

Panel Discussion: *Challenges Facing Patients and Providers in Rural Communities*

Panelists:

Subject Matter Experts

- [Janice Walters, MSHA, CHFP](#) - Chief Operating Officer, Rural Health Redesign Center
- [Meggan Grant-Nierman, DO, MBA](#) - Family Physician, First Street Family Health; Heart of the Rockies Regional Medical Center
- [Jen L. Brull, MD, FAAFP](#) - Family Physician and Vice President, Clinical Engagement, Aledade

Physician-Focused Payment Model Technical Advisory Committee

Roundtable Panel Discussion: *Provider Perspectives on Payment Issues Related to Rural Providers in Population-Based Models*

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- [Adrian Billings, MD, PhD](#) - Chief Medical Officer and Associate Professor, Family and Community Medicine, Texas Tech University School of Medicine
- [Howard M. Haft, MD, MMM](#) - Consultant and Former Senior Medical Advisor, Maryland Primary Care Program
- [Karen Murphy, PhD, RN](#) - Executive Vice President and Chief Innovation Officer, Founding Director, Steele Institute for Health Innovation, Geisinger

Previous Submitter

- [Jean Antonucci, MD](#) - Family Physician, Northern Light Health (*Previous Submitter – [An Innovative Model for Primary Care Office Payment Proposal](#)*)

**Panel Discussion: *Challenges Facing Patients and Providers
in Rural Communities***

Janice Walters, MSHA, CHFP

Chief Operating Officer
Rural Health Redesign Center

Janice Walters, MSHA, CHFP

Serving as the Chief Operating Officer and Interim Executive Director for the Rural Health Redesign Center. Background includes overseeing large scale change initiatives through the lens of the macrosystem. Janice has been leading the Pennsylvania Rural Health Model since 2018, including the creation of the Rural Health Redesign Center. Prior to healthcare Janice spent time in the communications and manufacturing industries.



The Rural Health Redesign Center (www.rhrco.org)

Provides valuable expertise to rural hospitals with the goal of helping them remain open to retain access to basic healthcare services in rural communities. Current programs it oversees include:



National Rural Emergency Hospital Technical Assistance Center

Helping hospitals across the country assess feasibility of the Rural Emergency Hospital provider type to maintain access to care in their communities.



Rural Northern Border Region Technical Assistance Center

Providing technical assistance to communities and providers in rural ME, NH, NY, and VT to help improve access to and quality of care.



Pennsylvania Rural Health Model

Impacting 1.3 million Pennsylvanians through rural healthcare transformation and payment innovation.



Peer Recovery Expansion Project

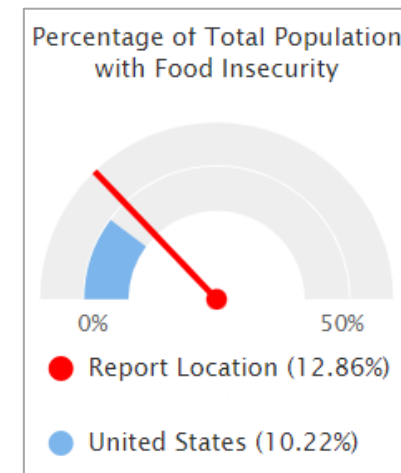
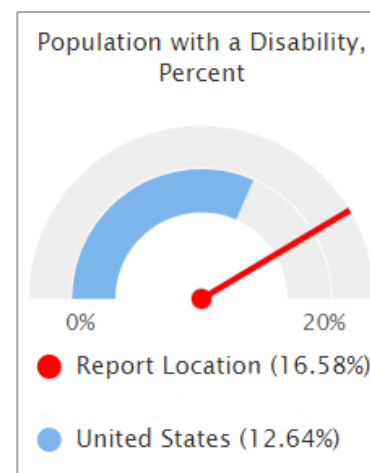
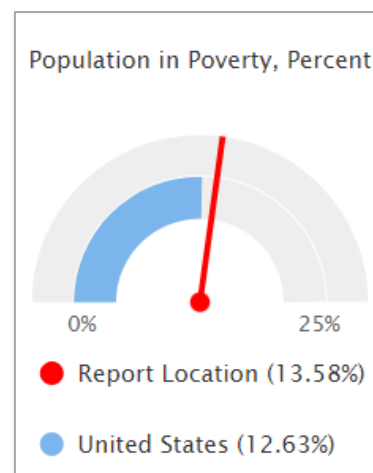
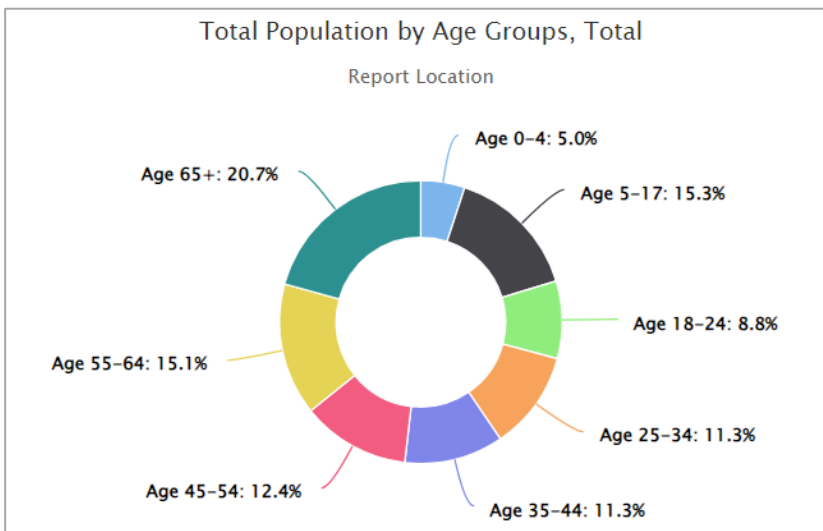
Enhancing access to behavioral health and substance use disorder services in rural P.A.

Insights into this topic:

Rural hospitals are often the employer of practicing physicians in rural communities, so ensuring rural hospitals remain viable is fundamental to the preservation of healthcare access, not only hospital care, but primary care and specialty care.

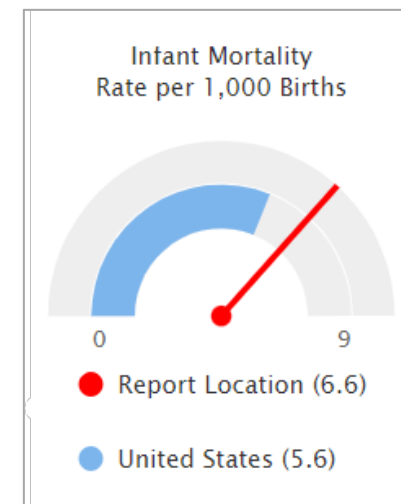
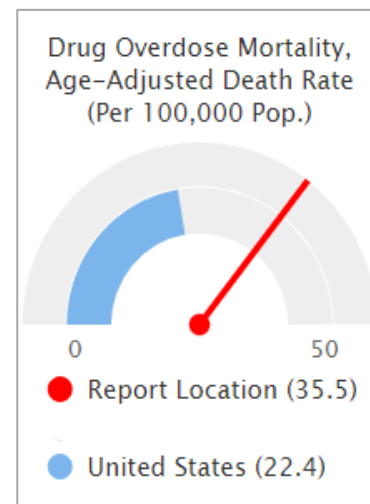
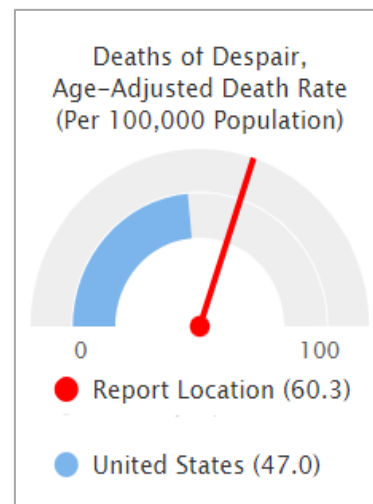
RHRC Service Area Characteristics

Common trends and demographic, social, and clinical disparities have been found in the communities we serve -- aging populations, poorer health outcomes, and elevated unemployment, poverty, and disability rates.



Key Takeaways:

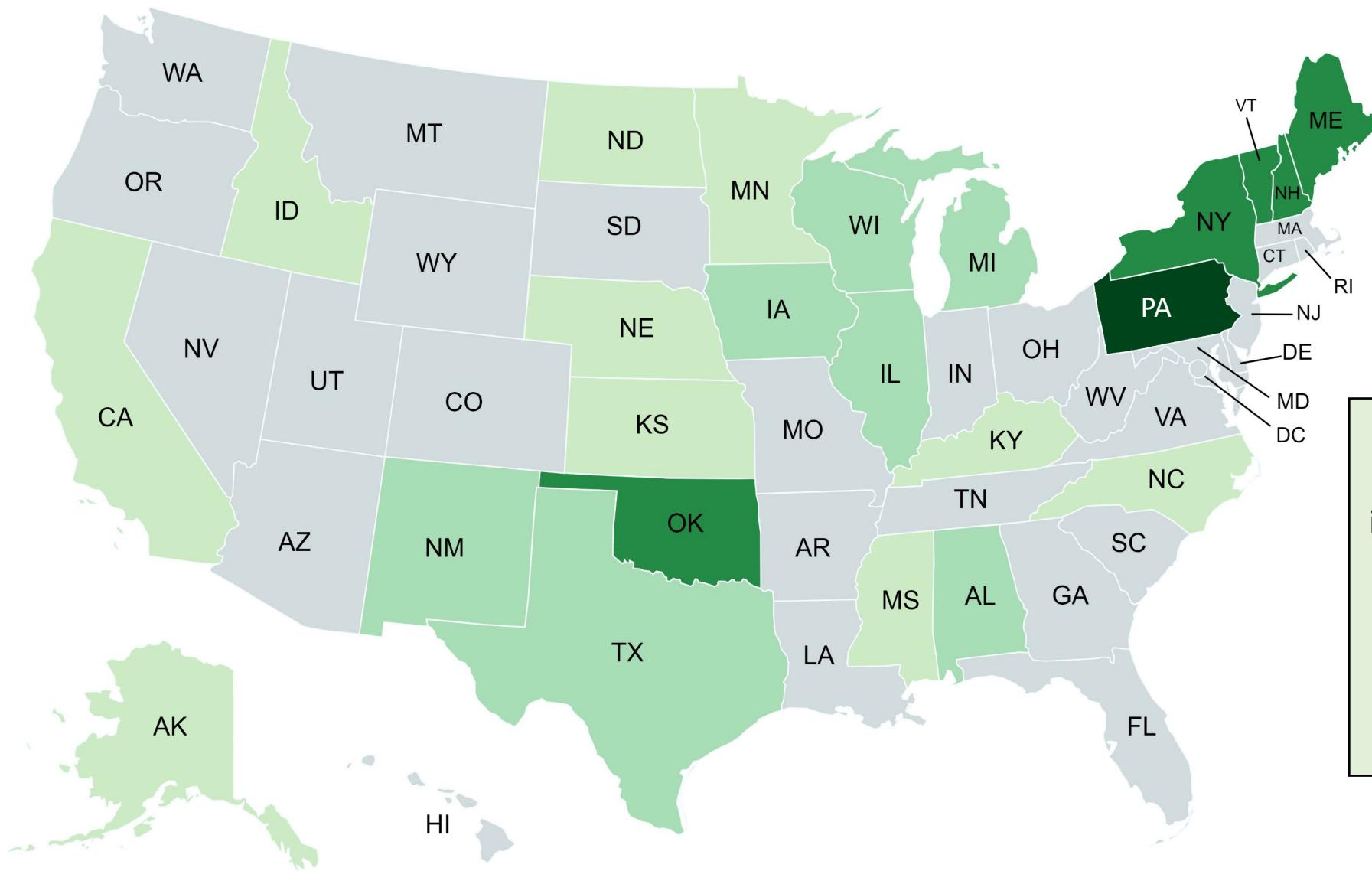
- These outcomes will only get worse if rural hospitals close.
- Many of the same social issues exist in urban and rural communities, but rural solutions must be vastly different due to the lack of infrastructure that exists to solve problems such as transportation, food insecurity, etc.
- Policy reform is needed to align incentives across the rural healthcare continuum in order to create reasonable, pragmatic solutions to these problems.



Appendices

RHRC Footprint

Through the footprint of those we serve, the RHRC's work impacts about **2,622,408 rural residents** across the Country.



Through its programs, the RHRC is currently providing in-depth technical assistance to **62 hospitals** across the Country. These hospitals span **23 states** as indicated by the areas shaded green on the map.

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in Rural Communities***

Meggan Grant-Nierman, DO, MBA

Family Physician

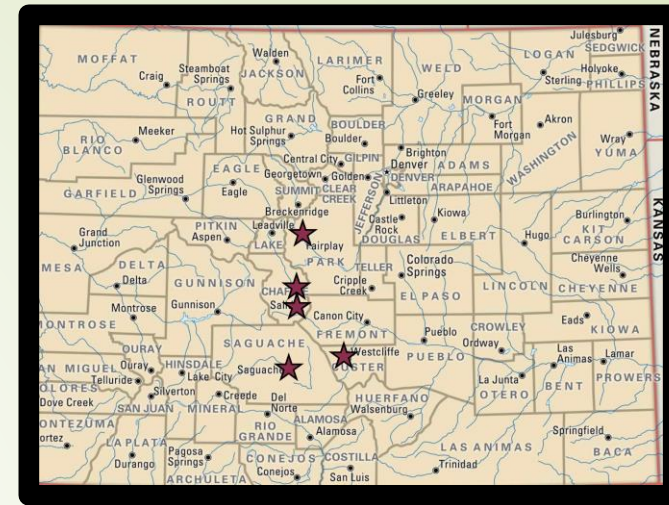
First Street Family Health

Heart of the Rockies Regional Medical Center

Meggan Grant-Nierman, DO, MBA, MHCDS

1

- Rural full spectrum family medicine physician in Salida, CO
 - 11 years in private practice as a physician owner at First Street Family Health and participant in value-based payment programs including CPCI, CPC+, PCF and MSSP ACO
 - TCPI faculty 2016
 - Currently joining HRRMC's RHC network after closure of FSFH
 - National Advisory Committee on Rural Health and Human Services 2019-2023
 - Masters of Health Care Delivery Science



First Street Family Health:
Independent practice in
business for 74+ years

- 8000+ patients
- 60% Medicare & Medicaid
- Independent practice in business for 74+ years
- 11 years participation in value-based care
- Closed in September 2023 and absorbed by HRRMC Rural Health Clinic

Heart of the Rockies Regional Medical Center:
Critical Access Hospital with
RHC's in following locations

- Buena Vista Health Center
- Outpatient Pavilion in Salida
- Salida Health Center
- Saguache Health Center
- Custer County Health Center
- South Park Health Care

Key Takeaways

2

- **Characteristics of rural health care providers**
 - Few (decreasing) numbers of private independent providers
 - Most are FQHC or RHC limited requirements or incentives for high level VBC contracts because reimbursement is facilities based or cost based
- **Challenges that affect rural health care provider**
 - Recruitment and retention
 - Professional isolation
 - Lack of specialty support
 - Inadequate support infrastructure including entry and mid level workforce
- **Health Services that are difficult to provide in rural areas**
 - Obstetrics care
 - Behavioral health
 - Specialty Care

Key Takeaways, continued

- **Barriers to effective care coordination**
 - **Wraparound support and services (i.e., home health care (HHC), area agency on aging support, long term care, responding to SDOH needs)**
 - **Data**
 - **Digital barriers (EMR's are less robust causing inconsistent integration to metric dashboards or to other healthcare facilities)**
 - **Patient connectivity**
 - **Rural primary care infrastructure is fragile limiting ability to accept at-risk contracts**
 - **Contradicting incentives across the medical neighborhood (i.e.,: rural clinician is incentivized to decrease utilization, but the hospital relies on cost-based reimbursement and needs the volume to remain viable)**

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in Rural Communities***

Jen L. Brull, MD, FAAFP

Family Physician and Vice President
Clinical Engagement
Aledade

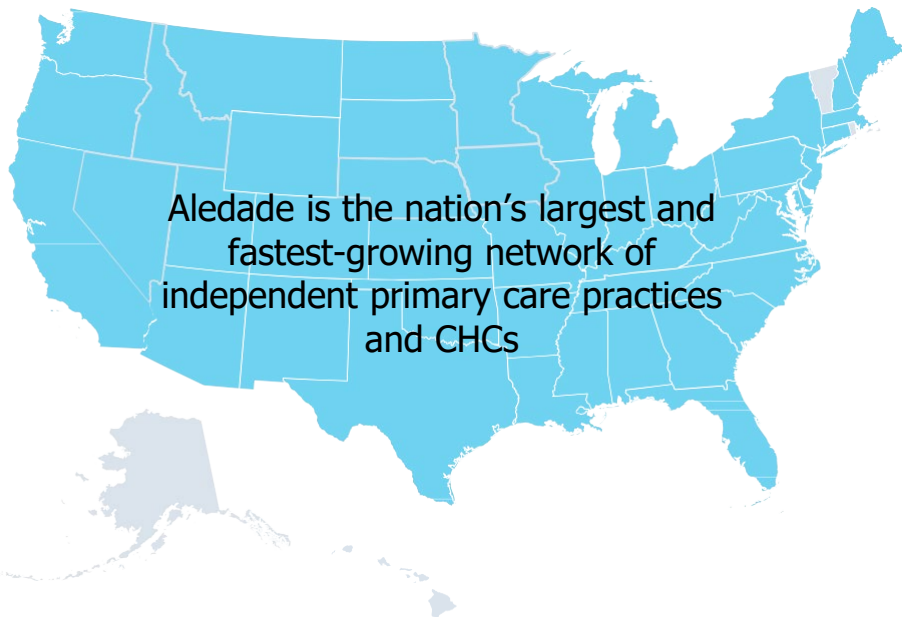
Jen Brull, MD, FAAFP @ Aledade

Vice President, Clinical Engagement

Rural full-scope family medicine x 22 years

Former ONC HIT Fellow and CDC Hypertension Control Challenge Champion

Top 25 Innovator by Modern Healthcare (2019)



46 States

16,300+ Clinicians

2M+ Patients

1500+ Practices & CHCs

\$20B+ Medical Spend Under Management

Key Takeaways

1

2

3

4

5

1 Solve the Rural Glitch

Rural clinicians who elect to participate in ACOs are disadvantaged because their own performance is included in the local reference population and they often have a significant market share.

2 Invest in Access

Community and specialty resources for identified patient needs are often nonexistent or underfunded in rural areas. Rural clinicians understand what their patients need but lack the ability to provide access.

3 Include CAHs and RHCs

Critical Access Hospitals and Rural Health Centers have been left out of some innovation models due to complexities of their normal payment structures; these organizations are key to rural health care.

4 Expand Advance Pay Options

Rural practices are often small businesses with little capital, making it difficult to set up the infrastructure necessary for value-based care. Models that build on the success of AIM offer only limited access to these funds.

5 Connect to Rural SMEs

Policymakers and administration officials have often not understood (and therefore not well represented) the needs of rural health care professionals.



Roundtable Panel Discussion: *Provider Perspectives on Payment Issues Related to Rural Providers in Population-Based Models*

Adrian Billings, MD, PhD

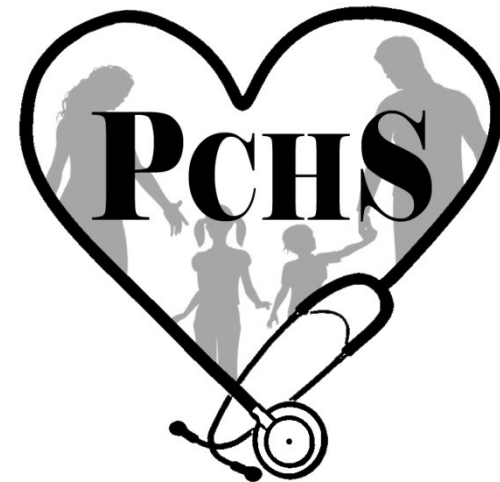
Chief Medical Officer and Associate Professor
Family and Community Medicine
Texas Tech University School of Medicine

Adrian Billings, MD, PhD, FAAFP

- Chief Medical Officer, Preventative Care Health Services
- Federally Qualified Health Center (FQHC) in rural southwest Texas in Alpine, Marfa and Presidio, Texas {HPSA score 19, PC MCTA score 21}

Service Lines-Primary Care, Dental Care, Behavioral Health Care, Pharmacy, Hospital Medicine including maternity care services

Rural Family Medicine Residency location in collaboration with Texas Tech University Health Sciences Center Permian Basin



Overview of Key Takeaways

Rural patients are sicker, die younger, suffer from higher chronic disease and live in higher score HPSAs with less access to care. The higher the HPSA the less access to **all** services impacting the social determinants of health.

How can rural clinicians and health care organizations be incentivized to participate in value-based care and not get penalized owing to the lack of resources in a HPSA?

Paucity of care management, specialist physicians, transportation options for patients

Rural food insecurity/deserts, connectivity and broadband challenges, social determinants of health

How can rural clinicians and health care organizations be incentivized to collaborate with academic health centers and larger urban health care organizations to improve access to care and expansion of rural health care services?

Overview of Key Takeaways, Continued

How can urban health care organizations be incentivized to collaborate with rural health care organizations?

How can academic health centers be incentivized to collaborate with rural health care organizations?

Financial incentives for sending/accepting students and trainees to rural health care organizations

The need for resources and knowledge for value-based care training extends beyond the clinician to the business and management teams of rural health care organizations as well as vital community organizations outside of the health sector.

**Roundtable Panel Discussion: *Provider Perspectives on Payment
Issues Related to Rural Providers in Population-Based Models***

Howard M. Haft, MD, MMM

Consultant

Former Senior Medical Advisor
Maryland Primary Care Program

Howard Haft, MD, MMM, CPE, FACPE

- Former Executive Director, Maryland Primary Care Program and currently consultant to primary care rural and urban clinics
- Maryland Primary Care Program is a CMMI model that includes 2/3 of all eligible primary care practices in Maryland, serving over 4 million people with offices in every county including 17 rural counties
- Relevant experience as a primary care Internist in a rural Maryland County for over 30 years and as the lead on a statewide primary care payment and delivery innovation model, as well as an educator at the Georgetown, McDonough Graduate Business School teaching American Healthcare Marketplace
- Finally, a Physician who has come full circle after a 50 year career and is returning to his roots as a primary care physician in a rural setting on Maryland's eastern shore

Key Takeaways

- ❖ Rural Primary Care is the foundation of primary care
- ❖ Rural providers are called upon to do more with less and under more challenging conditions than those in most settings
- ❖ Rural providers and their patients are relatively isolated and rely on having effective telehealth that has strong payment support
- ❖ Contrary to current payment models, delivering care in rural settings is not less expensive than other areas, payments should reflect the cost of delivering the full spectrum of advanced primary care



Norman Rockwell

Visiting the Family Doctor 1947

Foundation of Primary Health

Dr George Russell

- Provided Home visits
- Established Community Nursing
- Became the Public Health Provider
- Provided Transportation to specialists
- Was part of the community as the steward of health

Key Takeaways, continued

- ❖ Rural providers benefit from and enjoy the flexibility offered by non-visit-based population payments such as Care Management Fees
- ❖ The quality incentive benchmarks should be adjusted to reflect the rural population being served
- ❖ Payments should be liberalized to support practice wide transformation rather than pigeon-holed to serve only one payer
- ❖ Payment should be sufficient to support rural practices and attractive enough to encourage providers to establish or join rural practices
- ❖ Payments should favor timely bonus incentives for exemplary performance and eliminate financial risk that threatens infrastructure payments

**Roundtable Panel Discussion: *Provider Perspectives on Payment Issues
Related to Rural Providers in Population-Based Models***

Jean Antonucci, MD

Family Physician

Northern Light Health

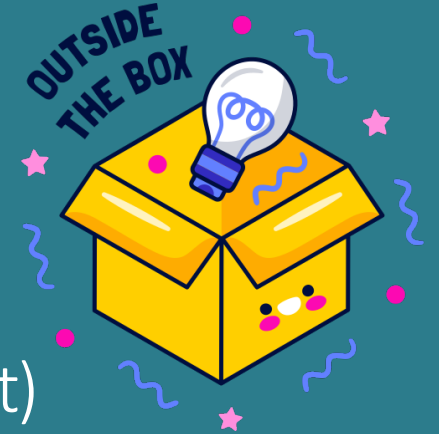
(Previous Submitter – *An Innovative Model for Primary Care Office Payment* Proposal)

Jean Antonucci MD

Family physician rural Maine 33 yrs

Solo innovative private practice 16 yrs (IdealMedicalPractices project)

Now providing chronic pain and acute care services part time in a large system



Superb access and continuity

PCMH 3 x 3

MIPS 98% til exempt

Running a practice teaches the burden associated with hospital policies, vaccine management, and other requirements and regulations

KEY TAKEAWAYS

- Rural communities' issues include access to services (e.g. psychiatry and dentistry), isolation, regulations, culture of poverty, aging, distance, and poor infrastructure.
- Small practices tend to have good referral networks, great continuity and have lower preventable hospitalizations rates (ref Casalino*), but need breathing room, support and shared access to resources – not directives (cottage industry dinosaurs vs nimble innovation)
- The survival of primary care is about policy and regulation changes, and good tools, in addition to payment.
- Language matters. Physicians need to be **paid**, not "reimbursed," fairly and simply.
- EMRs are flawed without ticklers, natural language processing, etc. We need unified EMR /single sign in.
- Employment has been bad for primary care with loss of control and policy disconnect.
- Physicians should not be asked to take insurance risk.
- Physicians cannot be responsible for the total cost of care since we cannot control costs.



* Casalino, Lawrence P. et. al. "Small Primary Care Physician Practices Have Low Rates Of Preventable Hospital Admissions." Health Affairs Vol. 33, No. 9, September 2014. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0434>

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Karen Murphy, PhD, RN

Executive Vice President and Chief Innovation Officer
Founding Director, Steele Institute for Health Innovation
Geisinger

Karen M. Murphy, PhD, RN

EVP, Chief Innovation and Digital Transformation Officer, Geisinger

Background:

- Registered Nurse
- Hospital CEO
- Director of the CMMI State Innovation Model
- Secretary of Health, Pennsylvania Department of Health

About Geisinger:

- Pennsylvania, Hospital System
- **Take care of Patients:** 10 hospitals, 1800 physicians, 25k employees
- **Manage cost of care:** > 600k health plan members
- **Research, educate and innovate** – 600 MD/MBA students, 1k research projects



Key Takeaways

RURAL HEALTHCARE IS IN CRISIS

- Provider shortage/difficult to recruit
- Fragile business model for rural hospitals
- Older, sicker population vs urban counterparts
- SDOH challenges

ALTERNATIVE PAYMENT MODELS

- Challenging due to size of population
- Global budget model – MD and PA

THE FUTURE

- Redesign payment models
- Leverage technology and strategic partnership with urban centers