The Role of Policy in Rural Health

Common and Chronic Health Care Management 589
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GoTo Webinar

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Center for Rural Health

• 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

- How values relate to policy?
- Why rural health policy is important and the relationship of policy to community health?
- What is the health policy process – formal and informal?
- What are the primary federal rural health policy areas?
- What is policy framing and why is this important?
- How is the health reform debate being framed?

Ultimately Public Policy is Influenced by Our Values

- Values guide behavior – how we see things
- Behaviors shape values – what we see – Civil rights protests
- Ideology - a system of beliefs and core values
- “I Centered” or Extrinsic values and “We Centered” or Intrinsic values
- Framing – the images in our head about issues – short cuts
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 (equity)
  - 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

Why Rural Health Policy is Important and the Relationship Between Policy and Community
Preliminary CHNA Issues (2014-2016)

- 41 CHNA analyzed out of 45
- 182 ranked needs (range 2 to 9 ranked needs per CHNA, most 4-5)

Issues

- Behavioral Health 23 out of 41
- Mental Health 20
- Health Workforce (physician/provider R&R, specialists) 17
- Obesity and Overweight 13
- Elderly Services (availability of 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
- Illness and disease (heart disease, cancer, diabetes) 6
- Housing 4
- Poverty 2
Community Health is Influenced by Public Policy

• Significant change in our thinking about health, our individual and collective view of health, and public policy is a strong catalyst
• Population health and determinants of health – public health
• New payment models associated with quality and outcome – “volume to value”
• Access to care and availability to care – viability of rural health facilities and availability of providers
• Impact on the rural community – improved health status? Viability and sustainability (some signs in ND)
• Importance of advocacy and framing issues to influence the public policy process

What is the health policy process – formal and informal?
American Government Short Course

- US government was designed to be a series of counter-balances – no single source of power, deliberately diffused, built in redundancy – slow by design
- Balance of power – executive, legislative, judiciary “equal branches of government”
- Legislative branch – no centralized source of power (no single Senate or House Health Committee)
- Politics of power – Committees and subcommittees of jurisdiction has dispersed power – shared power - voters

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Health Policy – The Formal Side

- Executive – Legislative Process (Congress and the Federal Agencies)
  - White House Rural Council to Strengthen Rural Communities
  - 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)
  - Senate Rural Health Caucus – history in North Dakota - 1985
  - House Rural Health Care Coalition - 1987
  - (16 Committees) Senate Finance, Senate HELP, Senate Energy and Natural Resources, House Ways and Means, House Energy and Commerce (Cramer), House Education and Labor, S&H Appropriations (Senator Hoeven), S&H Budget Committees (former Senator Conrad), S&H Indian Affairs (Hoeven and Heitkamp), S&H Judiciary, S&H Homeland Security and Governmental Affairs,
Health Policy – The Formal Side

- 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 Health Workforce – Scholarship and Loan programs, NHSC, and AHEC programs; Maternal and Child Health Program – MCH block grants to states.
    - Centers for Medicare and Medicaid Services (CMS) – CMS Innovation Grants for health reform; reimbursement; rule making
    - CDC – Community Transformation Grant – population health
    - ACL – programs for elders and disabled, education to elders on Medicare
  - USDA – Rural Development’s Community Facility program (Heitkamp –Ag Com)
  - HUD – HUD 242 program for capital loans to rural hospitals
  - Veterans Administration – access, CBOC (comm. based outreach clinic), mental health
  - Justice – fraud, Justice and Mental Health Collaboration Program, Law enforcement and mental health crisis training
  - Transportation – Tribal Transit TA Program, Highly Rural Transportation Grants (veterans)
Health Policy – The Informal Side

• Setting the Agenda (prior to formal policy formulation and during development)
  - Advocacy
    - Interest groups play significant role
      - Content experts – know the details – provide information (fact sheets, reports, meetings with staff, calls from staff, testimony), 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”)  
  - Control the information flow – resource to staff
  - Information – formal testimony, research, fact sheets but also behind the scene
  - Be honest and reliable (VERY IMPORTANT is YOUR CREDIBILITY) – your utility to staff is your reliability and your information
  - If you don’t know say you don’t know but will find out

• Re-setting the agenda (ABC of politics)
  - Continuous involvement with interest groups to prepare for next round
  - 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
  - Common questions – “What does this mean in North Dakota” “Is there an impact for us”
• **Types of Domestic Policy** (relies on Theodore Lowi, Randall Ripley and Grace Franklin)

  - **Distributive Policy** – disburse over wide range of beneficiaries – “seemingly unlimited number of recipients” – Iron Triangle
  - **Competitive Regulatory Policy** – influence a market for the public good – regulatory agencies much more important
  - **Protective Regulatory Policy** – protect the public – safety
  - **Constituent Policy** – benefit the public generally or serve the government (Foreign and defense policy, and government reform)
  - **Redistributive Policy** – Ideological – New Deal, Fair Deal, Great Society – ACA today?
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

Five Key Points on Policy Advocacy

• Policy is a continuous process
  o Congressional sessions begin and end, but the process of forming policy, influencing policy, changing policy, advocating for policy is ongoing
  o 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
  o Organizations similar and even dissimilar to your organization
  o 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 ‘80s 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
  o 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”

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What are the Primary Federal Rural Health Policy Areas?
Key Issues for Rural Health Policy

- CAVEAT: The diffused nature of government- multiple power sources
  - Access to care and services
    - Viability and survivability of health organizations
  - Availability of providers
  - Population health – CHNA, ACO, PCMH, Bundled payments
  - Technology
  - Mental and behavioral health
  - Veterans
  - EMS
  - Aging

What is Policy Framing and why is this Important
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, Medicaid Expansion, population health)
    - 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
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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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<tr>
<th>Episodic Frames</th>
<th>Thematic Frames</th>
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<tbody>
<tr>
<td>Individuals</td>
<td>Issues</td>
</tr>
<tr>
<td>Events</td>
<td>Trends</td>
</tr>
<tr>
<td>Psychological</td>
<td>Political/environmental context</td>
</tr>
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<td>Private</td>
<td>Public</td>
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<td>Appeal to consumers</td>
<td>Appeal to citizens</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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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 – access to care and availability
  - 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?

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
Health Reform Debate – How is it being Framed

Framing

• Equity and Interdependence vs. Personal Freedom
  o **Level One Frame** (big picture themes) – freedom and responsibility vs. equity, interdependence, and social justice – conflict or compatibility?
  o **Level Two Frame** (Categories of Ideas) – Health, Poverty, Income, Access
    ➢ Poverty and Income are social determinants of health that contribute to population health – how does this correspond or conflict with freedom vs. equity?
    ➢ Improved access to care and viability and sustainability in rural – corresponds or conflicts with personal freedom of urban tax payers?
  o **Level Three Frame** (specific policy issues and programs) – Medicaid expansion, population health, new payment models to support population health – personal freedom vs some level of equity and social justice
Contact us for more information!

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