



Defining Access to Rural Health using a Rural Integrated Services System

Overview

In 2019, the U.S. Department of Health and Human Service's Rural Health Taskforce solicited key questions on access to rural health services. These questions were rooted in defining access to care for rural populations, including necessary services, the delivery of those services, the necessary provider ratios, and how access should be measured.

To answer the proposed questions, NOSORH combined efforts on the Rural Integrated Service System (RISS) model with a state-based example, and existing network adequacy standards, to provide a comprehensive response. This issue brief provides an overview of the RISS model and the responses to the proposed questions from the Rural Health Taskforce for public comment. Modifications to the RISS model were undertaken to further incorporate influencers of health outcomes that have gained greater recognition since the original development.

Rural Integrated Services System

In 2012, NOSORH conducted an extensive planning process that produced a rural health system model, called the **Rural Integrated Service System (RISS)**. RISS planning was a collaborative process which included the input from multiple State Offices of Rural Health (SORH) from around the country. Its final specifications reflected a consensus of the participating SORHs.

The RISS model identifies three distinct types of rural communities. RISS sets separate minimum health service expectations – in effect, separate models - for each rural community category. The categories reflect an understanding is that there is a major difference between what residents in a small, isolated frontier community can expect versus what residents in a larger, non-metro Micropolitan community can expect. Most rural communities cannot have all services available at a local level – but must have adequate access to all services through a larger health care system. For this reason, the RISS model includes integrating and coordinating services as well as clinical health services.

The three community types in the RISS model are:

- **Core Service Communities:** Rural communities without a hospital.
- **Small Hospital Communities:** Rural communities with a small hospital or Critical Access Hospital – typically offering a limited range of specialist services.
- **Regional Hospital Communities:** Rural communities with a multi-specialty/regional hospital.

What are the core health care services needed in rural communities?

NOSORH recommends that HHS consider a detailed matrix of services in defining a rural health system model – more detailed than the eleven-service matrix used in the RFI to summarize the models developed by other stakeholders. As mentioned previously, NOSORH believes that an appropriate model should include both clinical health services and the integrating/coordinating services needed to create a true health system in rural

communities. **NOSORH's recommendations for a rural health system model are detailed below.**

NOSORH believes that the following **clinical health services** should be included in any rural health system model.

- **Outpatient Services** – including:
 - Primary Care Services
 - After Hours Medical Coverage
 - Ancillary Outpatient Services
 - Prenatal Care
 - Non-Surgical Outpatient Specialty Medical Services
 - Outpatient Behavioral Health Services
 - Oral Health Services
 - Ancillary Outpatient Therapies.
- **Inpatient Services** – including:
 - Hospitalization Services
 - Inpatient Surgical Services
 - Inpatient Non-Surgical Medical Services
 - Obstetrical Delivery Services
 - Emergency Department Services.
- **Pre-Hospital Services** – including:
 - Emergency Medical Services
 - Triage Services.
- **Long Term Care Services** – including:
 - Extended Care Facilities
 - Home Health Care Services.

NOSORH also believes that a rural health system model should include a full range of **non-clinical integrating and coordinating services**. These services tie together the clinical health services for patients and assure that patients have the support they need to make appropriate use of services. Some of these services help address the social determinants of health for patients – including food, housing, transportation and social integration. Integrating and coordinating services will help improve health outcomes and reduce avoidable health service utilization/cost.

NOSORH believes that the following health services should be included in any rural health system model:

- **Care Transition Management Services, including:**
 - Referral Follow-Up and Management Services
 - Hospital to Outpatient Transition Management
 - Hospital to Long Term Care Transition Management.

- **Patient Care Management Services, including:**
 - Chronic Disease/Disability Management Services
 - High Risk Management Services
 - High Utilization Management Services.
- **Community Health Promotion and Disease/Disability Prevention Services, including:**
 - Community Health Education
 - Patient Health Education
 - Clinical Prevention Services.
- **Social Support Services** including:
 - Social/Family Needs Assessment and Case Planning
 - Application Assistance
 - Follow-up and Home Visiting.

How should these services be delivered?

Subsequent to the development of the RISS, the Oregon SORH conducted a similar, year-long collaborative planning effort for rural communities in that state. The Oregon SORH created an **Oregon Rural Blueprint**, which was a rural health system model for Oregon's rural communities. The planning process was unique in that it culminated in a consensus-building model that reflected the input of over 200 people from rural communities throughout Oregon.

The Oregon Rural Blueprint is similar to the RISS – both define service models specific to the same three categories of rural community. The Blueprint was more specific than the RISS, however, in identifying the various ways in which different services should be made available. The Blueprint defined three levels of service *availability*:

- **Full time basis**
- **Part time basis**
- **Referral only.**

In its definitions of availability, the Oregon Rural Blueprint equates telehealth availability of a service with face-to-face delivery of a service. In doing this the Blueprint emphasizes that it is the *extent* of availability, not the *modality* of service availability which is most critical for rural communities.

For many outpatient services, full time was generally considered in the Blueprint as a five-day a week, 8

hour a day or more operating schedule. For hospital, pre-hospital and residential health services, full time was considered as a 24-hour 7-day a week operating schedule. Part time was considered to be any operating schedule which fell below a full-time operation.

NOSORH believes that the Oregon Rural Blueprint's three-level approach to specifying service availability is useful and recommends that it be used in the model developed for Federal purposes.

NOSORH has constructed, based upon the RISS and the Oregon Rural Blueprint, a **Baseline Rural Health System Service Matrix**. The Matrix includes suggested service availability levels for all recommended services in the expanded rural health systems model. These suggestions are identified for each of the each of the three types of rural community described previously.

The suggestions establish minimum expectations for the rural health system and are not prescriptive of what a local community might want for itself in excess of that minimum. While the Matrix is based upon previous consensus recommendations, it is not designed to be a final set of recommendations. It is, rather, designed to be a *preliminary* set of suggestions to be used as a basis for further discussion and consensus-building. It is submitted as a tool for building consensus among a larger group of stakeholders about what should be expected in a rural health system. **NOSORH recommends that HHS take the lead in building a national consensus on such a model.**

It should be noted that the NOSORH Baseline Matrix specifies what services should be made available but is silent on the modality by which a service is delivered. Either face-to-face or telehealth services, as appropriate, could be used in delivering the recommended services. NOSORH supports utilizing telehealth to increase access to quality health care services – including specialist and behavioral health services – without the need to refer to or travel to out of area services. This can substantially reduce both patient time and patient costs.

NOSORH also believes that interdisciplinary teams of health professionals are the most effective way of addressing health service needs in many rural communities. This includes appropriate teams of physicians, nurse practitioners, physician assistants,

dentists, dental hygienists, dental therapists, pharmacists, psychologists and counselors. Multiple providers, working in a coordinated manner to the maximum extent of their licensure, will be able to address the combined medical, dental and behavioral health service needs of rural residents.

What are the appropriate types numbers, and/or ratios of health care professionals needed to provide core health care services locally for rural populations of different compositions and sizes?

NOSORH believes that there are several good examples of approaches to specify the needed capacity of rural health systems. These specifications can be used identify minimum capacity for each service in a rural health system model and assess service capacity gaps. In addition, NOSORH believes that there is also a need to rank the relative needs of different health systems and identify priority targets for Federal and State program interventions. Both these topics and specific recommendations are discussed below.

Rural Health System Minimum Capacity Targets

With a well-defined model of minimum service expectations for rural communities, it is possible to establish quantifiable measures of minimum health system capacity for all health services in the model. This would more than just a binary shortage/non-shortage designation of the health system – it would be a discrete set of targets for each service in the model. This would allow a comprehensive picture of gaps in a rural area's health service mix.

An example of this approach is already in place for Medicare Advantage plans. CMS has established a matrix of minimum network capacity provider/population ratios for a comprehensive range of medical specialties. In addition, the matrix includes a set of facility capacity to population ratios for hospitals and other inpatient facilities. This specific approach is referenced in the RFI. It is updated annually - the latest iteration can be found at:

https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/HSD_2019_Reference_File_2018-08-01.xlsx

NOSORH believes that this type of approach should be applied, not just to individual health plans, but to rural populations. **NOSORH recommends that it be used in defining rural health system adequacy in the Federal model.** HHS could work with an expert panel to develop a consensus set of service adequacy measures for rural health systems.

It should be noted that CMS began to develop a similar type of service adequacy matrix for general population health plans on the direct purchase health insurance exchanges. CMS received substantial input on the approach from different groups, many of whom felt that the approach was feasible for uses other than Medicare Advantage.

Shortage/Priority Designations

In addition to having *rural health system adequacy specifications*, NOSORH feels that there is an additional need to have *rural shortage and priority designations*. These designations identify areas, populations or providers which are eligible for public programs or which have a priority for public investment. NOSORH recommends that a Federal rural health system model include definitions of what will be prioritized for Federal program support.

There are currently multiple Federal programs which have priority designations. For example, under the CMS Ambulance Fee Schedule different payment rates are specified for urban areas, rural areas and super-rural areas. Rural and super-rural areas are prioritized and ambulance services to patients in these areas are reimbursed at a higher rate. CMS updates the eligible priority areas annually. Health Professional Shortage Areas (HPSAs) are another example of a priority designation. HPSAs identify areas and populations with *critical* primary care provider shortages. This goes beyond identification of gaps in primary care services, and isolates areas and populations with the worst shortages. Eligible health service providers in HPSAs are eligible for Federal support under the National Health Service Corps and other programs. While not limited to rural areas and rural health systems, HPSA designations are important for rural health systems.

NOSORH recommends that HHS conduct a comprehensive review of shortage/priority designations that pertain to rural health systems. In the course of this review, it is recommended that HHS suggest changes to existing designations to assure that rural health systems significant gaps can receive appropriate consideration from all pertinent Federal programs.

How should we measure access to health care services in rural communities?

Adequate health system capacity in a rural area does not necessarily translate into health service access for rural areas. Several barriers can stand in the way of consumers being able to utilize rural health services:

- Distance to services is a major issue - both within a rural health system service area and between rural communities and outside sources of care.
- Type of health coverage may also create barriers. Not all health service providers accept all types of health coverage. This can reduce the effective level of available rural health system capacity.
- Financial barriers can also be a major factor. Most obviously, uninsured low-income residents of rural areas may be unable to afford the services they need. Less apparent are the financial barriers created by inadequate health coverage. Health plans may not cover all needed services. Further, health plans may have high co-pays, co-insurance and deductibles that exceed a rural resident's resources. All these financial issues can limit access to health care services.

The best way to measure access to care is through a systematic survey. Several types of surveys are currently being conducted and might be good models of what can be done in rural areas.

The Federal Behavioral Risk Factor Surveillance System (BRFSS) routinely queries respondents to its surveys about utilization of key services and financial barriers that might reduce utilization. A summary of some of these queries is included in the study linked below:

<https://www.cdc.gov/mmwr/volumes/66/ss/ss6607a1.htm>

This data is generally available down to a county level and may be useful as a way of exploring rural health services access. Unfortunately, the BRFSS has some significant limitations. The survey samples largely for national significance, and it may not appropriately sample all rural areas. In addition, the BRFSS limits its survey to adults – limiting its usefulness as a tool for looking at entire rural populations. Finally, health service access questions may not be asked in all locations every year.

Despite these limitations, the BRFSS may form a good basis for building an appropriate survey system that measures rural access to care. NOSORH recommends that HHS explore with the Centers for Disease Control and Prevention ways in which the BRFSS could be improved/expanded for purposes of measuring access to health services in rural communities.

It is worth noting that several states conduct their own surveying to assess access to health services. As an example, the State of Nevada has conducted a very extensive survey of Medicaid eligible individuals to assess their access to a range of important health services. See more details at in a report at the link below:

<http://dhcfnv.gov/uploadedFiles/dhcfpnvgo/v/content/Resources/MCandQ/Plan%20to%20Monitor%20Healthcare%20Access-FINAL.pdf>

NOSORH recommends that HHS consider developing a standard health systems access

survey tool and that HHS work with states to routinely conduct a comprehensive health service access survey nationwide. Such a survey mechanism, similar to the cooperative data gathering system for the BRFSS, would be of great value.

Summary

NOSORH appreciates Task Force's use of the RFI process to collect information about how to conceptualize and measure access to health care services in rural communities. The topic is a complex one, and the combined thoughts of rural health stakeholders will be helpful in defining a comprehensive approach to health service access in rural communities. NOSORH stands ready to assist, as needed, in review of the RFI results and in planning for the future based upon these results.