



# Let's Talk Rural Health

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SHELLY TEN NAPEL, NOVEMBER 14, 2019

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What are the core services needed  
in rural communities?

# Core Rural Health Services?

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- Comprehensive primary care (PCMH model)
  - Including ability to coordinate and consult with specialists
  - Including pre- and post-natal care for pregnant women
  - Urgent care; 24/7 access to care
- Behavioral health
- Home health
- Emergency medical services



# Core Rural Health Services (Secondary)

- These services may not be needed in every rural community, but there must be strategic planning and coordination to ensure there is reasonable, regional access
  - Dental care
  - Pharmacy
  - Public health
  - Nursing home
  - Maternity care



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Is the list too long? What is missing?  
Should anything be moved from a  
core service to a secondary core  
service?

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What policies would support access to health care in rural communities?

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# Rural Health Infrastructure (audio)

# How Do We Protect Core Rural Health Services?

- Critical Outpatient Center
  - Based on NRHA Critical Outpatient Hospital proposal
    - Eligibility: must have a CAH or rural hospital or closed in the last 5 years
    - Possible services include: emergency (required), observation care, skilled nursing facility care, infusion services, hemodialysis, home health, hospice, nursing home care, population health and telemedicine services
    - Medicare payment at 105% of reasonable costs + grants for population health
  - Cost-based reimbursement or a bundled rate for a hospital step down or FQHC step up to cover **core** services identified by community.
  - Limiting elements of FTCA would need to be addressed





# How Do We Protect Core Rural Health Services?

- Strategic planning
  - Support regional approach
  - Prevent uneven access to core services
- Specific reforms to BPHC new site funding process in rural communities?
- Workforce (see below)
- Payment reform for EMS



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What policy changes do you recommend? How can we support basic infrastructure in rural communities?

What type of policy solutions are rural people willing to support?

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What are the appropriate types, numbers, and/or ratios of health care professionals needed to provide core health services locally for rural populations of different compositions and sizes?

# Workforce

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- Better to consider **access to services** rather than specific provider types
  - Cross-training
  - Development of key competencies



# Workforce Policy

- The patient-to-primary care physician ratio in rural areas is only **39.8** physicians per 100,000 people, compared to **53.3** physicians per 100,000 in urban areas.
- Graduate Medical Education (GME) is heavily weighted to urban areas
  - GME-supported residents per 100,000 population is 1.63 in Montana vs. 77.13 in New York
  - 67% of states in Region VIII lack a dental school
- If those disparities can't be addressed, they should be remediated through NHSC and elsewhere



# Workforce

- Provider to population ratios; current methods fail to account for:
  - The higher range of services provided in rural primary care
  - A rural provider may help maintain a range of services including a local hospital, nursing home, ambulance services, home health agency, etc.
  - Planning for retirement and replacement of existing providers
  - A single provider serving 3500 people is not right for rural
    - Need to maintain 24/7 emergency access
    - Need for 2-3 providers per community for back-up and strong practice
    - Replacement of existing providers who may retire or scale back



# Workforce

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- Residency
- Core public health competency: Ability to engage the community and help it plan for its own health care needs
- EMS providers need advanced training



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What practices can impact local ability to recruit? What big policy ideas can change the paradigm relative to rural workforce?  
Poll: Choose top two workforce strategies.

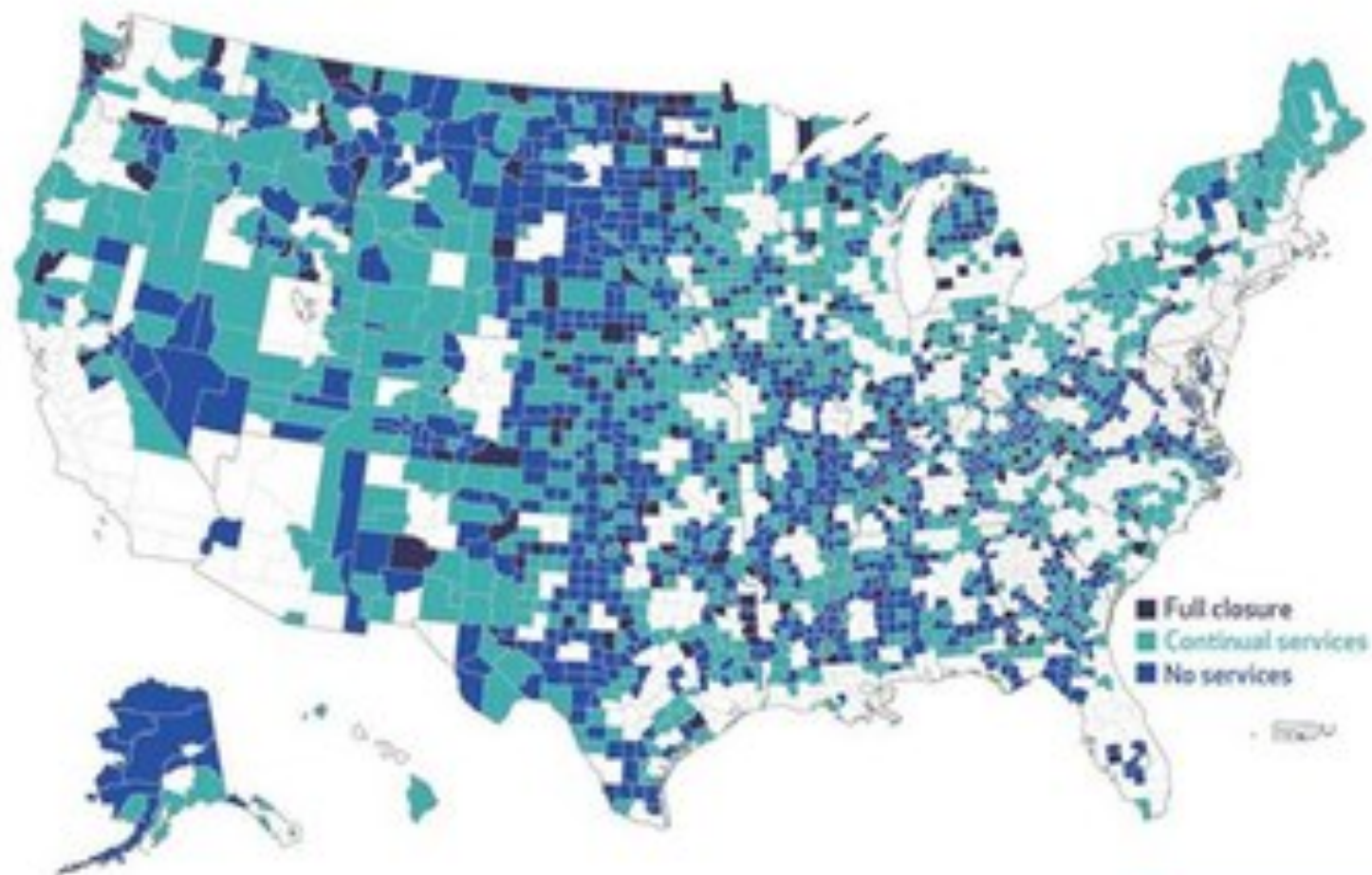


# Telemedicine and Telehealth

- Represents an opportunity to collaborate and build capacity
- The paradigm of connecting rural (no expertise) with urban (highly paid experts) needs reconsideration
  - Can be used to connect rural sites
  - Can be used to build capacity in rural
  - Adequate payment needed on both sides of connection
- Role of next generation telehealth



## Hospital obstetric services in US counties, 2004–14



Peixin Yong et al., *Health Aff* 2017;36: Published online

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Health Affairs

Medscape

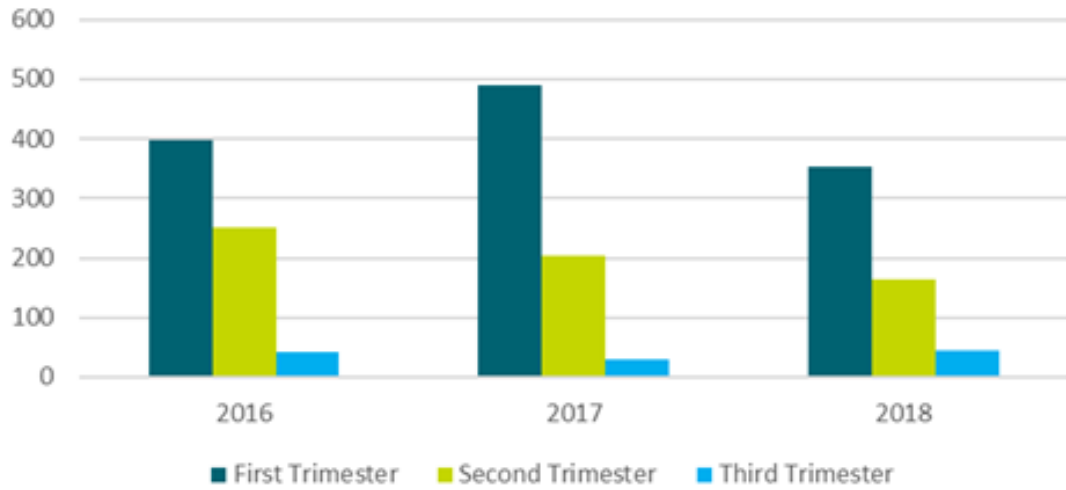
# Maternity Services by Dakota CHCs

North Dakota						
	Obstetrician/Gynecologist			Certified Nurse Midwives		
	2016	2017	2018	2016	2017	2018
FTE	0.14	0.10	0.16	2.00	2.35	2.46
Clinic Visits	164	162	158	4,804	5,347	4,918

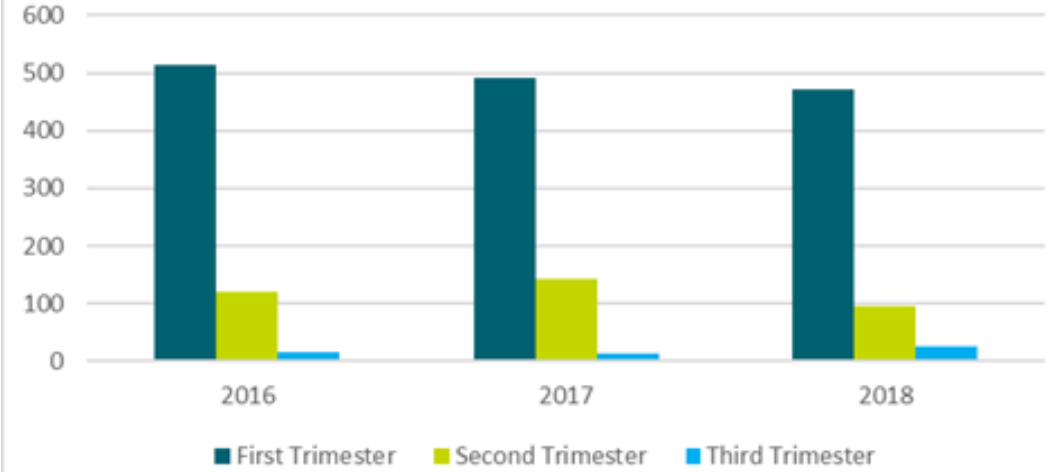
South Dakota						
	Obstetrician/Gynecologist			Certified Nurse Midwives		
	2016	2017	2018	2016	2017	2018
FTE	2.05	2.03	2.03	1.01	1.00	0.93
Clinic Visits	3,602	3,592	3,374	1,639	1,663	1,433



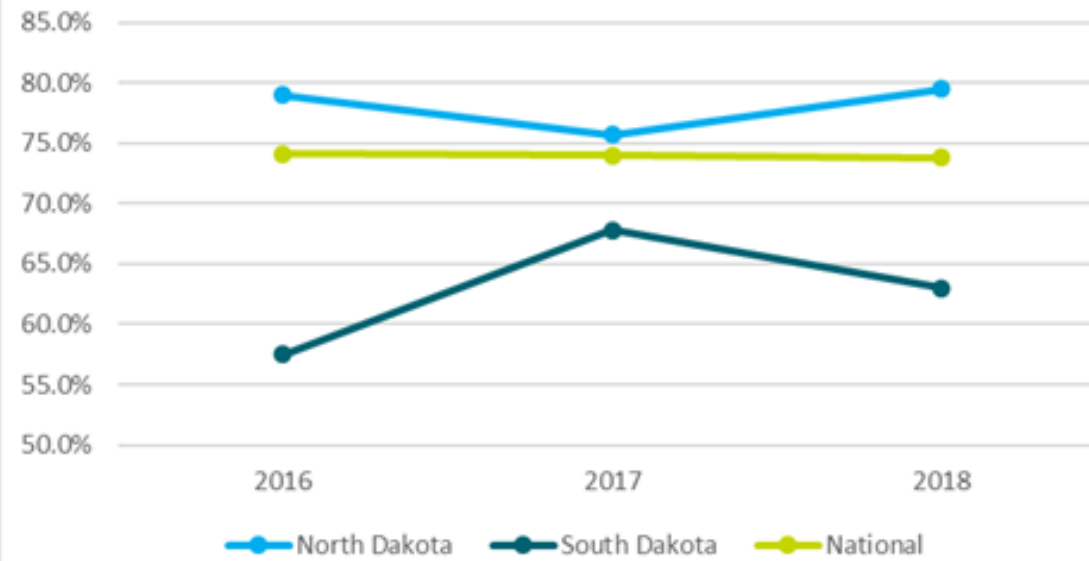
### Early Entry Into Prenatal Care South Dakota



### Early Entry Into Prenatal Care North Dakota



### Early Entry Into Prenatal Care



# Home Health

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- Like the rural hospital closures, nursing home closures can take all the oxygen in the room, when the more pressing need is access to home health
- What is access to home health like in your communities?



# Behavioral Health

- Suicide

	North Dakota	South Dakota	National Average
Suicide Death Rate	20.1 (ranked 12 <sup>th</sup> )	22.5 (ranked 7 <sup>th</sup> )	14.0

- Loneliness

- Addiction services

- Behavioral health services for children



# Dental

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- Disparities in access based on ability to pay
- Preventive dental for kids
- Dental for seniors and nursing home residents



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What rural health issue that we've discussed today should be a top priority for CHAD/Dakota health centers? Poll: Please choose your top 3.



QUESTIONS?



Community HealthCare Association of the Dakotas