The 2011 Report to the Secretary: Rural Health and Human Services Issues

NACRHHS

The National Advisory Committee on
Rural Health and Human Services

March 2011

Acknowledgements

The 2011 Report to the Secretary is the culmination of a year of collective effort by the National Advisory Committee on Rural Health and Human Services (NACRHHS). This effort was led by former Chairman David Beasley, who stepped down in June of 2010. I would like to thank each of the Committee members for their hard work and acknowledge the subcommittee chairs of each of the three chapters: Graham Adams, Rural Implications of Accountable Care Organizations and Payment Bundling; David Hartley, Rural Childhood Obesity; and April Bender, Place-Based Initiatives for Rural Early Childhood Development. Laura Merritt, Kai Smith, CJ Koozer, and Tish Scolnik, Truman Fellows with the Office of Rural Health Policy (ORHP) at the Health Resources and Services Administration (HRSA), provided research support and assistance in drafting key sections of the final report. Beth Blevins edited the report.

The Committee also benefited from the hospitality and rich information provided by various individuals connected with the Committee's two field meetings in 2010. The opportunity for the Committee to learn about rural health and human services delivery in the field from those who are actually providing the services was critical in creating this report and the recommendations that are included. More information on these meetings and site visits is provided in the appendices. The number of people who helped to make the field meetings possible is far too many to list here, but I want to acknowledge the help of a few individuals.

In June, the Committee visited the South Carolina Lowcountry where they heard testimony from health and human services providers in the surrounding communities. NAC Member Graham Adams assisted in planning the meeting and Dr. Amy Martin provided further support. The South Carolina meeting featured important presentations by a number of individuals including Jan Probst of the South Carolina Rural Health Research Center, Michael Byrd of the South Carolina Department of Health and Environmental Control, Francis Rushton of the American Academy of Pediatrics, Mary Lynne Diggs of the South Carolina Head Start Collaboration Office, Ed Sellers from BlueCross BlueShield of South Carolina, and Robby Kerr, formerly of the South Carolina Department of Health and Human Services. Committee member Sharon Hansen also presented.

In September, the Committee visited Eastern Iowa. Todd Linden, NAC Member and CEO of Grinnell Regional Medical Center played a key role in coordinating the meeting. Further meeting support was provided by NAC Members Donna Harvey and Maggie Tinsman. In addition, the Committee benefited from site visits hosted by Gloria Vermie of the Iowa State Office of Rural Health. The Committee benefited from presentations at the September meeting from Julie McMahon of the Iowa Department of Public Health; Deborah Waldron of Child Health Specialty Clinics; Linda Snetselaar of the University of Iowa College of Public Health; Bill Menner, Iowa's state director of USDA Rural Development; Keith Mueller of the Rural Policy Research Institute and University of Iowa College of Public Health; David Swieskowski of Mercy Clinics; former Iowa State Senator Charles Bruner, of the Child and Family Policy Center; and Shanell Wagler of Early Childhood Iowa.

The report benefited from the assistance of Federal staff from ORHP, including Tom Morris, Heather Dimeris, Carrie Cochran, and Jennifer Chang as well as Dennis Dudley from the Administration on Aging.

The Committee is grateful to many others, too numerous to mention, for their support of the Committee's mission to inform and make recommendations to the Secretary and others on the state of health and human services in rural America.

Sincerely,
The Honorable Ronnie Musgrove, Chair

About the Committee

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a citizens' panel of nationally recognized rural health and human services experts. The Committee, chaired by former Mississippi Governor Ronnie Musgrove, was chartered in 1987 to advise the Secretary of the U.S. Department of Health and Human Services (HHS) on ways to address health problems in rural America. In 2002, the Committee's mandate was expanded to include rural human services issues and a 21-member limit was set.

The Committee's private and public-sector members reflect wide-ranging, first-hand experience with rural issues, including medicine, nursing, administration, finance, law, research, business, public health, aging, welfare, and human services. Members include rural health professionals as well as representatives of State government, provider associations, and other rural interest groups.

Each year, the Committee highlights key health and human services issues affecting rural communities. Background documents are prepared for the Committee by both staff and contractors to help inform members on the issues. The Committee then produces a report with recommendations on those issues for the Secretary by the end of the year. The Committee also sends letters to the Secretary after each meeting. The letters serve as a vehicle for the Committee to raise other issues with the Secretary separate and apart from the report process.

The Committee meets three times a year. The first meeting is held during the winter in Washington, D.C. The Committee then meets twice in the field, in June and September. The Washington meeting serves as a starting point for setting the Committee's agenda for the coming year. The field meetings include rural site visits and presentations by the host community, with some time devoted to ongoing work on the yearly topics. The Committee is staffed by the Office of Rural Health Policy, located within the Health Resources and Services Administration at HHS. Additional staff support is provided by the Administration on Aging at HHS.

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For Committee members' biographies, please visit the National Advisory Committee on Rural Health and Human Services' web site at http://ruralcommittee.hrsa.gov/.

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Executive Summary

This is the 2011 Annual Report by the National Advisory Committee on Rural Health and Human Services (NACRHHS). This year's report examines three key topics in health and human services and their effects in rural areas: rural childhood obesity, place-based initiatives for rural early childhood development, and the rural implications of Accountable Care Organizations and payment bundling. The Committee chose these important issues during its February 2010 meeting because of their significance for rural America. The chapters draw from published research and from information gathered during the site visits to rural South Carolina and rural Iowa.

Rural Childhood Obesity

Recent research has shown that children today could have a shorter life expectancy than their parents. This is due, in large part, to the climbing obesity rates in America, which are even more pronounced in rural areas. Studies have shown that 16.5 percent of rural children are obese compared to 14.4 percent of urban children. Rural areas lack appropriate nutritional food sources and children often do not feel safe enough to exercise outdoors.

The Committee believes that as HHS addresses the problem of childhood obesity, rural children should be given priority. A range of factors contributes to this problem, therefore the Committee believes an interagency working group needs to be formed to develop and administer the comprehensive approach necessary to reduce the rate of childhood obesity. The Committee's recommendations to the Secretary include evaluating current provisions in the Affordable Care Act and the American Recovery and Reinvestment Act that support efforts to reduce childhood obesity in rural areas, and prioritizing funding for rural communities most in need.

Place-Based Initiatives for Rural Early Childhood Development

Rural children face some unique barriers that require more coordination in our approach to early childhood development. Geographic isolation and low populations make delivering comprehensive care a challenging task in rural areas. Experts believe a place-based policy approach is a better way to deliver services; the Administration for Children and Families within the Department of Health and Human Services has announced its commitment to this approach.

The Committee believes that the quality of early childhood development services will be improved if the place-based approach is implemented efficiently. In this report, the Committee recommends specific ways to achieve a place-based model in a rural community. These recommendations include offering non-categorical, community-based grants as well as collaboration grants for community-level cooperation. The Committee also believes a data strategy is critical to improving the coordination of services and overall efficiency.

Rural Implications of Accountable Care Organizations and Payment Bundling

The Accountable Care Organizations (ACOs) and payment bundling provisions in the Affordable Care Act have the potential to bring much-needed change to health care, but the challenge lies in ensuring these new models are designed to work as well for rural providers as they do for urban providers. The growing costs and concerns over quality of care must be addressed, but it is important to remember the lessons learned from implementation of Medicare's Inpatient Prospective Payment System in 1983, a system whose design flaws had catastrophic effects for many rural hospitals.

The Committee believes that rural communities must be included in the demonstrations of these mechanisms in order to best inform future Medicare policy development. The Committee recommends specific ways that rural communities can be supported, including revising the Small Rural Hospital Improvement Program to target ACO formation and creating payment bundling demonstrations that focus on care available in rural areas.

Discussion

None of the issues examined in this report operates in isolation. There are common links and concerns that bind them together. There are obviously cross-cutting themes between the focus on healthy weight and childhood obesity, and the focus on early childhood intervention. In both topics, there is a recognition of the need to invest in the future from both a health and human services perspective. While many of the issues raised in both these chapters may be as relevant in urban and suburban areas as they are in rural areas, there are also a number of considerations and challenges that are unique to the more isolated and less populated areas of the country.

The Committee was particularly encouraged by HHS' support of a place-based policy approach in the area of early childhood development. Clearly, the concept of looking at an issue such as this from a broad-based community perspective holds great promise. Although the report examines this issue from the early childhood development perspective, the reality is that all of the issues addressed in this report would benefit from this broader and more comprehensive approach. In many ways, this is already happening in the area of childhood obesity—the First Lady's Let's Move! program and similar programs at HHS and USDA have played a key role in bringing a coordinated program focus to this important health challenge.

The chapter focusing on ACOs and Payment Bundling focuses initially on a very different population (i.e., the Medicare population), but the Committee also believes it is important for HHS to focus on this topic in a similarly broad-based manner. The passage of the Affordable Care Act holds great potential for improving health care in rural communities. The challenge for HHS will be making sure that as it uses the legislation's broad authorities to help improve care and reduce costs, it does so in a way that provides opportunities for addressing long-standing health challenges in rural communities. That means not only ensuring rural participation in these reforms, but also doing so in a manner that protects the viability of a vulnerable rural health care delivery system.

Rural Childhood Obesity

Chapter Recommendations

- The Secretary should create an interagency working group that will focus on rural childhood obesity and develop action steps to eliminate the higher rates of childhood obesity in rural communities.
- The Secretary should ask departmental agencies to create a report card to demonstrate the current HHS investment and related results in addressing childhood obesity in rural communities.
- The Secretary should ensure that at least 5 percent of funding from the Prevention and Public Health Fund goes directly to rural health specific grant competitions, specifically to rural counties that fall under the national poverty level.

Subcommittee Members

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Larry Otis
Robert Pugh

Rural Significance: Why the Committee Chose this Topic

Over the past few years, concerns over childhood obesity have drawn considerable national attention and researchers are finding it to be more acute in rural areas.

The Federal government has responded strongly to the increases in obesity. Both the Affordable Care Act (ACA) and the American Recovery and Reinvestment Act (ARRA) include provisions addressing childhood obesity. In addition, President Obama created the White House Task Force on Childhood Obesity, which issued a national action plan with the goal of reducing child obesity rates to 5 percent by 2030. Most significant for children, First Lady Michelle Obama launched her hallmark domestic policy initiative, Let's Move!, a campaign to solve the childhood obesity problem within a generation. With Congress and the White House focused on childhood obesity, the Committee agrees this is a national concern that should include rural America.

In 2007, the South Carolina Rural Health Research Center reported that rural children were more likely to be obese[I] than urban children (see Figure 1). A national sample showed that 16.5 percent of rural children were obese compared to 14.4 percent of urban children. The rural South had the highest levels of overweight[II] (34.5 percent) and obese (19.5 percent) children.[1] Pennsylvania, New Mexico, Michigan, West Virginia, and North Carolina have shown the most rapid increases in rural child obesity.[2]

The disparity between rural and urban obesity rates pales in contrast to the disparity between races. The same study found that one in four black children were obese (23.6 percent) compared to 19.0 percent for Hispanic children and 12.0 percent for white children. Overweight followed the pattern of obesity with 41.2 percent of black children being overweight compared to 38.0 percent of Hispanic children and 26.7 percent of white children.[3] Combining the previous statistics, rural minorities are highly at risk for becoming overweight or obese. Rural blacks had the highest level of overweight (44.1 percent) and obesity (26.3 percent) in comparison to other race and ethnic groups, in both rural and urban areas.

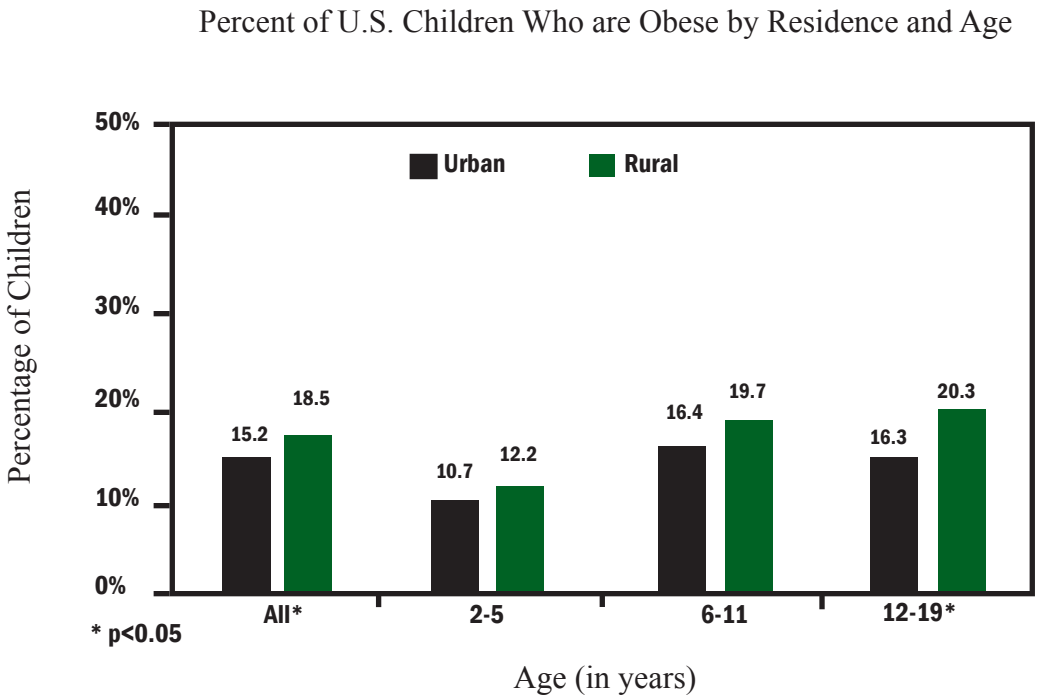

Figure 1: Graph from the South Carolina Research Center showing that a higher percentage of rural children are obese, 1999-2006

[I] The term obese will henceforth refer to those children with a body mass index (BMI) at or above the 95th percentile.
[II] The term overweight will henceforth refer to those children with a BMI at or above the 85th percentile and lower than the 95th percentile.

The Social Environment

Many factors have played a role in creating the obesity epidemic, but the influence of poverty cannot be ignored. Currently, more than 2.6 million rural children live in homes with incomes that are at or below the poverty threshold.[4] Similar to the misconception that obesity is more prevalent in urban areas, poverty has been found to affect rural areas at a higher rate than urban areas. In 2006, 21 percent of children in rural America were living in poverty in comparison with 18 percent of urban children. Over the past decade, the numbers of children living in homes experiencing severe or persistent poverty has grown considerably,[5] making many rural children dependent on Federal food assistance from programs like SNAP (Supplemental Nutrition Access Program).[6]

Factors that influence overweight and obesity are ultimately controlled by an individual, but available options and choices are strongly influenced by environmental factors. For children, environmental factors start with their families and educational institutions. Outside of school, children rely on their families for food and physical activity outlets. In most cases, parents will be most influential in terms of a child's food consumption and physical activity. Key informants from a study on active living for rural youth stressed the need for parents to consistently engage and support their kids in physical activity. The report suggested that rural leaders should recognize the importance of providing opportunities for rural families to be active together.[7] Similarly, there is a need for parents to be informed about how to provide healthy food options for their children.

The Food Environment

Families in isolated regions may be "food insecure" or may be living in a food desert—an area with limited access to affordable and nutritious food, often composed of predominantly lower income populations.[8] In 2006, one out of ten households in the United States were food insecure and, of those, one-third had very low food security, which is defined as one or more adults with reduced food intake because the household lacked money and other resources for food. Kentucky, Tennessee, Arkansas, Louisiana, Mississippi, and Arizona have more food insecurity areas than the national average. Ironically, the rural areas where food is grown to feed the country are often the same areas where residents have limited access to healthy food choices. Eight-hundred counties in these six States have almost 10,000 residents who live ten miles or more from a large food vendor.[9] The Maine Rural Health Research Center found that rural low-income parents realize that better prices and selection are available at the larger supermarkets in urban areas, so they are driving great distances, sometimes 40 miles or more, to get to those markets.[10]

When the child is not eating at home, he or she depends on the school system to provide food. Of course, school systems have provided meals for children for years, but recently the quality of school food programs is being closely examined. With more than 31 million children participating in the National School Lunch Program/Summer Lunch Program and more than 11 million participating in the National School Breakfast Program, good nutrition at school is more important than ever. The National School Board Association, the Council of Great City Schools, and the American Association of School Administrators Council have made it a goal that every urban school meets the HealthierUS School Challenge by 2015.[11]

Children in rural regions tend to live in environments that are less likely to promote physical activity. Almost 41 percent of rural children report not participating in any after-school sports or activities.[12] Rural children face unique barriers to being active and maintaining healthy weight. Low-income neighborhoods are less likely to have parks or playground equipment, and many rural communities lack sidewalks or bike trails.[13] Many rural children do not feel safe walking or biking to and from school because of these infrastructure problems. Proximity often plays a role in a child's activity. One rural student, who lived five miles from school, explained, "I wanted to do track but my mom won't let me because she doesn't want to drive me."[14] Recently, the Saint Louis University School of Public Health surveyed 2,500 rural residents in Missouri, Tennessee, and Arkansas. They found that increased distance from recreational facilities, stores, churches, and schools is associated with higher rates of obesity. Fear of neighborhood crime, worries about road safety, and poor neighborhood aesthetics were

also linked to obesity.[15] Safety concerns create limitations for possible exercise outlets. Research shows that youth can be deterred from physical activity due to fear of sex offenders, gangs, and unregulated traffic.[16] Because of the likely remote, isolated settings for physical activity in rural areas, the researchers suggested that these risks may be perceived to be greater than in urban settings. With these findings, it is becoming clear that community design, transportation availability, and safety take a toll on rural children's activity levels.

The Policy Environment

Eating Smart and Moving More in South Carolina

A statewide campaign focusing on nutrition and fitness in South Carolina communities provided the Committee with a firsthand example of how to address obesity at the grassroots level.

The Committee visited the Colleton County headquarters of the Eat Smart, Move More project in Walterboro. This initiative works with key local stakeholders to design the project, and this group identified cost as the strongest barrier to physical activity and healthy eating. The group also recognized the need for an indoor pool and safer walking trails. This assessment showed the strengths, weaknesses, and opportunities of Colleton County. The Eat Smart, Move More team outlined several goals that will address the main concerns voiced by the assessment. By using existing tools, they are addressing the specific needs of their town, with the goal of creating a healthier community.

Childhood obesity trends in rural America are influenced by policies that influence choice. Individuals and families are not always solely responsible for eating well and being active. According to Dr. Cornelia Butler Flora, of Iowa State University, "food producers, food procurers, food providers and food preparers" are rooted in a structure that is not easily altered. People can only eat as healthy as their food system allows. Similarly, physical movement is "determined in part by the degree to which the environmental context provides safe, fun opportunities for organized and recreational physical activity."[17] Alleviating environmental obstacles will require action from a multitude of stakeholders, including the local, State, and Federal government. The challenge is even more acute in rural communities as the data shows even higher rates of obesity among children, particularly minorities. The Committee believes HHS needs a more focused approach in understanding the challenges and marshalling the resources necessary to reverse these trends. Creating a more formal structure to do this could support and inform HHS and the Administration's larger activities on childhood obesity and healthy weight and the First Lady's Let's Move! initiative.

A study on the physical activity of rural youth found that rural residents felt physical activity was partly the community's responsibility. Students and key informants expressed the importance of community investment. They felt the community should invest in preserving old and creating new accessible recreational sites for youth. Also, funds should be reserved for street, sidewalk, and sign maintenance so youth can feel safe using all available facilities. Communities around the country are investing in their residents' health, and Colleton County in South Carolina is leading the way. Businesses, schools, and nearly the entire town of Walterboro there have come together in support of fighting obesity with the Eat Smart, Move More program.

Rural communities can assess their local environment, identify barriers to healthy choices, and take local action, but often need help in altering school, municipal, and transportation policies. Tools to assess these environmental barriers in rural communities are available — and were used by the Eat Smart, Move More initiative.[18]

Recommendation

The Secretary should create an interagency working group that will focus on rural childhood obesity and develop action steps to eliminate the higher rates of childhood obesity in rural communities.

While some communities are advancing, others are still struggling. This is the case for many southern counties in Iowa. USDA has created grants for communities for nutrition and social marketing campaigns, which are funneled through State offices. USDA requires that investments be made in areas that can prove they are targeting low-income populations. However, there is little funded research for sparse rural populations, for statistical reasons. Also, sparsely populated, less prosperous rural counties are not chosen for demonstrations by State agencies because they do not have a track record of successful implementation, and because outcomes may be hard to demonstrate among smaller populations.

Recommendation

The Secretary should ask departmental agencies to create a report card to demonstrate the current HHS investment in addressing childhood obesity in rural communities.

Federal Programs

Key HHS Programs

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is authorized to award community transformation grants to State and local governments and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities. Potential grantees are required to develop a detailed plan that includes the policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce health disparities. The Division of Nutrition, Physical Activity, and Obesity currently funds 25 States to address the problems of obesity and other chronic diseases through statewide efforts coordinated with multiple partners. The program's primary focus is to create policy and environmental changes that will improve the health of places where Americans live, work, learn, and play, while working to build lasting and comprehensive efforts to address obesity and other chronic diseases through a variety of nutrition and physical activity strategies. Title IV of the Affordable Care Act is the Prevention of Chronic Disease and Improving Public Health program (Prevention and Public Health Fund), which the CDC will allocate over the next four years. Given the severity of the childhood obesity problem in rural areas, the Committee believes that public health funding under the Affordable Care Act should designate a portion of funds for rural communities.

Recommendation

The Secretary should ensure that at least 5 percent of funding from the Prevention and Public Health Fund goes directly to rural health specific grant competitions, specifically to rural counties that fall under the national poverty level.

Health Resources and Services Administration (HRSA)

The **Maternal and Child Health Bureau** offers educational tools for new mothers through the Healthy Start program. This program provides health insurance to low-income, uninsured pregnant women to increase access to early, comprehensive, and continuous prenatal care, improving the health of newborns and their mothers. Healthy Start also provides crucial information to parents, through nutrition and activity guides, which helps them start their children in the right direction, encouraging practices to avoid overweight and obesity.

The **Office of Planning, Analysis and Evaluation** (HRSA/OPAE) will provide funding to support a Prevention Center for Healthy Weight and the Healthy Weight Collaborative. This collaborative will strive to spread the use of evidence-based practices for the prevention and treatment of overweight, with the goal of a reduction in the prevalence of overweight and obesity.

The **Bureau of Primary Care** also supports the Health Center program, which does not include rural specific funding opportunities, only funding for underserved populations. In effect, most support goes to States through block grants; this funding is used within the Federal guidelines, but ultimately at the State's discretion.

Administration for Children and Families

In 2006, **Head Start** began an innovative approach to obesity prevention called "I Am Moving, I Am Learning" (IMIL). This program enhancement offers a flexible framework that Head Start staff can use to integrate obesity prevention activities into their daily practices. The goals of IMIL are to increase the quantity of time children spend in moderate to vigorous physical activity each day, improve the quality of structured movement activities that are facilitated by teachers and other adults, and promote healthy food choices among children each day. IMIL was implemented in 53 Head Start facilities. The follow-up assessment found that staff gave IMIL an overall positive rating in its effects with daily physical activity.[19]

Other Federal Programs

United States Department of Agriculture (USDA)

Recently, the USDA's **National Institute of Food and Agriculture** (NIFA) awarded $11 million in grants to develop effective obesity prevention strategies along with behavioral and environmental instruments for measuring progress in obesity prevention efforts. The program also promotes strategies for preventing weight gain and obesity. Funded projects for the 2009 fiscal year include an obesity prevention trial for American Indian communities through Johns Hopkins University, a study at Colorado State University to determine if nutrition and physical activity behaviors learned in preschool are sustained through elementary school, and a study at the University of Miami targeted toward changing the nutritional behaviors of caregivers.[20] USDA's **Supplemental Nutrition Assistance Program** (SNAP) and its **Special Supplemental Nutrition Program for Women, Infants, and Children** (WIC) both play large roles in Federal efforts toward childhood obesity by issuing grants for supplemental foods, health care referrals, and nutrition education. These programs serve pools that are at a high-risk for childhood obesity, therefore, providing these tools is essential in reducing obesity rates.

Making Healthier Choices in Iowa

The fourth graders at Wapello Elementary in Iowa may not know what the acronym SNAP means, but they know to choose an apple over candy thanks to the SNAP-Ed program. This came through loud and clear when the Committee visited a USDA-funded project in this small community in Southeast Iowa.

Through USDA funding for SNAP-Ed, schools with at least 50 percent of their students on free or reduced-cost lunch can receive nutrition education for their students. The funds can be used for a spectrum of nutrition education activities. Wapello has chosen to hire an educator to come in once a week and work with students. She uses Pick a **better** snack™ lessons and social marketing materials. The kids were interested and active throughout the educator's message (probably because it came through a game of fruit and veggie bingo). Iowa schools are sending monthly newsletters as well as healthy snack recipe cards home to help parents and children make healthy food decisions. Community locations, like grocery stores, that meet SNAP-Ed qualifications can use Pick a **better** snack™ social marketing materials to expand the reach of the message. The school system, parents, and entire community have come together to ensure its members are eating well.

Summary

The country has taken some major steps in addressing childhood obesity, but this problem will require years of effort. The committee has seen positive results in communities like Walterboro, South Carolina and Wapello, Iowa, but many rural towns are still struggling. As the Administration addresses childhood obesity, it is imperative to keep rural children and the health obstacles, particular to their environment, in mind.

The Committee recognizes that HHS cannot address all factors that contribute to childhood obesity in rural America, but the following points should be kept in mind as major barriers there. Transportation is lacking for children, which is causing them to miss out on exercise opportunities. The Committee thinks a late/activity bus program would encourage more students to participate in after-school sports activities. Health facilities should be encouraged to open fitness centers up to the community (beyond their patient populations). By offering exercise options to the public, hospitals can itemize this action as part of their community benefit claims.

The Committee believes that community involvement is key in tackling the obesity epidemic nationwide, but especially in rural areas.

Place-Based Initiatives for Rural Early Childhood Development

Chapter Recommendations

- The Secretary should work with Congress to authorize and fund non-categorical, community-based outreach and coordination grants to support the development of place-based initiatives in rural communities.
- The Secretary should require all Early Childhood grant guidance, both block and community-based, to require collaboration with other HHS funded program activities and designated funds for rural child care.
- The Secretary should develop a data strategy that allows HHS programs to share client-level data to improve coordination and efficiency of services.

Subcommittee Members

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Rural Significance: Why the Committee Chose this Topic

What Does Place-Based Look Like?

Though many existing early childhood services are targeted to specific fields (e.g., health or education), policymakers and experts have begun to recommend a more integrated approach, drawing on the characteristics of "place" to inform policy. According to the White House, place-based policies work by "focusing resources in targeted places and drawing on the compounding effect of cooperative arrangements." In 2010, HHS launched the Early Learning Communities (ELC) Initiative, a working group given the task of developing and promoting a place-based strategy for providing and sustaining early childhood services. According to ACF, the implementing agency, core components of these place-based early learning communities include:

- **Governance structure** that is comprised of parents, schools, community-based organizations, experts, and other individuals and public and private entities
- **System of data collection** that provides information on the status and well-being of children and services available to them
- **Quality assurance system** that measures quality of services delivered and provides information, incentives, and support for improvement
- **School system involvement** to ensure that children are ready to learn as they transition into kindergarten and beyond

In 2010, the Administration for Children and Families (ACF), within the Department of Health and Human Services, announced plans for using a place-based policy approach to improving early childhood development.

A place-based policy approach has long been championed by community development experts and academics as a way to better coordinate services by moving away from a program-by-program investment toward a more coordinated cross-sector strategy. Because of the "place" related barriers and challenges facing children in rural areas, the Committee believes such an approach would be particularly beneficial for rural America. Rural communities are less populated, with limited economies of scale for service delivery, and face a variety of challenges that can serve to compound the geographic isolation. These factors can make effective service delivery to at-risk rural children particularly challenging. Rural children face some unique socioeconomic barriers that justify a more coordinated approach.

Consider the numbers:

- Rural children live in families that are poorer—the percentage in deep poverty is 12 percent compared to 9 percent in urban areas.[21] The poverty rate increases with rurality, with 27 percent of children in the most rural counties living in families at or below the Federal poverty level compared to 16 percent in the most urban counties.[22]
- Rural parents who are poor are more likely than their urban counterparts to have no high school diploma (44.5 percent compared to 40 percent), which has been linked with poorer health status and reduced access to immunizations for their children.[23]
- Less than one-half of rural fourth-graders score "proficient" or better in math and reading on the National Assessment of Educational Progress (NAEP) standardized test.[24]
- Three percent of rural children (compared to 1.9 percent of urban children) live with parents who report limitations in activities due to depression, anxiety, or emotional problems.[25]

Experts characterize the rural environment as "a patchwork of informal care provided by kith and kin," without the integration or quality assurance emphasized in a place-based model.[26]

HHS has a significant investment in service delivery to at-risk children ranging from programs in ACF such as Head Start and Temporary Assistance to Needy Families (TANF) to the Healthy Start program at the Health Resources and Services Administration (HRSA). In addition, programs such as Medicaid and the Children's Health Insurance Program (CHIP) play a critical role in covering screening and assessment services that can identify key needs for at-risk children. A true place-based policy approach would look at programs beyond HHS, however, and would also seek coordination and collaboration with Department of Education programs like Title III, as well as with U.S. Department of Agriculture (USDA) programs such as the Supplemental Nutrition Assistance Program (SNAP) and the Women, Infant and Children (WIC). For the purposes of this chapter, the Committee will focus primarily on the HHS programs but urges HHS to continue to reach out and link to other relevant cabinet-level departments.

Across the Federal and State government sector, there are programs in place to meet the needs of children and address the challenges faced by at-risk children (see Figure 2). The challenge comes in making them work at the community level. The reality is that rural children may not always get the same benefits from existing programs due to fewer providers, lack of access, and transportation difficulties. In addition, the challenge of attracting enough qualified practitioners, a fragmented infrastructure for delivery, and high per-unit costs per enrollee can hamper the effectiveness and economic viability of programs in rural areas. The Committee has reviewed evidence suggesting a more coordinated place-based approach could serve to ameliorate some of the rural-specific challenges of early childhood service delivery. Any move in that direction, however, has to take into account how well current Federal programs are meeting the needs of rural communities. In addition, the committee feels it is important to look at non-traditional partners, such as faith-based organizations. Faith-based centers play a large role in rural infrastructure; therefore, it is essential that HHS creates formal partnerships with faith-based sectors to improve services.

Faith-Based Groups A Key Part of Place-Based Policy

The Committee conducted a site visit at the Rural Mission, which is located on Johns Island in the low country of South Carolina.

This faith-based organization mobilizes community resources and volunteers to provide and sustain services such as Migrant Head Start, housing rehabilitation, and transportation for rural residents. The Committee found that the Mission possessed some, but not all, of the components of a place-based model for early childhood development. While the Mission collaborates with individuals and organizations, it is often done under informal agreements and networks. For instance, the Mission works with the Catholic outreach center, Our Lady of Mercy, for its dental care, prenatal care services, and other human services the families may need. If those efforts could be connected with the school system as well as sophisticated data collection to track children's well-being, the infrastructure at Rural Mission would fit the mold for the Early Learning Communities identified by ACF.

Federal Programs

Key HHS Programs

Administration for Children and Families

Head Start and Early Head Start play a lead role in providing early childhood services. Head Start and Early Head Start are federally funded programs that aim to enhance the development of children from birth to their transition to school. Both programs supply grants to local public and private non-profit and for-profit agencies that work with economically disadvantaged children and families, helping them develop social and cognitive skills.

As the Committee has noted in past reports, Head Start and Early Head Start programs can play a critical role in serving rural communities, particularly in reaching out to low-income children. Unfortunately, the geographically isolated nature of many rural communities may be the biggest hurdle. It can be difficult to offer the services when eligible children are not located near a central service site and public transportation is not available, especially given the distance between households and service sites. A greater percentage of rural families send their children to a relative for care (34 percent) than do urban families (26 percent).[27] This informal type of child care, as noted by the Committee in its 2005 Report, has been shown to be less reliable than care provided in formal settings.[28]

Temporary Assistance for Needy Families (TANF) provides financial help for families living below income and resource limits set by the program. Approved families receive TANF benefits for six months and have the option of renewing these benefits, if necessary, after the six-month period. The TANF payments may be used for food, clothing, housing, utilities, furniture, transportation, telephone, laundry, household equipment, medical supplies not paid for by Medicaid, and other basic needs.

To the extent that States can use TANF funding to provide child-care services, there may be opportunities to also serve two important goals. It could help ensure that kids are learning in a structured environment while also helping their parents' transition toward possible employment.

Health Resources and Services Administration (HRSA)

The **Healthy Start** program, administered by HRSA's Maternal and Child Health Bureau (MCHB), provides services tailored to the needs of high-risk pregnant women, infants, and mothers in communities with exceptionally high rates of infant mortality.

Of the 97 federally funded Healthy Start centers currently in operation only eight, or 8 percent, are located in rural areas.[29] Despite the fact that some of the centers in urban counties serve mothers from rural areas, the shortage of Healthy Start centers in rural areas (which specialize in providing perinatal care) is especially troubling given the lack of access to obstetric care among rural mothers. According to *Rural Healthy People 2010*, there are vastly fewer obstetricians per 100,000 people in rural areas compared to urban areas (5.1 compared to 13.7).[30] Also, as noted in the Committee's 2005 Report, existing rural providers are often squeezed by high costs and low incentives to cover obstetric services.[31] Any efforts to incorporate Healthy Start into the Administration's Early Learning Communities must first be coupled with efforts to expand the program's overall presence in rural areas. The Committee also encourages HHS to look at ways to increase the number of Healthy Start grantees in rural communities. HHS' effort to develop a place-based policy approach to early childhood services will be challenging without this necessary programmatic investment in rural communities.

Community Health Centers (CHCs) also are a key part of the health infrastructure for early childhood services. Community Health Centers (1,100 total) create the largest primary care system in the nation. Through 7,900 clinical sites, half of which serve rural residents, they care for 19 million people per year.[32] Of those 19 million, 23.1 percent are age 12 and younger.[33]

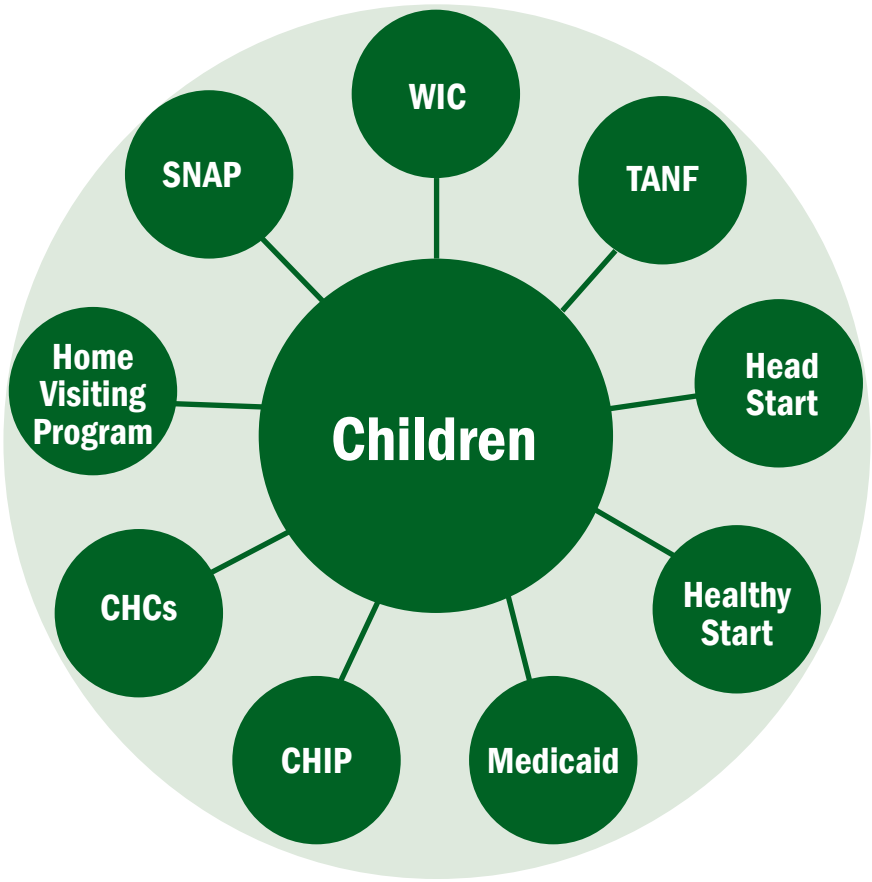


Figure 2: Federal programs that impact children

Centers for Medicare and Medicaid Services

Ensuring children's access to health care services helps them enter school ready to learn and thrive. Toward that end, programs which provide that coverage, such as **Medicaid** and the **Children's Health Insurance Program** (CHIP), play a critical role, particularly in terms of screening and assessment for services. The Early Periodic Screening and Diagnostic Testing (EPSDT) benefit, covered under Medicaid, includes a comprehensive assessment of the child and of his or her development. As a result, it serves as a gateway to other services for children, including referral to medical and oral health providers, parental training and education, and child welfare services. For children eligible for coverage under CHIP, State set-aside programs are currently not required to cover EPSDT services, as there is no Federal mandate to do so.

Joint Programs

HRSA and ACF are jointly administering the **Maternal, Infant, and Early Childhood Home Visiting Program**, which was authorized in the Affordable Care Act. It provides funding for evidence-based home visitation by child development professionals (e.g., nurses and social workers) to parents and families in at-risk communities. Services provided include health care, early and parental education, connection to community resources, developmental services, child abuse prevention, and nutrition assistance. The program will provide funding to the States to carry out the activities. The Committee has had a long-standing concern that funding often does not reach rural communities. Federal and State authorities, under great pressure to show quantifiable results, often will focus on population centers where it can be easier to show statistical improvement. This can be problematic if that influence overcomes sending the funding to areas of greatest need, particularly if those areas face infrastructure and geographic isolation challenges in terms of service delivery.

Other Federal Programs

USDA provides support for early childhood development through SNAP and WIC. Each program plays a critical role in ensuring the health of children so they may thrive in their environments. SNAP, formerly the Food Stamp program, provides over 29 million people with access to nutritional foods using a stipend system that recently was expanded to increase benefit amounts. WIC targets low-income pregnant women, breastfeeding women, infants, and young children to provide nutritional assistance. WIC operates through 1,900 local agencies in 10,000 clinic sites, in 50 State health departments, 34 Indian Tribal Organizations, the District of Columbia, and five territories (Northern Mariana, American Samoa, Guam, Puerto Rico, and the Virgin Islands).

Challenges and Opportunities

The Committee commends the Administration and ACF for moving toward a place-based approach in service delivery to early childhood services. In particular, the Committee was encouraged by ACF's sponsorship of the Rural Early Childhood Institute in March of 2010. The real challenge comes in moving from theory toward actual application. For many rural communities, the real difficulty lies in linking together the larger programs into a cohesive whole. While the Committee saw evidence that communities can move in this direction, the unfortunate truth is these communities tend to be the exception rather than the rule.

Rural communities faced much the same problem in terms of health care delivery in the

Super Nurse

Joyce Legg might only have one title behind her name, but in reality, she is a jack of many nursing trades.

As she explained her responsibilities to the Committee during a site visit to Tama, Iowa, she is the Head Start nurse for Tama County, WIC nurse, Empowerment nurse, Maternal Health Nurse, Tama County Nest educator, and public health and homecare nurse for Tama County Public Health, an agency for which she is also the Assistant Director. She also works closely with the school nurses, physician office, Early Access and Area Education Agency, and Mid Iowa Community Action programs.

It became very clear that Joyce was a strong link to Tama County's success in health care delivery. Although the lack of a formal data-sharing system results in duplication of data entry efforts, Tama County is able to treat patients across all systems, because of team efforts between agencies and Joyce Legg's dedication. Tama County is lucky to have a group of committed individuals who make up an informal place-based system.

early 1990s. While disparate Federal programs such as Medicare, the Preventive Health and Health Services Block Grant, and the Community Health Center program all played a potentially important role in improving local health care delivery, it was difficult for rural communities to connect those dots.

The authorization of non-categorical funding under Section 330A of the Public Health Service Act created rural-specific grant programs that could be targeted toward health service coordination. These grants, Rural Health Outreach and Rural Network Development, allowed the community to determine the need. The funding helped provide a way to link together services and try out new ideas to see if they were viable. They also helped many rural communities connect the dots between the larger programs in a way that built local capacity. Unfortunately, there is no such program corollary on the human services side of HHS.

Recommendation

The Secretary should work with Congress to authorize and fund non-categorical, community-based outreach and coordination grants to support the development of place-based initiatives in rural communities.

The Committee believes non-categorical, rural-specific program funding could help rural communities stitch together the various Federal and State programs needed to best serve rural children in a true place-based approach. To best achieve this approach, it is important to make existing programs support place-based initiatives.

Recommendation

The Secretary should require all Early Childhood grant guidance, both block and community-based, to require collaboration with other HHS funded program activities and designated funds for rural child care.

HHS would benefit from examining current program guidance for community-based funding such as Head Start and Healthy Start as well as State-administered programs such as TANF and home visiting programs and requiring coordination as a condition of the funding. This could take many forms, from data sharing to shared case management, since in many cases these programs are serving the same population.

There are a number of opportunities for more collaboration between TANF and other early childhood programs. This includes working more closely with Head Start, Early Head Start, and Even Start (child and family literacy) centers and grantees to establish more coordination between job readiness, literacy, and child care and development services.

Since a portion of money (30 percent) within TANF may go to providing subsidies for child care, there is an existing groundwork for collaboration with early childhood programs and potential for funding and delivery to become more streamlined within and between these programs.

There must also be connections established in an effort between the home visiting program and existing early childhood programs not only in the area of child care but also nutrition (WIC, SNAP, School Lunch Program), health (Medicaid, Healthy Start, CHIP), and other services vital for families to meet the needs of children in the home.

HHS could help communities interested in place-based approaches by assessing what could be done to reduce administrative burden. This could start with data collection.

Developing a Better Data Strategy

In its 2008 Report to the Secretary, the Committee emphasized the need for enhanced data collection and reporting to better inform policy decisions in rural areas. One such program, the State Longitudinal Data Systems (SLDS) Grant Program, sponsored by the Department of Education (DOE), is available to all States and provides grants to build systems that track children over time (from early childhood up to employment) by funding State clearinghouses that synthesize data across programs and departments. This allows State policymakers to make data-driven decisions to improve student learning, as well as facilitate research to increase student achievement and close achievement gaps.

The Committee noted in its Toledo, Iowa, site visit that multiple programs struggled not only with collecting data on the same population but also in using that data as a way to improve efficiency and to identify those in need of services through the mining and sharing of data. Instead, it was left to staff to identify those in need of services through regular meetings. In this regard, the small population size of this community made this approach possible. In larger rural communities however, the need to share data will only increase. As noted in the chapter, "Home and Community Based Care for Rural Seniors," in the Committee's 2010 Annual Report, a data sharing system will not only improve efficiency for children, but for all human services recipients.

Recommendation

The Secretary should develop a data strategy that allows HHS programs to share client-level data to improve coordination and efficiency of services.

Summary

As demonstrated by the findings from the Committee's site visits this year, there are many opportunities for HHS to ensure even greater connectivity between services provided at the local level that are funded through the Department. This is especially true in rural areas where better connectivity between programs orchestrated at a Federal level can result in better access to services in geographic areas where long distances, lack of transportation, and limited technology, for example, result too often in inaccessible, duplicated, and fragmented services even though those services are federally funded through the same Department.

One example would be the greater connectivity between health-related services and services provided through TANF (Part A of Title IV of the Social Security Act, (42 U.S.C. 601 et seq) within the context of the Deficit Reduction Act (DRA)). This connectivity would relate specifically to preventative services such as baby and well-child care and immunizations, health-related services provided to children under 18 years of age, children in foster care, and children with disabilities, towards an effort to provide better delivery of services often offered in isolation of each other even when funded through the same Federal Administrative Agency. Since so many people who need health care services for themselves and their families apply for TANF, TANF can be the conduit to needed services in a way that is more deliberate, substantiated, and holistic than current practice. For example, parenting skills offered within the Healthy Marriage Initiative for those receiving TANF could focus on the health of children and require connectivity to a TANF case manager who would ensure appropriate referrals are provided for all of the child's health care needs.

The Committee discovered, for example, that the DRA encourages collaboration between families of children and health professionals with the provision of training, outreach activities, and supportive services (as referenced in the DRA). However, it is often the motivation, personality, and resources of certain staff on the local level that connect the dots between programs funded through the same Federal administrative agency, which results in access and the delivery of cost effective, holistic services in innovative ways that help ameliorate the challenges in rural communities.

The Committee encourages the Department to continue working across its various programs to ensure that the coordination of holistic services are not contingent upon personal characteristics of staff at the local level, but rather, are embedded in the Department's regulations, policies, and guidelines as required standard operating procedures that result in institutionalization at the local level and greater accessibility, quality, and efficiency of services in rural areas. Still, it is recognized that personal characteristics of staff at the local level will make any program effective in the rural area. Nevertheless, having strong but flexible operating procedures that emphasize quality and not bureaucracy will make the rural services the best for rural citizens.

Rural Implications of Accountable Care Organizations and Payment Bundling

- The Secretary should use the authority granted to the Center for Medicare and Medicaid Innovation (CMMI) to determine whether HHS can support payment bundling demonstrations focused on those conditions for which care is contained in rural areas.
- The Secretary should ensure that rural providers, particularly CAHs, RHCs, and rural FQHCs, are eligible to participate in the Accountable Care Organization demonstrations.
- The Secretary should work with Congress to revise the Small Rural Hospital Improvement Program (SHIP) as authorized in statute 1820(g)(3) of the Social Security Act so that the funding can be targeted toward groups of providers that need support in forming an Accountable Care Organization.
- The Secretary should report to Congress, particularly the Senate Rural Health Caucus and the House Rural Health Coalition, within one year of implementation of Accountable Care Organization and payment bundling demonstrations about the impact of these mechanisms on rural health care providers.

Subcommittee Members
Graham Adams, Chair
Darlene Byrd
Larry Gamm
Dave Hewett
Tom Hoyer
Todd Linden
Clint MacKinney
Karen Perdue
John Rockwood

Rural Significance: Why the Committee Chose this Topic

The Affordable Care Act (ACA) provides HHS with the authority to develop alternative payment demonstrations in an effort to improve care and contain costs. It includes specific instructions to examine the implications of developing Accountable Care Organizations (ACOs) and demonstrations on payment bundling.

The Committee agrees that conceptually ACOs and payment bundling hold great potential for transforming the provision of health care, including the Medicare program. The challenge lies in ensuring that the practical applications of these new models work as well for rural providers, and the nearly 12 million rural Medicare beneficiaries they serve, as they do for urban areas.[34, 35]

With this chapter, the Committee seeks to provide input to HHS as it moves forward in the implementation of Sections 3022 and 3023 of the ACA, which provide the authority for conducting demonstrations for ACO development and payment bundling, respectively.[36] The Committee believes it is essential that rural areas be included in these demonstrations and testing in order to best inform future Medicare policy development. Accordingly, the Committee will offer a number of suggestions on issues and considerations for HHS to take into account as it tests these concepts.

This chapter is a departure from the standard annual report format in which the Committee typically analyzes existing programs. As ACOs and payment bundling are currently unimplemented, in this chapter we are providing a prospective analysis.

The Committee is mindful of the implementation of Medicare's Inpatient Prospective Payment System (IPPS) in 1983, a payment system that proved effective in most urban settings but had catastrophic effects on a large number of rural hospitals. The development of this system had been driven by concerns over rising costs and diminishing quality of care, similar to the concerns that have driven the payment reform seen in the ACA. Under IPPS, "average" prices for categories of services (called Diagnosis Related Groups or DRGs) were developed using cost data from Medicare's data from hospitals. In theory, the more efficient hospitals could profit by producing less costly results; the less efficient hospitals would need to improve their performance or cease to exist. In the broadest sense, the problem was that the IPPS was based on ideas that could only work effectively for hospitals that served a large enough caseload of paying patients for the averaging effect to work.

The creators of the system assumed that it would always be appropriate for inefficient hospitals to fail in favor of more efficient competitors. Because they were using national data, they failed to appreciate the impact of such a system on areas where the sparse population meant there would be both a limited number of patients and a limited number of hospitals. Many rural hospitals simply did not have a large enough patient base to enable the law of large numbers to work. As a result, between 1983 and 1987, the first few years of IPPS, rural areas lost over 300 rural hospitals, most of which they could ill afford to lose.

Congress recognized that this IPPS result had occurred, in part, because there was no organized process for looking at needs and interests of rural populations within HHS. It enacted legislation establishing the Office of Rural Health Policy (ORHP), which supports this Committee. The Committee believes it is critically important that the Secretary's approach to implementing the ACO concept recognize that it is accompanied by rural risks similar to IPPS in 1983. The Committee, therefore, strongly advises the Secretary to take careful account of the capacity of rural America to sustain ACOs and to make any adjustments in implementation that may be necessary to make that possible.

The ACO concept is largely theoretical at this point, but Medicare has seen the potential of the model in its Group Practice Demonstration and other programs funded by private insurers. Payment bundling is not necessarily new, as Medicare has long bundled services within its provider-specific payment systems (i.e., inpatient vs. outpatient); but, the bundling envisioned by the ACA is different because it would bundle payments across the continuum of care. The Committee is encouraged that the ACA included the kind of broad-based demonstration authority that will allow HHS to thoroughly test out new theories and payment approaches. The Committee strongly believes that HHS should incorporate demonstrations which include a broad range of rural providers and rural beneficiaries to make sure there is on-the-ground testing of the rural viability of new mechanisms such as ACOs and payment bundling.

Payment Reform and Rural Delivery Systems

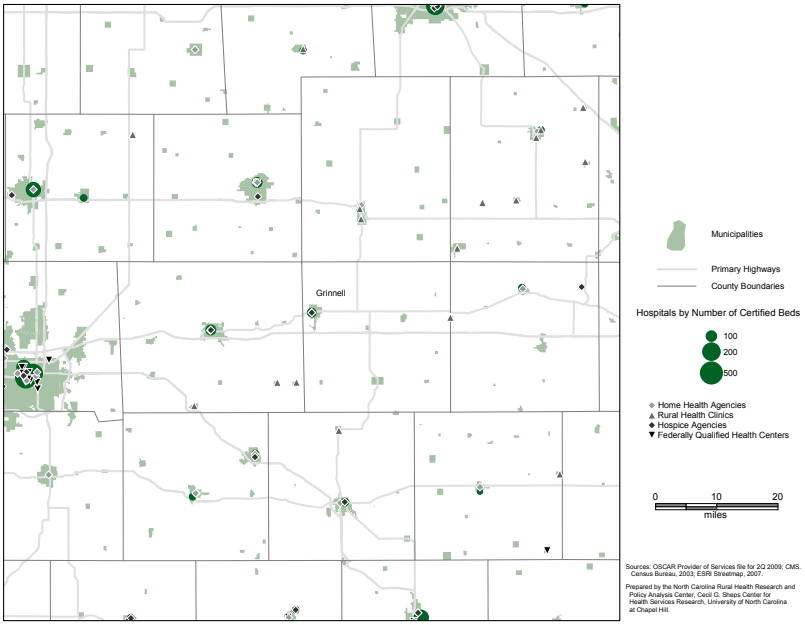
ACOs and payment bundling are a natural outgrowth of the move toward pay-for-performance and are driven in large part by concern over cost and quality. The challenge is that these concepts are still largely unimplemented. The system design is not completely clear in statute and the outcome is uncertain. Understanding the theory behind these concepts will help in the design of appropriate demonstrations that will shape the future of health care delivery.

In order for the demonstrations created under the ACA to provide the information needed to craft a fair national policy, it is important to ensure the meaningful participation of rural providers and rural practitioners. The argument for rural participation is plain and simple: if the capacity of rural health care systems is not explored during the demonstration period, the effects of payment reform on rural systems will not be understood, which will create potential threats to the viability of rural providers, and the patients they serve, if and when Medicare makes national policy changes based on the findings of the demonstrations.

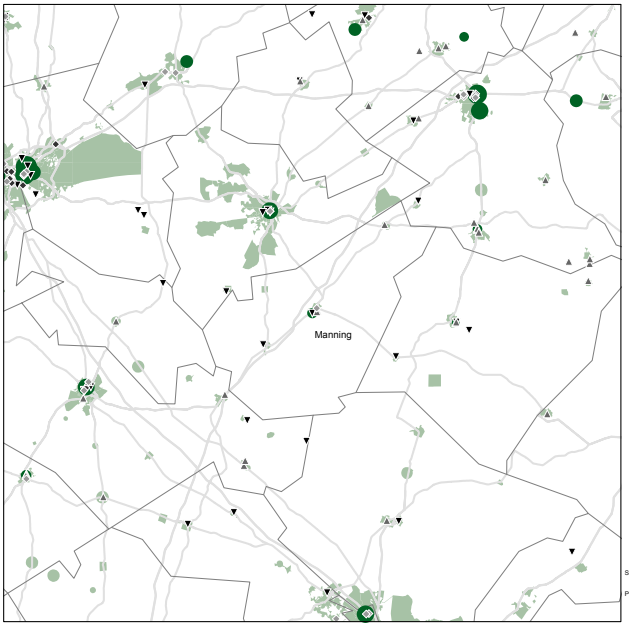
Health Facilities Near Site Visit Hospitals

During the Committee's two site visits in preparation for this report, it traveled to rural hospitals and met with panels of rural clinicians and administrators in two distinctly different regions of the country. Grinnell Regional Medical Center in Grinnell, Iowa, is a 49-bed rural hospital serving a rural region in Northeast Iowa with a significant elderly population. Clarendon Health System (CHS) in Manning, South Carolina, serves a largely poor region with significant health disparities; it has an EMS, a six-bed ICU, and 38 primary and specialized care physicians offering over 20 services that include radiology/imaging and home health, among others. Grinnell has two major natural referral partners but is the only hospital in its county and also serves an adjacent county with no hospital. Clarendon is in a region with more hospitals and also has referral relationships with a number of larger regional acute care facilities (see maps below for mix of providers in the two regions).

Health Facilities near Grinnell Regional Medical Center
Grinnell, IA



Health Facilities near Clarendon Health System
Manning, SC



As policymakers consider options for how to include smaller rural facilities such as these in new care models typified by ACOs and bundled payments, it will be important to realize that there is no "typical" rural model. Those crafting ACO and payment bundling policy will need to take into account the diversity of the existing rural health care delivery systems already in place, and work to fashion policies that create a level playing field.

Accountable Care Organizations

Theory

The ACA calls for the Centers for Medicare and Medicaid Services (CMS) to administer an ACO demonstration project by January 1, 2012.[37] An ACO is defined as a group of providers that is responsible for "the quality and cost of health care for a population of Medicare beneficiaries."[38] ACOs create a financial incentive to keep patients healthy by facilitating coordination and cooperation among providers to improve the quality of care, while at the same time slowing the growth of health care costs.[39] ACOs that meet specific organizational and quality performance standards—to be determined by CMS—would be eligible to receive payments for shared savings.[40] While the details about the financial incentives to ACO participation are not delineated in the ACA, it suggests payouts based on shared savings for reaching a target. Spending for the population of beneficiaries in the ACO could be compared to targets based on past experience for those same patients, or it could be compared to spending for similar patients in the community who are not assigned to the ACO.[41] A second incentive system has been proposed by the Medicare Payment Advisory Commission (MedPAC), combining shared savings and payback from a cash withhold into a bonus and penalty methodology that tracks adherence to both a quality target and a resource use target, with payouts varying accordingly[42] (see Figure 3).

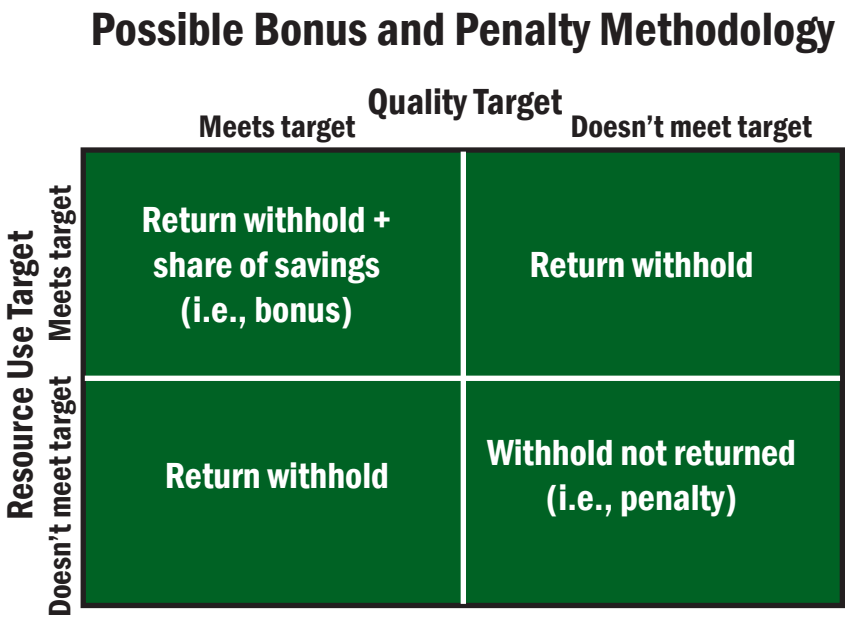


Figure 3: Sample incentive system

A Rural Version of Integrated Service Delivery

In South Carolina, the Committee observed a model of integrated service delivery at Clarendon Health System (CHS).

In addition to inpatient and outpatient care, CHS includes three nursing homes, EMS and Cypress Transport, a health and wellness center, five Rural Health Clinics, physical therapy, orthopedic therapy, home health, DME, general surgery, and respiratory care. CHS is also part a larger regional network called the Coastal Plain Rural Health Network that includes affiliations with other hospitals and Black River Healthcare, a nearby Federally Qualified Health Center (FQHC).

This covers a fairly broad range of the services needed locally, but does not represent the full continuum of care because it must refer some higher end specialty care cases. In an ideal world, CHS would be part of a regional ACO. The system may also be a candidate for looking at how some services could be bundled across the range of acute and post-acute services that are delivered locally.

Some policy experts see ACOs as either voluntary or virtual; in other words, they can be formed voluntarily by existing medical entities or a payer such as Medicare could associate patients with virtual ACOs—groups of providers shown by claims data to be their main source of care— and make payments based on their performance. In either case it is assumed that payment variations would ultimately provide incentives for efficiency.

The voluntary ACO would be formed by existing group practices and providers or integrated delivery systems that elect to participate.[43] In this scenario, they would be similar to physician group practice demonstrations. A multi-specialty group practice would volunteer to be responsible for resource use and quality for a panel of patients. Resource use would be measured relative to the ACO's own baseline and there would be rewards for constraining resource utilization and improving quality.[44] Obviously ACOs are most easily formed when there is an adequate supply of health care providers and practitioners. As MedPAC and others have noted, however, some areas, particularly rural ones, do not have multispecialty groups or integrated service providers that would meet the requirements for forming an ACO. This means that two or

more providers would have to come together to form an ACO, potentially raising issues under Medicare's Stark provisions. Additionally, with voluntary participation the program would likely only attract those groups that expect to succeed. It is clear to the Committee that many, if not most, rural areas lack the resources to make the ACO idea work, at least in the same way it might work in more populated areas.

The law allows the Secretary to implement ACOs in a budget neutral fashion so that, at least initially, there will not be high profits or penalties; however, it is anticipated that payment adjustments may have problematic effects. If patients are not locked into ACOs, the ACO has an incentive to drop those patients or providers who will have high costs—that is, higher than their baseline. Second, the health reform legislation does not indicate how baseline spending will be determined, but it is assumed that there is enough inefficiency to create both savings for the government and profits for the providers. The Committee believes the IPPS example and subsequent experience show that the achievable "savings" in urban and rural areas are likely to vary widely. Both these issues need to be taken into account when the ACO is tested and, again, when it is implemented.

Recommendation

The Secretary should use the authority granted under the Center for Medicare and Medicaid Innovation (CMMI) to determine whether HHS can support payment bundling demonstrations focused on those conditions for which care is contained in rural areas.

Challenges

Simply allowing rural providers to participate in the demonstrations is not enough. The Secretary must take steps to ensure that rural providers are included in a way that does not do collateral damage to an already vulnerable rural health infrastructure. Despite the conceptual soundness of IPPS, for example, we know that many vulnerable rural communities must rely upon cost-reimbursed Critical Access Hospitals. The Secretary needs to consider the potential need for alternative payment formulae for rural areas even in the ACO demonstrations.

It is clear to the Committee that, like the IPPS concept in 1983, the ACO model best fits large integrated delivery systems that provide the full range of care for patients. There are few of those in rural areas, where the system tends to be decentralized. One of the first challenges for HHS will be developing a practical model for ACOs that looks beyond the large integrated delivery system model. That is why rural participation in ACO demonstrations is essential. Rural health care delivery systems vary widely across the country, and as these demonstrations will form the basis of a national payment plan, it is important that a full spectrum of providers—a random, representative sample—is included.

Recommendation

The Secretary should ensure that rural providers, particularly CAHs, RHCs, and rural FQHCs, are eligible to participate in the Accountable Care Organization demonstrations.

It is also important to ensure that improving the quality of care for the patient is kept at the forefront as decisions are made, and not overshadowed by the emphasis on reducing costs. Patient choice is central—they need to have a say in where they receive care. As such, HHS must be careful to avoid creating incentives that might unintentionally cause practices to steer patients toward distant (rather than local) providers simply to improve their bottom line. The ACO idea should not work to reduce the local level of services available to rural beneficiaries.

A few questions remain. In designing the ACO demonstrations, will rural providers be held to the same beneficiary minimums as urban providers? If so, they will likely need to collaborate with other area providers. When thinking about ACO participation, most providers would like to see themselves in charge of the organization, managing the payments that flow through. In some cases this may be possible, but, in most cases, the rural provider will need to link to a larger urban unit in order to provide tertiary and specialty care. How do rural providers participate in a situation like this while ensuring they can remain economically viable? Can an ACO cross ownership lines, and what are the implications for Stark Laws if this happens?

Rural Market for ACOs

Accountable Care Organizations (ACOs) will be tasked with managing the full spectrum of care for a group of Medicare beneficiaries, currently recommended to be a minimum of 5,000 patients. Many rural providers are worried about how they will fit in and the possibility of being obscured by a larger urban hospital. But rural providers that work together to offer a greater range of care may be able to participate in a leadership role as these ACOs roll out. Providers in Manning, South Carolina, are a prime example of this. Anchored by Clarendon Health System, a rural hospital that covers a range of primary care, and further supported by Black River Healthcare, a FQHC known for its pediatric care, the county alone can cover 60-70 percent of the full range of care. A good working relationship with several large hospitals allows for referrals for the care that they cannot provide.

Payment Bundling

Theory

Payment bundling is another payment reform model that is being explored. The law calls for a national pilot program on payment bundling for the Medicare program by 2013 and one for the Medicaid program by 2012.[45] Administered by a new Center for Medicare and Medicaid Innovation (CMMI), the pilot will be a voluntary, five-year program.[46] The current fee-for-service (FFS) model has an inherent incentive to increase the volume of care. Payment bundling attempts to incentivize the right "mix" of care by rewarding collaboration across providers, which, it is hoped, will improve the overall quality of care.[47] Under a system of bundled payment, multiple providers would be reimbursed by a single, comprehensive payment, covering all of the services involved in a patient's care.[48] This model is appealing because it ensures that the financial risk in treating a patient is shared by both the payer and the provider. Potential pilot programs may involve hospitals, provider groups, skilled nursing facilities, and home health agencies, among others, for an episode of care that begins three days prior to a hospitalization and spans up to 30 days post-discharge.[49] Experts recognize that rapid changes in incentives could create unintended consequences, and so are advocating that this type of payment reform be implemented slowly, through policy, and that the Secretary expand the program after the pilot phase, based on performance.[50]

Criteria for Conditions in the Payment Bundling Pilot

The pilot program described in the ACA would be initially limited to beneficiaries having one or more of eight applicable conditions, to be determined by HHS. These conditions will be selected based on the following six criteria:

- Whether the conditions selected include a mix of chronic and acute conditions
- Whether the conditions selected include a mix of surgical and medical conditions
- Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title
- Whether a condition has significant variation in,
  - o The number of readmissions; and
  - o The amount of expenditures for post-acute care spending under this title
- Whether a condition is high-volume and has high post-acute care expenditures under this title
- Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title

[Compilation of Patient Protection and Affordable Care Act, Section 3023: National Pilot Program on Payment Bundling", p. 318-323.]

Challenges

Similar to the ACO demonstrations, payment bundling demonstrations need to include a range of rural providers in order to learn as much as possible about their implications for rural implementation. CMS should test this mechanism in a variety of contexts, not just in terms of the provider demographic, but in terms of the care that is being bundled. The ACA language that describes the payment bundling demonstrations illustrates how bundling would be used for complex cases that generally take place in urban hospitals, but it is unknown if payment bundling could take place around the episodes of care that are common in rural hospitals, such as pneumonia admissions or injuries from falls. If bundling is used primarily for complex cases, then care is likely to be driven away from rural areas, with rural beneficiaries getting more of their care from the urban provider. The rural provider will lose patients and the rural beneficiary will be deprived of the opportunity to recuperate close to home.

To avoid creating a two-tiered system where only urban beneficiaries get the quality benefits associated with the concept of bundling, payment bundling must be tested in a variety of rural settings, with a provision to ensure that those rural providers that participate are not economically disadvantaged as a result of their participation.

The consolidated billing provision within the Skilled Nursing Care PPS, which was created with the Balanced Budget Act of 1997, provides a glimpse into this. While it has created challenges for ancillary providers such as small businesses, for whom service volume is key (because they may get paid less as part of a bundled service than if they had billed separately), the provision has been successful in discouraging the provision of unnecessary items and services.

CMS' history of bundling research has shown how hard it is to find an organization that can, because of the distorting effects of its own interests, prove to be an even-handed steward of the payment that has been made on the patient's behalf. However, the Committee believes that payment bundling is a viable option for rural providers, so long as we recognize that it may work differently for rural providers than their urban counterparts.

Rural Considerations

The demonstrations that will be created under the authority of the ACA have the power to influence how health care is delivered across the country. It is important that rural providers and their beneficiaries are included in this movement, and that reform is not solely urban-based, as rural providers have a case mix and an infrastructure that is much different than their urban counterparts. In designing ACO and payment bundling demonstrations that will provide the most information about implications for implementation in rural areas, the following needs to be ensured:

- A representative sample of rural provider types
- Provisions that guarantee that participating rural providers are not adversely damaged
- Bundles around care that is common in a rural setting

In drafting regulations, HHS should pay particular attention to creating a regulatory framework that would encourage urban-based and regional ACOs to include rural partners. Ideally, this would be done in a manner that follows natural referral patterns and emphasizes patient choice in terms of site of care to the extent this is practical. HHS faces a distinct

Reimbursement Rates

As policymakers develop regulations for Accountable Care Organizations (ACOs), some rural providers feel they could be at a competitive disadvantage if success is defined exclusively in terms of reducing costs against the providers' own experience. Efficient providers need to be measured against National or State data.

The Committee's site visit in Grinnell, Iowa, included a panel of rural physicians, payors, and hospital administrators; all voiced concerns whether the ACO model will work in their region because of historical reimbursement patterns. The panelists said they have been paid less historically than their urban counterparts, and even less than rural providers in other states, which may make it difficult to achieve any meaningful savings relative to a historic benchmark.

The panelists cited findings from research such as the Dartmouth Health Atlas that shows that areas like Iowa tend to have higher quality scores with lower Medicare reimbursement relative to other regions of the country. They believe the combination of lower costs coupled with higher quality scores may make their region particularly unsuitable to the ACO model since they believe they will be hard pressed to achieve the shared cost savings that are at the core of the ACO model.

challenge in drafting regulations that are sufficiently flexible so that ACOs can develop creative models. But it must do so in a way that does not encourage cherry picking of low-cost providers with relatively healthy populations at the expense of other providers, such as CAHs, with different cost structures and diverse patient populations that may include significant health disparities. How HHS assigns patients to ACOs will be a critical issue.

Grant Funding

The Committee believes that ACOs can be formed in rural areas if the right groups come together, but recognizes that these providers will need support as they form these working relationships. It will require considerable coordination and collaboration among the various participants, which may include Critical Access Hospitals, Rural Health Clinics, private practice providers, and other care providers.

It is important to recognize that rural providers are unlikely to have margins that can fund extra time or staff to devote to ACO planning. As such, the Committee recommends that the Secretary work with Congress to revise the Small Rural Hospital Improvement Program (SHIP) to make it more useful for providers that want to use it help them lay the groundwork for an ACO. Interestingly enough, the ACA did re-authorize the program and expand its focus area to include working with small rural hospitals to help them prepare for taking part in ACOs, payment bundling, and value-based purchasing. Unfortunately, there are long-standing problems with the authorizing statute that the re-authorization did not change. For example, the statute caps awards at $50,000 per hospital. HRSA has chosen to administer the program so that each eligible hospital can get an award of approximately $8,000. It's not clear that that sending $8,000 to each eligible hospital will allow for the sort of targeted investment needed to have a significant impact. The Committee is aware that some States have chosen to pool the funds, which creates economies of scale that allow the funds to have a larger impact. Unfortunately, the current statute does not require this pooling of funds. The Committee suggests that the funding be distributed more directly to those groups of providers or networks of providers that are ready to work on forming an ACO and that the cap is lifted so that HRSA can make larger and more targeted awards to support those small rural hospitals ready to take part in ACOs.

Recommendation

The Secretary should work with Congress to revise the Small Rural Hospital Improvement Program (SHIP) as authorized in statute 1820(g)(3) of the Social Security Act such that the funding can be targeted toward groups of providers that need support in forming an Accountable Care Organization.

Summary

While the payment reform outlined in the ACA holds promise to improve health care in our country, it is important to ensure that efforts to reduce costs do not overshadow efforts to improve the quality of care. We need to recognize that while the Health Maintenance Organizations of the 1980s were focused solely on cutting costs, ACOs are designed to both cut costs that are unnecessary and to improve quality. Patient choice is an important part of quality and ACOs must be careful not to steer patient choice away from rational referral patterns. Throughout the implementation of payment reform, the Secretary needs to be mindful of the catastrophic effects on a large number of rural hospitals that occurred when IPPS was implemented in 1983. Many of these problems were attributable directly to the fact that IPPS planning had not adequately taken account of rural conditions and the effects of implementation on rural providers. Regular reporting to key Congressional Committees, the Senate Rural Health Caucus, and the House Rural Health Coalition, as well as key stakeholder groups, may help identify early policy concerns.

Recommendation

The Secretary should report to Congress, particularly the Senate Rural Health Caucus and the House Rural Health Coalition, within one year of implementation of Accountable Care Organization and payment bundling demonstrations about the impact of these mechanisms on rural health care providers.

Improved efficiency and quality do not always mean less costly care. Although the payment reform outlined in the ACA holds promise to bring costs down while also improving the quality of health care, many rural providers are burdened by reimbursement rates that make it difficult for them to provide services currently, and these providers do not see how improvements can be made by seeking further reductions. The Committee recommends that the Secretary evaluate reimbursement schemes to make sure they operate in a way that fairly accounts for the cost of delivering care in a rural setting.

Lastly, it is important to remember that ACO formation in rural areas will require the local providers to develop cost-effective relationships with tertiary care organizations for care that is not provided in the community. As most rural communities have not been through this process before, it is important to support the necessary changes in infrastructure before superimposing a new payment system. This means providing grant support to assist with the capital investments necessary for implementation of health information technology (HIT).

Acronyms and Abbreviations

ACA	Affordable Care Act
ACF	Administration for Children and Families
ACO	Accountable Care Organization
ARRA	American Recovery and Reinvestment Act
CAH	Critical Access Hospital
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHS	Clarendon Health System
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
DNPAO	Division of Nutrition, Physical Activity, and Obesity
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
ELC	Early Learning Communities
EMS	Emergency Medical Service
ESMMSC	Eat Smart, Move More South Carolina
EPSDT	Early Periodic Screening and Diagnostic Testing
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
GRMC	Grinnell Regional Medical Center
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources Services Administration, HHS
ICU	Intensive Care Unit
IMIL	"I Am Moving, I Am Learning"
IPPS	Inpatient Prospective Payment System
MCHB	Maternal and Child Health Bureau, HRSA, HHS
MedPAC	Medicare Payment Advisory Commission
NACRHHS	National Advisory Committee on Rural Health and Human Services
NAEP	National Assessment of Educational Progress
NIFA	National Institute of Food and Agriculture
OPAE	Office of Planning, Analysis and Evaluation, HRSA, HHS
ORHP	Office of Rural Health Policy, HRSA, HHS
PPS	Prospective Payment System
RHC	Rural Health Clinic
SHIP	Small Rural Hospital Improvement Program
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
USDA	U.S. Department of Agriculture
WIC	Women, Infants and Children

Appendices

Appendix A: June 2010 Site Visits

Rural Childhood Obesity

Sites: Eat Smart, Move More - Walterboro, South Carolina
Hosts: Amy Splittberger, Marilyn Peters
Speakers: Amy Splittgerber; Marilyn Peters; Rhonda Rawl; Jennifer DuMont

Background Information:
The South Carolina Coalition for Obesity Prevention Efforts and the South Carolina Coalition for Promoting Physical Activity formed a partnership to create South Carolina Eat Smart, Move More (ESMMSC). The program aims to coordinate obesity prevention efforts across the State. With a major grant from Blue Cross Blue Shield of South Carolina, ESMMSC has created a strategic plan with seven priority goals to eliminate the obesity epidemic:

- Collaborate with State level partners to encourage integration of the ESMMSC vision
- Encourage and support collaborative efforts on the community level that promote healthy eating and active living
- Develop and maintain an engaged and diverse partnership to promote healthy eating and active living
- Promote and support the use of evidence-based and promising practices to implement the South Carolina Obesity State Plan
- Generate public awareness of the ESMMSC brand and message
- Identify and secure resources to promote healthy eating and active living
- Advocate for local and statewide legislation, policy and funding to support healthy eating and active living

Site Visit Highlights:
Walterboro had a popular farmers market for the community, but incorporating the produce into school cafeterias is difficult due to the harvesting season for farmers starting when school ends for the summer. Some farm produce is ready for the school-year period, but the vast majority is available in the summer. There were many ideas formed about nutritional education and outreach through these groups. For this reason, it will be beneficial to look at cooperation between Federal agencies such as HHS and USDA. After the site visit, it became clear that obesity is a comprehensive problem, so it will require comprehensive solutions. The areas Walterboro has focused their attention on include school programs, parent education, community restaurants, and community businesses. The ESMMSC team also created a marketable plan that will simplify their message, relating all events to the phrase "Let's Go!" For example, Let's Go Run, Let's Go Garden, etc. The committee found that transportation is still an issue for rural children, especially if nutrition and activity programs occur in schools that use buses for transportation.

Place-Based Strategies for Rural Early Childhood Development

Sites: Rural Mission - Johns Island, South Carolina
Hosts: Mary-Lynne Diggs, South Carolina Head Start Collaboration Office
Speakers: Baron Holmes, Budget and Control Board Office of Research Statistics; Sherry Osborne, Manager, South Carolina Head Start Training and Technical Assistance Network, Region IV Head Start Training Office; Rosemary Wilson, Coordinator, South Carolina Early Childhood Comprehensive Systems Project, South Carolina Department of Health and Environmental Control

Background Information:
The place-based approach to integrating services is not solely a Federal policy, and can be used in the nonprofit and private sectors as well, as the Subcommittee learned during its June visit to South Carolina. The Rural Mission, located

on Johns Island, is a faith-based organization that mobilizes community resources and volunteers to provide and sustain services for its rural residents such as Migrant Head Start, housing rehabilitation, and transportation. The Committee found that the Mission possessed some, but not all, of the components of a place-based model for early childhood development.

Site Visit Highlights:
While the Mission collaborates with individuals and organizations, it is often done under informal agreements and networks. For instance, the Mission works with the Catholic outreach center, Our Lady of Mercy, for its food bank, dental care, and prenatal care services. The Board of Directors for the Mission is comprised of business, nonprofit, and other civic leaders, with strong representation from Johns Island. The Mission keeps careful track of in-house data on number of repairs, type of assistance, and hours of service provided. Staff members use this information to inform and recruit donors.

The Committee learned that features of the Mission include an active and representative governance structure and system for monitoring the quality of services provided by measuring impact on recipients. If merged with more involvement with the school system and sophisticated data collection to track children's well-being, the infrastructure at Rural Mission would fit the mold for the Early Learning Communities identified by the Administration for Children and Families.

Rural Implications of Accountable Care Organizations and Payment Bundling

Site: Clarendon Health System - Manning, South Carolina
Host: Edward Frye, CEO of Clarendon Health System
Speakers: Edward Frye, CEO of Clarendon Health System; Barbara Brooks, CEO of Blackriver Health Care

Background Information:
Clarendon Health System began in 1951 as an acute care hospital. Today they have 38 primary and specialized care physicians and offer over 20 services that range from inpatient and outpatient hospital care to home health services, EMS, and health and wellness programs. Clarendon partners with three area nursing centers to provide short-term, transitional care, post-hospitalization services, and long-term nursing services. They have a noteworthy working relationship with Black River Healthcare, a Federal Qualified Health Center that provides primary family health care for residents of eastern South Carolina. Clarendon Health System recently received $22.5 million through a bond referendum to expand their facilities, growing to 81 inpatient beds and more than doubling their number of ER beds from 10 to 22.

Site Visit Highlights:
Clarendon Health System demonstrated a level of comprehensive care and services that is not always found in a rural provider. The Subcommittee was impressed by the range of services CHS provides, as well as their deep commitment to serving the community. To foster collaboration in the community, they have partnered with a number of nearby organizations, hospitals, and health care entities to form the Coastal Plain Rural Health Network. The Subcommittee engaged in a productive discussion with the CEO of CHS and other senior level staff about how they and other rural providers will be affected by the provisions set forth by the Affordable Care Act. Their biggest obstacle to participation in an Accountable Care Organization (ACO) is developing a sustainable, economical model of specialty referral service. The Committee concluded that rural providers need to be included in the ACO demonstration projects that are being organized, and that special provisions may need to be made to ensure that rural providers are not unfairly excluded.

Site Visit Locations

Appendix B: September 2010 Site Visits

Rural Childhood Obesity

Site: Pick a Better Snack and ACT - Wapello, Iowa
Hosts: Christine Hradek, Bureau of Nutrition and Health Promotion, Iowa Department of Public Health; Gloria Vermie, Director, Iowa State Office of Rural Health
Speakers: Christine Hradek, Bureau of Nutrition and Health Promotion, Iowa Department of Public Health; Julie McMahon, Director, Division of Health Promotion and Chronic Disease, Iowa Department of Public Health; Patty Delger and Carrie Scheidel, Iowa Department of Education; Cheryll Jones, ARNP, Health Services Coordinator, Ottumwa Regional Center of Child Health Specialty Clinics

Background Information:
Pick a **better** snack™ is a nutrition education and social marketing campaign in Iowa that has the goal of helping children eat more fruits and vegetables by increasing how often they eat fruit and vegetable snacks, and highlighting the importance of daily physical activity. The program is provided in classes from preschool through sixth grade, with 30-minute lessons once a week, over the course of a semester. The Subcommittee observed a fourth grade class during a weekly Pick a **better** snack™ session at Wapello Elementary School. Stephanie Duncan, the BASICS Educator, provided samples of seasonal fruits for the students to try, talked about the quantity of fruit and vegetables that they need to eat each day, and the need to have a variety of color on their plate. They were shown fun physical activities that they can do and a hula hoop and frisbee were provided for the class to use. Students were encouraged to work towards a certificate by keeping track of their exercise activities and maintaining a healthy eating log.

Site Visit Highlights:
The Subcommittee felt the Pick a **better** snack™ class was effective and the students were engaged and interested. SNAP-ED evaluations demonstrate an increase in the preference towards a variety of fruits and vegetables for children who participate. The students have increased confidence that they can influence their parents to purchase fruits and vegetables.

The Subcommittee found that schools are an important focal point where changes can significantly affect children. A significant portion of a child's calories are consumed at school. Children take the knowledge home to their parents and into the community, which is how change happens. Through the USDA Team Nutrition grant, cycle menus have been made for schools to serve students. The campaign meets the gold criteria for Michelle Obama's Healthier US School Challenge and is being piloted in seven districts in the State.

Place-Based Strategies for Rural Early Childhood Development

Sites: Kids Corner and Healthy Families Program - Tama, Iowa
Host: Gloria Vermie
Speakers: Joyce Legg, RN, Tama County Public Health and Home Care; Royce Hickie, Mid-Iowa Community Action; Cindy Skopec, Area Education Agency 267

Background Information:
Located in Tama County, the Healthy Families Program offers a wide range of services to families with children from birth to age five ("0-5"). This program helps parents create a safe and healthy home, and helps them work toward economic and social self-sufficiency. Parents also learn how to help their children build social, emotional, intellectual, and physical skills through the following services: family development services, health services, nutrition education, quality child care, and child development services. The Tama County Healthy Family Program is available to all residents of Tama County, regardless of income. Kids Corner Daycare collaborates with Tama County Empowerment to provide a wide array of services, such as Respite and Preschool Scholarships, as well as one-on-one child services. Services are provided for school-age children before and after school and on no schooldays.

Site Visit Highlights:
It became evident that decision making should be at the local level. In other words, the Federal government should do its best not to interfere with relationships being built at the local level. The relationships create the caring communities that serve the children from birth to age five, who will be transitioning to school, and their families. When asked how the transition was made from "0-5" programs to school, the speakers explained there are programs to ensure children make the transition, but there is no funding for these programs. It was evident that rural people do things because it is the right thing to do, but they are not necessarily funded. The systems observed also relied on interaction between leaders for client data. The head nurses and teachers meet once a week and share data verbally, but this process would be expedited with data sharing technology.

Rural Implications of Accountable Care Organizations and Payment Bundling

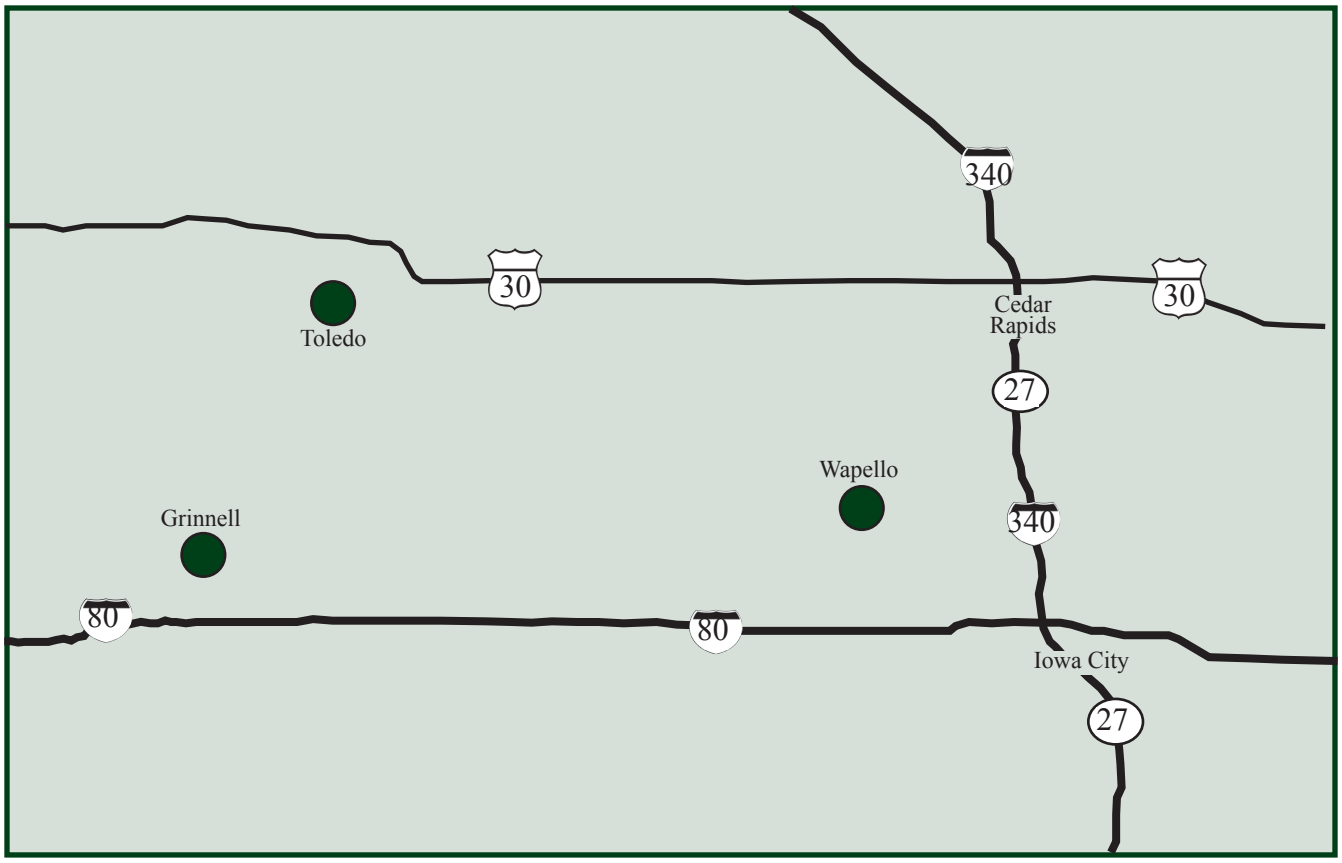
Site: Grinnell Regional Medical Center - Grinnell, Iowa
Host: Todd Linden, President and CEO, Grinnell Regional Medical Center
Speakers: Thomas C. Evans, President and CEO, Iowa Healthcare Collaborative; Tom Slater, CEO and Founder, State Public Policy Group; Michael D. Fay, Vice President, Health Networks; Greg Boattenhamer, Senior Vice President of Government Relations, Iowa Hospital Association; Sheila Laing, Vice President of Human Resources, Hy-Vee, Inc.; Skip Lowe, President and CEO, Bernie Lowe and Associates, Inc.

Background Information:
Grinnell Regional Medical Center (GRMC) is a 50-bed hospital with about 40 physicians in 12 different specialties, including anesthesiology, emergency medicine, family practice, general surgery, internal medicine, orthopedic surgery, pain medicine, pathology, podiatry, psychiatry, radiology, and urology. GRMC has six affiliated family clinics in a six-county area. A top rural medical center, GRMC serves approximately 40,000 residents in the greater Poweshiek County area. After touring the facilities, the Subcommittee heard from a diverse speaker panel of stakeholders on the relevant aspects of the Affordable Care Act, specifically payment bundling and Accountable Care Organizations.

Site Visit Highlights:
The Subcommittee was impressed with the facilities at GRMC, recognizing that it provides some services that are usually only found in major health care centers, which allows area residents to stay close to home for their medical care. GRMC has set out to create an "optimal healing environment," evident throughout the center's carefully designed patient rooms, family waiting space, and outside garden.

The speaker panel represented a range of viewpoints on payment reform, from physician to insurer to employer. The panel highlighted the importance of addressing Iowa's low level of Medicare reimbursement in payment reform implementation and stressed that efficient providers should not be penalized for already being resourceful. The Subcommittee appreciated hearing the employer perspective, which has often been left out of most dialogues on reform.

Site Visit Locations



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Note: All web pages cited were last accessed on January 12, 2010.