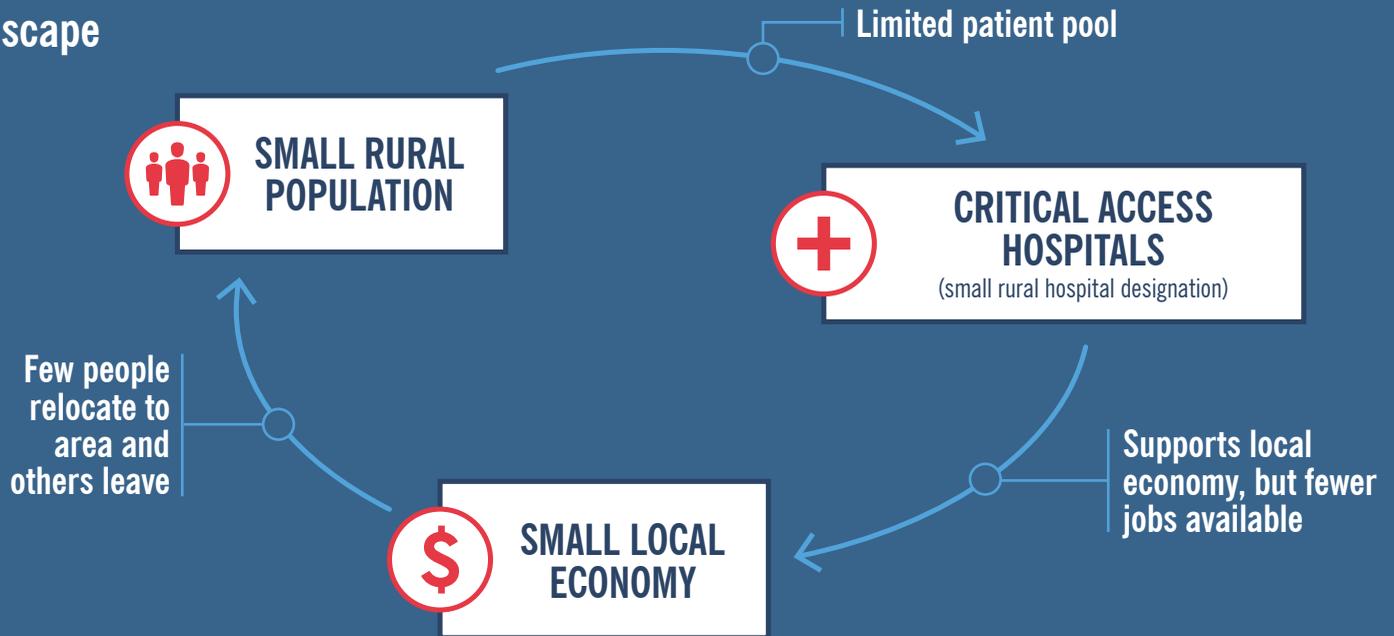


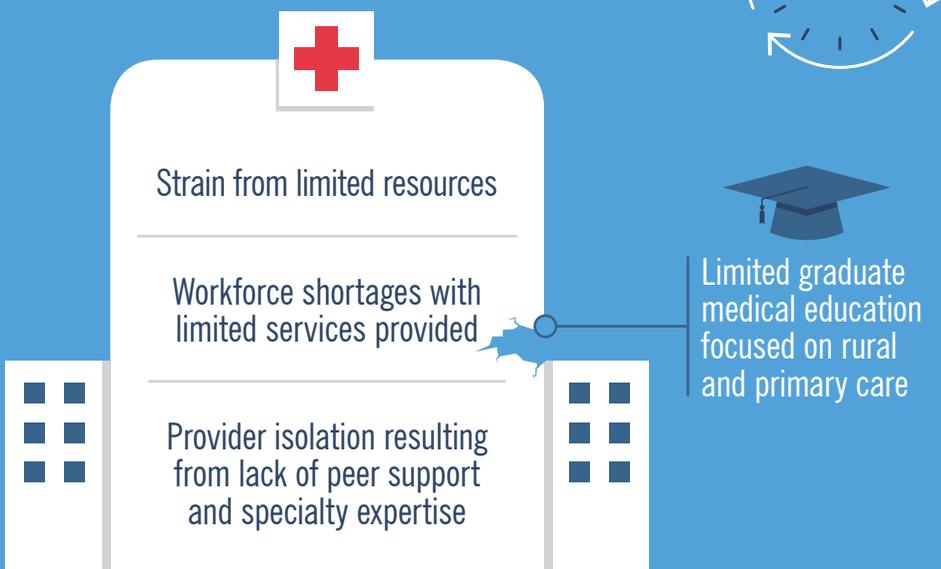
# Challenges and Opportunities in Rural Health Care

The Bipartisan Policy Center hosted a series of roundtables and interviews with stakeholders to assess the challenges and gaps in rural health care across **seven Upper Midwest states: Iowa, Nebraska, Minnesota, Montana, North Dakota, South Dakota, and Wyoming**. The series concentrated on three major areas of focus – the rural health care provider workforce, critical access hospitals, and telemedicine. Often, policy solutions in these areas take a siloed approach to reform. However, **BPC found many inter-dependencies between the key challenges and opportunities that demand a more holistic approach to reform.**

## Landscape



## Over time, rural hospitals face:



## FOUR PRIORITY AREAS FOR RURAL HEALTH TRANSFORMATION

- Right-sizing hospitals and services to meet community needs
- Modernizing reimbursement and supporting innovation
- Developing workforce pipeline programs
- Utilizing telemedicine to connect providers

Turn this page over to learn more about these challenges and opportunities, and how they are connected >>>

# Four Priority Areas for Rural Health Transformation

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**Concern is rising around closures of critical access hospitals (CAHs) and other rural hospitals.**

Re-imagining new forms for CAHs and a more holistic picture of health services in the community not only mitigates the issue of hospital closure, it also provides an opportunity for hospitals to become more primary care - and prevention-focused and would progress delivery system transformation overall. It also gives the opportunity for the community to weigh in on the services the CAH would offer and the type of providers staffing their local health center, as well as opportunities for better integration with the existing public health infrastructure and across multiple funding streams.

**Reimbursement is a multi-faceted issue.**

For example, the challenges around telemedicine – the lack of standardization around who gets paid what, and concerns about over-utilization and abuse – are relevant under a fee-for-service payment model. As such, rural movement toward value-based payment (VBP) models are intrinsically related: telemedicine might best be expanded underneath a capitated payment model, where it will be treated like an investment on the part of payers to improve quality. There is a similar connection with workforce development: community health worker positions can be funded by payers under a capitated payment model. All of these issues link, full-circle, to the structure and funding of local hospitals.

**Training of the next generation of rural care providers ties into other developments in rural health care.**

Universities and residencies should expose providers early to rural environments and the tools (such as telemedicine) that could equip them to serve rural communities more effectively.

**Telemedicine connects patients with providers that they would not otherwise have access to.**

Stakeholders also emphasized that one of its primary benefits is its ability to alleviate workforce retention issues through helping rural providers feel more connected to peers, reducing isolation, and mitigating the risk of poor patient outcomes due to inexperience. Telemedicine was seen as having the potential for compounded improvement on rural health care; many stakeholders were currently using telemedicine services through contracts with Avera Health, and were touting the benefits of telemedicine after experiencing them firsthand.

