Public Policy, Rural Health, and the Role of Advocacy

UND Department of Political Science

POLS -552 Health Policy

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e established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
• One of the country’s most experienced state rural health offices
• UND Center of Excellence in Research, Scholarship, and Creative Activity
• Home to seven national programs
• Recipient of the UND Award for Departmental Excellence in Research

Focus on
– Educating and Informing
– Policy
– Research and Evaluation
– Working with Communities
– American Indians
– Health Workforce
– Hospitals and Facilities

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Today’s Objectives/Questions

• What are the rural health issues and conditions?

• What is the health policy process – formal and informal?

• How does the health policy process work to advance rural health concerns and needs or how does rural health work within or use that process?

• What is Policy Framing and how can it be Used?

• Who are key actors in rural health policy development?

• What are some examples of successful rural health policy?

• Briefly – What is going on in health reform?

Ultimately Public Policy Originates from Our Values

“It is not what we have that will make us a great nation. It is how we decide to use it.”

Theodore Roosevelt

“Vision is the art of seeing things invisible”

Jonathan Swift

“Americans can always be relied upon to do the right thing…after they have exhausted all the other possibilities”

Sir Winston Churchill
What are the rural health issues and conditions?

What is Rural Health

- Rural health focuses on population health and improving health status
  - “Health outcomes of a group of individuals, including the distribution of such outcomes within the group” Dr. David Kindig, *What is Population Health?*
  - Rely on social determinants of health and their impact on the population (Health care system, Health Behaviors, Socio-Economic factors, Physical Environment) – “*drivers* of health policy” (Better Health, Better Care, and Lowered Cost – Three Aims)
- Historically, rural health has focused more on infrastructure: facilities, providers, services, and programs available to the public (all with quality, access, and cost implications) – *In the ACA world more emphasis on population health, but infrastructure is still critical as it is the pathway to achieve better population health.*
  - HRSA (ORHP, SORH, Flex, NHSC) – Federal bureaucracy orientation
  - Infrastructure improvement- health orgs, systems, payment structures
  - More and more health networks – independence with collaboration
  - Delivery systems: CAH, clinics, public health, EMS, nursing homes/aging services, home health, mental health, dental, pharmacy, and others
What is Rural Health?

- **Rural health is not urban health in a rural or frontier area**
  - Social determinants of health vary between urban and rural (economics/income, education, health systems, environmental conditions)
  - Rural is older, poorer, less insured, and has a higher level of morbidity for a number of conditions
  - Rural culture, relationships, how we do things are distinct

- **Rural health needs effective health policy, and health policy needs to rely on competent research**
  - Policy process that is reflective of rural health needs
  - Policy advocacy that tends to be bipartisan
  - Varity of advocacy groups
  - Rural health research community

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What is Rural Health?

**Philosophy: rural people have the same right to expect healthy lives and access to care as do urban people – fairness frame**

- Access essential services locally or regionally
- Access to specialty services through network arrangements
- Health outcomes should be comparable
- Quality of care on par with urban
- Availability of technology

**Rural health is very community focused – interdependence frame**

- Integral part of what a community is and how people see themselves
- Community engagement – public input is fundamental
- Sectors: Economic/business, public/government, education, faith/church, and health/human services
- Direct services provided to the public and secondary impact for other sectors
- Major employer
Preliminary CHNA Issues (2014-2016)

- 41 CHNA analyzed out of possible 45
- 182 ranked needs (range 2 to 8 ranked needs, average 4.4)

Issues

- Behavioral Health 23 out of 41 (56%)
- Mental Health 20
- Health Workforce (recruitment/retention, specialists) 17
- Obesity/Overweight 13
- Elderly Services (availability or resources) 10
- Wellness (lifestyle, exercise, physical activity) 10
- Costs (healthcare, insurance, prescriptions) 9
- Childcare/daycare 9
- Jobs with Living Wages 8
- Ability to Recruit and Retain Young Families 8
- Poverty 2
- Violence prevention 2
Key Concepts in Health Reform

- **2 Primary Changes: Insurance** and **Health System Redesign**
- **Population health** – improve outcomes
  - emphasize prevention, care coordination,
  - less hospital admissions/readmissions,
  - less inappropriate ED visits
- **Social determinants of health**
- **Volume to value** (changing how we pay for services to be less volume and more value – quality and outcomes)
- **Accountable Care Organization** (ACO) is an example (National Rural Accountable Care Consortium – 7 ND CAHs) - 20% of ND CAHs are associated with an ACO

What is the health policy process – formal and informal?
Health Policy – The Formal Side

• Executive – Legislative Process (Congress and the Federal Agencies)
  o White House Rural Council to Strengthen Rural Communities
  o National Advisory Committee on Rural and Human Services
    ➢ 21 members – nationally recognized rural health experts, nominated by NRHA and NOSORH – vetted through congressional office
    ➢ Provide recommendations to Secretary of HHS
    ➢ 1-4 issues per year – site visits
    ➢ Can lead to specific research requests to federally funded RHRC (e.g. hospice)
  o Senate Rural Health Caucus – history in North Dakota - 1985
  o House Rural Health Care Coalition - 1987
  o Senate Finance, Senate HELP, Senate Energy and Natural Resources, S&H Indian Affairs, S&H Judiciary, House Ways and Means, House Energy and Commerce (Cramer), S&H Appropriations (Senator Hooven), S&H Budget Committees (former Senator Conrad)

• Federal Agencies
  ➢ US Department of Health and Human Services
    ✓ HRSA and within it – Office of Rural Health Policy- SORH, FLEX, Rural Health Grants, Rural Health Advisory Council, Bureau of Primary Health Care – Community Health Centers, Bureau of Primary Health Care – Community Health Centers, Bureau of Health Professions – healthcare workforce issues, Bureau of Clinician Recruitment and Services – NHSC
    ✓ Centers for Medicare and Medicaid Services (CMS) – CMS Innovation Grants for health reform; reimbursement; rule making
    ✓ CDC – Community Transformation Grant – population health
  ➢ USDA – Rural Development’s Community Facility program (Sen. Heitkamp on Ag)
  ➢ USDHUD – HUD 242 program for capital loans to rural hospitals
  ➢ Veterans Administration – access, CBOC (comm. based outreach clinic), mental health
Health Policy – The Informal Side

• Setting the Agenda (prior to formal policy formulation and during development)
  o Advocacy
    ➢ Interest groups play significant role
      ✓ Content experts – know the details – provide information (fact sheets, reports, meetings with staff, calls from staff) and they rely on research
      ✓ Represent a point of view
      ✓ Relied upon by policy staff – develop close working relationships
      ✓ Interest groups want to be relied upon, “at the table”
    ➢ Important Rural Health Interest Groups
      ✓ National Rural Health Association (NRHA)
      ✓ National Organization of State Offices of Rural Health (NOSORH)
      ✓ RUPRI (other federally supported rural health research centers)
      ✓ American Hospital Association
      ✓ State Rural Health Associations
      ✓ American Medical Association
      ✓ American Nursing Association
      ✓ American Public Health Association

• Managing and influencing the agenda (called “setting the agenda”)
  o Control the information flow – resource to staff
  o Information – formal testimony, research, fact sheets but also behind the scene
  o Be honest and reliable (VERY IMPORTANT is YOUR CREDIBILITY) – your utility to staff is your reliability and your information
  o If you don’t know say you don’t know but will find out

• Re-setting the agenda (ABC of politics)
  o Continuous involvement with interest groups to prepare for next round
  o Continuous involvement with policy staff – preparing them, helping them to see the implications of policy, determining what needs to be changed, provide evidence and data
  o Common questions – “What does this mean in North Dakota” ”Is there an impact for us”
Iron Triangle of Public Policy

Health Policy – The Informal and Formal Side

• Types of Domestic Policy (relies on Theodore Lowi, Randall Ripley and Grace Franklin)
  
  o **Distributive Policy** – disburse over wide range of beneficiaries – “seemingly unlimited number of recipients” – Iron Triangle
  o **Competitive Regulatory Policy** – influence a market for the public good – regulatory agencies much more important
  o **Protective Regulatory Policy** – protect the public – safety
  o **Constituent Policy** – benefit the public generally or serve the government (Foreign and defense policy, and government reform)
  o **Redistributive Policy** – Ideological – New Deal, Fair Deal, Great Society – ACA today?
How does the health policy process work to advance rural health concerns and needs?

or

How does rural health work within the process or use that process?

So Really, How Does Rural Health Policy Work or Happen?

• Advocacy
  o Interest groups determine their agenda – internal process
  o Interest groups sometimes form alliances with others – share agendas, “back-scratching” – to build greater numbers
  o **Message framing or Policy Framing** – what messages work on policy makers, what do they like to hear, what format or communication strategy works best
  o Redundancy and repetition of messages are “positive” in policy – say the same thing over and over, try to have others (alliance partners) say your message
What is **Policy Framing** (setting the agenda process)

- **Beginnings**
  - FrameWorks Institute – national organization started in 1999
  - W.K Kellogg Foundation’s “Rural People Rural Policy” Program – building regionally-based rural networks (housing, economic development, health, faith based, minority, new Americans, poverty, and others)

- FrameWorks’ research showed the following:
  - A form of communications “pictures in our heads” – we take mental shortcuts in our understanding – quick, we know what this means
  - Organizing Principles – socially shared – work symbolically
  - Understand from a **frame-base**, not necessarily a **fact base**
  - Providing cues that link new information with our pre-existing pictures in our heads
  - Changing opinion you must shift the frame – DAPL – protector not protester

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**Levels of Understanding**

- **Level One Frames**
  - Big Ideas

- **Level Two Frames**
  - Issues – Categories of ideas
    - Health, Environment, Poverty, Education, Income distribution, Children (child care), Aging,

- **Level Three Frames**
  - Specific Issues (smaller subcategories, policy formulation, programs)
    - Health (policy to address access to health coverage, access to health providers, quality of care, reimbursement, organizational arrangements)
    - Environment (manmade damage, economic impact)
Currently Used Rural Frames and their Impact
– Distorted Frames

Stereotype 1 – Rural Utopia

Stereotype 2 – Rural Dystopia

Stereotype 3 – Rural Needs Protection

Stereotype 4 – Change is THE Rural Problem
Center for Rural Health
More Effective Frames and their Potential for Impact

• Fairness Frame (equity argument)
• Interdependence Frame (interconnection)
• Patchwork Simplifying Model (unfair distribution)
• Causal Sequences – hospital closure and impact
Underlying imagery of Rural Policy Based on…

• Connecting rural to the rest of the country – what is good for rural is good for America – we are part of it, not isolated
• Emphasizing fairness and interdependence, and patchwork does not work
• Positioning “change” on the side of positive rural values and policy – rural people are engaged in working for positive change, part of the solution
• Demonstrating empowerment, community engagements, investment, and solution-focused
• Securing self-reliance yet partnerships (reinvestment) – we don’t seek welfare or special treatment – fair play and investment in rural is an investment in all of America – we have a “shared fate”
• I use “skin in the game” argument frequently – partnership between rural communities and public sector – entrepreneurship
• Promoting empathy and identification with rural by underscoring sameness not differences -

Different Stories – Different Policies

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<thead>
<tr>
<th>Episodic Frames</th>
<th>Thematic Frames</th>
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<td>Appeal to consumers</td>
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<td>Better information</td>
<td>Better policies</td>
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<td>Fix the person</td>
<td>Fix the condition</td>
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Center for Rural Health
Some Specific Examples from the CRH using Policy Framing
NRHA Policy Institute North Dakota Hill Visits

- **Level 1 Frame (Big Ideas)** – Equal access to quality health care for all North Dakotans regardless of location (rural or frontier); income (higher levels of poverty; lower median income, and higher unemployment in rural /frontier); and ethnicity (four NA reservations)
  - All programs supported by federal funds are policies to address equal access – to improve health status
  - Fairness and interdependence are core frames
    - Fairness – equal access for all Americans not just the fortunate ones in Suburbs with access to hospitals, specialty clinics, physicians and specialists – improved health status policy goal in HP 2010 and 2012 and rural is a distinct health disparity identified
    - Interdependence – community awareness and engagement for support; intra-community teams (health, education, business, faith, and government); inter-community teams (regionalization); health integration (horizontal and vertical networks)

- **Level 2 Frame (Issues, categories)** – CRH seeks capacity building, infrastructure building – safety net
  - Fairness and interdependence frame in that rural should have the same reasonable chance to succeed and to do so they need resources, we need to work with them on building capacity and skill sets (it is not the individual it is the rural community, and it takes policy change)

- **Level 3 Frame (Specific Issues, most narrow, policy formulation/program)** – Individual rural health programs work to build capacity, develop skills, engage the community, form coalitions and partnerships
  - State Office of Rural Health (SORH) Rural Hospital Flexibility program (Flex), Area Health Education Centers, Rural Health Outreach and Network Development grants – policy and programmatic tools to “fix the condition”
Questions to Ask Yourself when Thinking of Policy Framing

• **How does the public currently think of the issue?** – Think of income inequality or gun laws

• **How is the issue currently being framed?** – individual vs. societal, fix the individual vs. fix the condition

• **Who is doing the framing and why?** (Motivation is an underlying driver, remember public policy is derived from values) – conservative/liberal dichotomy, individual responsibility/collective responsibility, individual solution/public policy solution

• **How could the issue be re-framed, if you see the need?**

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So Really, How Does Rural Health Policy Work, or Happen?

**Advocacy**

• Research shows for rural message framing concepts like “fairness” and “interdependence” work best and patchwork can be effective as something we need to guard against in policy

  o People who live in rural ND should have the same expectation for quality care as urban, have reasonable access to care – **fairness**

  o Rural providers use networks and collaborate – avoid duplication, efficiency, effectiveness – **interdependence**

  o Rural organizations tend to work together well for the good of the community, health care as part of the social and economic fabric of a community – **interdependence**

  o Payment for the same condition varies if rural or urban - **patchwork**

  o Under ACA movement to outcome based or pay for performance frame as “merit pay” to providers
Five Key Points on Policy Advocacy

- Policy is a continuous process
  - Congressional sessions begin and end, but the process of forming policy, influencing policy, changing policy, advocating for policy is ongoing
  - ACA is not the final Act in health reform – each Congress and President will make changes (every year multiple bills just on Medicare which goes back to 1965)
- Important to have partners, allies, coalitions, alliances– forge relationships, cultivate relationships – some short term, some long lasting
  - Organizations similar and even dissimilar to your organization
  - Relationships with policy makers and staff
- Extremely important to be a resource to policy staff
- Recognize there is a relationship between policy formulation and implementation with research and evaluation – rural paid price in early ‘80’s because no formal advocacy or policy structure
- Important to have a legislative champion/advocate

Importance of Having Partners

- Strength in numbers – more voices with same message
- Redundancy in policy can be actually good – more voices, same message
- An association if it is the primary advocate needs it members involved (elected officials like “real people”) but also other associations and their members
- Identify the commonality of issues and forge alliance around that subject – may be secondary for other association but can add to their message
  - Hospital Association and SORH – rural health outreach grant funding
- Need to be willing to make compromises – more and more important
- Willingness to support partner on their issues makes it easier for them to support you on your issues – their primary is your secondary issue, and your primary is their secondary issue, “you got to give to get in politics”
What are some examples of successful rural health policy?

But First a History Lesson!

- 1973 - 1st State Office of Rural Health in North Carolina
- 1980 - Center for Rural Health created in North Dakota – 5th overall
- 1983 – NRHA formed from merging two smaller rural and/or primary care oriented associations
- 1983 – Congress implements Prospective Payment System (PPS) Medicare Reimbursement
- 1985 – NRHA with leadership from Kevin Fickenscher, President of NRHA and Director of CRH works with Senator Mark Andrews and Senator Quentin Burdick of ND to create Senate Rural Health Caucus
- 1987 – House Rural Health Care Coalition created
- 1987 – Congress creates federal Office of Rural Health Policy
- 1988 -- ORHP creates Rural Health Research Center program
- 1991- ORHP creates SORH program and Rural Health Outreach Grant
- 1993 – NOSORH created
- 1997 – Congress passes CAH designation and Rural Hospital Flexibility
Overall Focus of Rural Health Policy

- For many years: Increasing or maintaining access to essential quality rural health services
  - Rural health clinic –federally certified
  - National Health Service Corps – loan repayment and scholarships
  - Critical Access Hospital designation and Medicare Rural Hospital Flexibility Prog.
  - Sole Community Hospital designation
  - Medicare Dependent Hospital designation
  - HIT grant development
  - Medicare Beneficiary Quality Improvement Program (MBQIP)
  - Creation of the federal Office of Rural Health Policy
  - Rural Health Grants – Outreach, Network Development, Network Planning
  - Demonstration Grants – EACH/PCH, F-CHIP, FESC
  - USDA Rural Development Community Facility Loan, Loan Guarantee, and Grant
  - HUD 242
  - 340 – B (low cost medications for CAHs, FQHC, and others – not RHC
  - Area Health Education Center (AHEC)
  - Title VII grant programs (e.g., Residency Training in Primary Care)
  - Title VIII grant programs (e.g., nursing education programs)

Rural Health Policy in Action

- Rural Hospital Flexibility Program – “Flex program”
  - Alliance of NRHA, NOSORH, AHA, SORHs, and State RHA
  - Each state worked with their congressional offices
  - 1st year grant for $200,000 went to SORHs in eligible states (distributive policy example)
  - Flex funded at $26 million a year
    - Grants to 45 eligible states
    - Flex Monitoring Team (RHRC research related to Flex and rural hospitals – evaluation leads to better data for congressional advocacy)
  - Flex is administered, like SORH, through ORHP
  - NRHA, NOSORH, and AHA push every year continued appropriation for Flex
  - CRH keeps in front of Congressional Offices
Rural Health Policy in Action

• Rural Health and the Affordable Care Act
  o Basically, every health interest group had a stake
  o NRHA position papers and fact sheets
  o Formed core set of expectations
    ➢ Health workforce
    ➢ Provider reimbursement
    ➢ Protect (and even expand) rural safety net – CAH, RHC, CHC
    ➢ Access for rural people – financial concerns, but also availability of providers and financial viability rural health providers
  o NRHA worked with AHA and NOSORH
  o State level work with congressional offices on needs and impact
  o CRH emphasized health workforce, safety net, availability of providers, and financial viability of rural health providers and systems

Rural Health Policy in Action

• What is the Status of Health Reform
  o Up and down year, 3 attempts at repeal and replace
  o President executive order – association health plans and CSR
  o Senator Alexander and Murray – ACA Fix Bill
  o Open enrollment is shorter and Navigator support cut by 90%
  o Chip away effort will continue
  o Possible try to link eliminating individual mandate into the Tax bill
  o Public attitude has become supportive of ACA and repeal efforts had less than 20% public support
  o Keep watching the Senate
Customized Assistance

Tailored Searches of Funding Sources for Your Project

Foundation Directory Search

FREE Service!

info@ruralhealthinfo.org
1-800-270-1898

Contact us for more information!

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