American Health Quality Association

How QIOs Achieve Safety and Quality in Rural America

Maggie Elehwany
National Rural Health Association
NRHA Mission

The National Rural Health Association is a national membership organization with more than 22,000 members whose mission is to 
provide leadership on rural issues through advocacy, communications, education and research.

• Goal: Improve health of 62 million who call rural America home
• Non-profit, non-partisan
Why rural health care is different...

1) The challenges of rural

2) Quality challenges and Achievements in rural America
62 million rural Americans rely on rural health providers.

20 percent of the population lives in rural America, yet they are scattered over 90% of the landmass.

Extreme distances, challenging geography and weather complicate health care delivery.

“Rural Americans are older, poorer and sicker than their urban counterparts… Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider.” (HHS, 2011)

Disparities are compounded if you are a senior or minority in rural America.
The Rural Provider

Critical Access Hospitals: 1,320
Sole Community Hospitals: 480
Medicare Dependent Hospitals: 550
Rural Referral Centers: 240
Rural Health Clinics: 3,757

FQHC
Community Health Centere
12 states have nearly half or more of the Medicare population living in rural counties— with Vermont (73 percent), Wyoming (69 percent), and Montana (67 percent) having the largest share.
Rural children

- Children in rural areas are more reliant on health insurance from public sources, including Medicaid and CHIP. In 2012, 47 percent of rural children were covered by public insurance compared to 38 percent of urban children.
- The share of rural children covered by Medicaid and CHIP increased from 28 percent in 2000 to 47 percent in 2012.
- Of the fifty counties with the highest rate of uninsured children, 45 are rural counties.
- In nearly every state, compared to urban children rural children are more reliant on Medicaid and CHIP.
- Due to steep decline in employer-based insurance in rural areas. In 2000, 63% of children were covered by EBI. In 2012, just 49% were covered.

First Focus, September 2014
A half century of political efforts…

- Owsley County is a county located in the Eastern Coalfield region of Kentucky. As of 2010, the population was 4,755. According to the 2010 Census reports, Owsley County is the "poorest county in the United States."

- Robert F. Kennedy famed poverty tour highlighted the malnutrition of eastern Kentucky (field hearings on hunger).

- His tour was not a unique event: his brother John had planned to come in December of 1963, Johnson, Nixon, Ted Kennedy, Bill Clinton, Paul Wellstone all conducted "poverty tours" that included eastern Kentucky.
Rural lifestyles – Portrait of Kentucky

• “Obesity, a major risk factor for disease and disability, is most prevalent for men in Owsley, Kentucky and women in Issaquena, Mississippi; obesity rates for men are lowest in San Francisco and for women in wealthy Falls Church, Virginia.”
Death by Zip Code
University of Washington Study, July 2013

• Largest report on status of America’s health in 15 yrs.
• Health equates to wealth

• The study found that people who live in a rich area like San Francisco, Colorado, or the suburbs of Washington, D.C. are likely to be as healthy as their counterparts in Switzerland or Japan, but those who live in Appalachia or the rural South are likely to be as unhealthy as people in Algeria or Bangladesh.

• For example, women in Marin County, California, where the median household income is $89,605, have the highest life expectancy -- 85 years -- while women in Perry County, Kentucky, with median income $32,538, have the lowest life expectancy – just under 73 years.

• Men living in wealthy Fairfax County, Virginia, median income $108,439, have a life expectancy of almost 82 years, while men in nearby McDowell County, West Virginia, where the median household income is $39,550, had the lowest life expectancy in the country – 63.9 years.
Figure 17: US life expectancy by county, females, 2010
Rural lifestyles –
Portrait of Kentucky

• “Obesity, a major risk factor for disease and disability, is most prevalent for men in Owsley, Kentucky and women in Issaquena, Mississippi; obesity rates for men are lowest in San Francisco and for women in wealthy Falls Church, Virginia.”
Workforce Shortages

• “Access to Quality Health Care” is the number one health challenge in rural America. Rural Healthy People 2020
• Only 9% of physicians practice in rural America.
• 77% of the 2,050 rural counties are primary care HPSAs.
• More than 50% of rural patients have to drive 60+ miles to receive specialty care.

![U.S. Primary Care Health Professional Shortage Area (HPSA): 2006](image)
Health care and the Rural Economy

- Health care is the fastest growing segment of the rural economy.
- On average, 14% of total employment in rural areas is attributed to the health sector. Natl. Center for Rural Health Works. (RHW)
- Each rural physician can more than 20 jobs in the local rural economy. (RHW)
- The average CAH creates 107 jobs and generates $4.8 million in payroll annually. (RHW)
- In most rural communities hospitals are the largest or second largest employer
- Health care often represent up to 20 percent of a rural community's employment and income. (RHW)
- 91% of job recovery after the recession is in urban areas.
If a rural provider is forced to close their door…

• Local economy experiences a severe decline.

• Physicians, pharmacies and other health providers will also leave the community.

• Quality health care is needed to retain/attract businesses, families, and retirees.
Is the ACA creating quality challenges?

A. Rural implications in Medicaid Expansion
B. Rural implications in Federal and State Exchanges
Is ACA Working?

Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?
Among adults aged 18 and older

% Uninsured

Quarter 1 2008-Quarter 2 2014
Gallup-Healthways Well-Being Index

GALLUP
Competitiveness

- 58.3% of rural counties only had 1 or 2 plan options
- 23.7% of rural counties vs. 5.5% of urban counties had only 1 plan option
- Over ¾ of urban plans had three or more choices of coverage

Affordability: Residents of rural counties face slightly lower median premium costs for all levels of coverage than do residents of urban counties. “This multi-state conclusion may not apply in any single state.”
High deductibles mean uncompensated care for rural hospitals

- 65% of plans selected in first year were silver plans. Average silver deductible if $2,907 (often higher out of pocket cost for prescriptions than employer-based plans).
- Average deductible for a bronze plan is $5,081.
- (52% of Americans have less than $3000 in non-retirement savings.)

Can Rural Providers afford ACA?

- Rural providers will have to absorb more bad debt and charity care. DSH cuts and bad debt cuts are a significant problem.
Narrow Networks and Lack of Transparency (9-2-14 Senate R Report)

• 70 percent of ACA plans analyzed had narrow or ultra-narrow networks—those with coverage of 14 or fewer of an area’s 20 largest hospitals.

• Many reports of misinformation or incomplete information on providers within a network. Consumers may not know before purchasing a plan whether or not that plan will cover the doctors or hospitals of choice.

• Of the nation’s top 18 hospitals, as ranked by US News and World Report, only 11 accept one or two carriers’ exchange plans, according to a survey by Watchdog.org.
MEDICAID

• Disproportionately important to rural America (rural patients and rural economies).
• Supreme Court decision: Allowed states to “opt-out” or seeking waivers
Current Status of State Medicaid Expansion Decisions

NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.
How Does Medicaid Expansion Affect Insurance Coverage of Rural Populations

• A majority of the states with the largest percentage of population living in rural areas are not expanding, while nearly all of the least rural states are expanding.

• Rural, poor states are the least likely to expand Medicaid.

• The majority of rural residents in the U.S. live in states that are not expanding. Only 3 of the 11 states with the largest rural population have expanded (IA, KY, MI)

• There is a wider rural-urban insurance coverage that existed pre-ACA.

• NC Rural Health Research Program, July 2014
### 10 States With Largest Reductions in Percentage Uninsured, 2013 vs. Midyear 2014

"Do you have health insurance?" (% no)

<table>
<thead>
<tr>
<th>State</th>
<th>% Uninsured, 2013</th>
<th>% Uninsured, midyear 2014</th>
<th>Change in uninsured (pct. pts.)</th>
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Gallup-Healthways Well-Being Index
Financial Crisis for Rural Hospitals

- 41% of rural hospitals operate at a financial loss.
- Cuts in Effect:
  - Medicaid and Medicaid Reductions
  - Sequestration
  - DSH
  - Bad Debt
  - Coding
- 79% of CAHs will be in financial distress in Congress acts on any of the current proposals for Medicare cuts.
The headlines are already here…

“10 Alabama hospitals have closed in the last 3 years: Will yours be next?”

“Rural hospital closing hurts more than just the hospital”

“Another Rural Georgia Hospital Closing”
8th Scope of Work (2005-2008)

- QIOs explicitly required to assist Critical Access Hospitals (CAHs) and rural prospective payment system (PPS) hospitals, providing a unique source of technical assistance and access to resources for small rural hospitals.
- QIOs were required to recruit and collaborate with a group of at least 6 CAHs and/or rural PPS hospitals to improve organizational safety culture.
- Specifically, the 8th SOW required that QIOs assisted CAHs and other rural hospitals in three areas:
  - Encouraging non-reporting CAHs to submit clinical process data to the QIO Clinical Data Warehouse via QualityNet Exchange;
  - Supporting CAHs that already report to the QIO Clinical Data Warehouse in improving performance on an Appropriate Care Measure, a composite measure of care at the patient level for any one of three clinical topics, including Acute Myocardial Infarction (AMI), Heart Failure, and Pneumonia; and
  - Assisting rural PPS hospitals and/or CAHs to improve organizational safety culture using the Agency for Healthcare Research and Quality’s (AHRQ) Hospital Survey on Patient Safety Culture.
• 8th Scope of Work offered considerable and concrete benefits for rural providers.
• QIOs that participated in study, stated lack of specific rural task would likely limit the financially in responding to rural provider needs.
What we learned…

• Gaining trust was key.
• Providing workforce/IT assistance key.
• Overcoming basic barriers such as lack of broadband width critical.
• Hospital turnover was a problem.
• “Hands-on” approach worked best.
• Rural providers are at many different levels.
Obstacles in rural collaboration

- Finances/resources
- Workforce
- Geography/Isolation
- CEO/hospital leadership turnover
- Mindset
Get Everyone in Same Mindset.

“We had to get everyone motivated, and had to deal with that completely. We tried to understand where each hospital was in thinking about quality and transparency. Our approach was to tell hospitals that this was an opportunity for them to develop QI infrastructure to get better, and to get better quickly. We told hospitals this would help them in the long run. It was a chance for them to learn and make improvements so that when CMS actually required them to report they’d be prepared. This approach really worked at all levels.”

- New York State QIO (IPRO) Representative
Workforce Issues

“Often, the problem is that people leave and there isn’t clear information and documentation about what needs to be done, how to do it, the process for reporting, etc… The hospital didn’t want this void of information, so we needed to fix these holes. We really knew that we weren’t where we needed to be. We’re a very small hospital with a lot of physician turnover. We really needed to get into the reporting system because of the turnover and because physicians were often taking calls for each other.”

- Margaretville Hospital Representative
Affiliation with larger system helpful

- CAHs that were linked or part of a larger health system already had good information technology (IT) infrastructure and capacity, and required the least amount of assistance.

- At the other extreme, a small hospital did not have access to broadband, making the it virtually impossible.

- Given that access to technological resources and staff expertise differed substantially across hospitals, progress in reporting of performance data also varied.
Summary of Findings

Across all QIOs, several factors were found to contribute to successful performance.

(1) In most cases the QIOs or CAHs collaborated with outside entities, such as professional associations, State Offices of Rural Health, and other QIOs and CAHs to leverage resources. In some cases outside funding was used to further QI objectives;

(2) QIOs involved in these projects recognized that successful partnerships required a strong relationship with hospital leadership, and that these leaders served as QIO advocates;

(3) QIOs disseminated and encouraged the use of existing tools or resources as a means to reduce the costs associated with the provision of technical assistance as well as to standardize the provision of care.
11th Scope of Work – Major organizational changes

Significant changes for rural providers.

Quality Innovation Networks

• Multi-state contracts are a concern.
• NRHA’s comments: “Single-state approach is most likely to help rural facilities maintain and improve quality and cost control.”
• Concern that face-to-face contact will be lost, and local, state-based assistance will be replaced by large, regional groups.
• State partner and state offices of rural health play and critical role - those bonds may be weakened by consolidation.
• State regions do no make geopraphic/cultural sense.
Rural emphasis in 11th SOW is minimal

QIN program will include areas of focus. Each has some emphasis on rural:
1. Prevention and treatment of chronic disease.
2. Patient safety

Lacks: rural mission/focus
CAHs and rural PPS hospitals have strong desire for performance and value-based compliance; Most are performing exceedingly well - providing both value and quality.
Delivering Value
Study Area A - Medicare Costs and Charges

Critical Access Hospitals vs. Non-CAHs

What if non-CAHs charged a CAH per case rate?

63% LESS

Of the 351 DRGs common to CAHs and non-CAHs

Total Medicare

$207 BILLION

Source: Rural Relevance Under Healthcare Reform 2014, Study Area A.
Delivering Value
Study Area B - Shared Savings (Medicare beneficiaries)

Rural vs. Urban Spending

- $1.5 BILLION: Less spending per beneficiary
- $5.2 BILLION: Apply the rural rate of spend to urban beneficiaries

Total savings if all beneficiaries were treated at the rural equivalent?

= $6.8 BILLION *

Medicare spends less on rural beneficiaries than on urban beneficiaries

* Approximate Totals
Source: Rural Relevance Under Healthcare Reform 2014, Study Area B.

Powered by iVantage® HEALTH ANALYTICS
Delivering Value
Study Area D - Emergency Department

14% Utilization Increase

56 mins Faster than Urban

50% Of ED Visits are Low Acuity

9 to 5 >50% of Low Acuity Visits Occur Between 9 am and 5 pm

Source: Rural Relevance Under Healthcare Reform 2014, Study Area D.
## Delivering Value

### Study Area C - Hospital Performance

### Who has the edge?
- Quality
- Patient Safety
- Patient Outcomes
- Patient Satisfaction
- Price
- Time in the ED

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**Rural hospitals match Urban hospitals on performance at a lower price**

Data sources include CMS Process of Care, AHRQ PSI Indicators, CMS Outcomes, HCAHPS Inpatient/Patient Experience, MedPAR, HCRIS

Source: Rural Relevance Under Healthcare Reform 2014, Study Area C.
The Top 100 Critical Access Hospitals are the nation’s best rural safety-net institutions. The Hospital Strength Index is a comprehensive scorecard that evaluates: market conditions, clinical and operational performance, and financial and quality outcomes.

Small and rural hospitals play a critical role in providing efficient and effective healthcare that is on par with other larger suburban and urban counterparts. “Rural hospitals have new and difficult demands that are best managed with actionable information.”
NRHA’s Rural Quality and Clinical Conference is an interactive conference for quality improvement coordinators, performance improvement coordinators, rural clinicians, quality improvement organizations, and nurses practicing on the front lines of rural health care.

You are invited.
Thank You!

Contact information:

Maggie Elehwany  
Vice President of Government Affairs  
National Rural Health Association  
melehwany@nrharural.org  
(202) 639-0550