

# Advancing Population Health in Rural Places: Key Lessons and Policy Opportunities

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## EXECUTIVE SUMMARY

**Purpose:** This paper aims to advance the policy discussion of population (defined as either a patient panel that is based on conditions such as diabetes, all enrolled patients, or the general community) health in rural places, with a focus on the role of rural health care organizations. Although efforts to address population health can originate in a variety of settings, the rural health care organization can be a natural place to start.

**Facilitative Considerations—Previous Demonstrations and Examples:** After a review of previous demonstration projects, public health and health care organization partnerships, urban system investments, and community health needs assessments; common facilitative considerations for successful population health interventions emerged. Communities and health care organizations interested in improving population health can benefit from creating community buy-in and participation, fostering collaboration within and across entities, engaging a diverse workforce, utilizing a variety of funding streams, planning for sustaining of funding after the original investment, and leveraging existing infrastructure.

**Key Findings—Medicare and Medicaid:** Though the demonstration projects discussed in this report have their roots in the Medicare and Medicaid programs, there are other ways that Medicare and Medicaid are addressing population health through policy. Within Medicare, care management programs, value-based payment arrangements, supplemental benefits, and telehealth expansion all help achieve population health goals. In Medicaid, the provision of preventive services, connection to social supports, State administrative flexibility, and telehealth do the same. Based on progress thus far, future efforts to address population health in Medicare and Medicaid programs must prioritize staff and infrastructure development, flexibility in covered benefits, and further expansion of telehealth.

**Critical Questions:** Consistent with the purpose of the paper to advance policy discussion, an important first is to identify policy levers that could facilitate actions by rural health care providers and community organizations to improve population health, the RUPRI Health Panel reviewed previous and ongoing activities in rural and urban places. Lessons from previous population health efforts and Medicare and Medicaid policy provide critical questions for future population health activity in rural communities.

- What strategies can be used to incorporate population health into rural health, and what are the ingredients necessary for these strategies to succeed?
- What unique features of rural communities give them an advantage in addressing population health?
- How can collaboration be used effectively to help rural hospitals implement population health strategies?
- How can rural health care systems (originating anywhere in the system, including public health agencies) gain broad-based community support for population health activities?
- How can the local health care workforce be further involved in addressing population health?
- How can rural systems sustain population health investment and progress?

**Policy Opportunities:** To determine the optimal structure of a strategy to incorporate population health in rural areas, more rural demonstration projects are needed (publicly or privately supported). These demonstrations must then be evaluated using rural-relevant metrics consistently across projects. Unique strengths of rural communities can be identified that help others replicate successful demonstrations. A population-health strategy will take advantage of

favorable rural community characteristics: smaller scale in terms of population served, existing collaboration between organizations that are already known to one another, and a strong sense of community strengths and needs. In addition, rural communities can benefit from effective collaboration within and across entities because community leaders and organizations can know each other personally and can clearly define the distinct assets each community organization can provide. A rural area's strong sense of community can be advantageous to gaining broad-based community support for population health activities, but to maximize this support, initiatives must have stable long-term funding, and the preventive services offered must be affordable. The community will also become more invested in population health efforts if the local workforce is embedded in the projects. Offering alternative pathways to rural provider inclusion in value-based payments, decentralizing training programs into rural environments, and updating payment policies can all facilitate local workforce engagement. Finally, the population health changes that take place can be sustained beyond a defined demonstration project period by offering transitional supports to providers, providing comprehensive technical assistance to the community, and using Medicaid authority to create policy changes that would provide long-term funding support.

***Future Considerations:*** Efforts at both the State and Federal levels aim to address the health challenges that face rural communities. These efforts, including rural-centered task forces, ongoing activities to implement population-health-centered legislation such as the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, and emerging rural health proposals and bills from Congressional members and presidential candidates alike must move forward grounded in population health strategies.

## **PURPOSE**

This paper aims to advance the policy discussion of population health in rural places, with a focus on the role of rural health care organizations. Efforts to address population health can originate in a variety of settings, from local health departments, primary care clinics, community-based organizations, hospitals, or health systems. Decisions around resource allocations within the \$3.3 trillion health care industry can drive or inhibit investment in population health activities. In many rural communities, the hospital serves as a central community entity, often the major employer. Spurring local action in population health initiatives can be an opportunity for hospital leadership. Public health departments that are funded to a level that gives them discretionary resources to invest in population health can act as the drivers of population health investments at the community or State level.

## **INTRODUCTION**

Central to this discussion of policy opportunities is how population health should be defined. In 2003, David Kindig offered an inclusive definition of population health, available below. This definition can be used to frame population health activities for a broad audience, such as a State or community. States implementing population health activities can recognize population health as inclusive of all residents within the state. County public health departments can view population health as the health outcomes of everyone within its borders. However, hospitals may want to define population health more narrowly as the health outcomes of the patients they serve. For example, inpatient admission for asthma could be decreased by implementing strategies to increase medication adherence.<sup>1</sup> This paper's focus on a variety of population health efforts, from

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<sup>1</sup> [https://www.aha.org/system/files/hpoe/Reports-HPOE/managing\\_population\\_health.pdf](https://www.aha.org/system/files/hpoe/Reports-HPOE/managing_population_health.pdf)

the hospital, to the community, to the State level, provides opportunity to use population health defined by both Kindig’s way and the American Hospital Association (AHA), below.

Kindig’s Definition of Population Health	AHA’s Definition of Population Health
“The health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.” <sup>2, 3</sup>	“The distribution of specific health statuses and outcomes within a population; factors that cause the present outcomes distribution; and interventions that may modify the factors to improve health outcomes.” <sup>4</sup>

Ongoing policy discussions in both the Medicare and Medicaid programs have addressed their role in population health and have resulted in a variety of actions. Medicare Advantage (MA) plans can now pay for services addressing some social determinants of health, such as transportation (including to grocery stores), meal kits, and telehealth; and Medicaid can use managed care organizations, State plan amendments, and waivers to do the same.<sup>5, 6</sup> These services “contribute to healthy lifestyles,”<sup>5</sup> a link to population health. In its movement toward value-based purchasing, the U.S. Department of Health and Human Services’s (HHS’s) second strategic goal is to “Protect the Health of Americans Where They Live, Learn, Work, and Play,” including objectives such as helping people make healthier lifestyle decisions and preventing and controlling chronic conditions.<sup>7</sup> Within the Centers for Medicare & Medicaid Services (CMS) the development of Center for Medicare and Medicaid Innovation (CMMI) demonstration projects such as State Innovation Models (SIMs) and Accountable Health Communities (AHCs) in states and local communities are underway to test various approaches in accomplishing these objectives. HHS secretary Alex Azar has remarked on the unique challenges rural areas can face in addressing social determinants of health, stating that rural areas may need more assistance in the area of transportation, in addition other challenges such as housing or food.<sup>8</sup>

### *The Rural Population Health Advantage*

How can rural health care organizations replicate the growing trend among large urban-based systems to become more directly involved in programs to address social determinants of health? What unique characteristics of rural communities give them advantages in doing so? What policies can support these transformation efforts? Rural areas have a unique role to play in the movement toward population health. This paper begins by providing a summary of developments related to population health in rural areas, as well as facilitative considerations gleaned from these examples. We then describe Medicare and Medicaid programs, initiatives, and funding mechanisms currently underway that aim to improve population health. These actions thus far provide critical questions, from which we identify future policy opportunities. We preface these future policy

<sup>2</sup> <http://www.ihl.org/communities/blogs/population-health-population-management-terminology-in-us-health-care>

<sup>3</sup> <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.3.380>

<sup>4</sup> [https://www.aha.org/system/files/hpoe/Reports-HPOE/managing\\_population\\_health.pdf](https://www.aha.org/system/files/hpoe/Reports-HPOE/managing_population_health.pdf)

<sup>5</sup> <https://patientengagementhit.com/news/cms-updates-ma-to-allow-for-social-determinants-of-health-benefits>

<sup>6</sup> <https://healthpayerintelligence.com/news/medicaid-programs-seek-to-address-social-determinants-of-health>

<sup>7</sup> <https://www.hhs.gov/about/strategic-plan/strategic-goal-2/index.html>

<sup>8</sup> <https://www.ajmc.com/focus-of-the-week/azar-cmmi-will-get-more-involved-in-addressing-social-needs-driving-health-issues>

opportunities in rural population health with a framing of previous related RUPRI Health Panel work on high-performing rural health systems and policy opportunities.

A rural approach to population health takes advantage of unique characteristics of rural communities including smaller scale (size of community) and interlocking positions held by community leaders (board of trustees and senior leadership of health facilities along with roles in community-based organizations such as the local United Way). These characteristics naturally lend themselves to a population health approach and can be used as building blocks in initiating population health interventions. The many challenges that rural communities are facing, from hospital closures, to a lack of specialists such as psychiatrists and OB/GYNs, to increased patient acuity levels, make it increasingly important to proactively implement measures to improve population health. There is a drive in rural hospitals and communities to take action, and these entities must be encouraged to do so in a sustainable manner. Creating sustainable population health infrastructure can help rural communities with the diverse issues they face, from hospital closures to mental health issues.

### *Rural Capital*

Rural communities must be valued for all of the resources they possess, beyond economic capital alone. Doing so can better capture a rural community's strengths and can change the perception of a rural community's ability to implement population health approaches. Looking comprehensively at a rural community's assets, stakeholders can identify the unique building blocks that can work to propel population-based strategies forward. The Comprehensive Rural Wealth Framework, developed by RUPRI scholars, provides an approach for doing so by summarizing eight separate capitals.<sup>9</sup>

1. *Physical capital*, such as infrastructure, can facilitate greater communication between hospitals and community-based organizations. Hospitals are often in close proximity to other key organizations and resources in rural communities. Community organizations external to the hospital can facilitate continuous and active communication between themselves. For example, a grocery store could collaborate with the hospital on promoting healthy diet changes. Similarly, a school could be a common point of contact for informing community residents about how the hospital and other community organizations can address needs such as hunger and housing.
2. *Financial capital*, or the money and other liquid assets a community possesses, will also look different in a rural community than in an urban area. Because rural communities don't have the same degree of large chain organizations present in the community as are found in urban areas, the financial capital that is generated is more likely to be invested in local organizations and businesses.
3. *Human capital* is the education, skills, and talents of the population. This includes health services and supports, such as hospital staff and those working in external community organizations, who can use their knowledge of these resources to connect community members when they are on and off the job.
4. *Intellectual capital* is the innovation possible because of a body of knowledge and ideas. This is a community asset, different from the individual assets embodied in human capital.

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<sup>9</sup> <http://www.rupri.org/wp-content/uploads/Rural-Wealth-Framework-Final-12.18.17.pdf>

5. *Social capital* includes trust among community members and organizations, and networks among members of the community. Because of the strong sense of community and open communication often present in rural areas, it can be easier to disseminate and gain support for population health investment and provide interventions once the initiative is underway.
6. *Political capital* is the influence that individuals and organizations hold and can be used to achieve population health goals. Unlike in larger communities, rural leaders of population health activities are likely to be individuals that community members know personally. This familiarity can facilitate trust and community buy-in throughout the process. When community members have questions or concerns, these leaders can be readily available to discuss them personally and make adjustments.
7. *Natural capital* is composed of the natural resources of the community such as clean water, air, landscapes, and climate. Though rural terrain can make it more difficult for some community members to reach health care providers, natural assets such as clean water and natural landscapes can be taken into consideration. For example, aspects of the built environment such as walkability can be higher in rural areas, which have the countryside and natural resources more readily accessible than urban and suburban areas.<sup>10</sup>
8. *Cultural capital* is composed of tradition embedded in community beliefs, values, and practices specific to that place, as well as activities resulting in works of art and artistic expression. These contribute to quality of life in a rural community, which in turn contributes healthy behaviors.

While the eight capitals are described and understood separately, the reality is that a blending of them contributes to population health. The abilities of individuals to live healthy lifestyles is related to sustaining vibrant communities. The interplay of using physical assets effectively (including structures that might become community fitness centers), maintaining financial assets that generate income, and taking advantage of intellectual and social assets can lead to healthier places and people.

### ***Pillars of a High-Performance Rural Health Care System***

For a hospital or community to successfully orient itself to address population health, its strategy must be built upon the pillars of a high-performance rural health care system, summarized in the bullet points that follow.

- A high-performance rural health care system must be *affordable*: Health care services provided must be both necessary and efficient. The cost of the care that one receives must not place significant financial strain on individuals and families.
- It must also be *accessible*: Whether located in an urban or rural area, individuals should have access to high-quality, timely health care. When types of care are not available locally, an infrastructure system must be in place to meet the needs, such as transportation, telemedicine technology, and referral.
- Related to population health, a high-performing system must also address *community health* needs. Collaboration must be fostered between health care

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<sup>10</sup> <http://www.rupri.org/wp-content/uploads/Rural-Wealth-Framework-Final-12.18.17.pdf>



organizations and the community to improve community health. This must be accomplished with an eye toward the specific needs of each community.

- High-performing rural health care systems must provide *high-quality* care: Though care should be as affordable as possible, quality cannot be sacrificed for the sake of affordability. Providers should be encouraged to strive to deliver the highest quality care possible, and the structure in which they work should facilitate their ability to do so.
- Finally, a high-performing rural system must deliver *patient-centered* care. Patients receiving care should understand the decisions made in regard to their health, and these decisions must be unique and targeted to each patient's needs.<sup>11</sup>

In achieving the above characteristics, a high-performing rural health care system would prioritize the health needs of their patients and community. Addressing population health is thus a distinct overarching feature of a high-performing system. Thus, as rural hospitals continue to strive for high-performance achievement, it will be increasingly necessary for population health to be part of their strategy. As innovators and Medicare and Medicaid programs continue to experiment with alternative payment and delivery models centered on improving population health, rural hospitals have a unique opportunity to take advantage of momentum and accompanying funding streams, both nationally and locally. Conversely, aspects of affordability, accessibility, community health, high-quality care, and patient-centeredness are inherent to a population health approach. Any efforts to prioritize population health must do so with these high-performance pillars as a foundation.

## DEVELOPMENTS IN RURAL PLACES

Transformative demonstration projects spearheaded by CMMI such as SIM grants and AHCs have been implemented successfully in states and communities with a focus on population health and the needs of rural areas. Hospitals, health systems, and public health departments are using collaboration and tools such as community health needs assessments (CHNAs) to identify and address population health needs. Medicare and Medicaid policy and program advances have prioritized community health and the integration of public health and clinical care. The diverse demonstrations and developments that have been taking place across the country provide examples of best practices and key lessons for future efforts to address population health in rural America.

### *State Innovation Models (SIMs)*

SIM demonstration grants allow states to design and test statewide health system transformation. Model Design and Pre-Test Awards give states the opportunity to plan their strategies, whereas Model Test Awards allow states to implement and test these strategies. There have been two rounds in the SIM program. Round 1 began in 2013; 16 states received model design awards, and six subsequently received model implementation awards.<sup>12</sup> Round 2 Model Test Awards were made to 11 states in 2011 and they posted their third annual reports in 2019.<sup>13</sup> We describe specific examples of rural innovation relevant to population health in paragraphs that follow.

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<sup>11</sup> [http://www.rupri.org/Forms/FuturesLab\\_Health\\_Jan2012.pdf](http://www.rupri.org/Forms/FuturesLab_Health_Jan2012.pdf)

<sup>12</sup> <https://innovation.cms.gov/innovation-models/state-innovations-model-testing>

<sup>13</sup> <https://innovation.cms.gov/innovation-models/state-innovations-round-two>

With its Round 1 Model Test Award, Minnesota created four practice transformation grants for rural providers. These grants aided activities including transition to performance-based payment, health information technology, and quality improvement. Minnesota found that these one-time grants were often enough for rural areas to sustain participation in SIM efforts. The State further reached rural areas by requiring that 10 of 25 care teams that received help from one of these grants be located in a rural or underserved area. These efforts led to a total of 43 percent of participating organizations being located in rural areas.<sup>14</sup>

With its Round 1 Model Design Award, Idaho planned transformation initiatives recognizing that 33 percent of the state is rural. To better engage its rural communities, Idaho held town hall meetings during the planning process. Recognizing that rural providers may need greater help to create patient-centered medical homes, Idaho created seven regional collaboratives to aid transformation efforts. Idaho's proposed activities indicate strong workforce concerns, including increasing medical education scholarships, increasing medical education slots for students at schools with rural training, and maximizing its existing workforce, such as emergency personnel and community health workers. One stakeholder noted, "The rural populations spurred us on. Why should someone who lives in rural Idaho get a lower standard of care than someone in Boise?"<sup>15</sup>

SIM demonstration projects offer several key lessons for future State efforts to include rural practices and communities. A common reason cited by many states for low rural practice participation in population health efforts was limited funding and time constraints on these practices. To overcome such hurdles, it can be helpful to give rural practices extra support to incentivize and encourage practice transformation, either in the form of increased financial assistance or administrative assistance. Second, to address population health, rural communities must take full advantage of their existing workforce and attract new professionals. To encourage this, states can expand scope of practice laws; provide attractive incentives to recruit practitioners, including tax incentives and loan forgiveness; and expand use of professionals beyond providers, such as community health workers, emergency service personnel, and social workers. Finally, states and rural practices can invest in telehealth expansion and training, which would not only provide expanded specialty care to rural communities, but would also relieve time constraints placed on rural providers, allowing them to devote more time to population health-centered activities.

### *Accountable Health Communities*

The AHCs model was created to test the theory that connecting patients to health-related social needs through their care providers can lower health expenditures and improve patient health. The CMMI announced the AHCs demonstration project in January 2018, allowing "bridge organizations," or those that act as a connector between clinical care and social needs, to apply to participate in one of two tracks, the Alignment Track or the Assistance Track. Through the Alignment Track, bridge organizations encourage alignment between community organizations so that services are available for patients, whereas through the Assistance Track, bridge organizations assist patients with accessing support for health-related social needs.<sup>8</sup> Thirty organizations across the country are participating in this 5-year demonstration, with 10 of these participants serving rural areas. In January 2018, a standard screening tool was released that helps participants identify social needs through questions regarding living situation, food, transportation, utilities, safety, financial strain, employment, family and community support, education, physical activity, substance

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<sup>14</sup> <https://downloads.cms.gov/files/cmml/sim-rd1-mt-fifthannrpt.pdf>

<sup>15</sup> [https://downloads.cms.gov/files/cmml/SIM-Round1-ModelDesign-PreTest-EvaluationRpt\\_5\\_6\\_15.pdf](https://downloads.cms.gov/files/cmml/SIM-Round1-ModelDesign-PreTest-EvaluationRpt_5_6_15.pdf)

use, mental health, and disabilities.<sup>16</sup> Though evaluations for this project are not yet available, the concept is not new. Several communities have designed and implemented similar models in a variety of community settings, informing future transformation efforts in rural areas. Examples of areas with projects similar to AHCs models include Colorado; Summit County, Ohio; San Diego County, California; Lane County, Oregon; and Bernalillo County, New Mexico.<sup>17</sup>

Colorado has had statewide success with this approach using Regional Accountable Entities, which are organizations that connect providers and behavioral health organizations for Medicaid patients through five key activities, including coordinating care, building networks, administering programs, monitoring data and metrics, and improving health. There are seven of these entities, each of which covers specific regions of the state, ensuring that all areas of the state, whether urban or rural, are supported. Two of these organizations are also solely dedicated to providing services to Federally Qualified Health Centers (FQHCs) and community mental health centers.<sup>9,18</sup> Similarly, Bernalillo County, New Mexico, created Pathways to a Healthy Bernalillo County, a central organization that acts as a hub in contracting and coordinating services to partner organizations and more rural areas of the state.<sup>9</sup>

A key lesson from the varied Accountable Care Community-like projects is the importance of community buy-in when developing and implementing population health integration. For example, Summit County, Ohio's, Live Healthy Summit County effort, which created a referral process between providers and public health organizations, garnered participation from 70 local organizations and all 4 of the county's major health systems.<sup>9</sup> They did so by engaging a group of diverse stakeholders on their executive committee and contracting with an organization dedicated to facilitating community engagement. Another lesson from these projects is the ability for communities themselves to leverage a variety of funding sources to commit to addressing population health. Live Well San Diego utilized general funds from the San Diego County Supervisors, State and Federal community transformation grants, and philanthropic resources.<sup>9</sup>

### *Urban System Investments*

Because of their scale and available resources, large and/or urban health systems and health plans have been investing in population health, some for close to 30 years. Their initiatives provide a history with specific programmatic elements that can inform rural initiatives. Bon Secours Health System in Marriottsville, Massachusetts, has provided financial support since the 1990s to organizations that improve access to affordable food and housing and help support the local community.<sup>19</sup> Similarly, Dignity Health in San Francisco, California, provides direct loans and partners with community development financial institutions to help create FQHCs, expand affordable housing, and reduce emergency department use by homeless populations.<sup>20</sup> ProMedica in Toledo, Ohio, went beyond investing in community organizations by creating a nonprofit of its own, the ProMedica Ebeid Institute for Population Health, which has a food market with affordable and fresh options, a classroom kitchen, and employment opportunities for local residents. ProMedica also created a screening tool for hunger when patients are admitted to its hospital, and provides a one-day emergency food supply for those in need. The health system is also an advocate

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<sup>16</sup> <https://innovation.cms.gov/initiatives/ahcm/>

<sup>17</sup> <https://www.preventioninstitute.org/sites/default/files/publications/Accountable%20Communities%20for%20Health%20Opportunities%20and%20Recommendations.pdf>

<sup>18</sup> <https://www.coloradohealthinstitute.org/research/ways-raes>

<sup>19</sup> <https://hospitaltoolkits.org/investment/case-studies/bon-secours/>

<sup>20</sup> <https://hospitaltoolkits.org/investment/case-studies/dignity-health/>

for encouraging other hospitals to repeat their own innovations, with transparent and transferrable models.<sup>21</sup>

For the health systems that have resources to invest, allocating funds to efforts or organizations that focus on population health can be financially desirable. Through its interventions, Johns Hopkins Medicine has achieved an average savings of \$1,643 per beneficiary per quarter in cost of care.<sup>22</sup> For some health systems, this behavior can be encouraged through State leadership. Maryland's health care mandate compels hospitals to control costs, improve quality, partner with community organizations, and measure population health outcomes.

### ***Extending to Rural Hospitals***

Though it is more common for large health systems such as Johns Hopkins to have resources to invest in population health, there are a variety of ways for rural hospitals to do so as well. First, if the rural hospital is part of a larger health system, it can tap into the larger system's resources. ProMedica, for example, also includes several rural hospitals that have been nationally recognized for their quality and outcomes metrics.<sup>23</sup> Second, a transition from fee-for-service (FFS) to capitation-based payment can give rural hospitals the resources to invest in population health. The Pennsylvania Rural Health Model, a CMMI model currently underway, gives rural hospitals a global budget. With this global budget, hospitals must meet targets, including one centered on population health.<sup>24</sup> Finally, rural hospitals can leverage local resources from the community to invest in population health initiatives. In the Columbia Gorge seven-county region (five in Oregon, two in Washington), hospitals, community clinics, public health departments, and other community organizations worked through the Columbia Gorge Health Council and the Columbia Gorge Coordinated Care Organization to create a collaborative CHNA process that focuses on topics including chronic disease, mental health, and health care access.<sup>25</sup>

### ***Rural Hospital Partnerships With Other Entities to Promote Public Health***

Rural hospitals are also working strategically with public health departments and community health centers to address the population health needs of their patients, and public health departments are partnering with hospitals to do the same. With either entity as the originator, this communication line between organizations creates the collaboration necessary to streamline population health activities and enhance community participation. Sakakawea Medical Center, a critical access hospital (CAH) in Hazen, North Dakota, has created this collaboration with the FQHC in the area, Coal Community Health Center. Because both organizations share the same CEO, competition between them is minimized, encouraging open communication. Sakakawea Medical Center employs a nursing care coordinator who creates a referral process between the hospital and community health and care management services. Sakakawea also holds monthly care coordination and population health meetings that include the nursing care coordinator, the patient care director, a licensed social worker from the hospital, as well as chronic care coordinators and

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<sup>21</sup> <https://www.promedica.org/socialdeterminants/Documents/Becoming-true-integrators.pdf>

<sup>22</sup> [https://www.hopkinsmedicine.org/international/partners-forum/2018/slides/Melissa.Sherry\\_Rethinking%20Value%20How%20Hospitals%20Can%20Drive%20Value%20in%20Communities%20They%20Serve.pdf](https://www.hopkinsmedicine.org/international/partners-forum/2018/slides/Melissa.Sherry_Rethinking%20Value%20How%20Hospitals%20Can%20Drive%20Value%20in%20Communities%20They%20Serve.pdf)

<sup>23</sup> <https://www.promedica.org/news/promedica-memorial-hospital-receives-national-recognition-for-performance-leadership>

<sup>24</sup> <https://innovation.cms.gov/initiatives/pa-rural-health-model/>

<sup>25</sup> <https://skylinehospital.com/wp-content/uploads/2019/06/Columbia-Gorge-Community-Health-Assessment-Full-Document-June-2017.pdf>

the director of patient care and innovation from Coal Community Health Center. One initiative that this structure has allowed the organizations to undertake is the reduction of ER use. By identifying patients who have been repeatedly admitted to the ER on a monthly basis, organizations can identify what can be done and by whom to prevent future admissions.<sup>26</sup>

In Missouri, the Health Care Collaborative of Rural Missouri, composed of 55 member organizations including area FQHCs, works to meet the clinical and social needs of community residents. This collaborative was created in 2004 with grant funding to provide community-based social services, but has evolved to a 501(c)(3) nonprofit with FQHC participation to integrate social services and clinical care. The board that governs the organization includes members from the FQHC, the local public health department, and dental and nursing schools to engage a variety of community members and perspectives. To improve care access, the Collaborative hosts Project Connect, which provides free preventive health care such as mammograms, flu shots, and blood pressure testing three times annually. To address health disparities, the Collaborative has hired community health workers that work both in the community and in local FQHCs. To improve transportation access, the Collaborative created HealthTran, a transportation network that gives free rides to patients in need.<sup>27</sup>

### *Community Health Needs Assessments (CHNAs)*

CHNAs are a tool that hospitals can use to identify and implement population health activities. CHNAs, required by 501(c)(3) hospitals by the Patient Protection and Affordable Care Act (PPACA) of 2010, allow hospitals to recognize and respond to the needs of their community in order to fulfill their requirement to provide community benefit.<sup>28</sup> These needs assessments and corresponding implementation plans can be used to assess the population health needs of a community and can aid development of collaborative solutions. To comply with PPACA requirements, hospitals must meet five conditions when conducting their CHNAs, including defining their community, assessing its needs, receiving input from broad community interests, creating a written report, and making this report widely available.<sup>29</sup> Many hospitals and health systems have gone beyond the minimum required by law in the ways they have used their CHNAs to improve population health.

The Association of American Medical Colleges' 2017 Health Equity Research Snapshot provided case examples of member hospitals with exemplary processes in conducting their CHNAs and engaging with their local communities. Dartmouth Hitchcock Medical Center in New Hampshire engaged four other local hospitals in the development of its CHNA. Its Population Health Council created priorities, including improving access to housing, transportation, and education. To fund achievement of these priorities, the medical center used a Population Health Innovation Fund that was created by its Board of Trustees. In Bethlehem, Pennsylvania, Saint Luke's University Health System used a variety of data sources including national, state, county, and ZIP code data, as well as primary sources such as focus groups and community surveys, in their assessment. Through these efforts, they were later able to implement strategies including a mobile food unit, a heart clinic run by medical students, and literacy initiatives. In New Jersey, Atlantic Health System achieved public

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<sup>26</sup> [http://www.hret-hiin.org/Resources/rural\\_cah/18/hret-hiin-rural-cah-readmissions-event-sequel-the-power-of-personalized-care-transitions-in-a-cah-setting-slides.pdf](http://www.hret-hiin.org/Resources/rural_cah/18/hret-hiin-rural-cah-readmissions-event-sequel-the-power-of-personalized-care-transitions-in-a-cah-setting-slides.pdf)

<sup>27</sup> <https://ruralhealthvalue.public-health.uiowa.edu/files/Whole-Person%20Care.pdf>

<sup>28</sup> <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>

<sup>29</sup> <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>

accountability by creating a website with 150 public health indicators that is updated to show the community's progress.<sup>30</sup>

How can rural hospitals and communities similarly leverage CHNAs to address population health? This innovative use of CHNAs is not limited to academic medical centers. Challenges that rural hospitals face when conducting CHNAs, such as limited resources, time constraints, and lack of scale, can be overcome through collaboration. Like Dartmouth Hitchcock, rural hospitals can engage other hospitals in the area, leveraging resources and community knowledge to generate the funding, engagement, and expertise that larger academic medical centers are able to utilize. In Illinois, the Illinois Critical Access Hospital Network (ICAHN), a group composed of CAHs from across the state, work together on data collection and analysis to inform their CHNAs. ICAHN also acts as a dissemination and support structure for new designs and collaborations for CHNAs.<sup>31</sup> For example, Fairfield Memorial Hospital in Fairfield, Illinois, engaged a variety of community organizations and members in the development of its CHNA. They then used ICAHN as a facilitator for focus groups, engaging community leaders from across the state.<sup>32</sup> Hospitals can also work with their local public health departments in data collection, evaluation, and implementation.<sup>33</sup> Similar to Saint Luke's in Pennsylvania, hospitals can utilize secondary data sources if they do not have the resources to conduct their own surveys or focus groups. Overall, collaboration with the community, other hospitals, public health departments, and other community organizations and stakeholders can be essential to successfully using CHNAs to improve population health.

### *Facilitative Considerations*

The RUPRI Health Panel identified common themes from the diverse demonstration projects and activities described above. Identifying these common considerations can provide guidance for subsequent efforts to improve population health for rural hospitals and communities.

- Create community buy-in and participation. This can be achieved by utilizing community partners throughout planning and implementation processes. These partners can be directly involved in future service provision, but can also be board members for communities using a central entity to facilitate activities.
- Foster collaboration between other hospitals, public health departments, behavioral health organizations, and other community organizations. With SIM and AHC demonstration projects, many efforts created a central entity to act as a coordinator between these stakeholders. They used different titles to encompass the same concept of extending health care services into communities: Community Health Teams, Community Health Innovation Regions, Regional Collaboratives, Healthy Neighborhoods, and Health Enhancement Communities.

These collaborations can take place at a variety of levels. SIM demonstration projects provide examples of statewide population health coordination, while AHC projects collaborate at the regional or county level, and other efforts are initiated by

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<sup>30</sup> <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>

<sup>31</sup> <http://www.chna.icahn.org>

<sup>32</sup> <https://www.fairfieldmemorial.org/sites/default/files/2016%20Fairfield%20Memorial%20Hospital%20Community%20Health%20Needs%20Assessment.pdf>

<sup>33</sup> <https://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>

a single hospital. Collaborations can successfully operate at each of these levels, depending on the needs, resources, and motivations of the State, community, or hospital. Each of these levels will base their projects on a different framing of population health. While activities at the State level can benefit from enhanced funding and resource support through grants and a broader knowledge base, operation at the local level can make it easier to sustain efforts once initial funding mechanisms are gone. It can also be easier to accomplish care coordination in a smaller community. For example, if a rural community has only one hospital, that hospital can act as the main facilitator in connecting its patients to social supports. Within smaller communities, it can be easier to disseminate a plan to address population health, and if disseminated through the right channels with the proper messaging, the plan can gain recognition and support from the broader community.

- Engage a diverse workforce. Burlington, Vermont's health system engaged 300 leadership team members in their CHNA. SIM findings highlight the importance of focusing rural recruitment and retention strategies not only on physicians, but also on those who practice outside of clinical care, and on the importance of allowing health care providers to practice at the top of their licenses. ProMedica's Ebeid Institute for Population Health not only provided nutritious food to its local community, but also employed community members, generating further sustainability as well as community buy-in. Recruitment and retention strategies for health care practitioners can be both financial and nonfinancial, including tax incentives, loan forgiveness, expanded scope of practice laws, and strategic targeting of physicians who wish to remain in rural areas.
- Use a variety of funding streams, from philanthropic resources, to State and Federal grants, to their own investments (especially nonprofit hospitals required to invest in community benefits). State and Federal grants can provide the initial resources necessary for communities to make investments in population health. Not all of these grants need to be large sums aimed specifically at changing entire social service delivery structures, such as SIM or ACH grants. Alternatively, communities can apply for smaller State and Federal grants to enhance infrastructure, such as telehealth or broadband capacity, to enable them to be ready for the collaboration necessary to implement population health activities. Public health departments and hospitals can use their own resources to create and/or sustain population health activities as well. Beginning with investments from the local community, public health departments and hospitals can incentivize planning for the sustaining of funds beyond the initial investment and can hold community organizations and members accountable for the work being done.
- Build upon an existing framework that works well. Primary care and patient-centered medical homes can be a natural building block to transition to person-centered medical homes. As envisioned by the Panel in the high performance rural health system framing, the latter would use teams of health care providers, community workers, and persons served to develop approaches to optimizing personal health in a community context. This is a more comprehensive model than the patient-centered health home references in the PPACA and described by the Substance Abuse and Mental Health Services Administration as a model for caring

for patients with chronic conditions including mental illness.<sup>34</sup> ProMedica built upon an already existing screening process to screen its patients for hunger. Utah's SIM effort used existing health education centers to train rural hospitals in peer support, programming, and behavioral health. However, building upon existing programming can also limit innovation. Existing programs must be carried forward because they hold the most potential, not solely because they are easiest to implement. If building upon processes already in place, organizations must understand why they are doing so and thoroughly consider alternatives before moving forward.

## MEDICARE AND MEDICAID POLICY

Though several of the above demonstrations had their roots in Medicare and Medicaid funding, the Medicare and Medicaid programs are also addressing population health through policy. As the single largest payer for health care in the country, CMS has the opportunity to be at the forefront of innovation in addressing population health through Medicare and Medicaid programs.<sup>35</sup> In a November, 2018 speech, HHS secretary, Alex Azar, stated, "What if we provided solutions for the whole person, including addressing housing, nutrition, and other social needs? What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food?"<sup>36</sup> In varying ways, both programs are beginning to do exactly this. MA's prospective capitation-based payment arrangements intuitively incentivize care provision that is focused on population health. Managed care organizations benefit from cost savings when their patient population is healthy and in need of fewer medical services. Because of this, MA has often acted as an "incubator" in population health efforts.<sup>37</sup> Original Medicare has developed many value-based payment incentives that promote quality improvement and care coordination. Within their Medicaid programs, many states are choosing to focus on population health through State plan amendments, waivers, and managed care organization requirements.

### *Medicare*

#### Care Management Programs

In both Original Medicare and MA, care management programs play a role in improving population health. Within MA specifically, per capita payments allow organizations to invest in the infrastructure necessary to provide care management, and the structure of managed care provides a panel of patients that can be construed as a population whose health can be improved.<sup>38</sup> For example, Johns Hopkins MA plan uses care managers and community health workers to coordinate clinical and community services for 5,000 MA patients in Maryland, living in both rural and urban areas.<sup>22</sup> Since 2015, in Original Medicare, patients with two or more chronic conditions can receive chronic care management services, which include development of a comprehensive care plan that

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<sup>34</sup> <https://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>35</sup> [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/RoadmapOverview\\_OEA\\_1-16.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/RoadmapOverview_OEA_1-16.pdf)

<sup>36</sup> <https://www.healthleadersmedia.com/innovation/azar-outlines-hhs-ambition-social-determinants-health-5-takeaways>

<sup>37</sup> [https://www.bettermedicarealliance.org/sites/default/files/2018-11/BMA\\_WhitePaper\\_MA\\_SDOH\\_2018\\_11\\_14.pdf](https://www.bettermedicarealliance.org/sites/default/files/2018-11/BMA_WhitePaper_MA_SDOH_2018_11_14.pdf)

<sup>38</sup> <https://www.bettermedicarealliance.org/sites/default/files/2017-06/Bright%20Spots%20in%20Care%20Management%20Report.pdf>



details health problems as well as community-based services that can address them.<sup>39</sup> Physicians are compensated for providing this care through a Current Procedural Terminology (CPT) code that pays them an average of \$42 per month for each patient.<sup>40</sup> In FFS Medicare, the Shared Savings Program uses accountable care organizations (ACOs) composed of doctors, hospitals, and other health care providers to coordinate care for beneficiaries, controlling costs and improving quality of care.<sup>41</sup>

#### Value-Based Payment

**Value-based payment arrangements** within Medicare that reward eligible health care practitioners for the quality of care they provide to patients can also be tied to population health goals. For health plans, value-based payment is often seen as the vehicle through which they can address population health.<sup>42</sup> Legislation including the PPACA, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Protecting Access to Medicare Act of 2014 (PAMA) all included provisions that created programs and incentives to increase the delivery of value-based care.<sup>43</sup> The PPACA created the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program. MACRA included expansion of alternative payment models and the creation of the Merit-Based Incentive Payment System. MIPPA created the End-Stage Renal Disease Quality Incentive Program, which provides payment adjustments depending on quality of care provided by outpatient dialysis clinics.<sup>44</sup> Finally, PAMA created the Skilled Nursing Facility Value-Based Purchasing Program, which provides skilled nursing facilities enhanced payments based on the quality of care they provide and hospital readmissions measures.<sup>45</sup> Though value-based payment initiatives and others also underway can help move health systems toward population health activities, these initiatives provide unique challenges for rural communities. Some are explicitly designed for testing in large populations to allow for statistically significant findings when evaluating their impact, making it difficult for rural providers to participate unless they find means of aggregating populations beyond their own service area. Rural practices often do not have the time, resources, or necessary infrastructure for added data collection and reporting requirements.<sup>46</sup> Thus, for these initiatives to be successful in rural areas, practices must also be equipped with proper staff and infrastructure.

#### Supplemental Benefits

Population health can also be addressed through **supplemental benefit offerings** of MA plans. The CHRONIC Care Act, passed as part of the Bipartisan Budget Act of 2019, allows for plans to tailor supplemental benefits for chronically ill beneficiaries. Examples of tailored supplemental benefits that can be provided to chronically ill beneficiaries include more frequent foot exams for a diabetic, nonemergency transportation to appointments for chronic disease patients, or waived fees

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<sup>39</sup> <https://www.medicare.gov/coverage/chronic-care-management-services>

<sup>40</sup> <https://www.mdmag.com/physicians-money-digest/practice-management/chronic-care-management-reimbursement-why-arent-more-doctors-billing-for-it>

<sup>41</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html>

<sup>42</sup> <https://healthpayerintelligence.com/news/value-based-care-drives-progress-in-population-health-management>

<sup>43</sup> <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html>

<sup>44</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html>

<sup>45</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.html>

<sup>46</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20181012.255573/full/>

to see a specialist related to their chronic condition.<sup>47, 48</sup> Benefits can also be tailored by geography. Health plans can tailor supplemental benefits for those living in rural areas by, for example, providing expanded transportation benefits to these populations who must often travel greater distances for services.<sup>49</sup> Currently, a CMS rule requires that these tailored supplemental benefits must be primarily health related, and a 2018 final rule expanded this requirement to benefits that “compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization.” However, beginning in 2020, health plans can offer supplemental benefits for nonmedical services that provide “reasonable expectation that the services will help people with chronic conditions improve or maintain their health or overall function.” This would include services such as nonmedical transportation, home-delivered meals, and pest control.<sup>50</sup> For those without chronic conditions, supplemental benefits offered must still be primarily health related. Examples of supplemental benefits now allowable for all MA beneficiaries include nicotine replacement therapy, caregiver support, and minor home modifications.<sup>51</sup>

## Telehealth

For rural communities, **expanded telehealth options** in Medicare can increase timely access to care, preventing future morbidity and enhancing population health.<sup>52</sup> Prior to the Bipartisan Budget Act of 2018, telehealth benefits in FFS Medicare were limited to specific conditions, offered only in rural areas, and still required to be provided in a health care setting.<sup>53</sup> The Bipartisan Budget Act of 2018 and subsequent CMS rulemaking now allows MA plans to offer telehealth services to beneficiaries in their homes and expands use beyond rural areas.<sup>54</sup> Historically, MA plans have had more latitude in introducing telehealth benefits to beneficiaries. Though MA plans are required to offer the same services as FFS Medicare, they can use revenue generated from rebates to expand telehealth through supplemental benefit offerings with CMS approval.<sup>36</sup> Further expansion in telehealth policies are in place during the Public Health Emergency, including: eligible sites of care, eligible services, and Medicare payment.<sup>55</sup>

## Medicaid

### Preventive Services and Social Supports

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<sup>47</sup> Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (2018).

<sup>48</sup> from <https://www.commonwealthfund.org/blog/2018/great-power-comes-great-responsibility-medicare-advantages-newfound-supplemental-benefit>

<sup>49</sup> <http://www.cierant.com/leveraging-the-expansion-of-supplemental-benefits/>

<sup>50</sup> <https://www.commonwealthfund.org/blog/2019/new-medicare-advantage-benefits-offer-social-services-people-chronic-illness>

<sup>51</sup> <https://blog.aarp.org/2018/10/30/supplemental-benefits-in-medicare-advantage-whats-changing-in-2019-and-whats-not/>

<sup>52</sup> <https://www.cms.gov/newsroom/press-releases/cms-finalizes-policies-bring-innovative-telehealth-benefit-medicare-advantage>

<sup>53</sup> [https://www.bettermedicarealliance.org/sites/default/files/2018-02/BMA\\_OnePager\\_Telemedicine%20in%20Medicare%20Advantage\\_2018\\_01\\_26\\_v2a.pdf](https://www.bettermedicarealliance.org/sites/default/files/2018-02/BMA_OnePager_Telemedicine%20in%20Medicare%20Advantage_2018_01_26_v2a.pdf)

<sup>54</sup> <https://www.cms.gov/newsroom/press-releases/cms-finalizes-policies-bring-innovative-telehealth-benefit-medicare-advantage>

<sup>55</sup> <https://rupri.org/2020/10/09/report-on-telehealth-policies/>

Because of its role as a safety-net provider for those with limited resources, Medicaid has long been involved in the **provision of preventive services and connection to social supports** for beneficiaries. In 1967, the Early and Periodic Screening, Diagnostic, and Treatment program was created to provide preventive health screenings such as vision and hearing for children and adolescents.<sup>56</sup> In 2010, the PPACA mandated coverage for a variety of other preventive services, such as routine immunizations, preventive care and screenings, contraceptives, and tobacco cessation for pregnant women. The PPACA also created State incentives for the creation of programs that help prevent chronic diseases, including tobacco cessation, weight loss, diabetes prevention, and chronic disease management.<sup>40</sup> Expansion of preventive services, coupled with expansion of Medicaid itself, is especially valuable to rural communities, whose residents are more likely to be uninsured, and of those who are insured, are more likely to be Medicaid beneficiaries.<sup>57</sup> <sup>58</sup>The Medicaid program can help keep rural hospitals open, especially in expansion states. In states that expanded Medicaid, the uninsured rate decreased from 35 percent to 16 percent, lowering the burden of uncompensated care for these rural hospitals.<sup>59</sup>

### State Flexibility

Beyond the mandated and incentivized provision of preventive care services, States themselves have latitude to implement their own population health efforts. This can be accomplished through a variety of mechanisms including **State plan amendments, waivers, managed care contracts, and State and Federal partnerships**.<sup>40, 60</sup> State plans are written agreements between each State and the Federal government and lay out how the State will administer their Medicaid program. The State must agree to abide by all Federal Medicaid requirements and describe how they will do so. This plan can later be altered through State plan amendments.<sup>61</sup> For example, a State can modify its State plan to provide targeted case management to specific populations or areas in need.<sup>53</sup> States can apply for waivers to deviate from specific sections of their Federal requirements with approval from HHS. A Section 1115 waiver allows states to waive a requirement for demonstration purposes if it furthers Medicaid program objectives. Twenty-four states have used this waiver to pay for substance use disorder treatment, while one state (Vermont) has used it to pay for mental health treatment.<sup>62</sup> States with Medicaid managed care plans can also address population health, either by the State requiring that a managed care company must provide services such as care coordination or other social services, or by the plan itself using funds for nonmedical services such as housing or transportation supports.<sup>44</sup> Finally, many State and Federal organizational partnerships with Medicaid were created with the goal of improving of population health. The Health Resources and Services Administration (HRSA) provides block grants to the states for maternal and child health services, and the Center for Disease Control and Prevention (CDC) collaborates with State Medicaid programs for newborn screening.<sup>40</sup>

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<sup>56</sup> [https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid\\_and\\_Population\\_Health.pdf](https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_and_Population_Health.pdf)

<sup>57</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5726939/>

<sup>58</sup> <https://rupri.public-health.uiowa.edu/publications/policybriefs/2017/Changing%20Rural%20and%20Urban%20Enrollment%20in%20State%20Medicaid%20Programs.pdf>

<sup>59</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20190124.621253/full/>

<sup>60</sup> <https://www.aha.org/system/files/2019-01/medicaid-financing-interventions-that-address-social-determinants-of-health.pdf>

<sup>61</sup> <https://www.macpac.gov/subtopic/state-plan/>

<sup>62</sup> <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table5>

States have used these various mechanisms to address population health in ways similar to the Medicare program. The increased prevalence of Medicaid managed care provides opportunity for enhanced coordination of services. Today, the majority of Medicaid beneficiaries are enrolled in managed care plans. However, there is large variation in the coordination of services by states and managed care plans, and the majority of spending in Medicaid is still based on FFS arrangements.<sup>63</sup> A common way for managed care plans to provide population health services is through contracting with limited benefit plans, which provide specific benefits such as behavioral health services or transportation services within an FFS structure.

#### Telehealth

Medicaid patients, especially in rural areas, have benefited from ***expanded telehealth options*** that provide services outside clinics and beyond typical benefit design. Because there is little Federal guidance on the use of telehealth in Medicaid, the extent to which Medicaid covers telehealth services, how it does so, and what is covered varies significantly across the states. In terms of how telehealth is delivered, every state except Massachusetts covers live video services, while 21 states cover remote patient monitoring. Nineteen states do not specify who must deliver telehealth services, while 14 states specify 9 or fewer types of providers who can deliver services. Some states cover telehealth within health home arrangements. For example, Ohio's health home for those with serious mental illness allows patients to receive care remotely through telehealth. Several states also use telehealth to provide home- and community-based services, such as monitoring of patients who would otherwise require care in a long-term care facility or for educational or disease management services.<sup>48</sup>

#### Future Action

HHS secretary Alex Azar encourages these approaches and other demonstration project measures to further embed population health into the Medicaid program will become more common. Azar has noted that his department's title of Health and Human Services indicates a responsibility to be a leader in the provision of human services, not just direct clinical care.<sup>64</sup> Even if the role of Medicaid is not to expand beyond clinical care provision, Medicaid and the health care system as a whole functions as a significant point of contact for citizens and the provision of social support services. This is especially true in rural communities, where hospitals often serve as the main employer and central entity in the community. Thus, even if State Medicaid programs themselves are not reimbursing for social service supports and population health initiatives, they can act as a facilitator in connecting beneficiaries to these services.

#### ***Supportive actions in public programs***

State Medicaid agencies can gradually invest in population health in a sustainable manner by leveraging existing Federal Medicaid and Children's Health Insurance Program authority. Moving Health Care Upstream, a collaboration between Nemours Children's Health System and the University of California, Los Angeles Center for Healthier Children, Families, and Communities, has created resources such as a toolkit, a white paper, case studies, and webinars that demonstrate how state Medicaid programs can deliver preventive services. The roadmap has five stages, each of which moves progressively closer to comprehensive population health strategies. Case studies and examples show how states have implemented various stages of this approach. For example, in stage

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<sup>63</sup> <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>

<sup>64</sup> <https://www.ajmc.com/focus-of-the-week/azar-cmmi-will-get-more-involved-in-addressing-social-needs-driving-health-issues>

one, physicians and other licensed health care providers provide preventive services in a health care setting. Oklahoma exemplifies the first stage of the roadmap by reimbursing for health and behavioral health services delivered by mental health providers. In stage four, population health interventions are not provided only to the individual, but to the whole community. Massachusetts fulfills the fourth stage of the roadmap by using Children’s Health Insurance Program funds to support nine different public health programs for children.<sup>65</sup> Moving Health Care Upstream also created an accompanying white paper that provides further detail on these strategies. It identifies facilitators to addressing population health such as a champion within the State government, robust infrastructure, and incentives in Medicaid managed care contracts, as well as challenges to doing so such as difficulty establishing return on investment and Medicaid’s historical clinical perspective.<sup>66</sup>

Hospitals and communities can participate in disease-focused programs or programs addressing specific populations that generate funding to leverage other activities because of investment in personnel and other resources. To combat the opioid crisis, HRSA is investing in specific areas of interest, including increasing access to primary care, using telehealth, connecting stakeholders to resources, sharing best practices, increasing primary care training, informing policy, and addressing drug overdoses. Each one of these objectives is accompanied with funding that hospitals and/or communities can use to accomplish these goals. For example, to increase opioid primary care training, HRSA gave \$18.5 million in support to expanding the behavioral health workforce through partnerships with academic institutions and health centers. Moreover, depending on the objectives, these resources can be specifically directed to rural areas. For example, HRSA has given \$298 million to rural communities specifically since September 2018 (through January 2021) to help their planning and coordination for opioid crisis response.<sup>67</sup> If a hospital or community expands services such as these, they can use this investment and momentum to sustain these activities and expand them to new areas and/or populations.

Within the Medicare program, providers can prioritize preventive service provision for their patients and be reimbursed for doing so. The Medicare program covers services such as diabetes screening, cardiovascular screening, behavioral therapy for obesity and cardiovascular disease, annual wellness visits, and personalized prevention plan services.<sup>68</sup> Beyond the individual patient-provider interaction, Medicare has also invested in larger demonstration projects centered on prevention and population health activities. The Medicare Diabetes Prevention Program was announced in 2016 with the goal of preventing those with prediabetes from developing type-two diabetes. The demonstration currently has 103 organizations participating as Medicare Diabetes Prevention Program suppliers, who provide education and follow up to help prediabetic patients live a healthy lifestyle.<sup>69</sup>

### *Summary of Policy-Based Activities*

Increased policy interest in investing in population health is evident through expanding programmatic and reimbursement options for population health-related activities, from care management to telehealth. The discussion in previous sections of this paper is summarized in the four statements below

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#### **Policy-based Activities:**

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<sup>65</sup> [https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/roadmapsummary\\_final6b.pdf](https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/roadmapsummary_final6b.pdf)

<sup>66</sup> [https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/whitepaper\\_final7a.pdf](https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/whitepaper_final7a.pdf)

<sup>67</sup> <https://www.hrsa.gov/opioids>

<sup>68</sup> [https://www.acog.org/-/media/Departments/Coding/Screening-Services-2018\\_final.pdf](https://www.acog.org/-/media/Departments/Coding/Screening-Services-2018_final.pdf)

<sup>69</sup> <https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>

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- Value-based payments can help incentivize population health investment, but rural hospitals must be equipped with adequate staff and infrastructure to participate.
  - Flexibility in covered benefits can tailor population health activities to the groups that need it most.
  - Individual states can be leaders in integrating population health and clinical care through Medicaid tools such as State plan amendments and waivers.
  - Telehealth can be a useful resource for both Medicare and Medicaid in reaching rural populations for clinical services, community-based services, and care coordination.
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## PANEL FRAMING

The RUPRI Health Panel's previous work on population health projects and Medicare and Medicaid policy analysis uniquely qualifies it to contribute to a discussion focused on the policy needs and opportunities for rural areas, particularly rural health care organizations. Specifically, this paper is framed by previous Panel work on high-performance rural health care systems and policy opportunities for advancing rural health.

## CRITICAL QUESTIONS AND POLICY OPPORTUNITIES

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### Critical Questions:

1. What strategies can be used to incorporate population health into rural health, and what are the key ingredients necessary for these strategies to succeed?
  2. What unique characteristics give rural communities an advantage in addressing population health?
  3. How can collaboration be effectively used to help rural hospitals implement population health strategies?
  4. How can rural health care systems (originating anywhere in the system, including public health agencies) gain broad-based community support for population health activities?
  5. How can the local health care workforce be further involved in addressing population health?
  6. How can rural systems sustain population health investment and progress?
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What policy facilitators can help answer these questions and accomplish population health and high-performance goals? In its report titled *Taking Stock: Policy Opportunities for Advancing Rural Health*, the Panel identified key policy opportunities across a range of health care topic areas. Because of the interrelated nature of population health and other high-performance system characteristics, many of these levers also aid in answering the critical questions (CQ) above.

**CQ1: *What strategies can be used to incorporate population health into rural health, and what are the key ingredients necessary for these strategies to succeed?***

Answering this question requires monitoring the impact of demonstration programs on rural beneficiaries, providers, health plans, and communities. Though this document has provided numerous examples of population health activities in rural areas, in order to translate these examples into structural recommendations, outcome metrics and evaluation processes should be in place. In addition, the development of rural-relevant performance measures must be supported.

Doing so in a similar manner across projects and organizations would allow for consistency in quality comparison across population health demonstration projects, which then allows for objectivity and ease in identifying successful rural programs to be expanded. Finally, it is important to recognize that many of the successful characteristics of population health approaches that have been identified were in an urban context. Consideration must be given to the unique characteristics of rural areas specifically that can lead to future success.

***CQ2: What unique characteristics of rural communities give them an advantage in addressing population health?***

The various types of capital discussed earlier (physical, financial, human, intellectual, social, cultural, political, and natural) that are present in rural communities, and the benefits they hold, provide a starting point to identify the ways in which rural communities can leverage their strengths. To further understand what unique features of rural communities can give them an advantage in addressing population health, these communities must have a prominent role in delivery system innovations. One advantage of demonstration projects originating from the local community is the flexibility and knowledge to capitalize on a community's strengths. Rural beneficiaries, providers, health plans, and communities may themselves know what characteristics such as these set them apart relative to other communities. For these characteristics to be recognized and realized when innovative activity originates at the state or national level, it is important to have rural organizations at the table in the development of these delivery system innovations. Finally, the impact of innovations taking place in rural communities should also be monitored over time.

***CQ3: How can collaboration be effectively used to help rural hospitals implement population health strategies?***

In the various demonstration project examples described previously, collaboration was often a key component to success in implementing population health strategies. However, collaboration within an urban system, where a variety of hospitals are already linked, may look vastly different than the collaboration necessary in rural communities, which are often composed of small, independent hospitals. It is important to expand collaboration opportunities for rural providers, particularly in a way that serves their unique situational needs. In rural areas specifically, this collaboration can often happen more informally. If leaders from hospitals and community organizations know one another personally, it can be easier to have an open line of communication and a long-term collaborative relationship. For hospitals with already strained resources, encouraging collaboration between rural hospitals and community organizations can also maximize efficiency and decrease duplication of services. It can help solidify clear population health roles for each organization, helping patients receive services at the appropriate venues. Collaboration in communities and organizations on population health can also lead to dissemination of best practices, both within and across communities.

***CQ4: How can rural health care systems (originating anywhere in the system, including public health agencies) gain broad-based community support for population health activities?***

Though important in any community, achieving community support for population health initiatives is particularly necessary in rural areas. The sense of community present in rural areas can mean that perception of activities can shift quickly by word of mouth. Having community support and a community feeling of contribution and accountability to the population health activities can help garner this support. Rural areas may have a smaller pool of community organizations to partner with, increasing the stakes for a health system that seeks to create a

sustainable partnership. In smaller communities, the attitudes toward an initiative can have a significant impact on its success. For population health measures to be favorable and widely implemented within the community, they must be affordable for residents. In addition to garnering external community support, rural health care organizations must gain support from their own staff members. Thus, population health initiatives must balance affordability with adequate compensation for providers taking on the responsibility of administering or coordinating population health services.

***CQ5: How can the local workforce be further involved in addressing population health?***

The full range of workers providing health services in rural places should be engaged in population health activities. In addition to traditional health care providers such as physicians, physician assistants and nurse practitioners, other providers such as health care workers include social workers, patient navigators, and community health workers are important in the delivery of population health care. Providing financial incentives for these various providers to deliver preventive services and care coordination is integral to population health initiatives. Because rural health care organizations may not have the same volume as urban providers, they may face more risk when attempting to transition to value-based payment approaches. Providing rural health care organizations with a longer transition period or technical assistance can help overcome this hurdle.

***CQ6: How can rural systems sustain population health investment and progress?***

Transitional supports are vital to sustaining population health activities in a local community beyond a defined demonstration or project period. It is important to provide long-term technical assistance support to health care and community organizations so that when difficulties arise, population health activities are not abandoned, but participants are instead armed with a variety of solutions to advance the initiative. The above activities, such as collaboration across communities and organizations and engaging the local community and workforce, will also provide rural communities and health care organizations with the knowledge and connections they need to continue to innovatively improve their population’s health beyond the short term.

**Questions and Opportunities Summary Table**

Critical Questions	Policy Opportunities
CQ1: What strategies can be used to incorporate population health into rural health, and what are the key ingredients necessary for these strategies to succeed?	<ul style="list-style-type: none"> <li>- Monitor the impact of demonstration programs on rural beneficiaries, providers, health plans, and communities.</li> <li>- Support development of rural-relevant performance measures.</li> </ul>
CQ2: What unique characteristics give rural communities an advantage in addressing population health??	<ul style="list-style-type: none"> <li>- Include rural beneficiaries, providers, and communities in Medicaid payment and delivery system innovations, and monitor innovation impact over time.</li> <li>- Develop and test alternative delivery models in rural communities through demonstration and pilot programs.</li> </ul>
CQ3: How can collaboration be effectively used to help rural hospitals implement population health strategies?	<ul style="list-style-type: none"> <li>- Expand collaborative opportunities among rural providers.</li> </ul>



CQ4: How can rural health care systems (originating anywhere in the system, including public health agencies) gain broad-based community support for population health activities?	<ul style="list-style-type: none"> <li>- Ensure affordability of clinical and community-based preventive services.</li> <li>- Provide stable long-term funding to support locally appropriate public health prevention programs.</li> </ul>
CQ5: How can the local workforce further be involved in addressing population health?	<ul style="list-style-type: none"> <li>- Offer alternative pathways to rural provider inclusion in value-based payments.</li> <li>- Update payment policies to non-physician and patient support providers.</li> </ul>
CQ6: How can rural systems sustain population health investment and progress?	<ul style="list-style-type: none"> <li>- Offer transitional supports to rural providers during payment policy changes.</li> <li>- Develop a comprehensive cross-agency approach to rural health care quality improvement technical assistance.</li> <li>- Leverage existing Medicaid authority and special programs for funding support.</li> </ul>

**FUTURE CONSIDERATIONS**

***CHRONIC Care Act Implementation***

The CHRONIC Care Act was passed in February 2018, with the goal of increasing care coordination and disease management for those with complex and chronic conditions. The Act does so first by allowing MA plans to cover expanded services for beneficiaries with chronic conditions, such as home modifications. It also expands use of telehealth for MA plans as well as ACOs. By permanently authorizing MA special needs plans, the Act continues to allow tailoring of benefits to best address the needs of dual-eligibles (Medicare beneficiaries also eligible for Medicaid), those with chronic conditions, and those in institutions. The Act also extends the Independence at Home demonstration program and expands access to home dialysis therapy. Through these efforts, the CHRONIC Care Act aims to improve population health by increasing access to preventive services, improving care coordination, and providing care for beneficiaries where they need it, whether in their home or remotely through telehealth services.<sup>70</sup> Most of these provisions take effect in 2020 and 2021; implementation may generate resources devoted to population health.

In July 2019, the Bipartisan Policy Center (BPC) released an analysis of the leverage created by the CHRONIC Care Act, *Next Steps in Chronic Care: Expanding Innovative Medicare Benefits*.<sup>71</sup> While not rural-specific, this report provides recommendations on what can still be done to improve care and outcomes for those with chronic conditions. The BPC recommends further integrating care for dual-eligibles through actions such as allowing states to keep Medicare shared savings that they receive through integrating Medicare and Medicaid services and providing funds for technical assistance teams to coordinate services. To improve supplemental benefit offerings for chronically ill beneficiaries, the BPC recommends standard language to communicate benefit coverage, educational materials for providers, and publication of outcomes research related to the

<sup>70</sup> [https://www.thescanfoundation.org/sites/default/files/chronic\\_care\\_act\\_brief\\_030718\\_final.pdf](https://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf)

<sup>71</sup> <https://bipartisanpolicy.org/wp-content/uploads/2019/07/Next-Steps-in-Chronic-Care.pdf>

supplemental benefits. Finally, for beneficiaries enrolled in FFS Medicare, the BPC suggests expanding chronic care management services and eliminating required co-pays, researching and identifying nonmedical benefits that could be covered for the chronically ill, and creating a process to facilitate which beneficiaries can be eligible for nonmedical benefit coverage.<sup>72</sup>

## *Federal Efforts*

### Ongoing Congressional Action

Bipartisan efforts to improve population health factors such as care coordination and disease management did not end with passage of the CHRONIC Care Act. Rural health care access is in the spotlight for both Democrats and Republicans as both parties grapple with how to keep struggling rural hospitals open, attract physicians to practice in rural areas, address high rates of preventable diseases such as obesity and diabetes, and transition rural entities toward value-based care delivery.<sup>73,74</sup> During the 116<sup>th</sup> Congress the Senate Health, Education, Labor, and Pensions Committee, the Senate Finance Committee, and the House Ways and Means Committee indicated their support for addressing population health, particularly in rural areas, through hearings and the consideration of a variety of legislation. There is renewed interest in addressing the health care delivery issues that face rural Americans, and in line with previous bipartisan legislation such as the CHRONIC Care Act, recognition of the value of a population health approach to doing so. The House of Representatives Committee on Ways and Means created a Rural and Underserved Communities Health Task Force in 2019, with four chairs including Rep. Danny Davis (D-IL), Rep. Terri Sewell (D-AL), Rep. Brad Wenstrup (R-OH), and Rep. Jodey Arrington (R-TX.) The committee members expressed a commitment to improving health care access for rural Americans, reducing disparities, and maintaining high-quality care provision.<sup>75</sup> In July 2020 they published a special report: “Left Out: Barriers to Health Equity for Rural and Underserved Communities”.<sup>76</sup>

### Administrative Flexibility

As CMS has done with the implementation of the CHRONIC Care Act, it can leverage its administrative flexibility to develop and implement programs and rules to improve rural population health. CMS has demonstrated its commitment thus far in this area and its continued interest to incent change. In her remarks at the National Rural Health Association annual conference in May 2019, CMS administrator, Seema Verma, spoke to the many challenges rural hospitals face and CMS’s role in addressing them. She stated, “Rethinking rural health is a vital part of CMS’s push to transform the health care delivery system to bring high quality, affordable, and accessible health care to all Americans.” In addition to the CHRONIC Care Act provision implementation mentioned above, CMS is taking a variety of actions to invest in high-quality rural health care delivery. To begin to address the lack of obstetric units and providers in rural areas, CMS hosted a Maternal Health Forum in June 2019 that convened experts and rural health care providers from across the country. CMS has also launched the first Rural Health Strategy,

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<sup>72</sup> <https://bipartisanpolicy.org/wp-content/uploads/2019/07/Next-Steps-in-Chronic-Care.pdf>

<sup>73</sup> <https://www.modernhealthcare.com/article/20181121/TRANSFORMATION01/181129977/politics-could-drive-2019-congressional-action-on-rural-health>

<sup>74</sup> <https://www.healthleadersmedia.com/strategy/rural-health-gets-hearing-congress-listening>

<sup>75</sup> <https://waysandmeans.house.gov/media-center/press-releases/ways-and-means-committee-launches-rural-and-underserved-communities>

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[https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Health%20Equity%20Report\\_07.2020\\_FINAL.pdf](https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Health%20Equity%20Report_07.2020_FINAL.pdf)

Rethinking Rural Health Initiative, tasked with developing programs and policies that capture and address the unique problems that rural communities face in health care.<sup>77</sup> Finally, the agency's development of ICD-10 (International Statistical Classification of Diseases and Related Health Problems), codes for Medicare and Medicaid programs that center on social determinants of health will help providers manage patients beyond the provision of direct clinical care. In 2019 Cara V. James, then the director of the CMS Office of Minority Health, stated, "These factors affect access to care and health care utilization as well as outcomes. As we seek to foster innovation, rethink rural health, find solutions to the opioid epidemic, and continue to put patients first, we need to take into account social determinants of health and recognize their importance."<sup>78, 79</sup>

## State Efforts

### Legislative Action

At the State level, legislators are scrutinizing the rural health challenges that are facing their constituents. In June 2019, the National Conference of State Legislatures released a document titled *Challenges Facing Rural Communities* that details both the difficulties that rural areas are facing and what states are currently doing to solve them.<sup>80</sup> Nine states have a rural development committee within either the House or Senate of the State legislature. Across the states 14 bills have been enacted related to broadband development and 12 related to economic development. Related to rural health specifically, Mississippi, North Carolina, New York, Pennsylvania, and Wisconsin have all introduced legislation in areas such as telehealth expansion, physician workforce shortages, and medication education. In 2017, the National Conference of State Legislators also published a report titled *Improving Access to Care in Rural and Underserved Communities: State Workforce Strategies*.<sup>81</sup> This document details State approaches to address an inadequate supply of health care providers in rural areas, such as attracting providers, expanding scope of practice laws, and establishing reimbursement for telehealth services. In August 2019, as part of its annual conference, the National Academy for State Health Policy held a session titled, "Innovations in Rural Health Policy Options: Getting Care Where You Need It," which focused on how access to care and workforce concerns can be improved, with an emphasis on successful efforts in Virginia and Tennessee.<sup>82</sup> While not specifically focused on population health initiatives these State actions address resource gaps relevant to implementing new programs addressing local health needs.

### Administrative Action

The National Governor's Association (NGA) has also taken an interest in issues related to rural population health. In January 2018, the NGA announced an initiative called "Improving Health in Rural America: Addressing the Leading Causes of Death." This project gives six states the opportunity to develop and implement action plans to improve the health outcomes of those in rural areas of their state for the top five leading causes of death. For many of these diseases, such as heart disease and stroke, a population-health approach focused on prevention is vital to improving

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<sup>77</sup> <https://www.cms.gov/newsroom/press-releases/remarks-administrator-seema-verma-national-rural-health-association-annual-conference>

<sup>78</sup> <https://healthitanalytics.com/news/cms-offers-resources-to-address-social-determinants-of-health>

<sup>79</sup> <https://healthitanalytics.com/news/food-insecurity-becomes-focus-for-population-health-programs>

<sup>80</sup> <http://www.ncsl.org/research/agriculture-and-rural-development/challenges-facing-rural-communities.aspx>

<sup>81</sup> <http://www.ncsl.org/research/health/improving-access-to-care-in-rural-and-underserved-communities-state-workforce-strategies.aspx>

<sup>82</sup> <https://nashp.org/innovations-rural-health-policy-options-getting-care-need/>

the health of these populations.<sup>83</sup> In March 2018 the NGA held “Rural Health Learning Collaborative: Improving Heart Health in Rural America,” a two-day conference centered on how to leverage Federal resources, utilize care teams, and promote community-driven options to improve heart health in rural areas.<sup>84</sup> At the State level, the State Offices of Rural Health (SORH), present in every state across the country, have opportunities to promote the importance of a population approach to rural health improvement. The National Organization of State Offices of Rural Health provides a document on social determinants of health for its State offices, which provides partners, resources, and national initiatives for housing, education, transportation, and food insecurity. The report also showcases successful State initiatives for each social determinant of health.<sup>85</sup> A similar document titled, *Best Practice Guide for Engagement with SORH and CDC-funded State Programs*, published in July 2019, shows how SORHs can use collaboration to improve rural health.<sup>86</sup> In 2018, the State Offices of Rural Health Reauthorization Act reauthorized the program for the first time since its creation in the 1990’s and provided \$12.5 million for Federal grant programs.<sup>87</sup>

## Enabling Actions

### Community Health Workers

Outside of legislative and administrative actions at the State and Federal levels, other movements currently underway will continue to drive an increase in rural population health investment. Increasing use of community health workers, who can act as a bridge between clinical care and social supports, will continue to help solve issues related to care access. The American Public Health Association’s definition of a community health worker emphasizes the role as a trusted member of the community. Community health workers with their knowledge of the external community services available, many of which may be focused around public health and prevention services, can help rural community members receive care in a timely manner and through the appropriate venue. The Children’s Hospital of Boston Community Asthma Initiative found that the use of community health workers resulted in a 65 percent decrease in emergency department visits.<sup>88</sup> Moreover, community health workers can be a cost-effective option to linking public health and clinical care in rural communities due to their affordability and larger presence in rural areas relative to other health care providers. To maximize the potential of community health workers, leaders must consider the policy levers through which these care providers can be compensated, such as expanded scope of practice laws and payment reform. States such as Minnesota, New Mexico, and Michigan have done so through Medicaid State plan amendments, waivers, and SIM grants.<sup>80</sup>

### Informal Caregivers

Population health improvement in the context of such service navigation is important in all care settings, including households. Family caregivers play an important role in the support of

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<sup>83</sup> <https://www.nga.org/news/press-releases/states-focus-on-improving-health-care-in-rural-america/>

<sup>84</sup> <https://www.nga.org/center/meetings/rural-health-learning-collaborative-improving-heart-health-in-rural-america/>

<sup>85</sup> <https://nosorh.org/wp-content/uploads/2017/09/Social-Determinants-of-Health-A-quick-reference-guide-for-SORH-and-STHO.pdf>

<sup>86</sup> [https://nosorh.org/wp-content/uploads/2017/09/SORH-and-CDC-Funded-State-Program-Engagement-Best-Practice-Guide\\_July-2019.pdf](https://nosorh.org/wp-content/uploads/2017/09/SORH-and-CDC-Funded-State-Program-Engagement-Best-Practice-Guide_July-2019.pdf)

<sup>87</sup> <https://nosorh.org/policy-update-40/>

<sup>88</sup> [https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/Advocacy/Policy%20documents/Community-Health-Workers\\_Feb-2017\\_NRHA-Policy-Paper.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf)

patients with complex care needs, and especially those with chronic conditions. For these patients, informal family caregivers can act not only as the provider of physical care needs, but also as the patient's knowledge base and connection to preventive and social service supports. Because of this, states are recognizing the importance of training these caregivers during the hospital discharge process. Twenty-five states now require caregiver education during discharge.<sup>89</sup> In a 2015 proposed rule, CMS has also considered requiring hospitals to consider community supports that could be available to the patient after discharge. The need to provide patients with these types of additional support will continue to be relevant as the use of informal caregivers continues to rise.<sup>90</sup> Additionally, there is opportunity to use care coordination and connection to social service supports for the providers of care themselves, who often experience high levels of emotional stress and financial insecurity.<sup>91</sup> A population health approach within the context of informal caregiving must prioritize not only the needs of the patient being cared for, but also the social, emotional, and physical well-being of the person providing that care.

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<sup>89</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20160908.056387/full/>

<sup>90</sup> <https://blog.caregiverhomes.com/stateofcaregiving>

<sup>91</sup> <https://www.cdc.gov/aging/healthybrain/issue-maps/supporting-caregivers.html>

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## About the Rural Policy Research Institute

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The Rural Policy Research Institute (RUPRI) provides unbiased analysis and information on the challenges, needs, and opportunities facing rural America. RUPRI's aim is to spur public dialogue and help policymakers understand the rural impacts of public policies and programs. RUPRI is housed within the College of Public Health at the University of Iowa. RUPRI's reach is national and international and is one of the world's preeminent sources of expertise and perspective on policies impacting rural places and people. Read more at [www.rupri.org](http://www.rupri.org).