NOSORH CA Rural Health Clinic TA Project Report

(September 1, 2010 through August 31, 2011)

National Organization of State Offices of Rural Health
44648 Mound Road, #114 | Sterling Heights, MI 48314-1322
Phone: 586-739-9940 | Fax: 586-739-9941 | Email: teryle@nosorh.org
www.nosorh.org

NOSORH
national organization of state offices of rural health

National Organization of State Offices of Rural Health
Rural Health Clinic Technical (TA) Assistance Project
Progress Report and Future Activities

During Year 7 of the NOSORH Cooperative Agreement the National Organization of State Offices of Rural Health entered its second year of activities to build the technical assistance capacity of State Offices of Rural Health for certified Rural Health Clinics. This report will provide an overview of the activities conducted, highlights some of the lessons learned during the year, and outlines the future cooperative work of NOSORH with ORHP, its partners and State Offices of Rural Health.

BACKGROUND

The rationale for this work to increase the capacity of SORH to provide technical assistance to RHCs was based upon the success and experience of some SORH in developing understanding and capacity to work effectively with hospitals and emergency medical services through the Medicare Flex Program. The Medicare Flex Program included significant resources and expectations that states would develop capacity within the SORH to work with rural hospitals and the health system in the service area. Further, the Flex Program provided resources and expectation that SORH work directly with the state hospital association and with rural hospitals that might want to convert to the Critical Access Hospital status. Those financial resources and expectations made it possible for most SORH to develop capacity, expertise and understanding to improve the fiscal viability and quality of care offered by CAH.

At the present time the SORH are not required or specifically funded to provide technical assistance to certified Rural Health Clinics. Even though SORH do not have specific funding, expectations or requirements; some states provide significant resources to support RHCs.

ACTIVITIES

Highlights of the work and progress in this second project year include the following.

- ✓ Work was continued with the RHC Advisory Team. All AT members were asked if they wanted to continue to serve and they did. A member of the ORHP team was added to the AT. AT members participate in conference calls, review written documents, plan and make presentations, participate in webinars and provide advice and encouragement. This is an invaluable asset for the project. Agenda are developed by the NOSORH RHC consultant, sent to NOSORH staff for distribution.

- ✓ NOSORH team developed and delivered a three-part webinar series introducing and encouraging SORH to work with RHCs. Presentations materials and the audio are posted on the NOSORH web site. Attendance and participation was good; evaluations of the webinars were also good. Several states targeted for helping develop their expertise and build capacity have commented that the webinar series was very helpful and inspired work.

- ✓ The Rural Health Clinic list serve was monitored for questions which could be answered by SORH and for opportunities to alert SORH of the need for TA in their state.

- ✓ Research on certified rural health clinics was reviewed with the advisory team which documents the contribution of certified rural health clinics as safety net providers and the a huge potential that certified rural health clinics are likely to miss any targets for achieving meaningful use of electronic health records.

- ✓ NOSORH's RHC survey results were shared with researchers and other potential partners in an effort to inform future work and avoid any duplication of effort or burden on certified rural health clinics and SORH.

- ✓ The NOSORH, SORH work was represented in two NRHA RHC CG meetings, January and May 2011.

- ✓ The work of SORH and NOSORH related to RHC was presented and discussed during the spring 2011 National Association of Rural Health Clinics (NARHC) meeting. A brief overview of SORH work was presented and RHC participants were encouraged to learn about their SORH and told how to connect with their State Office of Rural Health and NOSORH.

- ✓ The consultant met with the founders of NARHC, and the president of NARHC for the purpose of identifying opportunities to build collaboration with SORH and RHCs.

- ✓ A NOSORH Board member made a presentation about SORH, NOSORH and the work of this project during the fall 2010 NARHC meeting.

- ✓ The first in a planned series of RHC Learning Community calls was conducted. The discussion was focused on how SORH reach out to and assist RHCs. The discussion was robust. NOSORH staff convened the call and facilitated it.

- ✓ Three educational modules were finalized. The modules are designed to encourage and help SORH begin to work with RHCs or re-commit to working with RHCs. Modules and recommended reading materials are posted, and linked, on the NOSORH web site. RHC work and activity was discussed during at least two of the five regional SORH conferences.

- ✓ A fourth module focused on helping SORH build upon their internal expertise to connect and strengthen RHCs work with other rural safety-net providers in their community was developed. The module was made available during the September 2011 Annual Meeting.

FINDINGS AND LESSONS LEARNED

After the May 2010 survey of SORH and a call for interest from SORH in year one, State Offices of Rural Health were targeted to measure their level of interested in developing RHC technical assistance capacity and were approached regarding that interest. Each state was contacted during the year to identify their interest to advance the level of their TA work with RHC and their level of activities. The states identified by NOSORH for additional RHC TA activity and their levels of activity are summarized in the charts that follow.

Summary of Results	
Type of change	**Number of Target States**
No change	8
Initiated a new activity	7
Initiated more than 1 new activity	1

State	Level of RHC Activity on 9/1/10	Level & examples of NEW Activity for RHC on 8/31/10 1 – same 2 – initiated a new RHC activity 3 – initiated more than 1 new RHC activity
Alabama	No or little RHC activity	3- initiated more than 1 new RHC activity Planning 4 educational contacts, medical association referring providers to SORH, interest in providing CEU, more requests are coming to office, some interest in RHC association, advocacy for RHC, survey, possible ICD-10 training
Arkansas	No or little RHC activity	2 – initiated a new RHC activity Interest in a half day workshop
Georgia	No or little RHC activity	2 – initiated a new RHC activity Hosted first RHC workshop, well attended, planning 4 educational contacts per year, GRHA included a new breakout session for RHC
Idaho	Some RHC activity	1-same Lost staff person
Louisiana	A great deal of RHC activity	2 – initiated a new RHC activity
Maine	No or little RHC activity	1-same Lost staff, interest in telepsych for RHC
Missouri	No or little RHC activity	2 – initiated a new RHC activity Lost staff, survey completed, progress with state survey and RHC association
North Dakota	No or little RHC activity	1-same
New Hampshire	No or little RHC activity	2 – initiated a new RHC activity NOSORH assisted to re-send survey of RHC
New Mexico	No or little RHC activity	1-same
Pennsylvania	No or little RHC activity	1-same Other work load has a higher priority
Ohio	No or little RHC activity	2 – initiated a new RHC activity
Tennessee	No or little RHC activity	1-same
Texas	Some RHC activity	1-same SORH in organizational transition, provided funding for ICD-10 work
Vermont	No or little RHC activity	1-same New director getting oriented
Wyoming	Some RHC activity	2 – initiated a new RHC activity

As the charts above depict, three of the states who have made progress or expressed interest are now in a holding pattern due to staff loss. Fifty percent of targeted states increased their activities for RHC. Some states made real progress during the year and are considered now as having developed RHC TA capacity.

Utilizing the Advisory Team is a really good mechanism to provide direction and feedback for the project. AT members continue to provide candid feedback. Throughout the project the TA Advisory team's ten SORHs were asked to make recommendations; describe promising practices, as well as barriers to rendering technical assistance and advantages realized from providing TA to RHCs; identify and discuss elements necessary for SORHs to start offering, or expanding, technical assistance to RHCs. The SORH providing TA to RHCs are the best encouragers of other SORH. They have sound, relevant, recent advice and they have a shared understanding of the demands of SORH. It is noteworthy that one member of the advisory team was given recognition by her peers for her contribution and sharing of expertise in working with certified rural health clinics and received the NOSORH Jim Bernstein Mentoring Award this year. However, like all SORH, their ability to contribute their time and resources is increasingly under the pressure of reduced staff and increased demands in their own SORH, which on occasion interferes with the increasing demand for their expertise to be applied to the project.

The consulting role provides additional resources for an information conduit between what some states are doing and what some SORH are considering and an information broker about what RHCs need, as well as an encourager to SORH to reach out to RHCs. This role can be expanded. There is so much variation in the SORH in not only the type and level of TA they provide to RHCs but also in the varied ways they provide it. The variations can provide a rich ground for building the capacity of SORH to serve RHC in a unique way that meets the need of any state, regardless of their level of expertise.

The intent of the first three modules developed for the project was to help SORH staff with little expertise to build and strengthen their knowledge and to establish a firm foundation on which to build and develop more advanced expertise, with the hope that SORH would feel more comfortable providing increasing degrees of assistance to RHCs within a strategy that is appropriate for the individual needs of the SORH. Despite the fact that the modules were posted to the NOSORH web site and featured during a webinar series, feedback on the use of the modules is disappointing. SORH needs for information like that provided in the modules may vary from moment to moment and certainly varies across all the SORH at any given time.

IMPLICATIONS AND ACTIVITIES FOR THE FUTURE COLLABORATIVE WORK OF ORHP, NOSORH AND THE STATE OFFICES OF RURAL HEALTH:

During Year 2 of this project SORH have increasingly reported that they must now re-consider all the work they do based on state budget cuts, staffing lay-offs or cuts, feared federal budget cuts and escalating work demands. This is occurring in the same environment where safety-net providers are even more in demand due to the poor economy, job losses and increasing levels of poverty all over rural

America. Certified rural health clinics are clearly safety-net providers and provide significant and essential primary care to Medicaid and Medicare beneficiaries. Ever escalating requirements for RHCs to be up to date on changes in the health care market place are daunting. The challenges presented by ICD-10 conversion and for RHCs to have useful electronic health records continue as major issues. RHCs are safety-net providers without a safety net or subsidy for themselves. Without specific guidance and funding, SORH find it difficult to prioritize or even establish a technical assistance capacity that is so badly needed by RHCs to serve the millions of Americans they serve every day.

FUTURE NOSORH ACTIVITIES:

The focus of NOSORH's future work will be to build on the existing base of work with a goal to ensure that all 50 State Offices of Rural Health have at least a basic level of technical assistance capacity to serve rural health clinics. The future work of NOSORH will build on partnerships with the ORHP and other rural stakeholders, the TA Advisory team, the consultant and the SORH. These recommendations for the future activities and ORHP have been vetted by the

1. Work together with ORHP to:
    - Identify a strategy that will allow for additional funding and guidance to support SORH to build their capacity to provide technical assistance to RHCs.
    - Encourage SORH to report information on their TA work with NOSORH, report it in the SORH, SHIP or FLEX grant reports, PIMS reports and in the Tru-Serve performance measures tool.
    - Target the research and strategies and build partnerships among NARHC, NRHA, TASC and the Rural Health Research Centers work to build resources and disseminate information to RHC and SORH.
    - Identify strategies for ensuring RHC support by federal agencies such as Centers for Medicare & Medicaid Services (CMS), Regional Office Rural Health Coordinators, HRSA BPHC and NHSC
    - Update the Starting a Rural Health Clinic – How to Manual, last updated in 2004

2. Focus the staff, TA Advisory Team and consulting resources for SORH to build their RHC TA capacity to:
    - Establish a mechanism including e-tools and simple fact sheets to ensure ongoing awareness and educational exchange resources, research and other resources to build capacity of SORH TA for RHC.
    - Develop and support a simple workplan with each state that has a stated interest in developing their RHC TA services.
    - Document and disseminate SORH RHC services and best practices.
    - Provide on demand technical expertise to answer RHC and SORH inquiries.
    - Prioritize the development of additional RHC TA modules (from the attached inventory of possibilities) to ensure growth of SORH educational exchange and TA capacity and focus for quality improvement and other high priorities of RHC and SORH.
    - Ensure SORH and their partners are informed of regulatory or policy changes impacting RHC and that the NOSORH policy platform specifically includes certified rural health clinics.

3. Assess the value and feasibility to develop special projects to:
    - Support a multi-state demonstration effort to help RHCs collect data.

- Explore how to help states help RHCs with ICD-10 training including negotiating with national TA firms for a break in price, providing SORH discounted fees or scholarships to send staff, helping SORH identify excellent training providers
- Conduct a feasibility analysis of how RHCs may be able to add behavioral health providers to their services.

.

Attachment 1
An inventory of proposed NOSORH RHC Technical Assistance Module Outlines – For NOSORH use Only

Content	Resource Notes
Module # 5: Assisting with Clinical Systems and Quality Improvement	
Quality Improvement Best Practices Coding Practice Provider Relations Provider Recruitment Provider Retention Continuing Education – administrative and clinical Provider Enrollment Credentialing HIT, TA Resources and Getting to Meaningful Use	 ICD – 10 Regional Extension Centers – SORH working with these to help RHCs
Module # 6: Assisting RHCs after Certification	
Completing the Projected Cost Report Securing Medicaid and Medicare Provider Numbers (PIN) Assuring understanding of RHC billing and coding issues, differences Competing the Cost Report and Reconciliation Fee Schedules, Billing Practices Annual RHC Evaluations	Starting a Rural Health Clinic – A How-to Manual, 2004, Chapter 6, 7 Practice management consultation – variety of issues Primary Care provider - retention and recruitment assistance Staff retention and recruitment assistance, including management of staff

Content	Resource Notes
Post-survey plans of correction Qualitative Assessment Quality Assessment and Performance Improvement (QAPI) Securing additional resources Sliding fee scale	Suggested format for fee schedules Cost Report Template Peer Review resources developed and adapted, as possible, from SORH material PowerPoint presentations developed by reviewing, and adapting, when possible, material from selected SORH and NARHC. Use info from NHSC webinar.
Module # 7: Providing TA to Assist in Developing New RHCs	
Areas for consideration include: Are additional RHCs needed in the state? Are practices currently providing care, in eligible locations, that could benefit from RHC development, or conversion, assistance? Are there rural communities where an RHC would be beneficial? Does the SORH work with the PCO to develop new primary care access points? Are rural primary care providers interested in developing RHCs? Are other providers interested in developing additional primary care access points? Feasibility analysis – new clinic Feasibility analysis – existing clinic considering conversion to an RHC Introductions to key state resources, including the State Licensure and Certification staff	

Content	Resource Notes
Module # 8: Assisting Practices in Making Decisions to Apply for RHC Certification	
Is the RHC program right for the practice, community or hospital (or other provider base) considering RHC development or conversion? Does the site qualify? • HPSA, MUA • Non-Urbanized Does the staff model qualify? What primary care assets are available to the community? Overview of Certification Process • Including timeline Review RHC requirements and process to apply to become a RHC Discuss Licensure and Certification State Agency, including timeline, usual areas of concern Reviewing site or office for changes required Projecting a budget, review experience or cost report Feasibility Analysis Preparing documents, including policies and procedures, budget, projected users, staff, services, hours of operation, ownership decisions Assure site meets all specifications	Name and address and process of State Survey and Certification Agency, by state Sample Policy and Procedure Manuals (Advisory Team states to send Manuals for review and adaptation) Mock Survey forms and process (Advisory Team materials reviewed, adapted or developed) Projected Cost Report - includes a template with instructions on how to review historic patient services data, fees, staffing, expenses, productivity considerations, other business concerns Washington SORH check list – Process for Becoming A Medicare Certified RHC
Module # 9: The RHC Certification Process	
Developing Documents Needed, such as: — policies and procedures, — budget, — projected users, — staff, — services,	Starting a Rural Health Clinic – A How-to Manual, 2004, Chapter 4 Starting a Rural Health Clinic – A How-to Manual, 2004, Chapter 5

Content	Resource Notes
— hours of operation, — ownership decisions Assuring site meets all specifications Filing the application Conducting a Mock Survey	Recommendations for Electronic Medical Records and other Health Information Technology needs Mock Survey forms and process (Advisory Team materials reviewed or adapted) Business and practice management resources or referrals to experienced RHC consultants, CPAs, practice management companies (based on recommendations of other RHCs in the state), etc.
Module # 10: Assisting RHCs with Financial Management	
Financial policies and procedures Budgeting Accounting Systems Billing and collecting Managing Accounts Receivable Fee Schedules Sliding Fee Scale Fee Discount Policy Cost Reporting Provider Productivity Provider contracts	
Module # 11: Evaluating Effectiveness of RHCs in Increasing Access to Care	
To be outlined and developed	Review Safety Net report by J. Gale
Module # 12: Helping RHCs Attract Public and Private Resources to Increase Access for Special	

Content	Resource Notes
Populations	
Veterans *Pregnant women and provision of perinatal services* *Mental and behavioral health* Other components - to be outlined and developed	
Module # 13: Evaluating SORH Effectiveness in Assisting RHCs	
Satisfaction surveys Needs assessments Other components - to be outlined and developed	