Improving the Health and Well-Being of Rural Communities Through Collaboration

Housekeeping

- Q & A to follow – Submit questions using Q&A area
- Slides are available at https://www.ruralhealthinfo.org/webinars/collaboration
- Technical difficulties please call 866-229-3239
Featured Speakers

- **Alana Knudson**, NORC Walsh Center for Rural Health Analysis
- **Grace Gonzalez**, NORC Walsh Center for Rural Health Analysis
- **Amanda Arnold**, Health Care Collaborative of Rural Missouri
- **Suzanne Smith**, Health Care Collaborative of Rural Missouri
- **Christie Obenauer**, Board Chair of Sakakawea Medical Center, Hazen, ND

Innovative Strategies to Enhance Rural Health Care Collaboration

RHIhub Webinar
August 15, 2019
Recently Released Publication

- **Target Audience:** Leadership and rural health provider organizations
- **Development of the Guide:** Informed by local and national level rural health provider organizations

HRSA’s Guide to Rural Health Care Collaboration and Coordination: Why is this an important issue?

- Rural providers face unique challenges (e.g., limited economies of scale, heavy dependence on public payers, low patient volume)
- Lack of collaboration can put key services at risk given the often-fragile economic status of rural providers
- **Volume ➔ Value $$$**
- Growing interest in *patient centered* approaches to care to address social determinants of health
HRSA’s Guide to Rural Health Care Collaboration: Key Features

- “Elements of Rural Collaboration and Coordination”
- Case Studies
- Tools and Resources

**Collaboration** is defined as activities in which providers work together through various vehicles (e.g., contracts, formal memoranda of understanding, and data use agreements etc.) to maximize resources and efficiencies, with a common goal of ensuring access and provision of services to rural populations.
Coordination is the deliberate organization of, and communication about, patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of quality health care and social services.

Rural Health Safety Net Providers

- **Rural Health Clinics (RHCs):** Created by the Rural Health Clinics Act of 1977. RHCs are certified by CMS to provide primary care services in non-urbanized areas that have been designated by HRSA within the last four years as a shortage area.

- **“Health center” and “FQHC”** are often used interchangeably because the two are intertwined.
  - Health Center Program = Section 330 of the Public Health Service (PHS) Act in 1975. “Health center” refers to either Health Center Program award recipients or look-alikes.
  - Health centers are required to provide services regardless of patients’ ability to pay and to charge for services on a sliding fee scale.

- **Rural Hospitals:** Several rural safety net authorities to support hospitals (i.e. Critical Access Hospitals (CAHs); Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH); Medicare and Medicaid Disproportionate Share Hospital (DSH) payment adjustments)
  - The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 ensures that emergency services are provided regardless of ability to pay, and Medicare-participating hospitals with emergency services provide a medical screening examination when requested or treatment for an emergency medical condition regardless of ability to pay.
Elements of Rural Collaboration and Coordination: Areas to Consider

- Analyze the Environment
  - Develop an in-depth understanding of potential partners' organizations
  - Understand your environmental drivers (e.g., national, state, local levels)

- Engage with Potential Partners
  - Consider opportunities to engage potential partners
  - Use a community-minded approach

- Develop a Collective Strategy
  - Conduct collective discussions with partner organizations
  - Consider using a trained facilitator
  - Select measures to monitor strategy performance

- Review Requirements and Seek Technical Assistance
  - Ensure programmatic and regulatory compliance
  - Seek technical assistance

Case Study 1 | Missouri

“Needs were varied, we knew none of us could do it all, and if we didn’t come together, there’d be unmet need. We knew it wasn’t always going to be fair. It wasn’t going to be like going out to dinner and splitting the bill six ways down to the penny. That’s not the kind of relationship that was going to be successful.”

— Founding Rural Health Network Member, and CEO of a Rural Provider Organization, reflecting on the origins for developing the Network
Our Strategy: Create a Rural Health Network

WHY?
- Address unmet health care needs identified from a needs assessment done while planning a senior center

WHO?
- Critical Access Hospitals
- FQHCs
- Local Health Department
- Local Area Agency on Aging
- Behavioral Health (CMHC)
- Economic Development

Meaningful Collaboration Takes Time, Start NOW…

- **2003 - 2004**
  - Local Health Department Establishes Informal Coalition (Health Care Coalition of Lafayette County): The coalition is focused on serving the needs of one county
  - Senior Center Planning: Needs Assessment uncovers community needs
  - Coalition Wins First Grant Award (state funding award)

- **2006 -**
  - Informal Coalition Becomes a 501c3 Rural Health Network (Health Care Coalition of Lafayette County)
  - Lexington 4-Life Center Established

- **2007 -**
  - 501c3 Network Hires First Full Time Employee (CEO)

- **2008 - 2011**
  - 501c3 Network Wins HRSA Rural Network Development Planning Program Grant Award
  - Network Wins HRSA Rural Network Development Grant

- **2013 - Present (July 2018)**
  - 501c3 Rural Health Network Awarded Health Center Program Funding and Certified as FQHC: Two sites are opened in 2013 and two sites in 2015
  - 501c3 Rural Health Network Includes Close to 50 Member Organizations
Rural Health Network

**Mission:** Cultivate partnerships and deliver quality health care to strengthen rural communities

**Focus:** Implement programs that are innovative and responsive to the health care needs of its local residents

Rural Health Network’s Value and Impact

Federally Qualified Health Centers and other safety-net clinics such as Health Care Collaborative of Rural Missouri provide tremendous value and impacts to their communities—from JOBS and ECONOMIC STIMULUS to local community SAVINGS to the health care system, ACCESS to care for vulnerable populations. Highlights of 2016 contributions are shown below.

<table>
<thead>
<tr>
<th>JOBS and other positive impacts on the ECONOMY</th>
<th>$8,359,576 TOTAL ECONOMIC IMPACT of current operations.</th>
<th>$1,129,124 ANNUAL TAX REVENUES</th>
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</thead>
<tbody>
<tr>
<td>79 TOTAL JOBS</td>
<td>$4,189,002 DIRECT HEALTH CENTER SPENDING</td>
<td>$286,465 STATE AND LOCAL TAX</td>
</tr>
<tr>
<td>49 HEALTH CENTER JOBS</td>
<td>$4,170,574 COMMUNITY SPENDING</td>
<td>$842,659 FEDERAL TAX REVENUES</td>
</tr>
<tr>
<td>14 ENTRY-LEVEL and 14 SKILLED JOBS for community residents</td>
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<tr>
<td>30 OTHER JOBS IN THE COMMUNITY</td>
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<tr>
<th>SAVINGS to the health system</th>
<th>$4 Million SAVINGS to MEDICAID</th>
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<tr>
<td>24% LOWER COSTS FOR HEALTH CENTER MEDICAID PATIENTS</td>
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<tr>
<th>ACCESS to care for vulnerable populations</th>
<th>98% of patients are LOW INCOME (Below 200% of the Federal Poverty Level)</th>
<th>9% of patients identify as an ETHNIC OR RACIAL MINORITY</th>
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<tr>
<td>4,907 PATIENTS SERVED</td>
<td>1,776 patients are CHILDREN AND ADOLESCENTS</td>
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<td>12,235 PATIENT VISITS</td>
<td>3,131 patients are ADULTS</td>
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Capital Link prepared this Value + Impact report using 2016 health center audited financial statements and IMPLAN data system. Information, economic impact was measured using 2015 IMPLAN Online.

For more information, visit us online: www.caplink.org

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Our Strategy: Collaboratively Address Social Determinants of Health

WHY?
- Address barriers to care identified based on an analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) data

WHO?
- Rural Health Network (including its 50-member organizations and community-based organization partners)
- Community volunteers
- Missouri Valley Community Action Agency (MVCAA)

Collaboratively Address Social Determinants of Health

HOW EXACTLY?
- Warehouse Resources Hub
- Connector’s Program
- Project Connect
  - Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)
Outcomes

**Warehouse Resources Hub:**
- As of August 2017, the Rural Health Network donated $1M worth of goods and services to its patients

**Connector’s Program:**
- 2014: 60 local residents assisted with 130 patient encounters
- 2017: 550 local residents assisted with 3,900 patient encounters

**Project Connect:**
- An average of 125 people register for each event, and approximately 300 people receive services (includes adults registered and their families)

Advice/Lessons Learned from Collaboration and Coordination

“Look forward and focus on the best interest of your community. This is what helped us get through any collaborative hurdles we encountered along the way.”

— Rural Health Network Leadership
Case Study 2 | North Dakota

“I don’t think any of us would want to ever go back to how we were before. We all love knowing that we’re one team serving our community.”
— Rural Health Care Provider Staff, reflecting on the adversarial CAH and FQHC relationship that once existed

Our Strategy: Share Resources to Better Serve the Community

WHY?
- Address an unproductive Critical Access Hospital (CAH) and FQHC provider relationship rooted in competition
- Optimize limited resources
- Improve continuity of care

WHO?
- FQHC
- CAH
Share Resources to Better Serve the Community

HOW EXACTLY? Develop a transparent environment to promote a trusting relationship

1. **Functional**
   - *Operational* and *clinical alignment* to better serve shared community while maintaining themselves as separate provider organizations (including separate boards)

2. **Contractual**
   - Legal counsel hired to ensure compliance with Health Center Program and CAH regulatory requirements
     - *Executive Management Consulting Services Agreement*
     - *Coordination of Services and Capacity Agreement*

3. **Structural**
   - Shared board members

Outcomes

- Reduced Duplication of Services
- Improved Financial Outcomes
- Improved Clinical Measures
- “Community Health Needs Assessment”
- “Community Health Improvement Plan”
- “Population Health Committee” and “Multi-Provider Care Coordination Committee” established involving community providers
- ACO/ Value Based Participation
- Patient Center Medical Neighborhood

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<td><strong>Critical Access Hospital</strong></td>
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<tr>
<td>Cash-on-Hand</td>
<td>64 days</td>
<td>84 days</td>
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<tr>
<td>Net Margins</td>
<td>0.8%</td>
<td>4.2%</td>
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<tr>
<td><strong>Federally Qualified Health Center</strong></td>
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<tr>
<td>Cash-on-Hand</td>
<td>8 days</td>
<td>203 days</td>
</tr>
<tr>
<td>Net Margins</td>
<td>-11%</td>
<td>10.9%</td>
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Advice/ Lessons Learned from Collaboration and Coordination

“Understand and learn about your potential partner organization’s requirements; don’t let personalities get in the way.”
— FQHC Leadership

On Expanding PCMH outside the FQHC to involve other providers in the community: “Engaged leadership support and commitment is essential.”
—FQHC and CAH Leadership

QUESTIONS
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Questions?
Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website