

Joshua Wynne: I'm going to come down here. Good afternoon everyone. Thank you. Today is National Rural Health Day. We're very pleased to have a panel today where we're going to discuss some issues regarding the changes in how we deliver care in general and specifically for rural populations. The school does a pretty good job I think of both attracting students who are interested in practicing in rural areas and then actually having those students go out into the rural areas and deliver care. The Association of American Medical Colleges actually compiles data on this and it turns out we're at 95th percentile compared with all other medical schools in the United States. Congratulations to all of you for everything that you do for rural healthcare delivery.

I'd now like to turn it over to the panel. I'll be participating as well. There are going to be some questions and answers, but we'd really encourage you to participate as well, particularly from the student's standpoint as you think about what are the changes that are coming and what does that mean to all of you. I'll turn it over. We'll do some introductions and then get under way. Thanks for coming.

Teryl Eisinger: Thank you Dr. Wynne. It's really a pleasure to be here. I'm Teryl Eisinger. I'm with the National Organization of State Offices of Rural Health. It's a very exciting thing to be here on National Rural Health Day amongst the students and the future physicians of America. What a great topic for us to be able to be with you all today.

We're talking about delivery system reform. As we're beginning to do that I want to do a shout out and a thank you to the Rural Health Information Hub and Kristine Sande and her staff for the good work that they do in bringing resources across the country, and also to the folks from the Center for Rural Health, especially Brad Gibbens, Lynette Dickson, a former president of the National Organization of State Offices of Rural Health and Kylie Nissen who co-chairs our national committee to oversee activities for National Rural Health Day. Thanks to all of you for being part of this and having us here today.

I just want to do a little shout out to the med students. Today we released a small electronic publication called Rural Doc Hollywoods and Community Stars. We've written up profiles of physicians and community projects across the nation shouting out about the good work and the innovation that's happening there, which is what National Rural Health Day is all about. I hope to see every med student featured in that publication in the future. I hope that you'll check that out on our website at nosorh.org and all of you in the audience as well.

National Rural Health Day is about taking one day each year and focusing on what's positive, bringing to the attention of the public and to the media and to our partners the real different needs of rural Americans, the professionals that serve them and the disparities that exist, but also to focus on the positive and the innovation and the challenges. Looking at delivery system reform and what's happening in the future is really an important topic. It's something that none of us can stick our head

in the sand about. We really have to be on top of it. I can't think of three better experts that are part of the panel today.

Certainly Dr. Wynne, it's a pleasure that you could be part of this. Tom Morris is the Associate Administrator with the Federal Office of Rural Health Policy out of the Health Resources Services Administration at the Department of Health and Human services, and Dr. Keith Mueller is the director for the Rural Policy Research Institute at the Center for Rural Health Policy Analysis and head of the Department of Health Management and Policy at Iowa's College of Public Health at the University of Iowa. Thank you all for being here and being part of this panel. I have some questions for them. We're happy to have questions from all of you and also from our folks who are attending on the web cast. Let's just start out and talk about ... There's a lot of discussion about delivery system reform nationally. Any of you, maybe Tom you want to lead off. What exactly is meant by that and is it something new?

Tom Morris:

Delivery system reform is a new framework to look at issues I think that we've been talking about for, probably dating back to 1999 when the Institute of Medicine released its Crossing the Quality Chasm report. It's been a journey since then to think more creatively about how to move from a healthcare system built on volume to one that's more focused on value. This was continued I think when we had the triple aim that was talked about in the early 2000s. The whole notion of how can we link payment to outcomes in a way that promotes population health more creatively.

I think what the Department of Health and Human Services did last year was to release a delivery system reform framework that tied all that up and looked at what are the reimbursement mechanisms to do that, how do we have value-based payment that links quality and reimbursement? What can we do around population health to improve outcomes for folks, while also perhaps bending that cost curve of what we're spending as a nation? Then the third part of that is, what's the data infrastructure to support it? That's including health information technology ranging from electronic health records to telehealth and all those things that can enable that focus on population health.

We've released some pretty aggressive targets for moving as many providers as possible into value-based payment, what we're calling alternative payment models. These are things like the Patient-Centered Medical Homes, Accountable Care Organizations. It goes as far down the line as when we talk about bundling payments and giving one global payment to a system to care for the whole episode of care. That's it in a nutshell and I'd ask Keith to expand on that.

Keith Mueller:

I'd start with what is now a new characterization, relatively new of the triple aim that has been around, as Tom said, since the early work of the IOM and in the work of the Institute for Healthcare Improvement. Now with the Secretary's release of what are really payment goals through 2018 the Centers for Medicare and Medicaid Services (CMS) also released a series of documents, factsheets they're called, on

their website. I encourage you to go there and download those. They're using the framework of better care, smarter spending and healthier people.

Relatively easy to remember, even I can do it, as memory becomes an increasing issue as I approach my Medicare years, but that's the framing that we're using now. What's different from previous efforts along these lines is a more aggressive, as Tom put it, aggressive movement to change the way in which healthcare is financed. What we've learned in the past with lots of efforts to try to encourage more population based health activity is, you can do things like a one-time grant program, but to try to continue it and have it be sustainable, the payment system has to be altered, so that it becomes a source of patient revenue to support, say, population health activities. That's the major change that we're seeing now.

Joshua Wynne:

Let me try to frame this a little bit, especially for the students. The three issues that we've really been talking about inferentially are quality, access and cost. In North Dakota we're fortunate that relatively speaking quality is high, relatively speaking cost is low and access isn't too bad, except in certain areas like in specific rural communities, but at least we have a plan to try to work on that. The issue is how do we simultaneously improve access, improve quality and at least reduce the rate of growth of healthcare costs.

Let me emphasize that and you'll see it tomorrow again in my Enews column. When we talk about bending the curve or reducing healthcare costs what virtually everyone is talking about is reducing the rate of growth of healthcare costs and not the absolute amount. Over the last 50 years, other than in the last couple of years, the rate of growth of healthcare costs has exceeded the growth in the GDP by about 2.5%. That is not sustainable. We've done it for 50 years. We can't do it for 50 more years. The issue is, how do we get better outcomes with lower rate of growth and with more people who need care actually getting the care.

That's one of the reasons why there's a focus on population approaches. It's been estimated that at least 40% of morbidity and preventable mortality can occur just through behavioral approaches, simple things like taking your blood pressure medications, don't smoke, wear a seatbelt. Simple things conceptually; often difficult to do in practice. That's what we're talking about. If you could imagine a graph for a second, I'd just like to paint what we're trying to do. Consider a graph where the Y axis is benefit or utility or usefulness, and the X axis is cost. Consider a curve that goes up rapidly at first and then becomes pretty flat.

A lot of the care that we give is on the flat part of the curve where it's really expensive and the incremental value is pretty small. What we want to try to do, we collectively, what we need to do is to move more care on that steep part of the curve where we're getting a lot of benefit at relatively low cost. That's what we're looking for. The idea of shifting as people have talked about, shifting from an episodic approach to payment to a more longitudinal one is to try to do those things that really help patients a lot and cost relatively small amounts. I will use vaccinations as an example of something that gives enormous benefit at relatively

low cost. There are other things that we do that may well have benefit, but it's of relatively small amount and at huge cost. We need to try to start to do less of that and more of the real value.

Teryl Eisinger: In rural communities where healthcare is typically delivered and focused perhaps around a small Critical Access Hospital or a small Rural Health Clinic that's been focused on healthcare delivery and not necessarily on promoting the health. I think there are healthcare providers and all of us across the country asking ourselves, Tom and all of you, is this this really relevant? Is delivery system reform relevant to rural health and how is it relevant?

Tom Morris: I think it's definitely relevant. You made the point perfectly, which is the way we've done it, is not sustainable. The question is when you try to move the country as a whole along this goal towards value-based payment, how do you do it in a way that works as well in Boston as it will out in Williston for instance? I think that's the real challenge for it. A lot of the mechanisms we're using in our delivery system reform framework emphasize the traditional forms of Medicare payment. One of the policy conundrums we have is that for 25 years we've been trying to find a way to pay rural providers in a way that protects them and ensures access. Critical Access Hospitals are paid outside of the way traditional Medicare reimburses hospital care. Rural Health Clinics, Community Health Centers, the same way.

Some of the policy levers we're using to move people into value-based payment are not necessarily directly accessible, at least through Medicare, for some of these safety net providers. There's 1,300 plus Critical Access Hospitals, there's 4,000 Rural Health Clinics. There's 8,000 rural and urban Community Health Center sites around the country. The tools are not necessarily there in the same way they would be in a big city, but that doesn't mean that it can't be done or that it can't be emphasized. Medicaid is a big payer. We have a lot of innovation going on at the state level with Medicaid programs moving into different ways to pay and focus on population health.

Really a lot of this is transitional anyway. I think we will be moving, some day, towards a strict population based payment, but you can't go there overnight. You have to do a transition toward that. Even if you're not part of the financial mechanisms for delivery system reform there are opportunities to focus on quality, to focus on outcomes, to be ready for when that opportunity comes about. Even within the fee-for-service system, which isn't that amenable to population health payment, we've added codes within the physician fee schedule over the last few years that I think give an opportunity to do that.

Right now when you all come out of residency you'll be able to bill Medicare for doing post-discharge planning. You couldn't do that two years ago. You'll be able to do encounter care management without necessarily having a face-to-face visit under the Medicare fee schedule. You couldn't do that previously. Within the regulations we have we're trying to help give the clinicians the tools they need to focus on population health. I think you'll see more of this with the new payment

formula that's going to come down which is going to replace the old one, which was the sustainable growth rate formula.

The way we'll pay physicians moving forward will be under what's called the merit incentive-based payment system. That's going to directly tie the payment towards reaching measurable quality goals. It's a long journey to move this way, but in no way would we want to think for rural should they wait and see how it's going to turn out. They need to be part of this moving forward. You all are really going to be at the vanguard of this as you come out of residency.

Keith Mueller: That was a great answer. I'm going to approach it a little bit differently and say is it relevant for rural? Absolutely. When I say I approach it differently I approach it from the viewpoint, I teach in health management program. I approach it from the viewpoint that we would, with any organization, what's the organization's vision and mission? What are you trying to accomplish as an organization? I can't think of a healthcare organization whose mission and vision doesn't tie back to the health of the people of the community and the health of the people that it serves.

We've been caught in a bind for decades of a financing system that doesn't really serve that mission. The financing system has been one of, just provide more and more volume, so you're not really encouraged by that financing system, nor that is it to help you to provide basic services that keep a population healthy and that really serve the community. Starting from vision and mission, it's absolutely relevant to rural. The challenge is, as Tom did a great job of articulating, how do you make the specifics work out in a way that this can be done in rural places.

That's what you'll hear more about us from in the next 20-30 minutes. That's what we're all about trying to help do now, is how do we make a transition from a dependency financially on a system of finance that was not designed to support the behavior that the organizations have all along wanted to engage in in serving their populations.

Teryl Eisinger: We certainly want to hear from those on the webcast with questions. Feel free to type into and let us know your question. As we're doing that, Dr. Wynne, we certainly want to come back and talk about how we're seeing these activities play out in rural communities and resources that are available. Dr. Wynne, you're dean of the University of North Dakota School of Medicine and Health Sciences. Could you talk to us and give some insight on, since we're lucky enough to be in this room full of future physicians and you're dean of health sciences, how do see this playing out for future physicians and the rest of the health workforce, other health sciences?

Joshua Wynne: First of all, the room is full of future physicians and other healthcare providers. We're a school of medicine and health sciences which by the way relates directly to the prior comments because we think one of the approaches that we will see is a greater team-based approach to healthcare. One of the issues that any of us who've practiced for a long time are well aware of is the handoff issue, the transition from

the hospital to the post-hospital place, whether it's home or someplace else. The coordination of care, of different specialists with primary care providers. We as a profession and as a system haven't always done that optimally.

At least one of the approaches we are taking and we're doing it pretty aggressively, is to try to train the future healthcare providers in a more team-based collaborative approach. We think that we'll improve quality, reduce costs, improve access and by the way, directly relate into new payment models where it becomes much easier when you function as a coherent team than individual practitioners who at times are quite frankly competing with each other. We think that this integrated model will be very useful. The other thing that I would say to the trainees, if there's one constant coming in the future, that one constant is change. We will evolve these things. It's easier for us to say a transition from fee-for-service to value based. It's a lot harder to do it and to come up with approaches that really achieve what we're trying to.

The initial experience, by the way, with the shift in payment that maybe my colleagues will talk about this, has not been all that positive. Many of the experiences haven't saved very much money so far. I think if there's a message there, it's not that the concept is wrong. It's that it's going to be, as Tom suggested, that we're going to have to evolve this as we go along. We really need to have learning systems just like government learns where we take experiences and then integrate that into our approaches for the future.

It's really important that policy decisions and legislative mandates be based on good data as to what's going on and the impact of current policies. You can't really have good policy and good legislation unless it's based on good assumptions. The way we do that is to look at what's happening, see where we want to be. If we're there, great, but if we're not, then how do we modify things, whether it's policy or legislation, so we can get to where we really want to go. The constant that the students will see when they become practitioners is change. That's a good thing. That's not a bad thing.

Teryl Eisinger:

I think that some of the things that we know from rural physicians in rural communities addressing these things is there needs to be a champion for change. I think the future physicians will be and for collaboration, but I really want to follow up on that whole issue about public policies that need to be changed. Certainly there has to be a vision from the community and from change agents, but Tom, could you talk and Keith too, what can be do in public policies to help rural providers and communities participate in payment changes in a way that enhances their viability and sustainability and ensures essential local services?

Tom Morris:

I think there are some tools already. When they passed the legislation this past year to create the new physician payment system under Medicare they authorized \$20 million in technical assistance, because they realized the challenge that small practices were going to have in adapting to a new way of getting paid, and really a new way of delivering care. The language in the bill actually makes a nod towards

rural and underserved areas. These clinics tend to have less resources available to adapt to these changes. I think that's important, that that recognition was in there. I think Keith could share my thought here. We've seen legislation pass with big changes without any help to get people through that. I think they're starting to realize it, but it's going to be a period of adjustment even beyond that. I think that getting out into practice and trying new approaches towards population health is there's no one single way to do it. There's a lot of different ways to do it. We've been funding a project with Keith's shop for a number of years to help people think about how to adapt these broad national changes to rural communities. I think he can speak a little bit to that.

The other thing is I think that through Kris's work with the Rural Health Information Hub, we're trying to identify those community health projects that really have good outcomes, because I think the great thing about rural, the opportunity they have is they can turn on a dime. They don't have to spend a year in committee deciding whether to do something. They can make that decision as a small organization, try it out, adjust it and keep going. We've seen some real innovation. I think what we need to do is figure out how to better capture all of that and make sure other folks are aware of it. I think the work Keith's done has really helped in that regard too.

Keith Mueller:

Promoting what works is certainly part of the overall strategy of what we need to do. In public policy, a state legislator in Iowa once I thought captured this really well after a daylong session with some people around what could we do telehealth, in telemedicine that really improved health of local populations. His conclusion was the best thing I can do, is get out of the way. What he meant was we have along with that archaic payment system, we've got archaic regulation. We're designed for an era of nowhere near the technology that we're all sitting here with today, with the capabilities that you're learning as you go through the health professions training. Those regulations need to be addressed.

I'll give you one quick example that's in this region, speaking of telehealth, telemedicine, one of the barriers to effective use of that can be if you're trying to work with physicians in one state, but your remote site is in a neighboring state, how do you do that with all the licensing policies and regulations being state specific? The way through that is a multi-state compact. There's recently been developments in our region that has developed the multi-state compact so that now licensing from one state is recognized in another. Those kinds of very specific detail policies do not readily come to the attention of people like Tom in a Federal Office of Rural Health Policy or even me directing a research center. They come from people that are trying out the innovation, trying to do things better and then elevating the specifics that they find so that we can get some of these corrections done in policy.

In addition to those, on a more systemic level at the policy side, Tom touched on something which is also a lot of investment, resources and capital is needed to make some of these shifts. People have talked about for example a Hill-Burton, you wouldn't remember this of course, I barely do ...

Joshua Wynne: I unfortunately do.

Keith Mueller: This was the program that started in the 1950s, went through the early 1970s that gave us a lot of the community hospitals we have around the country. It was a federal investment in that capital infrastructure. We need a similar federal investment in information technology infrastructure now. That's happening. Not at quite that scale, but collaborative work between the USDA Research and Development branch and the Office of the National Coordinator for Health Information Technology and others in HHS are doing that now. They're saying, "How do we take funding from different streams, blend them in a way that creates the investment capital that's needed? How do we do that? How do we address regulatory policy so that it's not standing in the way as roadblocks or barriers?" Then as Tom said, how do we provide specific assistance when that's the appropriate thing to do, to move the ball forward if you will, toward the value system that we need in the future? And yes, work like ours and I appreciate the mentioning of it with the Rural Health Value. That's, by the way, on an easy website, RuralHealthValue.org, is designed to help do that. We're one of the ways, but there are others, the rural resource center, what's done at the information hub that Tom talked about.

Teryl Eisinger: I have a question from the web cast. I appreciate that. We'll do a couple of these and then we'll ask you all in the room to chime in with any questions or comments. This is a great Segway, what priority, what things, should rural healthcare organizations be doing to move themselves into that new system of healthcare moving from volume to value? You're studying this Keith, you've got a robust website. Could you talk about ... What would you say about that?

Keith Mueller: Two streams of activities. One would be internally within your own organization, whether it's a hospital, a clinic, skilled nursing facility, look at your revenue forecast and planning going forward and how that might change under some of these shifts in payment policy so that you're ready for those. By the way, for many of our rural healthcare providers, when they look forward, if you look forward assuming no changes in policy, I'll give you a heads up, it's not a rosy picture.

We're in a situation where we don't want the status quo, but then looking at what happens if we start making some changes in that, there are a couple of tools on our site now that help with that. We're currently developing one that's specifically targeting Critical Access Hospitals and how they need to be thinking of their accounting systems etc. as they move from an entirely cost-based system to a cost-based with a Medicare savings component, perhaps layered in under Accountable Care Organizations, perhaps a little bit of capitation under commercial contracts. How do you change your accounting system internally to do that and how do you change some of the way you manage, if it's a facility, how you manage that? How you manage the process of care internally? If you've got an opportunity to move the dollars around, which is what excites me the most about this. If you've got the opportunity to move the dollars around, you can move them to where you believe

you get the best value not to where some finance system says you get the greatest return on investment by some arbitrary calculation. That's internal.

The other stream is external. All the organizations involved need to be thinking about who else do I need to work with in my community if what I have is an opportunity to achieve population health goals. It's not just the hospital plus the clinicians. Now it's the hospital plus the clinicians plus the public health agency, the area agency on aging, other agencies that we can work with locally. The chamber of commerce because there's an economic development component to this activity. I'm not necessarily saying the hospital's going to be the lead in making all of that happen, but the hospital needs to be looking at what its role is in a new environment with a lot more collaborative activity across agencies in different sectors.

Teryl Eisinger: Which gets us right to the next question from the webcast. They've commented that in order to make progress with improving population health, shouldn't we be looking at social determinants of health such as poverty and housing and education? How can traditional healthcare organizations work on those issues? What do they do?

Tom Morris: I think it's what Keith said. I think the partnerships are key. So many of the things that really drive a lot of our expenditures to use the Dean's example are on the front end of that curve, and they're not necessarily in the clinical area. Does somebody have housing? Does somebody have access to a diet that would support improved health? There's so many things in the human service, social service side that I think healthcare is just now turning to and figuring out how to partner to do that. This whole concept of a high flier, a high utilizer in a health system. You can discharge them, but if they're going back to a bad situation at home it's not going to work. You see a lot of use of community health workers as a way to bridge that gap between what people are seeing in their home environment and then what they're trying to achieve clinically with them in terms of improving health.

The partnership aspect is really important and the whole notion of social determinants of health and thinking much broader than just the healthcare interventions is really going to be the key moving forward. Then also thinking in think in terms of a regional system of care. The days of the solo provider, that may be harder and harder to square in the future. As we think about the fact that people get care in multiple places, how do we create systems that allow the patient information to flow with them and for the group to work as a team towards advantaging those folks' care.

Teryl Eisinger: I think that's what's so great about this work, is that it really does take a focus on community and that collaboration and it does change the way we think about things. How about folks from the room, comments or want to jump in?

Joshua Wynne: I think there are two important points and they may seemingly be contradictory, but I'll try to explain that they're not. The first is that the medical schools and

educational institutions need to be involved and be advocates. On the other hand they need to focus on what they're best at which is education. To have mission creep, if you will, for educational institutions can be fatal, but you have to do both.

The example that I would give is, I mentioned the Association of American Medical Colleges, which is an amalgamation of all the 144 schools of medicine in the United States plus 17 or whatever it is in Canada. We just had our annual meeting and it was in Baltimore. We all know that a lot has transpired in Baltimore over the last little bit and the start of the meeting where all of the deans of all of the medical schools got together in the Council of Deans meeting, we were welcomed by the two deans of the two medical schools in Baltimore, the University of Maryland and Johns Hopkins.

Both of their introductory comments were about community engagement. Of how the school, while staying focused on its educational and research missions had as the third component of the school, of the mission of most medical schools or all medical schools, service. They specifically said our service is focused on advocating for and being involved with our local community. For the University of North Dakota, we say we're a community-based school, that is we don't have our own hospitals. We're a community-based school and our community is all of North Dakota. What those two deans said was what we are, although we are research intensive institutions we're focusing on our community and our community is the Baltimore area. They pledge to not only do the high level of education and research that they were doing, but also to be advocates in their local community for the things that needed to be changed, the social determinants of health if you will, and to work with the local community and being advocates for that. I think both focusing on what you're good at, but not just staying within the ivory towers and actually engaging partners in the community is critical. That's what we try to do and it's clear that's what those two deans were trying to do.

Teryl Eisinger: Excellent. Any thoughts from the room? Yes.

Audience

Member: I think that's a great way that ... I'm going to restructure my question, the comments that Dean Wynne just made. I think that's an excellent thing to hear and I'm going to take that, we're all going to take that as a pledge from our Dean that we're going to do a lot in community engagement, that we're going to pledge advocacy, that we're going to be involved in the social determinants of health in North Dakota. I think there's a lot of cultural transition particularly our very rural communities in the west. That stress is certainly something that is playing out.

My primary question though has to do with just having been involved in a group of folks around the state that's dealing with behavioral health issues. We had this large summit. Part of the issue is this concept of integration between primary care or what we think of as typical cost services in mental health and substance abuse kinds of services. It's very silo-ed and it's not working well for our communities.

We're all talking about the integration, but we're not really getting or seeing at the federal level the kind of way that we can make this happen. Obviously the Affordable Care Act has components that's helping us to think about this and HRSA has talked about this, but what kinds of initiatives do you think the Office of Rural Health Policy folks could be doing to help us to fully begin to integrate the healthcare that includes mental health and substance abuse?

Teryl Eisinger:

Let me repeat your question because I'm not sure the folks on the web cast were able to hear that. That was eloquently put that you've been working with coalitions around the state and you're happy to hear the pledge to community-based work. What you queried the panel about is what can HRSA and the Federal Office of Rural Health Policy do to engage and to ensure the meaningful integration between behavioral health and primary care. We've seen some great examples I think about behavioral health, primary care into behavioral health which is different than we sometimes think about it, but I'd love to hear the panel's reaction to that.

Tom Morris:

I think you've hit the nail right on the head. That's the challenge moving forward. On the micro-level we ran a small grant program for improving quality in Rural Health Clinics and Critical Access Hospitals and Community Health Centers and it used to just be focused on the disease management model. What we heard back from our grantees was one of the reasons we struggle with compliance reduced patients is because they have underlying behavioral health issues. We're getting ready to issue new guidance which will allow them to also bring in a behavioral health component. That's a small way where we're trying to be responsive to it.

I think we've seen a dramatic expansion through the Community Health Center program in terms of adding behavioral health to many of the health centers, which has been great, but not every community has a Community Health Center. What do those places do that don't have that? We've been moving towards parity in terms of reimbursement for a long time, but we've still got a long way to go. I don't have a perfect answer for you. I think you know these issues probably better than I do. I think we're trying to get at it where we can incrementally.

I think the real opportunity down the road lies in looking more broadly at the range of mental health providers. Medicare currently will pay a psychiatrist, a psychologist, a licensed clinical social worker and a psychiatric nurse practitioner, but the pastoral counsels, marriage family therapists, masters trained psychologist, they're not part of that. We know some states will reimburse for those services. One thing might be looking at those states where they are licensed, are we seeing better outcomes because they have a broader set of mental health providers.

Even with that as a possibility to move to down the line, it's still about the integration. The stigma issue is still there and especially in a small town, if you're driving up and you see someone's car in the Community Mental Health Center that can be an issue, whereas if we can integrate it into primary care in a meaningful way not only will we reduce the stigma, but then you really have the potential for that team-based care that really matters. Is somebody struggling with taking their

diabetes med? Maybe they need a consult. Maybe there's a depression going on underlying that. I hear about it all the time, open to solutions and suggestions from anybody, but it's a big problem. It's a particularly big problem in rural communities. Telehealth I think can be a solution, but not in and of itself. It's a tool towards that end.

Teryl Eisinger: Much of that is related we will say, it's about how they pay for it. I want to talk about are there creative designs we should be thinking about in terms of alternative payment programs in rural places? Keith, could you talk about that a little bit?

Keith Mueller: The answer is certainly yes. I don't know what all of those alternative payments designs would be. I do know one of the recommendations that our health panel has made with RUPRI over the last three years now is to move forward with demonstrations of different ideas which was authorized in the ACA for Critical Access Hospitals, but the program has never been funded and therefore executed. We've been saying this for about two and a half years now, that we really need to be trying out some new ideas.

Again, the issue here is, there aren't ideas out there for how you could shift to population-based payment. We've got the state of Maryland for example using a global budgeting strategy for all payers for all of their hospitals, including rural hospitals. That is one demonstration from which we will get some rural lessons. We need that kind of creative demonstration approach done in rural pockets of providers all around the country. We're working a little bit as I mentioned earlier, one of our projects is to examine how Critical Access Hospitals could transition from a payment system that's entirely volume-based and cost-based, per episode payment, to a system that includes a risk sharing for savings against expenditure benchmarks and how do you do that. Hopefully we'll have that product out in a couple of months.

The ideas are I think bubbling up now. There are some hospitals in Iowa that contacted me recently that are looking at the Maryland model and thinking could we do something like that here, but I'd close my answer at the same place I started, which is we need more of those kinds of demonstrations and we need them now to think about what could work.

Teryl Eisinger: Tom, I understand that the National Advisory Committee on Rural Health and Human Services is looking at a broad range of issues including delivery system reform as it relates to rural healthcare. What are they talking about? What are they finding? I'd love to see those reports that come out of that committee. They are powerful and I would encourage you to check those out and read them. I needed to just give you a little plug there. They're fascinating, well done.

Tom Morris: This is an advisory committee that makes recommendations to the Secretary of HHS on rural issues. We recently had a meeting in September in Minnesota on the White Earth Nation to talk about delivery system reform. We actually visited a couple of Medicaid ACOs that the state of Minnesota is running and got to see folks that are

really embodying, I think a lot of what Keith was talking about, trying out new things through a grant program called the State Innovation Model.

I think what the Committee came down on is that there probably are varying degrees of risk that rural systems could take on. There is a sector of hospitals and clinics that are high performing and probably ready to take on a higher degree of risk and we should try out things with that cohort. There is a middle group that I think perhaps would like to, but still is at risk financially. We need to be really careful about working with them, but we don't want to preclude them from participation. Then there's another cohort that's really struggling financially. We've had more than 50, I think 57 rural hospitals close over the last few years.

There's no one size fits all when it comes to thinking about innovation in rural communities. I think our challenge is taking that high performing cohort, testing things out, working a little bit with that middle cohort. The Committee's going to make recommendations towards that in its report. The other thing that they felt a lot of alignment with was, if you're talking about moving towards quality and towards outcomes focused care you've got to figure out how you're going to measure it. Measuring quality in rural settings is a little bit more challenging because of volume.

The National Quality Forum recently released a report that looked at some of those issues related to quality measurement in low volume settings. The committee felt that the recommendations that the National Quality Forum put forth really made a lot of sense. Maybe looking at measures that are specific to rural that really emphasize the way they provide care; that it's often in transition from one setting to another. The other thing they talked about was having a glide path into value-based payment without as much risk. It's not like all of a sudden they're at risk of losing payment if their score dips one year.

I think what they're going to recommend is a multiple avenue approach to let rural providers be part of it, without as much of the risk as say some of the urban providers have. I think that's just an opening salvo. I would encourage all of the folks, the students here to take a look at that National Quality Forum report because it highlights the issues and they're not going away. You've got to take into account that you can't measure quality the same in a Critical Access Hospital with an average daily census of three, as you would say in a hospital where I live in suburban Maryland. Our tendency with public policy is to do one size fits all and that's not going to work here. They need to hear from rural providers, rural communities about what methods work and then test those things out and make sure they work. That's the gist of the committee's recommendation.

Joshua Wynne:

I want to ask my colleagues a question to go back to a couple of things they said before and to try to integrate the question about public policy along with technology. The specific question relates to the electronic health records which particularly for rural communities arguably would be particularly important where communicating with other systems would be vital just because of the location

factors. The so-called interoperability, the ability of different systems to talk to each other, has not been ideal. We in North Dakota are trying to take specific steps within the state, but my questions for both of you is what can be done from a national policy point of view to try to speed up the roadblocks in true interoperability which I think for most providers does not exist today. Comments about that.

Tom Morris: I like my job, so I can't ...

Joshua Wynne: I didn't say the questions would be easy.

Keith Mueller: The traditional role would be for an office like the Office of the National Coordinator to basically throw out a lot of resources to see the efforts like you just alluded to here in North Dakota. I was heavily involved in one in Nebraska before I moved to Iowa a few years ago. I think at the state level we have a better chance of addressing interoperability because we've got a little bit more regulatory authority. I know for many providers and future providers it's hard to believe somebody has more regulatory authority than the feds do because we hear so much about theirs, but it's true. The state level has a lot more licensing and regulatory authority. It can do a lot more actually, but it doesn't always have the resources or the knowledge base. That's where the National Office should play and has played a role. Whether it's played it optimally, I think there's a lot of debate, but it has played some role in that.

The other piece is what is happening commercially. Again, in terms of public policy it's how you try to seed that, but with the move toward larger and larger healthcare systems I think we're getting the more natural occurrence of interoperability because we're getting it at least within a system. Then the systems are realizing they need to do it at least on a health information exchange level across each other. The capital and the ability are there for them to do that. How does that affect rural? In large sections of the country including where I'm from south of here in Iowa very much because almost all of our community providers are linked in some way with one of those systems or are benefiting from the systems saying, "We really need this. We'll cover some of the capital costs and operating costs of installation." and making that work.

The public policy roles I've just described, it is really quite minimal in this particular arena. It's got to be the seed resources and paying attention to the regulatory policies much like that representative from Iowa I alluded to earlier said, "Stay out of the way" and make sure that the systems that really are moving this can get the job done.

Tom Morris: I think one thing I'd add is that this is an issue we're concerned about as part of the Federal Office of Rural Health Policy. When we try to get a sense of what's going on out there it's so mixed. There are some states where they set up a fairly robust health information exchange and it's working exactly the way we envisioned it. Other places where it hasn't worked so well and you may go through three or four

exchanges and get a fee each time before you can get that record transferred to where it needs to go. It will be a challenge moving forward.

I think what we're going to have to do is do all we can to make sure that the State Health Information Exchanges that are up, are operational. I think we're doing what we can to set standards for when you purchase an EHR, that it has the capability to do that exchange. As you know, the vendor market out there is quite volatile. We have some hospitals that have bought EHRs and that company no longer exists. It may or may not be compliant with the next stage of requirements.

It's just going to take a little bit of a while to sort through all of it, but it will be an ongoing public policy challenge for us. It's embedded in the delivery system reform framework that we talked about at the beginning of this. From an HHS perspective we want to do all we can because we can't get to that value focused goal if we don't have a robust ability to share information across clinical settings, but it's not going to be without its bumps along the way.

Joshua Wynne: Thank you both for your comments because, pardon me again, as a clinician who spends a little of my time taking care of patients, it's difficult to reduce duplication of services if you don't have pretty instant access to what has been done before or recently. If you don't have a seamless access to it you often end up repeating something that you really don't want to do, but you can't get the data. That's one of the reasons why I asked that. That would be particularly important in a rural community where instant access to other colleagues is not available.

Teryl Eisinger: Certainly. I think one of the challenges with this issue is, are there resources available to support those small rural providers around the country who really must be able to make the link with their electronic health records and other data. I know there have been some valiant efforts that way and I know also that there are resources being developed around delivery system reform in general. I'm hoping that the panel would be able to address where people could find resources and information and tools that help them design and evaluate delivery system reform options. Lots out there to talk about, certainly the Rural Health Information Hub.

Tom Morris: That's where I'd start. I think if you're at the beginning of this journey, on this move towards value, I think if you look at a lot of the things that are on the Rural Health Information Hub, specifically around the Rural Community Health Gateway, there's toolkits on care coordination, on integrating behavioral health. Those are really good resources because they're a part how-to manual, they're an evaluation of our past projects that have been funded in that area, and there's a literature review too. You get a lot in one place. That can help you along that continuum.

We developed those toolkits specifically because, what we'd like to do is help folks understand what's already been done, and if they want to come in for funding through my office or anybody else, maybe they can use that tool kit as part of the reason to get there. If you're a little further along on the journey then I think some

of the tools that Keith's shop is offering are an opportunity to get there. He can comment a little bit on some of that.

Then, just in terms of the resources, we have roughly \$59 million in community-based grants we put out each year. We're really trying to align all those towards what we're talking about today, where healthcare's going with the idea being that we can then help people along that journey.

We also invest \$40 million with states to work with small rural hospitals. Again, we want to keep that aligned with this whole motion of moving towards quality. But on the HIT side USDA has funding that can support broadband, they have telemedicine funding. We have some telemedicine funding. The FCC runs a program that ostensibly can reduce transmission rates for rural healthcare providers. There are resources out there. There's no one program you can apply to that's going to address all of these challenges, but there are resources. That's one reason that we're so happy about the resource Keith runs, but also the Rural Health Information Hub because we're trying to make it easier for folks to get access to that information.

Keith Mueller:

Thanks for the question. Certainly the Rural Health Value Project which is what Tom was just alluding to and I alluded to it earlier and it's RuralHealthValue.org contains the kinds of tools that help people who are in organizations that are making the move, that want to know more precisely how to do things. A care coordination toolkit on our site will look different than on the Hub site because ours is based on what we learned working with someone who's already doing it and learning from them and then building that into a toolkit for someone else who's at that phase of implementation or just beyond implementation.

The site also includes examples of innovation around the country with contact information. If you want to know who else is doing this there are ways to get at that both on our site and the Hub site. There are ways to get at some other toolkits particularly with the hospital focus from the Rural Health Resource Center that's done a lot of work, particularly for Critical Access Hospitals. The National Opinion Resource Center has some toolkits available off of their site.

In the policy arena, I would send you to our site for a starting point, the RUPRI.org and go to the health panel's work. One of the documents that I should mention that's on there deals with the concept of Accountable Care Communities and has examples of rural places where they've done this coalition mutual governance across agencies merging funding streams. We did that in collaboration between our health and human services panels. Those are all resources. I would add to Tom's litany of federal resources by encouraging you to also look to local and regional philanthropies, foundations, who are interested in what happens in the community. They are the ones who could be funding sources for a lot of that interagency new activity on behalf of population health. I would be sure to throw them into the mix.

Joshua Wynne: We only have a couple of minutes left. Maybe could we open it up to people here in the audience for any questions you might have.

Audience Member:

My name is Colin Combs and I am the Director of Basic Sciences. I would like to share with this panel that one of the outstanding things we did was introduced the concept of population health and social determinants of health in our curriculum, and that was a watershed moment for curriculum. I am very proud of the team. Again, I would like to take you back to history. In 1978 there was a comprehensive primary healthcare conference in Alma-Ata, and one of the outstanding statesmen of this country, Senator Edward Kennedy visited that conference. That was the moment when the idea of comprehensive primary healthcare was fermented. And in many countries, I'm not talking about the Nordic countries, but many European countries and also Canada and in many developing countries the idea has been incorporated for a long time. I'm curious why it took more than two decades for the United States to get those ideas introduced in the curriculum, I'm just curious. And still some faculty do not feel comfortable introducing those ideas, system thinking in the curriculum, which I see a very important element in the training of the health professionals. What's your thoughts?

Teryl Eisinger: Let's repeat that question for the web cast, very briefly, and the fact that this is actually the dean's hour which we have about two minutes left to answer that question. That is why do we see efforts on comprehensive primary care like we've seen from Senator Ted Kennedy and it seems to be happening internationally and a quick comment about that in the United States and then we'll have a couple of closing remarks.

Keith Mueller: I can't resist Winston Churchill's quote. You can count on the U.S. to do the right thing after it tries everything else first. That really does explain a lot.

Joshua Wynne: What I would say, one of the things is because these are actually hard things. They're not easy. It's easy to do easy things. It's harder to do hard things, but that doesn't mean we shouldn't try and that doesn't mean that we should shy away from them. They really are important, but they're not easy. That's precisely why we need to focus on them.

Teryl Eisinger: Thank you Dean Wynne. Thanks to Keith and to Tom. Just a quick reminder that other resources available to you around the country in every state, there's the State Office of Rural Health. They are working to provide technical assistance and to provide resources as this delivery system reform unrolls. I hope that you know that you have a friend in state or university or a non-profit organization that's dedicated to helping you with that work. Throughout the rest of today you can see some of that difficult work and how it's being addressed when we have our webinar with the White House Rural Council. They've led some rural philanthropy efforts that Keith and Tom have been a part of.

We'll be visiting the Veterans' Administration Primary Care Community-based Outreach Clinic and learning about the needs of the veterans. We'll also be having a

webinar about the partnerships that are available from national organizations such as the National Rural Health Association, the National Cooperative of Health Networks, the National Recruitment and Retention Network talking about advocacy and collaboration and building that work together. We hope that you'll join us the rest of the day. For those of you in the room we'll have to go back to class. We wish you all a happy National Rural Health Day.

Joshua Wynne:

I'd like to thank all of my colleagues for participating on the panel. Here's a shout out for what's coming at future Dean's Hour. They will address many of the things that we've been discussing today. Over the next six months we have six wonderful speakers coming in. On December 10th we have Professor Dean Smith, Dean Dean Smith, formerly of the University of Michigan, now at Louisiana State, who is going to be talking about value-based purchasing. In January, Richard Derman of Thomas Jefferson who's going to be talking about global health and especially delivery of health in challenged areas.

In February we have one of the world's most renowned health economists Mark Pauly from the Wharton School coming here who'll be talking about future changes in reimbursement. Lloyd Michener of Duke University is coming in March who is a strong advocate of community engagement and the social determinants of health and will describe what they've done in Durham to address some of these issues.

Timothy Henry, a graduate of our school, is coming in April to discuss modern cardiac care with the particular challenge of what do you do when a someone has a heart attack in a rural community and the nearest cat lab is in Minot. What do you do with that?

Then we'll finish off this year's dean's hours with David Blumenthal, president of the Commonwealth Fund who's going to opine on a number of things, but not the least of which will be the IT question since he had been the IT guru for the Federal Government for a good number of years. If all of your questions were not answered today, I guarantee they will be over the next six months. Thanks very much for coming out and thanks to my colleagues.