



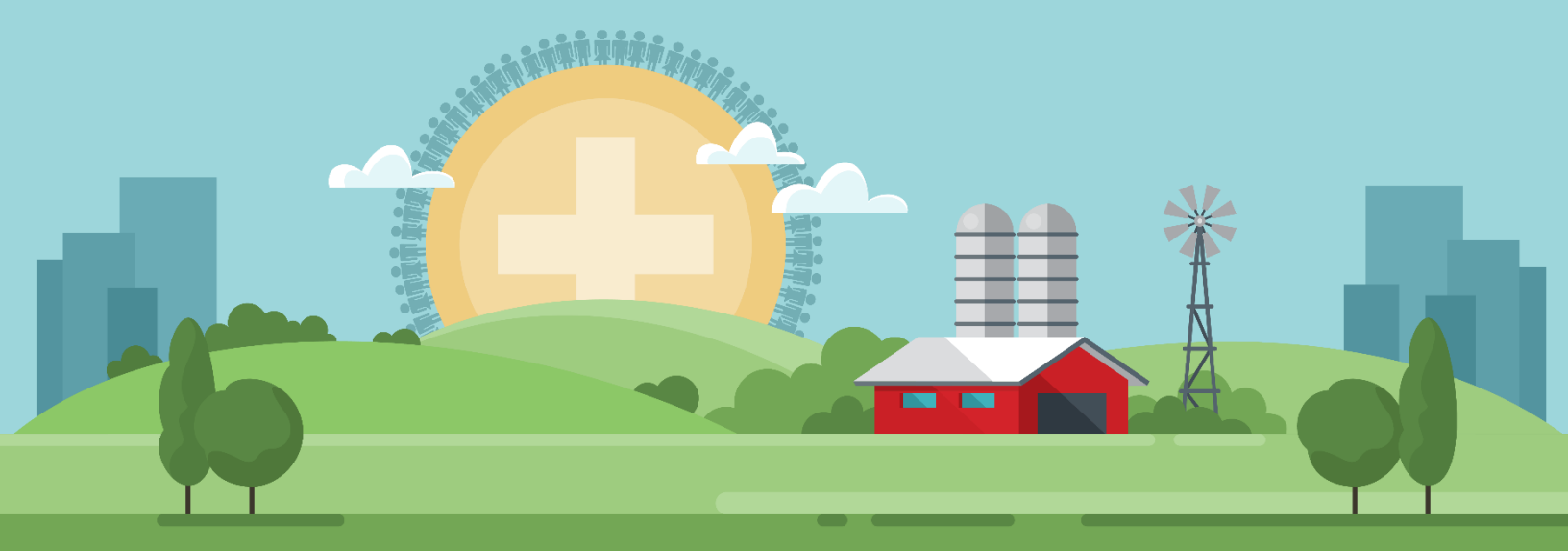
# Rural Health Forum

December 13 – 14, 2018 • FFA Enrichment Center, Ankeny, IA

## A Summary Report to Promote Action



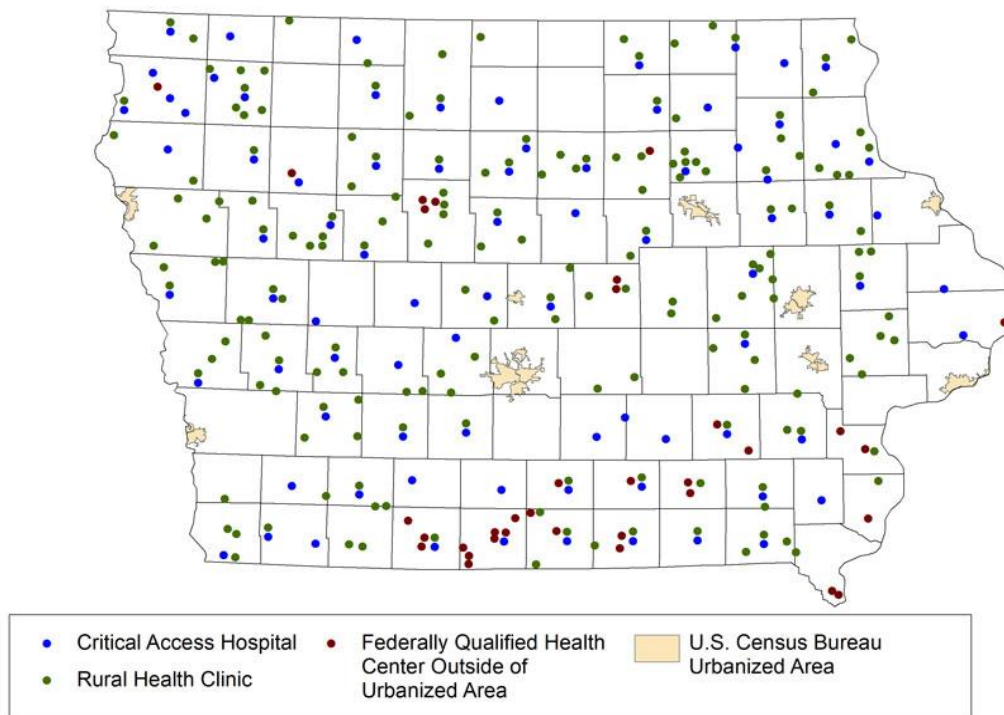
*A joint report by the Iowa Department of Public Health and the Iowa Healthcare Collaborative*



## Introduction

Healthcare delivery in the United States is amid profound transformation from a volume-based system to one centered upon value. This large-scale change brings with it sweeping shifts to traditional designs of healthcare with unique influence and impact for rural healthcare. Some of these impacts not only bring about new change, but exacerbate existing challenges being faced by rural healthcare systems, such as access, workforce recruitment & retention, and hospital vitality. Rural communities are

### Selected Rural Healthcare Facilities in Iowa



faced with access issues related to health care and social services, workforce shortages, and struggle to meet current value-base reimbursement programs and policies designed with larger, more metropolitan systems in mind (AHRQ, 2017). The prevalence of an aging population, higher rates of comorbidities, the increasing burden of the opioid epidemic, and the effects of lower incomes compound the healthcare transformation experiences for rural communities (Morton, 2017; CDC, 2017).

As a predominately rural state, boasting more 82 critical access hospitals, 170 rural health centers, and 76 local public health agencies servicing our 78 rural counties, working together to navigate the changing healthcare landscape is pivotal to being able to ensure the needs of Iowans throughout Iowa's rural communities are met and their health protected.

## **The Building Momentum & Priority for Rural Health – A Background**

### **CMS Rural Health Strategy and Federal Attention**

In 2018, the Centers for Medicare and Medicaid Services (CMS) released the [CMS Rural Health Strategy](#). This strategy is their first to specifically address high quality and affordable healthcare in rural communities. The strategy will provide a deliberate focus on rural health, making a commitment to integrate rural health applications into the vast initiatives, programs, and efforts throughout CMS, affecting policy, program design, and service delivery. The CMS Rural Health Strategy defines five specific objectives: apply a rural lens to CMS programs and policies; improve access to care through provider engagement and support; advance telehealth and telemedicine; empower patients in rural communities to make decisions about their health care; and leverage partnerships to achieve the goals of the CMS Rural Health Strategy. Through these objectives CMS aims to improve access to services, service delivery and quality of care, reimbursement, workforce presence and preparation, and improving patient options and experiences. These CMS Rural Health Strategy objectives align with rural health improvement aims at the local levels.

The CMS Rural Health Strategy provides a glimpse into the attention being paid to rural health by federal partners. Beyond the CMS strategy, rural health is taking high priority in many legislative discussions around healthcare transformation, from preparations around ever-advancing value-based payment structures to testimonies to the US Senate Finance Committee focused on the cost and impact of healthcare payment designs for rural systems and people. These discussions are informing the key decision-makers tasked with developing healthcare delivery systems of our future and directing related federal investments.

The CMS strategy and the federal priorities being placed on rural and rural healthcare delivery set the stage for action. The CMS and federal attentions establish an awareness and network of building support to not only guide local conversations, but to also inspire local action to be part of the solution-building process.

### **Healthcare Innovation and Visioning Roundtable Recommendations**

To address the socio-economic challenges in providing high quality healthcare in Iowa, Governor Kim Reynolds created the Healthcare Innovation and Visioning Roundtable, a group of major healthcare leaders representing state agencies, quality improvement and patient safety leaders, leading health systems and accountable care organizations, private and public payers, major professional associations, community-based service representatives, and so many more. This group convened numerous times from December 2017 through August 2018. In September, the Roundtable offered their [Recommendations to Governor Reynolds on Improving the Health of Iowans](#). In their report, they outlined recommendations to achieve sustainable healthcare transformation, enabling the transformation of the delivery and payment of care through technology, and ensuring sustainability of all strategies to improve the lives of Iowans.

Throughout each of these strategic focus areas, rural health and the unique applications for rural within broader initiatives were acknowledged. The special attention to rural healthcare transformation in the Forum event builds upon the momentum of discussions held through this Roundtable and expands the conversation around the recommendations with focus on applications within rural communities.

### **The Governor's Rural Priorities and Commitments**

On January 15<sup>th</sup>, 2019, Governor Reynolds delivered her [2019 Condition of the State](#) address. Within this address, Governor Reynolds recalled the statewide achievements attained in 2018 and outlined her priorities for 2019. As with previous years, Governor Reynolds paid special attention to rural Iowa, touting Iowa's small towns and rural communities as the backbone of the state. She recognized the guiding efforts of the Governor's Empower Rural Iowa Initiative and laid forth the intention to continue to support rural development through the proposed commitment of \$150 million to support rural broadband infrastructure development, high-speed internet connection investments, and workforce housing credits for rural communities.

Stemming from these commitments, Governor Reynolds announced the establishment of a Center for Rural Revitalization within the Iowa Economic Authority. This new center will be tasked with developing a roadmap to success and instilling supports to promote, protect, and advance rural communities. The attention and intentions being paid to

rural by Governor Reynolds reinforces this as the time to engage in practical and dynamic conversations, such as the Rural Health Forum.

## **The Rural Health Forum – An Opportunity to Connect Leaders, Stakeholders, & Advocates**

### **About the Event**

The Forum was convened in partnership between the Iowa Department of Public Health and the convened stakeholders from across the rural health landscape for a day and a half of sharing, sense-making, brainstorming, and commitment-making. Together attendees came together to form a common vision of what it means to be rural, the current issues affecting rural health -both nationally and in Iowa, and the primary policy and payment priorities impacting rural healthcare design and delivery.

Small group discussions facilitated translation of high-level policy, payment, delivery and design concepts and provisions into applications and recognized impacts at the local level. These small group discussions identified top challenges and opportunities affecting rural healthcare providers and communities and the development of strategic recommendations to carry beyond the summit to inform actions and investments at various levels of rural healthcare redesign and sustainability efforts

### **The Agenda & Execution**

#### Day One

Day One of the two-day event began with a welcome and introductions from the Director of the Iowa Department of Public Health, Gerd Clabaugh, and Iowa Healthcare Collaborative President/CEO, Dr. Tom Evans. Director Clabaugh and Dr. Evans set the tone for the Forum, establishing the event as a coming together of minds and calling on attendees to be actively engaged throughout the next two days – listening, sharing, and conversing – as work from this event will be used to inform and direct continued efforts surrounding the rural health topics and recommendations identified.

Sessions were designed to set the stage and provide a common foundation of shared information. Dr. Xi Zhu of the University of Iowa College of Public Health described the current state of rural health care nationally and in Iowa, outlining key policy considerations influencing and directing the future of rural healthcare. The background detailed by Dr. Zhu was offered into a specific rural health context to demonstrate the implications of rural healthcare transformation through the lens of the opioid epidemic.

The opioid rural health scenario provided by Dr. Sarah Derr, staff pharmacist with the Iowa Healthcare Collaborative, illuminated the unique challenges the epidemic presents within rural communities, exemplifying how healthcare challenges affecting the nation often amplify the gaps and needs of the rural healthcare delivery system. Access to needed treatment and care services, availability of specialized practitioners and providers, and the acute affects experienced throughout the communities while attempting to triage needs in their current state were core attributes of the rural crises characterized, reflecting universal challenges of rural healthcare.

The information from the morning sessions served as a platform leading to the crux of the Forum – the small group discussions and storyboarding. For the afternoon, the attendees were assigned to three different discussion groups with diverse stakeholder presence and perspectives in each group. For the small group discussions, each group was ushered into an individual room or space along with an assigned discussion facilitator. The facilitator was on hand to help illicit conversation and support interaction among all participants.

While flexibility was afforded to each group to self-select topics and key priorities to identify and address during discussion, facilitators were prepared with a selection of “Questions to Consider”. These questions were developed through reference of prior surveys and reviews administered to rural health stakeholders identifying some common concerns and challenges. The Questions to Consider provided a framework by which discussion could be initiated and offer in moments of transition.

### **Rural Health Forum Questions to Consider**

- What is rural? What is rural health?
  - Demographics
  - Economics
  - Culture
- What is rural health today?
  - Challenges/Barriers
  - Assets/Attributes
- What will be rural health tomorrow?
  - Hospital Vitality
  - Access
- Recruitment/Retention
- What is needed?
  - Design
  - Policy
  - Payment Systems
- What is being done?
  - Successes & Scaling
  - Lessons Learned
- Where to go?
  - Opportunities
  - Prioritization
  - Co-design

Two and a half hours were designated on Day One for small group discussions. Robust dialogue took place throughout the afternoon for all three groups. Facilitators tracked conversations and assisted in capturing resounding topics, common themes, and notable points of view.

## Day Two

Day Two expanded the engagement and storyboarding initiated on day one. The small discussion groups were re-convened. Topics, themes, and key points of conversations from discussions on Day One were summarized and the groups were able to elaborate, clarify, and supplement any pieces. The second day discussions served as an opportunity for the groups to establish their consensus around the status and future of rural healthcare in Iowa and potential recommendations to move forward.

Following this revamped discussion, the three small groups were called back together for large group dialogue and reflection. Time was allotted for each small group to report out on their two days of discussion, sense-making, and outlining of their perceptions of the rural situation, principal priorities, and suggestions for action. Throughout each report out, participants from the other groups were able to pose questions, offer opinions, and share comments.

After all groups presented, leadership in attendance had the opportunity to react and reflect. Leaders in attendance included Director Clabaugh and Dr. Evans, along with former Iowa Department of Human Services, Chuck Palmer, Chris Atchison, the former Director of Iowa's State Hygienic Laboratory and Emeritus Clinical Professor at the University of Iowa in Health Management and Policy, and Keith Mueller of the University of Iowa College of Public Health and Director of the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis.

The Forum concluded with final remarks from leaders and all attendees. Discourse from all attendees suggested commitment for further participation and involvement in continued solutions-focused collaborations. A copy of the complete agenda is included in Appendix A.

## **The Participants**

Attendees of the Rural Health Forum were selected based on their involvement in rural health care services, delivery, design, and advocacy. A diverse group of stakeholders were invited to represent disciplines across the health continuum and capture the rural experience from various levels – from the provision of direct care to large scale systems-approaches to public policy considerations – was vital to Forum success.

A total of 32 attendees participated in the Rural Health Forum, constituting more than 23 rural health stakeholder organizations represented. These participants constitute a small subset of rural health stakeholders and leaders, all of whom are actively and ardently engaged in the business of supporting and promoting rural health in Iowa. Forum attendees were selected from a network of individuals engaged in statewide discussions and efforts, such as state advisory councils or roundtables, those able to advocate for significant rural populations, and individuals with direct experience practicing in and administering services for rural communities.

Conveners and attendees recognize and appreciate that the forward work to progress efforts and implement change requires the input and involvement of a much larger grid of stakeholders, champions, and change agents. A list summarizing the Forum participants and their representative organizations is provided below.

### **Rural Health Forum Representatives**

#### **Convening Organizations**

Iowa Department of Public Health  
 State Office of Rural Health                      Office of Primary Care  
 Iowa Healthcare Collaborative

#### **Participant Organizations**

American Cancer Society  
 Dallas County Hospital  
 Hamilton County Public Health  
 Iowa Association of Community Providers  
 Iowa Caregivers Association  
 Iowa Department of Transportation  
 Iowa Department on Aging  
 Iowa EMS Association  
 Iowa Hospital Association  
 Iowa Pharmacy Association  
 Iowa Primary Care Association and Iowa Association of Rural Health Clinics  
 Iowa Specialty Hospital  
 Knoxville Public Health  
 Lucas County Health Center  
 MercyOne  
 Iowa Rural Health Association  
 UnityPoint Health  
 University of Iowa College of Public Health & the Rural Policy Research Center



## The Discussion

Discussion throughout the Rural Health Forum was dynamic and candid. Participants were earnest in sharing information, speaking for their experiences as rural health professionals as well as maintaining personal perspectives – demonstrating the personal and professional investment of these participants in the protection and advancement of rural health in Iowa.

The Questions to Consider provided a framework by which discussion originated, though within each group conversation took on an organic and progressive flow. Participants exhibited ownership over the conversation with facilitators able to focus efforts on gathering of common and emerging themes, topics, and suggestions. In consideration for rural health of today and tomorrow, attendees recognized the intertwined nature of challenges and strengths, status of the current systems and visions for the future. Thoughts around the core subjects of rural health access, workforce needs, and hospital vitality were prevalent and intermixed within all lines of discussion.

The full outline and summary of discussions, recommendations, and proposed next steps is detailed below.

## Definitions of Rural and Rural Health

- **Defined by sense of community** – Rural health is defined in various ways, by various people. A binding trait of those definitions is a sense of rural being community-based. Rural recalls small communities where members are interconnected, resourceful and invested in each other and their community.
- **Characterized by sparse population, agricultural landscape, and geographical isolation** – Visions of rural depict small communities consisting of modest resident populations. While the populace may be limited, the geographic reach may be vast, covering full counties or even regions, often of sweeping farmland dotted with farmhouses and the occasional town or housing cluster.
- **Various interpretations of rural** – The definition of rural is often dependent on who is doing the defining and what for. These considerations are especially pertinent in relation to healthcare and when determining eligibility or coverage as a Critical Access Hospital, a rural health center, or in application for funding support by federal or state agencies. These variations also spread to cultural representations where personal perceptions derived from nostalgic recollections where the “Main Street” and “Country Doc” mentalities can be pervasive. These perceptions can often be challenged by urban crawl and the influence of new community members with different visions for the community and not as tied to “the way things were”.
- **Limited resources, access, and choice** – A consistent acknowledgement of rural is the limitation of resources. Unlike urban communities, there tends to be

limitations in availability and diversity of selection. This applies across sectors from financial investment and economic prospects to physical availability of services, workforce, and commodities. Distance is an additional concern related to these limitations with geographical placement and service gaps often limiting access and choice.

- **A system of micro-systems** – The smaller sizing and prevalence of resources within rural communities should not be misconstrued to believe that there is a lack of infrastructure in rural communities. Rather they are comprised of a network of numerous micro-systems – hospitals and health services, businesses and economic development, public works, social and faith-based entities, etc. - that necessitate working together to maintain community function and safety. This collaboration by nature is a traditional hallmark of rural.
- **In transition** – It is well recognized that the rural landscape is shifting. Communities that were once rural hubs are dissipating; traditional small rural communities experiencing population booms with new housing developments and the effects of urban sprawl. As healthcare transformation takes hold of the nation, the standard operating procedures are no longer feasible. Navigating the shift from what has been to what is and trying to determine what will be is one of the greatest challenges facing rural communities, requiring a balance between responding to the right now while being proactive for the future.

### **Assets and Attributes**

- **Strong natural supports** – Rural communities are resilient and independent by nature. The strong sense of community enables local empathy and responsiveness to need, while a culture of self-sufficiency facilitates the growth and success of grassroots efforts where rural communities take on the role of problem-solving and are willing to act in-time to find real-life solutions.
- **Healthcare/hospital is the hub of the community** – In rural communities, healthcare systems and hospitals are not only independent providers of services but are the core of the community. The local hospital and health systems are primary economic drivers, serving as the largest employer and source of community revenue, as well as an infrastructure necessity for the enticement of new businesses and development. Community vitality and healthcare are inherently connected through Critical Access Hospital and Rural Health Center designations, which explicitly establish the provision of essential services as community investment. The mission and vision states of nearly any rural hospital and health system are a testament to their commitment to community investment and presence.
- **More natural integration/coordination of services** – In-line with the recognition of rural being defined by a sense of community comes the social connectedness and hospitality that ensues. Smaller communities, where people live and work

in the same community enables a greater awareness and first-hand knowledge of the community – what resources are present, what challenges are being faced, etc. This extended awareness and presence of existing relationships (between patients and providers, among care entities, etc.) can lead to the organic development of coordination of care and services. This collaboration often stems as a fundamental necessity for greater sharing and cooperation around limited resources. The translation of this characteristic collaboration into systematic coordination of care is an opportunity.

- **Flexible and adaptable** – By the nature of being smaller with fewer bureaucratic or corporate hurdles to jump in comparison to larger, more complex urban systems, rural healthcare tends to be more nimble and able to respond in real-time. Rural hospitals and health systems have repeatedly demonstrated the capacity to engage in rapid-cycle quality improvement, engaging in innovative process changes leading to proven clinical quality improvements.
- **Changing demographics** – The demographic make-up of rural is echoing some of the change being seen nation-wide. Communities in Iowa are starting to see a flux of residents seeking out the “small town life”, who often are younger families who may or may not have any previous ties to rural communities or lifestyles. Communities are also seeing greater cultural diversity coming to rural communities in the form of workers brought to town to work in manufacturing facilities or agricultural labor. These changes present an opportunity for redefinition and revitalization.
- **Desirable and committed workforce**- As with many in the healthcare arena, rural healthcare providers and professionals tend to wear many hats. This experience is often emphasized in rural settings where workforce availability and external supports are more limited, requiring and enabling workers to fill a broad spectrum of roles over the course of their careers. Those workers who practice in rural settings tend to understand the “bigger picture” in healthcare as they have been in various roles throughout the system. The opportunity to not be placed in a professional “box” and to learn skills in various roles is an attractive aspect in recruitment. The well-rounded and dedicated nature of many rural workers is attractive for recruitment and competition with temporary employment agencies and larger employers for employee retention must be acknowledged
- **Rural culture & community structure** – As mentioned throughout discussion, rural is defined by a sense of small-town community with a culture of hospitality, safety and independence. This culture of collectiveness met with self-sufficiency plays into a community structure that is built upon the notion of taking care of oneself while being willing to step up to help a neighbor in need. This often means that rural communities are able and desire to provide for themselves, rather than expecting or awaiting external support, lending itself to a population who want to be part of the solution rather than a recipient.

## Challenges & Barriers

- **Access** – Access is one of the biggest challenges affecting rural health and rural communities, as identified by the Forum discussion groups. Access limitations present themselves in terms of availability, distance (compounded by transportation concerns), and even awareness of existing or potential resources. These considerations for access include the presence of services, a skilled workforce, and the core infrastructure resources (i.e. broadband capacities, aging buildings) to respond to access needs. The example of telehealth advancing faster than rural systems are able to keep up exemplifies the multi-factor demands to adequately address access barriers to care. It is not simply an issue of creating more services or building additional physical points of access.
- **Current payment and reimbursement rates & structures** – Healthcare is in fact in a state of profound transformation. Unfortunately for rural, most of these changes have not been created with rural in mind. The structure for the shift from volume-to-value were designed to suit larger, more urban systems where there is a large enough population to offset the population health investment necessitated. For rural, current requirements and structures do not allow rural to transition at a pace that facilitates a more gradual approach. Rural systems are facing the considerable expense of the value transition before the benefit ratio can balance. The transition expense is compounded in Iowa by the already low negotiated payment rates and slow reimbursement times, a particular consideration for Medicaid-enrolled patient populations in the Managed Care Organization (MCO) domains. A system that does not consider rural limits rural innovation and exacerbates existing obstacles in rural healthcare.
- **Greater economic contraction in rural areas** – Economic vitality drives service offerings, and this is especially impactful on rural areas who are experiencing greater contraction of revenue and investment overall. While larger communities can shoulder the downward trends in the economic cycle by relying on more expansive commercial bases, rural communities feel these recessions acutely. Recovery in rural communities can often be stagnated with growth and returns to peak economic performance dominated by heightened fluctuation.
- **Changing demographics** – The greater diversity and generational shifts identified as an asset to rural communities are also recognized as a threat to rural sustainability. For every rural community experiencing a growth in population, there are numerous others who are experiencing the migration of residents, particularly young persons and families, for the convenience and opportunity of suburban and urban communities. This movement intensifies the experience of an aging population underway within the state. The impact of these shifts affects economic development as well as cultural considerations for rural.

- **Changing consumer expectations** – Along with these generational and population shifts come the changing dynamics of consumer expectations. With advancements in technology and the focus on customer-directed interactions, healthcare consumers have come to demand greater autonomy and personalization in how they seek out services. Immediacy and convenience are prime drivers of services with more patients seeking direct access to the services they desire rather than having to seek out referrals through intermediate sources. This change in expectations affects patient relationships with their providers, especially primary care services, who are used to consumer-driven responses and competitive choices in the services they seek. These changing expectations will necessitate collaboration with patients to co-design systems that will meet needs and support patient partnership in their care.
- **Lack of “core” specialty services** – Tied to the shift in consumer expectations is the expectation by local patients to be able to access and receive certain “core” specialty services in their local communities. If patients are forced to have to seek out these core specialty services, such as obstetrical care or behavioral health, they are more likely to also seek their primary care services in those other areas. Convenience and capacities for greater coordination of the full range of care services in larger, more integrated systems is a perceived benefit. The lack of these core specialty services in rural communities is not simply the result of not having enough patients to support such services locally, but rather is a result of a large-scale workforce shortage issue wherein there are simply not enough providers to go around and wherein rural communities cannot compete with the recruitment efforts of larger, more cash flush systems.
- **Workforce recruitment & retention** - Woes related to availability of a healthcare workforce are felt across the board, not just in areas of specialty services. As mentioned, workforce shortages are being experienced throughout the healthcare system and across disciplines, including physician, pharmacy, nursing, dental, direct care professionals. These shortages are felt acutely in rural with the lack of availability often meaning that rural communities may not solely be understaffed but may have to go without services altogether. The absence of a sufficient workforce has implications in how current providers and professionals' practice – What level the scope of practice? Who is a provider? What level of regulation is needed? Is over-regulation affecting the ability of rural healthcare systems to meet current needs with current resources? All of this results in stress and frustration, contributing to the sweeping tides of provider burnout. As workforce shortages lead to more and more providers having to shoulder the burden of care alone, it is becoming harder and harder to recruit and retain a rural health workforce.
- **Capacity to address social determinants of health** – A key asset of rural healthcare has been the personalized nature of services, where patients are also

neighbors and people are willing to set up to support one another. While individual support is a positive reflection of rural, the ability to address patient needs systematically, particularly for those non-medical social determinant of health needs, is less present. Addressing poverty, affordable & safe housing, transportation, food security, etc. at a population-level demands extensive and integrated community-based supports. With economic contractions, these services can often be the first line of cutback and the last to be reinstated.

- **Change culture** – Change is difficult and rarely occurs in a straight line. The act of transformation in-time, where people being asked to test out pathways and navigate in shades of gray intensifies the discomfort and anxiety that accompanies change. Feelings of nostalgia and commitment to maintaining practices because “that is how its always been done” can present significant hurdles in implementing change. Rural communities which pride themselves on reflecting a “simpler time” can take nostalgia from a place of positive reminiscence to that of harmful hindrance. As change is inevitable and necessary for survival, it is vital that rural communities are adept in adaptation and able to weather continuous change.

### **Visions of the Future**

- **It will look different** – The tide of transformation will necessitate a shift in how healthcare is delivered. The current system is unsustainable and rural healthcare systems are facing drastic shortages and struggling to keep the doors open in current arrangements. The next chapter(s) for rural healthcare delivery will most likely require a shift in how and where care is provided. Changing levels of services and classifications will likely affect the current structure of Critical Access Hospital designations. And workforce shortages will require reliance and better use of care providers at all levels with integrative multi-disciplinary teams. For rural healthcare to be successful in this transition fine balance between long-term value-based solutions and needed fee-for-service will need to be found.
- **Systems-based approaches** – Connection between and among traditional healthcare delivery and community-based services will be a necessity of the future. Strategies to support single service providers, facilities, or systems will not be meaningfully impactful nor sustainable. The transition to value-based population health will require integrative approaches and systematic collaboration. The organic processes of working together that exemplify many rural practices will need to become formalized with defined processes and procedures to ensure that they are *the* way of doing business not just a way of doing business. The systems-focus will also push for greater alignment and partnership among rural health systems and affiliate networks. The need to work together to mitigate shared risk among shared populations of patients and

consumers to effectively impact quality of care and total costs of care will only intensify in coming years.

### **What is Needed and Priorities Moving Forward**

- **Greater awareness and understanding of existing resources, services, & rural initiatives** – Rural champions and stakeholders cannot efficiently nor adequately respond to rural health needs now or plan for the future without having a better understanding of what is currently in place. This relates to better knowledge of what services and resources are currently available? How are they being used and by whom? Where are the successes and where are the gaps? Local providers and leaders alike need to be more aware of what rural initiatives are underway, who is leading them, and where might there be opportunity to engage and align? The ability to capture, share, and educate (including what services/resources/initiatives are, how to access, referral processes, etc.) will be pivotal to not only ensuring optimal use of current resources and supporting sustainability. This greater awareness and understanding should facilitate building of the business case for exiting and new services, including how to articulate their value and market them for rural audiences.
- **Payment redesign that is applicable to rural health** – Current payment and reimbursement structures do not adequately support nor apply to rural health. Innovation and value transitions look different in rural than they do in other landscapes. Redesigned payment structures that seek to protect and advance rural healthcare need to enable the design of up-stream systems that seek the prevention of root causes and provide for the long-term commitments that are necessary to create meaningful and sustainable value-based, population health in rural communities. This must also entail the re-examination of reimbursement rates, timely reimbursement processes, and the support of system applications - not just payment for “eligible provider” services.
- **Redefining what “access” means** – As pendulum of healthcare transformation continues the swing and rural communities continue to evolve, it will necessitate reinvention. What one has traditionally understood or defined as access may no longer suffice. The rural systems that we have become accustomed to may not look as they have. Thoughts around hospital vitality and access may require restructuring of what it means to be a Critical Access Hospital with various levels of classifications and service provisions. There will be discussions regarding what is considered core services versus specialty and where the balance should lie. The future of telehealth will be pivotal in these access conversations, not just in terms of direct points of access, but in terms for what it means for quality of care and services to be offered. Definitions of rural access as discussions progress will have a heavy focus on the spectrum of access and the coordination of services within and across systems of care.

- **Transparency** – Ability to access and share information has been a fundamental barrier throughout efforts to advance healthcare delivery. Transparency and ability to share information will be necessary to truly advance value-based care and population health – for rural and otherwise. Transparency must be applied across all areas of data – from clinical quality measures to best practices and processes to cost. Competition and propriety reconsiderations have drastically affected the how's and the what's of data sharing and collaboration, impacting overall patient outcomes and total costs of care. Enhanced transparency will facilitate the sharing of healthcare and patient experience stories to enable collaboration and drive innovation.
- **Integration** – Sustainable healthcare delivery will necessitate intentional and widespread integration - within and among systems, providers, payers, etc. This integration must incorporate traditional and less traditional healthcare partners, including community-based services and ancillary health professionals. As patients and consumers are the common denominator across all care and support services, direct partnership with patients, families, and caregivers is essential.
- **Technology** – The advancements in technology and its role in healthcare cannot be ignored nor minimized. Considerations for technology encompass not only services to support healthcare administration and quality reporting, such as Electronic Health Records, but also platforms and services that facilitate the actual delivery of care through telemedicine/telehealth. Emphasis on the interoperability of systems and platforms is priority, particularly in the current state of constantly evolving technology. The ability for technology systems to be able to inter-communicate is core to transparency and care coordination throughout the healthcare continuum. There must be an adequate infrastructure (i.e. broadband capacity) to enable advancing use of technology supports. Connectivity (whether infrastructure or interoperability) will be the lynchpin in optimal use and impact of technology in rural communities.
- **Workforce opportunity** – Unique applications and opportunities for recruitment and retention of a rural healthcare workforce exist. Incentives need to expand focus to not only incite providers to come but to stay. Special student loan forgiveness programs should be expanded while professional development opportunities enhanced. The capacity for rural health practitioners to experience various fields and levels of practice must be touted. Recruitment efforts should prioritize appropriate disciplines for services needed and/or desired in local communities, inclusive of healthcare professionals across the spectrum – physicians, nurse practitioners, physician assistants, pharmacists, nurses, direct care, etc. Providers willing to practice diverse and/or more encompassing care, such as primary care providers offering obstetrical care services, should be commensurately incentivized. Beyond professional components, promotion of lifestyle and community benefits of rural communities is an opportunity in both recruitment and retention. The sense of community, the collaborative nature,



and the ability to maintain more personal relationships with patients and colleagues can be a significant allure and should not be overlooked.

- **Policy changes** – Significant hurdles in the path to sustainable, value-based care transformation in the rural market will require policy interventions to change, particularly those around payment and reimbursement structures that are the primary leverage points for how care is designed and delivered. Policies that endorse applicable approaches for rural, incorporation beyond traditional systems/services, such as shared risk agreements between health systems and community-based partners, a necessary to create changes that will lead to consequential and long-term benefits. As touched on throughout discussions, ensuring more flexibility in the phases of transition will allow rural health systems to engage in innovation and change implementation at a pace and intensity that better suits their operational means. Policy changes must be expansive across payers, modifying necessary Medicare and Medicaid structures but also influencing commercial payer arrangements. Policy shifts that focus on systematic changes are necessary for long-term viability of solutions.
- **Change culture** – Adaptability has been identified as a strength of rural communities and the rural healthcare systems that serve them. A willingness and commitment to be part of the solution rather than simply responsive will be the difference between rural health systems that simply exist and those that thrive. A culture of continuous improvement must be embedded to ensure adaptability throughout all levels of care and maintain resilience in a healthcare world where change is/will be a constant. A culture of change is central to a progressive Culture of Patient Safety.

## Common Concluding Themes

Throughout all tenets and subsets of discussion, a selection of common, overarching themes resonated, which capture the general opinion and outlook of the small group discussions:

- **Rural health and rural communities are diverse**, vital, and an asset to the Iowa landscape.
- **Rural health is complex, yet adaptable.** The solutions may not be simple, but rural health systems have proven to be dynamic enough to transform.
- **Recognition that rural is changing.** The future will most likely not look the same as today.
- **Rural payment systems need to represent rural.** Advancing payment systems and system supports need to be designed in consideration for and applied with a rural lens to be stimulate meaningful and sustainable change.

- **Need for rural leaders, stakeholders, and advocates to be part of the change.**  
The ability to inform policymakers and decision-makers and help co-design opportunities will determine success, satisfaction, and sustainability.

## Leadership & Stakeholder Reactions

Following a robust two days of discussion and dialogue, key rural health thought and change leaders present throughout the Forum - Director Clabaugh, Dr. Evans, Dr. Mueller, Dr. Atchison, and Mr. Palmer shared earlier – had the opportunity to reflect on the days' events and share their remarks on the discussions had, knowledge shared, and themes to move forward on.

- The structure of rural health and attitudes of those in rural communities allows rural health to be nimble and experiential. This is a great asset in a constantly changing healthcare landscape, where innovation and rapid-cycle improvement are crucial.
- Rural is willing and wanting to be part of the change at any level it can. Even if directly impact immediate payment structures proves daunting, there are other objectives to move on.
- Recognition of the need to identify and address root causes, not just symptoms. Rural can and must focus on being proactive and solutions-oriented.
- The complexities and challenges of rural health are not new. These burdens have been faced by rural communities and systems for decades, some even spurred the policies and systems designs we have currently. There will always be challenges and nuances. Rural must continue adapting to meet the needs of rural people.
- These events are an opportunity to come together to discuss what we are doing. There is an opportunity to take these discussions to decision makers – locally, at the state and federal levels. Convenings like the Forum need to be captured and translated into critical next steps that can support decision-making and action.
- Collaboration relationships and connections are the hallmark of rural. Ways of maintaining those relationships and connections in current structures and building them into systems change need to be engrained.
- The perspective of rural and rural health is shifting from a town to a broader service area, with healthcare being defined or redefined based on how and where residents want to receive care; the success of rural health systems will not just be about the services offered but responding to consumer demand in how they are offered – which may mean local, regional, or point-and-place telehealth services.

- Change must be focused on systems-level change, recognizing emerging opportunities for access without losing quality, and must include the entire community. The shift to incorporate whole-person health cannot be accomplished just by payer and provider transformation. Community health takes a community.

## Recommendations to Advance Rural Health in Iowa

- **Reassess/Reaffirm**

To move forward, what *is* must be fully understood. There needs to be a comprehensive assessment of what rural health and systems as they currently are – their makeup, their services, patient populations and audiences, what partners are at play, what are their capacities for change, etc. From this gaps and opportunities can be identified that allow for focused responses and alignment of action and resources.

- **Redefine**

The next step after affirming what rural *is*, is to determine what rural *will be*. Rural leaders and stakeholders must envision and articulate what rural *is* and *can/should be*. This will require redefining rural – what access means, what systems mean, etc. Rural of the future will need to be defined in terms of systems-focus and community-based, not just by singular settings or simple health services.

- **Redesign**

Once the future of rural health has been redefined, it will be necessary to design those systems and strategies. This will require redesign of existing structures on all facets.

- Workforce recruitment and retention strategies will need to be more encompassing, calling on multi-disciplinary professionals practicing at the top of their scopes. Providers who are called to serve both their practice and their community.
- Service delivery and design will have to embed integrative services and coordination of care – for patient all patient needs, including medical and non-medical social determinants of health. This integration must be community-wide, connecting care and services across settings and service types and putting the patient/consumer at the center of team-based approaches.
- Payment structures will have to change. Methods for reimbursement affecting rural must reflect rural. Payment design that allows greater flexibility for systems-based approaches, expanding the purview of the provider-focused payment system and allowing rural systems to make investments in upstream services and population health strategies to improve outcomes, reduce costs, and improve care.

## Proposed Next Steps

The Rural Health Forum was more than a simple convening of the minds. This event brought together action-focused stakeholders who laid out a commitment to continue the work of protecting and progressing rural healthcare in Iowa. Through the conversations and partnerships facilitated through the Forum, the following next steps are proposed to advance the work of this Forum and the recommendations made:

- Create an environmental scan and inventory through comprehensive and evolving environmental scanning processes to increase awareness and utilization of existing services and resources and capture gaps and opportunities to collaborate.
- Continue conversations, collaborations, advocacy, and work to co-design solutions through efforts aligned among participants present and networks of stakeholders and champions.
- Reconvene a Rural Health Summit or the Rural Health Forum to facilitate broad-scale thought and cross-sector collaboration among these key rural organizations and stakeholders.
- Investigate and promote staged approaches with real-time, real-life applicability for rural patients, providers, and communities. Capture those best practices, the practical applications and processes, outcomes, and sustainability plans to share.

## Appendix A – Rural Health Forum Agenda



— Day One —

- 9:00 AM**      **Welcome and Introductions**  
*Gerd Clabaugh, Director, Iowa Department of Public Health, Des Moines and Tom Evans, MD, President/CEO, Iowa Healthcare Collaborative, Des Moines*
- 9:30 AM**      **Setting the Stage – The Current Landscape and the Future of Rural Health**  
*Xi Zhu, PhD, University of Iowa College of Public Health, Iowa City*  
 Describe the current state of rural health care nationally and in Iowa, outlining key policy considerations and priorities along with rural health barriers and opportunities that are defining and directing the future of rural healthcare.
- 10:45 AM**      **Break**
- 11:00 AM**      **A Rural Health Case Scenario – The Rural Implications of the Opioid Epidemic**  
*Sarah Derr, PharmD, Iowa Healthcare Collaborative, Des Moines*  
 The opioid epidemic presents unique challenges in rural communities, exemplifying and often amplifying the gaps and needs of the rural healthcare delivery system. This discussion will overview the opioid epidemic in Iowa detailing on effects on and experiences of rural delivery systems, providers, community resources and patients.
- 11:45 AM**      **Morning Recap and Visioning for the Afternoon**  
*Gerd Clabaugh, Director, Iowa Department of Public Health, Des Moines*
- 12:00 PM**      **Lunch (Provided)**
- 1:00 PM**      **Small Group Discussion and Storyboarding – Rural Health Priority Areas**  
 Define priority areas, storyboard current situation (barriers, assets), opportunities and optimal responses or conditions to issues, such as, but not limited to:
- Hospital Vitality
  - Access – Telemedicine/Transportation
  - Recruitment and Retention
- 3:30 PM**      **Day One Summary**  
*Tom Evans, MD, President/CEO, Iowa Healthcare Collaborative, Des Moines*
- 4:00 PM**      **Adjourn**



— Day Two —

- 8:00 am**      **Welcome Back**  
*Gerd Clabaugh, Director, Iowa Department of Public Health, Des Moines and Tom Evans, MD, President/CEO, Iowa Healthcare Collaborative, Des Moines*
- 8:15 am**      **Small Group Discussion and Recommendations – Summarize and Next Steps**  
Summarize discussion points from day one and outline recommendations, strategies and/or commitments to address and respond
- 10:00 am**      **Large Group Reconvene and Report Outs**  
*Kady Reese, MPH, CPHQ, Director of Patient-Centered Design, Iowa Healthcare Collaborative, Des Moines*
- 10:40 am**      **Summit Summary and Leadership Reactions**  
*Gerd Clabaugh, Director, Iowa Department of Public Health, Des Moines; Tom Evans, MD, President/CEO, Iowa Healthcare Collaborative, Des Moines and Keith Mueller, PhD, University of Iowa College of Public Health, Iowa City*
- 11:00 am**      **Adjourn**



## Appendix B – Quick-Reference Summary Table of Discussion Highlights

Discussion Topic	Key Content Highlights
Definitions of Rural and Rural Health	<ul style="list-style-type: none"> <li>• Defined by a sense of community</li> <li>• Characterized by sparse population, agricultural landscape, and geographical isolation</li> <li>• Various interpretations of rural</li> <li>• Limited resources, access, and choice</li> <li>• A system of micro-systems</li> <li>• In transition</li> </ul>
Assets and Attributes	<ul style="list-style-type: none"> <li>• Strong natural supports</li> <li>• Healthcare/hospital is the hub of the community</li> <li>• More natural integration/coordination of services</li> <li>• Flexible and adaptable</li> <li>• Changing demographics</li> <li>• Desirable and committed workforce</li> <li>• Rural culture &amp; community structure</li> </ul>
Challenges and Barriers	<ul style="list-style-type: none"> <li>• Access</li> <li>• Current payment and reimbursement rates &amp; structures</li> <li>• Greater economic contraction in rural areas</li> <li>• Changing demographics</li> <li>• Changing consumer expectations</li> <li>• Lack of “core” specialty services</li> <li>• Workforce recruitment &amp; retention</li> <li>• Capacity to address social determinants of health</li> <li>• Change culture</li> </ul>
Visions for the Future	<ul style="list-style-type: none"> <li>• It will look different</li> <li>• Systems-based approaches</li> </ul>
What is Needed and Priorities Moving Forward	<ul style="list-style-type: none"> <li>• Greater awareness and understanding of existing resources, services, &amp; rural initiatives</li> <li>• Payment redesign that is applicable to rural health</li> <li>• Redefining what “access” means</li> <li>• Transparency</li> <li>• Integration</li> <li>• Technology</li> <li>• Workforce opportunity</li> <li>• Policy changes</li> <li>• Change culture</li> </ul>

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