A Rural Health Perspective on National Health Reform: Access is More than Coverage
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Connecting resources and knowledge to strengthen the health of people in rural communities.

Center for Rural Health

- Established in 1980, at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, ND
- One of the country’s most experienced state rural health offices
- Focus on:
  - Education, Training, & Resource Awareness
  - Community Development & Technical Assistance
  - Native American Health
  - Rural Health Workforce
  - Rural Health Research
  - Rural Health Policy
  - Program Evaluation
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Web site: http://medicine.nodak.edu/crh
Why the Need for Health Reform

• U.S. health system – equity issues
• Spend the most but do not have the best health outcomes
• Growing recognition that we can no longer afford what we have, how we distribute services and benefits, how we pay for care, and how we access care
• Rural communities have unique issues
  o Access along with coverage
  o Population that is poorer, older, and sicker
  o Health care in a rural community is a community and economic resource – how we see ourselves

Why the Need for Health Reform (continued)

• Approximately 46-47 million Americans without health insurance or about 16% of population
• 12-14,000 Americans lose health insurance every day
• 2,500 file for bankruptcy everyday due to health and medical costs
• Health care spending was $2.4 trillion in 2008 and expected to grow to $4.3 trillion by 2018
• Health accounts for 17.6% of GDP (20% by 2018)
  o France spends 9.5%
  o Canada spends 9.7%
• In 2008, about $7,900 per person was spent on health care in the U.S.
• U.S. spends about twice as much per capita on health care as other countries
• Health care spending is over 4 times that spent on national defense
Why the Need for Health Reform (continued)

- **Insurance coverage**
  - 60% of Americans have insurance from their employer (down from 66% in 2000)
  - 28% have insurance that is government based (Medicare, Medicaid and military)
  - 9% have insurance they purchase themselves
  - 15% are uninsured
- Average premium paid by a business for a family of 4 health plan -$12,700 (2008)
- Since 1999, employment based health insurance premiums increased by 120% while inflation rose by 44% and wage growth by 29%
- Premium growth for employer plans has been highest for small firms with less than 24 people
- Average employee contribution has increased more than 120% since 2000
- About 1.5 million families lose their homes every year due to unaffordable medical costs

Why the Need for Health Reform (continued)

- **Health Status**
  - U.S. ranks 28th in life expectancy (2008) in comparison to other countries*
  - 21st in age standardized mortality rate for cardiovascular disease (2008)*
  - 14th in age standardized mortality rate for cancer (2008)*
  - The Commonwealth Fund rates the U.S. last in health care system performance when compared to a group of six countries that include Australia, Canada, Germany, New Zealand and the United Kingdom. The U.S. spends twice as much as these six countries on a per-capita basis, yet it is last on dimensions of access, patient safety, efficiency and equity.*
  - Fewer physicians per capita (2.4:1000 U.S. vs. 3.1:1000 other industrialized countries)
  - 54% of U.S. patients do not seek recommended care, fill prescriptions, or visit a doctor because of health costs (7-36% in other countries)

* United Health Foundation – America's Health Rankings 2008
Rural Health Advocacy

- National Rural Health Association (NRHA)
  - Coverage does not equal access
    - Rural population is older, poorer, and sicker
    - Major rural issues include basic access issues such as workforce and keeping rural hospitals and clinics open
    - We can improve coverage but risk losing access points such as hospitals, clinics, ambulances, and providers
  - Rural focus
    - Workforce – National Health Service Corps, Health professions education improvements, expand rural residency programs, expand Medical School rural training tracks, incentives for rural medicine
    - Medicare equity for rural facilities – improvements for Critical Access Hospitals and Prospective Payment System hospitals
    - Improve access for vulnerable populations – Mental health workforce, rural veterans (tele-health, contracts with local rural health providers, mental health), outreach to uninsured rural children, rural impact study for significant Medicare changes

Other Rural Health Considerations

- Rural health viability important for improvement of health status
- Rural health viability important to economic and community development
- Need for greater flexibility in health facility structures (new models of care)
- Need for greater flexibility to achieve better health outcomes and organizational performance (Medical Home Model)
- Need for rural communities and citizens to be advocates for collaboration, networks, and regional decision making
Health Reform Legislation and Rural Health

• Access Issues: Chronic Disease, prevention, and wellness
  o HELP – Community Health Teams (medical home model) of interprofessional
    provider teams focusing on patient centered and coordinated care with holistic
    and evidenced-based medicine and health
  o HELP - Right Choice Program – uninsured adults access to preventive
    services, chronic disease assessment
  o Tri-Committee – creates community based programs for prevention and
    wellness

• Access Issues: Health Facility
  o Finance Committee – addresses low volume hospital reimbursement,
    adjustment for PPS outpatient services, capital infrastructure revolving loan
    fund, extension of Medicare incentives payments in physician shortage
    areas, temporary payment increase for home health, pilot payment program
    for remote home monitoring
  o Tri-Committee – use of credits on sliding scale for Medicaid to 400% of FPL

Health Reform Legislation and Rural Health

• Access Issues: Health Workforce
  o HELP – State health workforce grants, improved federal support for student
    loans, health workforce loan repayment program, nursing and allied health
    loan program, mid career programs, improved National Health Service Corps,
    health professions training for diversity, interdisciplinary/interprofessional
    training, education and technical assistance on evidenced-based
    therapies/preventive care/health promotion
  o Tri-Committee - expands NHSC, increase in training for primary care,
    nursing, and public health, supports workforce diversity, expands scholarship
    and loans
Rural Health Efforts at Work Today

- Medical Home
  - Coordinate care for the patient (patient navigator or Medical Home coordinator)
  - Team approach to health and medical care (inter-professional team)
  - Manage multiple health conditions
  - Focus on prevention and wellness
  - "evidenced-based medicine"
  - Improve quality of care and patient outcomes
  - Reduce health care costs

Rural Health Efforts at Work

- Lakewood Health System – Staples, MN
  - Medical Home Model
  - Rural hospital
  - About 250 patients involved
  - Patients with 3 or more diagnosis or 4 or more medications or physician identified “good candidate”
  - Continue to work with their doctor and a RN Medical Home coordinator
  - Reminders, education, referral monitoring and coordination, work with specialists
  - About $200,000 start up and annual cost about $100,000
Rural Health Efforts at Work

• Community Care of North Carolina
  o Medical Home Model
  o State-wide Medicaid program
  o Primary care case management
  o 800,000 rural and urban Medicaid recipients
  o Local network of physicians and case managers – diabetes, asthma, and heart failure
  o Physicians and regional networks receive enhanced per member per month payments as incentives

Rural Health Efforts at Work

• Health Occupations Today and Tomorrow (HOTT)
  o Introduce K-12 students to careers in health care
  o Some states use small grants ($2-4,000) to rural hospitals to start up
  o One day to full week opportunity – job shadowing, mentoring, science and math projects, exercise and nutrition, learning what it is like to be a physician or nurse, seeing equipment used
  o Hands-on age appropriate learning process
  o ND requires network of hospital, school, and economic development
Rural Health Efforts at Work

- Mental and Behavioral Health
  - Rural Mental Health Consortium
    - Four Critical Access Hospitals in ND (Harvey, Kenmare, Bottineau, and Rolla)
    - Serves two frontier and two rural counties
    - Started with federal Rural Health Outreach Grant in 1995
    - 2-3 Master's level clinical nurse specialists
    - Psychologist in Minot, ND
    - 3rd Party Reimbursement and private pay
    - Hospitals add funds when necessary
  - Center for Solutions
    - Behavioral health and chemical dependency
    - Master's level clinical providers, MSW, and Counseling
    - 24 beds independent facility in Cando, ND
    - Tele-mental health to Minot
    - 3rd Party Reimbursement and private pay

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