DESIGNING A HIGH PERFORMANCE RURAL HEALTH SYSTEM IN GEORGIA:

Report Submitted to Georgia's Health Care Reform Task Force

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KEY RECOMMENDATIONS

1. *Develop a vision for rural health in Georgia*. Using best practices developed in other states to inform a discussion, work with stakeholders to develop a Georgia vision incorporating policy goals and service missions of healthcare organizations.

2. *Establish the Georgia Center for Health Innovation*. The Center should assure independent, objective analysis of rural health conditions and offer policy recommendations to address documented needs. The Center should also measure progress toward achieving the vision for Georgia rural health as a new blueprint (next recommendation) is written and implemented.

3. *Develop a Blueprint for the Future of Rural Health in Georgia*. The Blueprint should start with the vision statement from the first recommendation and incorporate an assessment of critical issues currently challenging the vision. Given that analysis, the Blueprint should then provide a plan of action to address priority needs and over time achieves the vision.

4. *Implement the Blueprint through the ongoing work of the Center*. The Center includes an advisory board drawn from the stakeholders that participated in creating the vision for rural health in Georgia. They should help guide the Center's work to develop specific plans implementing the Blueprint, assess progress, and recommend policies to facilitate building a sustainable rural health system in Georgia.

INTRODUCTION

This report recommends the state of Georgia develop and implement a blueprint to shape a sustainable, high performance healthcare delivery system to serve its rural residents. Developing and implementing an effective strategy requires the following, which will be sections of this report:

- Understanding national and regional trends that affect resources available to invest in and support change, and how those trends may affect available options to alter the healthcare infrastructure
- Understanding changes underway in health care delivery in Georgia
- Assessing the levers available to state government to favorably change trajectories in healthcare system development
- Summarizing tasks various stakeholders (including but not limited to state government) will need to undertake
- Detailing the elements of a blueprint with an orientation toward specific actions
- Describing initial actions to complete and implement the blueprint
- Defining a concrete action that will propel the state toward rapid transformation of the rural healthcare delivery system

Critically, Georgia's policy leadership recognizes the need to take actions assuring accessible and affordable healthcare for all the state's residents, including those in rural communities. Changes underway in healthcare finance and delivery systems could be a threat to that goal, or opportunities for change that create sustainable high quality services. The purpose of this report is to recommend actions that optimize opportunities.

BACKGROUND

National trends underway in healthcare delivery and finance are affecting service availability in rural communities not adapting to those changes. Facing the reality of budget pressures from ever-increasing health care expenditures, public payers (states and the federal government) have constrained payment to healthcare providers (in Medicaid and Medicare). Such reductions, in turn, affect ability to sustain those services in places lacking sufficient non-governmental payments and/or revenue (e.g., endowment revenue or local taxes). Circumstances beyond the immediate control of local providers, including changes in characteristics and circumstances of local residents, can turn fiscally marginal health care organizations (hospitals, clinics, nursing homes, home health agencies) into financially unstainable operations. The most telling data show the number of rural hospitals that have closed since 2010: 82 nationally since 2010, with six of them being in Georgia.[1]

Many rural hospitals are near the edge of financial failure due to a host of circumstances including: reduced payment from public payers, lower payment updates and sequestration in Medicare payment, serving an increasingly poor, uninsured, and underinsured population for payment that will not cover full costs, and rural residents bypassing local sources of care.[2] Changes to commercial and public insurance plan designs affect revenues for rural healthcare providers, such as use of narrow provider networks and increased levels of out-of-pocket expenses imposed on patients, which increase financial burdens associated with bad debt and charity care.[3] Without patient revenue to support new investments, rural health care organizations may fall further behind innovations in healthcare delivery (e.g., new technologies, use of patient information systems to improve patient engagement and seamless care transitions, modern facilities more appealing to consumers), that contributes to patients bypassing local services.[4]

Changes in payment policies are occurring at a time of increased demand for health care services in rural America, and Georgia in particular. The nation's opioid crisis creates a higher demand for clinical and social services, as does an increase in the overall prevalence of chronic ill health conditions as the population ages (disproportionately so in rural areas). These demand pressures are occurring in rural America simultaneous with a nagging problem of securing the appropriate number and mix of health care professionals in rural communities. Most of rural Georgia meets

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[1] Data from the University of North Carolina Cecil B. Sheps Center for Health Services Research. Accessed November 20, 2017: http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

[2] Kaufman BG, Thomas SR, Randolph RK, et al. The rising rate of rural hospital closures. *J Rural Health*. 2016 Winter; 32(1):35-43. doi: 10.1111/jrh. 12128. Epub 2015 Jul 14.

[3] Reiter KL, Noles M, Pink GH. Uncompensated care burden may mean financial vulnerability for rural hospitals in states that did not expand Medicaid. *Health Aff*. 2015 Oct;34(10):1721-9. doi: 10.1377/hlthaff.2014.1340.

[4] Weigel P, Ullrich F, Finegan CN, Ward MM. Rural bypass for elective surgeries. *J Rural Health*. November 2015. doi: 10.1111/jrh.12163

official designation for shortages of key personnel, including primary care, mental health, and dental health.[5]

Financial and delivery system challenges, creating an environment bordering on an oncoming crisis in access to services, also create an opportunity borne in part by necessity to change the rural health care delivery system. Payers are receptive to new delivery modalities, including telehealth and community health workers, as means of extending access to care outside of expensive settings and in a timelier manner. Health care organizations (HCOs) are more likely to realize benefits of transitioning out of historical models (i.e., emphasizing inpatient acute care) to alternative delivery models paralleling changes in payment incentives. In this environment, state governments will play pivotal facilitating roles through regulatory, payment, and health professions training policies. In addition, states are a prime source of financial support for services needed by persons unable to obtain private insurance and unable to pay full costs themselves (i.e., Medicaid populations and direct assistance to HCOs providing disproportionate shares of uncompensated care).

State roles are especially important as current federal policy discussions are trending toward increased state discretionary authority through waivers in the Medicaid program and under section 1332 of the Patient Protection and Affordable Care Act of 2010 (PPACA). Through waivers, federal funds are available to states for innovative activities, which can include efforts specifically targeting rural people, places and providers. Additionally, rural populations are considered "underserved" as the federal government and private foundations create preferences in programs supporting investments in new approaches to health care (e.g., the State Innovation Models and Comprehensive Primary Care Transformation programs within the Center for Medicare and Medicaid Innovation (CMMI); Culture of Health program of The Robert Wood Johnson Foundation). Additional investment resources are available from sources supporting rural communities generally, such as rural development investment capital from the US Department of Agriculture (USDA). In short, now is an ideal time for state leaders to develop and implement innovative strategies to advance rural health.

Summarizing the points of influence for state governments:

- *Optimizing new delivery modalities*: States regulate health professions and institutions; adjustments will allow for new configurations more suited to the shifts out of traditional emphases on inpatient acute care. The roles of professionals are changing with increased emphasis on care coordination and population health services, licensing and scope of practice regulations will need to keep pace.

- *Providing the workforce of the future*: State educational institutions are prime sources of trained professionals; programs will need to adapt to accommodate new skill sets. They will also need to create pipelines for professionals that establish practices in rural communities.

- *Affordability of care*: An expected expansion of waiver authority will enable state creativity to design programs consistent with state-specific needs and approaches to enabling rural residents unable to self-fund their care or purchase private health

[5] https://dch.georgia.gov/health-professional-shortage-area-hpsa-designations. Accessed November 20, 2017

insurance to access care. These programs include both consumer-based coverage and provider-based payment sharing the burden of uncompensated care.

In short, states have a unique opportunity to pursue *comprehensive strategies* to secure the best possible future in rural health care delivery. Georgia is particularly well positioned given a strong asset base of professional training programs, HCOs positioned throughout the state, strong educational institutions, private philanthropic interest, and commitment from state government.

RESOURCES FOR ACTION

As Georgia moves forward with a blueprint to improve the future of health care services in rural places, the following four types of resources can be deployed.

1. Direct state appropriations

The state can invest directly in the future of rural health, as it has done with the Rural Healthcare 180 tax credit program. In implementing an action plan assuring rural availability of all essential services and linkages to services available only in urban centers (through telehealth and transportation services) the state should consider investments beyond "the four walls" of local hospitals. Exact uses of direct appropriations, beyond supporting a center for rural innovation (key recommendation later in this report) evolve as a result the blueprint developed by stakeholders acting on data and recommendations from a state center. Notably, because of considerable work already completed and underway there will be a short timeline to develop the specific high-return investments for direct appropriations.

2. Intergovernmental revenue

Multiple sources of revenue could be used to improve the status of the rural health care delivery system. Foremost among them is direct payment to rural providers through Medicare and Medicaid. Sources through Medicare payment include:

- Maximizing reimbursement for providers in cost-based reimbursement methodologies (Critical Access Hospitals and Rural Health Clinics, subject to payment caps for the latter)

- Optimizing payment linked to quality performance measures for providers in the prospective payment system,

- Utilizing other payment incentives as available such as investment funds for qualified accountable care organizations (ACOs), and

- Utilizing payment for chronic care services and physician payment increases.

Medicaid payment is another revenue source for rural providers, especially important to those in high poverty rural counties. Supported disproportionately with federal dollars, these payments are affected by eligibility determinations qualifying patients for Medicaid and the payment rates determined by the program (either directly by the state or by managed care organizations under state contract). Recognizing the balance needed between using Medicaid resources and the state's need to be sure the program is affordable to the state and is not abused by residents, it is nonetheless a potential revenue stream to help sustain rural services. Given their importance as revenue for rural providers in particular, both Medicare and Medicaid are also sources of leverage

to encourage and facilitate changes improving delivery. For example, they can be used to encourage and accelerate transition to person-centered population health services that lower utilization of the most expensive services on the care continuum.

Medicare payment policies in place as of this report (they are subject to change, especially given the transition in presidential administrations) are intended to complete an evolution from volume-based incentives to value-based incentives. Rural HCOs may take advantage of that transition to solidify community-based services providing essential care locally. For example, if Medicare payment transitions to global budgeting or other form of capitated payment, HCOs could use a portion of the payment to support community-based services that in turn lower future health care expenditures.

Intergovernmental revenue is also accessible through grant programs. As noted earlier, the State Innovation Models program (https://innovation.cms.gov/initiatives/State-Innovations/) within CMMI has been a notable source of investment into innovate state approaches to system redesign. Special initiatives may be available as Georgia completes a blueprint with specific approaches that may be eligible for future programs. For example, CMMI has supported global budgeting initiatives in Maryland and Pennsylvania, and rural-focused demonstrations in the primary care transformation initiative. The Rural Health Value Project maintains an updated catalog of federal programs accessible by rural applicants, including information about who is currently participating and how to participate in those programs currently accepting applicants:

https://cph.uiowa.edu/ruralhealthvalue/files/Catalog%20Value%20Based%20Initiatives%20for%20Rural%20Providers.pdf.

A specific program of interest to rural Critical Access Hospitals (CAHs), and the state agency and/or hospital association serving them, is the Medicare Rural Hospital Flexibility Grant Program, administered by the Federal Office of Rural Health Policy (FORHP). That program includes funding targeting critical areas such as quality improvement, use of information technology, and system transformation. FORHP administers other grant programs also of interest to support rural network development and specific projects. In addition to the obvious sources through the Department of Health and Human Services (DHHS), funding from other federal agencies may help support rural health initiatives, including the USDA, the Interstate Commerce Commission, and the Department of Commerce. As community-based initiatives expand to include health in all policies, other agency programs also become relevant, for example those offered through the Department of Education. An example of an all-encompassing approach to building and sustaining local communities that includes health care by combining and integrating multiple resources is Save Our Appalachian Region, in eastern Kentucky:

https://www.soar-ky.org/.

3. Delivery System Actions

Health systems increasingly focus their strategic plans and actions beyond the confines of specific facilities and communities. As they do, their capital investments and operational changes become resources available to achieve goals of sustainable essential local services integrated into a continuum of care. Regional systems are investing in telehealth capacity in rural places as a means of extending their reach to incorporate rural residents into health plan contracts. These actions open new possibilities for investments into capacity of local providers to offer services through

telehealth linkages; examples include emergency medical services, intensive care, medication therapy management, and behavioral health services.

Studies of the benefit of telehealth are accessible through the National Center for Rural Telehealth research, http://ruraltelehealth.org/.

Within Georgia, there are multiple stakeholders with aggressive telehealth programs, including Georgia Partnership for Telehealth, Emory Healthcare and other health systems. Further, actions by the Department of Public Health facilitate spreading applications of this technology to rural sites, see https://dph.georgia.gov/office-telehealth-telemedicine. Beyond service expansion, regional systems may evolve to provide access to integrated care across geography, better serving rural residents. In Georgia, a leading example is Stratus Healthcare, which includes six CAHs.

4. Educational Programs

As described earlier, meeting the health care needs of rural residents can be particularly challenging due the geographic misdistribution of health care workers. Further, as the skill sets of workers change to keep pace with both clinical care advances and an emphasis on population health, recruitment and retention challenges in rural places evolve to include how to best train available workers (i.e., community health workers, certified nurse assistants). Educational institutions and programs are obvious assets to deploy to meet these needs. Importantly, while medical professions are certainly fundamental to meeting health needs, an evolving healthcare system must look beyond traditional categories such as physicians, nurses, physician assistants and advanced practice nurses. Therefore, the assets include technical training programs as well as medical education. An entity responsible for a state blueprint should incorporate capacity to inventory and monitor all training programs, including those with initiatives targeting rural needs.

SUMMARY OF TASKS TO UNDERTAKE

Taking full advantage of the resources just described, what follows are specific actions Georgia state leaders should undertake to achieve goals to develop and sustain a high performance healthcare system in rural communities.

Develop a Blueprint for Action

State policy officials, including the Georgia Health Care Reform Task Force, should develop a "breathing" document as a blueprint for action. Importantly, leaders must establish the vision driving the blueprint and a timeline for achieving goals and objectives.

Secure commitment from and facilitate participation of partners

As evident in the discussion of resources, there are multiple organizations primed to contribute to the overall vision and help develop a blueprint. State policy leaders should provide the general design of an initiative that engages stakeholders and contribute ongoing resources to sustain critical partnerships.

Establish entity to support stakeholder actions, evaluation to track success and modify action plans

A Georgia Center for Health Innovation should work with all stakeholders to develop, implement, and improve programs consistent with the blueprint. Important, the Center need not be the sole

entity involved in details of development and evaluation, especially since many program initiatives will be supported by independent funding sources. It will be a point of synthesis across initiatives to achieve goals and objectives of the blueprint.

Throughput for policy development

Policy makers should assure innovations emerging from a process engaging stakeholders to develop and implement a blueprint for rural health care delivery in Georgia. Appropriate vehicles for due deliberation need to be identified and maintained.

A DESIGN FOR ACTION (BLUEPRINT)

Developing a blueprint begins with a vision statement articulating a desired future for health care services in rural places. Georgia policy leaders should begin conversations among stakeholders with a vision statement, soliciting commitment. The second element of the blueprint is delineating the current landscape of rural health care services in Georgia, enabling an appreciation of how community-based strategies will vary across the state. The third element is to obtain commitment from stakeholders to specific milestones to achieve. The fourth element, which is constant, is to make progress on addressing key elements of sustainable rural health system including primary care, emergency medical services, and public health.

Vision statement

Georgia can draw upon statements developed by national organizations and by other states as examples to start its own conversation. The RUPRI Health Panel has developed a vision of a high performing rural health system based on these pillars: affordability (to individuals, communities, and public treasuries), availability (all services, whether provided locally or elsewhere), person-centered (engaging persons in all decisions involving health), high quality (using appropriate measures to assess), and community-focused (which will vary but includes essential services).

Other states have embarked on the journey of viewing rural health care needs holistically (i.e., more than a series of discrete, incremental actions:

Washington' Health Care Authority (https://www.hca.wa.gov/assets/program/RHIAC-report.pdf), Vermont's blueprint for health (http://blueprintforhealth.vermont.gov/), Pennsylvania's rural health redesign (http://www.health.pa.gov/Your-Department-of-Health/innovation/Documents/External%20Plan_Rural%20Health.pdf), and Kansas' rural primary care model, since expanded to include four states (http://www.kha-net.org/criticalissues/ruralissues/).

Pennsylvania developed a crisp vision statement to guide its activities: "By redesigning rural health through hospital financing, population health, healthcare workforce, and health information technology solutions, Pennsylvania will ensure that rural residents achieve greater health status and can readily access care when needed" (same as earlier url).

Delineating Current Landscape

An initial task of the Georgia Center for Health Innovation (described below) will be to synthesize existing studies and reports describing the current situation in rural health throughout Georgia. These include work completed by the Rural Hospital Task Force of Augusta University, the Georgia Health Policy Center at Georgia State University, the Georgia Hospital Association, the Georgia Alliance of Community Hospitals, and the Georgia State Office of Rural Health. The new

Center has the task of using those existing reports to place the current situation in the context of the vision statement for the future of rural health in the state.

General Direction for Action.

General approaches to building and sustaining a rural health care delivery system include:

- Supporting new means of providing care, in a rural context, such as person-centered health homes
- Developing new approaches to local governance of integrated services, including health and human services agencies sharing responsibilities
- Creating regulatory flexibility to promote new system designs appropriate to rural needs

Stakeholders should commit to specific milestones, including timelines, to reach desired ends in each general direction.

Starting with Essential Elements

As described earlier, elements of the rural health care system are clearly in distress, starting with rural hospitals. Threats to continued existence of local systems built to provide inpatient acute care services create opportunities for local stakeholders to rebuild community health systems centered on the essential services needed locally. An effective blueprint needs short-term action steps to deal with the most pressing problems in manners consistent with long-term system development.

Actions are needed in some rural communities now because of the financial peril facing rural hospitals. Responses to the current crisis of hospital closures should be consistent with advancing to high performing systems in rural communities. As communities face the challenge of sustaining services without the historical anchor of a full-service hospital, they can work with policy makers and health systems to design a service mix focused on the core needed in the community, that attracts quality providers and is financially sustainable. Examples occurring around the country include creating urgent care and emergency department facilities (in addition to primary care clinics), and emergency rooms with expanded services. Rural communities are resilient, but they will need help understanding the array of possibilities and they will need help creating the local dialogue to develop new models.

GETTING STARTED

Organizational actions

An initial task is to create an organization of key statewide stakeholders to participate in the process of developing the blueprint and advise the state and communities regarding specific actions. This organization could be the Board of Advisors (BOA) to the Center for Health Innovation. It should include representation of the following:

- State agencies
- Health care systems
- Community-based providers from rural regions

- University-based entities engaged in research and policy analysis
- Private foundations investing in rural health
- Health care associations

The board could solidify a commitment to the blueprint, general directions, and specific initial actions. The Center would prepare for future work by first synthesizing existing reports to lay out the current state of health care services in rural Georgia and catalog current initiatives supporting change. With that platform and a mission statement from policy leadership, the Board would develop specific goals, with milestones, and initial action steps.

Action levers to use

Georgia should use available policy levers to make immediate progress implementing a new blueprint for action. Initial steps are underway in Georgia. The Georgia Health Information Network helps with flowing patient information that contributes to integrated care across the care continuum. Georgia is a leader in developing and using telehealth (Emory University is one innovator in the state). Efforts are underway to benefit from networks of providers (Stratus Healthcare Network is an example). Through the Rural Hospital Flexibility Program Georgia's critical access hospitals (CAHs) have embarked on a project to utilize community health needs assessments to address local priorities. These actions are building blocks in a strategic approach to guide further policy development.

Three facilitators are necessary to realize full potential in a transformed system of care: an integrated health information system, value driven payment formulae, and strong collaborative relationships. Public policy can help create and sustain all three. Health information exchanges help move patient records to the right place and time for appropriate care. Medicaid payment policies can create incentives to address the health needs of the population, moving away from payment for services and toward payment for health outcomes. Policies and grant programs can help create new structures that bring together organizations with resources to address clinical needs and social determinants of health.

Activities in other states and technical assistance programs underway in national associations are sources of ideas to pursue. States modeling new approaches include Vermont (blueprint based in comprehensive primary care), Pennsylvania (all payer global budgeting for rural hospitals), Oregon (community care organizations), and Quad State Rural Initiative (KS, CO, NM, OK). National associations are sources of more information about innovative projects, as well as general guidance regarding pathways to reform. For state policy makers the National Governor's Association, the National Council on State Legislatures, and the Council on State Governments are leading examples. For providers the American Hospital Association has developed a series of helpful documents to help guide a decision-making process, as well as detailed examples of exemplary institutions in rural places. Other sources of technical assistance are accessible, including the Rural Health Value project (www.ruralhealthvalue.org).

As Georgia develops a blueprint and establishes specific policies and programs, an overall guideline is following the four approaches outlined by the RUPRI Health Panel. 1) Community-appropriate health system development and workforce design; Vermont's integrated health services model is an example of using multi-disciplinary community health teams. 2) Integrated

governance; post-acute care integration throughout the Mayo system in Minnesota, Wisconsin and Iowa is an example. 3) Flexibility in facility or program designation; evolving primary care through patient-centered medical homes to person-centered health homes. 4) Financing models promoting investment in delivery system reform; all payer accountable care organizations are being tested in a few states.

STAYING THE COURSE: A STATE CENTER FOR HEALTH INNOVATION

The core recommendation in this report that would propel rural health in Georgia toward a high performance system is to establish and provide continuous support to the Georgia Center for Health Innovation. Assets to create a successful center exist, described throughout this report. A strong academic base exists in multiple entities across the major universities in the state, including schools of public health in Emory, Georgia State, University of Georgia, Georgia Southern, Mercer, Georgia Tech, and Augusta. Published studies and ongoing research have emanated from such entities as the Georgia Health Policy Center at Georgia State, the Medical College at Augusta, Economic Evaluation Research group at the University of Georgia; and from researchers at all five institutions. Work completed by the Georgia Office of Rural Health will also contribute to the success of the new Center. While not necessarily incorporated within the formal structure of the Center, studies commissioned by other entities contribute to the knowledge base needed to inform implementation of the blueprint.

Design of the Center

This must be an independent entity to assure objectivity of its studies and recommendations, which underlie its integrity. However, it could be housed within an existing organization (e.g., one of the universities) to give it administrative support and a means of securing resources (e.g., federal and foundation grants) as a tax-exempt entity. Documents creating the Center should clearly establish its independence and specify direct participants in the Center's work, with a process for including other entities as appropriate. In particular, different dimensions of Center work would require different expertise. What follows are recommendations for a charter establishing the Center and alternative designs.

Charter

The charter establishing the Center as a nonprofit entity supported by the State of Georgia must provide for independence in setting its agenda, including ability to provide policy and program recommendations. The Center would be established to develop recommendations, design programs as appropriate (i.e., when options need to be created to meet circumstances in Georgia rural communities), and evaluate progress toward achieving the vision and goals detailed in the Georgia Blueprint for Rural Health. An organization housing the Center would agree to support it, with continuous financial support from the state, and to administer other sources of funding supporting the Center's work. Memoranda of Understanding would accompany the Charter, as appropriate, to engage other entities. The Charter would provide for a Board of Advisors, described earlier in this report. An initial timeline of five years is recommended.

Alternative designs

(1) The Center is a completely new entity, drawing on the staff of a home institution (e.g., one of the universities). It would have no programmatic responsibilities beyond developing and monitoring the Blueprint.

(2) The Center combines existing programs from numerous entities, giving it responsibility for implementing those programs in addition to developing the Blueprint. The programs could include merging the State Office of Rural Health into this entity (done in some states such as Arizona, North Dakota, and Kentucky).

(3) The Center is within an existing university-based entity under contract to the state, which in turn enters into affiliations with other entities as necessary to complete its work plan.

Elements of a work plan

The principal task of the Center is to work with its Advisory Board to complete the Blueprint for Rural Health Care in Georgia. Beyond initial tasks of developing goals and milestones for achieving Georgia's vision for the future, the Center will need to address immediate needs and build plans to address long-term transitions in health system configuration in rural communities. Five focus areas are recommended for Center attention.

(1) *Workforce*. A critical element of the Blueprint will be to meet needs for person-centered health homes in rural communities, with local access to essential primary care and emergency services. The starting point is a comprehensive strategy that includes training and recruiting programs for the full range of professionals needed, including obvious categories of primary care and emergency services, but including community health workers and certified nurse assistants, among others. Specific programs will be the responsibility of separate educational institutions; the Center's role will be to assess the overall impact, help identify innovative programs for replication, and assist in evaluating programs.

(2) *System development*. The Center will work with stakeholders to develop and implement appropriate configurations of healthcare organizations in rural locations. This may include developing business models demonstrating sustainability, reviewing and helping implement best management practices, assessing local markets to match services to needs of the population being served, and assessing benefits and risks in local rural provider affiliation with regional systems. Tools are available to help with many of these functions, from the Rural Health Value project (www.ruralhealthvalue.org) and other sources accessible through that web site.

(3) *Telehealth*. The Center will work with stakeholders to continue work begun in Georgia to take full advantage of telehealth as a means of expanding access to services in rural communities. This includes identifying communities needing connectivity to broadband (including "last mile" connections to rural residents), contributing to studies of the cost-effectiveness of telehealth, and promoting appropriate applications of this technology.

(4) *Community based services*. The Center will develop strategies to integrate community-based human services with health care services in ways that provide integrated services for residents. Shared governance models would be developed for those places interested in pursuing full integration of all relevant services. This work may lead to creating accountable care communities (ACCs). Members of the Health and Human Services Panels of RUPRI suggest the following design elements for ACCs: "collaboration and partnership for effective local

governance; structure and process to support the ACC; leadership and support; defined geography and geographic reach; and targeted programmatic efforts."[6]

(5)*Payment policy*. The Center will monitor changes in payment policy that affect rural providers, including changes in Medicare, Medicaid and commercial insurance. Policy briefs will be prepared to help Georgia providers understand direct impacts and develop adaptive change. For example, changes in Medicare policy as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is fully implemented could affect the economic viability of rural health provider organizations.

CONCLUSION

Rural health care in Georgia may well be at a crossroads. One pathway would be failure to sustain the current infrastructure (i.e., continuing closure of rural hospitals, departure of clinicians), resulting in inadequate services for rural residents. A different pathway is engaging rural stakeholders in creating new approaches to serve rural residents through a combination of local services and care coordination strategies integrated with regional care. This report has suggested a pathway to do so based on a blueprint developed by a Georgia Center for Health Innovation working with a Board of Advisors composed of stakeholders committed to developing a sustainable, high performance rural health system.

[6] Weigel P, et al. *Accountable Care Communities in rural: Laying the Groundwork in Humboldt County, California* March, 20015: RUPRI. Available at www.rupri.org.