

Transcript for RHIhub Webinar: Rural Hospital Closures 01/18/18

Kristine Sande:

Good afternoon, everyone. I'm Kristine Sande, and I'm the program director of the Rural Health Information Hub. On behalf of RHIhub and the Federal Office of Rural Health Policy, I'd like to welcome you to today's webinar on rural hospital closures. We are especially pleased to have those of you who participate in the Rural Health Philanthropy Partnership with us today. This webinar came about as a result of one of today's speakers, Dr. Shao-Chee Sim from the Episcopal Health Foundation, bringing some of the Foundation's recent work around this issue to the attention of the Federal Office of Rural Health Policy during the June Philanthropy Partners meeting. Today we'll hear more about the research that's been done on the causes and effects of rural hospital closures, as well as some of the strategies that can be used for assisting communities affected by rural hospital closures.

I'm going to quickly run through some housekeeping items before we begin. We do hope to have time for your questions at the end of the webinar today. If you have questions for our presenters, please submit them at the end of the webinar using the Q&A section that will appear on the lower right-hand corner of the screen following the presentations. We've provided a PDF copy of the presentation on the RHIhub website, and that's accessible through the URL that's on your screen. We have also sent the link via the chat function, so in that chat box you can find a clickable link, I believe. If you have any technical issues during today's webinar, we do encourage you to call WebEx support at 866-229-3239.

It is my pleasure to introduce today's speakers for the webinar. Unfortunately, Tom Morris, who directs the Federal Office of Rural Health Policy is not able to be with us today. He does send his regrets, but we have some really great speakers that we will be hearing from. Our first speaker will be Dr. George Pink. He is a Humana Distinguished professor in the Department of Health Policy and Management, a senior research fellow at the Cecil G. Sheps Center for Health Services Research, and the deputy director of the North Carolina Rural Health Research Program, all at the University of North Carolina at Chapel Hill, and he had to trudge through the snow to be with us today, so thanks for that. Dr. Pink teaches courses in healthcare finance and is involved in multiple research projects, including the rapid response to requests for rural data analysis and issue-specific rural research studies, the Rural Health Research Grant Program, and the Rural Hospital Flexibility Program Evaluation, all funded by the Federal Office of Rural Health Policy.

Our next speaker will be Dr. Shao-Chee Sim, and he serves as the Vice President for Applied Research at the Episcopal Health Foundation. Dr. Sim has over 20 years of extensive research, community engagement, planning and strategy experience within philanthropy, federally qualified health centers, and non-profit organizations.

Our final speaker, Dr. Nancy W. Dickey, currently serves as a professor at the Texas A&M Health Science Centers, College of Medicine, and School of Public Health. She also serves as executive director of the A&M Rural and Community Health Institute, which serves in a consultative role, easy for me to say, with hospitals and communities across the state of Texas to facilitate best practices in patient safety, enhanced quality of care, and physician excellence. At this point, I'm going to turn it over to Dr. Pink for his presentation.

Dr. George Pink:

Thank you very much. It's a great pleasure to be with everyone today. I'm going to be giving a brief overview of rural hospital closures, their prevalence and why they're closing, how they're closing, and so on. I anticipate being 10 to 12 minutes to do this. When we first started tracking rural hospital closures, we found it difficult because there is a lot of behavioral variations in how they close. Some hospitals are open for a long period of time, then they close, then they open,

then they close. There are no secondary databases to identify these closures, so we're really requiring to focus on media coverage and community sources, but for our study, we define closure as permanent cessation of acute inpatient care, because essentially, that is the way that Medicare defines a hospital. You have to have acute inpatient beds to call yourself a hospital.

Where have they happened? There have been 83 closed since 2010, and 125 since January 2005. The ink on these slides is barely dry, because there was a closure again last week, and so it's an interesting challenge trying to keep all these dates and maps up to date, but you can certainly see by the map that 2/3 of all rural hospital closures approximately have happened in the southern part of the country. When we talk rural hospital closures, we're really talking a southern phenomenon, to a large extent. When did they close? This is the number of rural hospital closures by year. Again, in this from 2005 to 2010, it sort of floated around in a range of 5 to 10 closures per year. It was really in the '11, '12 when we noticed a startling increase in the numbers. In '16 and '17, it actually leveled off a little. I will speculate in a few minutes as to why or why that might not continue.

We differentiate between hospitals that are abandoned and hospitals that are converted, and what we mean by that, many rural hospitals that close, in fact, the building and the staff morph into a new kind of healthcare facility, typically a primary care facility, emergency care, urgency care, primary care clinic, sometimes a SNF or a rehab facility. Then other facilities are abandoned, and what we mean by abandoned is there are no longer any healthcare services provided in that building. We had examples of one that was converted to a condo, one that is now an office building, and one that's a car wash. These are what I consider no longer in the healthcare business, and you can see by the graph that the majority of hospitals that have closed have been abandoned. There are no longer any healthcare services provided in those buildings.

Where have they happened? There was an article in Health Affairs earlier this week, looking at the relationship between closure and expansion state, and finding that hospitals in expansion states were much less likely to close, and I applaud that research. Certainly the data in this graph would certainly suggest that that is true. What kinds of hospitals closed? 1 to 25 beds. As all of you know, critical access hospitals are a maximum of 25 beds, so most of the hospitals in the left-hand bar are critical access hospitals, and the rest are a mixture of MDHs, Medicare-dependent hospitals, sole community hospitals, and rural PTF hospitals.

This is a graph that shows essentially ... The X axis is the number of miles to the next closest hospital, and the Y axis is ... Sorry, the X axis is the number of hospitals that have closed, and the Y axis is the number of miles that people in the communities where the hospitals have closed now have to travel. You can see at the bottom left-hand corner, there are 20, 25 where people in the communities are having to drive 5, probably 40 communities where they're driving less than 10 miles. It is the people in the communities in the far upper right-hand quadrant that worry us the most. These are people that are driving 15, 20, 25, 30 miles more to access inpatient care, and some of the initial studies we've done found that there are particularly three groups that are most at risk for this, and that's the elderly, the disabled, and the poor. For them, traveling another 20, 25 miles for many of these groups is very difficult.

Why are the hospitals closing? There are many, many reasons, but we sort of dumped them into three buckets, market factors. Again, these are not rocket science, and it wouldn't be a surprise to many people, but small or declining populations, high rates of un-insurance and employment, high dependency on Medicare and Medicaid, hospitals themselves having physicians to cover the emergency department, low volumes, and some cases, deteriorating facilities and patient safety concerns, but the most important bucket is the financial factors by far. These hospitals, closures are not overnight events. Typically they've been losing money for years, sometimes

decades. They tend to have high amounts of charity care and bad debt. They have sometimes insufficient, essentially cash flow problems that eventually lead to bankruptcy and then to closure, and as the graph says, a negative profit margin, meaning they've been unprofitable for a long period of time, typically.

There are exceptions to this rule. There are some hospitals that have closed because they're part of system consolidations, for example, but by far most of them have closed for financial reasons. We looked at closed hospitals in the year before they closed, and we found that almost all of them were unprofitable, illiquid, unable to service their debt. Most of them had fewer than 150 full-time equivalents, 10 million in salary expense. They had been unprofitable, and that negative net assets means that they were technically bankrupt. They had more liabilities than they had assets. Interestingly enough, that most had already closed obstetrics. Many hospitals closed obstetrics in the last 20 years as a way of coping with financial pressures, but it obviously didn't help these hospitals.

This is the latest closure. This is the one I was talking about that happened in a North Carolina town a few days ago, a few weeks ago. This is exactly, actually, an interesting example of what happens. This hospital closed on December 31st and essentially, the issues were again what I've been talking about, financial issues, low inpatient volume. It closed its Emerg. They are going to continue operating the 60 bed nursing home. They'll be talking with local docs about starting a primary care clinic and continuing to operate it, and the FQHC is actually stepping up to fill the gap by having longer hours and opening a half-day on Saturdays, but again, people in this community has to drive 20 miles further to access inpatient care.

To summarize, most rural hospital closures have been in the south. Most have them have been increasing until recently. Most have been critical access hospitals and PTF hospitals. They have happened in states that have not expanded Medicaid. Most patients are having to drive between 5 and 30 miles more to access inpatient care, and most closed because of financial problems. That's sort of a summary of what we have found to date.

In terms of the future, this is my last slide. I think beyond schedules changes, such as 340B, and again, that is still under appeal in the courts, but I think closures could stay the same as they are now, but they could rapidly increase if Brady-Neal, the Medicare extenders bill, for example, that included modification of payments to CAHs using the OIG recommendations of using the SNF PPS methods instead of cost-based reimbursement. That would be a big loss of revenue for critical access hospitals. Loss of Medicaid expansion, if we move to block grants. Essentially, any legislation or any policy changes that result in a rapid return to large numbers of uninsured, underinsured patients, I think that will likely not bode well for hospitals that are currently financially challenged, and keeping in mind that almost 40% of all rural hospitals in the United States are currently losing money.

If you are interested in following the rural hospital closures, we have an online website that you can go to. Again, this is maintained in real time, so every time a hospital closes, we update the information within a day or two, and it's interactive. It tells you where they are, their addresses, what they used to provide, and what's replaced them. Thank you very much for your time and your attention. I look forward to hearing from the other presenters.

Dr. Shoa-Chee Sim: Hello. This is Shao-Chee Sim from the Episcopal Health Foundation. Thank you for the presentation, George. I guess the story I'm trying to tell, or the insights I'm trying to share with you guys is the story of the Episcopal Health Foundation, a fairly new private philanthropy that was created about four years ago. Our foundation came about when our diocese decided to sell the hospital systems, and we used the profits to create the Episcopal Health Foundation. We cover about 57 counties in Southeast Texas, although 42 of them are in the rural communities,

rural counties. That's about 11 million population. In terms of the healthcare facilities, at a very high level, this area covers 38 rural hospitals, 33 federally qualified health centers, 72 rural health clinics, and 14 local mental health authorities.

In terms of an overview of rural Texas, Texas is a large state, and I would say overwhelmingly, 177 out of the 254 counties are rural counties. We have about a total of a little bit over 3 million populations that are living in rural communities, and I'm not going to go over all the statistics about the healthcare provider shortages, or the disparities that rural communities face in Texas you know, those data are pretty astounding. I guess one thing to follow up from George's presentation was that it doesn't matter what year or what data you're comparing with, Texas is the state with the highest number of hospital closures, so in a way, we are getting the brunt of hospital closure in the country.

Why is this issue important to us, to the Episcopal Health Foundation? I guess from our perspective, we feel it's important to start to learn about the issue, and trying to figure out what can we do to help the rural communities, in that 3/4 of our service areas are rural communities. We also understand fundamentally, a rural healthcare system resources and structures are very different from those that are in the urban settings. For us, one of the key pillars of our work in the foundation is that we wanted to ensure all residents, regardless of where they live, do have adequate and equitable access to healthcare services. Finally, a value that's very important to the foundation is that we want to ensure residents do have a voice in their healthcare.

As I mentioned earlier, the foundation is still in a very early phase of developing our rural health strategy. I think most of our work for the past two to three years or so has focused mainly on stakeholder engagement, community committing and research. What we hope toward the next couple years is that we would like to be able to develop a more impactful grant investment strategies. In terms of stakeholder engagement, the work that we have done so far is working with state associations, like the Texas Organization of Rural and Community Hospitals, the Texas Association of Rural Health Clinics, as well the state agencies, the State Office of Rural Health and the Office of Primary Care, to really figure out on the state level, what are some priorities? What are some work that's going on at the state level? We also understand that we are not in this alone, and that it's really important to collaborate and partner with other funders that are either local foundation or regional foundations in Texas. In fact, in a later slide, we actually have started to partner with the Robert Wood Johnson Foundation.

We also understand, as I mentioned earlier, that much of this work we feel like really needs to be driven from a bottoms-up perspective, in that community residents' perspective, it's a very, very important area of work for us. What we've done over the past couple years is that we have intentionally reached out to universities and research centers in the rural counties, whether those are Madison, Grimes, Robertson counties, or in the east Texas area, we have worked very intentionally and collaborative with Texas A&M University as well as UT Health Northeast. The work that they've been helping us to do is helping us to do community asset mapping, looking at community health coalitions, and really trying to get a sense of what are some priorities and our med needs in this rural communities?

We also spend some resources in the area of research. For us, we feel like having this very relevant incredible information, it's very, very important. We have been working with the Texas Association of Rural and Community Hospitals and the Texas Association of Rural Health Clinics, both looking at the state of the hospitals as well as the rural health clinics, and actually have really begun some very creative and innovating data collection. Again, it's trying to figure out who is doing what, what's out there, what are the gaps, and what could be some potential roles for private funders vis-à-vis the role of the federal government or the state government?

Other type of work that we have done in this area is also looking at other types of service models that exist in the rural communities. For instance, actually, this was going back to HRSA funding in the 1980s, this model called Health Resource Centers, a one-stop shop resource center that was created by HRSA. This is a model that is still going very strong these days, so we have been working to figure out to what extent we could help support the replication of the model. We are also looking into telehealth and telemedicine, and some potential approaches to address rural healthcare disparities. Of course, being in the south, in the coastal region area in Texas, many of the rural counties were hard hit by Hurricane Harvey, so part of our work in this area is also helping to assess the impact of Harvey on rural residents.

The project that I'm going to introduce later is the work that we have done in collaboration with Dr. Nancy Dickey at Texas A&M University College of Medicine. Let me just spend a little time, even though I had mentioned that we were very early in our grant making strategies, over the past couple years or so, we have invested about 10 million dollars supporting federally-qualified health centers, rural health clinics, local mental health authorities, and charitable clinics that serve the rural communities in our service areas. I would say that most of this work, we would like to tend to focus on leveraging existing partnerships, supporting existing system collaborations, rather than just making an independent silo-based investment in this organization. We feel very strongly about not starting from scratch, and we feel very strongly about, let's go with where the assets are, there are some important track record.

Finally, the work that we've been collaborating with Dr. Nancy Dickey, it also was an attempt to systematically examine rural hospital closure in Texas, which Nancy will be able to share in more detail. I'm very happy to report that after we released the report, I believe it was this past May or June, we've gotten a tremendous amount of interest from funders, from community stakeholders, from policy makers, that right now we are in our second phase of our work, which is to really look at a process or a tool in which rural communities can use to evaluate and to identify resources and needs of a community. This is the work that we are currently collaborating with the Robert Wood Johnson Foundation and the TLL Temple Foundation on. I think with that said, I would like to pass the baton over to Dr. Dickey.

Dr. Nancy Dickey: Now, like you, let me see if I can get to, there we go, get to the slides. I think I've unmuted all the necessary things, and appreciate the tremendous amount of information that Dr. Pink and Dr. Sim have both provided for you. I think I'm participating largely because the A&M Rural and Community Health Institute, which we lovingly call ARCHI, is actually hands-on working with a variety of communities. ARCHI actually was created about 15 years ago and functions much like a ag extension, in that we, from a healthcare perspective, reach out to small practices, small hospitals, to assist them in everything from getting electronic records, to meeting quality standards and improving patient safety issues.

When we began to talk to Episcopal Health about rural healthcare and closures, these were people that we considered our friends and often our contractors. In fact, it was over a decade ago that a graduate from one of our schools of public health approached us and said, "They're closing our hospital. Isn't there something you can do?" The answer at that time was, "Gee, we don't know." I think part of the project that we're working with Episcopal Health and Robert Wood Johnson and TLL Foundations are to see if we can't change that answer to yes.

That said, let me tell you a little bit about what we're doing. As described by George and Shao-Chee, the issues are not limited to Texas, although Texas and the south in general are disproportionately represented, and I think that that may have some impact when it comes to planning. I think there's also some impact from the rapidly changing healthcare delivery system. Certainly, as medical specialization has occurred, it has become more and more difficult for a substantial portion of health professionals, certainly some specialist physicians, but even our

nurse practitioners and sometimes our PAs have gone into a narrower field that requires a larger population to actually best utilize their skillsets. When we look at the graduates from medical school and advanced practice nursing, the reality is we no longer can look at the entire graduating class, but often a fairly small subset of that class.

The same is true for technology. As we become more and more dependent on highly specific, very expensive technology, it requires a widely based population in order to pay for itself, and so the technology that our patients have come to expect cannot be afforded by a hospital that's serving a relatively or even a very small population. Nonetheless, it has advanced the quality of healthcare. Then finally, mergers and acquisitions. As we get larger and larger systems of care, those systems certainly need and want patients feeding into their system, but they're often very business-like, looking at how much they can afford to support in a small town, and how to ensure that the appropriate and sometimes even the borderline cases get referred into the bigger systems of care.

Put those changes into a culture where many communities, many individuals remain anchored to a concept that the core of healthcare delivery is a hospital. The promise of President Truman back in the '40s was that essentially, every small community could anticipate a hospital, and the Hill-Burton Act would make funds available to do so, and that perception, it continues to be threaded throughout many, many of the conversations when you go to the community. How will we get healthcare if we don't have a hospital? Their concepts of what they do next are tied to that somewhat outdated issue.

I think, George, that probably also helps explain that phenomena. I was delighted to see the language on your slide, because it's one that appears in much of our background work. Open, closed, open, closed. You have to pick up the phone on any given day to find out whether a particular facility is in open status or closed status, and that seems amusing, but I think it speaks to this concept that they will go to any length to keep a facility open, because that's how they think of accessing healthcare, particularly in small towns. Parenthetically, I'm not sure it would be terribly different if you got out into the communities of a larger town.

Having done the scan that we were commissioned to do by Episcopal Health last year, Shao-Chee and his group looked at it and said, "So what's next?" We said, "Well, we really think that we need to go out and work hand-in-hand with a number of communities, and see if we can begin to identify any commonalities, any steps that A&M or any other interested entity might be able to take or suggest for a community who perceived their healthcare facility's wellbeing was threatened, that they were likely to face a closure." Hoping that by examining the specific issues, that we might develop better understanding of some of the potential solutions.

We have committed, over a 12 month period, to go out to no less than three communities, get to know those communities, what led up to their current crisis. In two of those three, the hospitals had already closed, but they were part of both the Episcopal Health Network, a region that served, and also had been partners with A&M in other issues, and so we chose those two as our first communities to go into. Oftentimes there was not a specific event that led to a crisis and closure, but rather, as George so well described, a shrinking over time of the inpatient census, of the breadth of what the healthcare providers could care for safely, and therefore kept in town versus transferring out, a constantly tightening noose around the financial wellbeing.

One of the things that we're beginning to find is issues regarding the sophistication of hospital leadership. Almost a surprise to some of the community board members who felt that they had been getting information, which they had interpreted as at least able to hang on, if not stable, when in reality the indicators as we came in suggested that there had been serious problems for some time. As we sit down with those same community leaders, the sophistication of leadership

and business acumen that they bring appears to be a challenge. Even things like holding both parties to contractual items, what belongs to who when you actually close a hospital, and where does the data go and so forth, so we think we're beginning to find some commonalities that may help us identify tools that would help communities to address some of their issues.

Again, let me call attention to a couple of things Dr. Sim said. He said they're approaching this bottom-up, and I think that in fact, it's important that any solution be from the community up, partly because they need to begin to understand that healthcare delivery looks extraordinarily different in 2018, and probably will look more different yet in 2025, and so whatever is designed for small towns is going to have to not only fit the small town needs and their economic and people capacity, but it's going to have to fit what the healthcare delivery system is morphing into. I think we need to help them move from this concept of, 'got to have a hospital', to, what are the services that your community needs to justify for safety reasons, or for morality compassion reasons, or because of the particular people who live in your community? If you have a high-risk industry, you want to be very sure that perhaps you've got easy access to 24/7 emergency care, and not have to drive a long distance if you had a serious industrial accident of some kind.

We have discussed some things that, again, have been a little surprising to me, that required somebody coming in from outside to have the conversation. How do you get people to come into an existing facility? Let's talk about the breadth of healthcare, including wellness, and labs, and imaging, and let's talk about the breath of healthcare resources. Can we move things into a facility in order to keep people tied to the concept that there are health services in town, even if there's not a hospital in town, in order to help whatever services you do preserve to survive the closure of the bricks and mortar?

Our goal at the end of these three communities, I think, is to have begun to outline issues and opportunities, processes to put in place before a crisis exists, before the proprietor arrives with keys to lock the front door. It's our perception, very early on, I'm not willing to call it a finding yet, but that there is a need for more intense training for facility leadership, and by that I mean as much the community governance kind of leadership as the paid administrative leadership, but training and support. Again, I think that Shao-Chee said that rural systems are fundamentally different, and so to simply believe you can pluck a young up-and-coming administrator out of a Texas medical center facility and say, "Here, we're going to give you a fast track to the top. It's going to be out here in tiny town," and think that the skillsets that he or she learned will be immediately applicable, probably not. Same is probably true for your hospital governance, so your boards.

We believe we need to develop a robust set of alternatives that are more or less off the shelf, a menu, if you will, to begin to talk to communities about healthcare delivery probably very often in the absence of something that we would call a hospital, in the absence of 24/7 inpatient care, but maybe 24-hour emergency care with agreements that facilitate transfer of things that need to move to a higher level of care. Here in Texas, we have relatively rudimentary telemedicine, having just passed legislation in our last session that makes telemedicine a much more doable alternative, and because of our geography, the breadth of the state, anticipate things like, "How much of what you currently do could you replace with telemedicine?" Those answers will be easier in the coming 12 months than they were in the previous five years, and networks of providers with non-physician providers that allow care, particularly for those populations George talked about, the elderly, the disabled, the poor who don't have transportation.

Part of this will likely lead up to some work on facilities and workforce that will tip their hat to acknowledge Shao-Chee's comment about rural systems being fundamentally different. Again, what we design for suburban American probably should look different in a relatively small town,

but I don't know that we've spent a great deal of time defining what that difference is, and how we might have to change planning, maybe regulation, maybe professional training in order to meet that difference.

What's next? As we finish these three communities, we hope that we'll develop a blueprint or a plan for each community, which ultimately may then lead to a more global algorithm, which we can encourage communities, hospital governance bodies, and others to use earlier in the process, because crisis decision making often limits things that might have been a possibility had you looked at them earlier in a decision tree, identification of common steps and processes for that algorithm and some hand-holding, frankly, to try to see how we can assist communities to begin to move beyond that concept of bricks and mortar hospitals. Certainly, there are likely to be issues, both state by state and federally, that might be addressed through legislation or regulation. The payment issues that George alluded to, which will help make or break some of the rural hospitals, maybe some innovative things that we can propose and endorse in legislation.

It seems to us that this is both a reaching a hand out to communities, because the solutions likely will work best if they are from the community up, but they also hopefully will lead to broader, more firm national policy, in that as we began this work a couple of years ago, it felt like there was a huge amount of work done in the early '90s, and then kind of a wall of silence. Nothing much happened, and then it has reemerged in the last many years. I think we'd like to make sure that perhaps we use this reemergence, this interest, to see if we can't create some long-standing solutions that help define what is different about rural systems? How do we support that difference? How do we create a workforce that is appropriate for rural? How do we attract people into that workforce? How do we use technology to make sure that care is available without undue travel issues, but at the same time recognize that the costs of specialization and technology mean that we simply won't have the full breadth of what medicine is capable of doing available in every small town?

With that, I think probably I'll stop talking about what we're attempting to do, and perhaps open it back up for discussion or questions.

Kristine Sande:

Thanks so much. Those were really interesting presentations, and we do now have time for a question and answer period. You should see the Q&A box that should have shown up in the lower right-hand corner of your screen, and you can enter your questions there. As you enter your questions, I do ask that you would select the option to send the question to all panelists, just so we don't miss your question. One question to start. From a finance perspective, have any of you looked at what models for providing 24/7 emergency care in the absence of a hospital, what models might work best from that finance perspective?

Dr. Nancy Dickey:

This is Nancy. Certainly, the standalone free-standing emergency rooms appear to be getting a great deal of activity here in Texas, and I'm going to assume wherever state law allows. At the same time, the same challenges will occur to that standalone emergency center as occurs for the small hospitals. The rural communities are disproportionately poor, their paying patients are disproportionately Medicare/Medicaid, and they have, at least here in Texas, a higher percentage of uninsured. We're not an expansion state, and so standalone centers will have the challenge of the same as the small hospital, can they keep the doors open?

I think on the other hand, if you look at how systems of care are developing, where we're moving slowly towards value-based care, covering the emergencies is more likely to have some form of funding, and if that 24/7 emergency center is an emergency center/continuity care, it makes sense for the systems of care to have somebody to send the discharged patient back to, to try to make sure the heart failure, the pneumonia, the MI, the diabetic, don't get readmitted

to the hospital, that they get the outpatient management that they need, so it's more than just an emergency department. It has to be kind of the community base of care with a capacity to stabilize major emergencies and ship them off.

Kristine Sande: All right, thank you. The next question we have is, what's the timeline on developing the tools?

Dr. Nancy Dickey: Well, we have committed to broad brushstrokes, at least, by the end of the summer of 2018. Three communities is certainly way too few to think that we will have all the answers at that point, but we might have a preliminary tool that we and others can then use to reach out to larger numbers of communities, and begin to improve the effectiveness and the quality of any tool that we have. Our first take on the tool will hopefully be available by late summer 2018.

Kristine Sande: Great, thank you. I'm not seeing any other questions at this time. If you do have questions, if you could please enter those. Any other comments from any of our speakers at this time?

Dr. Nancy Dickey: One of the questions that we have, I think, is whether anybody is working with the large systems of care. They're the ones most likely to, in fact, put together value-based payment systems, and yet as the small rurals close, they're going to be caring for people from an increasing radius from their hub. The further from that radius they are, the harder it is for them to manage the behaviors and the healthcare that will help dictate whether the patient gets readmitted. Is anybody aware of any systems that are looking at innovative ways for the hub to reach out, other than simply to staff positions and so forth, and hope that they buy in, if you will?

Kristine Sande: Right. Anyone want to weigh in on that? All right. If not, I think we'll move onto ... We did have a couple more questions come in. The first is, can someone describe in more detail what the health resource centers would be?

Dr. Shoa-Chee Sim: Sure. Can you hear me?

Kristine Sande: Yes, we can hear you.

Dr. Shoa-Chee Sim: Okay, great. Yes, the health resource center, it's a model that actually was originally funded by HRSA, I believe either in the 1990s or 2000s. It was really a model that was created to address many of the barriers in terms of accessing healthcare in the rural communities. Health resource centers, basically it's a one-stop shop in which they offer a lot of different help. They provide health education. Some of the health resource centers actually provide transportation services to transport rural residents to go for physical checkup, to access healthcare services. They also do very preliminary form of tele-mental health counseling or telehealth. At times they'll also help rural residents to apply for health insurance benefits and things like that, so it's really a one-stop shop. I mean, it makes a lot of sense for residents that work in rural communities that have very, very limited resources, and facing tons of barriers in terms of accessing healthcare services and securing appointments, trying to make sure that they can get to the appointment on time, or just in general, to help navigate our always complex health and social services systems in the rural communities. I hope that helps.

Kristine Sande: Okay. It looks like there's a follow-up question on that. How is it different from a federally-qualified health center?

Dr. Shoa-Chee Sim: Well, federally-qualified health centers is a very specific outpatient primary care facilities. They offer everything from pediatric services, to adult medicines, to OB-GYN. It has a medical provider. They have MDs, it has nurses. A health resource center does not offer any direct healthcare services, although federally-qualified health centers, what it's known for it's also that it's known for providing a host of enabling services, or what we call social work services at

federally-qualified health centers, so that's a major distinction. FQHCs offer healthcare services, and health resource centers is really more of a one-stop service referral hop.

Kristine Sande: Okay.

Dr. Nancy Dickey: I think if I can pile on a bit, I think in fact, federally-qualified health centers sometimes do some of the same things as health resource centers, but as Shao-Chee said, the health resource centers are often located either in a very poor part of town or in a small town, and it's a place for somebody to come in and say, "Is there help for transportation? Can you facilitate getting me an appointment so that when I do go into the bigger community, that's already taken care of? How do I apply for insurance or disability?" It's often access to the social service safety net that allows many patients to access healthcare, but historically, those pieces have been scattered across town and around multiple offices, and often difficult to find.

Kristine Sande: All right. The next question is, in exploring this topic in Alabama, I've been surprised to find that there doesn't seem to be much of an effort to bring these hospitals together to discuss their common issues. Is this the case in Texas as well?

Dr. Nancy Dickey: Texas has an Organization of Rural and Community Hospitals, so TORCH actually serves the purpose of bringing the hospitals together. They're not specifically the hospitals that are facing crisis or challenge, but they would be included amongst that, and there is of course a National Office of Rural Health that, to some degree, can serve a similar purpose, but I would say that we have perceived the same thing as we've gone out in the communities, that the hospital volunteer leadership often are either unaware of or at least non-participatory in any support or education processes that might kind of give them a hand up, if you will, during these discussions.

Kristine Sande: All right. Thank you so much. I don't see any other questions at this time, so I think we'll wrap things up now. On behalf of the Federal Office of Rural Health Policy and the Rural Health Information Hub, I'd like to sincerely thank our speakers today for the great information and the insights that they've shared. I'd also like to thank all of our participants for joining us. A survey will automatically open at the end of today's webinar, and we encourage you to complete the survey to provide us with some feedback, so that we can use that feedback when we host future webinars. The slides used in today's webinar are currently available on the link listed on this slide. In addition, those slides, and a recording and a transcript of today's webinar will be sent to you by email in the near future, so you can listen to the webinar again or share this presentation with your colleagues. Thank you again for joining us, and have a great day.