REPORT AND RECOMMENDATIONS

Rural Health Visioning Technical Advisory Group

VISION
A sustainable rural health delivery system for Kansas.

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Background

The KHA Board of Directors instructed staff to establish a Rural Health Visioning Technical Advisory Group during their annual strategic planning process. The Board adamantly believed that the health care environment was evolving quickly, and KHA should design the future rather than waiting for the federal government to do it for them. Our work should give KHA a voice in the national conversation. The Board’s three-fold charge to the group was:

1. To identify, evaluate and recommend strategies for KHA and its family of organizations related to the future of rural health delivery and structure;
2. To identify new models of rural health delivery and consider the potential for success of the model(s) in Kansas; and
3. To develop education and other resources related to the future of rural health delivery for KHA members and the public.

The TAG was formally appointed at the end of 2012 and began its work in earnest early in 2013. Members of the TAG were originally appointed to represent all aspects of KHA membership in terms of hospital size, location and type with the recognition that a rural health delivery system would incorporate all levels of care. After the first two years, volunteers were also encouraged and appointed to the TAG.

Within the charge, the TAG leadership and members established a work plan and revised that work plan as their work progressed. The TAG identified areas where work was necessary to address the charge. Agendas focused on strategies to educate the committee and then to develop relevant resources for the membership in all of these areas. What follows is a brief discussion of the issues, work done and resources developed.

Laying the Foundation

In the initial stages of the TAG’s work, time was spent in general discussion of local challenges, areas for improvement, regulatory barriers, and models from the TAG’s knowledge. These wide-ranging discussions served a number of purposes including educating staff and members of the TAG. These discussions also helped to develop relationships and trust between members, ultimately forming the basis for future, more challenging work.

Based on those general discussions, the TAG developed a vision for the future: “A sustainable rural health delivery system for Kansas” and a set of principles that were critical to the vision and would guide the TAG’s work. The development of these principles challenged the TAG and the KHA Board to think toward the future. The principles were approved by the KHA Board and finalized in early 2014. A sustainable rural health delivery system should:

- **Improve Health:** Focus on prevention, primary care, chronic disease management, emergency services and other essential services to improve the health of the population served.
- **Provide Access:** Provide access to essential health services within a reasonable distance and timeframe.
- **Encourage Collaboration:** Encourage collaborative local and regional solutions for service provision and governance.
- **High Quality:** Continue to pursue the highest standards of quality and patient safety.
- **Promote Efficiency and Value:** Promote cost and operational efficiencies and provide value in the provision of local and regional services.
- **Embrace Technology:** Embrace the use of technology to expand access and patient participation in his/her care.
- **Financed Fairly to Address Population Health:** Be reimbursed and financed fairly by federal, state and local resources, private payers and patients such that the health of the population can be improved.
A Case for Change

In the first discussions of the TAG, there was general agreement that CAHs and small rural hospitals were financially challenged. There was a difference of opinion around the table as to whether hospital services were essential in every community and/or if a need existed to change from the traditional array of those services. Many members of the TAG itself and certainly many hospital governing boards did not share the sense of urgency that change or a new model was needed. Rather, many felt that payment should simply be increased for the current services to allow for sustainability.

In an effort to gain consensus on direction, the TAG asked staff to gather facts about Kansas’ rural hospitals and their communities. Statistics were gathered from a number of sources including the Kaiser Family Foundation state comparisons, the Kansas census and abstract and KHA utilization and market share data. In many instances, the facts were not surprising, showing high numbers of beds per 1,000 with low utilization, personnel shortages, along with significant aging and population decline when compared to other states. The facts drove consensus that, for many communities, change was inevitable. This information was articulated in a document and PowerPoint resource entitled “The Case for Change” which has driven the TAG’s work and continues to serve as a core education piece for KHA members, boards and their communities.

This exercise also began to foster a consensus by the TAG that while increased payments for current services and processes were certainly desired and would support the principles, payment increases were not likely to happen. In fact, continued cuts and incentives for change were much more likely. As a result, the TAG created four “Scenarios for the Future” based on their educational efforts around trends nationally and in other states. These scenarios were used as a discussion piece during the 2014 Critical Issues Summit and by individual boards to help them talk about what strategies may be implemented locally to prevent or respond to the scenario if it were to occur. These scenarios and discussion questions are available on the KHA Website and are listed below:

- Diminished Local Support
- CAH Mileage Phase-in
- Physician-led ACO
- System Alignment

Later in the evolution of the TAG, there was a general feeling that only negative aspects and challenges of rural health care were being highlighted while the story of the value of rural health care was not being told. To assist in doing that, the brochure “Protecting the Foundation of Health Care in Kansas” was developed. The group also suggested that “Priority Messages for Communities,” a customizable community presentation be developed. Both resources are available on the KHA Website.

Review of Other Models

Throughout 2013, the TAG considered models and activities in other states, some of which are summarized on the KHA website including:

- Alaska Frontier Extended Stay
- Montana Frontier Health System
- Colorado Community Care Clinic with Emergency Services
- Emergency Hospitals and Urgency Rooms – Georgia, Oklahoma, Minnesota, Wyoming
Each discussion focused on the details of the model researched by staff and then a TAG discussion of how the model addressed the principles articulated earlier. While each model or activity provided learnings for the TAG about what they thought was or was not appropriate for Kansas, no model was identified that met the needs the TAG felt were key in Kansas.

**Essential Services**

Throughout the tenure of the TAG, the discussion of essential services was key. To begin the discussion of new models, the TAG reviewed work done by the State Office of Rural Health and was guided in an exercise by Greg Bonk, Bonk Consulting, to identify essential health care services for a community. The rationale was that if a set of services could be identified, models could then be identified with those services. A survey around Bonk’s work was developed. The group participated in a survey with mixed results. There was a particular division around the need for acute inpatient care in each community.

The work done by the National Organization of State Offices of Rural Health developed a three-tiered approach to essential services, beginning with basic primary care related services and building to a current CAH. Several states, Illinois as an example, has built on that work.

In 2015, the AHA Task Force on Vulnerable Communities was created with two subcommittees for Urban and Rural focus. Carrie Saia, CEO of Holton Community Hospital and Vice Chair of the KHA RHV TAG was appointed to the Task Force. She reported regularly to the TAG on AHA’s work and utilized the TAG to assist in responding to AHA’s polling questions.

Services for a payment approach for the Primary Health Center model (described later) follow:

- Services considered core or essential that must be provided by a PHC:
  - Primary health care including prenatal care (AHA, RHV)
  - Urgent care (RHV)
  - Emergency care (AHA, RHV)
  - Emergent and non-emergent transportation (AHA, RHV)
  - Observation (AHA, RHV)
  - Outpatient and ambulatory services (AHA, RHV)
  - Minor procedures
  - Ancillary services to support primary care and basic diagnostic (AHA, RHV)
  - Care coordination, chronic disease management (RHV)
  - Active telemedicine (RHV)
The following services should be available in the community and may be provided by a PHC based on community need and local sustainability and may be included in the payment model:
- Behavioral health (AHA essential)
- Dentistry (AHA essential)
- Transitional care – limited stay, non-acute overnight care (RHV essential)

Other services could be provided by a PHC based on justified community need and local sustainability, but would not be included in the payment model:
- A mechanism to include unique local/regional services should be considered

The discussion of essential services will continue to be at the crux of the emotional issue of change at the community level. Any reduction in current local service will be seen as giving up something they have always had, even if the community is not using the service to the extent necessary for sustainability. While community health needs assessments are becoming routine in many communities, a more in depth approach will be required to support these more difficult conversations.

**Identifying New Models**

In the spring of 2014, the TAG began to identify the need for and articulate the role of a new model that might provide an alternative and maintain access to health care for communities with extremely low inpatient and hospital volumes. Staff provided an outline of potential services and parameters for which the TAG had no consensus. As a result, a survey of preferences was conducted and from the result of each question, a “strawman” statement presented. Over the next six to nine months, the model emerged from repeated renditions of “strawman” statements and policy recommendations. Ultimately, the PHC was described with enough detail to consider a field test. The process and product were documented in a white paper entitled “Sustaining Rural Health Care in Kansas,” which is available on the KHA Website.

The model is intended for small rural communities that have existing services as a method to align their structure with the needs of their communities. The model envisions a payment method for a PHC that would incentivize an integrated health system at the local level rather than the current CAH payment method that carves out and consequently dis-incentivizes integration. Five payment options have been considered and pros and cons developed. The TAG did not select one method, understanding that the national discussion will dictate how an outpatient facility like this will be paid.
Funded by a one-year grant from the United Methodist Health Ministry Fund, KHA’s foundation, the Kansas Hospital Education and Research Foundation conducted a financial, operational and clinical “paper” test. Five current CAHs volunteered to provide information and serve as a case study to determine the potential impact of transitioning to the PHC. The TAG appreciates the following facilities’ willingness to test the model: Ellinwood District Hospital, Ellinwood; Fredonia Regional Hospital, Fredonia; Edwards County Hospital and Healthcare Center, Kinsley; Wilson Medical Center, Neodesha; and Washington County Hospital, Washington.

Both the 12 and 24-hour models were tested in each of the five sites. Local CPA firms identified the financial needs and worked with hospital leadership to identify operational changes that were considered. Nurse reviewers analyzed over 900 patient charts to determine how patients would be served.

The results show that although there are still many unanswered questions and many details yet to be determined, the two models portrayed in this document can address the seven principles and provide a cost effective alternative for communities that cannot sustain a CAH or small PPS hospital. The clinical review showed that the majority of patients can still receive services locally, and the financial analysis found that financial requirements can reduce the cost from the traditional CAH. The PHC 12 and 24-hour models can work in some Kansas communities and indeed some communities nationwide. The TAG realizes that the further development of these models will require the collaboration of many organizations and governmental agencies both statewide and nationally. The results of the test are documented in “Primary Health Center Test Findings Report,” which is available on the KHA Website.

**Barriers to Implementation**

In order for this type of model to work, regulations at the state and national level will need revision. Kansas and national rules require inpatient beds be available 24 hours a day. Both the bed type and hours of operation would need revision. National requirements articulate a three-day acute inpatient stay prior to a swing-bed stay. “Transitional Care” envisions care for patients that are not acute without previous acute stay. Rules embedded in the payment system along with staffing requirements and the ability to return to previous status if the model doesn’t work for the community will all need to be outlined or revised. In Kansas, recognition of the new provider type and common payment approach for Medicaid would also be important.

Throughout the discussion and development of the Primary Health Center Model, specific statutory and regulatory barriers were identified.

**Licensure and Certification** – Both state and federal statutes and regulations require Acute Inpatient Beds. The PHC or any outpatient hospital model would require a new category, waiver or language change to this requirement. Along with inpatient requirements, the requirement for 24/7/365 operation would have to be changed if the 12-hour model were to be an option. Discussions have also questioned if there would need to be definitions for what constitutes an emergency versus an urgent
care visit. Also, related to the 12-hour model, would there need to be protocols for handling a patient at the close of business?

The PHC model requires a clinical and administrative relationship with a Partner Organization. Current CAH requirements for a supporting hospital may need revision to strengthen the duties of both organizations in this relationship, as well as a recognition that distance to a partner organization by vary in different regions of the state or nation, in Kansas, restrictions on county hospitals may be a barrier to these relationships.

The PHC envisions an integrated relationship with Emergency Medical Services and medical transportation. Efforts to leverage the availability and skills of EMS personnel, integrating them with patient care on and off the facility grounds may require changes to the scope of practice and may also have implications for billing and payment. Requirements to transport to the nearest facility will also need review if the concept of a regional EMS Plan is to work effectively.

There are differing interpretations of how EMTALA rules would apply to this type of facility. Review and determinations would need to be made.

Finally, if the PHC is tested or implemented, the ability to return to CAH status should the model not work or not be a good fit for the community will be critical.

Clinical and Service Issues – The PHC envisions a more flexible and holistic use of personnel focused on both the response side of healthcare and the move to value based payment system and population health. A number of creative approaches have emerged which may need statutory or regulatory change or review. The use of telemedicine and technology are key to sustaining services in low volume areas. As the PHC envisions the use of telemedicine for emergency support, the discussion of the requirements for a physician’s physical presence and supervisory responsibilities opens the question of how telemedicine could be used to improve the care for the patient and expand the locally available resources. Roles for APRN, EMS, and Community Paramedicine will necessitate the review of state level scope of practice requirements. The TAG did not review these requirements in depth to determine if changes were necessary.

The relationship between the partner organization and the PHC would also need review in the context of STARK requirements or prohibitions for self-referral or provision of health IT. It will be critical to standardize the use of technology and develop protocols for the transfer of patients that may challenge these rules. Overall, any barrier to the clinical or administrative integration of services and entities would need to be identified and reviewed. Waivers may be necessary to test the concepts of the PHC or other similar model.

The PHC includes a new or combination of services which is referred to as Transitional Care. This is an overnight stay for sub-acute care which would not meet the currently required three-day acute stay or may need more than current observation regulations allow. The service is designed to keep the patient who does not need acute care but does need monitoring or other non-acute care most often preventing the need for an acute admission or readmission. This service will need more specific definitions and is currently not covered in regulation as it is envisioned. TAG discussion also indicated that some ancillary requirements may need consideration especially lab testing requirements.
**Payment and Accountability** – Without question, payment and reporting rules will need the most change if a PHC or other model is piloted. As the rules stand today, a PHC is likely to lose its Medicare Part A status as it will no longer have acute inpatient services. Losing Part A then returning to Part A, if they revert back to a CAH or PPS facility, would also be a difficult process. The PHC should remain a Part A facility for several reasons. First is its ability to provide Transitional Care or other subacute services. Second, it will be difficult to amend all the references to Part A to include the new model in federal statutes and regulations. Third, a facility that pilots this model should not lose current designations that affect its operation of a rural health clinic.

New services or services not traditionally allowed in a CAH will also challenge current statutes and regulation. For instance, care coordination and prevention are services and responsibilities that will grow in importance under bundled payment and population health approaches. Some payment is allowed for these services either in a CAH or a rural health clinic, but this service/responsibility is a critical role the PHC can and should play. To effectively manage or participate in population health initiatives, PHCs and their partner organization should also have access to beneficiary level data for their area.

The PHC is envisioned as an integrated entity, both locally and in relation to their partner organization. This allows flexibility and the ability to leverage scarce resources. Current rules that require space and costs to be carved out of the CAH cost base or not considered allowable costs, will need to be reconsidered. Eliminating payment silos and incentivizing integration will be key to the success of a model like the PHC. Other issues or barriers that impact payment include:

1. Mechanism for a grant to maintain access to emergency services would need to be established
2. Potential for global or inclusive budget incorporating all PHC services
3. Policy establishing low density population as “underserved” similar to FQHC underserved populations
4. Alignment of Medicare and Medicaid payment methods
5. Allowance for PHC to retain the benefit of RHC but through a payment vehicle that integrates the two entities
6. Changes to beneficiary outpatient costs
7. Alignment of required quality measures with service array and volume
8. Access to SHIP and FLEX funded activity

In addition, even if the models are approved and available, each community will need to make a community-based decision about adoption. In fact, there will be many communities that will not be attracted to the model. With the introduction of the Critical Access Hospital model, several years passed before the model was widely accepted as an alternative to the traditional community hospital provider type. Change will be difficult for some communities to embrace, now as in the past. The results are detailed in the “Primary Health Center Test Findings Report,” which is available on the KHA Website.

**Financing a Primary Health Center**

The TAG considered a number of approaches to financing the Primary Health Center. As it is not an FQHC nor a full service CAH, components of each of these models were considered along with principles embodied in the movement from volume based payment models to value based models. Five options and their pros and cons were identified, but no single model of payment was recommended. The TAG believes that some form of value incentive should be included in any payment method while some
models proposed nationally do not have this component. A summary of the payment models and related discussions can be found in “Financing the PHC,” on the KHA Website. The five options were:

1. **Global budget based fixed payments** – This option provides monthly equal Medicare payments based on a negotiated multi-year budget for all services provided by the PHC. The negotiated budget would include federal support for the emergency infrastructure in the form of a grant or additional budget amount along with local support. A value incentive providing an extra percentage in payments for meeting designated measures would be included.

2. **FQHC-like payment method with extended visit payments** – This option would combine the process of the FQHC payment approach setting visit or encounter payments based on a budget incorporating all services. Extended or add-on payments would have to be established for patients who remain in the facility for longer term or overnight services. Additional federal support for the emergency infrastructure would be provided in the form of a grant from Medicare at the same level as current FQHCs, a maximum of $650,000 per year. This option would also require local financial support and carry a value incentive for meeting designated measures.

3. **Blending fixed payment and encounter payments** – This option would have components of the fixed payment combined with the encounter method. The federal grant, local support requirement and value incentive would be the same as above.

4. **Global cost based approach** – This approach retains the traditional cost-based system of payment currently used for CAHs with several modifications. The intent is to avoid current carve-outs as all services in the PHC would be included in the cost base. Modifications to the definitions of “allowable costs” would be needed to assure that the emergency infrastructure is supported. The Grassley proposal suggests 110 percent of costs. The TAG would suggest that the local support and value incentive be included as well.

5. **Grant + fee schedule** – This approach is suggested by MedPAC in their recent release of “Improving Efficiency and Maintaining Access to Emergency Services in Rural Areas,” which can be found on www.medpac.gov. The report suggests a grant of $500,000 with services paid according to the PPS fee schedule. Local support is also suggested.

Regardless of the payment method used, the TAG developed a number of conclusions. First, any effort to preserve access and improve health through low volume facilities, like the PHC model, must be supported with additional financial resources in the form of federal grants and local tax or other support. Classic fee based reimbursement will not be sufficient to cover expenses in low volume facilities. Second, reporting requirements, especially quality measures, should be consistent with the scope of services and operations. Recognition that these facilities will be limited in their staffing and services, reporting requirements should not be burdensome. Third, payment models should incentivize integration of all essential services and the flexibility needed to apply staff and financial resources as service volumes fluctuate. Methods that carve out services or allocate space and staff, will limit the effectiveness of these facilities. Finally, while Medicare is the predominant payer for Kansas facilities, success will depend on the participation of Medicaid and private payers. Multiple payment models stemming from different payers will likely minimize the success of this model. For further information related to the payment method, see “Five Scenarios that Impact CAH Reimbursement,” on the KHA Website.

CAHs and Rural PPS hospitals have alternatives available to them today, including:

1. Operate as a Rural Health Clinic or Urgent Care Clinic without the inpatient hospital.
2. Convert to an FQHC. This could be done with or without the hospital. Two governance structures are required, but funding is enhanced.
3. Convert to a Hospital Outpatient Department with an ER. This requires becoming a department of another PPS hospital within a 35-mile radius and would be paid based on a PPS rate structure.
4. Work within the confines of the cost reimbursement structure to reduce costs or improve the revenue cycle. It has been noted, however, that reducing costs can negatively impact the cost report and, consequently, revenues may decrease more than the cost reductions.
5. Increase revenue via new services or increased volume.
6. Combine with another CAH to become a single provider.
7. Affiliate with a system or hospital that could provide for operational or financial efficiencies.
8. Increase local tax or other financial support.
9. Participate in Accountable Care Organizations or Alternative Payment Models.

Regional EMS Planning

As part of the Primary Health Center Model, the concept of a regional EMS plan was incorporated. To put more detail to that concept, the TAG created an EMS Workgroup made up of rural EMS and hospital leaders. The group identified three levels of transportation that should be available:
1. Emergency Transport - Response to 911 calls and the resulting transport of the patient to a receiving facility.
2. Non-emergency Transport - Response to an acute, but non-life threatening issue and the resulting transport of the patient to a receiving facility.
3. Care Coordination Transport - Movement of a person from one location to another while continuing health assessment/treatment. Two types:
   a. Skilled Transport – An acute patient requiring medical care and/or monitoring during transportation.
   b. Unskilled Transport – A non-acute patient not requiring medical care or monitoring during transportation.

This discussion highlighted the challenges that hospitals and EMS providers face in providing transportation based on the traditional EMS model. EMS is a tremendous resource that is assuming new roles in the health care environment, while the payment model has not changed or recognized the role of emergency and non-emergency transportation in health of a rural population.

The EMS Workgroup has articulated the content or areas to be considered in planning for emergent and non-emergent response and transportation. With or without the PHC model, the findings of the EMS Workgroup can be useful in critical local and regional population and community health discussions. Definitions and suggestions for discussion in the EMS plan are available on the KHA Website.

Affiliation and Collaboration

The TAG identified a sustainability strategy in the concepts of collaboration and affiliation. While that strategy is not right for everyone, many TAG members and other KHA members struggle with that discussion. It is evident in new payment models that the smaller facilities could be negatively impacted if they were not included in a larger system of care. While that does not always mean merging or joining a system or ACO, boards may need to consider the costs and benefits of all types of affiliation. It was apparent that tools and processes would be helpful. In an effort to leverage other resources, the FLEX grant was used to engage Maureen Swan, Principal, MedTrend, Inc. to design an evaluation tool and process. That project is in the development stage. Three hospitals have volunteered to pilot the process, which will then be made available to all hospitals.
Population Health and Data Analytics

Along with new structural and service models reviewed by the TAG, the emergence of Alternative Payment Models at the federal level will drive long-term change in service delivery. Those APMs described in the Accountable Care Act and most recently in MACRA will have significant impact in rural areas. CAHs have been exempted from many of the new ACA efforts; however, incentives applied to PPS hospitals may have a trickle down impact on CAHs.

With United Methodist Health Ministry Fund funding carried over from the PHC test, the TAG worked with CliftonLarsonAllen to develop an analysis for Kansas CAHs highlighting the impact of the current PPS policies should CAHs be included in the future.

ACOs are given access to significantly detailed patient data from all settings with the goal of identifying and ultimately reducing unnecessary costs. Referred to as population health, the concept includes identifying high cost health care populations and targeting these patient populations to improve outcomes, prevent readmissions and reduce overall costs. The TAG brought in experts from a variety of areas to better understand the impact of these and other policies and see first-hand how the data could be used. As the TAG reviewed the available data and ways it could be used, it was apparent that CAHs did not have access to the breadth of data nor the capacity to apply it.

On another front, the introduction of bundled payments – the goal of which is to reduce the overall cost of the full episode of care – is bringing to light a long debated disparity between payments for swing bed services and payments for other post-acute settings. For CAHs involved in the areas where bundled payments are being implemented, this effort could have a significant impact on hospital revenues and volume. Funded by the Kansas Heart and Stroke Collaborative CMMI grant, the TAG is working with PYA Analytics to determine if data can be used to show cost and value for swing beds.

Resources and Recommendations

During the course of the TAG’s visioning work, the following resources and whitepapers were developed and made available to the KHA membership. Many of these also received national attention and became starting points for other state associations. Staff and members of the TAG were often called upon to educate the Kansas Congressional Delegation, other state hospital associations, national gatherings of rural leaders, Kansas legislative and administrative leaders, local hospital staff and hospital governing boards. The educational opportunities fueled the critical conversations about the need and ideas for change. Here is a list of the tools and resources developed in the process:

1. “Principles for A Sustainable Rural Healthcare System”
2. “A Case for Change”
3. “Scenarios for the Future”
4. “Protecting the Foundation of Healthcare in Kansas”
5. Customizable Community Presentation – “Priority Messages for Communities”
6. “Sustaining Rural Health Care in Kansas”
7. “Primary Health Center Test Findings Report”
8. “Financing the Primary Health Center” (Draft)
9. “Five Scenarios that Impact CAH Reimbursement”
While the work is never really done, the TAG believes it has met its charge from the board. In finalizing its work, the TAG has made a series of recommendations for the KHA Board’s consideration.

**Managing the Health of a Population** – Rural hospitals will require new and improved relationships with other providers in their communities and their regions. The TAG was made up of KHA member hospitals representatives with the understanding that at some time in the future a broader group might well be established to improve communications and tackle barriers to clinical and other collaboration, affiliation and/or integration across settings.

1) **Develop a group of representatives that cross health care settings to focus on reducing barriers, identifying best practices and strategies required for population health management.**

**Community Needs** – As experienced by the TAG and other efforts to facilitate change, the discussion of essential services or the process to define community need, will be at the center of the community concern. Current requirements to conduct a community health needs assessment are not sufficient to support the difficult decisions faced by many communities. In addition, the TAG feels strongly that continued education of community leaders will be critical as communities grapple with change.

2) **Encourage and support the development of a comprehensive data driven approach to assessing actual community need.** This approach would serve to provide communities with a statistical analysis upon which decisions could be made about aligning community need with sustainable services and supporting the local responsibilities for population health, chronic care management and care coordination.

3) **Continue to provide members with up to date, customizable presentations and resources for use at the local level.** Resources that address key issues, but also include general health care messages to educate communities about the critical changes and decisions that will need to be made in the future are most needed by the KHA membership.

**Regulatory and Policy Barriers to New Models** – During the development of the PHC model, a number of regulatory barriers were identified. Based on those discussions, the following recommendations are made for consideration for KHA advocacy and other efforts.

4) **Advocate for flexibility in state and national statutes and regulations allowing for PPS hospital and CAH transition to new models of delivery and payment.**

5) **New models, such as the PHC or outpatient hospital models will require integration of services and payment.** Support and advocate for models that are consistent with the principles of the Rural Health Visioning TAG.

6) **Work with state leaders to develop and implement statutory changes supporting and allowing sustainable models such as the PHC to develop in rural parts of Kansas.**
7) Work with state leaders to enable and require Medicaid payments consistent with the Medicare payment methodology.

8) Advocate for payment parity and the use of telemedicine to support the providers in a community. Other uses of telemedicine, such as opportunities to use for supervision requirements, patient monitoring and care management should also be supported.

9) Continue to support the inclusion of “transitional care” as described in the PHC model, as an optional service for rural hospitals that would be included in the payment approach either for a new model or for current providers.

10) Seek a waiver of the required 3-day acute stay to allow the implementation of “transitional care” in these new delivery models and a level playing field to participate in bundled payment initiatives.

11) Continue to advocate for meaningful quality measures aligned with the services provided by rural hospitals.

12) New models of emergent, non-emergent and care coordination related patient transportation should be explored, tested and included in payment approaches that recognize the needs of rural communities and regions.

13) Participate and/or lead initiatives for demonstration or implementation of new models such as the PHC.

14) Assure that any pilot, demonstration or implementation of a new model allows hospitals testing the models to revert back to their previous status as CAH or PPS if the fit with the community is not realized.

Data and Analytics – Based on the education from invited experts, the TAG concluded that hospitals, primarily rural hospitals not in ACOs or joint bundle implementation areas, do not have access to either the data or the analytic expertise to apply the data. The TAG concluded that access to data and analytic capacity is not a level playing field. Without access, hospitals cannot prepare for change or begin to manage the health of their populations.

15) Continue to improve KHA’s data infrastructure to provide access to and apply critical beneficiary data in ways that support population health and care coordination.

Forum for Rural Hospital Leaders – Finally, while one of the key values to the members of the TAG was the ability to learn both from presentations and subject matter experts, there was significant value for participants in discussing difficult issues with their peers. These discussions highlighted successful practices and created an atmosphere where different opinions could be voiced.

16) Consider and implement strategies to continue to engage rural hospital leaders for the purposes of education, discussion, exchange of ideas and problem solving.
Conclusion

The work of the TAG brought value to both KHA’s membership and the national conversation of the importance of rural health care and the need for new approaches to service delivery and payment. Rural challenges, as well as challenges in urban areas, will always be at the heart of KHA’s work. While issues may change, strategies such as the charge to the Rural Health Visioning Technical Advisory Group can be effective when members are committed to putting aside traditional approaches and thinking about how barriers can be overcome.

This report both documents the work of the TAG and sets forth recommendations to bring about the strategies identified. The TAG participants would like to commend the KHA Board for identifying the critical nature of sustaining rural health care, creating the TAG and challenging it to think to the future.
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Leslie Lacy, Great Plains Health Alliance, St. Francis, 2013-2016
Brenda Legleiter, Rush County Memorial Hospital, La Crosse, 2016
Kile Magner, Ellinwood District Hospital, Ellinwood, 2016
Roger Masse, Ellsworth County Medical Center, Ellsworth, 2015-2016
Randall L. Peterson, Stormont-Vail HealthCare, Inc., Topeka, 2013-2016
James H. Reagan, PhD, Morris County Hospital, Council Grove, 2015-2016
Carrie Saia, Vice Chair, Holton Community Hospital, Holton, 2014-2016
Jodi A. Schmidt, The University of Kansas Hospital, Westwood, 2013-2016
Roxanne Schottel, Washington County Hospital, Washington, 2016
Dennis Shelby, Wilson Medical Center, Neodesha, 2014-2016 (Chair 2015)
Michael Sinclair, Rooks County Health Center, Plainville, 2014-2016
Greg Unruh, Citizens Medical Center, Colby, 2013-2016 (Chair 2014)
Larry Van Der Wege, Chair, Lindsborg Community Hospital, Lindsborg, 2014-2016 (Chair 2016)
Shae C. Veach, Hays Medical Center, Inc., Hays, 2013-2016
Kevin A. White, Medicine Lodge Memorial Hospital, Medicine Lodge, 2014-2016

Previous TAG Members
Teresa Clark, Wichita County Health Center, Leoti, 2013-2014
Dave Dellasega, Great Plains Health Alliance, Wichita, 2013
David Dick, Mitchell County Hospital Health System, Beloit, 2013
David Engel, Phillips County Hospital, Phillipsburg, 2016
Shannan Flach, Wamego City Hospital Wamego, 2013-2015
Robert Freelove, MD, Salina Regional Health Center, Salina, 2013
Dave Gambino, Via Christi Health, Wichita, 2014-2015
Steve Granzow, Sheridan County Health Complex, Hoxie, 2013
Charles G. Grimwood, Salina Regional Health Center, Salina, 2013-2014
Jay Jolly, Goodland Regional Medical Center, Goodland, 2013
Steve Kelly, Newton Medical Center, Newton, 2013
Blaine K. Miller, Republic County Hospital, Belleville, 2014
Mark Miller, Memorial Health System, Abilene, 2013-2014
Donna Myers, Hospital District #1 of Rice County, Lyons, 2013
Marion R. Regier, Hillsboro Community Hospital, Hillsboro, 2013
John Smith, Coffeyville Regional Medical Center, Coffeyville, 2014
Tyson Sterling, Wichita County Health Center, Leoti, 2015
Scott Taylor, St. Catherine Hospital, Garden City, 2013-2014 (Chair 2013)
Amber Withington, Rawlins County Health Center, Atwood, 2014

2016 EMS Work Group
David Adams, Pottawatomie County EMS, Wamego
Carman Allen, KDHE-Bureau of Community Health Systems, Topeka
Randall Allen, Kansas Association of Counties, Topeka
Terry L. David, Hospital District #1 of Rice County, Lyons
Dennis Franks, Neosho Memorial Regional Medical Center, Chanute
Jody M. Gragg, Chair, Via Christi Health, Wichita, (Chair)
Jim Hansel, Edwards County Hospital and Healthcare Center, Kinsley
Joseph House, Kansas Board of EMS, Topeka
Kerry McCue, Ellis County EMS, Hays
Doug Mogle, Cherokee County Ambulance Association, Columbus
Robert Moser, Kansas University Medical Center, Westwood
James H. Reagan, Morris County Hospital, Council Grove
Sara Roberts, KDHE-Bureau of Community Health Systems, Topeka
Dennis Shelby, Wilson Medical Center, Neodesha
Marvin VanBlaricon, Clay County EMS, Clay Center
Darlene Whitlock, Kansas Medical Society, Topeka
Jerrad Webb, Kearny County EMS, Lakin

2014-2015 Finance Work Group
Melissa Atkins, Graham County Hospital, Hill City
Jason Barb, BKD, Topeka
Tommy Barnhart, Ten Mile Enterprises, LLC, Silverthorne
Paul Bowerman, George, Bowerman & Noel, P.A., Wichita
John Helms, Wendling Noe Nelson and Johnson, Topeka
Les Lacy, Great Plains Health Alliance, St. Francis
Eric Meyer, George, Bowerman & Noel, P.A., Wichita
Eric Otting, Wendling Noe Nelson and Johnson, Topeka
Jodi A. Schmidt, The University of Kansas Hospital, Westwood
Eldon Schumacher, Great Plains Health Alliance, Wichita
Dennis Shelby, Wilson Medical Center, Neodesha
Brock Slabach, National Rural Health Association, Kansas City
Joe Watt, BKD, Topeka

2014-2015 Test Sites Subcommittee
Reta K. Baker, Mercy Hospital, Fort Scott
Curt Colson, Great Plains Health Alliance, Wichita
Sharon K. Cox, Rawlins County Health Center, Atwood
Paul Davis, Sheridan County Health Complex, Hoxie
David Engel, Phillips County Hospital, Phillipsburg
Niceta Farber, Sheridan County Health Complex, Hoxie
Jim Hansel, Edwards County Hospital and Healthcare Center, Kinsley
John Hart, Fredonia Regional Hospital, Fredonia
John Hughes, Ellinwood District Hospital, Ellinwood  
Christina Keating, Mercy Hospital, Fort Scott  
Robert Krickbaum, Edwards County Hospital and Healthcare Center, Kinsley  
Brenda Legleiter, Rush County Memorial Hospital, La Crosse  
Kile Magner, Ellinwood District Hospital, Ellinwood  
Jennifer Marcrum, Sumner County District #1 Hospital, Caldwell  
Cynthia Neely, Mercy Hospital, Columbus  
Michael Pracheil, Edwards County Hospital and Healthcare Center, Kinsley  
Roxanne Schottel, Washington County Hospital, Washington  
Dennis Shelby, Wilson Medical Center, Neodesha, (Chair)  
Penny Stephenson, Ellinwood District Hospital, Ellinwood  
Virgil Watson, Sumner County District #1 Hospital, Caldwell