

RURAL HEALTH CLINIC TECHNICAL ASSISTANCE EDUCATIONAL SERIES

MODULE 3

Helping SORHs Make Decisions about Providing Technical Assistance and Support to Rural Health Clinics

National Organization of State Offices of Rural Health

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Helping SORHs Make Decisions about Providing Technical Assistance and Support to Rural Health Clinics

Target Audience and Objectives: This module is designed primarily for State Office of Rural Health (SORH) directors and staff interested in developing technical assistance for Rural Health Clinics (RHCs). Objectives for this module are:

1. To provide information, ideas and suggestions to help SORHs develop basic technical assistance services to RHCs.
2. To outline opportunities for SORHs to provide technical assistance to RHCs.
3. To outline the benefits to SORHs for providing technical assistance to RHCs.

Module #3: Helping SORHs Make Decisions about Providing Technical Assistance and Support to Rural Health Clinics

Content	Resources
Resources required to provide varying levels of technical assistance Why should SORHs provide technical assistance to RHCs; what's the incentive/benefit? How are decisions made? Developing the plan to take RHC technical assistance to the next level	Results of NOSORH RHC TA survey Survey results from SORHs

Suggested Resource Materials and Background Reading:

[Introduction to the Rural Health Clinic Program \(Rural Health Clinic TA Project Educational Module 1\), NOSORH, 2010](#)

[Learning about Rural Health Clinics \(Rural Health Clinic TA Project Educational Module 2\), NOSORH, 2010](#)

[Starting a Rural Health Clinic: A How-to Manual \(Chapters 4 & 5\), 2004](#)

Am I Rural? Rural Assistance Center (<http://www.raconline.org/>)

National Association of Rural Health Clinics (<http://www.narhc.org>)

Rural Health Clinic Center, Centers for Medicare and Medicaid Services (<http://www.cms.gov/center/rural.asp>)

Apply to Become an NHSC Site, National Health Services Corp (<http://nhsc.hrsa.gov/communities/apply.htm>)

A Quick Guide for Rural Health Clinics Applying for NHSC Site Approval, Health Resources and Services Administration, May 2010

NHSC and HPSA Designation (PowerPoint Presentation), A. Jordan, May 11, 2010

RHC Survey Summary, NOSORH, May 2010

SORH RHC Activity Survey

Technical Assistance Resources – Public Resources Available

There are quite a few technical assistance and training (TA/T) resources available at no cost to Rural Health Clinics (RHCs). Most of these resources are provided through the U.S. Department of Health and Human Services (HHS) – either through Health Resources and Services Administration (HRSA), the Centers for Medicare and Medicaid (CMS) or through Cooperative Agreements with national partners such as NOSORH or the National Association of Rural Health Clinics (NARHC).

Not all RHCs are aware of these publicly available TA/T resources. A positive, helpful step for SORHs would be to let RHCs know about these services. Module 2 in this series outlined publicly available resources; the list below highlights some of these. For more information, consult Module 2 or follow the links below.

Free RHC Technical Assistance Resources – What SORH should know and do.

Federal Office of Rural Health Policy: The Office of Rural Health Policy (ORHP) provides direct support to several organizations that in turn assist Rural Health Clinics. The [ORHP website](#) contains links to assets and provides helpful RHC information. Go to the ORHP web page, select **Policy and Research** and then select **RHC TA Series**; this link provides information about the work supported through NARHC, including the listserv and the conference call series. Archived conference call information is available, as is information and links for calls conducted from July 2008 through the present. SORHs should sign up for the listserv and the ORHP conference call series sponsored by ORHP. Enrollment information is located on the ORHP page, as well as the NARHC page.

National Association of Rural Health Clinics: RHC technical assistance calls and the listserv maintained by NARHC are valuable assets to RHCs and SORHs. SORHs should encourage RHCs to sign up for the listserv and conference calls by going to either the ORHP web page or the NARHC site. The NARHC home page provides an invitation and prompts for signing up to the NARHC listserv. There are other resources available through NARHC; the website provides links to those.

National Rural Health Association: The National Rural Health Association (NRHA) is a national nonprofit membership association made up of diverse individuals and organizations that share the common bond of an interest in rural health. For NRHA members, assistance is available via the NRHA annual meeting and a fall Rural Health Clinics educational meeting. For information about dues, membership benefits and RHC resources go to <http://www.ruralhealthweb.org/>

Rural Assistance Center: Most RHCs can benefit from assistance and information offered by the Rural Assistance Center (RAC). RAC provides a list of frequently asked questions for RHCs and links to various websites and documents useful to existing RHCs, practices considering becoming an RHC or SORH staff interested in learning more about the RHC program. SORH staff should become familiar with the types and scope of information available at the RAC website.

National Health Service Corps: RHCs can become eligible for recruitment and retention assistance from the National Health Service Corps (NHSC) either through loan repayment or the assignment of an NHSC scholar. State Primary Care Offices (PCOs) should be able to provide information about how RHCs can be eligible for assistance through the NHSC. SORHs and RHCs can also review the [NHSC website](#).

NARHC hosted a webinar on May 11, 2010, as part of the ORHP supported TA/T. A fact sheet was developed for RHCs and is included in the resources section of this module, and of Module 2. The NHSC resources for which RHCs can become eligible are very valuable; SORHs are encouraged to fully investigate this opportunity to assist with the primary care safety net for which RHCs are major assets. Information on how the NHSC can assist RHCs is located in the ***Communities*** section of the [NHSC website](#).

Centers for Medicare and Medicaid Services: One of the features of the Centers for Medicare and Medicaid Services' (CMS) website is its [Rural Health Clinic Center](#), which links users to a plethora of RHC-related regulations; the RHC legislation itself; information about billing, enrollment, CMS manuals, payment manuals; and many, many other links, resources and topics. The website also provides free information, technical support and assistance. SORHs should know the CMS site exists and what information is available so they can refer RHCs to the CMS page for TA/T resources.

RHC Fiscal Intermediaries (FI) and Medicare Assistance Centers (MAC) should also provide free consultation and technical assistance to RHCs.

The Rational for Technical Assistance and Training Provided by SORHs to RHCs

SORHs throughout the nation provide varying levels of TA/T to Rural Health Clinics. Some SORHs are interested in developing more expertise and making more TA available to the RHCs; some are actively working to develop their internal expertise; some are partnering with other SORHs to make RHC TA/T more widely available. This interest in assisting RHCs comes at a critical time in the evolving health care marketplace.

Within health reform, a major area of interest and concern is whether communities have the primary care infrastructure required to expand services to the millions of people who have been uninsured. For those who have been uninsured for a long time, there is likely a great need for preventive screenings, as well as for diagnosis and treatment of chronic diseases and other health issues. Most of this type care is managed by primary care providers.

In rural communities the concern is even more acute as rural America does not have the number and distribution of primary care providers needed. Though about 25% of the United States population lives in rural America, only about 10% of all physicians practice in rural America.¹

RHCs are a valuable part of the healthcare safety net in rural America. While RHCs do not receive federal operational subsidies (grants) like Federally Qualified Health Centers (FQHCs), RHCs do provide access to primary care for Medicaid and Medicare beneficiaries, to people with private health insurance and to the uninsured. Many use a sliding fee scale or discounted fee schedule to assure people who live in poverty can still receive access to primary care. Because of the value of the RHCs, SORHs are working harder than ever to provide assistance and support to RHCs so RHCs will remain in business and continue to function as part of the safety net.

Need for Assistance in Developing RHC Technical Assistance

There is considerable variation in the scope, type and depth of TA or training offered by SORHs to RHCs. Because of the interest of many SORHs and the expertise of some, NOSORH embarked on a project to help SORH either begin providing TA/T, consultation or referral or increase the amount and scope of TA/T currently provided.

In mid-2009, NOSORH asked SORHs to describe the type of TA/T they provide RHCs, topics covered and tools used. Eventually, ten SORHs provided the information requested and agreed to provide guidance to the project. These states were/are providing significant TA to RHCs and are donating their time and expertise to help guide the development of TA/T modules to help other SORHs develop technical assistance and training resources.

The ten offices identified the types of TA they were providing. This initial listing revealed the tremendous scope and type of assistance already available, as well as the type of expertise resident in these ten SORHs. Types of TA currently being provided included:

- √ Communication and Advocacy for RHCs
- √ RHC Development
- √ Strengthening and/or Expanding Existing RHCs

Services being provided by the ten SORHs serving on the Advisory Team include the following. Not all of the SORHs provide all of these services, but most provide some service in each type and sub-type.

Type I: Communication and Advocacy for RHCs

- **Communication and Promotion**
 - Distribution of information via website, email or newsletter
 - RHC Toolkit
 - RHC conferences or workshops
 - TA conference calls and/or Webinars
 - Site visits to RHCs or potential practices
 - Membership support for NARHC or state RHC Associations
 - RHC program promotion or marketing to non-RHC primary care practices
 - Point of contact for RHC issues and questions
- **Advocacy or Education**
 - Advocacy at the local, state or national level
 - Work with state survey agencies (see Module 2)
 - Work with Medicaid on reimbursement issues
 - Facilitation with other state agencies or offices

Type II: RHC Development

- **Decision to Apply, Survey and Certify**
 - Economic impact analysis
 - Financial feasibility study
 - Assistance with conversion to RHC
 - Data analysis for eligibility
 - Designation issues
 - Mock survey
 - Policies and Procedure Manual
 - Ownership decisions
 - Annual RHC evaluations
 - Medicare enrollment
 - Change of ownership
 - Post-survey plans of correction
 - Qualitative assessment
 - Quality Assessment and Performance Improvement (QAPI)
 - Projected interim cost report

Type III: Existing RHCs – Strengthening and Expanding

- **Fiscal**
 - Financial Policies and Procedures
 - Budgeting
 - Accounting Systems

- Billing Systems
- Coding
- Managing Accounts Receivable
- Fee Schedules
- Sliding Fee Scales (or discounted fee schedules)
- Cost reports
- **Administrative**
 - Personnel Policies and Procedures
 - Staffing
 - Organization Chart
 - Position Descriptions
 - Management and/or leadership skills
 - Strategic Planning
 - Marketing, outreach
 - Staff training – various
 - Ownership, governance
 - Board training
- **Clinical**
 - Quality Improvement
 - Best practices
 - Coding practices
 - Provider relations
 - Provider recruitment and retention
 - Continuing education
 - Credentialing
 - RHC Provider enrollment
- **Information Systems**
 - Health Information Technology
 - Patient registration, eligibility
 - Patient appointments
 - Electronic Medical Records
 - Clinical tracking
 - Management Information Systems
- **Other**
 - Annual RHC evaluations
 - Consortium or network development, management
 - Emergency preparedness
 - Pharmacy assistance programs
 - Migrant, seasonal farm workers
 - Grant development

SORH RHC TA Capacity Development and Priority Assessment

Using the information provided by the Advisory Team members, NOSORH designed a survey to be distributed to all SORHs. In April and May 2010, all SORHs were surveyed to determine what services are currently provided to RHCs, what services SORH are not providing but are considering developing, and what services SORHs are not considering developing. The Survey Summary results are included in the Resources section for this module and on the NOSORH website; the actual survey is also posted on the NOSORH web site. SORHs are encouraged to review the full result summary.

Thirty-eight (38) states responded to the NOSORH SORH TA survey as of mid June 2010. The survey queried current TA services provided to RHCs and asked if the SORH does not currently provide a specific service is the SORH currently developing the service or does the SORH intend to develop the service in the next two years.

The amount and scope of technical assistance and outreach provided to RHCs by SORHs is wide ranging. For example, 91% of the SORHs responding to the survey note they either routinely or currently provide TA to RHCs in their state, while 48.5% of the respondents state they routinely or currently provide assistance to RHCs by distributing information via the SORH website. Of those who are not currently providing RHCs information via the SORH website, 71.4% are either developing that capacity or intend to do so in the coming two years.

The RHC survey (see Module 2 and the RHC Survey Summary results posted on the NOSORH website) identified RHC TA needs. It is clear that some SORHs already provide TA the RHCs noted they needed, especially when practices were developing their RHC. For example, RHCs needed assistance with data analysis for eligibility, shortage area designation aid and help with the state survey agency. These are services SORHs could develop fairly easily by working with the state Primary Care Office and by developing rapport with the state survey agency staff.

SORHs could develop other TA services, education or outreach initiatives for RHCs without large investments in staff or direct funds. For example, every SORH could, at a minimum, develop and maintain a mailing list (or e-mail list) of RHCs. The CMS list discussed in Module 2 is available, by state and updated frequently. SORHs could use the CMS list to contact all the RHCs in the state to introduce themselves, provide information about the SORH website and offer to include RHCs in training offered by the SORH agency or SORH home institutions and partner training. SORHs could provide information in the initial contact letter or e-mail about the free resources outlined earlier in this module and in Module 2, particularly the listserve and TA calls offered by ORHP through the NARHC.

Full results of the SORH RHC TA survey are provided to inform SORH what colleagues in other states are doing to assist RHCs or are planning. Again, the successful implementation of the Affordable Care Act of 2010 is reliant on a strong primary care system. SORHs can assist with strengthening the safety net of

primary care providers by assisting RHCs. SORHs should consider RHCs partners in improving and increasing access to primary care for rural residents and make connections for RHCs with other state, regional and federal partners.

The SORH survey asked about current work being done with RHCs, as well as about the SORH development priority. Reviewing the responses reveals broad interest in RHC development.

Options for Staff/Resource Development for RHC Technical Assistance and Training

As SORHs consider the level of TA they want to develop and the timeline for development, offices will consider a variety of options such as contracting with a more experienced SORH to assist with development of expertise or tools. SORHs also could ask NOSORH directly for assistance developing TA. Building in-state SORH TA capacity is the preferred and recommended approach because in-state consultation is considered the most available and useful to RHCs. This is the best path for SORHs to pursue for many reasons: many important primary care resources and relationships are state based; there is such variation among states in the rural primary care environment; and HRSA has at least two points of contact in each state for primary care development, i.e. the SORH and the Primary Care Office. Most states also have a state primary care association and some states have a state rural health clinic association.

The NOSORH Advisory Team, of course, acknowledges the current economic and state revenue situation in most states and the SORH's burden of maintaining priority services and how that reality impacts developing and maintaining services. On the other hand, now is a good time for development as states are currently eligible to apply for resources from DHHS, ORHP and other offices within HRSA to expand capacity especially in primary care development.

Even with building internal SORH TA/T capacity, there are still several considerations about hiring new staff and if so what type staff to hire, how to train them, how to market services, whether or not to charge for services and if so, how much.

Some SORHs currently providing RHC TA started their service by hiring experienced practice management consultants experienced with RHCs rules and regulations and then making the consultants immediately available to the RHCs. Other SORHs started by assigning RHC work to staff with field experience, such as those who work with Critical Access Hospitals, staff who have a strong fiscal or healthcare billing background (or knowledge), or staff with clinical expertise.

SORHs have learned that keeping staff skills working with RHCs honed and up to date is essential. Providing TA/T staff with learning opportunities and providing flexibility to learn, grow and be available to RHCs and rural primary care providers is essential.

Numbers and Types of SORH Staff Assigned to RHC Technical Assistance and Training

The SORH RHC TA survey revealed a lot of interest in developing more RHC TA/T resources. Question 13 asked “How many FTEs in your Office are currently assigned to work on RHC services?” Thirty SORHs responded; the range of FTEs was from a low of .1 FTE (about 4 hours a week) to six FTEs. Other responses follow.

- ⇒ Hard to say. The FTE it is one of many duties of the Flex Coordinator.
- ⇒ Part of my SORH Director duties.
- ⇒ 4 Field Staff; 2.5 Recruitment; 4 Migrant Farmworker; 1 Designations; 5 Medication Assistance Program
- ⇒ Between HPSA, RHC preparation for certification, recruiting, payment and other TA – it may total 1 FTE. But many people make up the one FTE.

The total number of FTEs reported as assigned to work with RHC services is 21.35 FTEs, according to the 30 SORHs providing a numeric response to Question 13.

The SORH members of the Advisory Team provided information on the background and training of some the TA staff in their offices. The array of expertise and background experiences include clinically trained staff (i.e. one staff member is a nurse), administrative training, a retired Medicaid official with many years of RHC program experience, two states hired (or contract with) practice management consultants or people with primary care practice experience, one staff person is a certified medical coder.

Why Some SORHs Invest in Technical Assistance/Training for RHCs

As healthcare reform is implemented and as a result of the economic and job environment in many rural communities, RHCs are essential assets in providing needed primary care. By definition, RHCs are primary care providers located in medically underserved rural areas. Developing avenues to strengthen RHCs through providing TA could be a priority activity in states where little TA has been provided in the past to these essential primary care providers. Helping communities understand resources available to their rural community is a pressing issue and adding RHC development to the SORH portfolio of resources and assistance is important and could be extremely helpful. Understanding and explaining clearly the differences and similarities between RHCs and Federally Qualified Health Centers, for example, is a subject some SORHs are currently helping rural providers and communities understand.

Some states have a long history of providing assistance to RHCs. The North Carolina Office of Rural Health and its founding director, Jim Bernstein, were instrumental in drafting the Public Law 95-210 legislation and then working with Congress to get the law passed in 1977. The legislation’s “two main goals: improve access to primary health care in rural, underserved communities; and promote a collaborative model of health care delivery using physicians, nurse practitioners and physician

assistants”² defined a primary care practice model that Jim Bernstein and others thought would work. They were right. RHCs today still provide access to primary care throughout rural America using the practice model first described in the legislation. The requirement that RHCs had to use physician extenders, i.e. physician assistants and nurse practitioners, helped solidify those provider types and helped extend primary care to vulnerable populations – primarily rural Medicaid and Medicare beneficiaries.

During a May 2010 meeting of the Advisory Team, SORH members were asked why they invest in providing RHC consultation. The responses are varied, as well as motivating. Representatives from the Advisory Team offered the following reasons why they elected to invest in extending TA, training, consultation and other assistance to RHCs in their state.

- There are a lot of RHCs in the state
- Outcry from RHCs, mostly for help in completing cost reports.
- No good resources to help RHCs in the state.
- RHCs are truly rural. The providers and staff are familiar with local issues and often live in the community. Also, RHCs contribute to and support the economy base of the rural community.
- No one was providing great service and so there was a void the SORH could fill.
- A private consultant had been doing most of the cost reports in the state and suddenly his services were no longer available. The SORH was asked to act.
- The SORH began providing consultation and practice management assistance through a Robert Wood Johnson Foundation grant titled Southern Rural Access Program. From the work, supported by RWJF, and from being present in rural communities providing consultation and workshops, the demand for RHC consultation grew.
- SORH recognized a void in appropriate coding in RHCs as it was help frequently requested. From that root, coding workshops grew. Currently the state assists staff in some RHCs to become certified coders. Building the coding expertise in even a few rural communities is considered especially relevant and very helpful.
- RHC work is beneficial and is the cornerstone for the work for the SORH. The approach was (and is) go out and do the work and help rural providers.
- Communities want to keep primary care in their area and RHC designation has been a key approach to helping communities, primary care providers and the population. Often RHC certification was the only opportunity available or the only opportunity that fit what the providers and communities wanted to retain.
- RHCs and FQHCs are both options in some rural communities, especially now with the growth in the resources available for FQHCs. Both models are explained and offered to communities and the

choice is left to the community leaders and providers. The SORH provides assistance with both or either model as the Office's goal is to help extend access to primary care.

- RHC designation and TA fit well within the mission of the SORH and the needs of rural communities.
- Developing technical assistance was possible through the flexibility of funding sources, problem solving, SORH leadership and creative thinking.
- There was a need for consultation and assistance and no one was filling it so the SORH stepped in to help.
- Rural primary care practices were struggling with working with state surveyors and trying to follow the federal requirements. Through listening to rural providers, the need for direct assistance was recognized and then a plan was developed for providing assistance.
- Began providing TA because it made business sense. RHCs or rural practices need the help, RHCs are an effective, efficient model for providing primary care and so the need and the opportunity to assist made providing TA compelling.
- RHCs do not have status working with either the federal government or the state government. They needed advocacy help as well as technical support. The FQHCs in the state are very powerful and they have a lot of assistance from the state's primary care association and the National Association of Community Health Centers. RHCs are not eligible for membership in the state PCA. There was a void.
- There was a need for a bridge between the state surveyors and the potential RHCs and RHCs. The SORH was a natural choice for bridging the gap and helping (again) increase access to care in rural communities.
- RHCs are local businesses. Health services dollars are desperately needed in rural communities. Helping RHCs is helping rural development and the rural economy. Helps keep jobs locally.
- Working with RHCs is very beneficial because it gets the SORH into the communities. In turn, then RHCs and rural communities get a conduit into the state. State officials can then see communities and primary care providers from a larger picture perspective and begin to think about what else RHCs could do to help the state meet objectives, i.e. immunizations pneumococcal vaccination, cancer screening, diagnosis and treatment of chronic diseases, etc.
- Why help RHCs? Because that's what we do in the SORH. We help rural providers.
- The SORH is making some money or breaking even providing TA and training to RHCs. RHC services is the first break-even program.
- SORH charges for RHC workshops, TA, cost reports, coding expertise
- Potential to document best practices and/or help clinics improve their quality of care as site visits are made and doors opened.

- We are helping RHCs with benchmarking their performance. We use the Medicare audit tool to plot coding profile and then compare with national profile
- The SORH wants and needs to retain primary care providers in rural communities. RHCs are a way to do that. For those reasons, the SORH developed resources to help RHCs be strong and viable and helped developed RHCs when the improved reimbursement could make the difference in retaining services or developing services.

Basically, the underlying rationale is two fold – there was/is a need and the SORH exists to assist rural providers, communities and others to meet needs and help ensure access to health care in rural America.

What Are Barriers to Investing In and Providing TA to RHCs?

The SORH RHC Survey asked about obstacles to providing TA to RHCs. During the May 2010 meeting of the Advisory Team, barriers to developing and continuing RHC TA services were noted. Below are comments taken directly from those both sources.

Question 11 of the SORH RHC TA Survey asked respondents to “describe obstacles to providing TA or developing new TA services for rural health clinics in your state.” A checklist of obstacles was provided and respondents were asked to check all that apply. Space was also provided to list other responses.

Obstacles Options from the April/May 2010 SORH RHC TA Survey	Response %	Response Count
No (or not enough) funding to provide additional TA to RHCs	76.7%	23
Not enough staff to provide the TA we provide now	70%	21
No expertise to provide TA	53.3%	16
Another entity with the necessary resources provides TA to RHCs	26.7%	8
No support from authorities in our organization to provide additional TA	10%	3
There is no substantial need for RHC TA in our state	10%	3

Thirty SORHs answered the above question; additional comments included.

- No time to develop materials.
- No RHCs in the state (New Jersey).
- I feel that I would need more in-depth training in RHC related items such as billing and regulations before I’m comfortable being the “go to” person in the state.
- Not enough staff to increase the level of TA provided.

Clearly, insufficient resources are the major obstacle to providing RHC TA services from the SORH staff completing the survey. The responses do not reveal either a lack of need or that the need for TA is being met by another group.

Other obstacles or barriers mentioned by Advisory Team members:

- Lack of sustainable funding
- All the services are grant funded
- Trying to collect money RHCs owe the SORH for services provided is uncomfortable.
- Barrier is having the resources to hire staff and also to pay for travel and other expenses for the staff providing TA to RHCs. Tight budgets are threatening the TA and consultation service.
- A barrier for our SORH is that we have to charge for services to RHCs. A lot of people would like to have the service, and could benefit, but the SORH can't provide services without payment. There is a lot that is needed and could be done but not without resources.
- The state is large and travel is expensive so both of those are barriers. Currently we are exploring more web based opportunities. Trying to develop and market web based consultation.
- Very concerned about the economy and the threat that the SORH may lose staff and thus momentum in this important work.
- Travel expenses are a real barrier.
- RHCs want the SORH to help with cost report but the SORH does not feel comfortable with that level of work. Could be an area for growth of the program but it would take a lot of work and sustained effort.
- How can the SORH get out in front of independent RHCs? Outreach to RHCs is expensive.

Additional Observations from Advisory Team members include:

- Developing relationships with state survey people took longer than expected but now the relationship is excellent.
- RHCs are efficient and with a little help they can be even more efficient.
- The SORH now works closely with the state health standards staff (i.e. survey staff). Health Standards staff say the SORH is helping them a lot.
- Medicaid and the state survey people used to not like to work with RHCs at all. Now that the SORH is involved that is changing with both groups. Medicaid staff now routinely refer RHCs to the SORH for assistance.
- Helping more office managers develop their skills and providing certification opportunities for coders in RHCs are both avenues the SORH is pursuing, as it improves the RHC service and builds the skills of workers in rural communities.
- There are real training and development needs for RHC staff. There is a significant need for office manager training and a standardized class could be developed. The office managers need

broad training, including basics such as introduction to health care terms, the health care marketplace and the national and state environments. There is no consistent training or orientation for these staff. The turnover is high and it is very expensive for the practice. NOSORH could consider development of a RHC staff orientation or introduction curriculum.

- When workshops are sponsored by the SORH, we hire the best trainers possible. RHCs could not afford this type training unless highly subsidized by our SORH.
- We attempt to provide workshops in rural communities throughout the state to cut down the expense of travel for RHC staff. Leaving clinics for travel to workshops puts a big burden on the small RHC but they desperately need training.
- It would be very helpful for the Office of Rural Health Policy to provide targeted funds for RHC consultation and a requirement that SORH provide consultation.

Steps to Consider When Developing RHC Technical Assistance Services

Reasons why SORHs develop and provide RHC TA services are compelling, as is the concern and difficulty of the work as outlined in the sections above on obstacles and barriers. The other comments section above is provocative and reveals a deep level of thought and work invested by SORHs in developing, fielding, building and maintaining consultation services for RHCs.

The difficulty of hiring or re-assigning staff, developing expertise and then providing and evaluating the quality of the TA provided are daunting tasks. The level of need expressed by the RHCs (see Module 2) and the considerable thought many SORHs have invested in beginning, expanding or maintaining the level of consultation provided to RHCs is obvious.

Simple steps and suggestions follow for SORHs that want to begin providing assistance to RHCs. Other modules, workshops or Webinars are planned by NOSORH and will be forthcoming.

RHCs were asked through the RHC TA survey if they know staff in their SORH; fifty-five percent (55%) said yes. This percent could and should be higher. By taking a few simple steps, it could be.

Suggested Steps:

1. Develop a mailing list from the CMS list posted on the CMS website.
2. Ask for a map of the RHCs in the state from NOSORH developed for this project. (Keep in mind that both the list and map are only correct as of the date on the document.)
3. Send an introductory letter to RHCs. Provide overview information about the SORH, contact information and invite them to use the SORH web site. Include in the letter, information about the ORHP supported services available free through the NARHC and provide a link to the ORHP

and NARHC web site, with simple instructions on how to access the link. Link them with the RAC.

4. Read these three modules again. Read specified sections from the *Starting a Rural Health Clinic: A How-to Manual*.
5. Schedule an introduction and orientation meeting with the State Survey staff.
6. Ask for an orientation session with the PCO staff. Ask them what help they provide RHCs and how they assist RHCs become NHSC sites. For example, do they help RHCs develop a sliding fee scale? Are they interested in developing a small RHC work group to determine what could be easily offered to RHCs that would help retain primary care services?
7. Review the Summary Results of the RHC TA survey and the Summary Results of the SORH RHC TA survey and share results with other state partners.
8. Develop a workplan for RHC workshop or consultation service expansion. Develop a business plan for RHC services. Ask NOSORH for assistance with developing a business plan.
9. Review which SORHs provide RHC services and then ask NOSORH for mentoring resources to work with a fellow SORH.
10. Consider contracting directly with fellow SORH for faculty for RHC workshops or for help training you and your staff. Members of the NOSORH Advisory Team are very willing to assist with training, developing expertise, advising on staffing and each member is committed to helping SORH succeed with this RHC work. Contact an Advisory Team member for assistance or contact NOSORH directly and ask for support.
11. Review your Flex budget and determine how RHC support fits with Flex objectives.
12. Develop an evaluation plan to accompany the business plan. Think about how to move forward, as well as how to determine if the investment made in RHC services is meeting the objectives set.
13. Start. Start small if necessary, but start. Take the first step.

Conclusion

The current, precarious economic situation in many rural communities makes ***now*** a compelling time to start work designed to enhance RHC primary care services in rural areas. There are federal HRSA resources available to assist with primary care development, as well as with primary care workforce development. The National Health Service Corps (NHSC) has never been so well supported and funded.

For rural communities to benefit greatly from this influx of federal resources, the SORH must be fully engaged. SORHs can be gate openers for RHCs and other primary care practices. Starting work to

develop RHC services can begin with an introduction. The needs of RHCs have been documented through the NOSORH RHC Survey. Opportunities exist for building resources and creative, thoughtful work can be done.

¹ Healthy People 2010: A Companion Document for Rural Areas (<http://www.srph.tamhsc.edu/centers/rhp2010/Volume1.pdf>)

² *Starting a Rural Health Clinic: A How-to Manual*, HRSA Office of Rural Health Policy, National Association of Rural Health Clinics, April 2004, page i.



NHSC AND HPSA DESIGNATION

NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS TECHNICAL ASSISTANCE CALL

Andy Jordan
U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions

May 11, 2010



TYPES OF SHORTAGE DESIGNATIONS

- HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA) AND POPULATIONS
- MEDICALLY UNDERSERVED AREAS (MUA)
- GOVERNOR'S CERTIFIED SHORTAGE AREAS
- AUTOMATIC FACILITY HPSAS



HOW ARE THEY USED?

Shortage Designation Option	National Health Service Corps	Federally Qualified Health Ctr Program	CMS Medicare Incentive Payment	CMS Rural Health Clinic Program	J-1 Visa Waiver
Primary Care HPSA	X		X	X	X
Dental Care HPSA	X				
Mental Health HPSA	X				X
Geographic HPSA	X		X	X	X
Population HPSA	X			X	X
Facility HPSA	X				X
Automatic Facility HPSA	X				X
Exceptional MUP		X			X
Medically Underserved Area		X		X	X
Medically Underserved Population		X			X
State Governor's Certified Shortage Area				X	



IMPORTANT REMINDER!!!

- New CMS regulations require that the shortages areas used for RHC eligibility must be **“UPDATED WITHIN THE CURRENT YEAR OR THE PREVIOUS 3 YEARS”**.
- Sites need to be aware of the most recent date of their designation; this can be found on our web site www.bhpr.hrsa.gov/shortage
- Office of Rural Health Policy is supporting assistance for designations through NARHC
- Assistance can also be obtained from the Primary Care Offices in each state; check www.bphc.hrsa.gov/osnp/PCODirectory.htm



AUTOMATIC FACILITY HPSAS

- **Health Care Safety Amendments of 2002 allow for the automatic designation as HPSAs of Rural Health Clinics which met certain requirements. Key elements include:**
 - **Services cannot be denied to individuals unable to pay for services or those covered by Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)**
 - **Site must have a schedule of fees and corresponding discounts adjusting for ability to pay**
 - **Sites must accept Medicare assignment and assure coverage for Medicaid and SCHIP beneficiaries**



HOW DO YOU GET AUTOMATIC HPSA STATUS?

- Initial letter and Certification form mailed to RHCs in August 2003; individual requests since then
- As of 4/20/10, 800 sites have returned the forms and been designated as Automatic HPSAs
- Automatic HPSAs are entered into the data base and appear on the SDB Web Site
- For a copy of the certification form, contact Tracey Martin at tmartin@hrsa.gov.



HOW DO YOU GET AUTOMATIC HPSA STATUS? (cont.)

- RHC Certification must be confirmed before auto HPSA status is granted. New sites that apply will be checked against CMS lists to confirm RHC status; if they are not on the latest list we have, other documentation of certification will be required
- HRSA is working with CMS to discuss how to incorporate these requirements into the periodic site reviews conducted by the Survey and Certification staff



WHY WOULD YOU WANT AUTOMATIC HPSA STATUS?

- You might become eligible for for NHSC or State Loan Repayment recruitment assistance if you are not currently in a regular HPSA
- It **CANNOT** be used for initial or continued eligibility for RHC status



How Can I find Out Where HPSAS Are??

- FIND HPSA BY STATE AND COUNTY: <http://hpsafind.hrsa.gov/>
- FIND SHORTAGE AREA BY ADDRESS:
<http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>
- HRSA GEOSPATIAL WAREHOUSE
 - <http://datawarehouse.hrsa.gov/>
 - Quick Access Reports
 - Find Shortage Areas
 - HPSAs by State and County

Note: Advanced selection will give dates of designations too

THESE DATA ARE UPDATED DAILY, SO THEY REFLECT DESIGNATIONS AS THEY ARE COMPLETED. THIS IS THE BEST WAY TO CHECK ON THE STATUS OF A HPSA

HPSAFIND

Find Shortage Areas: HPSA by State & County - Microsoft Internet Explorer

Address: http://hpsafind.hrsa.gov/

Viewpoint | Web Search | Amazon | Search Results | Bookmarks

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Find Shortage Areas: HPSA by State & County

Shortage Designation Home

Find Shortage Areas

HPSA & MUA/P by Address

HPSA Eligible for the Medicare Physician Bonus Payment

MUA/P by State & County

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population. [More about shortage areas](#)

Updated 2/11/2009

[Advanced search by HPSA Type, Score, Metro, and Status](#)

Find a Designated HPSA: Choose a State, County & Discipline

State	<input type="text" value="Select a State"/>	First, choose a State.
County	<input type="text"/>	Now, choose All Counties, one county or each of the counties you wish to search. To select more than one County, hold down the Ctrl key while making your selection
Discipline	<input type="text" value="Primary Medical Care"/> <input type="text" value="Dental"/> <input type="text" value="Mental Health"/>	Finally, choose a discipline. To select more than one discipline, hold down the Ctrl key.

Done | Local intranet

start | AIM | Inbox - Micro... | QW53270 PL... | 2 Microsoft ... | 2 Internet E... | 8:44 AM



HPSAFIND REPORT

HPSA - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Favorites Refresh Print

Address <http://hpsafind.hrsa.gov/HPSASearch.aspx>

Designated	Population Group						
031 - COVINGTON COUNTY							
COVINGTON	128031	Designated	Single County	5.7	0.7	7	06/29/2004
033 - DESOTO COUNTY							
DE SOTO	128033	Proposed Withdrawal	Single County	42.8	0		12/19/2005
HERNANDO	1289992835	Withdrawn	Geographic Area	2.0	0		05/30/1997
C.T. 0709.00		Withdrawn	Census Tract				
C.T. 0710.00		Withdrawn	Census Tract				
C.T. 0711.00		Withdrawn	Census Tract				
C.T. 0712.00		Withdrawn	Census Tract				
035 - FORREST COUNTY							
FORREST	128035	Undetermined	Single County	66.0	0		06/02/1988
EAST LEAF RIVER	1289992837	No New Data	Geographic Area	3.0	2.0	12	06/27/2003
C.T. 0001.00		No New Data	Census Tract				
C.T. 0004.00		No New Data	Census Tract				
C.T. 0005.00		No New Data	Census Tract				
C.T. 0006.00		No New Data	Census Tract				
C.T. 0105.00		No New Data	Census Tract				
SOUTHEAST MS RURAL HLTH INITIATIVE	1289992847	Designated	Community Health Center			10	07/15/2003
037 - FRANKLIN COUNTY							
FRANKLIN	128037	Designated	Single County	2.4	0.4	7	08/14/2003
039 - GEORGE COUNTY							
GEORGE	128039	Proposed Withdrawal	Single County	6.0	0		02/17/2005
041 - GREENE COUNTY							
GREENE	128041	Designated	Single County	1.8	1.4	14	06/22/2004
GREENE AREA MEDICAL EXTENDERS, INC.	1289992854	Designated	Community Health Center	1.0	3.0	13	10/26/2002
043 - GRENADA COUNTY							
GRENADA/YALOBUSHA	1289992821	Withdrawn	Geographic Area	11.6			05/07/1987
GRENADA		Withdrawn	Single County				
045 - HANCOCK COUNTY							
LOW INC - HANCOCK	1289992850	Designated	Population Group	3.8	1.2	6	06/14/2004
HANCOCK		Designated	Population Group				
047 - HARRISON COUNTY							
LOW INC - HARRISON	1289992802	Designated	Population Group	15.5	6.3	6	02/02/2005
HARRISON		Designated	Population Group				

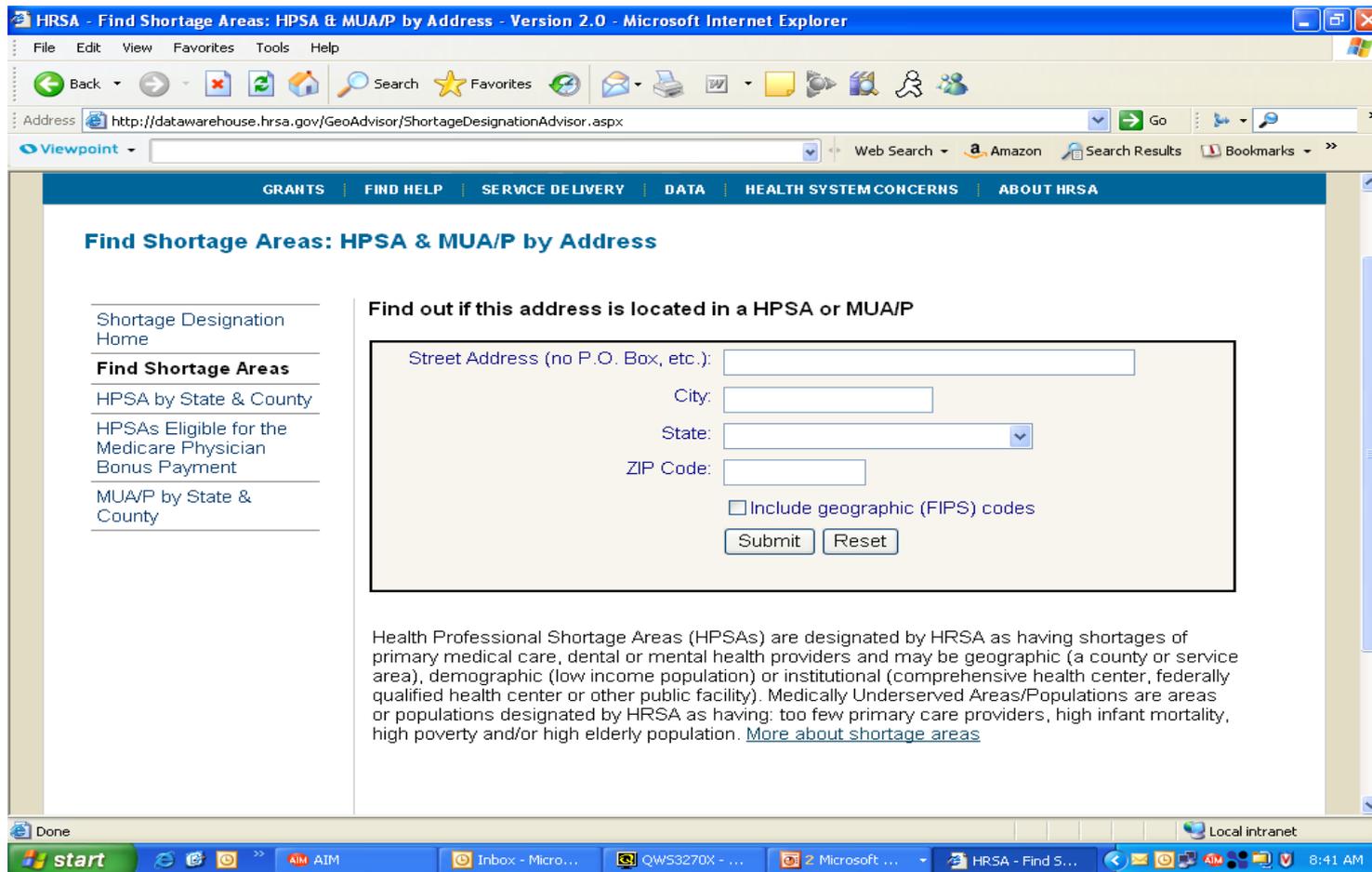
Done Internet



How Do I Find Out If a Site is in a HPSA ?

- FIND SHORTAGE AREA BY ADDRESS:
- <http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>
- STATUS MUST BE “DESIGNATED”

HPSA FIND BY ADDRESS



The screenshot shows a web browser window titled "HRSA - Find Shortage Areas: HPSA & MUA/P by Address - Version 2.0 - Microsoft Internet Explorer". The address bar shows the URL: <http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>. The page has a navigation menu with links: GRANTS, FIND HELP, SERVICE DELIVERY, DATA, HEALTH SYSTEM CONCERNS, and ABOUT HRSA. The main heading is "Find Shortage Areas: HPSA & MUA/P by Address". On the left, there is a sidebar with links: Shortage Designation Home, Find Shortage Areas, HPSA by State & County, HPSAs Eligible for the Medicare Physician Bonus Payment, and MUA/P by State & County. The main content area has the heading "Find out if this address is located in a HPSA or MUA/P" and a form with the following fields: Street Address (no P.O. Box, etc.): [text input], City: [text input], State: [dropdown menu], ZIP Code: [text input], and an unchecked checkbox for "Include geographic (FIPS) codes". There are "Submit" and "Reset" buttons at the bottom of the form. Below the form, there is a paragraph of text explaining HPSAs and MUA/Ps, with a link to "More about shortage areas". The Windows taskbar at the bottom shows the Start button, several open applications, and the system clock displaying 8:41 AM on 8/11/2009.



HPSA FIND BY ADDRESS REPORT

HRSA - Find Shortage Areas: HPSA & MUA/P by Address - Version 2.0 - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address <http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>

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Find Shortage Areas: HPSA & MUA/P by Address

Shortage Designation Home

Find Shortage Areas

HPSA by State & County

HPSAs Eligible for the Medicare Physician Bonus Payment

MUA/P by State & County

Reported location: 1334 N Lansing Ave, Tulsa, OK 74106
(---- Input location: 1334 N. Lansing, Tulsa, Oregon 74106)

[Start over with a new query by address](#) 

In a Primary Care Health Professional Shortage Area: Yes	
Primary Care HPSA Name:	North Tulsa
Primary Care HPSA ID:	1409994007
Primary Care HPSA Status:	Designated
Primary Care HPSA Score:	17
Primary Care HPSA Designation Last Update Date:	09/22/2003
In a Mental Health Professional Shortage Area: No	
In a Dental Care Health Professional Shortage Area: Yes	
Dental Health HPSA Name:	North Tulsa

Done Local intranet

start AIM AIM Inbox - Micro... QWS3270 PL... 2 Microsoft ... HRSA - Find S... 8:42 AM



Contacts

Andy Jordan

Director, Office of Shortage Designation

Bureau of Health Professions

HRSA

301-594-0197

ajordan@hrsa.gov

SORH Survey Of Work with RHCs



2010

SORH Survey of Work with RHCs

- Sent to all SORH Directors in early May 2010
- 38 States completed the survey

SORH Survey of Work with RHCs

- 45.5% of SORHs routinely provide TA to RHCs
- 45.5% of SORHs occasionally provide TA to RHCs
- 9% do not work with RHC

Communication

Most SORHs are:

- Distributing info to RHCs via their websites
- Distributing info via email or print newsletter

Some SORHs are:

- Providing a toolkit
- Providing workshops, conferences, webinars
- Conducting site visits
- Providing TA conference calls
- Support State RHC Assn.
- Market to non-RHCs

RHC Survey & Certification

Most SORHs are:

- Data analysis for designation
- Shortage designation information

Some SORHs are:

- Economic impact analysis
- Financial feasibility
- Assist w/conversion
- Mock survey
- Policies & procedures
- Ownership decisions
- Annual Evaluation

RHC Survey & Certification, cont.

Most SORHs are:

Some SORHs are:

- Medicare enrollment
- Post-survey plans of correction
- Quality assessment & performance improvement (QAPI)
- Qualitative assessment

RHC Advocacy Services

Most SORHs are:

- Work with state dept. for survey & certification
- Advocate for SORHs
- Provide facilitation with other state agencies

Some SORHs are:

- Work w/ Medicaid to resolve reimbursement issues

Financial Services

Most SORHs are:

Some SORHs:

- Operate a billing service
- Provide coding and documentation education
- Provide capital equipment purchase ed.
- Assist with financial revenue management
- Cost report preparation

Financial Services

Most SORHs are:

Some SORHs:

- Provide Medicare and Medicaid training to billers

Clinic Management Services

Most SORHs are:

Some SORHs:

- Board orientation
- On-going board education
- Leadership skills training
- Clinic management
- Physician or clinical roundtable discussion
- Strategic planning

Other Misc. Services

Most SORHs are:

- Providing grants
- Recruitment and retention

Some SORHs:

- Emergency preparedness
- Network development
- Grant writing
- Peer review
- Pharmacy assistance
- HIT implementation

Other Misc. Services

Most SORHs are:

- Providing grants
- Recruitment and retention

Some SORHs:

- Data collection
- Working with migrant and seasonal farmworkers

SORH Survey of Work with RHCs

If you have questions or would like additional information, please contact:

Stephanie Hansen
Education Coordinator
208-375-0407
steph@nosorh.org