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Written Statement for the Record

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Before the

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Committee on Agriculture
Subcommittee on Specialty Crops,
Rural Development and Foreign Agriculture

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The Rural Policy Research Institute provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places.

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Chairman McIntyre, Ranking Member Musgrave, and members of the subcommittee, it is an honor to appear before you again. I applaud your leadership in assuring that the rural development concerns addressed under the purview of this subcommittee include attention to rural health care. As you know, quality health care that is equitable, affordable, and accessible is one of the most critical components in the continuing viability of our nation's rural regions.

I am Charles W. Fluharty, Director of Policy Programs for the Rural Policy Research Institute, and a Research Professor in the Harry S Truman School of Public Affairs at the University of Missouri-Columbia. RUPRI is a multi-state, interdisciplinary policy research consortium jointly sponsored by Iowa State University, the University of Missouri, and the University of Nebraska.

RUPRI conducts research and facilitates dialogue designed to assist policy makers in understanding the rural impacts of public policies. Continual service is currently provided to Congressional Members and staff, Executive Branch agencies, state legislators and executive agencies, county and municipal officials, community and farm groups, and rural researchers. Collaborative research relationships also exist with numerous institutions, organizations and individual scientists worldwide. Since RUPRI's founding in 1990, over 250 scholars representing 16 different disciplines in 100 universities, all U.S. states and 25 other nations have participated in RUPRI projects, which address the full range of policy and program dynamics affecting rural people and places. Collaborations with the OECD, the EU, the German Marshall Fund, the Inter-American Institute for Cooperation on Agriculture, the International Rural Network and other international organizations are framing RUPRI's comparative rural policy foci.

As this committee begins consideration of the future design of USDA organizational structure and program delivery, it is important to note that we also anticipate a renewed discussion of more systemic change in health policy in the next session of Congress. I would hope that this committee and USDA Rural Development will also engage those discussions, as you represent a very critical building block in sustaining a viable rural health system.

The Rural Policy Research Institute established the RUPRI Rural Health Panel in 1993 to provide science-based, objective policy analysis to federal policy makers. While panel members are drawn from a variety of academic disciplines and bring varied experiences to the analytic enterprise, panel documents reflect the consensus judgement of all panelists.

This panel, comprised of many of our nation's leading rural health researchers, has advocated since its inception that federal, state, and local public sector decision makers create innovative investment approaches which unite multiple funding streams to ensure local sustainability. For this to be accomplished, two major shifts must occur. First, we must consider public sector expenditures to be investments, designed to force local grant and loan recipients to demonstrate long-term benefit. Secondly, this process must also create synergy across investment streams, so that the whole of these investments is greater than the sum of their parts. Today, in most developed nations, these principles are driving rural regional innovation approaches, across all public sector policy and program design.

In discussing this global rethinking before this subcommittee last spring, during your consideration of the Farm Bill Rural Title, I offered the following rationale for such an approach:

> *"...The promise of such a Regional Rural Innovation Policy is premised upon the following realities:*
>
> > *1. National competitiveness is increasingly determined by the summative impact of diverse regional actions, capturing asset-based competitive advantage.*
> >
> > *2. Support for such an approach will require a substantive rethinking of core missions across federal departments, state agencies, and regional and local governments, and a commitment to leadership renaissance within these institutions and organizations.*
> >
> > *3. Funding support for these place-based policies are WTO green-box compliant, non-trade distorting funding opportunities for the federal government.*
> >
> > *4. Finally, such a commitment improves the potential for Congressional Agriculture Committees to retain existing funding baselines, and for these Committees to retain statutory responsibility for rural development policy..."*

Nothing has changed since to alter my perspective. In fact, most OECD nations are now moving to align policies and programs with this new rural paradigm.

We all recognize the importance and challenge of rural health care delivery, but this paradigm offers a very specific framework for how this committee might approach its work in this regard, to ensure the emerging cooperation between USDA Rural Development and HHS/Office of Rural Health Policy is supported and enhanced. Other panelists will no doubt speak to other specifics within the health sector. I would like to limit my comments to the very real opportunities which exist to better align and target USDA investments in rural health care, to complement and expand HHS/ORHP programs and facilitate even greater inter-agency alignment.

We are pleased these efforts are already underway, and commend the leadership of both agencies for these innovative developments. In this regard, we are perhaps uniquely positioned to comment, since RUPRI receives significant policy research support from both agencies, and works across the entire federal portfolio to assist decision-support in both rural development and rural health care delivery and finance.

We were very encouraged by the possibility for expanded RD rural health program support within the Rural Development Title of the new Farm Bill, and were very disappointed that these

new mandatory commitments were not included in the final legislation. However, as these programs were under consideration by the Senate Committee on Agriculture, Nutrition, and Forestry, our rural health panel was asked to assist USDA RD Community Facilities program staff in exploring a new grant and/or loan framework which could be utilized in implementing this expanded authority, should it be enacted into law. While this outcome did not materialize, recommendations of our panel could also be applied to existing RD rural health programs, and could inform future approaches which better integrate USDA RD and HHS/ORHP investments.

I have summarized our recommendations below, and included the full working document developed by our panel for USDA RD at the conclusion of this testimony. Any major policy shift should ensure that core health services are available locally, that they are integrated into services outside the local area, and that this is done in a manner consistent with science-based evidence, to ensure results which both improve the quality of life for residents and better health quality integration, across rural geography. USDA investments in rural health care have implications beyond the bricks and mortar of individual facilities; they are part of a mosaic readying the rural areas of our nation to be fully advantaged by systemic improvements in health care delivery and finance.

Specifically, future USDA Rural Development investments in rural health care should be framed around these considerations:

I. *Access to Affordable Care*. USDA loan and loan guarantee programs sustain the presence of hospitals in rural areas, enabling rural residents to receive essential hospital services locally.

II. *Value of Health Care.* As in urban areas, health care value must be measured in relationship to health care costs. USDA Rural Development programs should use this goal as one criterion in assessing applications for loans and loan guarantees. These return-on-investment considerations ensure that program investments are assessing economic realities, while helping to create the infrastructure needed to advance the more ambitious goal of system improvement.

III. *Choice Considerations Apply to Both Providers and Treatment Options.* The effective exercise of choice assumes information is available to compare alternatives. USDA RD facility investments are assisting in the development of these information systems. Significant additional work should be done in this area.

IV. *Capacity Must Exist in Systems of Care.* Beyond affordability, we must ensure that systems of care exist to address the rural health needs of a region. One critical element to assure this outcome is adequate consideration of rural interests in any resource allocation within the sector. USDA, as a long-standing spokesperson for rural interests, advances this goal by collaborating with other agencies, especially HHS, to use its investments in combination with rural program spending within those agencies.

V. *High Quality Health Care is Delivered Through Coordinated Care*. In the enclosed document, the RUPRI Health Panel recommends that USDA consider targeted investments (through a priority-setting scheme) in rural institutions with ties to larger geographic systems of care (formal or informal). USDA investments could create incentives to leverage interest in building information systems and relationships necessary to better coordinate patient care across providers not practicing in the same large groups or even the same localities. This is one of the most promising potentialities within a USDA/HHS collaboration, and should be specifically pursued in an interagency agreement.

VI. *A Redesigned System Elevates the Health of Populations*. Public health services are essential in all local areas, including rural regions. USDA programs supporting local infrastructure can and should require applicants to demonstrate linkages to local public health agencies. Examples can include sharing information to help identify local health issues (e.g., hospital admissions for asthma in children), programs the loan or loan guarantee institutions support (e.g., special wellness programs using hospital facilities and hospital-employed nutrition and health counselors), and organizational participation in regional efforts designed to improve the health of the public (e.g., comprehensive community-based programs targeting important goals, such as obesity reduction).

These recommendations are more fully addressed within the following document. I hope they are helpful to this subcommittee, and I thank you, again, Mr. Chairman and members of the subcommittee, for the opportunity to testify before you today. Your continuing leadership in crafting a twenty-first century rural policy is critical, and we look forward to working with you in the future. I'll be pleased to answer any questions you have.

RUPRI Health Panel
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March 2008

Implementing A New USDA Rural Development Program Targeting Small Rural Hospitals and Their Communities

Recommendations of the RUPRI Health Panel: Andrew F. Coburn, A. Clinton MacKinney, Timothy D. McBride, Keith J. Mueller, Rebecca T. Slifkin, and Mary K. Wakefield

The RUPRI Health Panel was asked to offer recommendations for implementing a new USDA Rural Development program, included in the Senate Farm Bill proposal, should it be enacted into law. The goal of this program is to strengthen rural health care delivery systems, to provide necessary health care services to rural residents in a cost-effective manner. We believe this goal is best accomplished through a comprehensive, coordinated approach that fosters community-based efforts to promote health and wellness, in addition to innovative programming designed to improve quality of services. These recommendations can also be used to inform other programs already managed by the USDA, such as the Community Facilities Program.

Eligibility

- Small rural hospitals that are capable of repaying loans

Criteria to Assess Proposals

Context

The Panel recognizes that the USDA must assess the financial feasibility of the proposed projects for which loans would be made. We recommend that the criteria and process for this assessment allow for flexibility to offer loans to some rural hospitals that might be excluded from commercial markets, because of considerations related to their business environment and management, even though their current financial condition may be solid. This is especially true for hospitals that have a compelling need for investment to secure their future, because they are the sole provider of acute care health services for a large geographic area or for populations that traditionally lack access to the health system (e.g., the uninsured, ethnic and racial minorities).

Some portion of available funds should be explicitly dedicated to supporting those hospitals excluded from commercial markets that can provide evidence of ability to repay loans, based on reasonable assumptions of how the capital investment will improve financial performance (e.g., increase market share or improve efficiency). To help the USDA with these determinations, we recommend consulting with rural health services research centers funded by the Office of Rural Health Policy that have analyzed the financial condition of Critical Access Hospitals.

Program Goal and Related Criteria

The Panel believes that beyond assisting individual hospitals with their capital needs, this loan program also can help strengthen rural health care delivery systems and thereby assure the sustainability of necessary and cost-effective health care services to rural residents. To this end, we suggest priority for loan assistance be given to hospitals that propose capital projects which:

1. Meet a documented need for health service improvement or new services in the hospital's service area,
2. Promote the involvement of other health care providers that serve the same population, in an integrated approach to service delivery,
3. Coordinate with other USDA-funded activity in the region evident in the state strategic plan as submitted by USDA Rural Development state directors, such as loans and loan guarantees for community facilities and possible linkages with the Extension Service, where the latter has health-related activity relevant to the applicant's population,
4. Coordinate with other federal- and state-supported projects to improve rural health care delivery infrastructure,
5. Have a strategy to sustain any service(s) initiated with these funds.

Elements of a Proposal

In order to judge applications based on the above criteria, the Panel suggests that the funding announcement request the following information, both current data and projections for the next five years:

1. A demonstration of a need for health service improvement or new services through capital investment that is responsive to quantifiable community need by:
   - Demonstrating the need for services or service improvement based on available demographic data and a community assessment,
   - Identifying any population groups (such as the elderly, recent migrant groups, low income, disabled, etc.) whose special needs would be met by the capital investment,
   - Incorporating population health data,
   - Identifying other community assets that can be used to help meet needs, including those of the hospital,
   - Demonstrating how local sectors can work together to meet the needs of particular populations, e.g., meeting the needs of the elderly with a coordinated approach that links housing with health care.

2. A description of the involvement and commitment of other health care service providers where appropriate, as evidenced by:
   - Identifying the hospital market area for the capital improvement-supported services, including an assessment of whether the applicant is the primary source of the services (e.g., more than 70% of the market share) or whether there is market area overlap with other small rural hospitals,

- Demonstrating collaboration with other small rural hospitals (through specific signed agreements) where there is overlap in hospital market areas,
- Including memoranda of understanding with any providers involved in providing local services to the population(s) being targeted with this intervention, including private physicians, long-term care facilities, home health agencies, emergency medical service providers, assisted living, special health services (e.g., for those needing assistance with activities of daily living),
- Identifying linkages to services provided to target populations by providers located outside the rural community,
- Including services other than acute care in plans to meet community need, such as assisted living, independent living, and community-based social services,
- Explaining how the investment would improve the coordination of health care services in the community, including improvement in coordination of care across the continuum of care (for example, with providers who are outside the immediate service area but provide important services that are locally unavailable).

3. A description of how the project would coordinate with other USDA-supported entities, as evidenced by:
   - Presenting an inventory of relevant USDA projects in the region obtained from the USDA Rural Development state director and other state and local offices participating in USDA programs,
   - Including an analysis of potential interaction with those projects.

4. A description of how the project would coordinate with other federal- and state-supported projects focused on rural health care delivery, including:
   - Coordinating with programs monitored by the state office of rural health,
   - Coordinating with any programs sponsored by the Federal Office of Rural Health Policy,
   - Coordinating with any projects supported by other federal agencies, such as telehealth projects.

5. A demonstration of the sustainability of changes induced by the capital project. Elements to be included in this section depend on the type of project proposed, but might include the following:
   - Ability to meet operating expenses of new or improved facilities and/or services,
   - Evidence of a replacement plan, where appropriate,
   - Ability to secure necessary technical support, whether through direct hiring of staff or through contracts,
   - For HIT proposals, evidence of a business plan that (1) projects the impact on revenue or changes in efficiency, both in the implementation phase and over the long term; (2) describes practice improvements to encourage continued use; and (3) identifies methods for continuous technical support of the system,
   - Incorporation of expected changes in population and demographics (including growth or decline in numbers of residents) in a plan for sustainability,
   - Evidence of a proposed action plan.

Evaluation

The Panel recommends that USDA require each application to include an evaluation plan. This evaluation should assess how well the funded project has strengthened the rural health care delivery system and improved the quality and efficiency of health care services provided to rural residents. Furthermore, when evaluating return on investment, USDA should evaluate not only financial parameters (loan repayment), but also quality, access, and service parameters. Potential parameters for evaluation include:

- Service line expansion and/or new service line development,
- Health care delivery efficiency,
- Health care quality and patient safety,
- Access to health care services,
- Collaboration activity,
- Impact across the care continuum,
- Completion of goals identified in the original application.

RUPRI Health Panel

Andrew F. Coburn, Ph.D., is a professor of Health Policy and Management, directs the Institute for Health Policy in the Muskie School of Public Service at the University of Southern Maine, and is a senior investigator in the Maine Rural Health Research Center.

A. Clinton MacKinney, M.D., M.S., is a board-certified family physician delivering emergency medicine services in rural Minnesota; a senior consultant for Stroudwater Associates, a rural hospital consulting firm; and a contract researcher for the RUPRI Center for Rural Health Policy Analysis at the University of Nebraska Medical Center.

Timothy D. McBride, Ph.D., is a professor of Health Management and Policy in the School of Public Health at St. Louis University.

Keith J. Mueller, Ph.D., is the Rural Health Panel chair, associate dean of the College of Public Health at the University of Nebraska Medical Center, a professor of Health Services Research and Administration, and director of both the Nebraska Center for Rural Health Research and the RUPRI Center for Rural Health Policy Analysis.

Rebecca T. Slifkin, Ph.D., is director of the North Carolina Rural Health Research and Policy Analysis Center, director of the Program on Health Care Economics and Finance at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and a research associate professor in the Department of Social Medicine in the University of North Carolina Medical School.

Mary K. Wakefield, Ph.D., R.N., is a professor, director of the Center for Rural Health at the University of North Dakota, and deputy director of the Upper Midwest Rural Health Research Center.

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Charles W. Fluharty is founder, President Emeritus, and currently Director of Policy Programs with the Rural Policy Research Institute (RUPRI), the only national policy institute in the U.S. solely dedicated to assessing the rural impacts of public policies. This comprehensive approach to rural policy analysis involves scientists from member institutions at Iowa State University, the University of Missouri, and the University of Nebraska, as well as numerous researchers, policy analysts and policy practitioners from other universities, research institutions, governments, and non-governmental organizations.

To date, over 250 scholars representing 16 different disciplines in 100 universities, all U.S. states and 25 other nations have participated in RUPRI projects. National RUPRI Centers, Initiatives, Panels, work groups and research projects address the full range of policy and program dynamics affecting rural America. Collaborations with the OECD, the EU, the Inter-American Institute for Cooperation on Agriculture, the International Rural Network and other international organizations are framing RUPRI's comparative rural policy foci.

Chuck was born and raised on a fifth generation family farm in the Appalachian foothills of eastern Ohio, and is a graduate of Yale Divinity School. His career has centered upon service to rural people, primarily within the public policy arena. A seasoned policy analyst and practitioner, he has authored numerous policy studies, journal articles and policy briefs addressing the rural differential in public policy decision making. Chuck is a frequent speaker before national and international public policy, private sector and nonprofit audiences, and has presented dozens of Congressional testimonies and briefings. He has also provided senior policy consultation to most federal departments, state and local governments, associations of government, planning and development organizations, and many foundations.

A Research Professor in the Harry S Truman School of Public Affairs at the University of Missouri-Columbia, he also holds an Adjunct Faculty appointment in the UMC Department of Rural Sociology. Among his numerous awards are the Distinguished Service to Rural Life Award from the Rural Sociological Society, the USDA Secretary's Honor Award for Superior Service (jointly to RUPRI), the President's Award from the National Association of Development Organizations, and the Distinguished Service Award from the National Association of Counties.

Chuck and his wife Marsha are the parents of two sons and a daughter.

Committee on Agriculture
U.S. House of Representatives
Required Witness Disclosure Form

House Rules * require nongovernmental witnesses to disclose the amount and source of Federal grants received since October 1, 2004.

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Organization you represent (if any): Rural Policy Research Institute

1. **Please list any federal grants or contracts (including subgrants and subcontracts) you have received since October 1, 2004, as well as the source and the amount of each grant or contract. House Rules do NOT require disclosure of federal payments to individuals, such as Social Security or Medicare benefits, farm program payments, or assistance to agricultural producers:**

Source: _____ Amount: _____

2. **If you are appearing on behalf of an organization, please list any federal grants or contracts (including subgrants and subcontracts) the organization has received since October 1, 2004, as well as the source and the amount of each grant or contract:**

RUPRI FEDERAL SUPPORT RECEIVED SINCE OCTOBER 1, 2004

USDA	$	3,217,521
Office of Rural Health Policy / Dept of Health & Human Svc (incl sub-contractual funds)	$	1,110,750
US Department of Education (incl sub-contractual funds)	$	274,718
Assistant Secretary of Planning & Evaluation / Dept of Health & Human Svc	$	399,295
Department of Labor (incl sub-contractual funds)	$	405,966
Appalachian Regional Commission	$	38,400

Please check here if this form is NOT applicable to you: _____