Securing High Quality Health Care in Rural America:

The Impetus for Change in the Affordable Care Act

Prepared by the
RUPRI Health Panel

Lead Authors:
A. Clinton MacKinney, MD, MS

Jennifer P. Lundblad, PhD, MBA

Panelist Coauthors:
Andrew F. Coburn, PhD

Timothy D. McBride, PhD

Keith J. Mueller, PhD, Panel Chair

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Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) contains a wide variety of rural-specific provisions related to health care quality, plus other provisions that are not specific to rural, but have rural health quality implications. Additionally, multiple federal programs exist that can bolster ACA quality improvement provisions.

The ACA calls for the development of a National Health Care Quality Strategy and Plan (National Quality Strategy) that, by definition, will affect health care that is delivered to millions of Americans who live in rural areas and thousands of health care providers who care for them. The goal of this paper is to answer the question, "What *rural considerations* should be addressed in a National Quality Strategy?"

This document may be used as:

- An agenda-setting document for rural health quality strategy to support commission and committee members as they design and implement ACA quality improvement provisions;
- A call to coordinate current quality improvement efforts and programs with ACA provisions; and
- A guide for policy makers, agency leaders, provider leaders, and other rural stakeholders whose creativity and participation are necessary to fully realize the potential for highest quality and value care in rural America.

Figure 1. ACA-Defined Components of a National Health Care Quality Strategy

- Support initiatives that have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;
- Identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;
- Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measure, and data aggregation techniques;
- Improve Federal payment policy to emphasize quality and efficiency;
- Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;
- Address the health care provided to patients with high-cost chronic diseases;
- Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;
- Reduce health disparities across populations (as defined in section 485E) and geographic areas; and
- Address other areas as determined appropriate by the Secretary.

In the new National Quality Strategy, we have the opportunity to collectively make the next strides in U.S. health care quality and patient safety improvement (Figure 1). A carefully crafted National Quality Strategy provides the opportunity to prioritize and target quality improvement programs and initiatives, to coordinate these quality improvement efforts across many federal government agencies, and to align public and private sector initiatives.

In recent years, there have been a number of documents focused specifically on rural health quality. Notably, the 2006 Institute of Medicine report, *Quality Through Collaboration: The Future of Rural Health Care*, provides a useful framework for addressing rural health quality (Figure 2). In addition, many existing programs support rural health quality improvement, including the Health Resources and Services Administration's (HRSA's) Rural Hospital Flexibility Program, the Centers for Medicare and Medicaid Services' (CMS') Medicare Quality Improvement Organization (QIO) program rural improvement projects, and the Office of the National Coordinator's (ONC's) health information technology (HIT) portfolio of programs. The experience and lessons of these programs can inform the question of how a National Quality Strategy can enhance quality and quality improvement capacity in rural America.

Figure 2. Quality Through Collaboration: The Future of Rural Health Care

- Adopt an integrated, prioritized approach to addressing both personal and population health needs at the community level.
- Establish a stronger quality improvement support structure to assist rural health systems and professionals in acquiring knowledge and tools to improve quality.
- Enhance the human resource capacity of rural communities, including the education, training, and deployment of health care professionals, and the preparedness of rural residents to engage actively in improving their health and health care.
- Monitor rural health care systems to ensure that they are financially stable and provide assistance in securing the necessary capital for system redesign.
- Invest in building an ICT infrastructure, which has enormous potential to enhance health and health care over the coming decades.

The National Health Care Quality Strategy and Plan

The Department of Health and Human Services has proposed an initial set of potential "core principles" for the National Quality Strategy. These core principles include:

- Person-centeredness and family engagement will guide all strategies, goals, and improvement efforts.
- The strategy and goals will address all ages, populations, service locations, and sources of coverage.
- Eliminating disparities in care—including but not limited to those based on race, ethnicity, gender, age, disability, socioeconomic status and geography—will be integral to all strategies and goals.
- The design and implementation of the strategy will consistently seek to align the efforts of public and private sectors.

Two of the principles specifically include rural considerations: "The strategy and goals will address . . . *service locations" and "Eliminating* disparities of care—including . . . *geography*—will be integral to all strategies and goals." The challenge now becomes coordinating specific ACA programs, policies, and initiatives with current quality improvement initiatives and programs to advance a National Quality Strategy.

An analysis of the ACA from a quality improvement perspective reveals four broad health care quality improvement categories: (1) measurement and transparency, (2) payment and incentives, (3) support and tools, and (4) workforce improvement. This categorization may inform decision making during ACA implementation in support of rural health care quality.

Measurement and Transparency

The ACA builds on the quality measurement and transparency activity of multiple initiatives, including the family of "Medicare Compare" tools, such as Hospital Compare, which are intended to be consumer-friendly approaches to publicly reporting quality measures at the provider organization level. Measurement and transparency are tools to assess performance, foster accountability, stimulate improvement, allow comparison, and inform choice—all appropriate for rural and urban providers alike. But measurement should reliably assess aspects of performance that are important and relevant. Rural-relevant measures should assess performance based on the scope and type of services appropriately delivered in rural communities. Benchmarks and performance standards should be rigorous, and expectations should be for high quality of care within the scope of services provided. Rural providers should not be disadvantaged by measurement systems (and associated incentive or payment systems) that focus on services not generally provided in rural settings. In addition, quality measurement strategies and specifications should be designed to accommodate differences in services offered, volume differences, and statistical variability associated with smaller numbers. Furthermore, measures should provide a valid and reliable assessment of quality in smaller locales and thereby create opportunities and incentives for rural providers to aspire to do well on these measures.

While measurement is critically important as a foundation for quality improvement, the activity of performance measurement can be onerous, especially for rural providers with limited resources. Although rural patient volumes are often less than urban, the measurement and reporting systems are similar, making per-patient quality measurement/reporting more burdensome and costly for rural providers. Access to technology is typically more limited today in rural than urban locales, and the types and scope of services are different in rural than urban. Thus, the National Quality Strategy should address the following rural concerns and needs:

- Technical assistance support should be made available to assist rural providers in developing quality measurement/reporting infrastructures.
- Public reporting systems (web-based and other reports) should display data in a manner that does not disadvantage rural simply due to small size. Furthermore, public reporting systems should specifically acknowledge that smaller health care systems and lower patient volumes do not necessarily imply poorer quality.
- Public reporting systems should recognize the "digital divide"; broadband communication infrastructure may not be as developed in rural areas, making web-based reporting systems less accessible.

- Finally, individuals with rural health care experience and sensitivity should be included in developing measurements, benchmarks, implementation requirements, and public reporting designs.

Payment and Incentives

The ACA supports new payment systems, collectively referred to as *value-based purchasing*. U.S. health care services are currently reimbursed primarily by a fee-for-service system—the greater the number (or complexity) of services provided, the larger the payment—regardless of the quality of care delivered. But that dynamic is changing. CMS plans to increasingly purchase high clinical quality and patient-centered services in ways that reflect coordinated approaches to health care delivery rather than simply purchase individual medical services (i.e., individual tests, procedures, hospitalizations, and visits). The ACA contains numerous strategies to purchase value—the combination of cost and quality. Some reward high quality and efficiency; others penalize poor quality and inefficiency. As noted above, quality measurement and transparency efforts will be accelerated to serve as a platform for informed value-based purchasing. Additionally, although not a direct payment (or financial penalty), accountability through quality performance reporting will eventually drive market share to high performing providers.

The ACA purposely establishes a link between quality performance and payment. Preventable readmissions will be monitored; hospitals with a higher than predicted readmission rate will not be paid for readmission care, thereby incentivizing improved post-hospital discharge care. The Accountable Care Organization (ACO) program is a new Medicare payment system in which provider organizations share savings with Medicare for any reduction in the cost of services (Parts A and B combined) from a predicted benchmark. Bundled payments will pay one fee for all medical services for one episode of care (e.g., coronary artery bypass surgery). For both the ACO program and the bundled payment demonstrations, providers must maintain certain quality of care standards to be eligible for new payments. The Medicare Advance Primary Care and Medicaid Health Homes Demonstrations will pay for care coordination and chronic disease management (among other services) designed to improve quality and patient-centeredness while controlling cost.

In addition to the link between quality and cost in the ACA, the legislation also emphasizes improving care coordination. Through a combination of payment changes (e.g., ACO demonstrations and reduced readmission incentives) and care delivery redesign (e.g., Advanced Primary Care, health homes), the ACA signals strongly that a reformed health system must better manage care coordination and care transitions. Rural health care providers are particularly well positioned to be leaders in this work, building on locally based rural health care delivery organizations, strong patient-provider relationships, and well-established communication structures that already exist in many rural communities.

Public policy should be consistent with the expectation that all providers will participate, so pilot projects should be open to all, including non-PPS hospitals. While an adequate patient volume may be important for achieving cost efficiencies, the National Quality Strategy should

strive for creative and innovative program designs such as regional network approaches that include rural providers. Currently many rural hospitals (i.e., Critical Access Hospitals [CAHs]) and primary care clinics (e.g., Federally Qualified Health Centers [FQHCs] and Rural Health Clinics [RHCs]) are excluded because of their cost-based reimbursement status from policies, programs, and demonstrations that provide payment incentives for quality performance. In many ACA provisions, eligible hospitals are defined as "Section D" hospitals, which by definition excludes the more than 1,300 CAHs that serve rural communities. Moreover, past experience reveals that pilot and demonstration project participation can be challenging for rural providers. For example, the ACO program requires a minimum of 5,000 fee-for-service Medicare beneficiaries. In the end, it is critically important that the National Quality Strategy that links payment to performance allows rural providers to demonstrate and to be rewarded for the quality and value of the services they provide.

Support and Tools in the ACA

Quality improvement initiatives will be ineffectual without health care provider knowledge, experience, infrastructure, and resources to implement the initiatives. Yet many well-intended rural providers who desire to improve health care quality do not have these prerequisites. In response, the ACA provides grants or contracts for technical support to health care institutions and providers with limited infrastructure and financial resources to implement and support quality improvement activities. The ACA calls for development of tools, methodologies, and interventions that can successfully reduce variations in the quality and efficiency of care. The ACA also calls for best practice dissemination plans that facilitate adoption of new strategies to improve quality, safety, and efficiency. Rural models and examples are needed for dissemination that will advance rural health quality. As technical assistance and best practice dissemination strategies become available, researchers and key stakeholders should assess the effectiveness of rural quality improvement support and tools.

The ACA charges the Secretary of the Department of Health and Human Services (DHHS) to "collect and aggregate consistent data on quality and resource use measures from information systems." But if rural providers cannot afford the information systems required for data collection and aggregation, they will not have the opportunity to demonstrate quality of care or participate in national quality improvement efforts. Therefore rural providers need access to specially designated resources to assist and support them. For example the new federal HIT Regional Extension Center (REC) program has a mission to improve adoption and implementation of electronic health records by primary care providers in rural and underserved areas. The HIT REC effort was mandated as part of the American Recovery and Reinvestment Act (ARRA) and is an example of how efforts that span multiple legislative initiatives can align to support an effective rural quality strategy.

Workforce Improvement

ACA health care workforce provisions address health professions shortages and have the potential to improve quality by expanding access to rural health care services. To address national workforce concerns, the ACA establishes a new National Health Care Workforce Commission and a new National Center for Health Care Workforce Analysis. The Center will

serve as a clearinghouse for data collection and dissemination and a locus for workforce policy analysis. Grants will also be available for regional and state health care workforce planning. The ACA provides a 10% bonus to primary care providers for primary care services if those services represent 60% or greater of the practice's Medicare allowable charges. However, rural primary care providers may be more likely to provide procedures (e.g., colon endoscopies or exercise testing procedures) because there are no nearby specialists to provide these services. Thus, a rural physician's efforts to serve the rural community may reduce the percent of primary care services to the point where the physician will be ineligible for the primary care bonus. Other ACA provisions expand the National Health Service Corps that provides clinicians with loan repayment and scholarships in exchange for practice in rural shortage areas (and other shortage areas) and expand categories of providers eligible for loan repayment to include public health professionals, allied health professionals, and nurses. The ACA also increases funding for health centers that deliver health care in underserved areas.

As ACA provisions expanding health insurance coverage are implemented starting in 2014, the impact that increased demand for health care may have on rural providers must be monitored to ensure that provider availability keeps pace with the increased demand for and the changing nature of services. The new Workforce Commission should make recommendations to increase the supply of primary care services where needed.

Linking Rural ACA Efforts with Quality Improvement Programs

The goal of the National Quality Strategy is a national comprehensive and coordinated approach to continuous and demonstrable quality improvement. Although the ACA provides unprecedented legislative energy to health care quality improvement and patient safety, existing programs remain powerful tools for improvement. Current federal programs to improve health care quality and patient safety that the new National Quality Strategy should leverage, coordinate, and build upon include:

- CMS' flagship quality improvement program, the Medicare QIOs, assures and improves the quality of care provided to Medicare beneficiaries across the continuum of care in hospitals, clinics, nursing homes, and home health settings. CMS contracts with a locally based organization in each state, which is expert in quality improvement and patient safety, and integrated with the local health care community, to serve as its field force in improving quality for Medicare beneficiaries.
- HRSA's Medicare Rural Hospital Flexibility Program (Flex) supports the quality improvement activities of CAHs across the country.
- HRSA's Federal Office of Rural Health Policy (ORHP) supports several programs designed to improve quality, including the Small Rural Hospital Improvement Program, the Rural Health Services Outreach Program, and the Rural Health Network Development Program.

- HRSA's Bureau of Primary Care supports health centers that are community-based and patient-directed organizations that serve populations with limited access to health care—including many in rural areas.
- The ONC's set of programs funded by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") offer incentives (via Medicare and Medicaid) and technical assistance (via the Regional Exchange Center program) to rural and underserved providers to adopt and achieve "meaningful use" of electronic health records. In addition, the ONC supports the Beacon Community Program, through which 17 geographic areas across the country, including rural areas, have been identified as leaders in HIT and health information exchange, and are receiving supplemental funding to accelerate and disseminate their efforts as models for other communities. Lastly, the ONC workforce programs are infusing funds to universities and community colleges to prepare an HIT workforce to deploy, including in rural areas.
- The Agency for Healthcare Research and Quality research and demonstration programs in patient safety, quality improvement, and comparative effectiveness are funding projects that can inform the development of effective and sustainable models of health care delivery and quality and safety improvement in rural areas.

Next Steps

To help ensure that rural providers, people, and places receive the full benefit of the National Quality Strategy, we suggest the following rural-specific and nationwide actions:

- Develop quality measures and a public reporting system that are both relevant and meaningful to rural providers and patients, and address low volume statistical challenges.
- Design reporting systems that do not imply that small size and low volumes mean poorer quality.
- Ensure that rural providers (including CAHs, FQHCs, and RHCs) participate in new payment and demonstration programs that reward quality of care, patient safety, and efficiency, as well as care coordination/care transition opportunities.
- Provide technical assistance, support tools, and information dissemination strategies to assist and build the long-term capacity of rural providers to continually improve quality.
- Monitor rural health care workforce status to ensure that new programs designed to improve provider shortages keep pace with demand.
- Coordinate quality improvement activities within DHHS and among other federal departments to minimize effort duplication, to leverage existing programs, and to utilize common rural-relevant quality measures. Design DHHS agency-specific strategic plans to achieve national priorities and to be sensitive to unique rural issues and concerns.

- Establish annual benchmarks for each relevant agency that support national priorities.
- Report agency-specific National Quality Strategy progress regularly to the Secretary.
- Implement strategies to align public and private payers regarding quality and patient safety efforts.
- Incorporate quality improvement and measurement in the strategic plan for health information technology as required by ARRA.

Summary

Manifest by the call for a National Health Care Quality Strategy and Plan, the ACA represents landmark law in national efforts to improve health care quality and patient safety. Nonetheless, without careful consideration and active inclusion, there is risk that rural providers and rural communities may be left behind in national quality improvement strategies. As the ACA is implemented, rule makers and key stakeholders should always consider unique rural situations such as limited quality improvement resources, cost-based reimbursement, and low patient volumes. Although challenging at times, rural realities should not prevent the 20% of the U.S. population that lives and works in rural areas, and those who visit rural places for recreational benefit, from receiving robust quality improvement benefits. Rural quality improvement efforts should focus on four areas: measurement and transparency, payment and incentives, support and tools, and workforce improvement. Several federal programs already exist that support rural quality improvement. These programs should be bolstered and coordinated with new ACA programs to ensure that rural providers and communities are provided equal opportunity to participate fully in the national quality strategy and quality improvement efforts.

About the Authors

The RUPRI Health Panel is led by Keith J. Mueller, PhD. He can be contacted at (319) 384-5121, keith-mueller@uiowa.edu. Authors of this report are:

Andrew F. Coburn, PhD, is a professor of Health Policy and Management, directs the Institute for Health Policy in the Muskie School of Public Service at the University of Southern Maine, and is a senior investigator in the Maine Rural Health Research Center.

Jennifer P. Lundblad, PhD, MBA, is president and CEO of Stratis Health, an independent non-profit quality improvement organization based in Bloomington, Minnesota, that leads collaboration and innovation in health care quality and patient safety. Dr. Lundblad has an extensive background in leadership, organization development, and program management in both non-profit and education settings.

A. Clinton MacKinney, MD, MS, is a board-certified family physician delivering emergency medicine services in rural Minnesota; a senior consultant for Stroudwater Associates, a rural hospital consulting firm; and a contract researcher for the RUPRI Center for Rural Health Policy Analysis at the University of Iowa.

Timothy D. McBride, PhD, is a professor and associate dean for Public Health in the George Warren Brown School of Social Work, and a faculty scholar in the Institute for Public Health at Washington University in St. Louis.

Keith J. Mueller, PhD, is the Rural Health Panel chair. Dr. Mueller is the head of the Department of Health Management and Policy in the University of Iowa College of Public Health, where he is also the Gerhard Hartman Professor and the director of the RUPRI Center for Rural Health Policy Analysis.

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