

# A Call to Action in Nebraska: The Institute of Medicine Report “Quality Through Collaboration: The Future of Rural Health”

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# Setting the Context

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- National trend demanding accountability for quality
- But we don't know what quality is when we see it, or don't see it
- So growing use of easy to obtain measures, developed in large urban centers
- Leaving rural with a challenge and an opportunity

Challenge: How to get into the game

Opportunity: Redirect and lead the charge



# Enter the Institute of Medicine (IOM)

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- Responding to request for a study, backed by \$\$
- Assemble experts in health policy and practice
- Collect information and testimony
- Be bold and creative in recommending a future course



# Result: 5-Pronged Strategy

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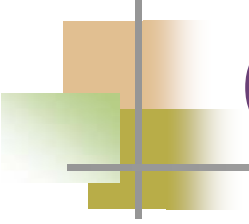
[The slides summarizing the IOM report were prepared by the Center for Rural Health, University of North Dakota for use by Mary Wakefield, Chair of the Committee on the Future of Rural Health, and other members of the Committee]



## 5-Pronged Strategy to Address Quality Challenges in Rural Communities

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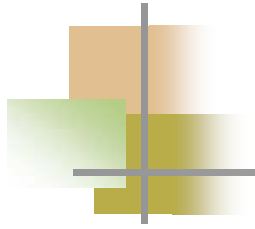
1. Adopt an integrated, prioritized approach to addressing personal and population health needs at the community-level.
2. Establish a stronger quality improvement support structure to assist rural health systems and professionals.
3. Enhance human resource capacity of rural communities –
  - health care professionals
  - rural residents



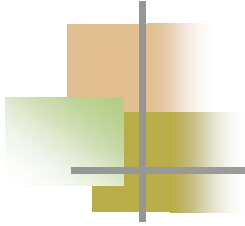
## 5-Pronged Strategy to Address Quality Challenges in Rural Communities (continued)

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4. Monitor and assure that rural health care systems are financially stable.
5. Invest in building an information and communications technology (ICT) infrastructure.



# Addressing Personal and Population Health Needs



Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (IOM, 1990: p.4).

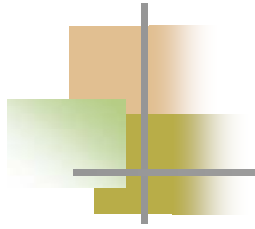




# #1

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- Congress should provide the appropriate authority and resources to the DHHS to support comprehensive health system reform demonstrations in five rural communities.
- Demonstrations should evaluate alternative models for achieving greater integration of personal and population health services and innovative approaches to the financing and delivery of health services, with the goal of meeting the six quality aims. AHRQ should work collaboratively with HRSA to ensure the lessons learned from these demonstrations are disseminated to other communities.



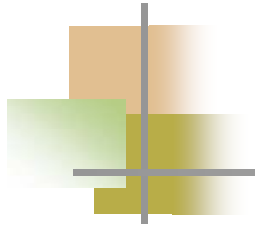
# Establishing a Quality Improvement Support Structure



## #2

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- DHHS should establish a Rural Quality Initiative to coordinate and accelerate efforts to measure and improve the quality of personal and population health care programs in rural areas.....Coordinated by HRSA's ORHP with guidance from a Rural Quality Advisory Panel consisting of experts from the private sector and state and local governments having knowledge and experience in rural health care quality measurement and improvement.



# Strengthening Human Resources



## #3

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- Congress should provide appropriate resources to HRSA to expand experientially based workforce training programs in rural areas to ensure that all health care professionals master the core competencies of providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics.



# #4

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- Schools of medicine, dentistry, nursing allied health, and public health and programs in mental and behavior health should:
  - Work collaboratively to establish outreach programs to rural areas to attract qualified applicants.
  - Locate a meaningful portion of the educational experience in rural communities. Universities and 4-year colleges should expand distance learning programs and/or pursue formal arrangements with community and other colleges, including rural tribal and traditionally black colleges.



## #4 (continued)

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- Make greater effort to recruit faculty with experience in rural practice, and develop rural-relevant curricula.
- Develop rural training tracks and fellowships that:
  - 1) provide students with rotations in rural provider sites;
  - 2) emphasize primary care practice;
  - 3) provide cross-training in key areas of shortage in rural communities.

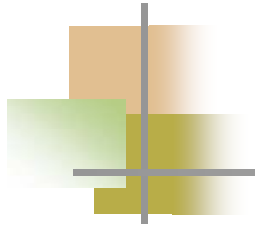


## #4 (continued)

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The federal government should provide financial incentives for residency training programs to pursue rural tracks by linking some portion of the graduate medical education payments under Medicare to achievement of this goal.





# Providing Adequate and Targeted Financial Resources



## #5

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- CMS should establish a 5-year pay-for-performance demonstration projects in five rural communities starting 2006.
- During the first 18 months, communities should receive grants and technical assistance for establishing processes to capture patient data and other information needed to assess performance using a standardized performance measure set appropriate for rural communities.



## #5 (continued)

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- For the remaining 3.5 years, different approaches to implementing pay-for-performance should be tested.
- Selected communities should be diverse with respect to socio-demographic variables, as well as the degree and type of formal integration of local and regional providers.



## #6

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- AHRQ should produce a report no later than FY '06 analyzing the aggregate impact of changes in the Medicare program, state Medicaid programs, private health plans and insurance coverage on the financial stability of rural health care providers.

The report should detail actions that should be taken, if needed, to ensure sufficient financial stability for rural health care delivery systems to undertake the desired changes described in this report.



# #7

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- HRSA and SAMHSA should conduct a comprehensive assessment of the availability and quality of mental health and substance abuse services in rural areas.
- This assessment should include:

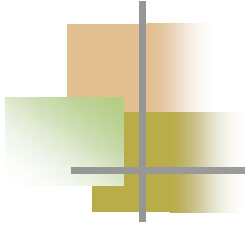


## #7 (continued)

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- Review of insurance and direct service programs in the public and private sectors that provide financial support for the delivery of mental health and substance abuse services, and the populations served by these payers and programs.
- Evaluation of current funding adequacy and analysis of alternative options for better aligning various funding sources and programs to improve accessibility and quality of services.

Attention should be focused on identifying and analyzing options designed to encourage collaboration between primary care and specialty settings.



# Utilizing Information and Communications Technology



# Strategy to Include Rural Communities

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1. Include a rural component in the National Coordinator for Health Information Technology (NCHIT) plan,
2. Provide all rural communities with high-speed access to the Internet,
3. Eliminate regulatory barriers to the use of telemedicine,





# Strategy to Include Rural Communities (continued)

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4. Provide financial assistance to rural providers for investments in EHR's and new ICT,
5. Foster ICT collaborations and demonstrations in rural areas, and
6. Provide ongoing educations and technical assistance to rural communities to make the best use of ICT.



## #8

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- The Office of the National Coordinator for Health Information Technology should incorporate a rural focus, including frontier areas, into its planning and development activities:
  - Include a specific rural and frontier areas component that provides programmatic and financial resources necessary for rural areas to participate fully in the NCHIT.



## #8 (continued)

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- ORHP should be designated lead agency for coordination of rural health input to the NCHIT.
- In providing input, ORHP should seek the advice of the DHHS Rural Task Force.



# #9

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- Congress should ensure that the rural communities are able to use the Internet for the full range of health-related applications. Specifically, consideration should be given to:
  - Expanding and coordinating federal agency efforts to extend broadband networks into rural areas.
  - Prohibiting LATA's from imposing surcharges for the transfer of health messages across regions.
  - Expanding the USF's Rural Health Care Program to allow all rural providers to participate, and to increase the amount of subsidy.



# #10

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- Congress should provide appropriate direction and financial resources to assist rural providers in converting the EHR's over the next 5 years. Working collaboratively with the NCHIT:
  - HIS should develop a strategy for transitioning all of its provider sites (including those operated by tribal governments under the Self-Determination Act) from paper to electronic health records.



## #10 (continued)

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- HRSA should develop a strategy for transitioning CHC's, RHC's, CAH's and other rural providers from paper to electronic health records.
- CMS and state governments should consider providing financial rewards to providers participating in the Medicare and Medicaid programs that invest in EHR.
- These two programs should work together to reexamine their benefit and payment programs to ensure appropriate coverage of telehealth and other electronic health services.



# #11

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- AHRQ's Health Information Technology Program should be expanded.
  - Adequate resources should be provided to allow the agency to sponsor developmental programs for information and communications technology in five rural areas. Communities should be selected from across rural environments, including frontier areas. The five-year developmental programs should begin 2006 and result in the establishment of the state-of-the-art information and communications technology infrastructure, accessible to all providers and consumers in those communities.



## #12

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- NLM in collaboration with the NCHIT and the AHRQ should establish regional information and communications technology/telehealth resource centers interconnected with the National Network of Libraries of Medicine. These resource centers should provide a full spectrum of services, including:





## #12 (continued)

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- Information resources for health professionals and consumers.
- Life-long educational programs for health care professionals.
- An on-call resource center to assist communities in resolving technical, organizational, clinical, financial, and legal questions related to ICT.



# More Context for Change

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- Leapfrog interest in rural indicators
- National Advisory Committee on Health and Human Services Report in the spring
- National Rural Health Association Strategic Direction
- Showing effective use of Flex dollars
- National Health Information Infrastructure
- Future programs of the Agency for Healthcare Research and Quality



# So, for Nebraska

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- Balanced Scorecard initiative
- Future generations of Clinical Outcomes Measurement System
- Patient Safety Initiatives
- Multi-state demonstration of measures
- Electronic Health Record



# But ... At Least Get the Head Out of the Sand

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- The limitations of one provider at a time
- The limitations of one condition at a time
- The limitations of one payer at a time
- Multiplied if additions within any category



# Now Get Completely Out of the Box and Take a Lead

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- The IOM pushes for “Community-Centeredness”

**TABLE 2-3** Personal Health Care System and Community-Level Interventions: Illustrative Examples for Patient- and Community-Centeredness

<u>Definition</u>		<u>Measures</u>		<u>Interventions</u>	
<i>Personal Health Focus</i>	<i>Population Health Focus</i>	<i>Personal Health Care System</i>	<i>Community Level</i>	<i>Personal Health Care System</i>	<i>Community Level</i>
Provide care that is respectful of and responsive to patient preferences, needs, and values	Ensure that public- and private-sector stakeholders (e.g., education, business, transportation, health care) are respectful of and responsive to community preferences, needs, and values regarding health and health care	Measures of patient satisfaction with health care services	Measures of the extent to which community priorities have been identified and incorporated into community health improvement and investment decisions  Measures of satisfaction with various aspects of the community that influence health, including availability of parks and recreational facilities, levels of environmental hazards (e.g., air and water quality), and investments in health care	Establishment of training programs for health care professionals to enhance communication skills and interactions with patients  Assurance of the availability of language translation and other services that are responsive to the needs of the patient population being served	Establishment of tailored population health programs for minority populations, which are responsive to ethnic, cultural, and language issues  Redesign of community space to encourage biking and walking

**TABLE 2-5** Personal Health Care System and Community-Level Interventions: Illustrative Examples for Efficiency

<u>Definition</u>		<u>Measures</u>		<u>Interventions</u>	
<i>Personal Health Focus</i>	<i>Population Health Focus</i>	<i>Personal Health Care System</i>	<i>Community Level</i>	<i>Personal Health Care System</i>	<i>Community Level</i>
Avoid waste, including waste of equipment, supplies, ideas, and energy, in the delivery of personal health care services	Avoid waste, including waste of equipment, supplies, ideas, and energy, in the delivery of population health services	Measures of clinical efficiency (e.g., rates of use of evidence-based practices)	Tobacco cessation rates associated with per capita expenditures on community-wide smoking cessation programs	Dissemination of best practices regarding outpatient and inpatient workflow efficiency	Public reporting of population-based measures of health care use
	Seek efficient allocation of community resources and assets to personal and population health services to maximize health impact for the community	Measures of production efficiency (e.g., average annual health care costs for care of a patient with diabetes)	Measures of average days lost from work or school due to preventable illness per resident	Financial incentives to providers to reward adherence to protocols and coordination of care	Development of public policy that encourages (through financial and other incentives) a balance between personal health care and community health improvement programs
		Measures of clinician time spent on paperwork		Finance strategies that allow for more flexible integration of services (e.g., behavioral health, long-term care)	
		Measures of service duplication (e.g., ordering of redundant tests)		Investment in electronic health records	



# So Just Do It

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- Think about the continuum of care
- Think about all the agencies that might play an effective role
- Take advantage of scale in reverse: rural communities have the edge!





# Thank you!

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- For more information, go to:

RUPRI Center for  
Rural Health Policy Analysis



[www.rupri.org/healthpolicy](http://www.rupri.org/healthpolicy)