

Center *for* Rural Health



## Rural Health Policy: How does Rural Health Overlap with Policy and Policy Formulation?

**NURS 586 Rural Health Programs and Research**

**November 1, 2016**

**UND College of Nursing and Professional Disciplines**

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Center *for*  
Rural Health

The University of North Dakota  
School of Medicine & Health Sciences

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

[ruralhealth.und.edu](http://ruralhealth.und.edu)

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### Todays Objectives:

1. To better understand the relationship between the rural setting and health policy.
2. To gain insight into current rural health policy issues.
3. To understand how health policy is developed.



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### Rural Health (REVIEW)

- Rural Health focuses on **population health**
- Rural Health focuses on **infrastructure** that impacts access to care
- Rural Health **is not** urban health in a rural or frontier setting
- Rural Health can be framed as a **health equity or fairness issue**
- Rural Health can be framed as **interdependent/collaborative** or community engagement
- Rural Health is inclusive of **community sectors**
  - Business/economic
  - Education
  - Local/area government – public sector
  - Faith-Based
  - Health and Human Services
- Rural Health exists in a larger **environment** which has an affect on rural health or the rural community, but the **community can take action** (engagement) that in turn **impacts the environment**.

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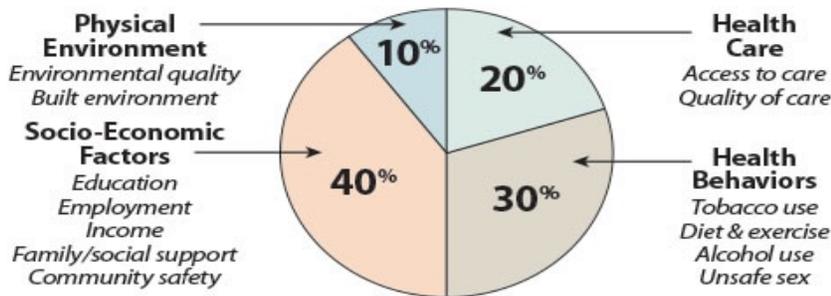
**Significant Areas of Interest Addressed in Rural Health Policy**

- **Reimbursement/Payment/MONEY**
- **Health Workforce**
- **Health Care Quality and Performance** (also HIT) – relationship to health reform
- **Population Health** – significance within health reform
- **The Silos (Infrastructure)** – Hospitals (private for-profit, non-profit, specialty, rural including CAH, SCH, MDH); physicians (primary care, specialty, independent solo, small group, larger system) ; nurses; clinics (including for-profit and non-profit, RHC, FQHC, specialty); pharmaceuticals; oral health; mental health; behavioral health; EMS (including private for-profit and non-profit, EMTs and numerous types including community paramedic); nurse practitioners; physician assistants; allied health; long term care (nursing homes or other settings like independent living, basic care, assisted living); aging (including aging services, nutrition, “money follows the person or helping elders stay in non-institutionalized settings); human services; Medicaid; Medicare; CHIP; veterans; Native Americans (IHS); health reform (insurance and health system reform); and MORE (We will discuss interest groups later).

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**Social Determinants of Health**

**Population Health**



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's *County Health Rankings* model ©2010, <http://www.countyhealthrankings.org/about-project/background>

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## 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 (CHI-St. Alexius Primecare Select ACO – 10 ND CAHs; National Rural Accountable Care Consortium – 5 ND CAHs) - 42% of ND CAHs are associated with an ACO



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### Preliminary CHNA Issues (2014-2016)

- 34 CHNA analyzed out of 45
- 151 needs (range 2 to 9 ranked needs, most 4-5)
- Issues
 

○ Behavioral Health	29 out of 34
○ Ability to Attract and Recruit a Provider	20
○ Mental Health	18
○ Cost (insurance and health care)	15
○ Obesity/overweight	11
○ Child Care	10
○ Availability of Resources to Help Elderly (stay in home)	10
○ Jobs with Living Wages	8
○ Wellness (life style, fitness, exercise)	8
○ Ability to Recruit and Retain Young Families	7
○ Housing	4
○ Bullying/Cyber-bullying	2
○ Poverty	2



## 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?



### Health Policy – The Formal Side

- **Executive – Legislative Process (Congress and the Federal Agencies)**
  - White House Rural Council to Strengthen Rural Communities
  - Senate Rural Health Caucus – history in North Dakota - 1985
  - House Rural Health Care Coalition - 1987
  - Senate Finance, Senate HELP, Senate Energy and Natural Resources, Senate and House Indian Affairs, Senate and House Judiciary, House Ways and Means, House Energy and Commerce (Cramer), Senate and House Appropriations (Senator Hoeven), Senate and House Budget Committees (role of 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 Health Professions – healthcare workforce issues, Bureau of Clinician Recruitment and Services – National Health Service Corps
      - ✓ Centers for Medicare and Medicaid Services (CMS) – Medicare reimbursement and rules, CMS Innovation Grants for health reform
      - ✓ CDC – Community Transformation Grants
    - USDA – Rural Development program has Community Facility loan/loan guarantee/grant program for capital improvement (Sen. Heitkamp on Ag. Comm.)
    - USDHUD – HUD 242 program for capital loans to rural hospitals
    - Veterans Administration – access to care, VA hospitals, VA CBOC (community based outpatient clinics, mental health)



### 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)
      - ✓ 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 - NDRHA
      - ✓ American Medical Association
      - ✓ National Nursing Association
      - ✓ American Public Health Association



### Health Policy – The Informal Side

- **Managing and influencing 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**
  - 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”



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

- **Advocacy**
  - Interest groups determine their agenda – internal process
  - Interest groups sometimes form alliances with others – share agendas, “back-scratching” – to build greater numbers
  - Message framing – what messages work on policy makers, what do they like to hear, what format or communication strategy works best
    - Research shows for rural message framing concepts like “fairness” and “interdependence” work
      - ✓ People who live in rural ND should have the same expectation for quality care as urban, have reasonable access to care - fairness
      - ✓ Rural providers use networks and collaborate – avoid duplication, efficiency, effectiveness – interdependence
      - ✓ Rural organizations tend to work together, health care as part of the social and economic fabric of a community - interdependence
      - ✓ Under ACA movement to outcome based or pay for performance frame as “merit pay” to providers
  - 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



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

- **Role of Research**
  - 7 Rural Health Research Centers and 3 Policy Analysis Initiatives (UNDCRH has with partner NORC the Rural Health Reform Policy Research Center)
    - <http://ruralhealth.und.edu/projects/health-reform-policy-research-center>
    - RHRPRC focus on:
      - ✓ Hospice and end of life – request from ORHP
      - ✓ Hospice family member survey
      - ✓ Hospice workforce
      - ✓ Hospice CEO study
      - ✓ Rural Health Chartbook
      - ✓ Care coordination on frontier Medicare beneficiaries’ quality and cost of care
      - ✓ Emergency Department variation improving quality/reducing costs
      - ✓ Rural definitions
  - Rural Health Research Gateway <http://www.ruralhealthresearch.org/>
    - “One stop shop (located at CRH) for :Research projects, publications (peer reviewed, policy briefs, fact sheets, annotated literature reviews, maps, and other products

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

- **Role of Research**
  - NRHA Policy Congress
    - About 50 people elected from Constituency Groups –about 1/3 academic
    - CG develop issue papers – primary and secondary data sources
    - PC reviews and votes, those adopted become official NRHA documents, and are used by Government Affairs staff in policy documents
  - National Advisory Committee on Rural Health and Human Services
    - <http://www.hrsa.gov/advisorycommittees/rural/>
    - 21 members – nationally recognized rural health experts
    - Provide recommendations on rural issues to Secretary of DHHS
    - Focus on 1-4 issues per year - Review background documents, site-visits
    - Issues report of recommendations
    - Hospice interest started here - *Rural Implications of Changes to the Medicare Hospice Benefit* (NACRHHS Policy Brief)
      - ✓ Member of Committee had hospice background, and pushed the issue
      - ✓ ORHP after funding RHRPRC “requested” us to study this issue
      - ✓ RHRPRC works with NHPCO Rural Hospice Task Force
      - ✓ About 5 studies in process

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

- **Role of Research**
  - Example from ORHP Rural Health Research Program
    - Office of Inspector General (for DHHS) report on CAHs – very negative and not well founded
    - ORHP relied on research from the field (National Rural Hospital Flexibility Monitoring Project and other research programs)
    - ORHP issued response that took exception to many points in the OIG report
    - Thus, research was relied on to argue points that had policy implications
    - Information shared with NRHA, Senate Rural Health Caucus, and House Rural Health Care Coalition
  - National Conference of State Legislatures <http://www.ncsl.org/>
  - National Governor’s Association <http://www.nga.org/cms/home.html>
  - National Academy for State Health Policy <http://www.nashp.org/>

### 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 actually be good – more voices, same message**
- **An association if it is the primary advocate needs its members involved (elected officials like “real people”) but also other associations and their members) – CAH administrators on hill visits**
- **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?



### 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
  - 1<sup>st</sup> year grant for \$200,000 went to SORHs in eligible states
  - 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**
  - Basically, every health interest group had a stake
  - NRHA position papers and fact sheets
  - 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
  - NRHA worked with AHA and NOSORH
  - State level work with congressional offices on needs and impact
  - CRH emphasized health workforce, safety net, availability of providers, and financial viability of rural health providers and systems



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