Innovative Strategies to Enhance Rural Health Care Collaboration

NOSORH Region A

Eastham, MA

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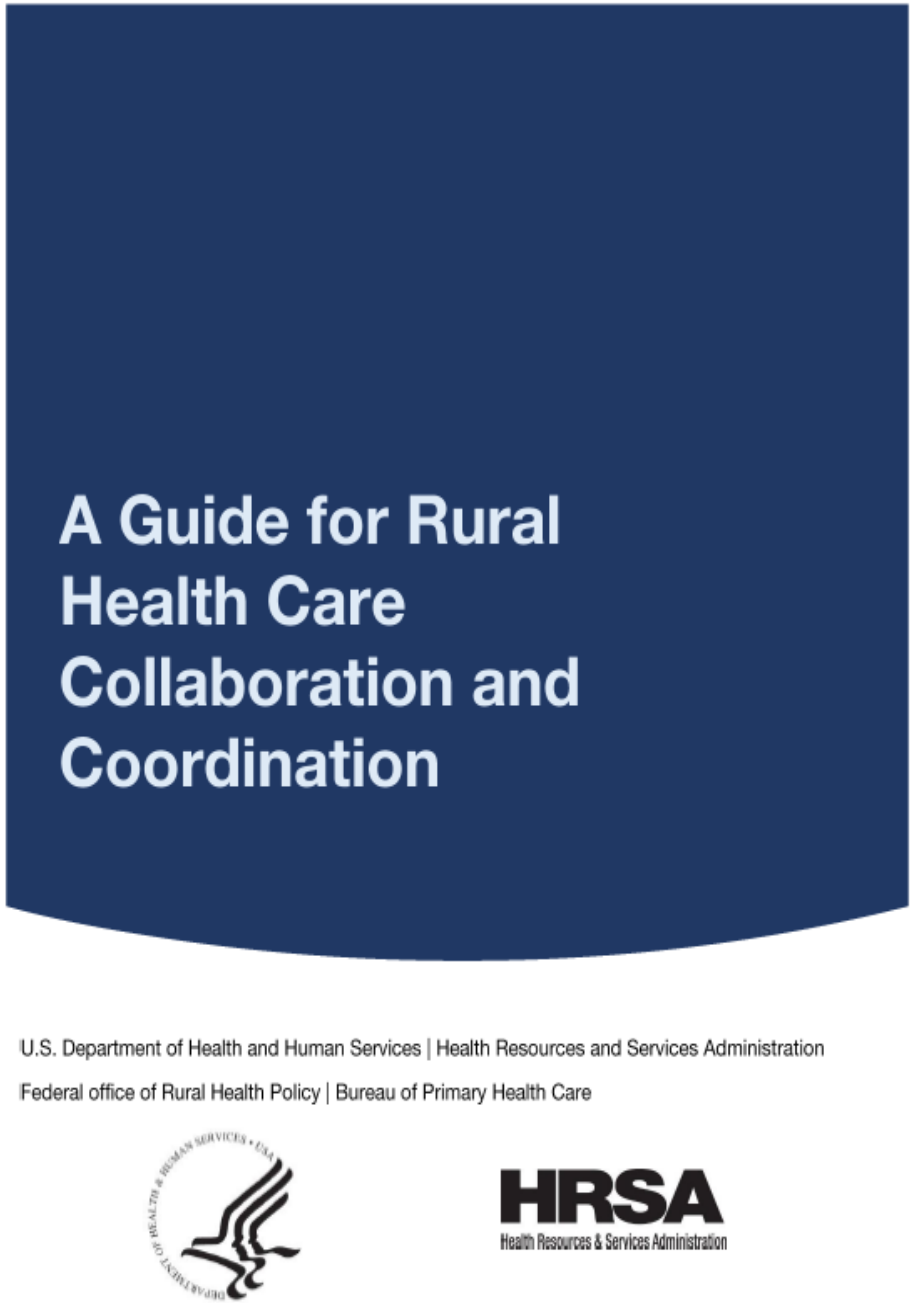
HRSA Publication to Be Released

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

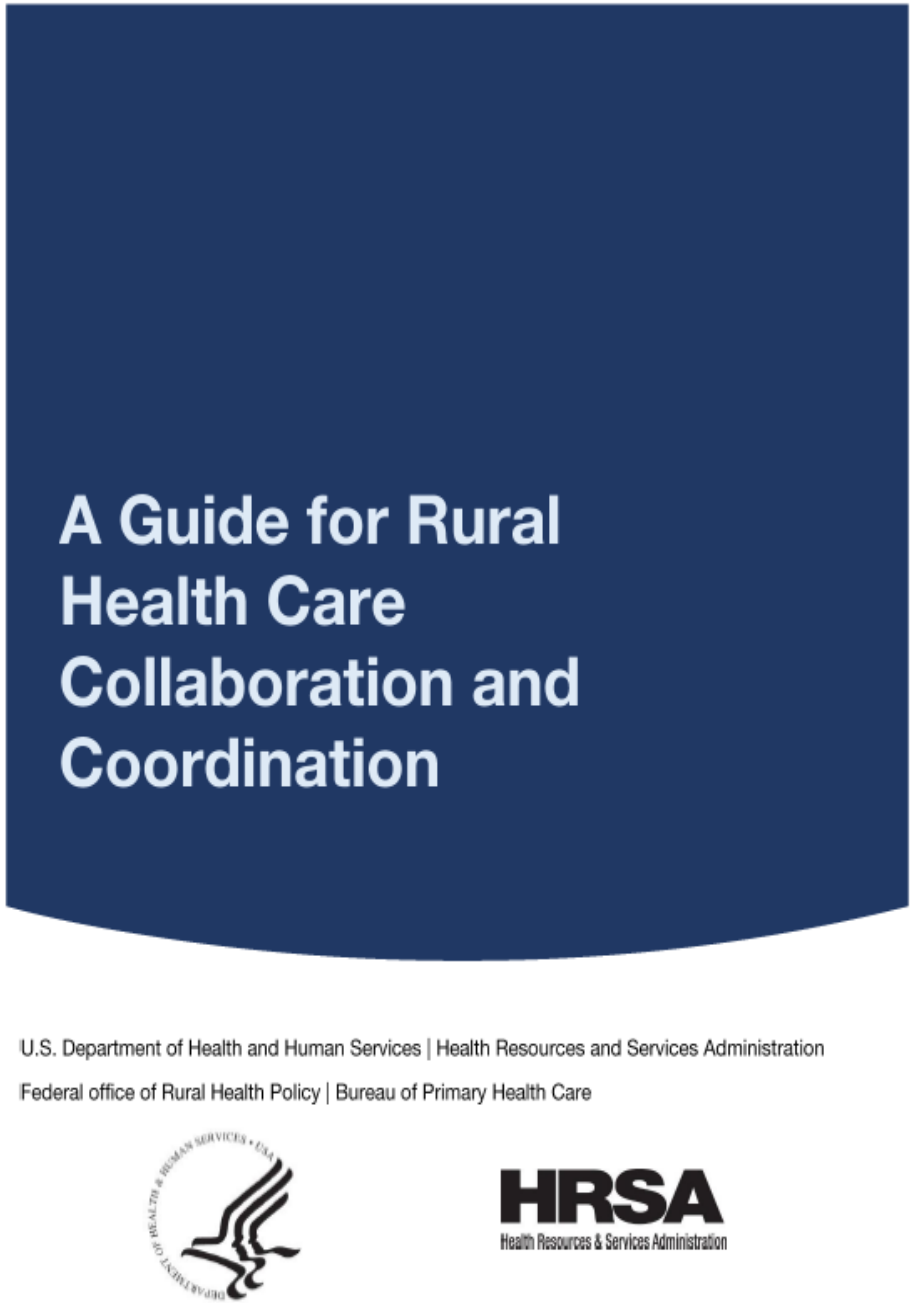


HRSA's Guide to Rural Health Care Collaboration and Coordination: Why is this an important issue?

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

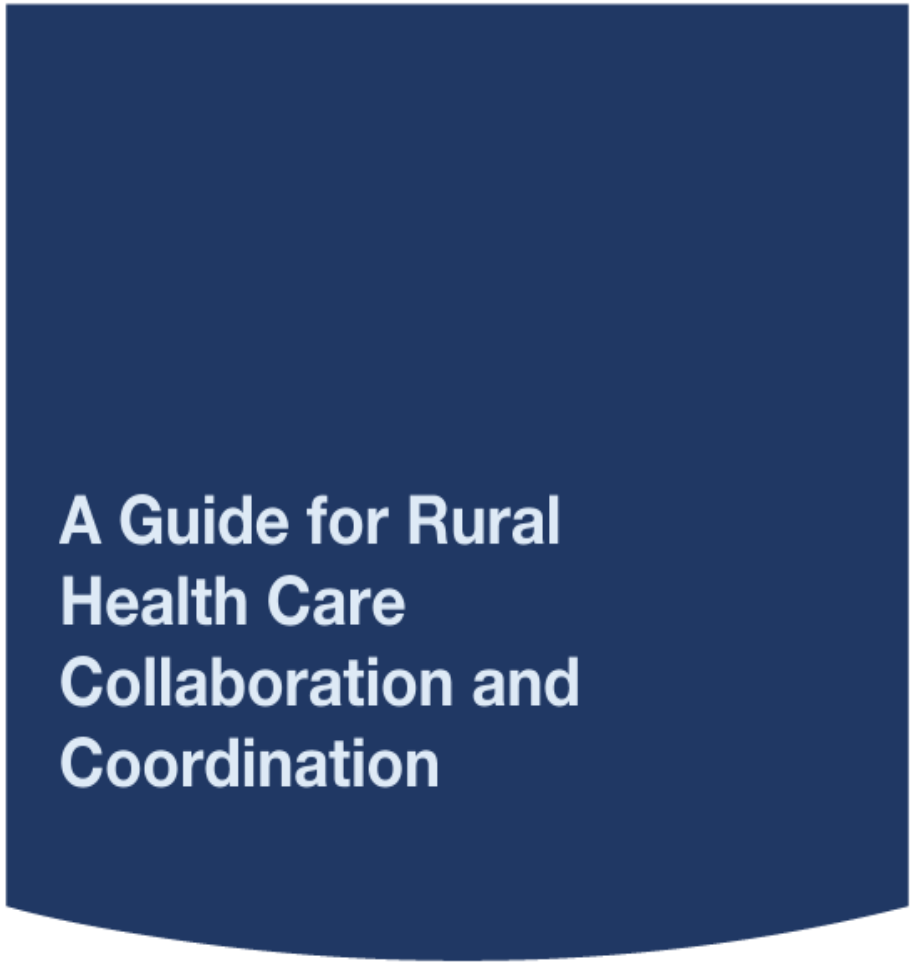
HRSA's Guide to Rural Health Care Collaboration: Key Features

- "Elements of Rural Collaboration and Coordination"
- Case Studies
- Tools and Resources



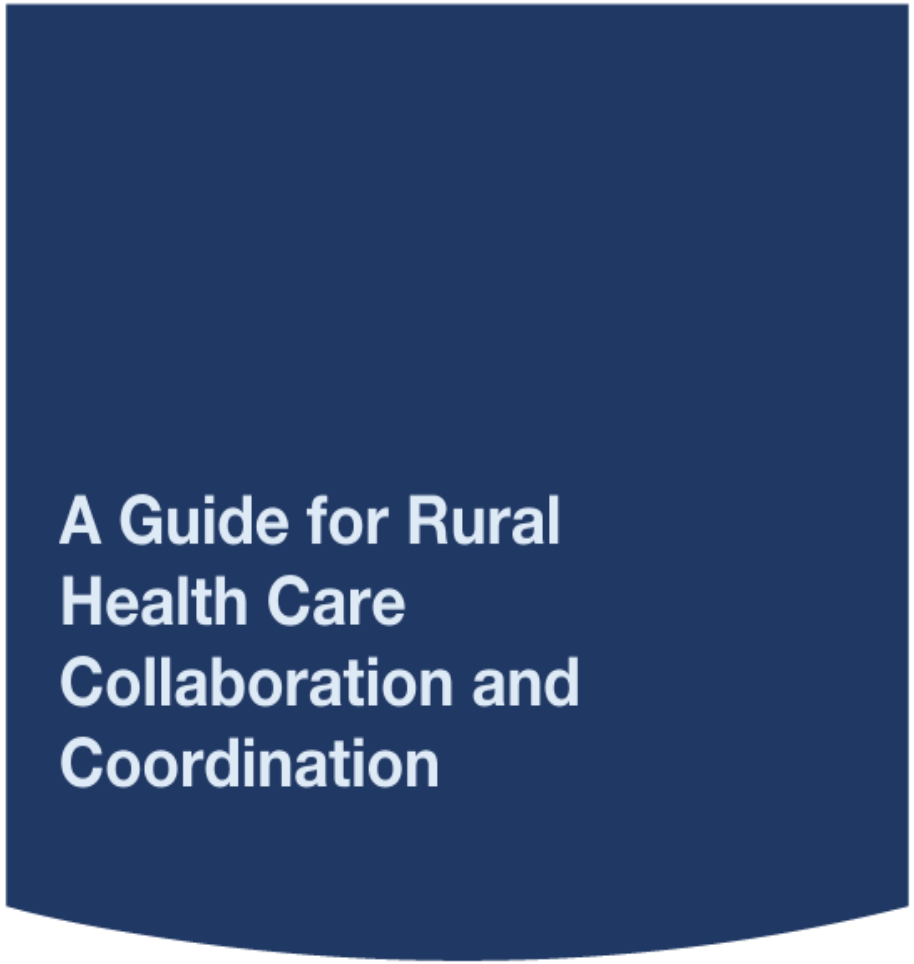
HRSA's Guide to Rural Health Care Collaboration and Coordination

Collaboration is defined as activities in which providers work together through various vehicles (e.g., contracts, formal memoranda of understanding, and data use agreements etc.) to maximize resources and efficiencies, with a common goal of ensuring access and provision of services to rural populations.



HRSA's Guide to Rural Health Care Collaboration and Coordination

Coordination is the deliberate organization of, and communication about, patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of quality health care and social services.



Rural Health Safety Net Providers

- **Rural Health Clinics (RHCs):** Created by the Rural Health Clinics Act of 1977, RHCs are certified by CMS to provide primary care services in non-urbanized areas that have been designated by HRSA within the last four years as a shortage area.
- **"Health center"** and **"FQHC"** are often used interchangeably because the two are intertwined.
  - Health Center Program = Section 330 of the Public Health Service (PHS) Act in 1975. "Health center" refers to either Health Center Program award recipients or look-alikes.
  - Federally Qualified Health Center (FQHC) Certification = Omnibus Budget Reconciliation Act of 1990. Health Center Program designation is needed *first* before applying for FQHC Certification.
  - Health centers are required to provide services regardless of patients' ability to pay and to charge for services on a sliding fee scale.
- **Rural Hospitals**: Several rural safety net authorities to support hospitals (i.e. Critical Access Hospitals (CAHs); Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH); Medicare and Medicaid Disproportionate Share Hospital (DSH) payment adjustments)
  - The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 ensures that emergency services are provided regardless of ability to pay, and Medicare-participating hospitals with emergency services provide a medical screening examination when requested or treatment for an emergency medical condition regardless of ability to pay.

Elements of Rural Collaboration and Coordination: Areas to Consider

Case Study 1 | Missouri

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

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

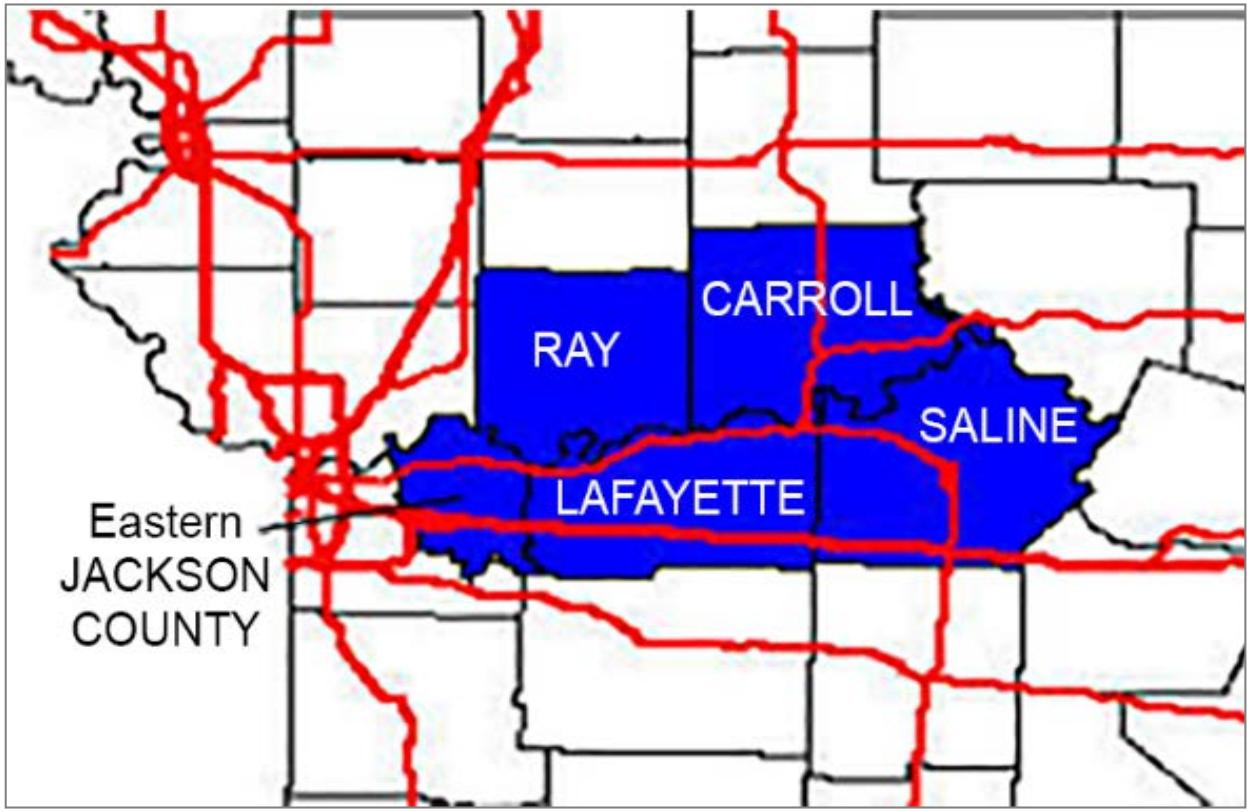
Our Strategy: Create a Rural Health Network

WHY?

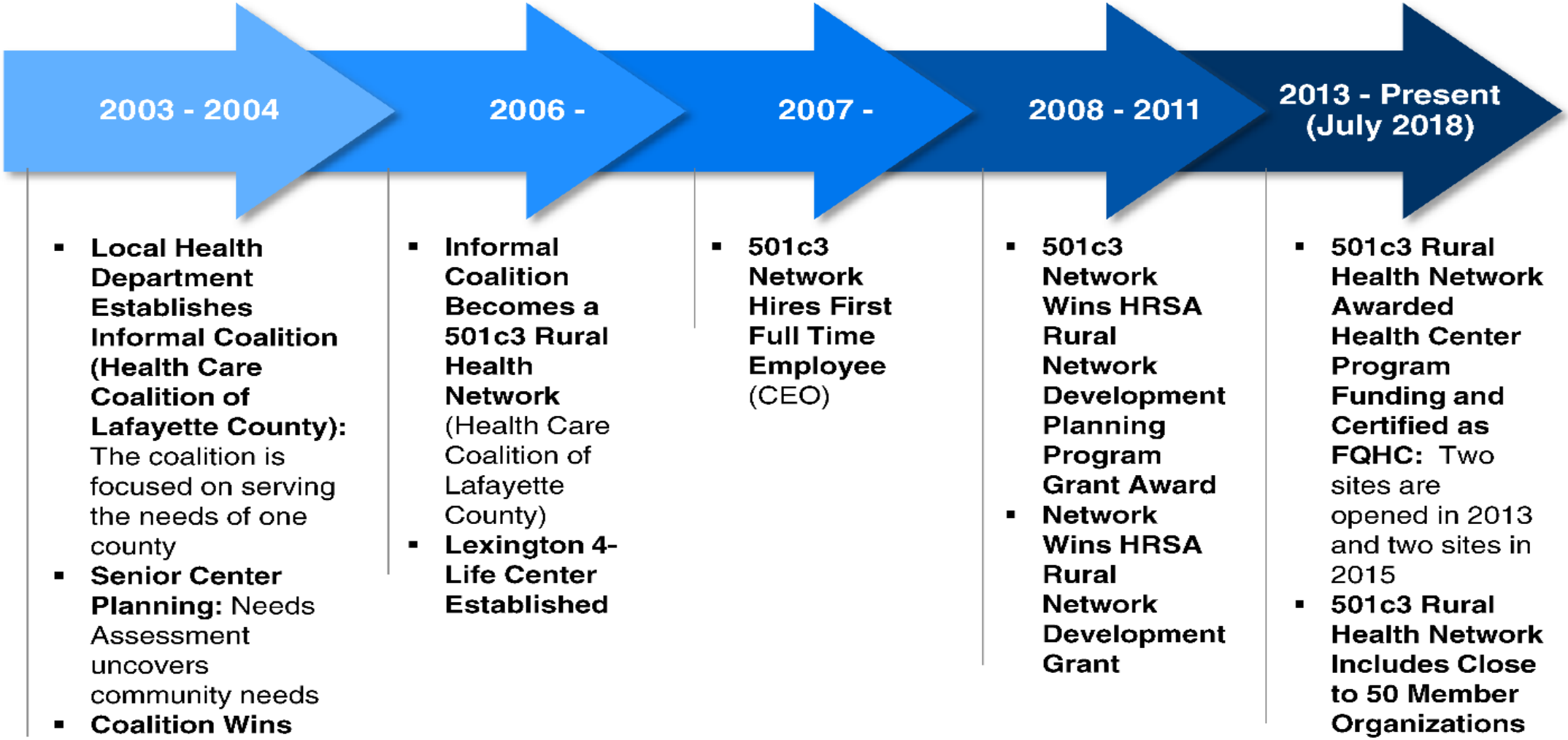
- Address unmet health care needs identified from a needs assessment done while planning a senior center

WHO?

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



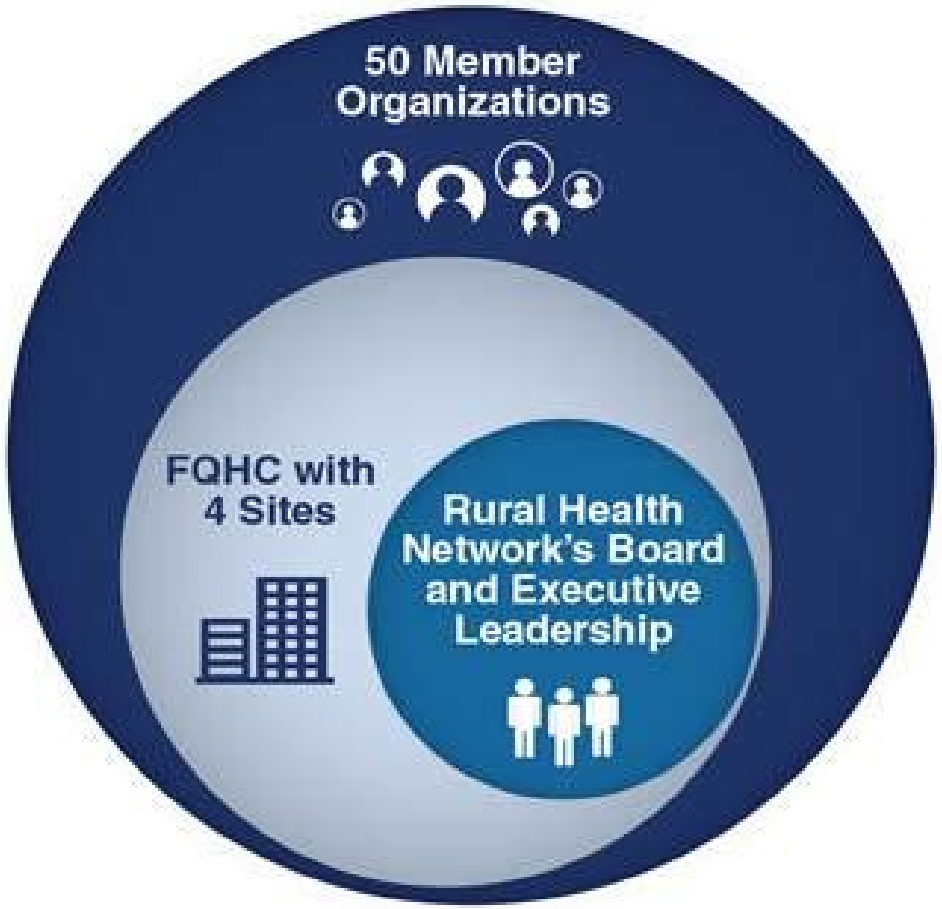
Meaningful Collaboration Takes Time, Start NOW…



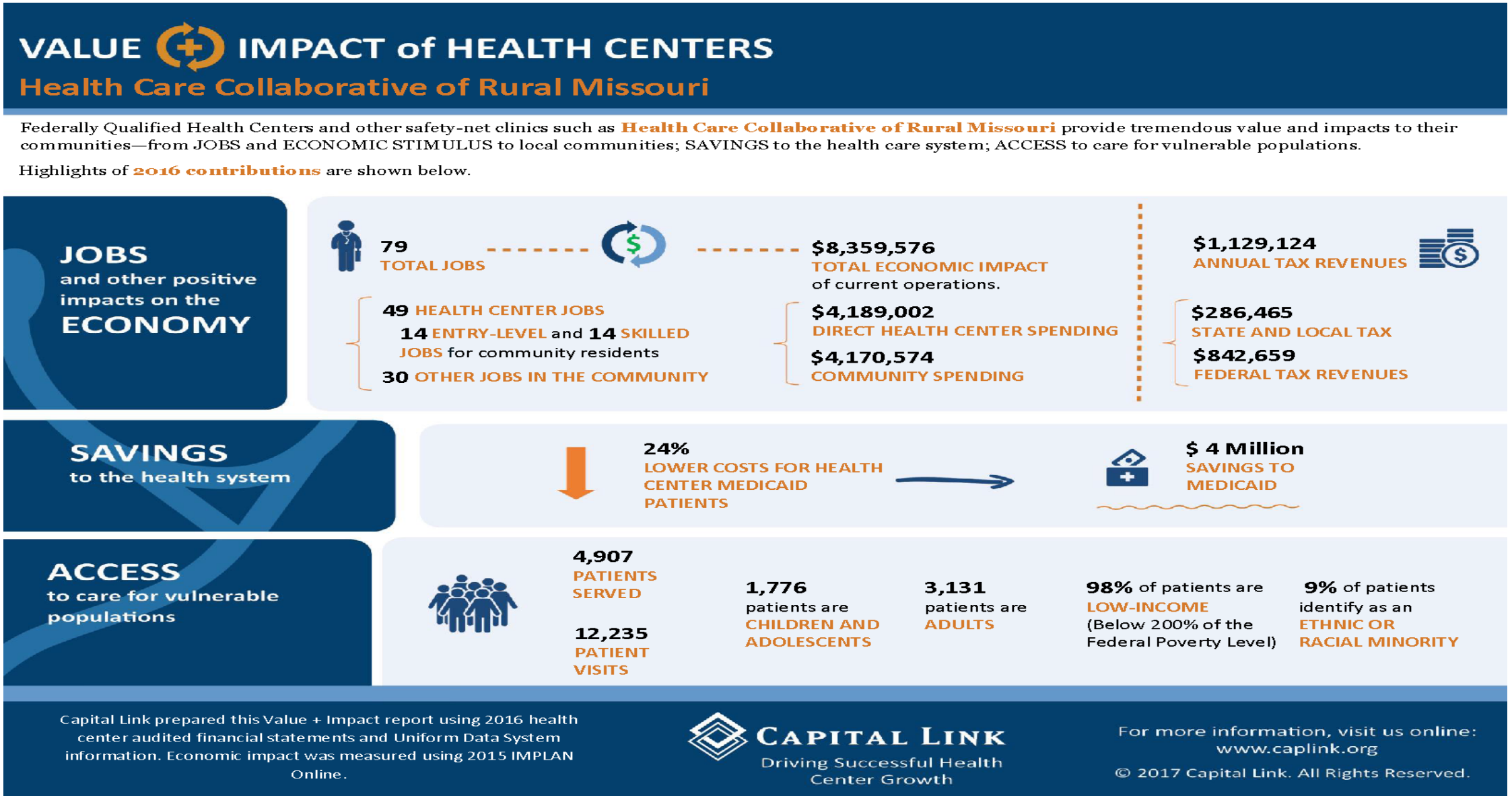
Rural Health Network

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

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



Rural Health Network's Value and Impact



Our Strategy: Collaboratively Address Social Determinants of Health

WHY?

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

WHO?

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

Collaboratively Address Social Determinants of Health

HOW EXACTLY?

- **Warehouse Resources Hub**
- **Connector's Program**
- **Project Connect**
  - *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*

Outcomes

Warehouse Resources Hub:

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

Connector's Program:

- 2014: 60 local residents assisted with 130 patient encounters
- 2017: 550 local residents assisted with 3,900 patient encounters

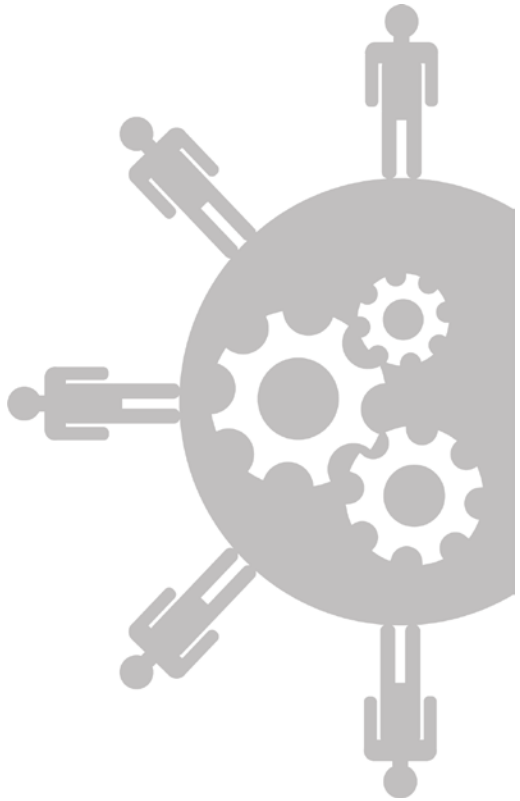
Project Connect:

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

Advice/Lessons Learned from Collaboration and Coordination

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

— Rural Health Network Leadership



Case Study 2 | North Dakota

“I don’t think any of us would want to ever go back to how we were before. We all love knowing that we’re one team serving our community.”

— Rural Health Care Provider Staff, reflecting on the adversarial CAH and FQHC relationship that once existed

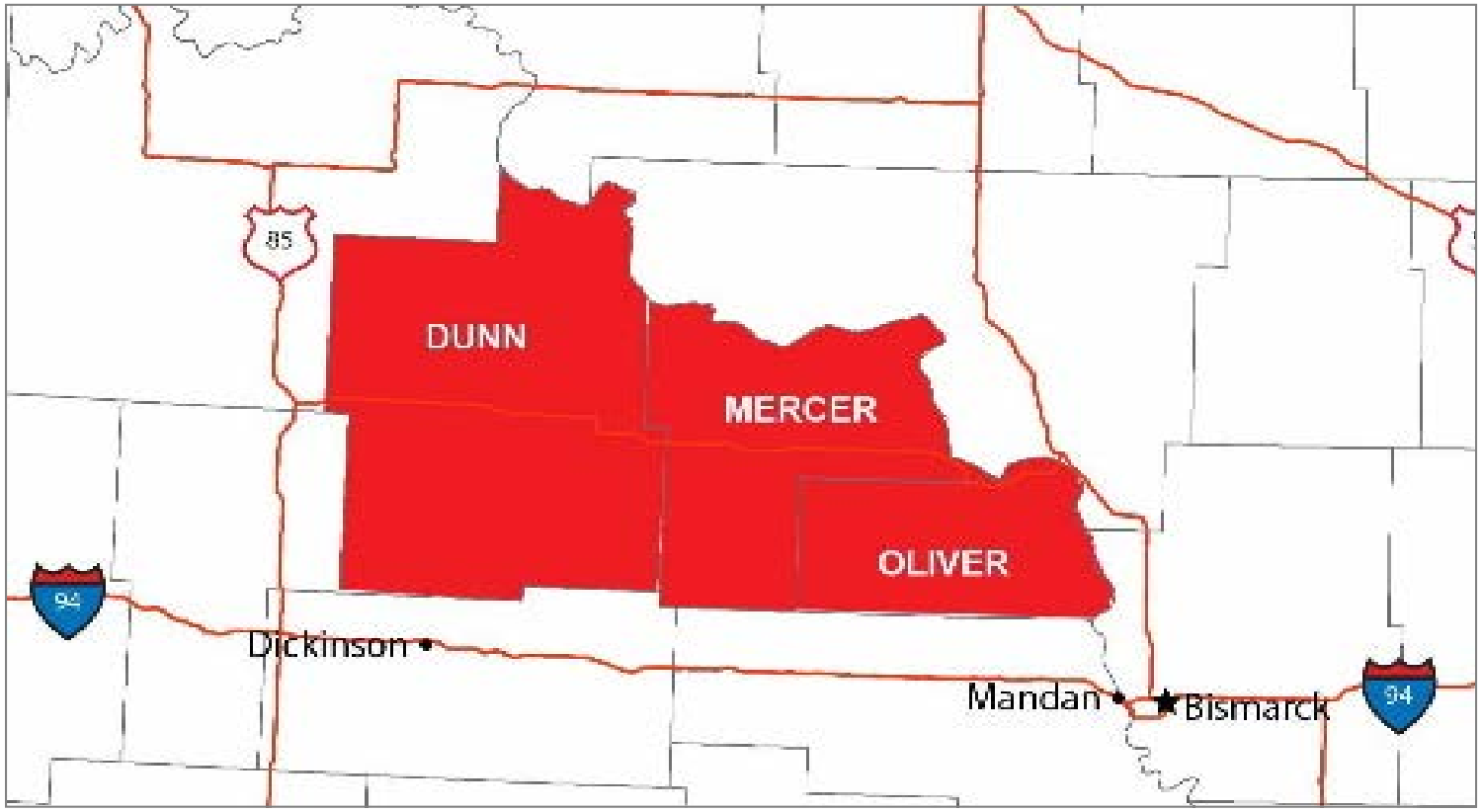
Our Strategy: Share Resources to Better Serve the Community

WHY?

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

WHO?

- FQHC
- CAH



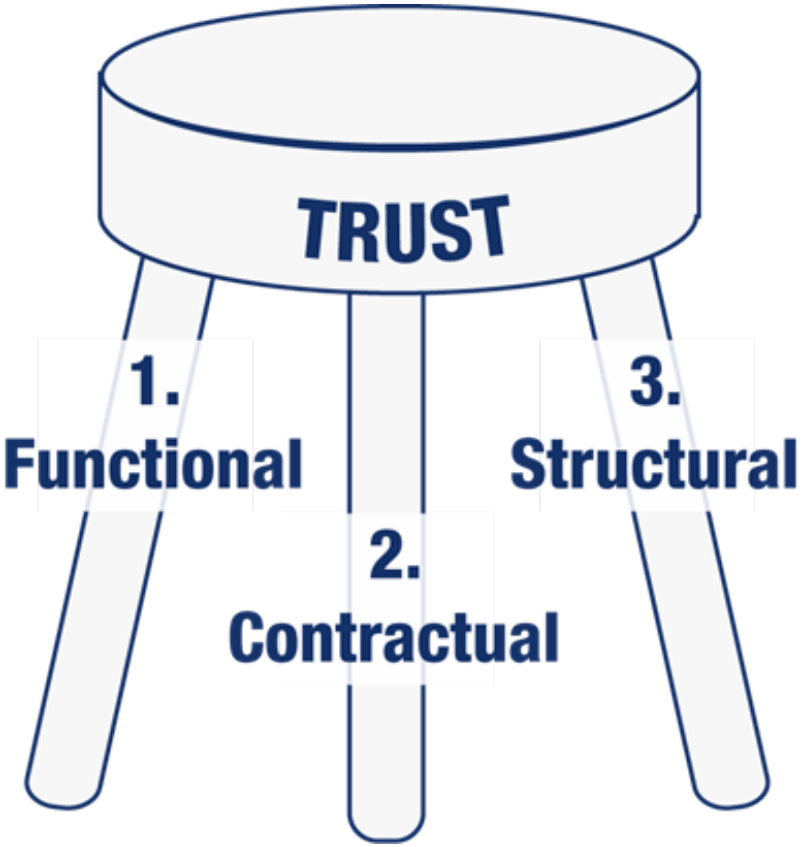
Share Resources to Better Serve the Community

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

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

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

3. **Structural**
   - Shared board members



Outcomes

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

	Before Collaboration (2011)	After Collaboration (2017)
Critical Access Hospital		
Cash-on-Hand	64 days	84 days
Net Margins	0.8%	4.2%
Federally Qualified Health Center		
Cash-on-Hand	8 days	203 days
Net Margins	-11%	10.9%

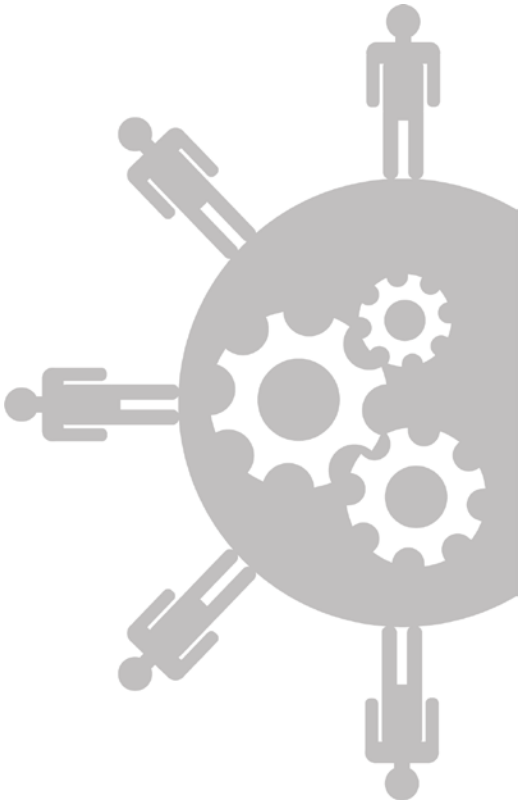
Advice/ Lessons Learned from Collaboration and Coordination

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

— FQHC Leadership

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

—FQHC and CAH Leadership



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