see “Regional Systems of Care” booklet at www.waruralhealth.org. Although regional systems of care present in different forms, the principles behind them remain the same.

Principles for Regional Systems

1. Collaborations between providers should be designed around the co-development of comprehensive care programs for defined medical conditions, not just arrangements for a specific service or specific type of back up. Care programs include all necessary care for patients, such as prevention, patient education, diagnosis, treatment, primary care case management, transfer when necessary, specialist consults or treatment, return to the community for follow-up care, etc.
2. Tertiary care centers should take all referrals regardless of source of payment, including Medicaid and uninsured.
3. Collaborations should be based on evidence-based treatment guidelines or protocols that spell out what aspects of care can be provided in the rural setting and which require referral for specialty care.
4. Collaborations should have effective communication between all care providers for a patient.
5. Collaborations should utilize technology to support the primary care provider-specialist relationship.
6. The tertiary care center’s mission should demonstrate a commitment to supporting healthcare for individuals living in rural communities. For example, the tertiary center should become an integrated part of a regional health system incorporating rural providers, rather than providing care on a case-by-case, service-by-service basis or only when it is profitable.
7. The regional system should hold value for prevention, primary, and tertiary providers and patients.

Strategies

Local health leaders should consider:

1. Proactively striving to improve the quality and efficiency of care in the local community while positioning themselves to respond to the demands and incentives of health care reform.
2. Including all community providers (tertiary hospital, rural hospital, clinics, local health jurisdictions, etc) to jointly conduct a community health needs assessment.
3. Exploring marketing their programs, such as swing beds and primary care resources, to PPS hospitals as a way for these hospitals to cut costs by reducing lengths of stay and preventing readmissions.
4. Actively participating in the planning and operation of the Emergency Cardiac and Stroke (ECS) System in their area, and build on the relationships with their ECS System urban partners to broaden the scope of collaborative care planning to encompass additional diagnoses and providers.
5. Either individually or together as regional networks, proactively exploring collaborating with an urban medical center, physicians, and other providers in a “bundled payment” pilot.
6. Establishing a comprehensive relationship with a major medical center or hospital system, similar to that used by the Olympic Peninsula hospitals.
7. Proactively participating in discussions with regional providers about Accountable Care Organizations (ACO).

Building a Comprehensive System of Care on the North Olympic Peninsula

Three hospitals on the Olympic Peninsula—Olympic Medical Center, Port Angeles (80 beds); Jefferson Healthcare, Port Townsend (25 bed CAH); and Forks Community Hospital (25 bed CAH)—have entered into a strategic affiliation with Swedish Medical Center, Seattle, to establish a regional system of care. Driven by the economic pressures of the current recession, the expectation of cuts in Medicare and Medicaid reimbursement, the coming demands of health care reform, meaningful use requirements, and workforce shortages, the three hospitals began to explore together the possibility of linking with a major tertiary medical center to address gaps in services and resources that they were able to support locally.

The process of selecting a strategic partner began with a jointly-developed Request for Information (RFI) sent to all of the major medical centers in the Puget Sound region. The RFI asked interested entities to describe how they might support the hospitals on the Peninsula in several areas:

- To increase the availability of and/or strengthen health care services provided in the local communities
- To coordinate access to tertiary services by patients referred from the local communities
- To assist the hospitals in implementing an EMR system
- To assist the hospitals in recruitment and retention of medical staff
- To provide access to education and training for professional staff
- To provide access to emerging technologies to support local services
- To provide access to the purchasing power and administrative services of a larger entity

The RFI made it clear that the three hospitals were seeking a partner whose mission and culture would be compatible with theirs, and who would be capable of one day forming an ACO and executing population health management strategies in response to health care reform. The hospitals were not interested in a merger, but in an affiliation in which they would remain independent and locally owned, but be a part of a large regional health system. Proposals were received from all of the major medical centers in the region and after a five month review process with extensive participation by board, medical staff and senior management leadership, Swedish Medical Center was selected.

The strategic alliance is structured as a long-term (20 year) contractual relationship. A leadership committee from the four institutions was appointed to direct the affiliation and investigate additional opportunities for collaboration, including working with local tribes and local health jurisdictions. By acting as a group, the three North Olympic Peninsula hospitals brought more patient volume and negotiating power to the discussions with potential partners. A key was to identify a partner committed to and capable of developing and supporting a regional health system.

Strategic Plan

CRITICAL SUCCESS FACTORS

Community Leadership & Civic Engagement

Local leaders have a critical role in voicing community needs at the local, regional, state, and national levels. A key issue in rural communities is access to appropriate health care services. A critical role of local leaders is to secure resources to preserve local health care delivery systems. Organizations such as public hospital districts, federally qualified health centers, and local public health boards each offer models for local health system advocacy and leadership. Collaboration is an important strategy to achieve the economies of scale necessary to create professional, cultural, and educational opportunities in all of Washington’s rural communities.

Community Leadership Models

- **Hospital Districts** – Under Washington law, localities may form Hospital Districts for the purpose of “delivering health to their communities. Hospital districts are authorized not only to operate a hospital, but to deliver any service to help people stay healthy-physically, socially and mentally.” The majority of Washington’s rural hospitals are structured as hospital districts. Hospital districts are governed by boards elected by the citizens served by the hospital district. De facto, this form of governance assures a community-centric focus for the hospital district. The hospital district may take the leadership role in community-based planning by bringing in representatives from the non-hospital sectors of the local community.
- **Public Health/Hospital partnerships** – In a growing number of Washington counties, health departments and hospitals have joined forces to improve the health of their local communities. This model brings together the two key health policy boards in the county – local boards of health and hospital boards of commissioners/directors. These agencies have financial resources, are governed by locally elected officials, and can recruit other public and private agencies to form community health partnerships to accomplish specific objectives.
- **Federally Qualified Health Centers (FQHCs)** – The governance structure of FQHCs assures that the community is well-represented on their governing boards. Through federal grant support, they may have the available resources to assemble a broad array of stakeholders, and take a leadership role in furthering the health care system in a rural community.
- **Interagency Groups** – This model is less formal than the first three, but is not dominated by a hospital, health department or FQHC. Under this approach, interested agencies or individuals may participate. Governance structures may be consensus-based and flexible, or more formalized with bylaws and budgets. Economic development councils could serve as the foundation for this type of group.
- **Some communities may develop unique hybrid entities that draw from each of the models above.**

Strategic Plan

The following section identifies elements of strong community leadership demonstrated and vetted by rural communities in Washington and corresponding strategies.

Elements of Strong Community Leadership

1. There is a healthy turnover of community members in positions of authority. Positions of authority include elected officials, members of governing boards, and officers of clubs and other agencies. For turnover to be healthy, there is a continual influx and nurturing of citizens new to leadership positions while at the same time citizens stay in leadership positions long enough to gain the skills and knowledge to be effective leaders.
2. The community invests in its local leaders by supporting governance education and by holding annual planning retreats.
3. The demographic make-up of the leaders in the community reflects the demographics of the community.
4. There is a local agency that has taken upon itself to assess the health of the population on a regular basis. This agency includes the local citizenry in the design and analysis of the health assessment process.
5. There is a mechanism for local leaders to meet on a regular basis to plan for maintaining and improving the health of the local population. Because leaders meet on a regular basis, local leaders know and trust each other. A broad array of agencies participates in these meetings and no local agency concerned with population health is excluded.
6. Local leaders live and work in the community and they support and rely on local services (education, health care, long term care, etc.) and they do as much business as possible locally.
7. Local leaders understand the social determinants of health and they work on creating a strong and sustainable local economy, excellent schools, and a safe environment. The “people connectors” in the community are interested in health.
8. Individuals and organizations participating in community leadership activities have specific roles to play in the process. Individuals and organizations share their own priorities and goals in leadership activities.

Strategic Plan

Strategies

Local health leaders should consider:

1. Developing and identifying collaborative leadership organizations and bring together community leaders to educate and plan for the improved health of the community.
2. Adopting a leadership structure appropriate to their circumstances to create community-centric local health systems.
3. Completing a regular community health assessment, and developing an action plan and community health scorecard.
4. Building succession planning into their work, ensuring training for future community leaders.

Statewide rural health leaders should consider:

1. Engaging rural communities in the implementation of the Washington Rural Health Care Strategic Plan and other aligned statewide plans to meet the ongoing challenges of access to care.

ADEQUATE FINANCING

This strategic plan recommends an enhanced payment framework that preserves current federal and state programs, aligns incentives between primary, specialty and acute care providers, and supports a strong rural health care system. As outlined on pages 13-15, special payment programs have been put in place to maintain the viability of rural health care services. If such programs are eliminated, alternative programs must be established to financially support health care services in rural communities. **Until a financial plan to support rural health care is secured, however, we must advocate for the protection of the CAH, RHC and FQHC programs from:**

- a. **Funding cuts**
- b. **Regulations that constrain the ability of rural providers to meet the care needs of the populations they serve.**

Federal and state leaders are trying to create strategies to maintain appropriate services while reducing health care costs. One model that has emerged as a frontrunner is the concept of shared savings. Rural communities may consider shared savings arrangements as a strategy to align with policy makers and other health care agencies.

An Alternative Model for Financial Viability: Negotiating Shared-Savings Payment Arrangements

Shared-savings has emerged as a reimbursement model that incentivizes providers to reduce health care spending by offering them a percentage of the net savings they achieve. As a payment strategy, shared savings has received a great amount of attention in the Accountable Care Organization (ACO) model design and has been incorporated in a significant number of medical home pilots. Rural providers will face some challenges in negotiating these types of arrangements, especially if they aspire to become the hub of an ACO.

Rural providers are the sole providers of health care services in the community, which makes it easier to define the population which can be attributed to them. Rural clinics and hospitals, however, provide mostly primary care services, inpatient and emergency department services. In order to increase the opportunities for savings by reducing elective procedures and readmissions, rural providers would likely have to enter into agreements with larger, urban health systems and take ownership of stabilization and rehabilitation care.

Shared-savings agreements often involve a minimum threshold patient population per payer for participation. This is important to ensure savings calculations are accurate and not the product of random variation. In some instances, shared savings are contingent on other performance indicators, such as quality, outcomes and productivity measures. The adequate sizing of the risk pool or population under agreement presents an opportunity to create regional pools that would negotiate with each payer and allocate the savings among rural providers that do not reach minimum thresholds individually.

Savings strategies often rely on better care coordination and a more comprehensive approach to health care that includes dental, preventive and behavioral services. Rural areas have a shortage of primary care providers and any increase in access would demand considerable capital investments and training. Without a stable funding source to invest in technology, facilities and personnel, rural providers will find it difficult to achieve significant savings. Most medical home pilot programs offer a supplemental per-member-per-month (PMPM) payment to providers to cover up-front investment costs. If PMPM payments have to be returned to the insurers before providers are allowed to share in any savings, the supplemental payment becomes an unreliable source of funds.

With the planned expansion of managed care of the elderly, blind, disabled and children, capitated systems are likely to emerge as an alternative to both cost-based reimbursement and to fee-for-service systems. Future payment models are also expected to incorporate shared-savings agreements.

Strategic Plan

Strategies

Local and statewide rural health leaders should consider:

1. Engaging in discussions around delivery system design and payment models that support the medical home, the formation of regional networks, and value-based payments, while maintaining the essential nature of cost-based reimbursement and enhanced payments so critical to the viability of rural providers.
2. Advocating for more comprehensive or global payment models that are best suited for bringing about fundamental, systemic, sustainable reform of health care delivery while preserving the long term financial viability of the rural network.

ADEQUATE SUPPLY OF PROVIDERS

The limited supply of providers increases the vulnerability of rural communities. In order to maintain access to care by sustaining critical health care services, rural communities must actively pursue innovative strategies to recruit and retain health care professionals and use their skills appropriately. There is much diversity in rural communities and many types of providers to consider when examining shortages. The health care work force includes public health and information technology experts and language interpreters, as well as traditional medical providers. Opportunities for cross-training are abundant when looking at the scope of health services and diversity across a community or region.

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An Alternative Model to Train Rural Nurses – The Rural Outreach Nursing Education (RONE) Program

RONE is a two-year associate degree RN program, designed to meet the critical need for more registered nurses in rural health care agencies in Washington State. The program uses the latest in distance education teaching and technology so that employed health care workers can pursue an Associate Degree in Nursing in their home community. The courses, including prerequisites, are available online through Lower Columbia College in Longview, WA. Clinical education occurs at the student/employee's hospital or clinic, and is augmented with additional experiences within the student's community. Additional information about the RONE program can be found through the Western Washington Area Health Education Center (<http://www.wwahec.org/>).

Strategies

Local and statewide rural health leaders should consider:

1. Utilizing new technology to:
 - Improve support for providers practicing in rural areas by increasing options for continuing education and training;
 - Address professional isolation issues;
 - Increase opportunities for specialty care to be delivered to rural communities.
 - Provide increased training opportunities for health care professional programs in rural areas and recruit local residents.
2. Advocating for maintaining federal and state programs with incentives to attract and retain health care professionals to rural communities, such as scholarship and loan repayment programs.
3. Reviewing professional licensure and regulatory requirements and reduce barriers to expanding the roles of health professionals by:
 - Allowing providers to practice to the full limits of their license;
 - Identifying and changing institutional policies and regulations, administrative, financial and clinical, that impede optimal work of health care professionals;
 - Embracing care redesign strategies that more effectively and efficiently utilize health care professionals.

HEALTH INFORMATION TECHNOLOGY

Health information technology (HIT) can make or break the future of the health care system. Its applications can improve the patient and provider experience, improve access to care in health professional shortage areas, and reduce costs. HIT includes a broad range of tools: electronic medical records and patient registries, the technologies required to move these across settings and between providers, and the technologies required to support remote specialty consults and distance learning. Many barriers limit the implementation of HIT, including: lack of financial resources, interoperability and limited information on statewide best practices, limited access to rural HIT experts and adequate telecommunications bandwidth (commonly referred to as “limited internet access”). HIT presents an opportunity for rural communities to assure access to services for their residents.

Example: The Critical Access Hospital Network’s (CAHN) Rural Health Information Technology Project

The Critical Access Hospital Network (CAHN), with the support of federal grant funds, is implementing a regional HIT and quality improvement (QI) project in four rural counties of Eastern Washington. The CAHN is a nonprofit, multi-county vertical network that was developed in 2002. The hospitals in the network are: Garfield County Public Hospital District, Newport Hospital and Health Services, Lincoln Hospital, and Coulee Medical Center. The goals of the project are to: (1) enhance access to reliable and complete patient data for local/regional reporting purposes, (2) deploy a regional central data repository to enable local/regional quality improvement activities and position CAHN for statewide healthcare reform opportunities; and (3) secure the long term HIT sustainability of the CAHN.

This project aims to share data among a network of primary care providers to improve clinical performance and health outcomes. It promotes efficient and effective delivery systems and fosters a learning community by helping providers connect with each other more easily, and empowering patients to better understand and access their health information. The grant funds have supported purchasing of equipment and hiring a shared Chief Information Officer, in order to promote sustainability of HIT systems in the CAHN. This project is an example of many uses of HIT to improve rural systems of care.

Strategic Plan

Strategies

Local and statewide rural health leaders should consider:

1. Growing rural expertise in HIT. Creating opportunities to continuously train health care staff and patients in new technologies available to them.
2. Assuring broadband high speed internet access for all rural communities by engaging with community-level and statewide broadband access efforts.
3. Redefining success for rural HIT systems. Broadening peer-to-peer communication to share best practices in HIT developments and working together to adopt a compatible system.
4. Using HIT as a tool for collaboration, patient management, access to specialty services, and quality improvement.
5. Following national guidelines, within the financial capability of each community, to achieve meaningful use requirements and access available funds.

QUALITY IMPROVEMENT

Rural health care delivery systems face continuing challenges in meeting state and federal quality standards. Funding shortages force difficult decisions about which services can be offered in rural communities as they strive to maintain high levels of quality care. Despite these challenges, rural communities, with strong administrator and provider leadership, are achieving high and continually improving standards of care in their organizations and assuring that specialized care is available through regional referral systems. Rural healthcare systems aim to offer appropriate quality patient care services. This includes providing seamless referral, care coordination, and follow-up to and from larger urban facilities.

A culture of quality improvement is critical to keeping health care services in the local community. As quality is being redefined as a principle market driven value and shifting from purchasing service units to purchasing outcomes, rural health care organizations have a great opportunity to define quality for both individual and population health. Thus far, quality improvement measurement has been designed in settings that are not rural, and this has made it hard for quality improvement to have significant measurement and meaning in rural communities. System improvements, rather than just scoring improvements, should be a priority for rural health care quality improvement. National lessons learned from the Institute of Medicine (IOM), Centers for Medicare & Medicaid Services (CMS), and National Quality Forum (NQF) are defining the path in measuring the impact of medical errors on patients, public reporting of quality initiative data, and measuring the coordination of care across time and location, particularly for the chronically ill patient population.

Strategic Plan

Using Rurally Relevant Data for Improvement

In 2002, thirty-four Critical Access Hospitals created the Washington Rural Healthcare Quality Network (RHQN) to improve quality care for their communities. RHQN hospitals share data to identify best practices and areas for improvement.

A quarterly RHQN Clinical Quality Comparative Report contains over 70 CMS, Washington State and RHQN selected rurally relevant measures covering Cardiac, Stroke, Emergency Department, Heart Failure, Pneumonia, Surgery, Perinatal, Swing Bed, Infection Prevention and Quality Improvement. Additionally, all RHQN hospitals will be sharing their data in the 2012 national Medicare Beneficiary Quality Improvement Project (MBQIP) CAH database and also will be participating in CMS Public Reporting. More information can be found at <http://www.rhqn.org/>.

Strategies

Local health leaders should consider:

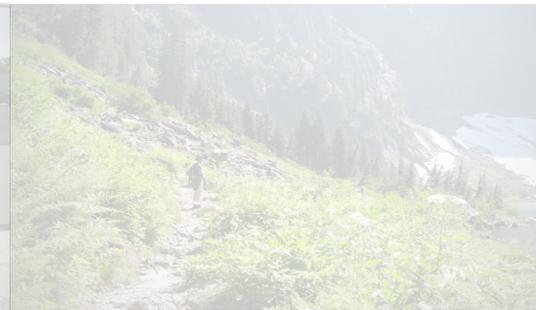
1. Promoting high quality local care delivered safely, effectively, and in a timely manner by defining core services appropriate for local delivery given the resources available to each community.
2. Advocating for the development of quality improvement (QI) evaluation measures that demonstrate system improvements and relevance to rural areas.
3. Practicing transparency by participating in public reporting initiatives and taking action when standards are not met.
4. Participating in a network that facilitates QI activities by rural providers.
5. Working with health care support organizations and referral specialists on QI care management activities that foster regional systems.
6. In collaboration with board members and medical staff, setting QI goals and developing a QI plan, identifying measurement criteria, and engaging all organizational staff in QI activities.

LONG TERM STRATEGIC PLANNING

It is hard to plan for the future when the present is a time of extraordinary challenges and change. However, it is imperative to have a strategic plan that brings the state toward a common vision for rural health. This vision for the future hinges on how well we take information, align it with current successes and failures, and use it to plan for healthy communities. This plan is driven by a vision (page 1) for rural health and a set of guiding principles (page 2-3) for strategic long term planning first created in 2007. It has never been more important that institutions conduct strategic planning to set a vision and goals for the future.

FINAL COMMENTS

While the health care system is in a time of continuous change, there are clear actions that rural communities and rural health supporters can take to mitigate crisis and plan for a better future. They can stand together to protect health care resources while simultaneously pursuing the goals in this document. They can follow principles described in this plan to secure the long term health and well-being of rural communities and create the environment necessary for a strong future for rural health.



For more information, visit www.waruralhealth.org.