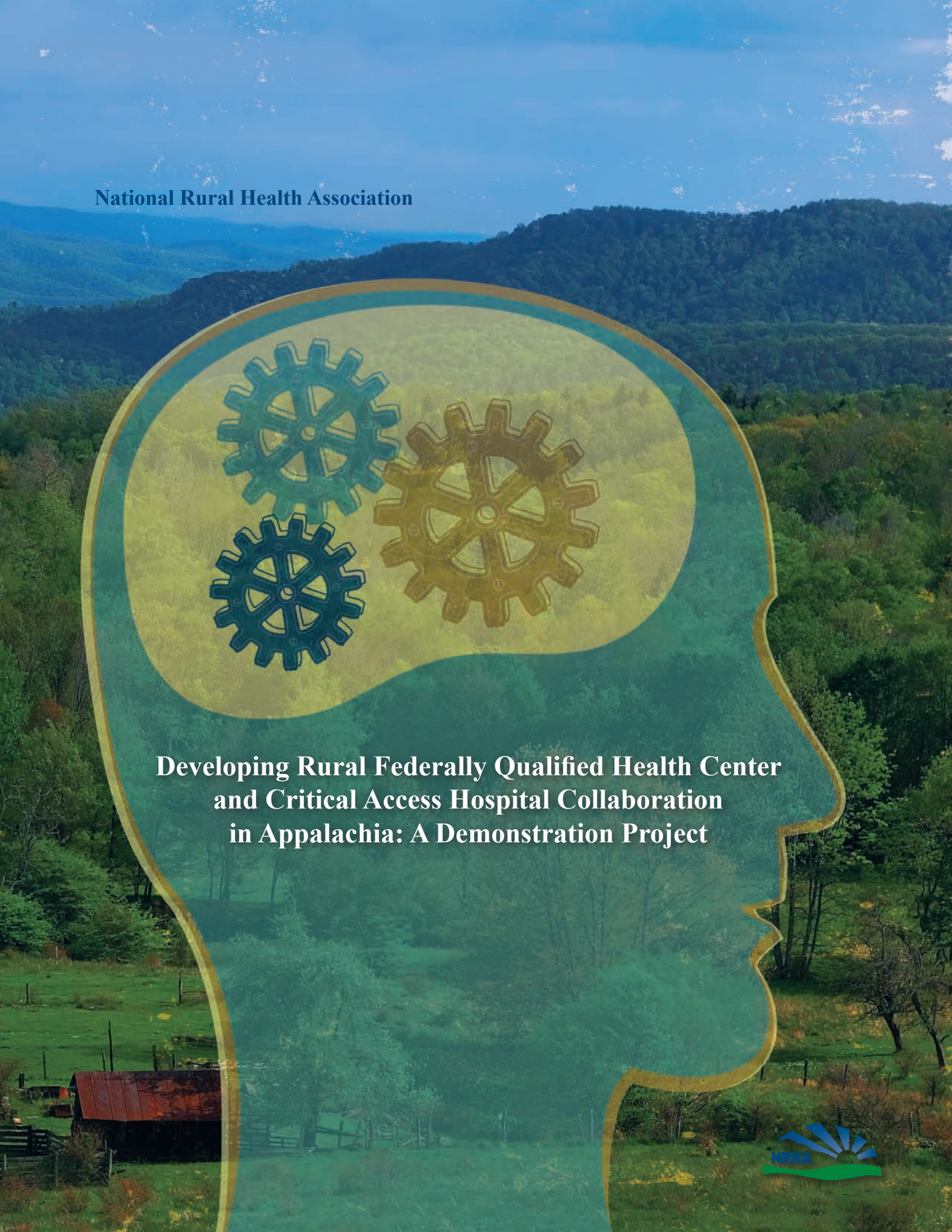
National Rural Health Association



Developing Rural Federally Qualified Health Center and Critical Access Hospital Collaboration in Appalachia: A Demonstration Project

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October 12, 2007

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Background: The Health Resources and Services Administration is the federal agency responsible for addressing health disparities through its safety net health delivery programs. Critical Access Hospitals (CAHs) and Federally Qualified Health Centers (FQHCs) are the major health safety net institutions in many rural communities. The Institute of Medicine recommended that rural health disparities call for an integrated approach to address both personal and population health needs. Responding to this opportunity, the National Rural Health Association (NRHA) and Bureau of Primary Health Care (BPHC) sponsored a study of CAH-FQHC relationships in 2003 to find out whether rural CAHs and FQHCs have established collaborations or areas of collaboration, how they are functioning, and how well these relationships are working. They first identified the five most outstanding rural community health center/ hospital collaboration models and did case studies on them. The result of this activity was a report "Model Relationships Between Rural Community Health Centers (CHCs) and Hospitals" submitted to the Bureau of Primary Health Care (See Appendix A). NRHA also published a popular version for distribution to rural CHCs, hospitals and policy makers (See Appendix B).

The next activity in the series was a national mail survey of 386 Critical Access Hospitals located in 41 states that had at least one CHC within a 60-mile radius. The purpose of the study of CAH-CHC relationships was to find out whether rural CAHs and CHCs have established collaborations, how they are functioning, the functional areas of collaboration, and how well these relationships are working. The results of the study "NRHA National Survey of Critical Access Hospitals Relationships with Community Health Centers" were reported to the BPHC (See Appendix C). Based on this report, the study's investigators, Michael E. Samuels, Dr. P.H. and Sudha Xirasagar, Ph.D., developed a journal article, " Enhancing the Care Continuum in Rural Areas: Survey of Community Health Center-Rural Hospital Collaborations." It has been accepted by the Journal of Rural Health and is scheduled for publication in the December 2007 edition (See Appendix D). The results of these studies have been presented at two NRHA and two NACHC national conferences. We also developed the NRHA publication "Practical Tips and Information Resources for Developing Collaborative Relationships Between Rural Community Health Centers and Rural Hospitals" which has been widely distributed (See Appendix E). NRHA has also conducted two national teleconference calls on these issues (See Appendix F).

Project Design: The Developing Rural Federally Qualified Health Center and Critical Access Hospital Collaboration in the Appalachia Demonstration Project was designed, as the final study, to examine the actual process of an FQHC and a rural hospital coming together to consider joint activities that would mutually benefit them and their community. The project documented the collaborative process and its outcomes to guide other CAH/FQHC collaborative efforts. It was jointly (equal contributions) funded by the NRHA/BPHC Cooperative Agreement and the FLEX grant to the Center for Excellence in Rural Health, University of Kentucky, College of Medicine, Hazard, Kentucky.

The original paired CAH/FQHCs selected for this collaboration demonstration were:

CAH	FQHC
Berea Hospital *Berea, KY*	Health Help White House Clinic M*cKee, KY*
Our Lady of the Way Hospital *Martin, KY*	Big Sandy Health Care, Inc. *Prestonsburg, KY*

After the proposal was submitted and approved, the administrator of Berea hospital left. There was a period of time without an administrator. The new administrator did not feel that he could participate in the project at this time. We substituted Marcum and Wallace Memorial Hospital, a Critical Access Hospital in Irvine, Kentucky.

Project Conduct: One of the barriers immediately obvious to FQHC/hospital collaboration was the very busy schedules of their CEOs. It was very difficult to coordinate a meeting that they could both attend. Our first meeting with Ancil Lewis, CEO, Big Sandy Health Care, Inc., Prestonsburg, Kentucky, and Cathy Stumbo, Administrator, CEO, Our Lady of the Way, Martin, Kentucky, was held on ???. We explained the nature of the project. This was followed by presentations on the nature and function of FQHCs. The assumption being that lack of understanding of each other's roles and functions in the community is a barrier to cooperative activities. This was followed by a presentation by both CEOs on the specifics of their operations and perceived roles in the community. The conversation then turned to opportunities for collaboration. The FQHC indicated that they had peaks and valleys in their demand for physician-delivered services. The hospital CEO said they had a similar situation. The FQHC indicated that he had an endocrinologist that had some spare days and the hospital CEO indicated that they would be very interested. There was a general agreement that they would explore the specifics of physician sharing. The issue of 340B pharmacy purchasing was raised. In this case, the hospital was part of a large chain of Catholic hospitals with their own purchasing power and 340B would not be of interest to them. There was some discussion of electronic medical records, but discussion was tabled until another date for the hospital to check out interest at their corporate headquarters. There was also discussion of physician malpractice insurance. The CHC CEO explained that they came under the Federal Torts Claim Act which would not be directly available to the hospital, but might be useful in shared physicians and joint clinics. The hospital CEO explained that they had six rural health clinics and that there was a good possibility of coordinated activities at these sites. There was a discussion about possible joint physician recruitment. There was also a discussion about their mutual concern about the increasing incidence of diabetes in their community. The meeting concluded with an agreement to meet again and consider the next steps in collaboration. One of the interesting observations was that the two CEOs stayed and talked to each other long after the meeting had adjourned.

It was not possible to arrange a meeting with Health Help White House Clinic, McKey, Kentucky, and Marcum and Wallace Memorial Hospital, Irvine, Kentucky, until July 23, 2007 (See Attachment 1). Our process was similar in this meeting to what we had done in the first meeting with Our Lady of the Way Hospital and Big Sandy Health Care, Inc. In addition, we were also able to share with them what the Our Lady of the Way Hospital and Big Sandy Health Care, Inc., collaboration had accomplished to date (e.g., specialty physician sharing). However, we were also able to share what that collaboration had already accomplished. This was a larger meeting with three representatives from Marcum and Wallace Memorial Hospital and five representatives from Health Help White House Clinic. The FQHC was particularly concerned about issues related to behavioral health and this consumed a major part of the meeting. There was some discussion of the 340B pharmacy program and physician malpractice coverage under the Federal Tort Claims Act. The meeting was affable and a second meeting was scheduled. However, it was decided that the prospects for collaboration were not promising. It appeared to be a mismatch between a very large and sophisticated FQHC and a small rural hospital. We decided not

to pursue this relationship, but are in the process of paring Marcum and Wallace Memorial Hospital with a smaller FQHC in their service area to see if there are collaborative activities they can share.

In a subsequent meeting on August 16, 2007, (See Attachment 2) between Big Sandy specifics with regard to sharing physicians was worked out. However, beginning with the second meeting, the focus shifted to "what can we do" to make their community healthier. They selected two projects. The first one was a community-wide dental project to make the community more aware of the need for oral health and to get children and adults involved in preventive care, screening, and restorative care. The effort will center on the dental services offered by the Big Sandy CHC. Since it is to be a community effort, there is a need to involve local public health officials and private dentists. On August 16, 2007, Our Lady of the Way Hospital and Big Sandy Health Care, Inc., signed a formal memorandum of understanding to facilitate the informal agreements they had made regarding physician sharing, administrative management, diabetes, and oral health. They have been invited and will meet in Prestonsburg, Kentucky on October 16, 2007, to work out the details. The second project that was agreed on was a diabetes prevention campaign for Floyd County. The Big Sandy CHC is a member of the CHC Diabetes Collaborative and will take the lead. This campaign will also require the participation of local public health officials and educators, as well as local physicians. A meeting will be scheduled for December in Prestonsburg to develop the implementation plan.

What Did We Learn?

1. It is probably best to limit the first meetings to the CEOs of the rural FQHC and hospital. Additional staff members tend to sidetrack discussions to items of their particular interest. Collaboration is greatly facilitated by having the institution's top executive understand the role and capability of the other institution. The CEOs are more likely to have a better overview of their operations and a vision for the future. They can make decisions on the spot.
2. There should be an outside catalyst to facilitate collaboration. Rural FQHCs and small hospitals are struggling to stay in business. They value their communities and will do what they can to improve them, however, they need additional resources to help them develop collaborative activities.
3. Collaboration should not be limited to FQHCs and small hospitals. In our successful case, they were interested in broad community issues (e.g., diabetes) that require several cooperating institutions. This recommendation is in concert with HRSA Policy Information Notice 2007-09: Service Area Overlap: Policy and Process that says:

I. Collaboration

In order to maximize limited resources and access to care for their patients, health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, state and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made "and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center" (PHS Act section 330(k)(3)(B)). As stated in section V., of this PIN, "HRSA Policy," the goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the

area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, existing or potential service area overlaps.

1. Collaboration will not work every time. Each potential collaboration should be approached as unique. Any policy directives or incentives directed at improving collaboration should be very flexible.
2. There needs to be an effort from the national and state level to increase the knowledge base of FQHCs by hospitals and hospitals by FQHCs. In both of our cases there was a very limited knowledge of the other institution.
3. Only by bringing rural FQHCs and hospitals together will we know what the potential for collaboration is (e.g., small rural hospitals that are part of a larger hospital chain may find no advantage in the 340B program).
4. Competition and lack of trust are barriers to collaboration. They were not an issue in these two cases.
5. Community interest is a major catalyst in bringing together a rural FQHC and hospital. In both of these cases, concern about the health of the community seemed to greatly outweigh parochial interests.
6. In both of these cases the FQHC was the stronger institution. With growing acceptance of FQHCs there may be a real opportunity for them to exercise leadership in improving health at the local level (e.g., the dental and diabetes initiatives that our first pair agreed to develop).
7. Collaboration with rural FQHCs and hospitals is greatly facilitated by the informal culture of rural America. Their lives are no less complicated, but their style of doing business lends itself to the collaborative model.

Rural FQHC and hospital collaboration is in its infancy. NRHA, with the support of BPHC, has developed the tools and rationale to facilitate this activity. The next step is to build on supportive policy development at the federal level that builds on the HRSA Health Disparities Collaboratives effort to achieve strategic system change in the delivery of primary health care, with the emphasis on building strategic partnerships. HRSA should also consider the deliberations of the NRHA National Rural Task Force on Strengthening Rural Partnerships: Expanding Access to Primary Care. The purpose of the task force is to help rural communities move toward the improvement and expansion of access to health care, encourage continuation of partnering with other organizations in order to expand and improve access to culturally competent, quality health care and to ensure that services are appropriately available to rural and frontier patients, including primary and preventive services, as well as enabling services.

Where Do We Go From Here?

Although this phase of the project is completed, the project will continue under the direction of the Center for Excellence in Rural Health, Hazard, Kentucky, as part of our mission in support of small rural hospitals and FQHCs. We will continue to facilitate the oral health and diabetes initiatives of Our Lady of the Way Hospital and Big Sandy Health Care, Inc. We have paired Marcum and Wallace Memorial Hospital, Irvine, Kentucky, with Juniper Health, Inc., (FQHC), Beattyville, Kentucky, and anticipate an initial meeting in November.

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Evaluation

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	Strongly Agree	Agree	Disagree
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Information presented increased my knowledge on the subject.	❑	❑	❑

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