Sustaining Rural Health Care in Kansas
The Development of Alternative Models

Presented for Discussion by Kansas Hospital Association
Rural Health Visioning Technical Advisory Group

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Executive Summary

Two rural health care models have been developed by the Kansas Hospital Association Rural Health Visioning Technical Advisory Group (TAG). The TAG has developed these models to offer “a sustainable option for rural areas to provide preventive and primary care, chronic disease management and emergency services; serving as an access point, and coordinating care for the individual when higher levels of service are needed.” The models would move the focus of resources from the traditional episodic care while assuring continued local access to primary care, emergency services, a new transitional care service and a continued role as a driver and leader for health in the community.

Two models have emerged as potential opportunities that provide alternatives to a CAH as it is currently defined. The models are: 1) Primary Health Center – a 12 hour facility; and 2) Primary Health Center – a 24 hour facility with or without transitional care. Both options provide ambulatory, initial assessment and interventional services for the hours in the day that they are available. Both are open to the community every day of the year to provide the consistent service array most needed and sustainable by the community. Both would focus their efforts on the primary care needs of the community. Both would be supported by a robust EMS plan and a formal relationship with a larger Partner Organization to assist with operational and clinical aspects of delivering services to their community.

The payment method envisioned for these would incentivize an integrated health system at the local level rather than the current CAH payment method that carves out and consequently disincentivizes integration. The TAG has discussed the importance of developing a financing method that recognizes both the need to promote health and value over volume AND appropriately funds the local health needs. Several potential methods have been discussed, but it will be important to identify what is being paid now and how the models will either refocus financial support to services needed by the community or provide sustainable funding.

Community needs and data driven decision strategies would identify the services for which volumes allow the highest level of patient safety and quality. This process would align the structure for service delivery with community need. Communities would retain local governance, but also be a strong partner in a regional system. These models would require formal arrangements with a variety of partners. The first and most critical is a relationship with a Partner Organization that has specific capabilities to handle patients referred from a PHC. The Partner Organization would have 24 hour surgical and obstetrical services and the ability to support operational functions that are a burden to their partnering PHC. Other relationships such as those with EMS and public health would also be key.

Critical to the transformation of the local health system is the ability to coordinate the care of residents throughout the continuum of care provided locally and in the region. This will require dedicated staff and resources currently not adequately recognized in the payment system. The financial and operational assumptions will include the expense and workforce needs.
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Background

In 2011, The Kansas Hospital Association (KHA) Board of Directors identified the need for KHA to look to the future of rural health care and "get in front of the issue" by designing our own future. As a result, they appointed the Rural Health Visioning Technical Advisory Group (TAG). While the membership of the TAG has evolved over the past 2 years, it is made up of hospital CEOs and other volunteers from all shapes and sizes of hospitals in Kansas with a passion for rural health care and a conviction that while still uncertain, change is here.

The TAG identified five areas of work: 1) establishing a case for change and principles for the future of rural health care in Kansas; 2) identifying and reviewing best practices and emerging models to learn from and guide hospitals and KHA; 3) finding or developing models that could be an option for small rural communities to sustain access to primary care; 4) developing scenarios of the future to assist members in structuring leadership discussions about their role and future; and 5) providing resources for members to evaluate collaboration and affiliation. Resources in all of these areas are available on the KHA website.

No “one size fits all” model for rural health care will address all situations, but new options for local health systems must be developed and tested. To help guide that discussion, KHA recommends that “a sustainable rural health delivery system should …

- Focus on prevention, primary care, chronic disease management, emergency services and other essential services to improve the health of the population served.
- Provide access to essential health services within a reasonable distance and timeframe.
- Encourage collaborative local and regional solutions for service provision and governance.
- Continue to pursue the highest standards of quality and patient safety.
- Promote cost and operational efficiencies and provide value in the provision of local and regional services.
- Embrace the use of technology to expand access and patient participation in his/her care.
- Be paid and financed fairly by federal, state and local resources, private payors and patients such that the health of the population can be improved.”

While KHA and its TAG work to identify opportunities, it is important to note that our work is designed to spur conversation and provide information for local, state and national leaders to make decisions. The models we are developing and hopefully testing are presented as choices that may fit or align with the community's need and its ability to sustain services. Recently, based on the work and research the group has done, a concept has begun to emerge. The concept builds on the experiences and discussions across the country in an effort to embrace the Principles for Sustainable Rural Health Care adopted by the KHA Board in January 2014.
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Alignment with Other Efforts

Kansas has long been a center for innovation. The work in Kansas toward transformation of the health system is widespread and collaborative. To name just a few historical initiatives, Kansas successfully leveraged the Hill Burton program to establish centers for health care access in communities throughout the 1940s and 1950s. We tested and implemented the Swing Bed program and assisted in designing the program as it now stands in small hospitals around the country. Kansas was one of the first seven states to test and demonstrate the Essential Access Community Hospital/Rural Primary Health Center (EACH/RPHC often called “each/peach”) program which led to the current Critical Access Hospital (CAH) program, now 84 hospitals strong in Kansas. We created and now support a national quality and benchmarking system entitled Quality Health Indicators. Today is no exception. KHA collaborates in as many ways as possible to leverage our scarce resources and assure that access to health care is continued throughout the state. KHA believes that our efforts to design our own future and identify models that may create choices for small rural communities is only part of a larger effort. Here are some of the many efforts currently underway in Kansas:

- National Platform
  - NRHA Framework for Transformation
  - Potential for Kansas as a demonstration state with other states developing models (Louisiana, Mississippi, Illinois, Kentucky, Georgia, others)

- Clinical Integration and Transformation
  - KDHE Primary Care Integration Initiative
  - Kansas Heart and Stroke Collaborative – The how-to of clinical integration
  - United Methodist Health Ministries Fund (UMHMF) HRSA Network Grant – Care Coordination module
  - Health Systems active in regional support

- Service Needs
  - EMS Community Paramedic discussions
  - UMHMF HRSA Network Grant – Mental Health Service module
  - Oral Health Kansas – New dental service delivery models for rural areas

- Community Building and Needs Assessment
  - Kansas Partnership for Improving Community Health (KanPICH) – KSHealthMatters.org
  - UMHMF Rural Health Systems Improvement Pilot Project – Community building and needs assessment
  - Harper County/Via Christi/Cerner Collaboration – Multi hospital county needs and planning

- Technology
  - UMHMF HRSA Network Grant – Telemedicine Technology Platform module
  - Kansas Health Information Network – HIO, secure messaging, patient portal
  - Avera eEmergency and other telemedicine implementation
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Why Should We Focus on Kansas?

Kansas, like other predominantly rural states, faces challenges in many areas. As the TAG identified the facts behind these challenges, it became evident that Kansas faces issues common to all rural hospitals as well as its own unique challenges.

Rural Kansans and their communities are critical to sustaining the overall resources of the state. They support and protect our environment; produce food and fiber, are often a laboratory of social innovation, and produce healthy, well-educated future citizens. In smaller communities, hospitals are a critical piece of the economic engine and a symbol of continued community cohesion. They are important not only for the health care services they deliver, but for maintaining the overall economic vitality and viability of the communities they serve.

In today’s health care environment rural hospitals are facing federal and state reimbursement shortfalls, low population service areas, high community expectations and difficulties recruiting and retaining physicians and other highly trained staff. The “Case for Change” is clear; these challenges impact current health care delivery and threaten the sustainability of the health care system in the future.

Kansas rural hospital data show that 70% or more have negative operating margins. In 2013, 65 hospitals had fewer than 5 acute inpatients on any given day; 18 of those had less than 1 patient per day. The Kansas State Board of EMS tells us in 2012 47 services had less than 150 responses/year. In 2013, 39 EMS services had less than 150 responses/year and 51 EMS services had less than 150 transports/year. Many responses can be handled on the scene and do not result in a transport. And yet, these hospitals and EMS services are the crucial access points for jobs, provide services the community depends on to attract business and provide a center for the local economy.

As the TAG looked at CAH acute patient data in Kansas, they identified a lack of options for communities to continue providing locally needed services. Kansas has more acute beds per 1000 population than 41 other states. When we apply national averages to Kansas population, we have approximately 2000 more staffed acute care beds than the national norm. While Kansas has not seen hospital closures largely due to the local tax support provided to hospitals, many CAHs are in serious financial crisis. Generally if the hospital closes, the only option is the continuation of their Rural Health Clinic or even worse, the loss of all primary care providers along with the traditional hospital services.

Reimbursement and payment requirements leave communities with no options to their current CAH structure. The KHA Rural Health Visioning TAG has worked to develop alternatives for communities whose need for and ability to sustain services does not fit the CAH structure. The gap between RHC or FQHC and sustainable CAH is a large one, leading the TAG to focus its energy on what could work for these communities.
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The hospital of the future will likely not be characterized by the number of beds it has but the organization will look beyond bricks and mortar to their role as a physical or virtual hub of service delivery.\(^1\) NRHA also notes that the need for financial support for providers that are attempting to move to new models cannot be over emphasized noting rural payment and delivery policies “must preserve what we have until we have clarity of where we are going.”\(^2\)

In accord with these themes, the TAG has embarked on the development of the models described in this document. Alternatives must be available to communities to avoid the complete closure of existing hospitals and the loss of the health services and economy.

A New Concept

The TAG proposes a concept that would offer “a sustainable option for rural areas to provide preventive and primary care, chronic disease management and emergency services; serving as an access point, and coordinating care for the individual when higher level services are needed.”

The focus of resources would move from the traditional episodic care while assuring continued local access to primary care, urgent and emergency services, a new transitional care service and a continued role as a driver and leader for health in the community.

The concept focuses on ambulatory and initial assessment and intervention services. We have attempted to focus on core, essential services for communities that do not have the volume of patients locally to sustain what has evolved to the Critical Access Hospital of today. Community needs and data driven decision strategies would identify the services for which volumes allow the highest level of patient safety and quality. This process would align the structure for service delivery with community need. *We do not use the traditional terms that have evolved in current regulatory language. Rather, we utilize terms that describe the service itself, thus avoiding the assumptions and definitions traditionally used.* Doing this has allowed the TAG to think creatively and effectively about what may fit and address the particular challenges in Kansas, rather than the silos developed by regulation and payment.

Two models have emerged as potential opportunities that provide alternatives to a CAH as it is currently defined. The options are: 1) Primary Health Center (PHC) – a 12 hour per day facility; and 2) Primary Health Center (PHC) – a 24 hour per day facility with or without extended care. Both options would provide ambulatory, urgent and emergency services for the hours each day that they are available. Both are open to the community every day of the year to provide the service array most needed and sustainable by the community. Both would focus their efforts on the primary care needs of the community. Both would be supported by a robust EMS plan and a formal relationship with a partner organization to assist with operational and clinical aspects of delivering services to their community. It is envisioned that the payment method for these would incentivize an integrated health system at the local level rather than the current CAH payment method that carves out and consequently disincentivizes integration.

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1 National Rural Health Association (NRHA), The Future of Rural Health, February 2013 (page 7).
2 Ibid.
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The models function as either a new provider type that fills the gap between Rural Health Clinics (RHC) or Federally Qualified Health Centers (FQHC) and truly sustainable Critical Access Hospitals or a refined version of CAH that can be sustainable in a very low population area. It would provide the alternative in the all or nothing decisions communities currently face as they struggle to sustain a Critical Access Hospital.

The models are intended for small rural communities that have existing services as a method to align their structure with the needs of their communities. However, the TAG notes that these models could well be a way for communities without access now to develop services that both lead the charge to improve health in their communities, support regional efforts of population health and play a role in community sustainability.

Today’s health care delivery discussion is often centered on bed size, length of stay limits and distance requirements. KHA data shows that our smallest CAHs in Kansas currently serve less than 1 patient per day at the acute level on an average day and rarely have more than 5 swing bed patients. Therefore, the TAG has assumed that the 24 hour PHC would have the capacity to treat 3 patients in their urgent/emergency service and 5-10 in a transitional care service (described later in this paper). A clinical chart review in the test facilities will tell us if this capacity is appropriate. We believe that the chart review will show that the vast majority of patients can be served in these models and that savings gleaned by refocusing the resources used to sustain a full service CAH can be redirected to services that better align with community need, maintain a health care presence for the community and continue to provide an economic base in the community.

The concept focuses on core, essential services for communities that do not have the volume of acute inpatients locally to sustain what has evolved to the Critical Access Hospital of today. Community needs and data driven decision strategies would identify the additional services for which volumes allow the highest level of patient safety and quality. This process would align the structure for service delivery with community need.
Community Need: As the work of the TAG has evolved, the premise has remained that a sustainable rural health system must be based on the needs of the area served by the health system. Several initiatives in Kansas have emerged that support local discussion around community health needs. First, current requirements for public health agencies and 501(c)3 hospitals to conduct a community health needs assessment (CHNA) was the impetus of the development of the Kansas Health Matters initiative to provide communities direct access to the data necessary to drive community based discussions around need and priorities. A second initiative lead by the UMHMF has combined funding and community partners to participate in the Kansas Rural Health System Improvement Pilot Project (KRHSIPP) whose vision is to test transformational and transitional changes that reduce health care cost and improve health system sustainability. These discussions have engaged community leaders in the financial issues and uses of current services. Their goal is community-developed ideas for improving rural health systems. This project truly meets the principles set by the TAG.

What has become clear in the CHNA and, to some extent the KRHSIPP work, is that:

- Few communities identify areas of service they can’t sustain, don’t use or can use at a reduced capacity;
- When a set of services is identified to fit their community need, no current structure allows the flexibility to pool and allocate limited human and financial resources across provider types; and
- Local providers (hospital, RHC, EMS, long term care, home care, behavioral health, oral care, etc.) are all challenged to look at new structures as each is concerned about the sustainability of their own entity.

Therefore, new models must be developed as a choice for communities to integrate services and transform the health system for small communities with strained resources. These models should have both a pre-determined a set of services that are expected and a set of services that are based on local volumes, need and sustainability.

The first phase of work in Kansas proposes to test the models using circumstances of the community, but does not propose a full community needs analysis. Needs will be determined through questions posed to and discussions with key hospital, EMS and community leaders. If this project results in a demonstration, communities will need to be engaged in the process to assure successful transformation.

None the less, even with options for new structures, a data driven process is needed that engages the community at large in the need for change. The now traditional CHNA does not currently engage the community in the issues of system sustainability. Rather, the intent is to identify needed services in the community that are not currently provided or gaps in populations served. A more robust process, including the financial use patterns associated with current and potential services is necessary. Changing the array of services may also impact community perception in many ways which may in turn impact use of the services and tax support. Community
engagement and educational processes must be developed to minimize any unnecessary negative impacts.

**Ancillary Services**: Ancillary services are a key to meeting community need and for supporting the initial assessment and intervention which forms the basis for urgent and emergency services in the region. The PHC will also be a hub for local health services and will need to have the capacity to provide the ancillary services directly or provide a link to the service regionally. It is the responsibility of the PHC, 12 or 24 hour options, to have a capacity to provide care coordination as patients utilize local services and seek services in the region. Both models will need a lab with capability for moderately complex testing, basic X-ray and basic formulary or dose pack capability. Additional ancillary services should be added locally, if volume can support them or if the distance to the service will have a negative patient care impact. Services that could be provided locally or regionally include: CT scanning, ultrasound, pharmacy, physical therapy and respiratory therapy. Regional or mobile approaches are strongly encouraged for MRI, mammography, cardiac rehab therapy, wound care and other niche services. It is important to note that some ancillary services appear duplicative when provided both locally and regionally may actually be critical to the patient assessment process and may help rule out conditions and prevent unnecessary treatment or transport.

If the models are successful, scarce resources dedicated to acute capacities could be redirected to support services that are often not available in small rural communities such as in home monitoring, nurse access line, specialty clinics, home care or visiting nurse w/ therapy, nutritional services, community paramedic services and others depending on the community need. The TAG encourages these planning discussions to have a regional view and look for ways that collaboration can support additional services.

**Emergency Services**: The question, “What if an emergency happens?” is an extremely emotional one for communities. Emergency services are critical and most often at the top of the list of community needs. These services are also the most difficult for small communities to staff and sustain. Anecdotally, we know that even in communities that do not have a CAH or hospital today, members of the community will go to the physician’s office or clinic in an emergent or urgent situation. The clinic then calls 911 or EMS to take the patient to the appropriate setting. The question, “What if an emergency happens?” is an extremely emotional one for communities. Emergency services are critical and most often at the top of the list of community needs. These services are also the most difficult for small communities to staff and sustain. Anecdotally, we know that even in communities that do not have a CAH or hospital today, members of the community will go to the physician’s office or clinic in an emergent or urgent situation. The clinic then calls 911 or EMS to take the patient to the appropriate setting.

Urgent care, emergency services, emergency rooms, and emergency departments all have a wide range of definitions and community expectations. The PHC is designed to receive, provide the initial assessment and intervention necessary and to prevent further deterioration. In most instances, we believe the PHC will be the final treatment location. In many locations in the state, the majority of current emergency room patients are either discharged to home or could be cared for appropriately in some form of transitional care, but do not truly need an acute admission. In the cases when the patient needs additional services, an acute admission, higher level surgical or trauma related services not provided in the PHC, protocols for transport and destination would be determined locally and in conjunction with the Partner Organization. Patients may remain in the PHC until stable enough for further transport, treatment is complete and further care coordination identified or provided transitional care while planning for the longer term is conducted. As part
of the regional trauma system, patients would be transported directly to the appropriate level of care according to accepted protocols. Undoubtedly, like the clinic example above, patients may arrive via personal cars that could require higher level of care than even small CAHs today can handle and protocols and processes need to be in place to handle these patients.

EMS response and transport services are without a doubt crucial to any system of care. Rural Kansas has an abundance of small, county-based and volunteer services. Kansas had 39 services conduct fewer than 150 responses in 2013 and 51 services with fewer than 150 actual transports per year.\(^3\) Funding for EMS services is difficult to obtain and is eroding. Small hospitals are often the base of operations for EMS; however, hospital-based EMS usually has a negative impact on the hospital’s cost based reimbursement. In addition, practice protocols and protocols/scope of practice limits in Kansas make it difficult for hospitals and EMS to work together to efficiently and effectively staff the needs of the community. Addressing this problem is key, not only to the PHC models, but to all small communities. In the long run, these services in low volume areas are not self-sustaining and will need to be subsidized in some form.

Kansas EMS leaders are also proposing some form of Community Paramedic Services which may address community needs. Current training of paramedics in Kansas does not allow for this service; however, discussions are occurring that look at solutions to barriers for implementation or piloting a service of this type. The TAG believes that initiatives such as this should be allowed, at least in pilot or demonstration form, to augment and address community needs not currently supported by Kansas law or state and federal payment mechanisms. As a note, however, the TAG suggests that these services be fully integrated into the PHC or regional system of care to assure medical direction and care coordination.

Concepts like community paramedic programs could allow EMS services in low volume areas to provide home based monitoring and support. We understand that Kansas has the same shortage of trained paramedics found in many rural communities and that training programs as well as potential staff need to be developed.

Much has been discussed about the need for an EMS Plan that fits the needs of the community and sensitive to the needs and capacities in the region. While the issues to be addressed in an EMS plan have yet to be fully outlined, issues of transportation between a PHC and its Partner Organization both in emergency situations and the return of patients to transitional care will need to be addressed. Plans should consider and include:

- Diagnostic capabilities of the PHC and Partnering Organization
- Ancillary service capacity
- Capability of Emergency Medical Services (i.e. level of staff, medications on board, remedial intervention capability)
- Current trauma protocols

\(^3\) Kansas Board of EMS data
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• Bypass protocols
• Distance to necessary services
• Availability of active telemedicine

Bottom line, the PHC will, together with the local emergency transportation and response systems, be the first line of defense for communities and provide those “instant” services when needed. EMS and the PHC will necessarily need to be clinically and operationally linked, and regulatory barriers and financial disincentives removed.

The TAG has discussed the issues embodied in EMTALA and recognizes that EMTALA would likely apply to the extent the PHC has the capacity to assure that the patient’s condition is aided by intervention and certainly that no further deterioration of the patient was likely with that intervention. Again this will depend largely on the capability of the local EMS and the capabilities of the individual PHC.

**Regional Relationships:** Several key points are worth noting. Communities would retain local governance, but also be a strong partner in a regional system. While most Kansas hospitals have a variety of relationships with neighboring and regional providers, these models would require formal arrangements with a variety of partners. First and most critical is a relationship with a Partner Organization that has specific capabilities to handle patients referred from a PHC. The Partner Organization and PHC must develop a specific agreement that addresses mutual interests and increases the likelihood of each achieving its mission, amplifying the ability to serve the needs of their communities and the region.

The Partner Organization would necessarily have 24 hour surgical and obstetrical services and the ability to support operational functions that are a burden to small hospitals. The TAG envisions that the Partner Organization would have nationally or state recognized trauma capabilities (Level 1-4). Most importantly, the relationship would establish protocols for coordinating the care of patients. While the Partner Organization may have more than one PHC relationship, the model does not assume that it be the only Partner Organization in a geographic area. It would, however, likely have a regional presence as it level availability of service is higher.

Selection of a Partner Organization would be a local decision requiring agreement from both parties. The facility in the supporting role could be any facility regardless of its Medicare status or classification, but should likely be a facility within the region seen as a referral option for the community and have capacity for the following:

• Inpatient capacity to serve patients transferred or referred from PHC
• Full service surgery available with surgeons on staff
• Full obstetrical service with available providers on staff
• Trauma Center (either national level 1-3 or Kansas verified level 4)
• Capacity to support patient surge needs
• Administrative, quality, credentialing and clinical supervision functions as needed
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• Financial consultation as needed
• Ability to provide coordinated peer review
• Protocols for patient return to their community and follow up care

Each relationship would need to address local needs. It is not assumed that all of the above capacities would be necessary in every instance. Some of these functions would also be supportive in nature and not replace local functions. As many small hospital staff wear a number of hats, it may be possible to provide relief in areas that would free up local staff to attend to their other responsibilities more effectively. While relationships for specialty clinics and other services not provided locally may develop from a variety of providers and hospitals in the region, the TAG feels that a primary relationship is critical to assure that patients have access to care when higher levels of care are needed. This relationship would outline the commitments of both facilities to relationship.

Relationships with local physicians and other independently licensed providers will be critical as well. In many of the locations likely to consider these models, providers are employed either by the hospital directly or in a RHC that is managed by the hospital. Formal relationships that underscore the willingness of providers to work collaboratively, share patient information through the regional system of care along with the administrative information necessary to organize a system of care efficiently and effectively will be necessary.

Communities taking advantage of these models will also be encouraged to develop or build upon relationships with entities and providers offering health related services to their community. Applicable agreements with local and regional service providers would necessarily support care coordination activities and the sharing of quality related information to promote care and process improvement.

We recognize that many communities do not have all of the following services locally. Where they do, we believe it is important for their relationship to be strong and their vision of their local and regional health system to be a common one among the various players. Horizontal integration may not be appropriate in all communities, but certainly, these new models with their structure and payment system should incentivize a system of care among:

• Hospitals
• Public health
• EMS, transportation, community paramedic services
• RHCs
• FQHCs
• Long term care: assisted living & nursing homes
• Home care and hospice
• Behavioral health
• Oral health
At a minimum, this new concept is predicated on strong and sustainable relationships that include what is now the hospital, public health, EMS and primary care physician practices (usually rural health clinics). All struggle to maintain services and are challenged with financing that does not cover the cost of providing services to meet the needs of their community.

The Kansas Department of Health and Environment has already initiated efforts to consider the integration along a continuum between Public Health and Primary Care across Kansas. In rural Kansas, they recognize that both are focused on the health of their communities and both are challenged with limited resources. KHA and the Rural Health Visioning TAG commend these efforts and suggest that communities that wish to take advantage of one of these new models be actively identifying ways to integrate these services. We recognize that at present, these efforts are stymied by the funding mechanisms for CAH and Public Health. Our goal is to not only overcome these barriers but propose a funding mechanism that supports and incentivizes integration.

**Transitional Care**: Transitional care is envisioned as an opportunity to serve patients who transition to home or need a protracted plan of care. These patients would not require acute care, but cannot return home because they are isolated, have no one to care for them, or because they need to be monitored and receive services for a longer length of time. The PHC-24 hour would offer transitional care if this meets a need in the community. During transitional care, care coordinators would work with the patient, their family if available and other providers to prepare the patient for discharge and develop a care management plan that would assist the patient with medications, follow up care, a more permanent care setting if necessary and prevent further acute admissions and emergency situations when possible.

Transitional care in this model should not be confused with long term care, today’s “swing bed” care nor is it a place where people would live. In addition transitional care in a PHC is not intended to always be the equivalent of the current “observation” status since unlike observation status there would be no expectation of acute admission as a potential result of observation. Currently a patient that needs swing bed service must have a 3-day inpatient acute admission and then be admitted to a swing bed status or admitted to a nursing home. We believe this requirement is not necessary in most cases; therefore would not be a requirement of the PHC model.

We believe that many of our patients would be well served to have transitional care as an option following assessment and intervention, or as they return from higher level care in the region. In some communities, this service may provide the services that could be provided through home care, but due to the distance and sparse population, home care is not feasible. Or assist and monitor a patient’s ability to continue therapies that will be continued by the patient at home. This is an obvious area for savings to both the system and the patient and more closely meets the patient’s need for care.
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National discussions highlight the need for longer hour or day limits for current observation patients. This could be embodied in the PHC transitional care approach, but further discussion is needed to assure that patients receive the appropriate level of care.

**Care Coordination and Clinical Integration:** Critical to the transformation of the local health system toward a system that focuses on health, primary care, chronic disease management and emergency services, is the ability to coordinate the care of local residents throughout the continuum of care provided locally and in the region. This will require dedicated staff and resources, currently not adequately recognized in the payment system. These services should be available locally, but could be part of a regional effort and supported by the Partner Organization.

It will be necessary for providers to have the ability to send secure messages and share patient level data electronically. The data will need to be accessible by the broad care team and by the patient and their family caregivers. Without question, EHRs and HIE will play a critical role in this process. The TAG is less concerned about the specifics of CMS and ONC rules around meaningful use and more concerned about the functionality necessary to care for the patient. In some instances requirements for meaningful use will not be attainable by the PHC, especially Stage 2 and 3 requirements. This functionality is already a struggle for many CAHs and an extreme cost burden to purchase and maintain. Relationships with the supporting hospital may offer options as IT support is difficult and expensive for small operations.

As the TAG discussed what care coordination means, we referenced the work of the Kansas Department of Health and Environment and their definition of Health Homes for the Medicaid program KanCare. A summary of the expected activity include:

- Support adherence of patient to treatment recommendations
- Design transitional care coordination to streamline processes, interrupting patterns of frequent ED use, and reducing avoidable hospital stays
- Engage patients in chronic condition self-care, provide health education and coaching about chronic conditions and ways to manage health conditions
- Engage patients in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports
- Coordinate and collaborate with other providers to monitor the patient’s condition, health status, and medications and side effects; create and promote linkages to other agencies, services, and support
- Monitor quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact
- Offer prevention education to patients, family patients/support persons, guardians about proper nutrition, health screening, and immunizations

While care coordination has been a practice, for some time, exactly how clinical integration is developed and implemented will necessarily be a process designed by the participants. Providers will need to commit to working collaboratively to identify common clinical practices, support
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care coordination activities, as well as participate in quality improvement and patient safety processes established locally and with the Partner Organization. It is also assumed that the PHC will be participants in the Kansas Regional Trauma System and preparedness-based Regional Healthcare Coalitions.

KHA is excited to support and learn from the work of the newly established Kansas Heart and Stroke Collaborative (formerly the Rural Clinical Integration Network) funded recently by CMMI. The Kansas Heart and Stroke Collaborative is an innovative care delivery and payment model to improve rural Kansans’ heart health and stroke outcomes and reduce total cost of care. Their work will inform the clinical integration processes for providers in small communities with their clinical referral locations in larger rural and urban communities.

More work is necessary to identify how local protocols and primary care practices can be integrated between a PHC and a Partnering Organization. Examples of prenatal care and well woman/mammography have been highlighted. Other issues of testing and patient education prior to a surgical referral could be worked through between the PHC and the Partnering Organization to increase patient satisfaction and to implement efficiencies. The same is true for patients returning from the Partnering Organization to the PHC. The initial feasibility or paper test of this model will not address this. We would propose that these issues be addressed in the piloting or demonstration of the model should feasibility be determined.

Even without this model, rural hospitals and clinical staff will need to considering strategies to address clinical integration, as improving a population’s health requires the continuity of care across communities and provider settings. Rural providers are in a unique position to impact a population’s health and have the obligation to coordinate care, provide patient education and prevent unnecessary admissions for the population in their communities. The Rural Health Visioning TAG, therefore believes that new models of delivery that do not incorporate these concepts will not be successful or sustainable.

**Staffing:** Recruiting and retaining clinical staff is one the most difficult challenges faced by rural Kansas hospitals, especially those in our very small communities. From the beginning, the KHA Rural Health Visioning TAG has been assuming that very active telemedicine was a precursor to maintaining health services in these communities. Supported by the UMHMF, Kansas has explored the eHealth services offered by the Avera Health System which provides a best practice method for providing services to small rural hospitals. Just recently, Avera has begun serving Kansas hospitals. In addition, UMHMF and its partner Great Plains Health Alliance was awarded an HRSA Network Development Grant to fund initiatives in three areas: Mental Health, Telemedicine and Care Coordination. KHA is a member of the network identified in this grant and continues to support their work.

One of the largest costs and a challenge in some communities is the 24-hour provider coverage of a CAH. This is true even when most of the call is taken by APRNs and PAs. If sufficient primary care providers are locally available and on-call, certainly this would be ideal. However, our research has indicated that even when providers are locally available and on call, the support
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of telemedicine services provides immediate support while on call providers are in transit, welcomed documentation, additional resources and expertise to local providers. The telemedicine service can provide access to emergency physicians and can assist APRNs, PAs and local physicians when a clinically challenging patient presents.

Hospitals in our small Kansas communities struggle to keep primary care locally available. Communities without hospitals find it almost impossible to establish and maintain consistent, regular access to primary care. A health system that provides essential services and takes the requirement off small physician practices to cover extended hours may save a community’s access to primary care and care coordination services necessary to support a healthy population. The PHC offers communities a 12 or 24 hour option. The 12 hour options would offer the opportunity for consistent, regular access without the cost of 24 hour coverage.

Assuming access to either local primary care providers and/or active telemedicine similar to the Avera model, the TAG recommends that minimum staffing during the hours of operation (12 or 24 hours/day) be a Registered Nurse (RN). It is expected that this facility would be co-located with a rural health clinic (or FQHC) to allow primary care providers to be immediately available for at least some of the hours of operation. RNs are trained and capable to handle the vast majority of care necessary during the evening or night time hours in transitional care.

Recently, physician supervision requirements have been reinterpreted by CMS in a way that is extremely difficult for small rural communities to meet. The TAG proposes that if local supervisory resources are not available, telemedicine and/or the relationship with the Partner Organization could both provide more real time supervision and better clinical support for the APRNs, PAs and ancillary therapy personnel.

Quality Care: Small hospitals and community providers care deeply about their patients and their families. Patient safety and quality are paramount. While their volumes are low, quality measures are monitored carefully to assure that best practices are followed. The PHC provides hybrid models for which quality measures must be developed or adapted from both ambulatory and hospital settings.

The TAG proposes to establish measures through the Quality Health Indicators (QHi) benchmarking tool already used pervasively by CAHs in Kansas and 17 other states. Core measures from the array of CAH and RHC measures already in use and vetted would be identified, reported, monitored and benchmarked. These measures are available in QHi in four areas: Clinical Quality, Financial and Operational, Employee Contribution, Patient Satisfaction.

For the PHC, obvious measures would relate to transitions of care, readmissions for local patients, time to home and other similar measures.

Operational Efficiencies: Communities rely on their hospitals as both a health service provider and as a vital part of their economic engine. One of the largest generators of revenue to the community and certainly one of the largest employers is the local hospital. It is also a part of the
local economic development efforts since recruiting business to small rural communities is
difficult without a health service system. At the same time, hospitals and health providers
struggle to make ends meet as they face increasing regulations and constantly decreasing
payments. In Kansas, many are supported by local property and/or sales taxes. The models
Kansas is developing would offer opportunities for operational efficiencies which will
necessarily be determined locally and with the regional partnerships required by the chosen
model. Compared to a typical CAH, the PHC, as a 12 hour model, would have obvious savings.
We believe the PHC 24 hour model could also achieve savings. The TAG has identified cost
saving opportunities available to communities including:

- Shared administration w/ Partner Organization
- Shared administration of local services
- Shared HR, EMR, IT, billing, coding, medical staff support services, dietary, linen
- Common policies and procedures
- Reduced duplication of tests through clinical integration
- Local integration of care for the aging services
- In home monitoring
- Regional call center
- Regional imaging
- Regional advanced EMS
- Telemedicine support for ER
- Regional behavioral health and social services

Conducting the paper test will help identify potential savings for the sites that participate and
will inform the TAG as they modify and continue the development of the PHC models. We need
to test how limited rural resources on the local, state and national level can be aligned rather than
“silo’d” so that communities can sustain access to care.

**Financing**

Aligning the compendium of services needed in a community with the ability to structure an
organization that can support those services is largely dependent on the payment methods of
government and private payors. It is clear that all payors, but government payors in particular,
envision a new system of payment. This new system is largely based on the existence of
significant population which can support efficiencies and economies of scale. Rural Kansas does
not have the population sufficient to meet these requirements. In addition, while affiliation and
collaboration are strategies being considered by most rural providers, local communities take
pride and ownership in their health system and rely on that health system both for its service and
as an economic mainstay.

Overall health improvement and management of disease cannot be done when local access to
basic services is lost. Balancing essential services and the ability to sustain the services is the
challenge the TAG is addressing. Now that the basics of the models have been identified, a financing method can be considered. While the adage, form follows function still applies, the realities of the health care system are that form follows payment.

The TAG has discussed the importance of developing a financing method applicable to small rural populations that recognizes both the need to promote health and value over volume AND appropriately funds the local health needs. Several potential methods have been discussed, but it will be important to identify what is being paid now and how a chosen model will refocus financial support to services needed by the community and provide sustainable funding.

The TAG proposes that a paper test or feasibility study be conducted that identifies current costs and payments, profiles the patients currently using the local system and tests how new payment systems would work. Some of the methods being discussed are:

- Global cost basis – All services, no carve-outs equal to or less than combined payments and other support allowing flexible use of resources to assure that higher cost services can be supported.
- Per capita payment – Consistent with services, including new services (prevention, care coordination) recognizing a need to manage services and coordinate care in such a way that higher cost services and duplication are avoided but recognizing that small populations may make this strategy difficult.
- Global budget – Incorporating the services indicated by community need establishing a negotiated budget that is need based and data driven, taken with modification from the FQHC process.
- Foundational grants or fees – Similar to FQHCs, to support the sustained access to basic emergency services and transportation along with care management and coordination activities. Emergency services in areas with low volumes are not self-sustainable but important to prevent further disease and ultimately higher costs upstream.
- Modified Frontier Extended Stay Clinics (FESC) structure that would address the issues encountered in Alaska. This may be appropriate for the PHC 12 hour option in particular.
- Performance and Population Based Health Incentives and Shared Savings could also be developed, but are not seen as a long term sustainable approach.
- Flat rate for transitional care – data shows average length of stay for swing beds is currently 10 days. A flat rate approach to transitional care would assume a fixed day cost, e.g. 5 days, regardless of the length of that stay.

The method or methods will be explored in the financial analysis to determine if one method is more reasonable alone or if methods may need to be combined for sustainability. We would like to determine if systems are already in place that could be modified to provide the appropriate payment and incentives.

Access to Medicare Cost per Beneficiary and Shared Savings data sets for the test facilities would be most beneficial in the feasibility process. Even more so, should the model be the
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subject of a pilot or demonstration as the need to evaluate the impact on the costs to Medicare will be a primary benchmark.

Going Forward

Change is a difficult thing. In Kansas, we have community hospital leaders recognizing that the future health system for their community will likely not be the same as it is today. But communities are skeptical of change without facts. The paper test and continued work with partners to design that method will be critical. The PHC will:

- Focus on prevention, primary care, chronic disease management, emergency services and other essential services to improve the health of the population served.
- Offer an alternative to continue access to essential health services within a reasonable distance and timeframe.
- Encourage collaborative local and regional solutions for service provision and governance.
- Continue to pursue the highest standards of quality and patient safety.
- Promote cost and operational efficiencies and provide value in the provision of local and regional services.
- Embrace the use of technology to expand access and patient participation in his/her care.
- Propose financing and payment mechanisms fair to federal, state and local resources, private payors and patients such that the health of the population can be improved.

The proposed health care delivery transformation will require the alignment and waiver of both current state and federal rules and regulations allowing the community to demonstrate the benefits of the new concept. Also critical to the transformation, payors will need to assure communities and patients willing to try the new models that the resources and payments from the previous models can be sustained as the transition is made.

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