Exploring Access and Integration Opportunities for Rural Practices and Communities

Mary M. Ford, MSc
Andrew Philip, PhD

About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Catalyzing excellence in primary care to achieve health equity

TRANSFORM

We partner with health care providers to build capacity and improve services and outcomes

INVEST

We provide capital to integrate services, modernize facilities, or expand operations

ADVOCATE

We advance policy initiatives to bring resources, attention, and innovation to primary care

Our Impact

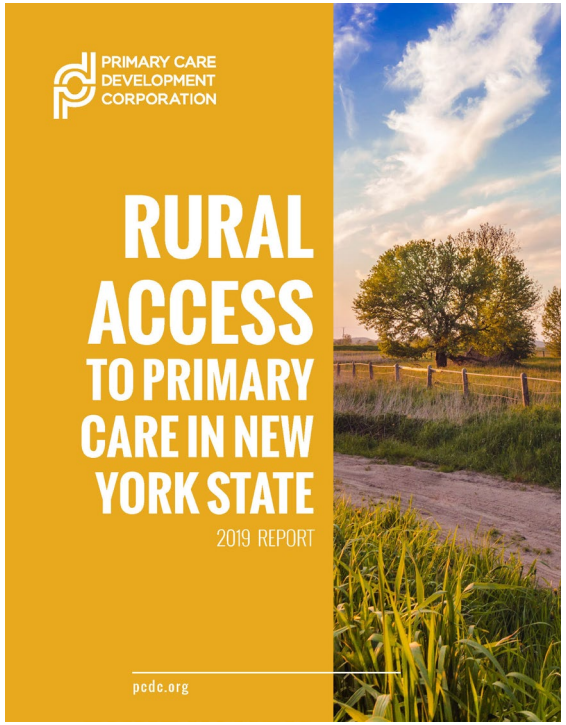
2,800
Organizations
strengthened

10,630
Jobs
created or preserved

3.8M
Medical visits
added through expansion

1.1B
Dollars leveraged
in low-income communities

Rural Access To Primary Care in New York State

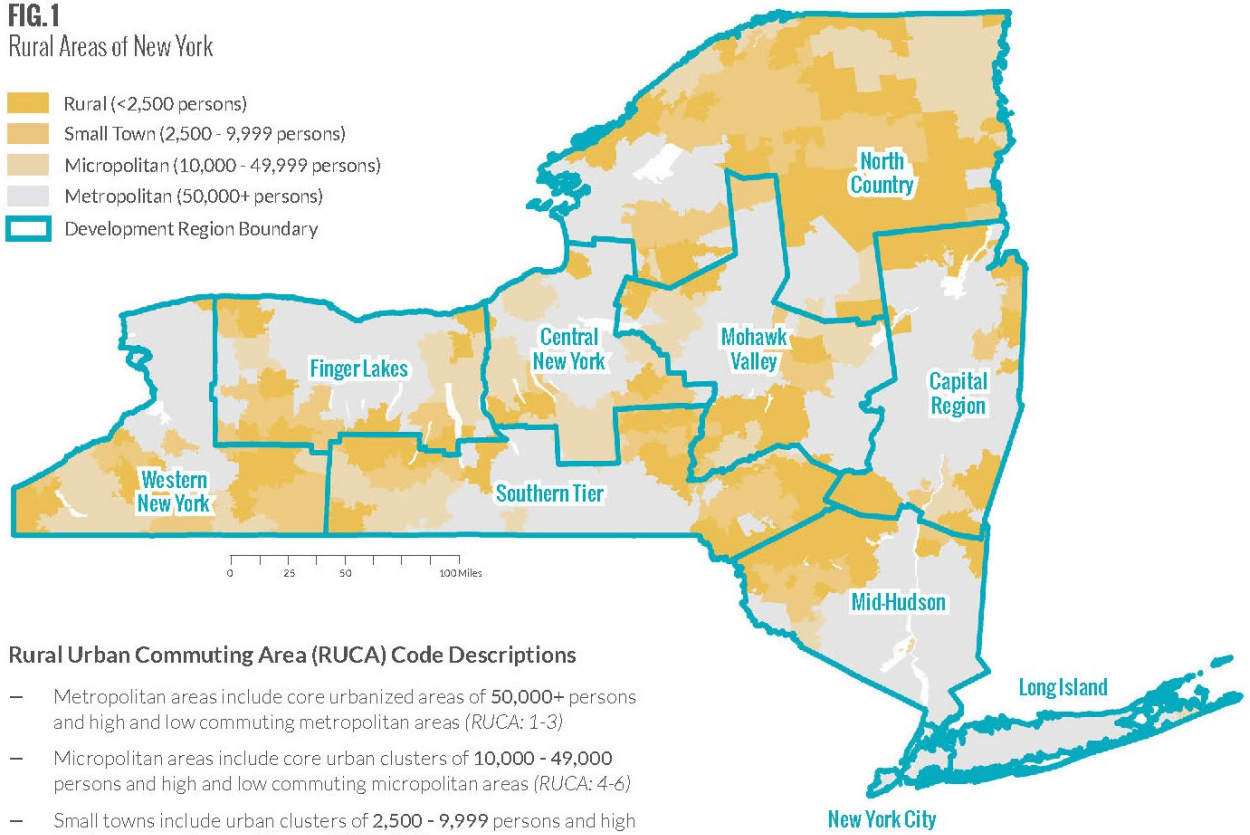


- Access to care is one of the most frequently cited and urgent problems faced by rural populations.
- Inequalities in primary care access are driven by economics, including insurance coverage, reimbursement, and social determinants of health.

> *If you're in a rural practice, you really have to see everybody. You can't tell someone to go down the road. There's nothing down the road."*
>
> - Dr. John Rugge
> Hudson Headwaters Health Network

Defining Rural New York

FIG. 1
Rural Areas of New York



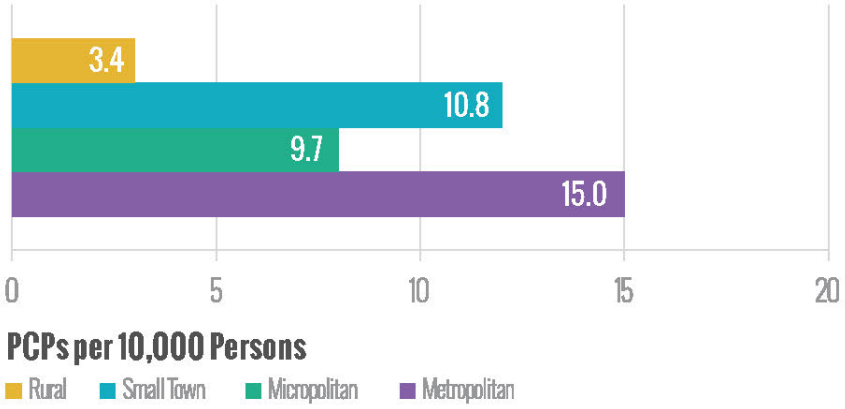
Rural Urban Commuting Area (RUCA) Code Descriptions

- Metropolitan areas include core urbanized areas of **50,000+** persons and high and low commuting metropolitan areas *(RUCA: 1-3)*
- Micropolitan areas include core urban clusters of **10,000 - 49,000** persons and high and low commuting micropolitan areas *(RUCA: 4-6)*
- Small towns include urban clusters of **2,500 - 9,999** persons and high and low commuting small towns *(RUCA: 7-9)*
- Rural areas include clusters of **<2,500** persons *(RUCA: 10)*

Access to Primary Care Providers

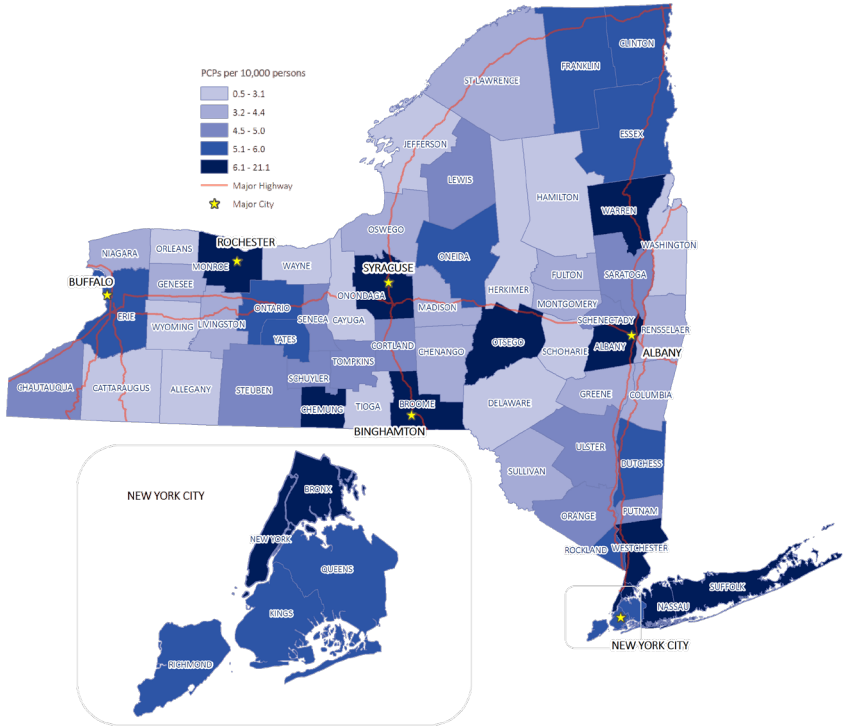
- Metropolitan areas have over three times more PCPs than in rural areas.

FIG. 2
Provider Availability by RUCA Category

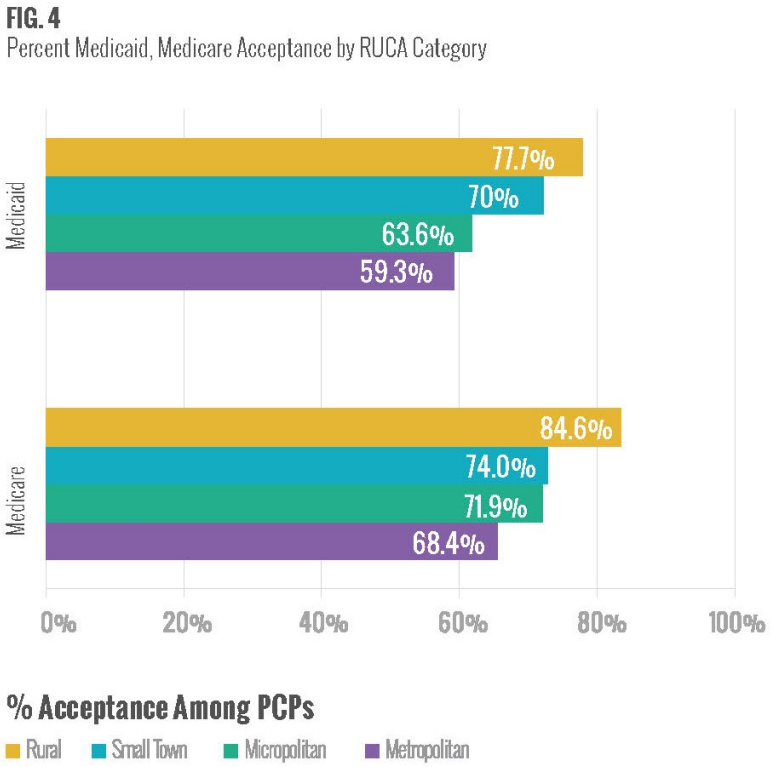


Availability of primary care providers (PCPs) within communities has been associated with positive health outcomes and increases in health care service utilization.[11,20] People who live in areas with fewer primary care providers may have to travel farther or wait longer to be able to access primary care services.[21]

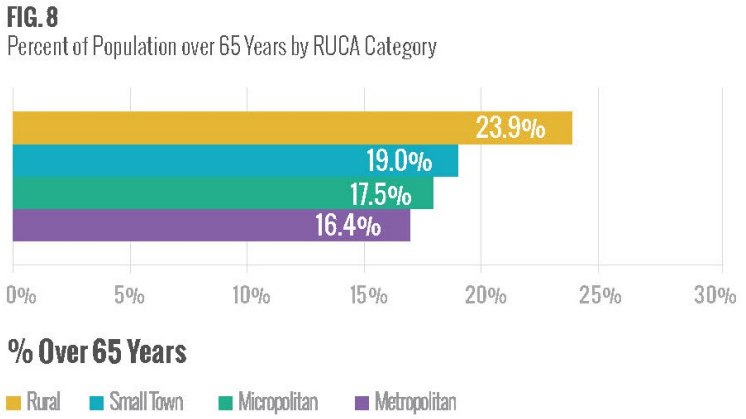
Rural areas of NYS had the fewest PCPs per 10,000 persons



Providers Accepting Public Insurance



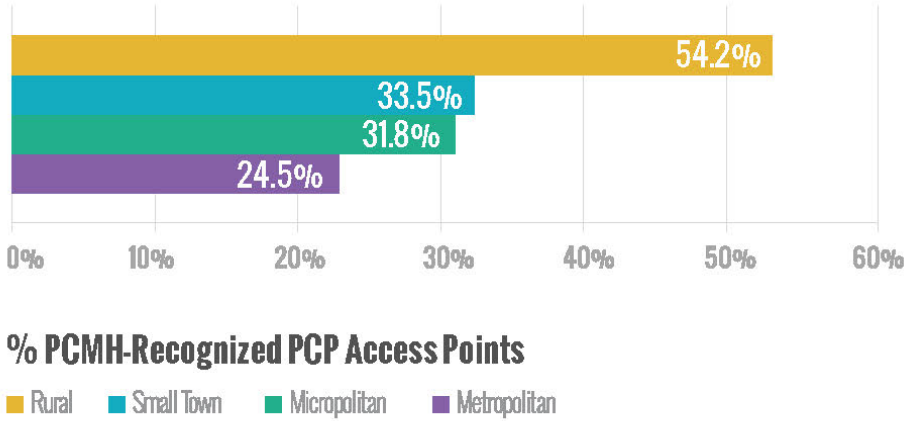
- More PCPs in rural areas accept Medicaid and Medicare.
- Higher proportions of the population are over 65 years of age in rural areas.



The Patient-Centered Medical Home

- Rural and small town areas have the highest percentages of PCMH-recognized access points.

FIG. 5
Percent PCMH-Recognized Access Points by RUCA Category



The Patient-Centered Medical Home (PCMH) is a care model aimed at transforming the delivery of primary care through a commitment to quality improvement and a patient-centered care approach.[27] In New York State's Medicaid program, PCMH-enabled primary care practices receive additional reimbursement.

Rural and small town areas had the highest percentage of PCMH-recognized access points

Provider Interviews – Workforce Shortages

> *Rural providers know it not only takes a willingness, but an understanding of rural New York's heritage of providing amazing support. It really is community health"*
>
> - Dr. John Rugge
> Hudson Headwaters Health Network

- Specific characteristics of NYS rural communities make them more sensitive to primary care workforce shortages.
- PCPs in rural communities have a greater workload, work longer hours, see more patients, and provide care for patient populations with higher percentages of Medicaid recipients.
- Provider recruitment and retention strategies are critical to improve access.

Provider Interviews – Financial Sustainability

> *It is disappointing to have to add more billing staff instead of clinical staff, but otherwise, we fall even further behind in collecting payment for services we've already provided."*
>
> - Robert Ross
> St. Joseph's Addiction Treatment & Recovery Centers

- Medicaid and Medicare cover a disproportionate percentage of rural patients.
- Rural hospital closures result from aging, poor, and shrinking populations.
- Primary care practices face specific challenges that are compounded in rural areas.
  - Primary care practitioners' reimbursement rates are inadequate.
  - Fewer commercial insurance options are available in rural areas.

Provider Interviews – Special Populations

> *One of the challenges to opioid epidemics in rural communities is that when you call an ambulance, you might be waiting 20 to 30 minutes before anybody arrives."*
>
> - Robert Ross
> St. Joseph's Addiction Treatment & Recovery Centers

- 1.2 million New Yorkers did not receive needed treatment for substance use, and about half as many are estimated to abuse pain relievers (including opioids).
- Rural areas have higher rates of opioid prescribing, due in part to older populations who suffer from chronic pain.

> *Reducing stigma leads to earlier treatment, and ideally, earlier recovery."*
>
> - Robert Ross
> St. Joseph's Addiction Treatment & Recovery Centers

Policy Recommendations to Improve Access

Redefine Geographic Designations for Reimbursement

Currently there are only two geographic designations for setting Medicaid base rate reimbursement in New York State: Upstate and Downstate.[12] This is an overly simplistic system which does not account for multiple factors that may additionally impact reimbursement. Creating reimbursement policies would encourage provider access and public health, including region-specific payment adjustments and sustained support for programs that increase access in these areas.

Recommendation:
Add a third tier *(based on rural area)* for Medicaid base rate reimbursement in New York.

Policy Recommendations to Improve Access

Preserve Coverage Gains from the Affordable Care Act

The Affordable Care Act (ACA) expanded Medicaid for childless adults with an annual income up to 138% of the federal poverty line (FPL). Many beneficiaries of this expansion were residents of rural areas where there were few private insurers in the market or options that were previously unaffordable. Federal attempts to limit or repeal the ACA put coverage for rural New Yorkers at risk if the federal match for the Medicaid expansion population or subsidies for those under 400% of FPL were to cease.

Recommendation:
Preserve coverage gains and subsidies in the ACA.

Expand Rural Workforce Incentives

Attracting new primary care health workers to rural counties should be a priority of the Department of Health in New York and the Health Resources Services Administration (HRSA) at the national level, among others. Programs that allow for loan forgiveness, scholarships, or financial aid for the commitment of time in a rural community have shown to be valuable in recruiting new providers.

Recommendation:
Extend and strengthen tuition reimbursement and loan forgiveness programs to draw PCPs to work in rural NYS.

Medical school residency programs are often focused on acute care settings in major urban areas. Working with academic medical centers to increase community health and rural exposure in both medical school and residency training would allow students and doctors to better understand the needs of the rural community and work in more diverse care settings.

Recommendation:
Promote medical school residency in rural areas; encourage medical schools to partner with rural providers.

Policy Recommendations to Improve Access

Increase Reimbursement Rates

Primary care has historically been undervalued and underfunded. Increased spending on primary care is essential to reducing costs elsewhere in the health care system. In fact, while primary care accounts for more than half of health encounters nationwide, it receives only an estimated 5-8% of the total health care spend.[13,14] When primary care providers in rural areas are paid less than their urban colleagues and overburdened because of undersupply of providers, it is even harder to retain providers in these areas.

Recommendation:
Measure the primary care spend in NYS and designate a percentage of health care spending to go toward primary care.

Recommendation:
Adjust and increase Medicaid and Medicare reimbursement rates for primary care across the board.

Standalone primary care providers practicing in designated rural areas do not get cost-based reimbursement such as with Critical Access Hospital or Rural Health Clinic programs. Providing an increase in reimbursement as a recognition of the additional burdens on sole providers in rural areas would incentivize providers to stay in the community, easing travel times and other obstacles to care.

Recommendation:
Create a designation for 'sole community provider' to allow for cost-based reimbursement, similar to the Critical Access Hospital or Rural Health Clinic programs.

Policy Recommendations to Improve Access

Eliminate Barriers to Care

Telemedicine has become a key method for overcoming transportation and mobility barriers for rural residents. Advances in telemedicine have led to improved access and quality of care for many rural residents. Travel time can be reduced substantially, which is of particular importance for patients with chronic conditions that require frequent encounters with their providers. Through telemedicine, rural providers and residents alike can connect with specialists who would otherwise be out of reach.[15-18]

Transportation is often a limiting factor when seeking medical care, especially in areas of the state that experience harsh winter weather and for people without access to private transportation, particularly older adults.

Recommendation:
Encourage policies and reimbursement to expand the use of telemedicine in New York State. Evidence indicates that integration of behavioral health practitioners in rural primary care offices can reduce the need for and utilization of costly services like emergency visits and labs.[19]

Recommendation:
Expand home visit models for those with limited mobility including the use of visiting primary care providers.

Recommendation:
Expand funding for programs that provide transportation to medical appointments for those without vehicles.

Integrating primary care and behavioral health in rural communities

The Current Healthcare System: Dis-integrated

- Mental Health, substance use, and physical health care providers are typically:
  - **Located in different facilities**/spaces
  - **Non-holistic in approach**: focus only on a narrowly defined set of problems (assessment, treatment, and outcomes)
  - **Lacking in communication/coordination of services** for patients with multiple needs
  - Limited in interactions with other provider types
  - **Regulated, licensed, and credentialed by separate agencies**
  - Lacking in understanding of the interdependence of emotional functioning, physical health, and substance use
  - **Unfamiliar with multi-disciplinary team work**

Cost of Treating Comorbid Conditions is High

- Costs for treating patients with chronic medical and comorbid mental health/substance use disorders can be **2-3 times higher**
- Additional costs incurred by people with behavioral comorbidities estimated to be **$293 billion** in 2012
- Estimated **$26 - $48 billion** can be potentially saved annually through effective **integration** of medical and behavioral services

Source: Melek, et al (2014). Economic Impact of Integrated Medical-Behavioral Healthcare Implications for Psychiatry.
https://integrationacademy.ahrq.gov/resources/new-and-notables/economic-impact-integrated-medical-behavioral-healthcare-implications

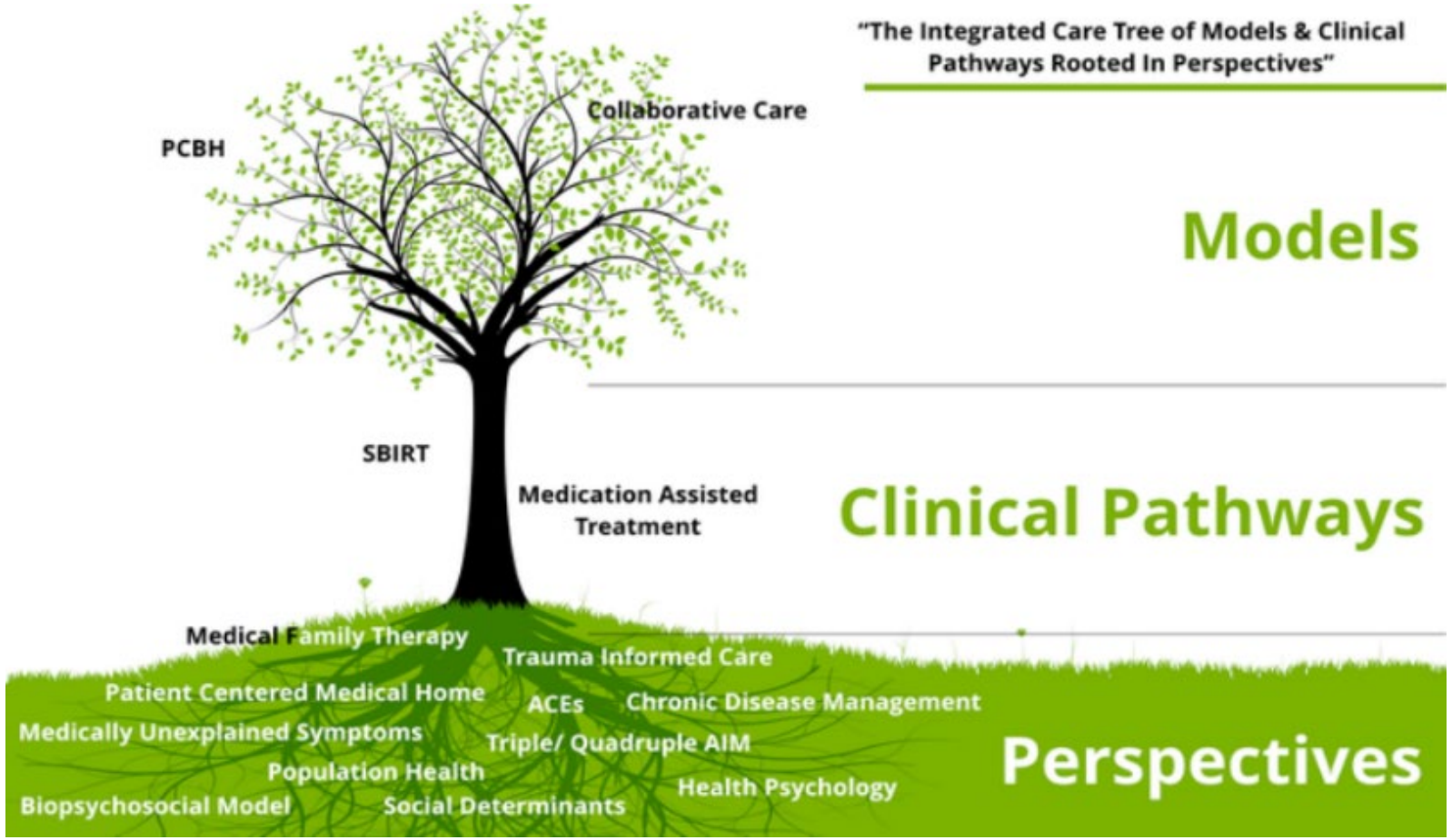
What is Behavioral Health Integration?

"The care a patient experiences as a result of a **team of Primary Care & Behavioral Health clinicians, working together** with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."

Source: C. J. Peek & The National Integration Academy Council's Lexicon for Behavioral Health and Primary Care Integration (2013)

From Roots to Leaves

(or leaves to roots?)



A *Spectrum* of Integration

Coordinated care (off-site)

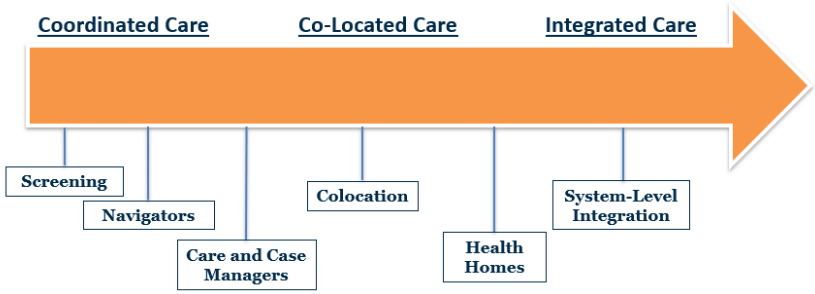
- Level 1: Minimal collaboration
  - Patients are referred to a provider at another practice site, and providers have minimal communication
- Level 2: Basic collaboration
  - Providers at separate sites periodically communicate about shared patients

Co-located care (on-site)

- Level 3: Basic collaboration
  - Providers share the same facility but maintain separate cultures and develop separate treatment plans for patients
- Level 4: Close collaboration
  - Providers share records and some system integration

Highly integrated care

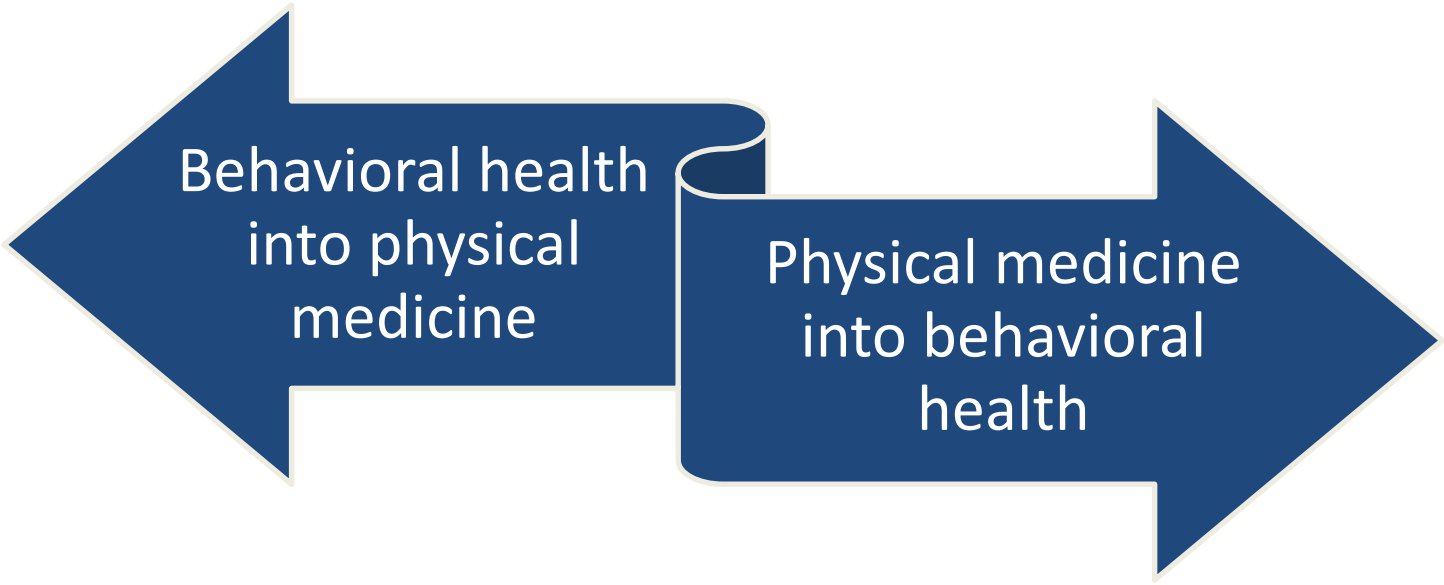
- Level 5: Close collaboration
  - Providers develop and implement collaborative treatment planning for shared patients but not for other patients
- Level 6: Full collaboration
  - Providers develop and implement collaborative treatment planning for all patients



Source: Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund.

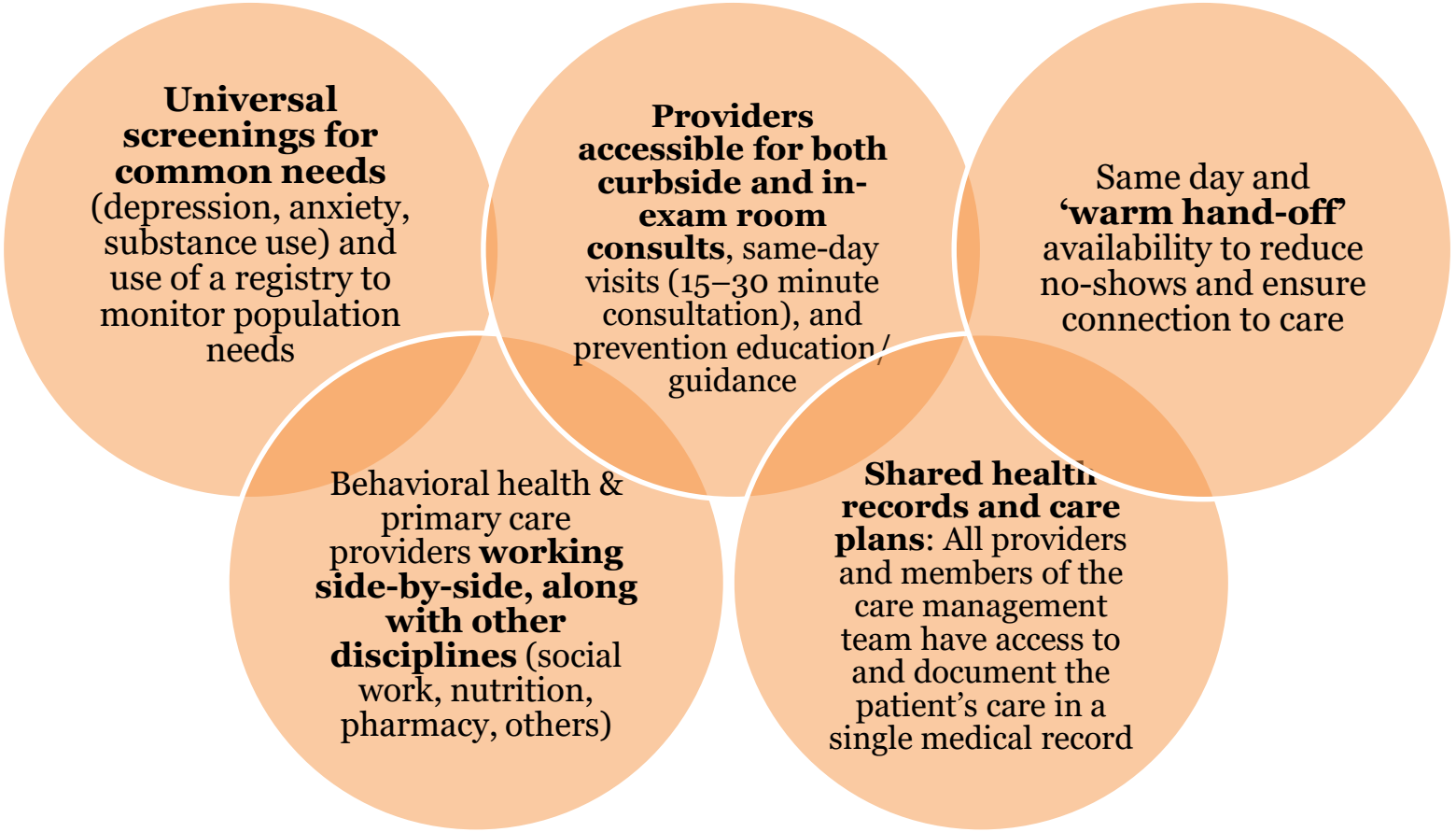
Adapted from: Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund

Bi-Directional Opportunities in an Integrated System of Care



Does direction make a difference?
CCBHC? FQHC? Small Practice?

Integrated Care in Practice



Partially adapted from: Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp 1-16). N.Y.: Springer Science + Business Media.

Considerations for Rural Clinics

Access

- Mobile clinics
- Transportation
- Telehealth
- Same day and combined visits
- Creative clinic co-locations
- Home-based care
- Reminders
- Revisit clinic grids regularly

Recruitment & Retention

- Use of loan forgiveness programs, federal incentives
- Pipelines with training programs
- Shared staff
- Leadership/innovation opportunities
- Realistic panels and workload
- Peer engagement

Considerations for Rural Clinics

Cultural Considerations

- Stoicism vs hardiness
- Mistrust and trauma
- Community buy-in and involvement
- Representative staff
- Language support

Information Sharing

- Multi-agency release of information
- Health Information Exchange
- Shared EMR
- Huddles
- Shared metrics

Considerations for Rural Clinics

Partnership and networks

- Accurate community directory
- Referral monitoring/care coordination
- Incentivize quality referral relationships and partners

Finance

- Grants (Office of Rural Health Policy, state, local, foundation)
- Sustainability from the start
- CDFIs and investment (e.g., PCDC)
- Accurate billing and coding
  - Importance of risk stratification
- Partners with payers
- Link practices to utilization and ROI (within reason)

Considerations for Rural Clinics

Physical Space

- Strategic location
- 'Bull pen' and consultation rooms
- Trauma-informed design
- Proximity of BH and PCP
- Maximize use and flexibility of rooms
- Involve patients and community

Training

- Cultural competency
- Integrated care (hand-offs, brief visits, documentation)
- Billing & coding
- Population health management
- Motivational Interviewing
- Trauma-informed Care
- Team-based Care
- Cross-disciplinary training

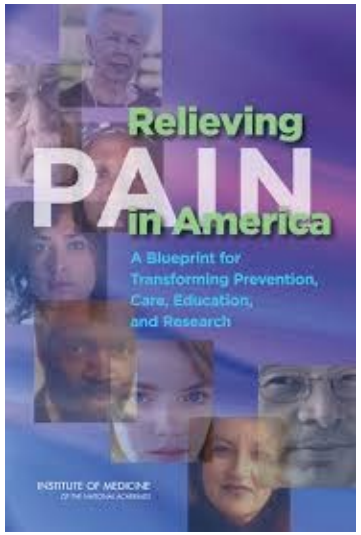
Integrated Care Applied

Pain & Opioids

Public Health Crisis: Pain

Human and financial toll of pain

- 100 million = More Americans than diabetes, heart disease, and cancer combined
- $635 billion annually



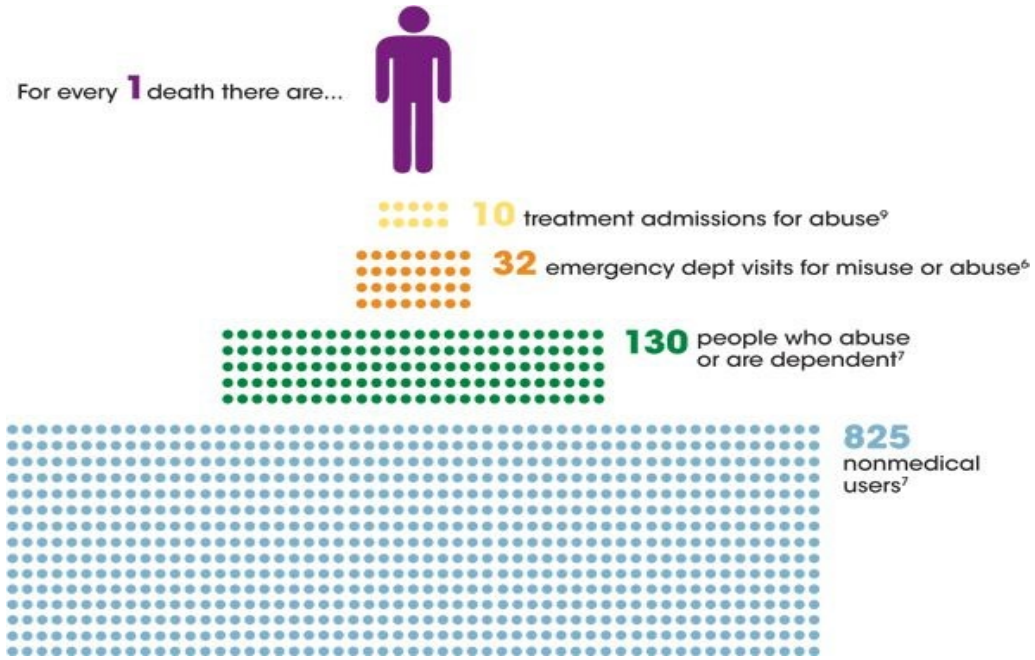
The Interagency Pain Research Coordinating Committee

National Pain Strategy

A Comprehensive Population Health Level Strategy for Pain

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Public Health Crisis: Opioids



Each year more Americans die from drug overdoses than in traffic accidents, and more than 72% of these deaths involve an opioid

Pain and Mental Health

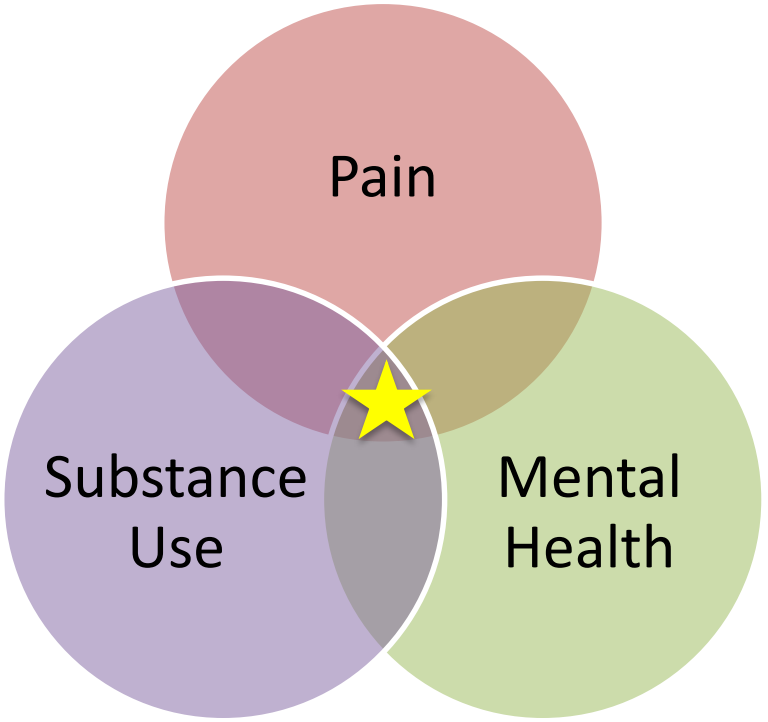
- Top 5 conditions leading to greatest years living with disability:
  1. Low Back Pain
  2. Major Depressive Disorder
  3. Other Musculoskeletal Disorder
  4. Neck pain
  5. Anxiety

[1]Murray et al., 2013

Bidirectionality

- Pain & mental health problems share common neural pathways & risk factors
- Bidirectional relationships affect treatment engagement & outcomes

Why Integrate Now: Complex Presentations



Why Integrate Now: Common Ground

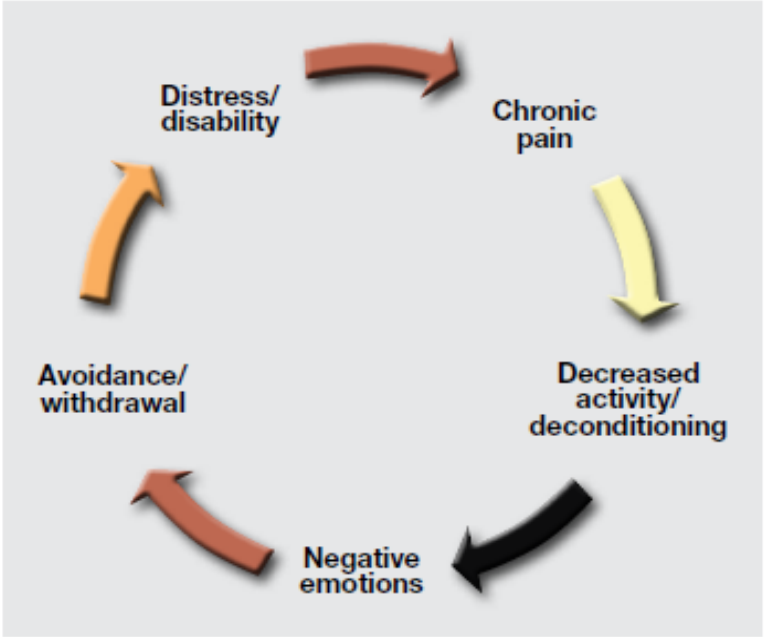
Provider Frustrations	Patient Frustrations
▪ Unknown cause and/or diagnosis	▪ Unknown cause and/or diagnosis
▪ Numerous unsuccessful treatments – not getting any better	▪ Numerous unsuccessful treatments – not getting any better
▪ I'm not sure I believe him/her – are they exaggerating?	▪ I'm not sure they believe me – I'm not exaggerating!
▪ I want to help and it seems like there's nothing I can do	▪ I want help and it seems like there's nothing they can do

Evidence-based Behavioral Medicine Approaches

- **Cognitive Behavioral Therapy for Chronic Pain**
- Acceptance and Commitment Therapy for Chronic Pain
- Meditation and Mindfulness-Based Stress Reduction

CBT-CP Principles

- Change how you REACT to pain through education, exposure, and skill-building
- Give control back and teach to self-manage a chronic condition
- **Focus on FUNCTION**



Integrated Care Applied

Substance Use & SBIRT

Substance Use in the U.S.

- In 2016, ~**21 million people aged 12 or older needed treatment for a substance use disorder (SUD)**
  - Only **3.8 million** people received treatment
- **One in 14 stays in US Community Hospitals involve SUDs**
  - Account for $2 billion in health care costs nationally
- **Five out of six patients** who meet diagnostic criteria for alcohol use disorder **go unrecognized in primary care settings**
- Individuals living with SUD have:
  - 9x greater risk of congestive heart failure
  - 12x greater risk of liver cirrhosis
  - 12x the risk of developing pneumonia
- **Families of SUD patients have higher medical costs** than families without SUD
- SUDs are exacerbated by:
  - Social determinants of health
  - Trauma
  - Socio-economic status
  - Education
  - Living in a rural area

Barriers to Care for Substance Use Disorders

- **Provider attitudes** around substance use
  - Stigma and discrimination
- "Not within my scope"
- Competence
  - Not **comfortable addressing, discussing, treating**
- Time
- Workflow structures
- Resources
- **SBIRT adaptability**
- Organizational support
- **Client characteristics**, culture

What is SBIRT?

- **Evidence-based model of care** designed to **identify, reduce, and prevent risky use** and dependence on alcohol and other drugs
  - **Screens for all types of substance use across the DSM5 spectrum**
  - Can be adapted for use in hospital emergency settings, primary care centers, and community settings
- Intended as an **integrated, harm reduction approach** to care
  - Can be tailored depending on the population being served (i.e., youth vs. adults)

Why SBIRT?

- Improves clinical care
- Transforms organizational culture
- Expands reach to new audiences
- Replaces less effective screening methods
- Prepares organizations for systematic health care changes (i.e., Value Based Payment models)

SBIRT In Action

- **Screening** — a healthcare professional **assesses a patient for risky substance use behaviors using standardized screening tools**
  - Screening can occur in any healthcare setting
- **Brief Intervention** — a healthcare professional **engages a patient** showing risky substance use behaviors in a **short conversation, providing feedback and advice**
- **Referral to Treatment** — a healthcare professional **provides a referral to brief therapy or additional treatment** to patients who screen in need of additional services

Integrated Care and SBIRT

Utilizing an integrated care team approach to substance use can impact outcomes for other chronic health conditions:

- Diabetes
- Gastrointestinal issues – constipation, IBS, acid reflux, GERD
- Hypertension
- Chronic pain – central sensitization
- Sleep problems

Contact Us

Mary Ford, MS
Director
Evaluation and Analytics
Mford@pcdc.org
(212) 437-3942

Andrew Philip, PhD, LP
Senior Director
Clinical and Population Health
APhilip@pcdc.org
(212) 437-3956

PrimaryCareDevelopmentCorp

@PrimaryCareDev