

Rural Health Systems of the Future

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Rural Health and Human Services

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Keith J. Mueller, Ph.D.
Director, RUPRI Center for Rural Health Policy Analysis
Head, Department of Health Management and Policy
College of Public Health
University of Iowa



Context of Change

- Increasingly intensive focus on cost
- New models rolling out – ambulatory
- System expansion/growth
- Mergers, acquisitions, affiliations



What It All Means

- A rural community focus
- What is needed?
- What do we have?
- How do we play in a way that sustains essential local services?



Buzzwords of the day



- Value
- Patient-centered
- Choice
- Savings



Future Should be: RUPRI Health Panel Vision

The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance rural health care system informed by the needs of each unique rural community will lead to greater community health and well-being.

Should be: Foundations for Rural Health


- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

Source: "Pursuing High Performance in Rural Health Care." RUPRI Rural Futures Lab Foundation Paper No. 4.

http://ruralfutureslab.org/docs/Pursuing_High_Performance_in_Rural_Health_Care_010212.pdf



A High Performance Rural Health Care System Is

- **Affordable:** costs equitably shared 
- **Accessible:** primary care readily accessible
- **Community-focused:** priority on wellness, personal responsibility, and public health
- **High-quality:** quality improvement a central focus
- **Patient-centered:** partnership between patient and health team



Central points from RUPRI Health Panel regarding change

- Preserve rural health system design flexibility: local access to public health, emergency medical, and primary care services
- Expand and transform primary care: PCMH as organizing framework, use of all primary care professionals in most efficient manner possible



Continued

- Use health information to manage and coordinate care: records, registries
- Deliver value in measurable way that can be basis for payment
- Collaborate to integrate services
- Strive for healthy communities

Innovate to accelerate pace of change

- In health care work force: community paramedics, community health workers, optimal use of all professionals, which requires rethinking delivery and payment models – implications for regulatory policy including conditions of participation
- In use of technology: providing clinical services through local providers linked by telehealth to providers in other places – E-emergency care, E-pharmacy, E-consult
- In use of technology: providing services directly to patients where they live

The future can be healthy people in healthy communities

- Where people choose to live
- Through local providers linked to integrated systems of care
- Who, together with their patients, manage health conditions
- Not the same design everywhere, but the high quality, patient-centered everywhere



Health Care Organizations of the Future

- Accepting insurance risk
- Focus on population health
- Trimming organization costs
- Using the data being captured (e.g., electronic health records)
- Health care as retail business



Considerations



- Using population data
- Evolving service system (e.g., telehealth)
- Workforce: challenges to fill vacancies, and shifts to new uses of new categories
- Best use of local assets; including physical plant (the hospital)

Local Assets to Consider

- Raw material
- Data and information
- Connectivity
- Core capabilities, e.g., primary care
- Leadership

Recommendations for Hospitals

- Align with primary care doctors
- Ratchet all costs out
- Measure and improve quality
- Know your value proposition



Change is Underway



- FFS to VBP
- PC Physicians to Other Primary Care and PCMH personnel
- Face-to-face encounters to telehealth
- Independent entities to systems
- Encounter-based medicine to person-based health
- Revenue centers to cost centers and vice versa

Implications

- Transitions have to be managed
- First do no harm
- Relationships among strange bedfellows (urban and rural, systems and independents, institutions and community-based providers)
- Value, value, value proposition is critical
- Flexibility in business plans means flexibility in policy models

Welcome to the World of ACOs

- Not just a buzz word
- Is a new model, built on use of data systems and management strategies
- Provider systems focused on health



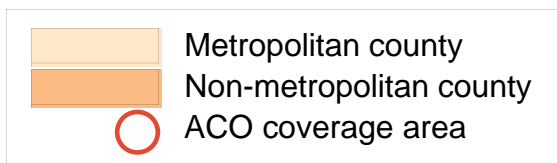
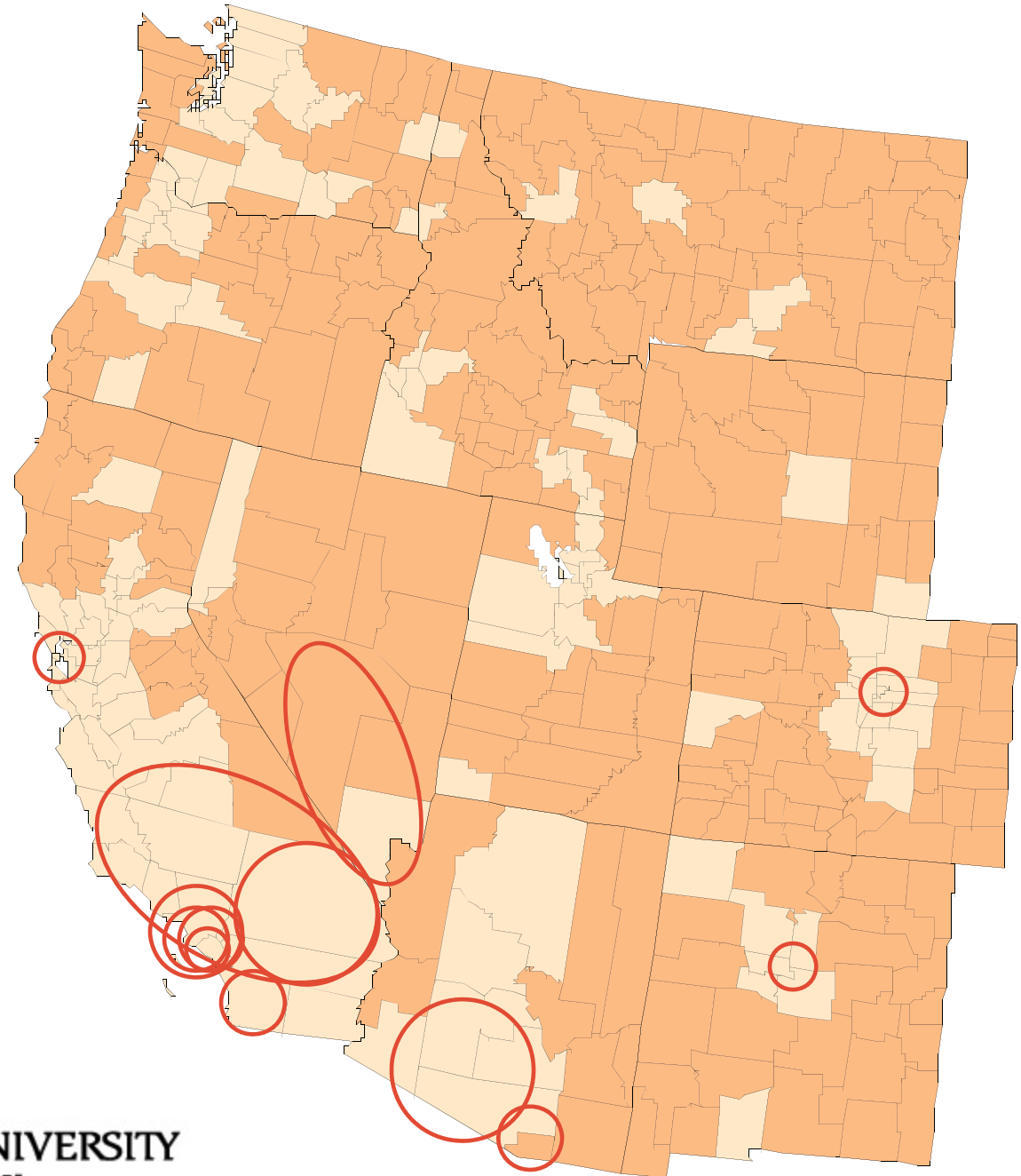
They're Here



- Private started before Medicare
- Medicare Pioneer, MSSP, Advanced Payment
- Almost daily stories on more being formed
- And they are in rural places

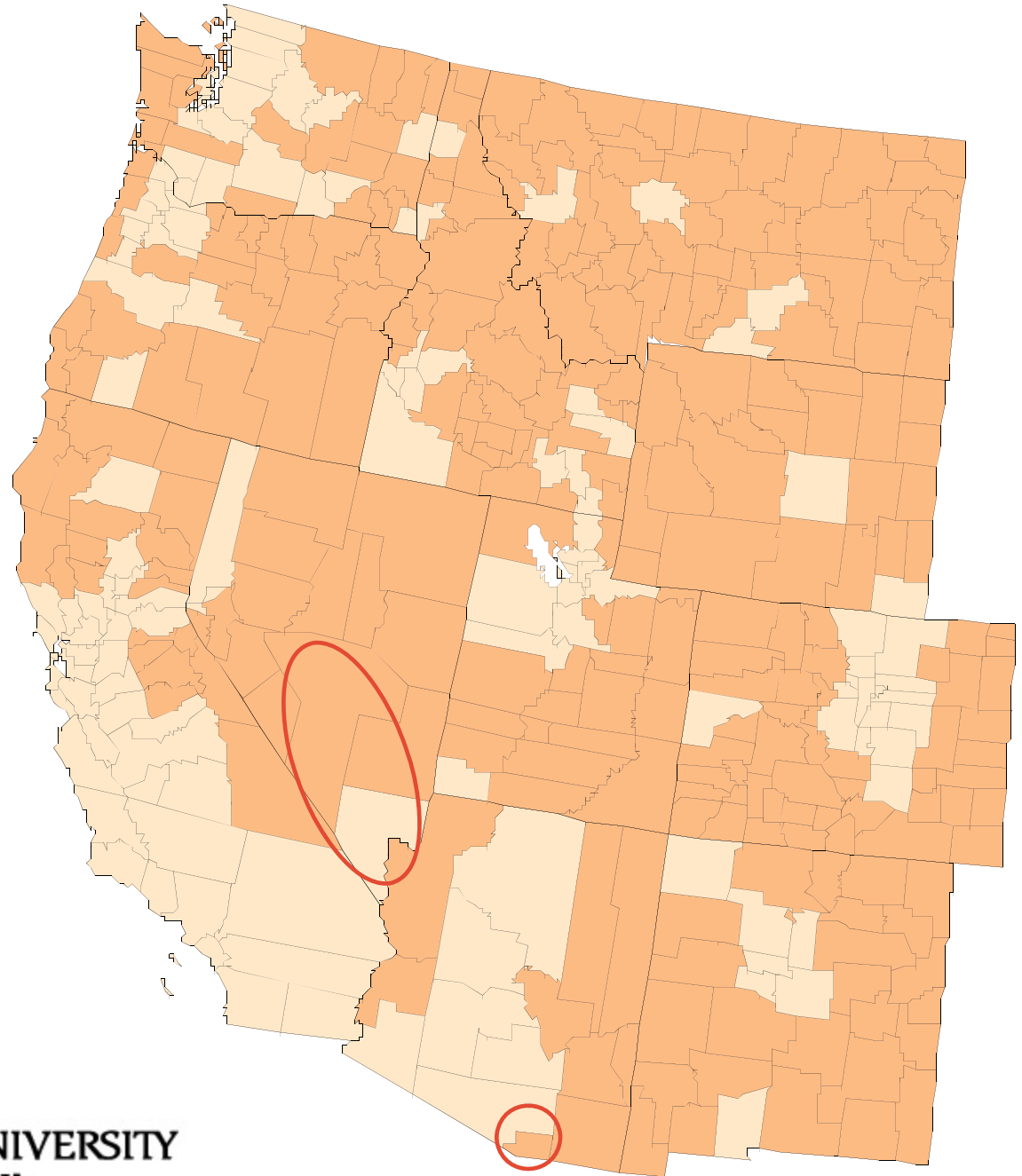
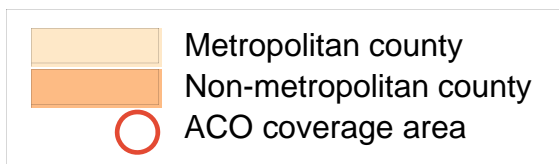
Accountable Care Organizations

Pioneer and Shared Savings ACOs,
Western Census Region



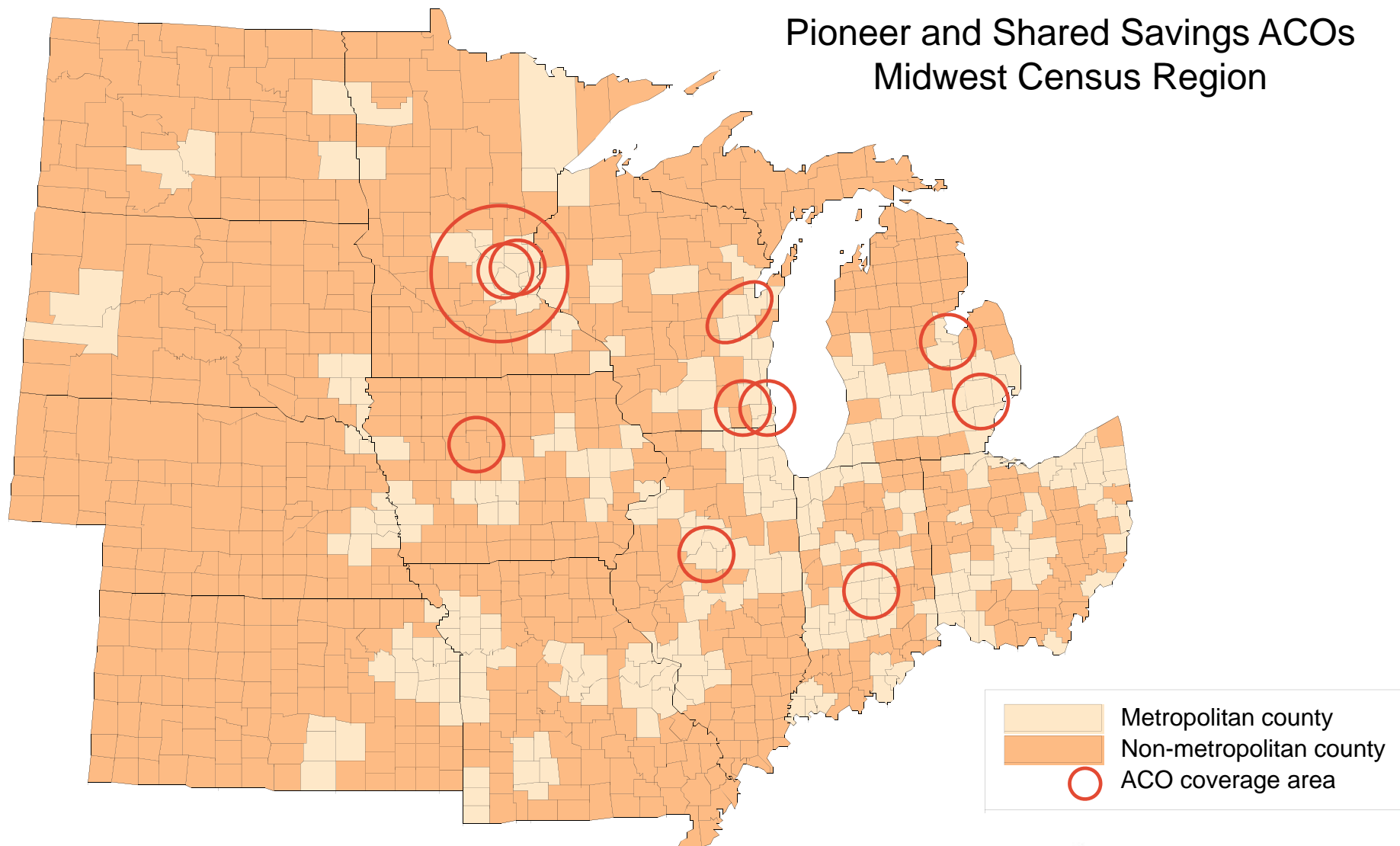
Accountable Care Organizations

Pioneer and Shared Savings ACOs with rural coverage, Western Census Region



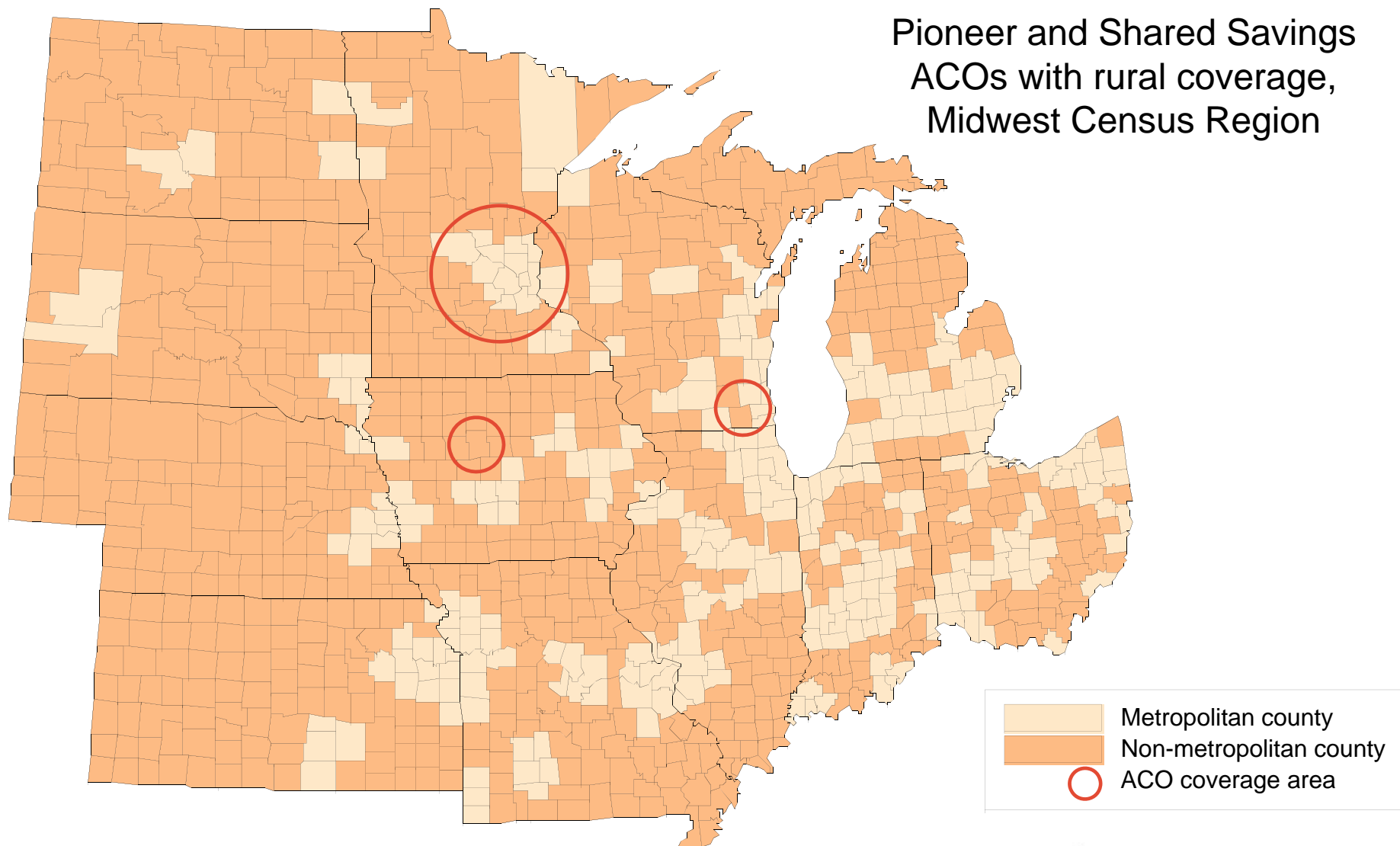
Accountable Care Organizations

Pioneer and Shared Savings ACOs
Midwest Census Region



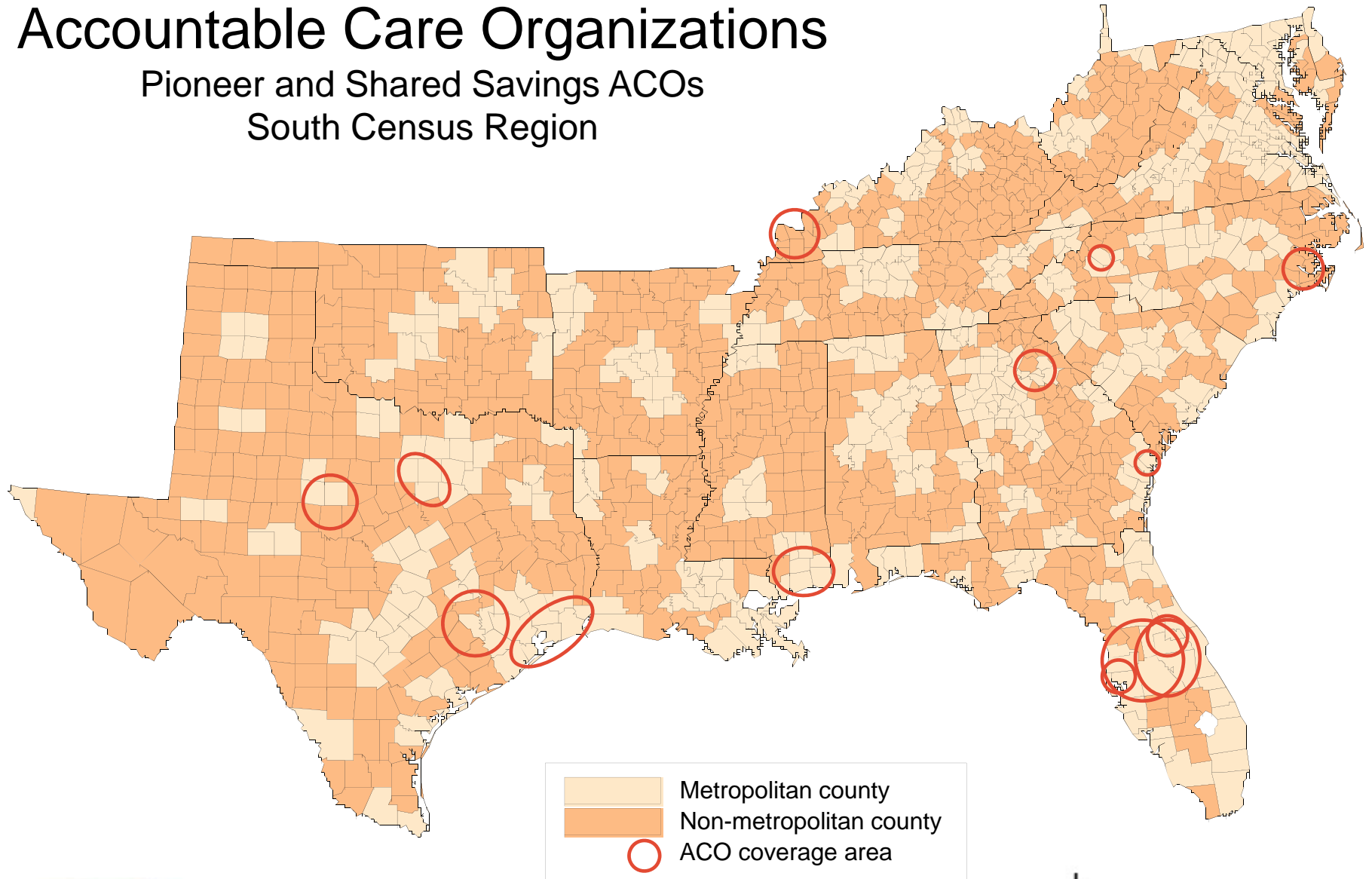
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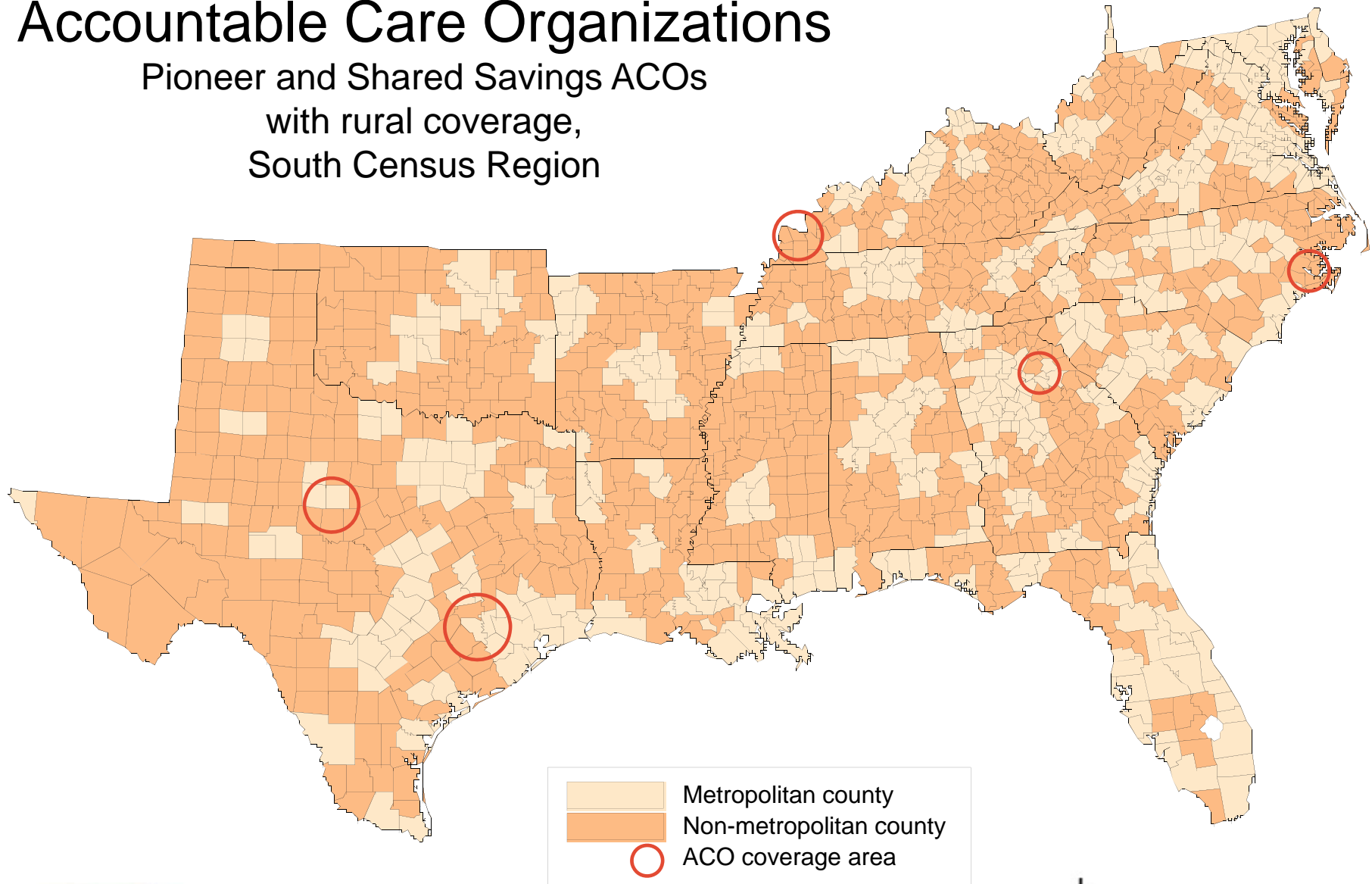
Accountable Care Organizations

Pioneer and Shared Savings ACOs
South Census Region



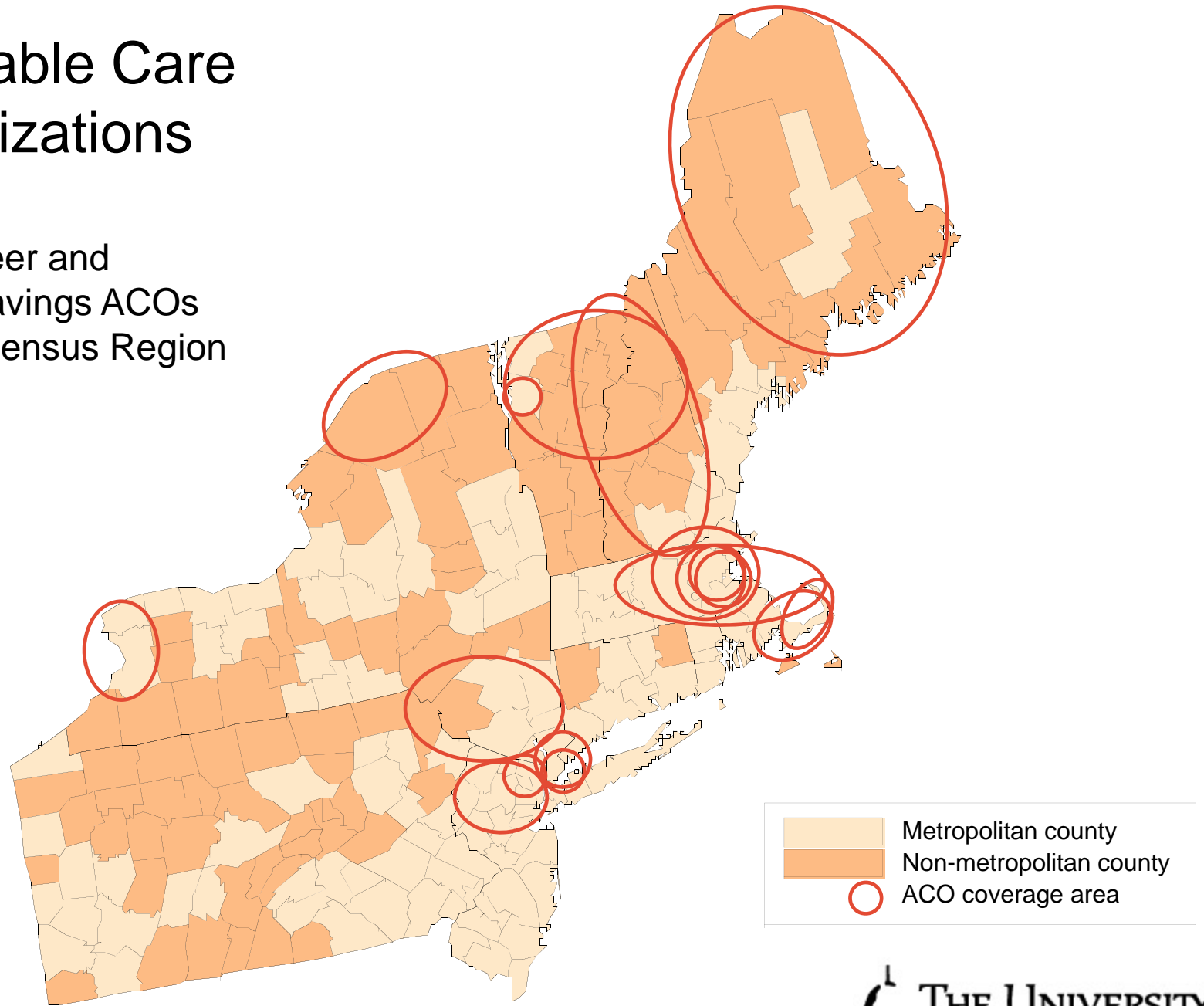
Accountable Care Organizations

Pioneer and Shared Savings ACOs
with rural coverage,
South Census Region



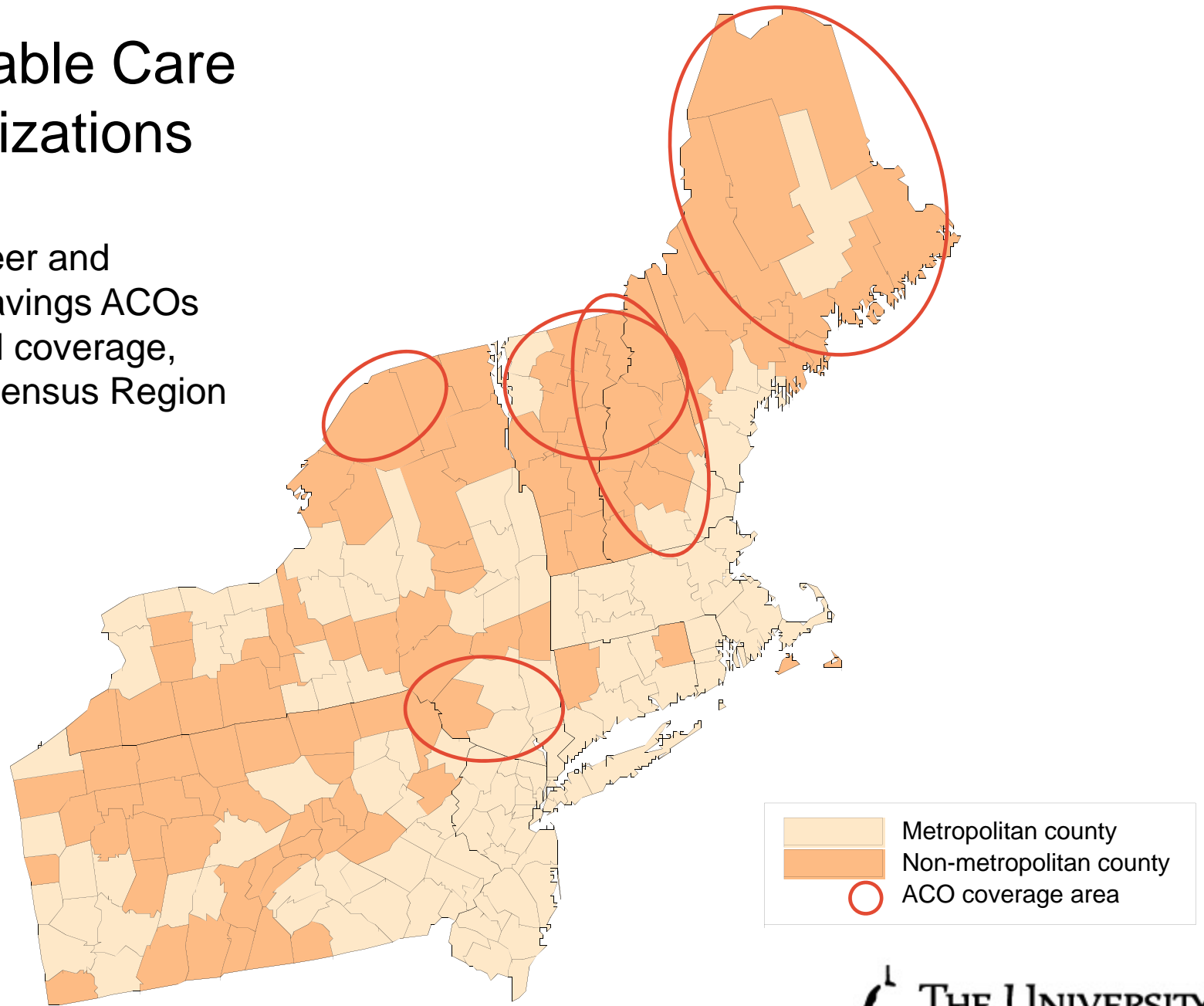
Accountable Care Organizations

Pioneer and Shared Savings ACOs
Northeast Census Region



Accountable Care Organizations

Pioneer and Shared Savings ACOs with rural coverage, Northeast Census Region



Tally Sheet



- 32 Pioneer ACOs
- 27 MSSP ACOs
- 5 of the 27 are Advanced Payment
- 151 applicants for July cycle
- 160 private sector ACOs

For Further Information

***The RUPRI Center for Rural
Health Policy Analysis***

<http://cph.uiowa.edu/rupri>

The RUPRI Health Panel

<http://www.rupri.org>



Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health
105 River Street, N232A, CPHB

Iowa City, IA 52242

319-384-3832

keith-mueller@uiowa.edu

