Avera Health Sees Medicaid's Benefits For Rural Patients

DEB FISCHER-CLEMENS

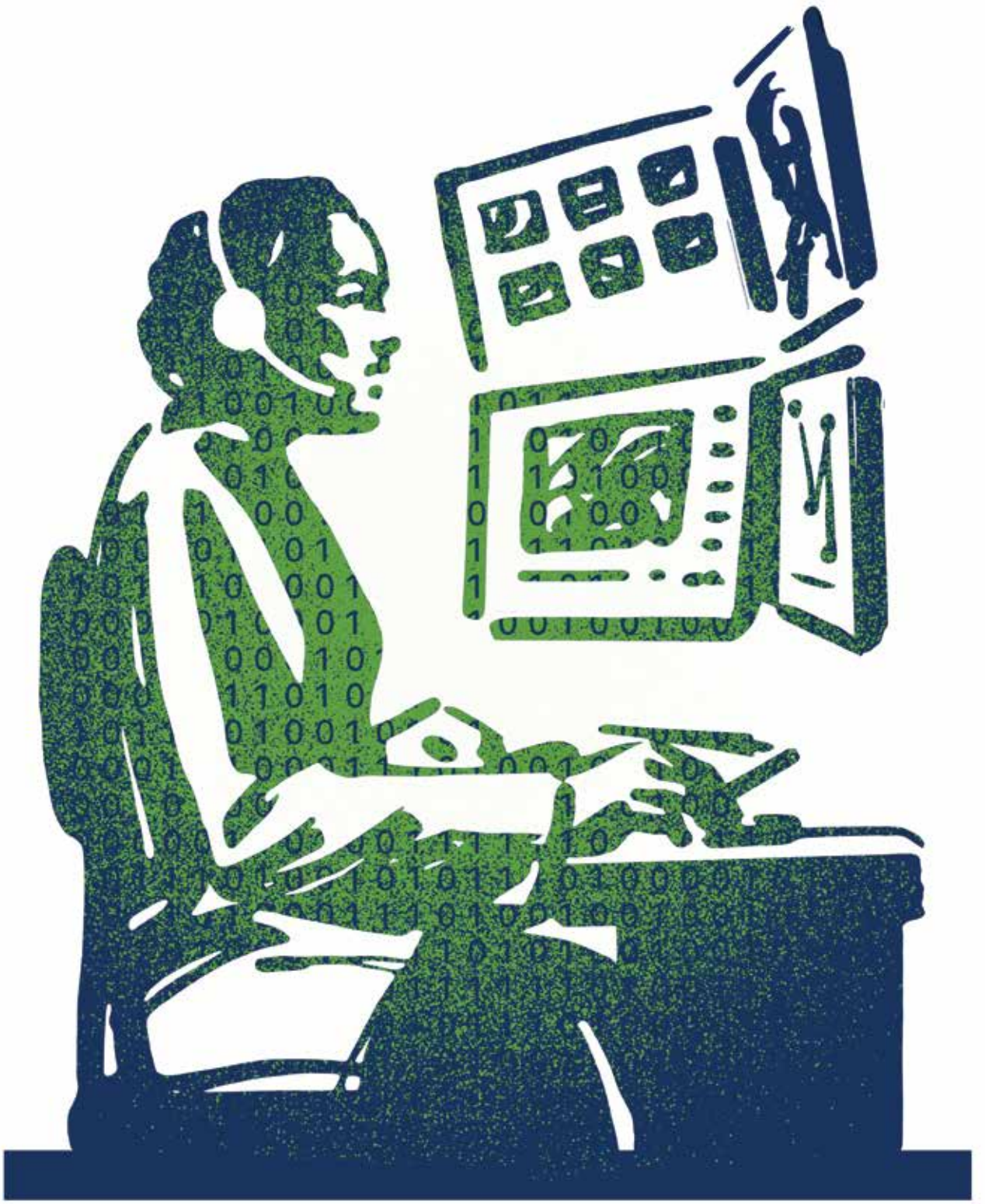
Medicaid is an integral source of health care coverage and access for low-income Americans. In the Avera Health rural service area comprising 72,000 square miles, Medicaid is critical to ensure that children, pregnant women, individuals with disabilities and people age 65 and older can obtain care at the right time and right place.

As a health policy advocate on behalf of Avera, I believe it's important that our legislators understand what makes rural health care unique. Rural Americans are more likely to die from the five leading causes of death than their urban counterparts: heart disease, cancer, chronic respiratory disease, accidents and stroke. Rural residents encounter health disparities like higher rates of chronic disease and greater difficulties accessing health care services than urban residents.

For our facilities in rural areas, the low population density often results in decreased patient volumes, along with fixed overhead expenses, high percentages of subsidized and uninsured patients, a disproportionately high elderly population and decreased access for low-income patients.

Avera serves portions of five states across the Upper Midwest: Minnesota, North Dakota, Iowa, Nebraska and South Dakota. Medicaid expansion has happened at various levels — or not at all — throughout our service area. For example, Minnesota and North Dakota, like much of the nation, expanded Medicaid to people who earn 138 percent of the federal poverty level. Iowa's expansion of Medicaid differed from most states. Iowa residents who need health coverage and are newly eligible for Medicaid — those who earn less than 138 percent of the federal poverty level — may go to the health insurance marketplace. In addition, then-Gov. Terry Branstad followed Iowa's Medicaid expansion by privatizing all of Medicaid by contracting with three managed care organizations. During the November midterm elections, Nebraskans voted on and passed a measure to expand Medicaid.

South Dakota, where Avera is headquartered, represents the largest portion of Avera's service area and is not a state that has expanded Medicaid. In South Dakota, there are 119,000 Medicaid beneficiaries representing 14 percent of the state's population. The majority — 68 percent — are children and 35 percent are American Indians eligible for Indian Health Service. Medicaid coverage for adults is limited to adults with a disability, very low-income parents and pregnant women. Medicaid expansion would impact approximately 50,000 individuals. One-third of this population represents parents with children, and 60 percent



are working adults — two-thirds of whom are working full-time.

MEDICAID REFORM IN SOUTH DAKOTA

Although South Dakota chose not to expand Medicaid, Gov. Dennis Daugaard was instrumental in a hard-fought battle to change the federal government's payment terms for South Dakota Medicaid enrollees who also are eligible to receive health care services from IHS. Avera was invited to participate in the South Dakota Health Care Solutions Coalition in 2015, which developed and implemented strategies to improve health outcomes. This included efforts in concert with a 2016 national Medicaid funding policy update, allowing states to claim 100 percent federal match instead of the regular Federal Medical Assistance Percentage for certain services to American Indians referred by IHS under care coordination agreements. These agreements were developed in collaboration with stakeholders in South Dakota.

The changes increase the federal match rate for services and generate state savings to allow the state to reinvest in Medicaid. Participation is voluntary, and services outside of IHS must be provided via a written care coordination agreement (a contract signed by the state, IHS and the health system). IHS maintains responsibility for patient care.

Much was accomplished through the work of the task force. Savings to the state have been generated, with the first $1.2 million appropriated for the state fiscal year 2018-19 to address service gaps in Medicaid. Substance abuse services also were added for 1,900 adults, and licensed mental health and family therapists were added to serve 465 people. The work of the task force continues and, as the Avera advocate at this table, I find it to be one small way to continue Avera's opportunity to realize our mission. We are committed to making a positive impact in the lives and health of people and communities by providing quality services guided by Christian values.

MAKING A DIFFERENCE FOR PATIENTS

One way Avera fulfills our mission is through the Avera Coordinated Care Program, in collaboration with the South Dakota Department of Social Services Health Home Program. Through these partnerships, Avera provides care management using a team approach to individuals with chronic disease in an effort to improve health and manage cost. Avera has seen numerous cases in which Medicaid, coupled with Avera Coordinated Care, has made the difference for patients in need.

For example, a middle-aged Native American man who is on Medicaid has Type 2 diabetes, major depressive disorder, an alcohol abuse issue and obsessive compulsive disorder. Our coordinated care team of a physician, registered nurse, social worker and a medical assistant has worked closely with this patient. He meets with the nurse case manager on a biweekly basis to fill his medication box, which assists him in taking his prescribed medications. He was struggling with his motivation levels, so he works on goal setting as part of biweekly counseling sessions with his social worker, who also works to ensure he attends his scheduled appointments with his psychiatric nurse practitioner. Without Medicaid as a payer, he would be unable to utilize South Dakota's Health Home program. As a result, he is reaching goals he would otherwise be unable to meet.

Another way that Medicaid supports care is through reimbursement for virtual health care visits.

Another person participating in coordinated care/Medicaid management is a woman who has previously attempted suicide. She has schizoaffective disorder bipolar-type, a seizure disorder and Type 2 diabetes. The patient's psychotic symptoms have decreased since beginning regular mental health counseling. Her ability to follow her care team's instructions has greatly improved. Since working with the nurse on her care team, she can identify each medication, knows the reason for that medication and is taking each appropriately. She continues to struggle with her suicide ideations but will now tell someone before acting on those thoughts. Her diabetes is better managed as she works on healthy eating and exercise.

Another way that Medicaid supports care is through reimbursement for virtual health care visits. Avera is home to Avera eCARE, the robust telemedicine program that reaches over 400 sites in 19 states and 1.1 million people. This program extends medical specialty services to support

emergency rooms, intensive care unit beds, hospital pharmacies and long-term care centers, saving health care costs and thousands of miles of travel. Service lines also include behavioral health, hospitalist and specialty clinic care, senior care and care in correctional and school settings.

Medicaid pays for eCARE virtual visits for patients and long-term care residents. Avera eCARE offers hospitals, clinics and long-term care facilities with ready access to physicians and other experienced health care professionals from a variety of disciplines. This greatly expands access to urgent care and specialty care for people who might otherwise have to travel long distances or forgo care altogether.

MEDICAID SUPPORTS MENTAL HEALTH

In South Dakota, 28.5 percent of adults report poor mental health, while 15 percent have been diagnosed with some form of depression. In addition, 9.9 percent of youth have had at least one major depressive episode. Medicaid funding helps with behavioral health treatment.

A 122-bed facility, serving patients from children to the elderly, is located on the southeast side of the state, a challenge for families from the western and northern reaches of South Dakota. When a person needs to seek treatment at the Avera Behavioral Health Center, it can be up to a six-hour drive. This, of course, results in a separation from a patient's family and support system. Additionally, getting appointments with a nearby mental health professional can be difficult. South Dakota would need 38 additional practitioners to remove the Health Professional Shortage Area for mental health designation from the state. To complicate matters further, suicides are increasing in South Dakota, with 192 deaths in 2017, the most ever reported. There are rural-specific factors that increase the rate of suicide. These rural area risk factors include:

- Living in isolation, which may reduce one's sense of connectedness
- Socio-economic factors, such as unemployment and living with persistent poverty
- Difficulty obtaining mental and behavioral health services due to high cost, lack of transportation and other distance-related concerns.

To help in addressing some of these issues, Avera uses telemedicine to offer behavioral health assessments around the clock. Avera also is developing a behavioral health team, with members scheduled on shifts to be available 24 hours, 7 days a week via telemedicine. The team can provide immediate consults and treatment to patients in crisis. Avera is using more suicide and depression screening tools at clinics, emergency rooms and other access points.

In this last year, we provided inpatient care at the Avera Behavioral Health Center for an adolescent girl who was suicidal. The patient, who was on Medicaid, completed psychological testing and was offered medication, but declined. The patient and her parents agreed to individual and group therapy to teach new skills for management of moods. This young person was able to rejoin her classmates in school as she continued therapy.

More needs to be done to meet mental health needs, including for Medicaid patients. Avera has a 10-bed inpatient psychiatric unit in the north-central region of South Dakota. Recently, a resident at a long-term care facility suffering with violent dementia was transferred to the local emergency room by ambulance. Following the resident's stay in the hospital, there was no facility in which to place the patient because the 10-bed psychiatric unit was filled to capacity. To further complicate the situation, the long-term care facility where the resident had been living contacted the family and said for safety reasons, the resident could not return to that facility. In this situation, safety concerns were based on the staffing and workforce challenges that all rural long-term care facilities are facing.

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Avera has formal partnerships with community mental health centers in states where Medicaid expanded — two in Minnesota and one in Iowa. Those who work at these facilities tell Avera that more people are seeking treatment and seeking it earlier in the course of having a behavioral health issue. The Iowa Community Mental Health Centers note that there has been a significant increase in children being brought by parents for

treatment, which was an unanticipated effect of Medicaid expansion.

Several years ago, the South Dakota Department of Social Services requested proposals to create the needed and only traumatic brain injury facility for citizens of South Dakota. Avera answered the department's call and established the Avera traumatic brain injury long-term rehabilitative care program in a rural community.

The progress of a patient there highlights the importance of Medicaid funding. One young woman was admitted with two goals: to live in her own home and to graduate from using a wheelchair to walking on her own. When admitted, she demonstrated multiple disruptive behaviors due to frustrations about her limitations. She was unable to do her own hair and makeup, dress herself or care for her catheter. Staff needed about two hours for care, including dressing the woman, to prepare her for the day during her first six months in the facility.

She worked with physical, occupational and speech therapists daily to restore her ability to live more independently. In addition, she participated in a job training program and received weekly counseling during her stay at the traumatic brain injury unit. After a little over 18 months in the program, she met many of her goals. She could move herself from the dining room to her own room on the traumatic brain injury unit with a walker and assistance from one staff member. She was able to communicate with her family using an iPad. She started applying her own makeup, fixing her hair and learning processes to maintain her catheter. She could detail her medications, and when and why she takes them. She learned to transfer herself from the wheelchair to her own personal van, which others drove for her. She then moved into her own apartment with long-term services and supports, including outpatient therapy through use of Money Follows the Person, a Medicaid-funded initiative to reduce reliance on institutional care.

IMPORTANCE OF TRANSITIONAL CARE

In collaboration with the South Dakota Department of Health, Avera developed the Avera Transitional Care Unit in former nursing home space in Sioux Falls. This unit, which opened in November 2016, assists patients who are not yet able to return home, but no longer need the services of an acute care facility. One patient was admitted to the Avera Transitional Care Unit after being hospitalized with West Nile Virus. When he came to the transitional care unit, he had a feeding tube and was barely able to move his hands or turn his head. He worked with the therapy department every day and was able to become free of his feeding tube. He propels himself in his wheelchair and has regained independence with some activities of daily living. Using a gait trainer, he has walked up to 700 feet. He continues to make progress toward his goal of going home and being independent again.

Another Avera Transitional Care Unit patient previously had his right leg amputated below the knee. Prior to his admission, he had been in a rural hospital to have a flap reconstruction surgery to his left foot due to an ulcer from uncontrolled diabetes. He came to the transitional care unit with a feeding tube, needing post-flap reconstruction wound care as well as needing extensive rehabilitation and nutritional education to control his diabetes. His feeding tube was removed, and he received a prosthetic left lower limb. He completed therapy and became independent with most of his activities of daily living. He was able to temporarily move to an assisted living facility and then to his own apartment, where he is thriving.

As these stories illustrate, Medicaid provides the means for a variety of patients to access vitally needed care. Its origins and roots are evident in today's program, even after years of change and a dramatically expanded program in terms of beneficiaries and cost. Medicaid has survived at least in part because the law has proven to be remarkably adaptable. While fundamental reform may be long overdue, the basic principles established more than 50 years ago have proven difficult to redefine, so the debate about reform continues.

Medicaid is a critical federal-state partnership. In South Dakota, this partnership is being reformed to ensure that the state will increase resources for those ranging from children to the elderly for years to come.

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