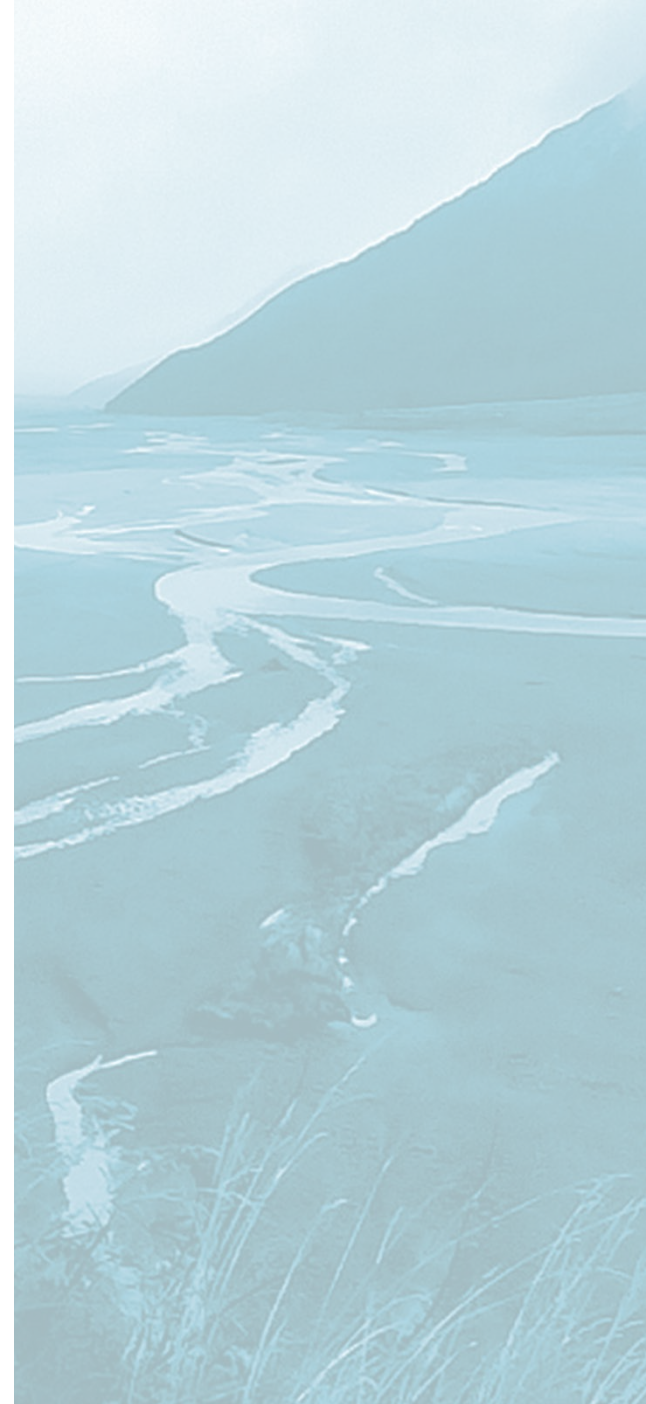


Rethinking Value-Based Payment and Care in the Rural Ambulatory Safety Net

Recommendations for Policymakers
and Funders

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About the Delta Center

The Delta Center for a Thriving Safety Net provides technical assistance to state primary care associations and state behavioral health associations to build a stronger safety net, particularly in ambulatory care settings. Support for the Delta Center is provided by the Robert Wood Johnson Foundation (RWJF).

The Delta Center is led by JSI Research & Training, Inc. (JSI) in partnership with the MacColl Center for Health Care Innovation at Kaiser Permanente, the Center for Care Innovations (CCI), the National Council for Behavioral Health (NCBH), and the National Association of Community Health Centers (NACHC).

Executive Summary

Advancing payment and delivery reform in the ambulatory safety net in rural areas presents unique challenges and will require solutions specific to this context, for both primary care and behavioral health. The Robert Wood Johnson Foundation (RWJF) sponsored the Delta Center to conduct an environmental scan about how to best advance value-based payment and care (VBP/C) in rural areas.

For this environmental scan, JSI Research & Training, Inc. (JSI) reviewed 39 peer-reviewed journal articles and gray literature on rural health research and resource centers, and conducted key informant interviews with over 15 rural health experts and providers at rural health “bright spots.” This executive summary accompanies a slide deck that summarizes the environmental scan findings for state and local policymakers and foundations/funders. It first describes the current status and issues for the ambulatory safety net (community health centers and behavioral health organizations) in terms of payment and delivery transformation in rural areas. It then identifies potential high impact opportunities for policymakers and funders to advance rural safety net delivery and payment transformation.

Key Takeaways

1. Overall, rural residency is associated with significant health disparities, which are exacerbated by significant barriers to healthcare access. Compared to individuals residing in urban areas, rural Americans have higher rates of morbidity and mortality related to both physical and behavioral health conditions — the opioid and suicide epidemics being two poignant examples. Increased access to healthcare in rural areas is urgently needed to address these health disparities, but rural residents currently face major barriers to care. Rural residents are more likely to be uninsured, and have less benefits when they are insured, which leads to reduced ability to get care and pay for it. Rural residents also have less ability to obtain care when needed due to shortages of primary care and particularly behavioral health providers, and the need to travel long distances when seeking care, often without a means of affordable transportation.

2. There is a need to “rethink” VBP/C in rural areas to acknowledge the primacy of maintaining access to care. Rural contexts violate many of the premises of VBP/C, which assumes adequate patient volume, data and IT infrastructure, and workforce to provide better access to ambulatory care, care management, and delegation of financial risk, all of which could lead to reduced total cost of care. Rural practices also often operate on thin financial margins, which can make investing in additional services and taking on financial risk infeasible. Maintaining or increasing current spending on the overall rural health infrastructure may need to be conceived of as a “public good,” even if it is inefficient. Ultimately, VBP/C in rural areas may need to emphasize more investment in ambulatory care and improving outcomes while maintaining critical access to care with less focus on assuming reductions in total costs.

Key Takeaways (cont.)

3. Rural primary care and behavioral health providers face challenges to participating in VBP/C due to challenges of underfunding, lack of data and IT infrastructure, workforce, stigma related to seeking preventative care and treatment for behavioral health, and the policy environment.

Rural safety-net providers across the board report challenges with underfunding. Behavioral health providers face the particular challenge of the limited block grant dollars and lack of prospective payment system (PPS) rates that are available to health centers. These funding barriers have prevented many community behavioral health organizations from expanding services to populations beyond individuals suffering from serious and persistent

mental illness (SPMI). Providers face challenges with data and IT due to a lack of broadband services, investment capital to implement electronic health records, and analytic workforce to translate data into actionable information. Workforce issues include a lack of policy and payer support for funding care management/coordination staff, the financial difficulty of sending limited staff for training, trouble attracting and retaining clinical and administrative skilled workforce, and provider burnout. Culturally, in many rural communities there is pervasive stigma with seeking preventative care and treatment for behavioral health, including mental health and substance use.

Key Takeaways (cont.)

4. The literature and expert interviews offer potential solutions for policymakers to consider to address challenges faced by rural providers.

Examples include: pooling resources across providers to achieve economies of scale; encouraging local hospitals to share and pay for an extension of their electronic health record (EHR) systems to ambulatory care providers; utilizing telehealth when possible to mitigate rural workforce scarcity; implementing programs and campaigns in rural areas aimed at reducing stigma, particularly for mental health and substance abuse; and promoting policies that result in more similar rates paid to rural and urban providers. The appendices include examples of states that have taken advantage of their state policy environments to advance VBP/C in various ways, including participating in state Medicaid accountable care organizations.

5. There are opportunities for RWJF and other funders to promote understanding and testing of novel approaches to advance rural safety net participation in VBP/C.

Recommendations include: funding research to articulate the value of rural providers that can be used to negotiate with payers; conducting exploratory research to create an all-payer Federally Qualified Health Clinic/Certified Community Behavioral Health Clinic (FQHC/CCBHC) payment demonstration; convening key funders investing in rural communities to share best practices; creating grant opportunities for rural communities to blend public funding programs; and funding the development/scaling of rural programs to reduce stigma of substance use and SPMI.

Purpose of Rural Scan

Advancing payment and delivery reform in the ambulatory safety net in rural areas presents unique challenges and will require solutions specific to this context, for both primary care and behavioral health. RWJF sponsored the Delta Center to conduct an environmental scan about how to best advance value-based payment and care (VBP/C) in rural areas.

This slide deck summarizes the environmental scan findings for **state and local policymakers** and **foundations/funders** on:

1. The current status and issues for the ambulatory safety net (community health centers and behavioral health organizations) in terms of payment and delivery transformation in rural areas
2. Potential high impact opportunities for policymakers and funders to advance rural safety net delivery and payment transformation

Rural Scan Overview

- 1. Methods**
- 2. Current Status of the Rural Safety Net**
 - Rural Demographics and Disparities
 - Rural Ambulatory Care and Payment Reform Landscape
- 3. Findings Regarding Advancing VBP/C in the Rural Areas**
 - Rethinking VBP in Rural Areas
 - Challenges in Rural Communities
- 4. Potential High-Impact Opportunities**
 - Recommendations for Policymakers and Funders
- 5. Key Takeaways**
- 6. Appendices**

Rural Scan Methods

- Environmental scan
 - Conducted search on PubMed and Google
 - Reviewed 39 peer reviewed journal articles, gray literature, rural health research and resource centers (see Appendix D)
- Key informant interviews
 - Snowball sampling, rural health experts and providers (see Appendix C)
 - 12 60-minute interviews using a discussion guide focused on key issues and recommendations
- State primary care and behavioral health association proposal content regarding rural related activities

Scan Search Terms:
payment reform, rural primary care, rural behavioral health, rural substance abuse, rural health, rural health reform, and rural quality measures; included sources recommended by key informants



Findings Regarding Advancing VBP/C in the Rural Areas

Defining “Rural”

Multiple definitions are available; the Delta Center uses the definition from the Federal Office of Rural Health Policy

- **Rural - less than ~35** people per square mile (18% of population)¹
- **Frontier - less than ~7** people per square mile (3% of population)¹



Rural Demographics

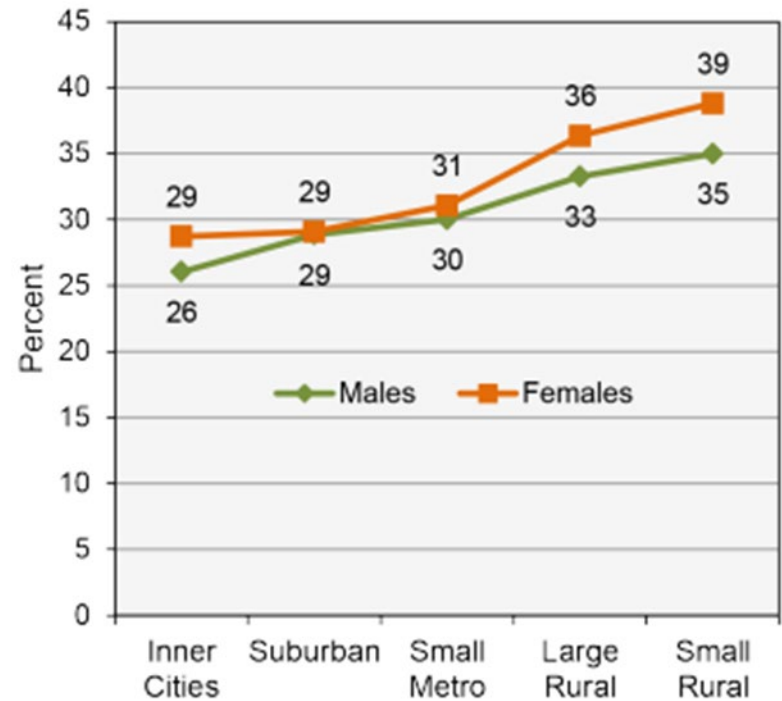
- Compared to non-rural areas, people in rural/frontier areas differ from urban residents
 - Demographics & Socioeconomic Status:²
 - Older
 - Lower incomes
 - Higher unemployment and poverty rates
 - Lower educational attainment
 - Insurance Coverage:³
 - Greater percentage of uninsured
 - Less access to affordable insurance and worse benefits
 - More likely to be on Medicaid
 - More likely to fall into Medicaid coverage gap in non-expansion states³

Rural Health Disparities: Morbidity

Higher rates of:

- Obesity⁴
- Chronic conditions (diabetes, heart disease)⁴
- Toxic stress and trauma among children⁵
- Risky behaviors (alcohol, tobacco, inactivity)²

Exhibit 3. Obesity among persons 18 years of age and over by sex and rural/urban status categories: United States, 2010-2011



SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Rural Health Disparities: Mortality

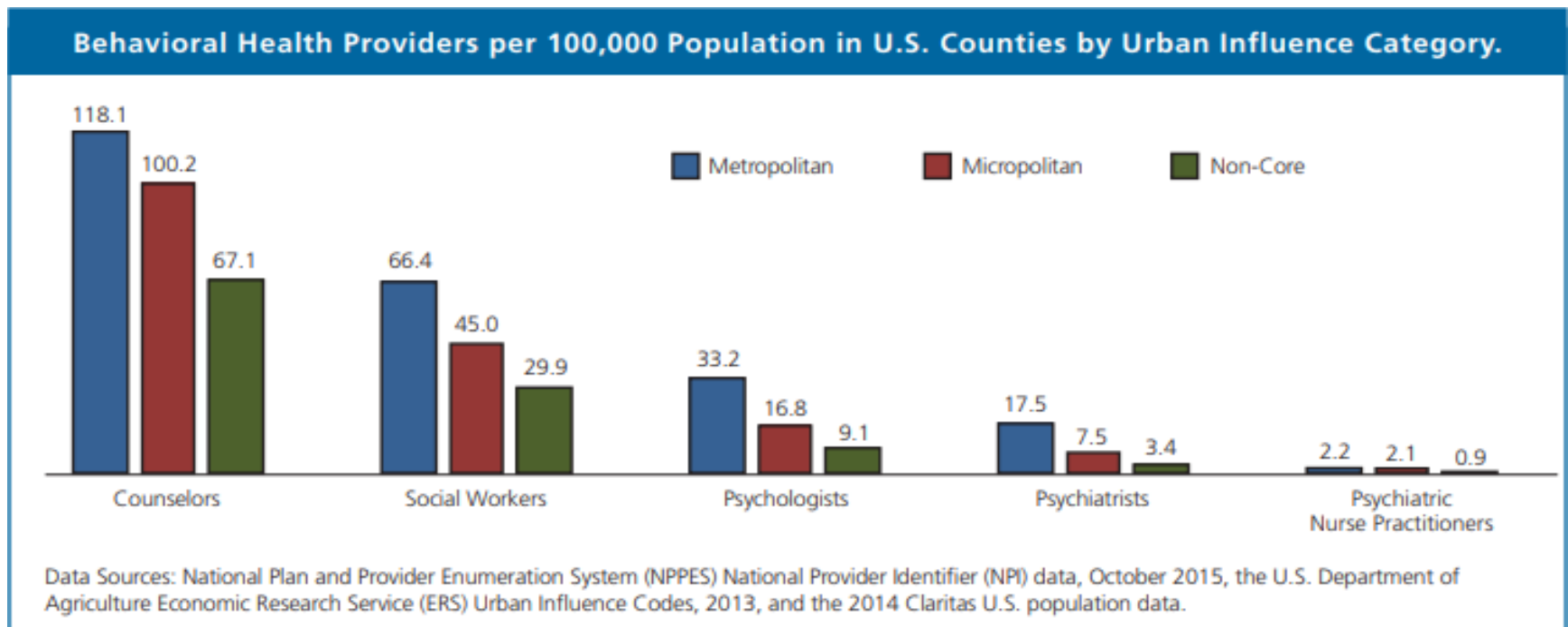
Rural suicide rates are nearly double those of **urban areas**
(19.93 and 10.31 per 100,000 people respectively)



- Higher rates of:⁴
 - Infant mortality
 - Suicide
 - Opioid overdose

Rural Health Care Disparities

- Less accessibility⁶ (ability to get to care and pay for it when needed) and availability (health care available when you are)⁷



Rural Ambulatory Care Landscape

There is a different mix of provider types in rural areas than urban, and fewer health resources available overall.²

Hospitals	Systems of Care	Preventive, Primary & Behavioral Health Care Providers
<ul style="list-style-type: none">• Critical access hospitals• Small, rural non-critical access hospitals (acute care hospitals)	<ul style="list-style-type: none">• Indian Health Services• Veterans Administration• Healthcare in criminal justice systems• Federally Qualified health centers (FQHCs)• Private providers	<ul style="list-style-type: none">• Rural health centers• School-based health centers• County health departments/districts• Community Behavioral Health Clinics• Crisis Centers

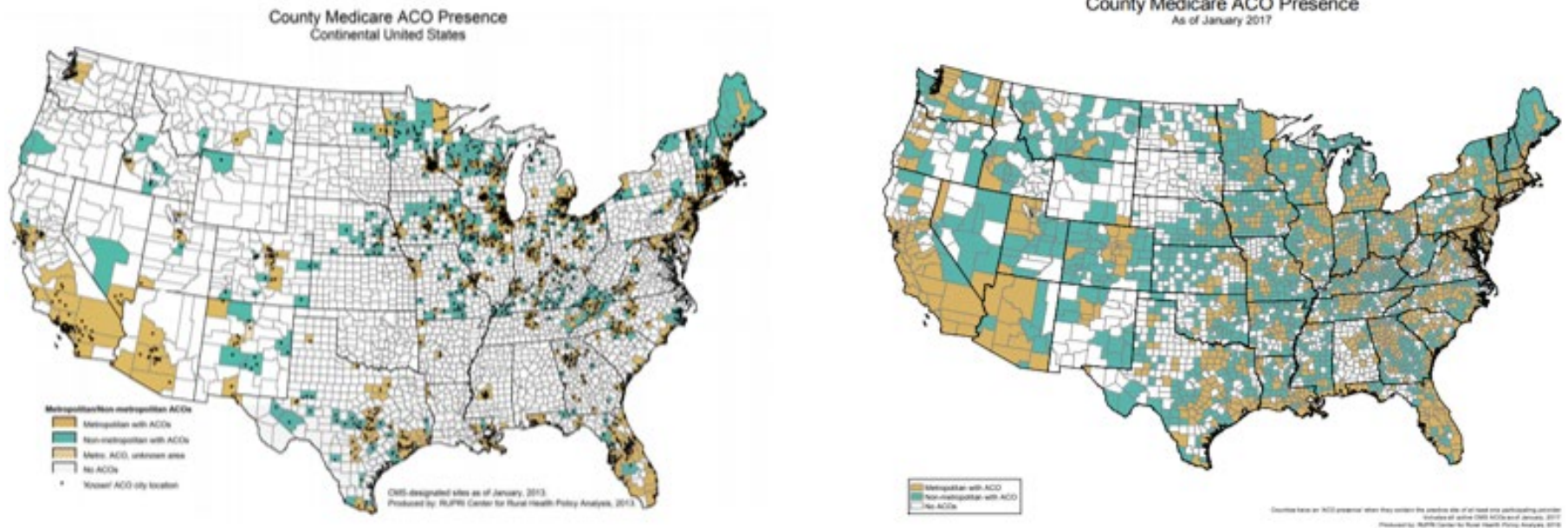
Payment and delivery systems need to be tailored to this care landscape in order to be effective.

Rural Payment Reform Landscape

- Payment reform is taking place through Medicare ACOs, Medicare Advantage, Medicare shared savings, 2703 SPAs, and others embedded in 1115 waivers (see Appendix A)
- Payment reform is occurring in rural areas, though at a lesser rate than in urban areas

Growth in Rural ACO Providers, 2013-2017:

● Metropolitan with ACOs ● Non-metropolitan with ACOs ○ No ACOs



The Need to Rethink VBP in Rural Areas

- Risk-based VBP can be challenging in rural areas due to low patient volume, lack of infrastructure for data and IT, and infeasibility of increasing provider organization size through mergers to take on additional risk
- Rural practices are often operating on thinner margins and are risk-averse to any change (particularly FQHCs are protective of PPS) that might compromise their slim financial operating margins and push them into unsustainability
- The notion of VBP resulting in lower TCOC may not be applicable in rural areas where access depends on maintaining or increasing current spending on the overall rural health infrastructure

The Need to Rethink VBP in Rural Areas (cont.)

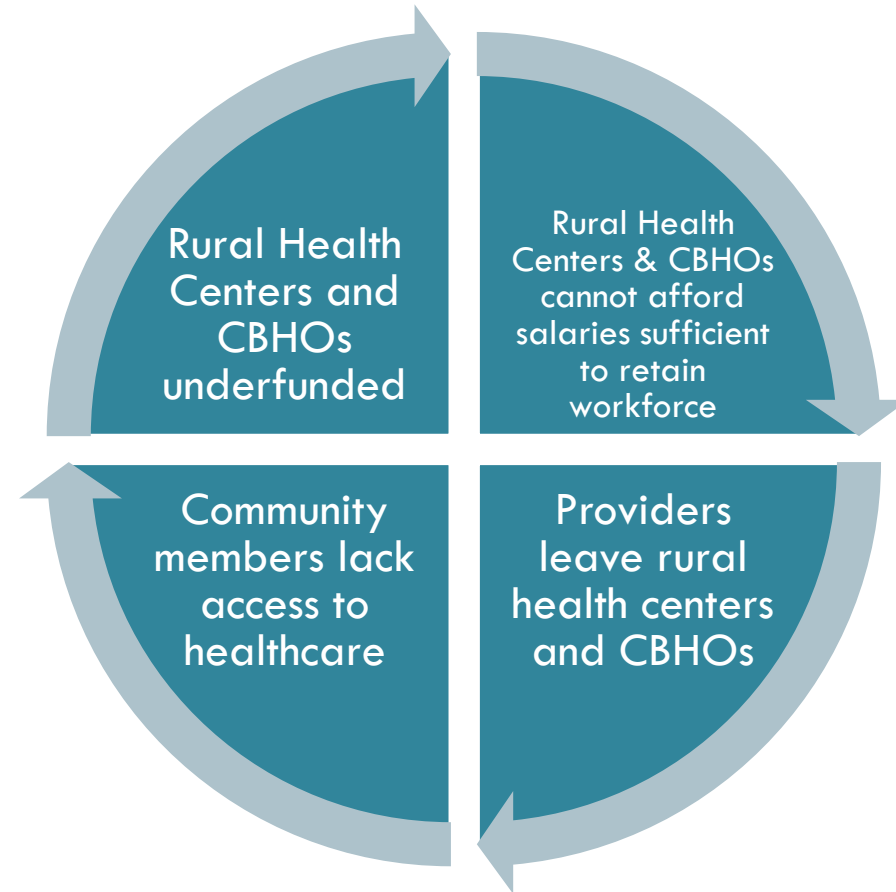
- Having sufficient health system infrastructure in rural areas is a public good, which may require higher spending to offer access to care and comprehensive services than in urban areas
- Though VBP/C should continue to focus on improving and incentivizing quality outcomes, it should be recognized that low patient volume results in erratic variation in quality measures, and rural practices will require more latitude in receiving quality-related payment bonuses
- Supplemental payments that invest in high-value services that are not currently reimbursed (e.g., care management) and performance-based payments for improving quality can meet the need for sustained or additional investment in rural areas and can have valuable economic benefits for rural communities by supporting jobs and reducing out-migration

Rural Primary Care and Behavioral Health Challenges

1. Underfunding
2. IT infrastructure and data metrics challenges
3. Workforce challenges
4. Cultural barriers
5. Policy environment challenges

Challenge #1: Underfunding

- Underfunding creates a vicious cycle for rural health centers and CBHOs and their communities
- Reasons for underfunding:
 - Fewer residents have health insurance
 - Due to small size, rural provider organizations may have limited ability to negotiate with health plans
 - Block granting of mental health has focused services on serious and persistent mental illness (SPMI) to the exclusion of other groups needing BH services



Challenge #2:

IT Infrastructure and Data Metrics

- Limited broadband in rural areas
- Lack of reliable data related to diagnostic and CPT coding
- Lack of funds to hire “high-cost vendors” to retrieve data from IT systems, data analytics, or data reporting
- Perceived lack of ROI for investing in EHR systems
- In BH, there is uncertainty about measuring basic costs of care and population health measurement

Challenge #3: Workforce

- Recruitment and retention, particularly related to specialists e.g., psychiatrists, pediatric psychiatrists, addiction specialists, and OB GYNs, can be difficult with lower salaries and fewer opportunities for their families
- Professional training opportunities (e.g., medical residencies) are scarce; the limited existing workforce also makes it more difficult to take providers “offline” for training
- Workforce challenges are not limited to provider workforce

Challenge #3: Workforce (cont.)

- Low cost staff (e.g., care coordinators) often face unique challenges related to training and licensure/credentialing
- High-skilled workforce (e.g., finance, accounting, IT) can be difficult to recruit and retain
- Burnout from providers who are expected to work at multiple sites 1-2 hours apart from each other while ‘wearing multiple hats’ may not have capacity to take on care and payment transformation efforts

Challenge #4: Cultural Barriers

- Lack of perceived need by community members for preventative care in many rural communities
- Reluctance to visit FQHCs, specifically, because of perceived stigma around being low-income in rural areas
- A stronger reluctance to access BH treatment due to a pervasive stigma surrounding behavioral health issues
- “If we build it, they won’t come:” Providers reluctant to provide additional services because they believe that stigma will keep many patients from accessing it
- Patients treated for mental health crises in jail contend with stigma of mental illness and incarceration, which can reduce their access to care when released

Challenge #5: Policy Environment

- Largely rural states are more likely to have not expanded Medicaid, and are forgoing an influx of Medicaid funding (and accompanying economic development and access to care)
- Regulatory barriers can make care and payment more challenging (e.g., telehealth regulatory barriers) and some states have regulations preventing providers from billing for primary care and behavioral health visits on the same day
- States with a smaller population of rural residents may be more likely to leave out rural implications in policy making
- Rural areas are less likely to be included in federal payment demonstrations, which tend to focus on large-scale, urban areas. This also results in less research/literature about rural areas (See Appendix for maps).



Potential High-Impact Opportunities

Recommendations for Policymakers and Funders

Potential Policy Solutions #1: Underfunding

- Push for all-payer payment reforms in rural areas to prevent fracturing incentives across payer populations
- Work with provider groups to develop their value proposition to strengthen their position in negotiations with health plans, state Medicaid agencies, and legislators
- Incentivize the formation of provider-led independent practice associations (IPAs) or clinically integrated networks to pool resources across providers to achieve economies of scale to allow systemic/infrastructure investments
- Consistent with recent CMS policy, address disparity in rural vs. urban wage index values as a means of improving payment rates in rural areas

Potential Policy Solutions #2:

IT Infrastructure and Data Metrics

- Encourage and support rural providers to collect and store data (e.g., coding, filing claims) more consistently
- Highlight rural-sensitive quality measures for BH and PC (currently PC measures are being developed by an NQF workgroup)
- Engage health plans around improving data collection and sharing
- Convince local hospitals, where possible, to share and pay for an extension of their EHR systems to ambulatory care providers

Potential Policy Solutions #3: Workforce

- Encourage Medicaid agencies and managed care plans to provide funding for care management and coordination staff, including non-licensed, lower cost staff
- Utilize telehealth when possible to take advantage of urban workforce and mitigate rural scarcity
- Maximize workforce/skills trainings that can happen on the ground/in the practice (e.g., demonstrations, pilots, and in-house training rather than learning communities or trainings that require travel)

Potential Policy Solutions #3: Workforce (cont.)

- Provide scholarships and backfilling funding, such as through NHCS and state loan repayment programs, to support professional training opportunities
- Pursue strategies to reduce workforce burden/burnout, such as advancing high performance work systems
- Any workforce strategy will also be an economic development strategy in a rural community where jobs are scarce and the healthcare industry is a major employer

Potential Policy Solutions #4:

Cultural Barriers

Reduce stigma of accessing behavioral health treatment, reduce discrimination against persons with behavioral health issues, and promote preventive care through multi-sector community awareness building efforts by:

- Building on cultural values of self-reliance and social cohesion in small communities
- Engaging with local community leaders, businesses, criminal justice, and social service organizations
- Providing training in businesses, schools, and healthcare organizations, with speakers to share personal stories and support resources and interactive discussion
- Implementing programs and campaigns aimed at reducing stigma (e.g., Project Lazarus)

Potential Policy Solutions #5: Policy Environment

1. To reduce rural underfunding, promote policies requiring payers to offer the same or higher rates for rural providers compared to urban providers
2. To address rural workforce shortages, reduce regulatory barriers related to telehealth
3. Actively encourage rural demonstrations for payment reform, with the rural VBP considerations mentioned earlier

Future Opportunities for RWJF and Other Funders to Advance Rural Safety Net Transformation

- Fund research articulating the value of rural primary care and behavioral health safety net providers that can be used to negotiate with payers
- Convene key funders investing in rural communities to share best practices and successes
- Conduct exploratory research with NACHC, NCBH, and Medicare to craft an all-payer FQHC/CCBHC payment demonstration similar to Comprehensive Primary Care Plus and Primary Care First
- Create a grant opportunity for rural communities to blend multiple public funding streams with the goal of improving health outcomes
- Fund development/scaling of rural programs to reduce stigma of substance abuse/SPMI

Key Takeaways

1. Overall, rural residency is associated with significant health disparities, which are exacerbated by significant barriers to healthcare access.
2. There is a need to “rethink” VBP/C in rural areas to acknowledge the primacy of maintaining access to care.
3. Rural primary care and behavioral health providers face challenges to participating in VBP/C due to challenges of underfunding, lack of IT infrastructure and data for VBP/C, workforce, and stigma related to seeking preventative care and treatment for behavioral health.
4. The literature and expert interviews offer potential solutions to challenges related to participation in VBP/C with regard to underfunding, IT infrastructure and data metrics, workforce, cultural barriers, and policy.
5. There are opportunities for RWJF and other funders to promote understanding and testing of novel approaches to advance VBP/C in the rural ambulatory care safety net.

Appendices

- A. Policy Context
- B. Interviewees
- C. National Rural Organizations
- D. References

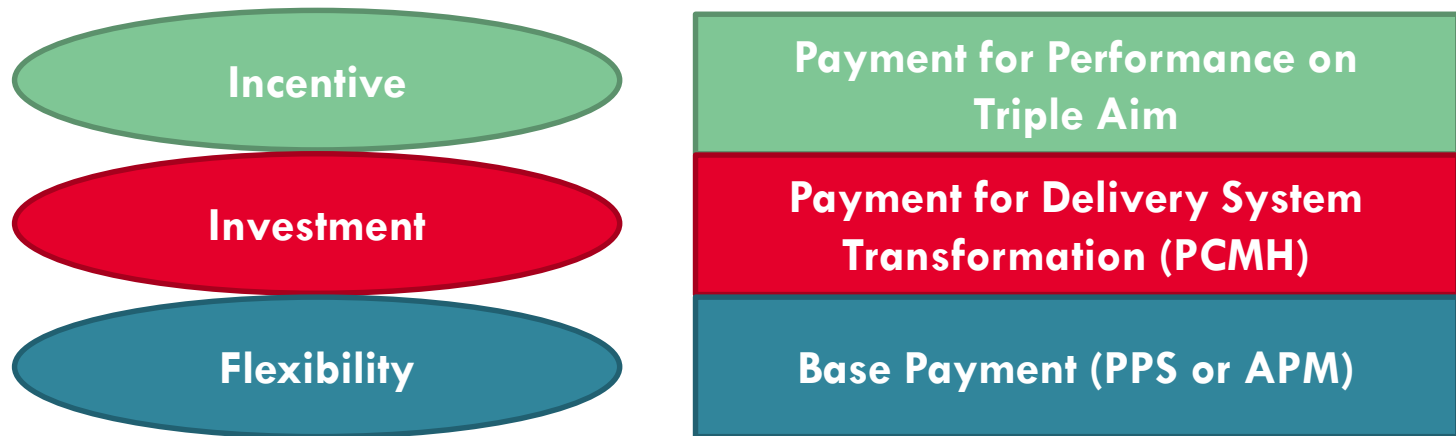


Appendix A

Policy Context

Overview of Payment and Delivery Reform

- Overview of 3-Layer Payment Model



- Though developed for primary care, this model is also relevant to ambulatory behavioral health

Payment and Delivery Reform Landscape

- Federal Policy
- State-Level Initiatives with Federal Funding:
 - 2703 SPA for Primary Care
 - 2703 SPA for Behavioral Health
 - Medicaid waivers
 - Medicaid ACOs
 - CCBHCs
 - FQHCs with Proposed APM PMPM
- State-Level Policy
- Summary of Payment and Delivery Landscape

Landscape: Federal Policy

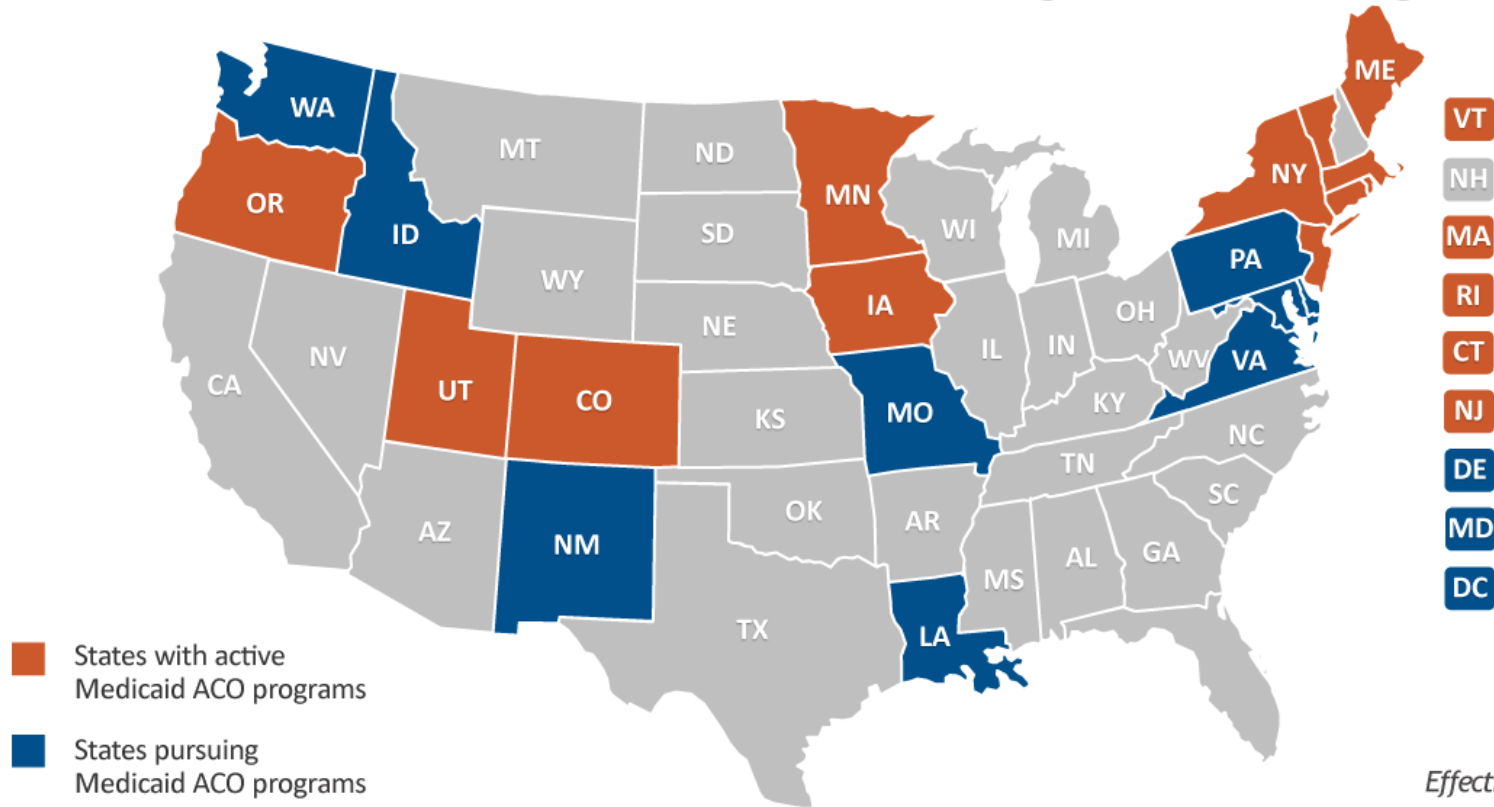
- Federal payment reform has largely focused on urban areas and providers groups with large scale
- CMS has announced its intentions to specifically evaluate the impact of its policy changes on rural areas
- Some federal programs, such as Medicare and the VA, are important to rural ambulatory care and therefore their policies can have a big impact
- Indian Health Service (IHS) still has predominantly rural focus, even as more of the Native American population is based in urban areas

Landscapes: State-Level Initiatives with Federal Funding

- 2703 SPA for Primary Care
- 2703 SPA for Behavioral Health
- Medicaid Waivers
 - Medicaid ACOs
 - CCBHCs
- FQHCs with Proposed APM PMPM

Medicaid ACOs

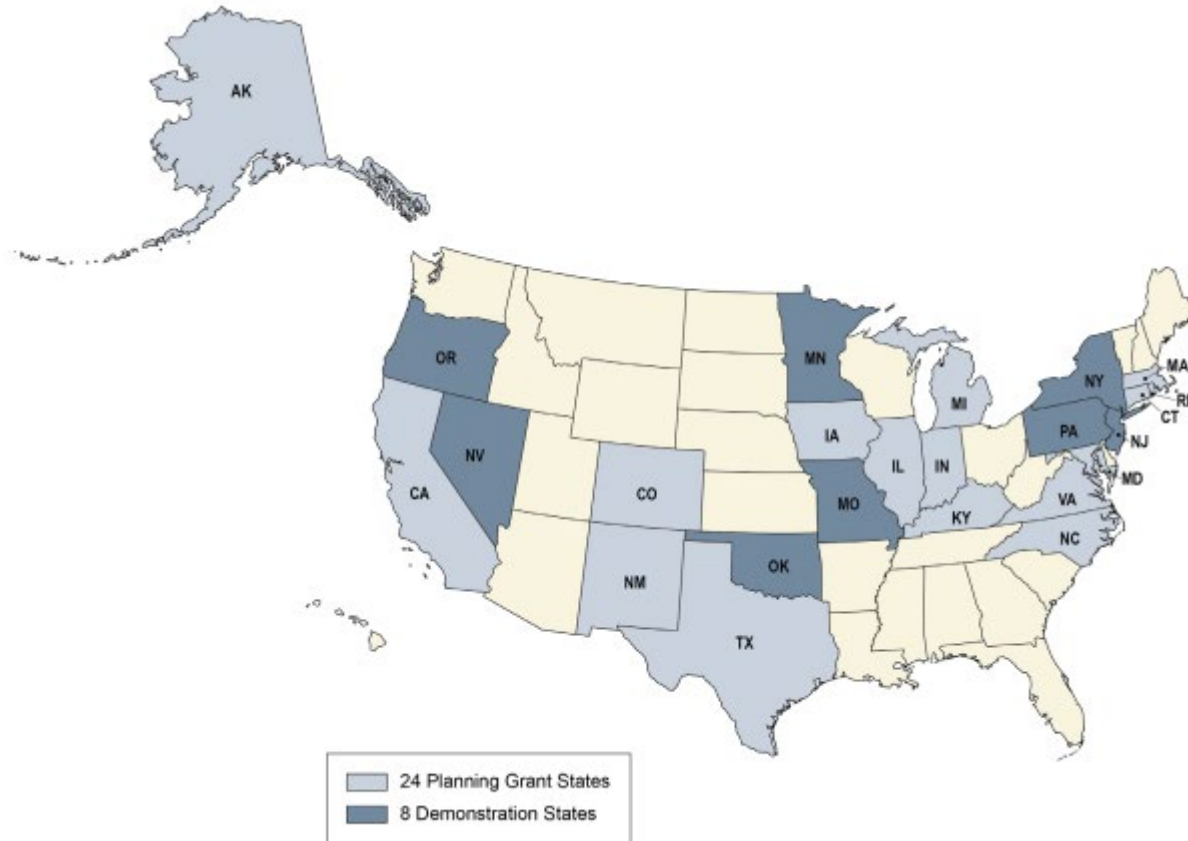
State Medicaid Accountable Care Organization Programs



Effective February 2018



Certified Community Behavioral Health Centers (CCBHCs)



Priority of Rural Considerations in Policy Making

- States vary significantly in terms of their progress towards payment and delivery reform
 - “Majority rural:” policies may account more for rural opportunities/barriers
 - “Minority rural:” policies may leave out rural implications
- Federal policies play a significant role in determining how far states progress on payment and delivery reform in rural areas
- Rural areas are usually not the center of payment and delivery reform efforts

Examples of Policy Promoting VBP in Rural Primary Care

- Missouri: Implemented chronic care supplemental payment model under 2703 SPA to demonstrate value
- Oregon: health centers in eastern OR transformed care under a 3-layer payment model by leveraging state Coordinated Care Organizations (a type of Medicaid ACO) and health center payment reform to promote payment and delivery system reform

Examples of Policy Promoting VBP in Rural Behavioral Health

- New Hampshire: Adopted behavioral health capitated payment reform under an 1115 waiver
- Texas: Adopted innovations in staffing under an 1115 waiver, including using CHWs in rural areas
- Utah and Virginia: Provided therapy and consultations for opioid treatment via telehealth services



Appendix B: Interviewees

Appendix B: Interviewees

- **Jessamy Taylor:** team lead in the Office of Policy and Program Development in the Bureau of Primary Health Care at the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS)
- **Adam Archuleta:** Chief Financial Officer, Indian Health Service
- **Keith Mueller:** Head of the Department of Health Management and Policy, University of Iowa, and the Director of the RUPRI Center for Rural Health Policy Analysis and Chair of the RUPRI Health Panel
- **Lynn Barr:** Founder and CEO, Caravan Health
- **Michelle Mills:** CEO, Colorado Rural Health Center
- **Tom Morris:** Associate Administrator for Rural Health Policy, HRSA, DHHS
- **Charles Alfero:** Executive Director, Hidalgo Medical Services – Southwest Center for Health Innovation and the founder of HMS, a Community Health Center
- **David Weden:** CAO and CFO, Integral Care, and President-Elect of the National Association for Rural Mental Health
- **Ralph Provenza:** Former National Council Board member and former Executive Director of United Counseling Service in Vermont
- **Andrew Coburn:** Research Professor and Director at the Maine Rural Health Research Center University of Southern Maine
- **Karen Linkins:** Co-founder and principal of Desert Vista Consulting, and Director of Integrated Behavioral Health Partners
- **Megan Haase:** CEO, Mosaic Medical
- **Carlos Olivares:** CEO, Yakima Valley Farm Workers Clinic



Appendix C: **National Rural Organizations**

National Rural Organizations

National Rural Health Resource Center: The National Rural Health Resource Center provides technical assistance, information, tools and resources for the improvement of rural health care. It serves as a national rural health knowledge center and strives to build state and local capacity by helping rural health providers transition to value and population health, improve their workforce and performance, adopt health information technology, and create collaborations and partnerships. Current projects include:

- **Small Rural Hospital Improvement Grant Program (SHIP):** Provides resources to approximately 1,600 participating hospitals in 46 participating SORHs to help small rural hospitals participate in value-based payment and care delivery models.
- **Delta Region Community Health Systems Development Program:** A comprehensive multi-year program to support selected hospitals and communities in the Delta region with financial, quality, population health, telehealth, EMS and workforce improvement assessments, consultations, educational training and ongoing coaching.
- **Network Technical Assistance:** Provides education and resources to support network leaders with facilitation and leadership development that strengthen and sustain networks, as well as meet the unique challenges and goals of each community.

National Rural Organizations

Georgia Health Policy Center (GHPC): The Community Health Systems Development (CHSD) team at GHPC has expertise in assisting rural communities to improve health and health care delivery in an affective and sustainable manner. Through tailored technical assistance designed to build local capacity by using technical and adaptive approaches and with a focus on long-term sustainability, communities working with GHPC have been able to implement strategies and achieve impact through:

- Expanding direct services
- Improving appropriate use of services, including screenings
- Tailoring evidence-based disease managements and education practices to local culture and community context
- Changing awareness, knowledge, attitudes, and behavioral through workforce and partnership development
- Initiating policy, systems, and environmental change with an emphasis toward improving population health measures

National Rural Organizations

Western Interstate Commission for Higher Education (WICHE): The WICHE Behavioral Health Program is an organization dedicated to improving behavioral health systems of care in the West and beyond. By providing technical assistance, education, consulting and research services, the program works to continually improve the qualifications of the behavioral health workforce, and overall improvements in the public mental health system. In addition, training is provided throughout the community to support consumer prevention, treatment and recovery efforts. The program also has a long history of delivering expert mental health services in rural areas. Areas of expertise include:

- Suicide Prevention in Rural Primary Care
- Integrated Care: Primary Health Care and Behavioral Health – Rural Settings and College Campuses
- Rural Behavioral Health Workforce Development

National Rural Organizations

National Rural Health Association (NRHA): The National Rural Health Association (NRHA) is a national nonprofit membership organization with a mission to provide leadership on rural health issues through advocacy, communications, education and research. Programs include:

- State Rural Health Associations: A network of rural health associations
- Rural Medical Education; A special interest group of NRHA committed to advancing the training of physicians for rural practice through network development and advocacy
- Rural Primary Care: NRHA works with its members to identify best practices for healthcare professionals providing primary care in various settings
- Community Health Worker Training Network: An official Rural Community Health Worker Training Network that now spans the U.S.-Mexico border, along with partnerships in the Appalachian region
- Health Equity Council: Promotes and enhances physical and mental well-being for rural and frontier underserved populations through national leadership, representation and advocacy for accessible, affordable, and high-quality services

National Rural Organizations

Rural Policy Research Institute (RUPRI): Based at the University of Iowa, RUPRI provides unbiased analysis and information on the challenges, needs, and opportunities facing rural America. RUPRI's aim is to spur public dialog and help policymakers understand the rural impacts of public policies and programs.

Programs include:

- **Center for Rural Health Policy Analysis:** Conducts original research in the areas of access to health care services, Medicare policies, development of rural delivery systems (including effects of national policy), and public health. Specific objectives for the Center's work disseminating policy analysis that assures policy makers will consider the needs of rural health care delivery systems in the design and implementation of health policy
- **Rural Health Value Center:** Assesses rural implications and facilitate rural adaptability to changes in health care delivery, organization and finance, develops and tests technical assistance tools and resources to enable rural providers and communities to prepare for and take full advantage of public policy changes and private sector initiatives.

National Rural Organizations

North Carolina Rural Health Research Center (NC RHRP): The program addresses problems in rural health care delivery through basic research, policy-relevant analyses, geographic and graphical presentation of data, and the dissemination of information to organizations and individuals who can use the information for policy or administrative purposes. Projects include:

- Rural hospital closure tracking: Current rates of rural hospital closures are the highest seen in the last few decades. What can we be learned from the experiences of communities experiencing hospital closures.
- Medicare rural hospital flexibility program evaluation: A comprehensive multi-year review of the Medicare Rural Hospital Flexibility Program, conducted in collaboration with the University of Minnesota and the University of Maine.
- Rapid Response Project: Provides rapid rural data analysis and issue-specific rural research studies in response to emerging policy issues.
- Creating a culture of health in Appalachia: A research initiative that aims to identify factors that support a culture of health in Appalachia through producing a series of case study reports.

National Rural Organizations

Center for Optimizing Rural Health/ARCHI: The Center concentrates its efforts on helping hospitals and communities determine how to sustain critical health care services locally. This may not include maintaining a hospital, but rather “right-sizing” care to match the resources, demographics, geography, and availability of providers in the community Programs include:

- **Healthcare Data Integration (HDI):** Provides hospitals with a service to streamline flow of accurate and complete data to monitor clinical quality and financial performance.
- **Consultation:** Provides health care consulting that is dedicated to fulfilling the special needs of small and rural health care organizations
- **Brazos Valley Care Coordination Program:** Aims to decrease the number of frequent emergency department users by ensuring appropriate follow-up care upon discharge, and connecting patients to a regular source of primary care services.
- **Texas A&M Regional Extension Center at ARCHI:** Offers technical assistance, guidance, and information on best practices to support health care providers efforts to become meaningful users of Electronic Health Records.

National Rural Organizations

National Associations of State Office of Rural Health (NOSORH) Assists State Offices of Rural Health (SORH) in their efforts to improve access to, and the quality of, health care for nearly 60 million rural Americans. NOSORH enhances the capacity of SORHs to do this by supporting the development of state and community rural health leaders; creating and facilitating state, regional and national partnerships that foster information sharing and spur rural health-related programs/activities; and enhancing access to quality healthcare services in rural communities. Priorities include:

- Education Exchange Committee: supports and enhances the leadership of state offices of rural health through education and training assistance.
- Flex Program Committee: provides the State Office of Rural Health perspective on policy issues and serve as a link between State Offices of Rural Health and others implementing the Rural Hospital Flexibility Program including the Federal Office of Rural Health Policy and the Technical Assistance and Services Center.
- Policy Committee: responsible for tracking Policy issues of interest to NOSORH and coordinating Policy communication and educational activities for the organization.
- Joint Committee on Rural Emergency Care :a group of organizations working together to improve the quality of care in rural and frontier communities.
- Rural Health Clinic Committee: provides technical assistance and education to State Offices of Rural Health that are interested in providing technical assistance to RHCs and safety net providers.



Appendix D

References

Endnotes

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