

A Manual on  
Effective Collaboration Between  
Critical Access Hospitals  
and Federally Qualified Health Centers

APRIL, 2010

**U.S. Department of Health and Human Services  
Health Resources and Services Administration  
Office of Rural Health Policy**



CONTRACT

**HSH250200826185P**

PREPARED BY

**HMS Associates, Getzville, NY**

# Table of Contents

Forward	i
Executive Summary	1
1. Importance of Collaboration between CAHs and FQHCs	6
The Meaning of Collaboration	
The Importance of CAHs and FQHCs	
2. FQHCs from A to Z	10
Definition	
Key Features	
Key Benefits	
History	
3. CAHs from A to Z	16
Definition	
Key Features	
Key Benefits	
History	
4. Collaborative Potential of CAHs and FQHCs	22
Concepts	
Lessons Learned	
5. Examples of Successful Collaboration	31
Site A - Minnie Hamilton Health System, Inc.	
Site B - Community Health Centers of the Berkshire, Inc. & Fairview Hospital/Berkshire Health System Inc;	
Site C - Early Memorial Hospital/John D. Archbold Memorial Hospital, Inc. & Primary Care of Southwest GA, Inc.	
Footnotes	44

## Forward

Collaboration between health care providers can have dramatic positive effects on a rural community's access to high quality health care services. Critical Access Hospitals (CAH) and Federally Qualified Health Centers (FQHC), also referred to herein as Community Health Centers (CHC) or Health Centers, are highly specific types of health care providers so designated by the Federal government<sup>i</sup>. CAHs and FQHCs are in a unique position to fortify fragile rural health care service networks by partnering with one another. Health Centers and CAHs, given the important roles they play in providing services in rural communities, are often the foundation of local delivery systems. This capacity and the potential for collaborative action have grown considerably in recent years, with CAHs experiencing high levels of growth during the early and mid 2000s and FQHCs growing in number significantly over the last decade. Currently, there are 1,302<sup>ii</sup> CAHs and 3,442<sup>iii</sup> Health Center service sites in rural communities across the Nation.

The central point of this manual is to illustrate that through cooperation and collaboration, CAHs and FQHCs, especially those in proximity to each other and serving similar communities, can better meet community need, enhance each other's roles, and stabilize and expand needed services and rural delivery systems.

Given the traditional challenges faced by many rural communities relative to lower socio-economic status, higher disease burden, and lower health care reimbursement rates, these key safety net service providers have a responsibility to seriously consider cooperation and collaboration as mechanisms for maximizing the return on investment of the various types of Federal support associated with CAH and Health Center designations.

Since tangible benefits are the driving force behind effective collaboration, this manual documents the experiences of several rural CAH/FQHC collaborations, highlighting the specific ways in which CAHs and Health Centers benefit individually, and ultimately how their communities benefit from collaboration. These relationships unequivocally facilitate service development and financial stability for both CAHs and FQHCs. The three sites studied realized at least \$2,225,000 in direct grant or financial support for numerous needed programs and \$1,083,000 in annual operational savings. These numbers represent substantial benefits for any health care provider, but they are large savings for those in rural communities. Although these providers represent the safety net capacity for a large percentage of underserved or disadvantaged populations, the benefits of collaboration also enhance their respective ability to provide viable high quality, cost effective health care to the community at large.

Other providers, including over 3,600 Rural Health Clinics<sup>iv</sup> and tribal health care services, emergency medical services providers, public health departments, private practitioners and small rural hospitals are also critical components of rural health in many communities and represent potential collaborative opportunities. Collaboration is a strategy that is often used across the full range of these providers in order to stretch scarce resources and avoid duplication. However, due to the recent growth of CAHs and FQHCs, and their specific types of "shareable" Federal support, the focus of this manual is on CAH/FQHC collaboration.

This manual is intended to be a resource for several different audiences including staff and boards of CAHs and FQHCs, state Offices of Rural Health and state primary care, and hospital associations. Input obtained from many participants at the state and local levels during its development continuously emphasized the importance of local leadership including county government, civic groups, and businesses and health care service providers. This manual ideally will act as a bridge toward serious consideration or re-consideration of collaborative potentials.

The manual is a continuation and expansion of activities supported by the U. S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health on CAH and FQHC collaboration and conversations with rural health leaders across the Nation. Additionally, a manual workgroup, CAH/FQHC collaborative sites and a variety of contributors helped to guide the content and focus of this manual.

## Executive Summary

Critical Access Hospitals (CAH) and Federally Qualified Health Centers (FQHC) are highly specific types of health care providers so designated by the Federal government.<sup>v</sup> They differ from other types of hospitals or outpatient clinics in that they are designed to stabilize and enhance health care services, especially for the uninsured and underserved, and are also expected to be integral parts of local networks of health care services. As a result of these unique roles and responsibilities, CAHs and FQHCs, also referred herein as Health Centers or Community Health Centers (CHC), receive enhanced reimbursement for health care services as well as Federal grant funds to help them finance targeted services to needy populations. Those enhanced rates are also intended to provide greater financial stability to these providers and the other service providers they impact, strengthening local health care services' financial base as a result.

### **Contents**

The central point of this manual is to illustrate that through cooperation and collaboration, CAHs and FQHCs, particularly those in close proximity and serving similar communities, can better meet community need, enhance each other's roles, and stabilize and expand needed services. Although directed at FQHCs and CAHs, many insights on collaboration can be applied to small rural hospitals and FQHCs serving similar communities.

The manual has five sections, the first three of which convey the importance of these rural health service providers and specific information on the definitions, roles, responsibilities and other key attributes of Critical Access Hospitals and Health Centers. Those sections show that the number of CAHs and FQHC service sites have grown considerably over the past ten years, giving them pivotal and evolving roles in rural health delivery systems. Yet, much of what CAHs and FQHCs do is done in part to satisfy the requirements of their designations, such as the consumer majority requirements of FQHC governing boards and the provision of Emergency Department services by hospitals to people regardless of their ability to pay. Additionally, the presence of CAHs and FQHCs has been shown to further strengthen rural delivery systems through more appropriate use of health care services, improved patient safety and continuity of care and expanded service availability in rural communities. An understanding of those issues sets the stage for the depiction of collaborative potentials, successes and challenges portrayed in the last two sections, which focus on lessons learned and site specific examples.

### **Target Audiences and Theme**

The manual is designed to provide a common frame of reference for informed discussion and examination of collaborative potential by the rural health care delivery system stakeholders. These stakeholders have vastly different collaborative roles and include state offices of rural health, state hospital or primary care associations, and leadership at the local community level such as county government, business groups, civic organizations, and most importantly, leadership of Health Centers and Critical Access Hospitals. Consequently, a rather broad brush stroke is initially applied and then refined

through detailed portrayals of challenges and successes in several different types of rural settings, providing specific examples of collaboration that has led to significant improvements in the availability and quality of health care services and more cost efficient use of scarce health care resources.

A central theme of the manual is to convey to CAH and FQHC leadership the benefits which can accrue to those organizations and their communities as a result of strong partnerships with each other. The advantages described herein show how both programmatic and financial strengths of each provider type can be “shared” to support local rural health care delivery systems and reduce the likelihood of deficit operations.

### **Methodology**

This manual is a continuation and expansion of activities supported by the Federal Office of Rural Health Policy on CAH and FQHC collaboration and conversations with rural health leaders across the Nation. The input from the Manual Workgroup helped to guide the content of and provide focus to materials developed by the HMS Associates Project Team. The project was not intended to develop extensive new information but rather to examine, augment and focus information on collaboration and CAH, FQHC and community benefits.

Initially, a National workgroup with representation from different rural areas of the country and CAHs and FQHCs was formed to guide the project. Relevant literature was reviewed and summarized, three site visits were conducted and conversations took place with approximately 15 organizations regarding rural collaborative ventures. The featured sites were those that could readily document cost savings and community benefits associated with their collaborative actions. Results were summarized and discussed at four meetings of the workgroup which took place between January and August 2009.

### **Lessons Learned**

#### *Lesson 1– Leadership, Continuity and Commitment*

Although needs and benefits are what drive the development of collaborative ventures, the importance of leadership at the state, community and provider level cannot be underestimated. The traits which seem particularly relevant to effective CAH/FQHC collaborations include: (1) recognition that networks or systems of services are essential to meet health care needs and (2) realization that individual actions must take into account the potential impacts of those actions on needed partners and services.

Continuity of leadership and technical capacity throughout the development of collaborative actions was also a critically important variable in the three studied collaborations. FQHCs and CAHs with board-adopted strategic and business plans that incorporate collaborative initiatives were in a better position to pursue these objectives when changes in leadership have occurred.

#### *Lesson 2 – Compelling Needs and Solutions*

The initial collaborative actions undertaken addressed current or emerging compelling needs. For two of the three communities reviewed, the compelling need was the

impending loss of primary care capacity. The actual closure of a small rural community hospital was the driving force behind collaboration in the third area. In the former cases, hospitals joined forces with community groups and clinics to remedy the impending lack of primary care. In the latter, community groups, clinics, and government agencies joined forces with hospital leaders to maintain emergency, inpatient and specialty care access in the community. For all three sites, there was clear recognition that primary care and hospital care needs are interdependent and that both needs must be met for either type of care to be effective. The best approach to meeting the compelling need included the stabilization of both primary care and hospital capacities. Once again, the motivating precondition was a compelling or critical need which, if left unaddressed, would have extremely deleterious effects upon the health and well being of rural communities and the stability of other health care service providers in the area.

### *Lesson 3 – Collaboration Instead of Competition*

Community, administrative, and medical leadership must recognize that the local system of health services is best served through collaborative approaches rather than competitive ones. In some rural communities, dual capacity at Health Centers and CAHs (for example, in outpatient and laboratory services) may preclude collaborative activity. In these situations, collaboration with the intent of supporting unique service capacities may appear infeasible on the surface, though closer examination may reveal other issues that can be the basis for a collaborative compromise. The community benefit perspective indicates that support of primary care at FQHCs is a good collaborative agreement on behalf of the uninsured and support for laboratory service at CAHs helps to maintain local needed hospital related capacity – specifically ER, inpatient and access to specialty care. In such a scenario, the community, the CAH and the FQHC all win. These are synergistic rather than competitive scenarios wherein business plans portraying pros and cons help to augment philosophy of care distinctions – Health Center philosophy vs. CAH philosophy vs. local rural health system philosophy – with financial impact data.

### *Lesson 4 – Regional Linkages for Frontier Counties and Tribal Health Services*

Just as attributes of the rural health delivery systems can differ from those of urban health care systems, attributes of rural areas also vary considerably by the remoteness or frontier<sup>vi</sup> nature and the presence of various Native American Tribes<sup>vii</sup>, whose culture and traditions vary significantly including their tribal operated health care services in some remote communities.

Strong CAH linkages with regional hospital systems and strong FQHC “linkage/ownership” to regional FQHC capacities has been shown to be an effective way to promote collaboration between these two types of providers in northern New Mexico. A consortium of tribes operates both FQHCs and CAHs in Alaska. Communities benefit from this joint corporate level management of FQHCs and CAHs, especially in terms of telehealth, telemedicine, health information technology (HIT), and shared “back-office” administrative support. However, long distances between clinics and CAHs can preclude the sharing of clinical staff.



## *Lesson 5 – The Pay-off: Significant Benefits*

### **Rural Communities**

Communities benefit when collaboration results in a local network of needed high quality sustainable health care services. This local network service mix includes but is not limited to:

- Primary and Preventive Health Care Services
- Inpatient Care
- 24 Hour Emergency Care
- Access to Specialty Services

Access to care is maintained and strengthened through shared use of health care resources such as grants and cost reduction mechanisms. Successful collaboration between Health Centers and CAHs strengthens the local health network infrastructure, maintains and increases access to needed services and maintains or enhances quality and continuity of care.

### **Benefits of Collaboration Between CAHs and FQHCs**

Each provider contributes unique resources to the collaboration that foster infrastructure, access, and quality of care improvements. These unique resources can be “shared” through collaboration and viewed as benefits to either party.

FQHCs benefited through sharing CAH unique resources such as facilities, recruitment services and medical records. CAHs benefited through association with the FQHC in terms of medical malpractice coverage under certain conditions<sup>viii</sup>, increased resources to serve the uninsured, and a stabilizing effect on primary care capacity and demand for hospital related services. Both CAHs and FQHCs (comprising key parts of the core of local rural health infrastructure) benefited from increased grant support for personnel, equipment and facilities for shared services; Shared community, administrative and medical leadership; Shared access to patient care records; and Shared quality improvement programs.

### **Financial Implications**

The financial implications of collaboration identified by the organizations themselves are equally compelling. Twelve areas of collaboration with financial impact were noted across the three sites. Six areas had quantifiable cost savings or new financial resources. In total, \$2,226,000 was obtained for one or two year related costs such as start-up and time-limited grants for three collaborative areas and \$1,083,000 was identified as annual savings for the other three collaborative areas. Significant cost savings were also noted in six other areas but data on actual savings was not available. CAHs and FQHCs benefited financially in different ways.

FQHCs benefited from:

- Start-up costs assistance directly from hospitals for FQHC establishment services, i.e. FQHC studies, operational plans, and applications – \$75,000
- In-kind or community benefit contributions for several start-up years – \$150,000
- Grants contingent upon collaboration with the CAH – \$2,035,000
- Reduced administrative costs – \$400,000
- Reduced physician recruitment costs through shared recruitment and credentialing capacities
- Medical leadership by CAH Medical Director

CAHs benefited from:

- Reduced medical malpractice related costs<sup>ix</sup> for ER coverage, primary care, and OB/GYN practitioners – \$500,000 per year
- Grants contingent upon collaboration with the FQHC – \$183,000
- Reduced variable costs for ER services to the uninsured or underserved through referrals to primary care providers at FQHC
- Reduced physician recruitment costs through reduced fees
- Reduced physician retention costs through reduced ER call coverage
- Indirectly stabilized revenue for services related to primary care capacity

**Other general findings showed that:**

- Successful collaboration was found in many different types of rural health care delivery systems.
- Collaboration is a clear path to better use of scarce health care dollars.
- Both organizations represent pathways to improved access to and quality of care in rural communities.
- King-of-the-hill mentalities, broken promises, referral patterns which bypass local hospital capacities, and conflicting corporate philosophies were often cited as collaboration deal breakers.

Although portrayed to some extent as CAH or FQHC benefits, the community as a whole benefited most because the overall impact of collaborative action was a more cost efficient viable system of care.

# 1. Importance of Collaboration between CAHs and FQHCs

## THE MEANING OF COLLABORATION

Collaboration occurs when two or more organizations work together to address a common goal or objective. The impact on each organization may be expected either immediately or over a longer term. Ultimately, organizations pursue collaborative ventures because through them, they are better positioned to accomplish their own particular missions and, in the health services realm, provide value to the patients and communities they serve.

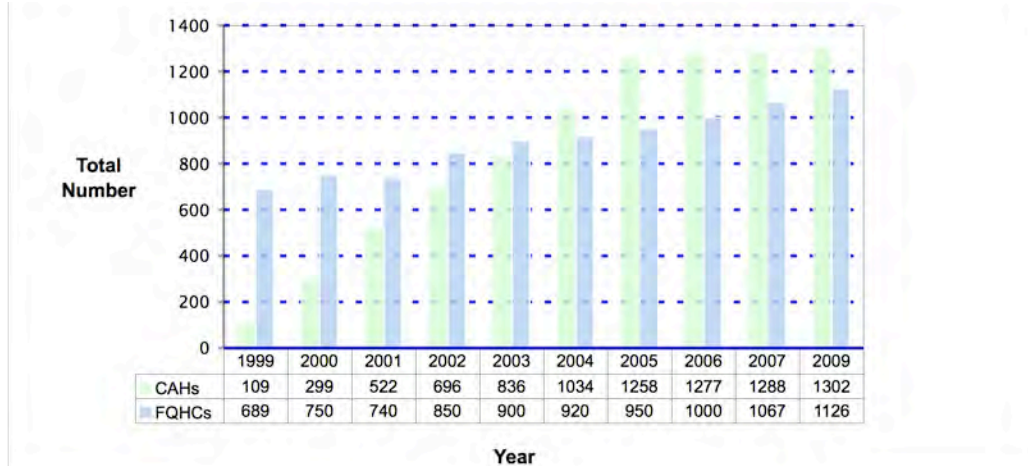
Collaborations are often formed when individual organizations do not have sufficient resources to implement solutions on their own. Simply put, they can't do it alone. Capacities of other individuals and organizations are needed to effectively accomplish goals or objectives. As a result, each organization has unique critical capacities that define its importance and role within the collaboration.

Collaborations between Critical Access Hospitals and Federally Qualified Health Centers also have two other key definitional characteristics. All Health Centers and the vast majority of CAHs are either public or private not-for-profit corporate structures, providing community betterment through the delivery of high quality, cost effective services as key parts of their missions. A second and equally important consideration is that both of these organizations to varying degrees have a responsibility to provide health care services to uninsured and underinsured groups and share this unique responsibility and market niche.

## THE IMPORTANCE OF CRITICAL ACCESS HOSPITALS AND FEDERALLY QUALIFIED HEALTH CENTERS

The past 10 years have seen extraordinary growth in these two types of health care service providers. From 1999 to 2009, the number of hospitals with the CAH designation increased from 109 to 1,302. Peak growth of CAHs occurred between 1999 and 2005 when an average of 177 small rural hospitals were certified each year as CAHs. FQHCs have grown from an estimated 700 in 1999 to 1,126 grantees in 2009<sup>x</sup>. This rapid and relatively recent growth is depicted in FIGURE 1: Number of CAHs and FQHCs.

FIGURE 1: Number of CAHs and FQHCs



CAHs will not see much additional growth because most hospitals that can qualify for designation have already done so, but FQHC expansion is expected to continue at current rates. A combination of Federal, state, local and not-for-profit resources have stimulated this growth, resulting in the stabilization of small rural hospitals as Critical Access Hospitals and the growth of service capacity and Health Centers in rural communities. As these capacities have grown, so has the potential for collaboration between these newly certified or created organizations.

Health Centers operate programs at multiple sites. The number and growth of Health Centers does not reflect the actual number of sites or growth of sites in rural communities. In 2009, there were 3,442 Health Center service sites in rural counties.

The most common forms of collaboration are occurring between similar types of organizations serving different communities. That is, collaboration is occurring between Health Centers or between Critical Access Hospitals serving different communities. These types of collaborations or networks are generally designed to improve the operational status of those particular types of health care service providers.

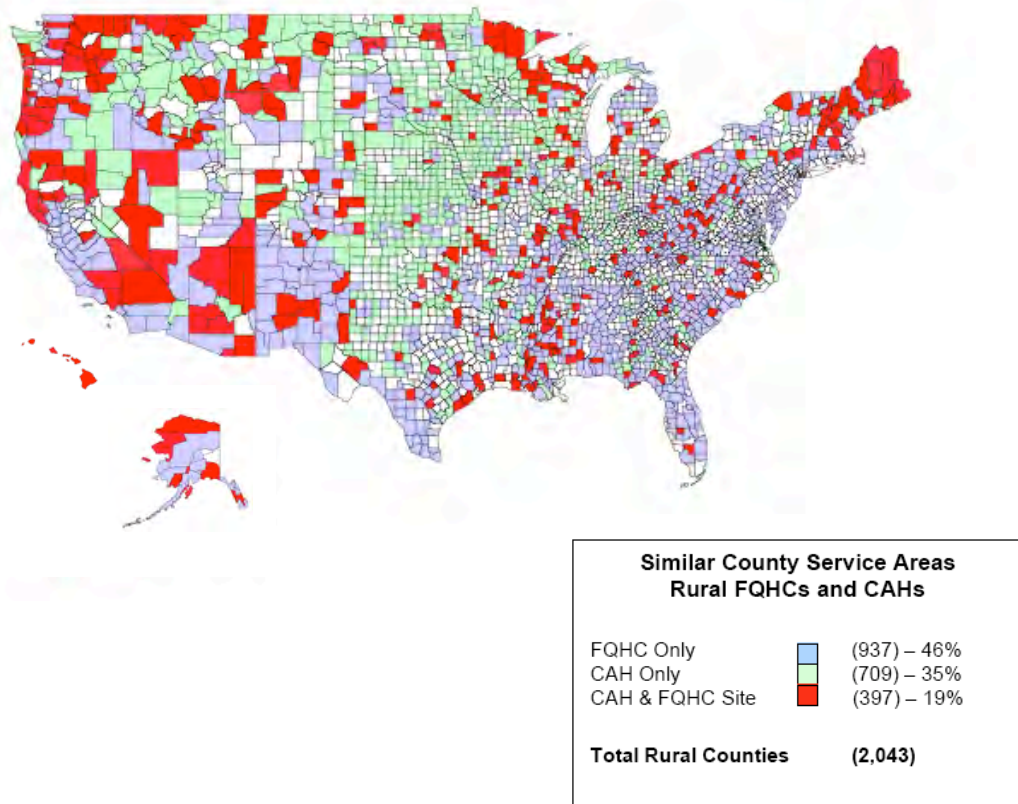
However, the collaborative context for this manual is not focused on collaboration between similar types of organizations serving different communities, but on organizations of different type or purpose, partnering to serve the same community. Employing county as a rough definition for community or service area<sup>xi</sup>, many CAHs and most FQHCs rural service sites qualify for single community collaboration because they treat the same communities. Forty six percent or 593 of 1,302 CAHs are located in rural counties which have FQHC service sites and 73 percent of all Health Center rural service sites or 2,505 of 3,442 are located in counties also served by a CAH. Essentially, the potential for collaboration between these two different safety net providers should be high, based upon similar service areas or communities.

FIGURE 2: Similar County Service Areas: CAHs and FQHCs

	CAHs	FQHC Rural Service Sites
<b>Total</b>	<b>1,302</b>	<b>3,442</b>
<b>Same Community</b>		
Number	593	2,505
Percent	46%	73%
<b>Different Community</b>		
Number	709	937
Percent	54%	27%

From a community impact perspective, 397 rural counties could benefit from a collaborative CAH/FQHC based delivery system. A total of 2,043 rural counties or communities have either a CAH or FQHC service site. However, most of these rural counties have only one or the other. A total of 397 rural counties or 19 percent of all these 2,043 rural counties have both a CAH and FQHC service site and hence are candidates for delivery systems enhanced by collaboration between CAHs and FQHCs<sup>xii</sup>. FIGURE 3 depicts rural counties with CAH or FQHC service sites and associated collaborative potential. Counties in red are those with both CAHs and FQHC service sites and represent communities with the highest potential to develop local FQHC/CAH based delivery systems.

FIGURE 3: Rural Counties: CAHs or FQHCs Only, CAH and FQHCs



While the unique capacities of CAHs and FQHCs can promote collaboration, their similar capacities often tend to promote competition. However, the need for local rural networks of health care services is widely recognized. Providers delivering individual components of care may excel in particular areas, but their positive impact can be severely offset by their patients' inability to access other needed programs or services. Often, continuity of care needs can be overshadowed by compelling institutional needs to develop programs that generate revenue or reduce costs that contribute to the health of the institution's overall bottom line.

**These are tough choices and collaborative examples cited herein show that both continuity and financial viability can be accommodated. Although focused on CAHs and FQHCs, collaboration between small rural hospitals and FQHCs that serve similar communities is equally important.**

## 2. FQHCs from A to Z

### DEFINITION

FQHC is a designation of the Center for Medicare & Medicaid Services (CMS) and entitles qualified organizations to set reimbursement rates controlled or influenced by CMS. Section 1905(1)(2)(B) of the Social Security Act identifies three types of FQHCs: (1) those receiving a grant, directly or through sub-recipient arrangements, under section 330 of the Public Health Service (PHS) Act; (2) those determined to meet the requirements of a grant but do not receive Federal funding (i.e., FQHC Look-Alikes); and (3) an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

For the purposes of this manual, FQHCs are specific to those organizations receiving a grant under section 330 of the PHS Act and those organizations, based on the recommendation of HRSA, that meet the requirements for receiving a grant (i.e., FQHC Look-Alikes). FQHCs designated under the Indian Self-Determination Act or by an urban Indian organization are not applicable to this manual.

FQHCs and FQHC Look-Alikes, also referred to as Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations regardless of their ability to pay. They must be private, charitable, tax-exempt nonprofit organizations or public entities. FQHC and FQHC Look-Alike designations require two actions, one from the Health Resources and Services Administration (HRSA) that “recommends” that the organization meets the eligibility and program standards of the Health Center Program and one from CMS that is more related to fiscal management and reporting.

FQHCs that are awarded a grant under the Health Center Program, as authorized in section 330 of the PHS Act (42 U.S.C. 254b), receive funding for one or more of the following types of section 330 programs:

- Community Health Center (CHC) Programs, funded under section 330(e);
- Migrant Health Center (MHC) Programs, funded under section 330(g);
- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

FQHC Look-Alikes (FQHC-LA) do not receive grant funding under the Health Center Program, however, they must meet all statutory requirements under section 330 of the PHS Act. FQHC-LA designation requires two actions, one from the Health Resources and Services Administration (HRSA) that “recommends” that the organization meets the eligibility and program standards of the Health Center Program and one from CMS that is more related to fiscal management and reporting. Additionally, at the time of applying for FQHC-LA designation, the organization may not be owned, controlled, or operated

by another entity. FQHC-LA can access some but not all of the program related benefits of FQHCs that are described later in this section. FQHC-LA may have stronger incentives to collaborate with CAHs than FQHCs because of their lack of grant funds to support services to the uninsured and underserved and more probable need for community benefit support from CAH structures.

Health Centers offer a variety of programs to the communities they serve. They are required to provide comprehensive primary care services as well as supportive services (i.e. health education, translation, transportation, etc....) that promote access to care. In addition, Health Centers may provide additional clinical and non-clinical services that support primary care. Such programs may include the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or services specifically designed for children with special needs or people living with HIV or AIDS (PLWHA).

Although this document focuses specifically on the primary and preventive health care capacities of FQHCs, it should not be overlooked that in addition to providing those services as discrete components of health care services, they may also offer a broad range of supportive services that populations with low incomes often need. Consequently they are not only a portal to effective primary-care preventive health services but also potentially to other health and social services.

## KEY FEATURES

### **Designation**

The process of developing compliant structures and capacities to meet health center requirements is complicated and costly. It includes needs assessment, preparing applications for Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA) and Medically Underserved Population (MUP) designations, developing compliant corporate structures, drafting service delivery plans or capacities, and preparing grant or FQHC designation applications.

### **Need**

FQHCs must serve, in whole or part, a Federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by HRSA as having: Too few primary care providers; High infant mortality; High poverty; and/or High elderly population.<sup>xiii</sup> MUA/MUP designation is an eligibility factor for receiving FQHC status.

### **Health Services**

FQHCs must provide primary care services, and as may be appropriate for particular centers, additional health care services necessary for adequate support of the required primary care services. The following clinical services must be provided directly, through contractual agreement, or through formal referral arrangements:

- Primary medical care
- Diagnostic lab and x-ray
- Screenings
- Emergency medical services



- Voluntary family planning
- Immunizations
- Well child services
- Gynecological care
- Obstetrical care
- Prenatal and perinatal services
- Preventive dental
- Mental health services (referral)
- Substance abuse services (referral)
- Specialty services (referral)
- Pharmacy

The following non-clinical services must be provided directly, through contractual agreement or through formal referral arrangements:

- Case management
- Counseling/assessment
- Referral
- Follow-up/discharge planning
- Facilitated enrollment services for Medicaid, CHIP, and other public insurance programs
- Health education
- Transportation
- Translation
- Outreach

FQHCs often provide services beyond the core requirements based on an assessment of the needs of the population and the availability and accessibility of services in their area.

FQHCs must provide access to their full range of services to all health center patients regardless of ability to pay. They are required to have a discounted fee schedule for patients whose incomes are below 200 percent of the Federal poverty level and full discounts for people with incomes at or below 100 percent of the Federal poverty level. FQHCs must provide care in a manner that is culturally and linguistically competent.

Health centers maintain appropriately credentialed and licensed providers (as applicable and necessary) to carry out their full range of services. Health Centers must offer their services at times and locations that assure accessibility and meet the needs of the population being served. In addition, health centers must provide professional coverage during hours when the health center is closed. Health Center physicians are expected to have admitting privileges at one or more referring hospitals to follow hospitalized patients. Where this is not possible, arrangement for hospital-based coverage and services must be established. Health Centers are also required to have an ongoing quality improvement/quality assurance (QI/QA) program that includes clinical services and management and that maintains the confidentiality of patient records.

### **Management and Finance**

FQHCs must establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center.<sup>xiv</sup> This requirement and several other clinical requirements helps to ensure continuity of patient care, essentially requiring arrangements or “collaboration” between health care service providers.

FQHCs must maintain a fully-staffed management team that is appropriate for the size and needs of the center. They must exercise appropriate oversight of billing and collections, have appropriate financial management and control policies, and have systems in place for collecting data and program reporting.

### **Governance**

A core component of FQHCs in their communities relates to the governing board requirements. The governing board must have a majority (minimum 51 percent) of members who are patients of the Health Center and who, as a group, reasonably represent the patient population. In addition, there are restrictions on the percent of nonpatient board members who earn 10 percent or more of their incomes from health care-related industries. Board members should bring areas of expertise that are relevant to Health Center operations and a community presence. FQHC governing boards must maintain appropriate authority to oversee the operations of the health center, including: Establishing policies; Approving budgets; Selecting services provided; and Selection, dismissal, and performance evaluation of the Executive Director.

## **KEY BENEFITS TO THE HEALTH CENTER**

### **Grant Funds**

Section 330 Health Center grant funds offset the costs of uncompensated care for the uninsured and underinsured and for key enabling services. Organizations that receive a section 330 grant for the first time receive “New Start” funding of up to \$650,000 annually. Additional HRSA and BPHC grant funding for service and capacity expansion may become available to existing Section 330-funded health centers.

### **Minimum per Encounter Medicaid or Medicare payment**

Both FQHC grantees and FQHC-LAs are covered by payment methodologies that guarantee health centers a minimum per encounter payment for services provided to Medicaid and Medicare beneficiaries.

### **Federal Medical Malpractice Coverage (Federal Tort Claims Act Coverage)**

The intent of the Federal Tort Claims (FTCA) Act is to increase the availability of funds for the provision of direct primary care services by reducing administrative costs associated with malpractice insurance premiums that health care centers have to fund. Health centers that are “deemed” under FTCA receive Federal protection for malpractice allegations made against the center for services and providers included in their Federal scope of project. This coverage applies to deemed Health Center grantees only, and is not available to FQHC-LAs.

### **340B Drug Pricing – Prescription Drug Discounts**

Significant savings on pharmaceuticals may be accessed by participating entities. FQHC grantees and FQHC-LAs are among the entities that may participate in the program.

### **Loan Guarantees**

Loan guarantees may be extended or made by non-Federal lenders for the construction, renovation and modernization of medical facilities that are owned and operated by Section 330 Health Centers. This only applies to FQHC grantees, not FQHC-LAs.

### **Other Federal or National Programs**

FQHCs and FQHC-LAs qualify for Health Professional Shortage Areas (HPSA) designation, which confers a basic eligibility to apply for National Health Service Corp personnel (scholars, loan repayors or Ready Responders) as well as eligibility to be a site where a J-1 Visa Waiver physician can serve. Rural areas often experience difficulties in the recruitment and retention of physicians. Due to these difficulties, many communities turn to the recruitment of foreign medical graduates with J-1 Visa Waivers to fill their physician vacancies.<sup>xv</sup> This program helps FQHCs recruit physicians.

*Grant funding, medical malpractice coverage and Health Personnel Shortage Areas designations appear to have the greatest positive financial relevance for collaboration between FQHCs and CAHs.*

### **Health Center Impacts on Rural Uninsureds' Use of Hospital EDs**

A study conducted in 2009 on rural communities in Georgia, showed that FQHCs in rural counties reduce ED use by the uninsured. Counties without a health center clinic site had 33 percent higher rates of uninsured all-cause ED visits per 10,000 uninsured population compared with CHC counties. Higher ED visit rates remained significant after adjustment for factors associated with high ED use, specifically, percentage of population below poverty level, percentage of black population, and number of hospitals.<sup>xvi</sup>

## **HISTORY**

In the mid-1970s, Congress permanently authorized neighborhood health centers as “Migrant Health Centers” under sections 329 and “Community Health Centers” under section 330 of the PHS Act. This signaled a movement towards the development of independent health centers governed by a majority of consumers of health center programs. On a related primary care access track, Congress passed the Rural Health Clinic (RHC) Services Act of 1977 (Public Law 95-210) which provides cost-based Medicare reimbursement for a defined set of core physician and non-physician outpatient services.

Throughout the 1970s, the number of health centers grew from 158 in 1974 to 802 in 1980. In the latter part of the decade, Federal support for health centers diminished but not as much as for other “War on Poverty” programs. In the early 1980s, these Community and Migrant Health Centers received more funding.

In 1989, the Federally Qualified Health Center (FQHC) program was established by the Omnibus Budget Reconciliation (OBRA) Act. This act provided for reimbursement of reasonable costs for legislatively specified FQHC services covered by Medicaid. The OBRA Act of 1990 enacted Medicare reimbursement of reasonable costs and recognized

the importance of FQHC-LAs, which met the requirements under section 330 of the PHS Act but did not receive Federal grants for operation.

The 1990s saw a much greater degree of interest on the part of the Federal Government in developing programs that could more consistently maintain providers in rural communities. At present, over 1,200 health centers and FQHC Look-Alikes are operational. FQHC Look-Alikes grew both in number and importance during this time period and program focus included primary care in sparsely populated and frontier areas. There are a total of 1,126 health centers with 7,610 service sites, 3,442 of which are located in rural counties.

### 3. CAHs from A to Z

#### DEFINITION

The term Critical Access Hospital used herein is a formal designation conferred by the Federal Centers for Medicare & Medicaid Services (CMS) and state health departments. A facility that meets all of the following criteria may be designated by CMS as a CAH:

- Is located in a state that has established with CMS a Medicare Rural Hospital Flexibility Program
- Has been designated by its state as a CAH
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital
- Is located in a rural area or is treated as rural
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles)
- Maintains no more than 25 inpatient beds
- Maintains an annual average length of stay of 96 hours or less per patient for acute inpatient care
- Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services 7 days per week and comply with the Emergency Medical Treatment & Labor Act (EMTALA)<sup>xvii</sup>

A CAH may also be granted "swing-bed" approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds. "Swing beds" programs are so named because the bed can be used for two purposes: as acute-care or post-hospital skilled nursing care depending upon the needs of the patient. CAH inpatients become eligible for swing-beds when their needs at the CAH shift from acute-care services to skilled nursing care. This is a dual licensure that permits the CAH to operate and bill accordingly.

## KEY FEATURES

CAHs can operate a variety of programs and services that include:

- 24-Hour ER Department
- Inpatient Services
- General Surgical
- Obstetrical
- Rehabilitation
- Intensive Care
- Outpatient
- Surgical
- Psychiatric
- Rehabilitation
- Specialty Clinics
- Rural Health Clinic
- Support Services
- Radiology
- Lab Services
- Ambulance
- Long-Term Care Services
- Skilled Nursing
- Swing-bed Services
- Home Health
- Hospice Services
- Special Units
- Assisted Living
- Psychiatry

Fundamentally, CAHs are expected to:

- Improve access to services that meet identified local needs
- Engage rural communities in health care decision-making and system development
- Develop collaborative delivery systems in their communities with CAHs as the hub of those systems of care
- Undertake collaborative efforts to address unmet community health and health system needs.<sup>xviii</sup>

## KEY BENEFITS OF CAHs

### **ER Safety Net**

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals like CAHs that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.<sup>xix</sup>

### **Community Benefits**

There currently are 1302 CAHs in operation in 46 states, approximately 96 percent of which are not-for-profit organizations.<sup>xx</sup> Not-for-profit CAHs are required by law to provide community benefits to the residents of the communities they serve as a result of their not-for-profit status.<sup>xxi</sup> Community benefit programs are programs or activities that provide treatment and/or promote health in response to an identified community need and help to define Federal requirements of the relationship between the CAH and its community. These requirements are based in IRS law and define required

community/CAH relationships. There are five general categories of community benefits and examples of CAH impacts for each type follow:

### **Provision of charity and uncompensated care**

Nearly all (99 percent) CAHs offer financial assistance to patients; 87 percent offer both charity care and discounted charges; 33 percent have discount eligibility at 100-200 percent of the Federal Poverty Level; and 25 percent have higher income eligibility levels.<sup>xxii</sup>

### **Identifying and addressing unmet community needs**

Nearly half (48 percent) of CAHs report having conducted a formal Community Health Assessment in the last 3 years. Two-thirds have a formal planning process for addressing new services or other hospital and community needs. Community needs addressed include: adding or expanding services, public health activities (e.g., screenings, fairs), recruitment and retention of providers, chronic illness prevention and education, and capital improvements.

### **Prevention and health improvement**

Nearly all CAHs offer some combination of community health education, preventive screenings, clinical preventive services, and support services (e.g. Medicaid enrollment assistance). Moreover, these services are typically subsidized or offered at a final loss.

### **Building a continuum of care and enhancing community health system capacity**

Many CAHs provide financial support and help to other community health care providers including primary care providers (46 percent), FQHCs (29 percent), LTC (40 percent), Mental Health (31 percent), and EMS (34 percent). Other health system development activities include: active recruitment of providers, job creation and training programs, and workforce education.

### **Stabilizing Rural Health Services**

#### **Enhanced Reimbursement Rates and Access to Grants**

CAHs may elect to bill Medicare outpatient facility services and professional services through the Optional (Elective) Payment Method (also known as Method II billing). This option allows for cost-based payment for facility services plus 115% of the Physician Fee Schedule payment for the professional services. CAHs that elect to bill in this manner can generate additional revenue that can be used to improve the financial stability of CAH-supported services and affiliated practitioners. This option also allows for decreased administrative burden and can be used as recruitment and retention tool for rural providers. Additionally, physicians who furnish care in a CAH that is located in a geographic-based Health Professional Shortage Area (HPSA) are eligible for a 10% HPSA incentive payment for outpatient professional services furnished to a Medicare beneficiary.

### **Improved Hospital Quality**

Critical Access Hospitals have been shown to have better patient safety than some non-CAH rural hospitals. A study of rural hospitals in Iowa in 2008 found that conversion to CAH status resulted in enhanced patient safety.<sup>xxiii</sup> Specifically, Iowa CAHs performed better on three of five specific Patient Safety Indicators (PSI) and the overall score for the five indicators. Performance was shown to be better on iatrogenic (medically caused) pneumothorax, selected infections due to medical care and accidental puncture or laceration. This analysis controlled for the impact of patient case mix, market variables, and time trend which were thought to influence the rate of these indicators.

### **Expanded Services**

Many CAHs have added or expanded services not dependent on inpatient capacity.<sup>xxiv</sup> Of the 474 CAHs surveyed in 2004, at least 20 percent added or expanded radiology, specialty clinics, outpatient rehabilitation, and laboratory services, while others commonly added or expanded outpatient surgery and rural health clinics. Of the 540 CAHs surveyed during the three survey years, at least 25 percent added or expanded radiology, specialty clinics, outpatient rehab and laboratory services. In 2004, CAH administrators were asked the reason they changed the services offered. For over half of the added or expanded services, the majority of administrators reported that community need was the reason for these expansions.

## **HISTORY**

In 1946, the Hospital Survey and Construction Act, the law commonly known as the Hill-Burton Act, was enacted. Hill-Burton was designed to address severe shortages of hospital beds in underserved areas, particularly the rural south. From 1947 until the program ended in 1971, the law sponsored the creation of a modern health care infrastructure. During that period, space for nearly half a million beds was created in 10,748 construction projects that included hospitals, nursing homes, mental health and other specialized facilities, and public health centers.

In 1983, the Medicare Inpatient Prospective Payment System (PPS) was established. More than 400 rural hospitals in the United States closed during the period 1983 to 1987. A major reason for the closures was the inability of rural hospitals to generate positive financial margins under PPS. The PPS Medicare reimbursement formula pays hospitals at rates that vary significantly by geographic region, generally paying substantially lower rates to providers in rural areas in contrast to urban areas for the same services. In addition, the relatively low number of medical procedures performed by smaller hospitals made them financially vulnerable under the PPS formula, which is based on averages.

The impacts of these closures were felt throughout local communities. Hospital closure negatively affected access to emergency room and ambulance services, physician recruitment and retention and both primary and secondary care. Additionally, these hospitals were major employers and significant contributors to the economic



infrastructures of their rural communities. Their closure adversely affected schools, business recruitment, retiree attraction and local businesses in general.

In 1989, Congress authorized the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/ RPCH) Demonstration Project in its Omnibus Budget Reconciliation Act. This project was implemented in seven states and was designed as a hub and spoke model with EACH being the hub and RPCHs being the spokes and was a precursor to the CAH program. RPCHs had 72-hour inpatient limits and could have no more than six beds. They were required to offer 24 hour emergency care and were linked to an EACH, or larger rural hospital which could provide a variety of supportive functions. The RPCHs were given cost-based reimbursement for their Medicare patients.

This demonstration project was an extension of the Medical Assistance Facility (MAF) Demonstration Project in Montana, the earliest model of limited services hospitals. These MAFs, which incorporated cost-based reimbursement, were located in frontier counties more than 35 miles from other hospitals and ranged in size from two to ten beds. Inpatient stays were limited to 96 hours, and virtually no surgery was performed at these facilities.

In 1997, the Balanced Budget Act of 1997 (BBA) merged the RPCH program into a new category of hospitals, called Critical Access Hospitals (CAHs). Conversion to CAH status was part of the Medicare Rural Hospital Flexibility Program (Flex Program), outlined in the BBA. The Flex Program consisted of two separate but complementary components: (1) a state grant program, and (2) a certification process for designating Critical Access Hospitals.

The State Flex Grant Program was administered by HRSA's Office of Rural Health Policy (ORHP) to support the development of rural community-based, organized systems of care. Forty-seven rural states were eligible for participation. Grants totaling approximately \$25 million were awarded in 1999 to the participating states, averaging around \$500,000 per grant. Required areas of focus were on Critical Access Hospital conversion, Emergency Medical Services, Quality Improvement, and Networks. A Technical Assistance and Services Center (TASC) was created to provide technical and educational support and to foster state-to-state learning.

The CAH development and designation process itself required strong linkages with the states and was overseen by the departments of health in each of the participating states. A formal state survey was required prior to certification to ensure compliance with the conditions of participation in the CAH program or unique characteristics of CAHs. If a hospital fails to meet the above conditions, it may still be designated by other state criteria as a Critical Access Hospital.

Hospitals that met the conditions, once designated, converted their hospital licenses to Critical Access Hospitals, and were reimbursed for Medicare patients on a cost-based formula for both inpatient and outpatient services. The change in reimbursement method had an immediate and largely positive impact on the CAHs' financial performance.

The Balanced Budget Refinement Act of 1999 (BBRA) included several changes aimed at increasing the flexibility of the Critical Access Hospital program. The BBRA changes to the program criteria include the following:

- Replaced the per patient 96 hour length-of-stay limitation with an annual average 96-hour length-of-stay limitation
- Granted CAH status to hospitals that had closed in the past 10 years, and to those hospitals that had downsized to a health clinic or center
- Extended CAH eligibility to for-profit hospitals

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) further enhanced the CAH program. The majority of provisions included in that legislation pertain primarily to reimbursement policies or rates. BIPA also provided increased flexibility in bed limitation up to 25 beds and made changes to staffing and ambulance provisions. In addition, it provided greater flexibility for a CAH to serve as a reference laboratory for rural communities.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. 108-173 is landmark legislation that provides prescription drug benefits for approximately 40 million seniors and disabled Americans beginning in 2006 and approximately \$25 billion in relief to hospitals over 10 years. Section 405 contains important provisions for CAHs that enhance reimbursement, expand bed-size flexibility, and provide continued funding of the Medicare Rural Hospital Flexibility (FLEX) Program grants. The MMA allows CAHs to establish psychiatric and rehabilitation distinct part units. Beds in these distinct part units are excluded from the bed count. Services provided in these distinct part units will be under the applicable payment system for those units.

This modification reinforces the potential for collaboration between CAHs and FQHCs in the area of mental health, where CAHs provide the inpatient component and FQHCs operate the outpatient component. This is especially relevant due to the FQHCs' recently obtained access to Federal grants for outpatient mental health service expansion.

## 4. Collaborative Potential of CAHs and FQHCs

CAHs and FQHCs have evolved over the past ten years as major parts of the rural health landscape. Scope of service has expanded, quality of and continuity of care have been shown to improve in some communities, and their importance to the community has grown correspondingly. Along with that growth, the potential for collaboration appears to have also increased and additional opportunities are emerging for collaborative approaches to community health and mental health needs.

Prior sections of the manual showed that as Federal initiatives, the Health Center and CAH Programs are designed to stabilize and enhance the array of health care services in rural communities. Primary and preventive health care services, 24-hour emergency, and inpatient care and access to specialty services make up the core of the rural health delivery system. An equally important requirement is that primary and 24-hour emergency care must be accessible to underserved and uninsured residents of rural communities.

Health Centers and CAHs access different Federal and state supported financial mechanisms to address these needs. Several relate to enhanced set Medicare and Medicaid reimbursement rates for outpatient, ER, and inpatient services and others are more general forms of support such as grants. The overall intended effect of these mechanisms or incentives is improved fiscal bottom lines and operating margins of these safety net service providers so that the needed array of services can be strengthened and maintained.

Collaboration offers a mechanism through which both organizations can work together in supporting that needed array and share and conserve their own unique incentives. Four concepts which relate FQHC and CAH unique roles and responsibilities to the potential for collaboration have emerged:

1. Challenges faced by rural communities
2. The extent to which these “community benefit” mechanisms can be shared and foster collaboration between these two organizations
3. Barriers to collaboration in rural communities
4. Implications to Frontier Counties and Tribal Health Services

Several practical lessons have been identified which can guide current and future collaborative efforts:

1. Leadership, Continuity and Commitment
2. Compelling Needs and Solutions
3. Collaboration Instead of Competition
4. Significant Benefits
5. Financial Implications

## CONCEPTS

### **Concept 1 – Challenges Faced by Providers in Rural Communities**

Differences between CAHs and FQHCs can reinforce each other's roles and stability. Yet there are several commonalities in their relationships to rural communities that engender collaboration as well:

- While CAHs and FQHCs are very different providers with different rules and regulations, they both have a legal safety-net role in rural communities. FQHCs are required to see all patients regardless of ability to pay and CAHs must see all patients presenting themselves for emergency care. Not-for-profit CAHs are also required to document their benefit to the community.
- They both share a desire to provide high-quality health care services in their community and to be patient-focused in a way that makes it easy for the patient to get care as close to home as possible.
- Geographic isolation, lack of economies of scale, high disease burden, and lower reimbursement rates represent specific challenges common to all service providers in rural communities
- The majority of Health Professional Shortage Areas are in rural communities and as such, rural communities are in greater need of recruitment resources. It takes an average of \$20,000 to \$30,000 to recruit physicians and collaboration can help to spread those costs.

This combination of factors begins to show that it would be very difficult to have a functional rural health care delivery network in an area with an FQHC and a CAH if they are not collaborating. Potential focus areas for collaboration which stem from these special challenges include:

- Services to uninsured, underserved and low-income populations
- Recruitment of staff
- Credentialing
- After-hours and on-leave staff coverage
- Seamless continuum of care
- Health information technology investments

### **Concept 2 – Community Benefit Mechanisms Fostering Collaboration**

Health Centers can access four highly important collaborative mechanisms:

- Direct grant support for primary care services including mental health and oral health to underserved and uninsured populations
- Federal medical malpractice coverage
- Enhanced health professional recruitment status for National Health Services Corp physicians needing to provide 30 hours per week of primary care services which they may not be able to do at CAHs
- Health Center controlled grant funds

Grant support can be indirectly shared with CAHs to the extent that the CAH can reduce its own costs for providing primary care services to low-income, underserved and

uninsured at its own ER (Federal regulations require all hospitals to treat all people that seek care at their ERs.) This has been accomplished in two ways:

1. CAH-ER variable costs for medications or diagnostic tests can be reduced by referring the patient to the Health Center for those follow-up services
2. CAH-ER efficiency is improved by linking these patients with the FQHC, which has been shown to reduce unnecessary ER use

Medical malpractice coverage under certain conditions may represent the largest potential indirect benefit to CAHs. FQHC and CAH partnerships can reduce and/or eliminate financial restraints associated with supporting primary care physicians. The FQHC does not have to pay for medical malpractice coverage for its physicians and this cost is eliminated from its own balance sheet. The indirect savings to the CAH and local health network can be considerable, ranging from \$10,000 up to \$250,000 per year depending upon type of primary care malpractice coverage. Organizations interested in this type of collaboration must thoroughly examine associated Federal requirements.

Health Center controlled networks are eligible for grants for improvements in administrative capacities and health information technology. These networks can have non-CHC members, such as CAHs, which can access these Health Center controlled network capacities as well.

Critical Access Hospitals have access to four highly important mechanisms:

- Enhanced reimbursement for 24-hour emergency coverage for the underserved as well as the general population
- Enhanced reimbursement for inpatient and outpatient services
- Financial support through Federal and State Flex grants
- Indirect linkages with regional medical centers

Health Centers can indirectly benefit from CAH enhanced reimbursement mechanisms through the CAHs provision of 24/7 ER coverage and potential back-up to the FQHC, the local availability of needed inpatient care and in some areas inpatient psychiatric care, and enhanced continuity of care relationships with the CAHs with which the FQHC physicians have admitting privileges. The physical location and probable proximity of these services minimizes geographic access barriers and helps to assure that FQHC patients can access services beyond the scope of the FQHC. It helps to assure that the core of needed services infrastructure is maintained.

CAHs can be self-sufficient independent corporations, public entities or be affiliates or subsidiaries of regional health systems. A strong relationship to a regional system in some instances benefits the FQHC. Regional health systems can provide public benefit contributions which can take a variety of forms including operational support for FQHC development and bridge funding for start-up operations, in-kind or fair market value contributions for rent or equipment for services to the underserved or uninsured. This increased access to capital appears to have the most relevance for FQHC Look-Alikes which qualify for, but do not receive, grant funding and need some form of financial

support for the services it provides to low-income, underserved and uninsured populations.

### **Concept 3 – Barriers to Collaboration in Rural Communities**

The abundance of rural community needs and unique attributes of Health Centers and Critical Access Hospitals appear to make collaboration almost a “no-brainer”. However, studies have shown that documented successful collaboration in rural communities appears to be the exception rather than the rule. Apart from general barriers to collaborative endeavors such as differences in corporate culture, loss of autonomy and control, inadequate patient base to support both types of providers and philosophies of medical care, certain behaviors of Health Centers and Critical Access Hospitals can implicitly challenge collaborative endeavors. Examples of such specific behaviors include king-of-the-hill mentality, broken promises, duplicating service lines, expanding into service lines already covered by a Health Center or CAH, and hospital referral patterns that bypass or disregard the availability of local capacity.

Arguments for duplicative capacities generally stem from perceptions of better quality and revenue generation needs. Referrals to other hospitals may be related to continuity of care or quality of care relationships, but have negative revenue implications for the CAH.

*Successful collaboratives recognize these dynamics and establish relationships which maintain access and quality and the underlying financial viability of the local service system rather than focusing only on individual provider capacities.*

### **Concept 4 – Implications for Frontier Counties and Tribal Health Services**

Just as attributes of the rural health delivery systems and communities can differ from those of urban health care systems and communities, attributes of rural areas also vary considerably by the remoteness or frontier<sup>xxv</sup> nature and the presence of various Native American Tribes, whose culture and traditions vary significantly including their tribal operated health care services in some remote communities.

Strong CAH linkages with regional hospital systems and strong FQHC “linkage/ownership” to regional FQHC capacities has been shown to be an effective way to promote collaboration between these two types of providers in northern New Mexico. In this instance collaboration occurs between FQHC and Hospital System corporate levels as well as the rural community service provider levels. Both the local FQHC and CAH also benefit from services they receive from their corporate affiliates.

Native Americans and the presence of Tribal Health Services are found in frontier communities. A consortium of Tribes operates both FQHCs and CAHs in Alaska. Communities benefit from this joint corporate level management of FQHCs and CAHs, especially in terms of telehealth, telemedicine, HIT, and shared “back-office” administrative support. Shared clinical staff, however, due to the distances involved between clinics and CAHs can preclude that type of collaboration. Subsequent materials summarize how these areas have been addressed in successful collaborations between CAHs and FQHCs.

## LESSONS LEARNED

### **Lesson 1 – Leadership, Continuity and Commitment**

Needs and benefits drive the development and continuation of collaborative ventures. Yet, the people factor – in terms of leadership at the community and provider level – cannot be underestimated for collaboration between hospitals and Health Centers to succeed. Apart from general characteristics of leadership, the traits which seem particularly relevant to effective CAH/FQHC collaborations include:

(1) recognition that networks or systems of services are essential to meet health care needs and

(2) realization that individual actions must take into account the potential impacts of those actions on needed partners and services.

Continuity of leadership and technical capacity throughout the development of collaborative actions was also a critically important variable in the three studied collaborations. In all instances, leadership remained constant over the period in which the major changes took place, which was several years. Leaders continued to demonstrate a commitment to the need for the collaborative action, and it was aggressively communicated throughout their respective organizations. Technical resources, such as strategic planners and facilitators, associated with collaborative actions were shared by individual organizations, delivering knowledge and expertise to the collaboration and helping to incorporate it into their individual organization's strategic business plans and objectives.

The importance of continuity in leadership driving successful collaborations cannot be overstated. The mere fact that two or more organizations are involved means that there are two or more possibilities for changes in leadership. The collaboration can be jeopardized by changes in leadership at any partnering organization, where the perceived importance of the collaboration and assignment of resources might change. This is a very important dynamic in that it has been reported that more than 20 percent of CAH leadership in a state may change each year. FQHCs and CAHs with board-adopted strategic and business plans that incorporate collaborative initiatives were in a better position to pursue these objectives when changes in leadership have occurred. CAH and FQHC Board and administrative leadership participation in collaborative projects also helps to provide continuity in the event either type of leadership changes.

## **Lesson 2 – Compelling Needs and Solutions**

Successful collaboration and related benefits were demonstrated in three rural communities. The initial collaborative actions undertaken addressed current or emerging compelling needs. For two of the three communities reviewed, the compelling need was the impending loss of primary care capacity. The actual closure of a small rural community hospital was the driving force behind collaboration in the third area. In the former cases, hospitals joined forces with community groups and clinics to remedy the impending lack of primary care. In the latter, community groups, clinics and government agencies joined forces with hospital leaders to maintain emergency, inpatient and specialty care access in the community. For all three sites, regardless of the precipitating compelling need or lead organizations, there was clear recognition that primary care and hospital care needs are interdependent and that both needs must be met for either type of care to be effective. The best approach to meeting the compelling need included strategies with multiple impacts which stabilized both primary care and hospital capacities.

Once again, the motivating precondition was a compelling or critical need which, if left unaddressed, would have extremely deleterious effects upon the health and well being of rural communities and the stability of other health care service providers in the area.

## **Lesson 3 – Collaboration Instead of Competition**

Rural service areas in which collaboration between Health Centers and Critical Access Hospitals has been effective share one key characteristic. First and foremost, community, administrative, and medical leadership in those areas recognize that the local system of health services is best served through collaborative approaches rather than competitive ones. As noted in previous sections of this manual, a major precept of collaboration is that each of the collaborating partners has a unique capacity that the other organization does not have. In some rural communities, there is an inherent structure – dual capacity at Health Centers and CAHs – which may preclude collaborative activity. The two areas where this seems to be most prevalent are outpatient services and laboratory services. In those instances where FQHCs and CAHs provide both of these services either directly or through affiliation with rural health clinics or laboratory services, collaboration with the intent of supporting unique service capacities may be infeasible on the surface. However, closer examination may reveal other issues that can be the basis for a collaborative compromise.

For example, FQHC primary care related capacities are targeted at the underserved or uninsured to some degree through Health Center grants. The importance of services for the underserved population can weigh heavily in discussions on collaboration and supports capacity at FQHCs rather than other service providers. Arrangements for laboratory services can shift in the direction of the CAH and the related viability of its local capacities. The community benefit perspective indicates that support of primary care at FQHCs is a good collaborative agreement on behalf of the uninsured populations and support for laboratory service at CAHs helps to maintain local needed hospital related capacity – specifically ER, inpatient and access to specialty care. In such a scenario, the community, the CAH and the FQHC all win.



In communities where Critical Access Hospitals were key formative partners of the collaboration, decisions had been made by those hospital structures that it was in the best interests of the community and their own organizations that they assist Health Centers in the provision of primary care services, especially to underserved populations, rather than compete and duplicate them within their own structures. Similarly, FQHCs established referral relationships with CAH laboratory services rather than creating their own competing labs. These are synergistic rather than competitive scenarios wherein philosophy of care distinctions – Health Center philosophy vs. CAH philosophy vs. local rural health system philosophy – are reconciled with community benefit and organizational profit or loss considerations.

#### **Lesson 4 – Significant Benefits**

##### *Rural Communities*

Communities benefit when collaboration results in a local network of needed high quality sustainable health care services designed to maintain and improve the health of the community. Access to care is maintained and strengthened through shared use of health care resources such as grants and cost-reduction mechanisms. Successful collaboration between Health Centers and CAHs strengthens the local health network infrastructure, maintains and increases access to needed services and maintains or enhances quality and continuity of care. Additionally, when local health care providers refer patients to other providers in the community, those health care dollars do not bypass the community and can directly and indirectly fortify the local economy. Access to care can be enhanced through co-location of FQHC services on the grounds of the CAH. As need for inpatient care declines, CAHs in some areas may have space which can be used as an FQHC service site. In instances where the patient needs services operated by the CAH and FQHC service site at the CAH, both needs can be met without traveling to multiple locations.

##### *Benefits of Collaboration Between CAHs and FQHCs*

Each provider contributes a unique resource to the collaboration that fosters infrastructure, access, and quality of care improvements. These unique resources serve as the basis for the collaboration itself. When neither provider can accomplish an important objective alone, concerted action is needed. In addition, the collaboration itself is a source of unique benefits or resources that cannot be obtained by individual organizations.

FQHCs benefited by accessing CAH unique resources:

- In-kind administrative and financial support
- Facilities and equipment
- Health-related professional specialists such as physical and occupational therapists
- Health personnel recruitment capabilities
- Medical leadership
- Hospital related patient care records or laboratory reports

CAHs benefited by accessing FQHC unique resources:

- Medical malpractice coverage in specific instances
- Physician recruitment and retention capacities
- Stabilizing effect on primary care capacity and concomitant patient needs for hospital related services
- Increased financial support for the uninsured or underserved

Both CAHs and FQHCs (comprising the core of local rural health infrastructure) benefited from:

- Increased grant support for personnel, equipment and facilities for shared services
- Shared community, administrative and medical leadership
- Shared access to patient care records
- Shared quality improvement programs

### **Lesson 5 – Financial Implications**

Financial implications or benefits of collaboration identified by the organizations themselves are equally compelling. Twelve areas of collaboration with financial impact were noted across the three sites. Six areas had quantifiable cost savings or new financial resources. In total, \$2,225,000 was obtained for one or two year related costs such as start-up and time-limited grants for three collaborative areas and \$1,083,000 was identified as annual savings for the other three collaborative areas. Cost savings were also noted in six other areas but estimates of the actual amounts were not available. Methods for estimating costs savings or sharing are depicted in the subsequent community descriptions.

CAHs and FQHCs benefited financially in different ways.

FQHCs benefited from:

- Start-up costs assistance directly from hospitals for FQHC establishment services, i.e. FQHC studies, development and operational plans, and applications - \$75,000
- In-kind or community benefit contributions for several start-up years - \$150,000
- Grants contingent upon collaboration with the CAH - \$2,035,000
- Shared administrative costs - \$400,000
- Use of CAH physician recruitment and credentialing capacities
- Medical leadership by CAH Medical Director

CAHs benefited from:

- Reduced medical malpractice related costs for ER coverage, primary care and OB/GYN practitioners - \$500,000 per year
- Grants contingent upon collaboration with the FQHC - \$183,000
- Reduced variable costs for ER services to the uninsured or underserved through linkage with primary care providers at FQHC
- Reduced physician recruitment costs through reduced fees
- Reduced physician retention costs through reduced ER call coverage responsibilities
- Indirectly stabilized revenue for services related to primary care capacity

Compelling needs, unique institutional capacities and benefits, and the overall community benefit of a more financially stable network of local health care services make these collaborations attractive. However, unequivocally, the direct and indirect financial benefits associated with these ventures are a major determinant of success. Business plans which are predicated upon a thorough examination of the pros and cons of partnering are important prerequisites.

Given these financial implications, CAHs or FQHCs contemplating collaborative arrangements are advised to review their plans with their own legal counsel. References herein are meant as examples with the understanding that any type of arrangement between health care providers requires due diligence scrutiny to help to assure compliance with applicable regulations and statutes.

## 5. Examples of Successful Collaboration

CAH and FQHC collaborations in three rural communities resulted in improvements in infrastructure, service access and quality. Each of the sites provided information on the type of improvement as well as estimates of financial benefits.

The sites are located in West Virginia, Massachusetts, and Georgia and varied by

- Compelling need
- Lead organizations
- Complexity of relationships between FQHCs and CAHs
- Extent of involvement of state government and state primary care and hospital associations

In addition to the similarities referenced earlier in the manual, i.e. Compelling needs; Community, administrative, and medical leadership; and Commitments to maintaining local systems and services, the physical proximity of collaborating entities was also very similar – nearly adjacent or within two miles of each other. Physical proximity itself however, did not appear to be part of the rationale for working together.

One site represents the highest level collaboration in that the FQHC actually governs and operates the CAH. It shows that both types of facilities can merge and form a single system as long as governance and programmatic aspects coincide with various Federal requirements. The second site includes collaboration serving two different communities approximately 160 miles apart and a FQHC, FQHC-LA, a CAH managed by a larger regional hospital based health system and the larger regional hospital system itself. The third site is an individual FQHC and CAH affiliated with a large regional health system.

Individual summaries of each site provide information on the background behind FQHC and CAH collaboration, and the types of infrastructure, access, quality and financial benefits that accrue to the community and respective organizations as a result of the collaboration.

Site A – Minnie Hamilton Health System, Grantsville and Glenville, West Virginia  
FQHC and CAH services with one governing and operating authority

Site B – Fairview Hospital (CAH), Great Barrington, Massachusetts, an affiliate of Berkshire Health Systems, Inc., Pittsfield, Massachusetts  
Community Health Center of the Berkshires (FQHC), Great Barrington, Massachusetts, a component of Community Health Programs, Inc., Great Barrington, Massachusetts

Site C – Early Memorial Hospital (CAH), Blakely, Georgia  
John D. Archbold Memorial Hospital, Inc. (Managing Hospital), Thomasville, Georgia  
Primary Care of Southwest GA, Inc., Blakely, Georgia (FQHC)

## SITE A

### **Minnie Hamilton Health System, Grantsville and Glenville, West Virginia FQHC and CAH services with one governing and operating authority**

#### **Background**

The Minnie Hamilton Health System provides a robust variety of health care services at four sites in a two county area in central West Virginia. It is a unique health care organization in that both the Federally Qualified Health Center service programs and Critical Access Hospital programs are governed and operated by the same community board structure. Minnie Hamilton provides a practical example of how both programs can be totally compatible partners in a community controlled health care delivery system.

Minnie B. Hamilton (1900-1981) was a native of Calhoun County who tirelessly served her community as the Public Health Nurse for more than thirty years. In 1985, when a community health center was opened in Grantsville, WV adjacent to Calhoun General Hospital, it was named in her honor. In the early part of 1996, Calhoun General Hospital closed due to financial difficulties, and the directors of Minnie Hamilton Health System (MHHS), with considerable support from the local community, health care organizations and state officials, elected to incorporate the hospital building and its operations into their services. Efforts to negotiate a merger prior to closure were impeded by differences in corporate culture between the hospital and community clinic. The actual closure, although traumatic to the community, was a necessary precondition to the creation of the combined FQHC/CAH entity. The State of West Virginia assisted through grants and consultants; Stonewall Jackson Memorial Hospital of neighboring Weston, WV provided guidance and services through an affiliation agreement; and a new Medicare program designation of EACH/RPCH, the precursor to the CAH program, all combined to help the new operation get underway.

During 1996, inpatient, outpatient, clinic, emergency and ancillary services were provided, and an average of eighty employees were on payroll. After six years, the financial report for the year 2008 showed an annual operating budget of \$14,200,000 and employment of 223 individuals.

The growth of MHHS and its services has included: a 24-bed long-term care unit, a satellite clinic in Glenville, WV, daycare services, critical care emergency medical services, ambulance transport services, school-based health clinics in Calhoun and Gilmer counties, outreach programs, physical therapy and CT scan services. More than \$2,035,193 in capital equipment has been acquired since 1996 and various additions and improvements have enhanced the hospital building. Presently, Minnie Hamilton Health System is a 43-bed facility with FQHC and CAH designations.

## **Summary**

Current collaborative efforts address the three main areas of local health care system infrastructure, access to and quality of care. Forty-five areas of collaboration were identified that positively impacted access to primary care, emergency department, inpatient services and specialty care. The financial implications of this venture are equally impressive. The system in its entirety experiences a minimum \$650,000 cost savings due to the dual designation it holds. Approximately \$400,000 is saved in administration and overhead, as calculated in the institution's cost report, and approximately \$250,000 is saved per year in medical malpractice coverage for primary care physicians providing the emergency room coverage at Minnie Hamilton. Essentially, the FQHC saves \$400,000 through this allocation of administration and overhead costs to the hospital and conversely, the CAH saves \$250,000 in medical malpractice costs that it would have to pay if it employed its own emergency room physicians.

## **Major Areas of Collaboration**

### *Local System Infrastructure*

The governance structure, operational and financial planning and service oversight is provided through one community board, administrative and support services team and medical staff. Additionally, Minnie Hamilton can access grant funds for FQHCs and CAHs and apply those funds in a manner, which is designed to improve the overall system of services as well as respective grant requirements. Examples of other infrastructure benefits include reduced duplication of equipment between ambulatory and inpatient care and the same health information technology system and information technology staff. All inpatient and outpatient needs for laboratory and radiology are met by one hospital operated laboratory and radiology department as appropriate.

### *CAH or FQHC Benefit*

The FQHC benefits from an allocation of administrative overhead of \$400,000 to the CAH. Other savings although apparent were not quantifiable at this time.

### *Access to Care*

The main site in Grantsville in Calhoun County houses many different health care programs. Three school-based health clinics are also located in Calhoun County. A separate clinic and two school-based clinics are located in nearby Glenville, WV in Gilmer County. Access to care has been maintained and improved relative to ambulatory, emergency, and inpatient, dental and ancillary services through this collaborative structure. FIGURE 6 Minnie Hamilton Health System Collaboration Summary lists the service mix operated by Minnie Hamilton.

### *CAH or FQHC Benefit*

The CAH benefits significantly through the medical malpractice coverage provided to primary care doctors for primary care and most specifically ER coverage. ER coverage savings equal \$250,000 per year.

*Quality of Care and Continuity of Care*

Both the CAH and FQHC have the same medical director, credentialing department and quality improvement department. Coordination or continuity of care between different hospitals and primary care clinics is less of an issue here because these types of services are all operated directly by and overseen by Minnie Hamilton and utilize the same health information technology system.

*CAH or FQHC Benefit*

No specific dollar figures were provided.

*Quantifiable Financial Impacts of Collaboration*

The following chart provides a snapshot of areas operated by Minnie Hamilton and impacted by the “collaboration” in varying degree. The ultimate beneficiary once again is the community as a whole.

FIGURE 6: Minnie Hamilton Health System Collaboration Summary

Area	Focus	Annual Savings
Infrastructure	Fully Integrated Health Care System	\$400,000
Infrastructure	Board Leadership	X
Infrastructure	Administration Leadership	X
Infrastructure	Medical Leadership	X
Infrastructure	Information Technology	X
Infrastructure	Billing	X
Infrastructure	Credentialing	X
Infrastructure	Human Resources	X
Infrastructure	Quality Improvement	X
Infrastructure	Facility Management	X
Access	Equipment	X
Access	Facilities	X
Access	Dental Services	X
Access	Out-Patient Primary Care Clinics	X
Access	Dental Services	X
Access	Pediatrics	X
Access	Immunization	X
Access	School Based Clinics	X
Access	Emergency Room – 24 hour Physician coverage	X
Access	Ambulance	X
Access	Air Support	X
Access	Transport Services	X
Access	In-Patient	X
Access	Long Term Care	X
Access	Observation beds	X
Access	Swing beds	X
Access	Hematology Services	X
Access	Respiratory Therapy	X
Access	Physical Therapy	X
Access	Laboratory	X
Access	Radiology	X
Access	CT Scan	X
Access	Ultra Sound	X
Access	Pharmacy	X
Access	Sleep Clinic	X
Access	Day Care	X
Access	Outreach Services	X
Access	Wellness Center	X
Access	Social Services	X
Access	Sleep Clinic	X
Access	Recruit Primary Care Physicians	X
Access	Retain Primary Care Physicians	X
Services	ER Coverage – FTCA Coverage	\$250,000
Quality	Access to All Records	X
Quality	Fully integrated services structure – medical direction	X
<b>Grand Total</b>		<b>\$650,000</b>



## SITE B

**Fairview Hospital (CAH), Great Barrington, Massachusetts, an affiliate of Berkshire Health Systems, Inc., Pittsfield, Massachusetts  
Community Health Center of the Berkshires (FQHC), Great Barrington, Massachusetts, a component of Community Health Programs, Inc., Great Barrington, Massachusetts**

### **Background**

Berkshire County, the community served by this collaborative effort, is located in the western portion of Massachusetts and bordered by New York State to the West. The area has an unusually high composition of working poor residents with an estimated 50 percent of births occurring to households with incomes less than 300 percent above of the Federal poverty level standards.

The major impetus for the current collaboration began in 2000 when Fairview Hospital and the Children's Health Program, Inc. worked together to develop and establish a Federally Qualified Health Center to meet the growing needs of uninsured and underserved residents of the community. Both organizations had strong ties to the communities and region. Fairview is an affiliate of Berkshire Health System, Pittsfield, MA, a private, longstanding not-for-profit organization that serves the region through a network of affiliates which include Berkshire Medical Center, the BMC Hillcrest Campus, Fairview Hospital, Berkshire Visiting Nurse Association, and long-term care associate Berkshire Health care Systems. A physician founded the Children's Health Program over 30 years ago as the only pediatric health clinic in South Berkshire County responding to the needs of "invisible" rural children living in poverty and isolation. Services had expanded to include a range of parenting support and childhood education services (the Family Network), a Women, Infants, and Children (WIC) program, and the First Steps program to provide early intervention therapies for children with delays or disabilities.

In 2000, a new community-based organization was formed – Community Health Programs – which included programs formerly operated by the Children's Health Program and Federally Qualified Health Center related programs. At that time, the health care services for that population were very limited and not sustainable. Since that time, a variety of joint initiatives have been pursued by the two entities which have helped to promote a coordinated system of inpatient, emergency room, primary care and specialty care services to residents of the Great Barrington, Massachusetts community.

### **Summary**

Current collaborative efforts address the three main areas of local health care system infrastructure, access to care, and quality of care. They also have positive cost implications. Eighteen areas of collaboration were identified that positively impacted access to primary care, emergency department, inpatient services and specialty care. The financial implications of these joint ventures are equally impressive. Fairview Hospital/Berkshire Health Systems, Inc. has provided an estimated \$75,000 for FQHC

structure development related tasks in 2000. Both organizations currently benefit from \$183,000 in grants for services in which they share resources and experience significant cost savings in several other joint programs. The local OB/GYN capacity, which had been supported by Fairview Hospital/Berkshire Health System in the past, saves an estimated \$250,000 each year in medical malpractice insurance costs. Without this “savings” and FQHC partnership, people in need would have to travel 30 miles for such care.

## **Major Areas of Collaboration**

### *Local System Infrastructure*

Initial collaborative efforts involved Fairview Hospital/Berkshire Health System providing financial support for technical community needs assessments studies and FQHC development and grant application preparation. Governance structure and operational and financial plans had to be developed which would substantiate need and guide the development of the FQHC. Considerable linkages were put in place through the initial agreement to have the same medical director for the FQHC and the hospital. This was recently expanded to the area of pediatrics relative to the FQHC pediatrician’s role as associate medical director at Fairview.

### *CAH or FQHC Benefit*

The FQHC benefited directly from the \$75,000 of support provided by Fairview Hospital/Berkshire Health System for needs assessment and FQHC development and grant preparation functions. FQHC medical director costs are absorbed 100 percent by Fairview in addition to approximately 50 percent of the compensation for the pediatrician for quality improvement oversight.

### *Access to Care*

The physical location of the Federally Qualified Health Center is the fourth floor of Fairview Hospital and support has been provided to the FQHC relative to primary care facilities and equipment.

The next most notable form of collaboration relates to the maintenance of OB/GYN capacities in the area. In early 2003, the OB/GYN practice in the area advised the hospital and FQHC that it was no longer viable from a financial standpoint. The hospital and the FQHC agreed to work together to recruit two obstetricians for the area. The FQHC eventually hired and provided medical malpractice insurance coverage for two OB/GYN practitioners. Pediatric services have also been stabilized through joint efforts of the FQHC and hospital.

A variety of other clinical services have been developed by this collaboration. The FQHC and the Critical Access Hospital are partners in a comprehensive medical home/care coordination joint grant. In this program, they share the services of nurse case managers from Fairview and patient navigators from the FQHC. In all likelihood, the program would not be possible without this joint effort because the FQHC would have had considerable difficulty recruiting nurse case managers. They also have shared programs in the area of diabetic education.

*CAH or FQHC Benefit*

If the hospital had been required to hire and support OB/GYN practitioners, the hospital would have had to cover \$250,000 per year for medical malpractice insurance. The FTCA medical malpractice coverage of FQHC practitioners provides a major incentive for collaboration between the FQHC and the CAH.

For the pediatrician, salary-based compensation is split equally between the FQHC and CAH, with the FQHC covering malpractice and the CAH covering fringe benefits.

The previously referenced comprehensive medical home/care coordination project provides a total of \$183,000 to both organizations. Of that amount, \$125,000 goes to Fairview Hospital/Berkshire Health Systems for support of 1.5 full-time equivalent nurse case managers and \$58,000 goes to the FQHC for the support of 1.5 full-time equivalent patient navigators.

Costs for diabetic education services are absorbed one hundred percent by Fairview.

*Quality of Care and Continuity of Care*

The FQHC utilizes the continuing medical education services of the CAH rather than creating their own CME program and structure. As noted previously, the same physician is medical director of the FQHC and Fairview Hospital/Berkshire and the FQHC pediatrician is associate medical director at Fairview.

Continuity of care is enhanced directly through FQHC practitioners' ability to access the medical records of patients treated by Fairview/Berkshire Health Systems. This is because all FQHC physicians have privileges at Fairview and accordingly can access medical records there. They can access such records through computer capacity within the medical offices of the FQHC.

*CAH or FQHC Benefit*

No specific dollar figures were provided.

*Quantified Benefits of Collaboration*

The following chart provides a snapshot of the specific areas of collaboration and an indication of which organizations benefit fiscally and the source of the benefit. The ultimate beneficiary, however, is the community as a whole. The focus on financial benefits is made to help convey to Critical Access Hospital and Federally Qualified Health Center leadership how they can improve access and quality of care while sharing, reducing or restraining costs through partnerships with each other.

FIGURE 7: Fairview/CHC Berkshire Collaboration Summary

Area	Focus	Benefit To		Source or Mechanism
		FQHC	CAH	
Infrastructure	Board Leadership	X		HospSxRes**
Infrastructure	Administration Leadership	X		HospSxRes
Infrastructure	Medical Leadership	X		HospSxRes
Infrastructure	FQHC development - formation - needs assessment, FQHC designation application*	\$75K		HospSxRes
<b>Subtotal</b>		<b>\$75K</b>		HospSxRes
Access	Equipment	X		HospSxRes
Access	Facilities	X		HospSxRes
Access	Laboratory/Radiology/Inpatient/Telemedicine		X	Reimbursement
Access	Recruit Pediatrician		X	FTCA/HPSA
Access	Retain Pediatrician		X	FTCA
Access	Recruit Primary Care Physicians		X	FTCA/HPSA
Access	Retain Primary Care Physicians		X	FTCA
Access	Recruit OB/GYN Physicians		X	FTCA/HPSA
Access	Retain OB/GYN Physicians		\$250K	FTCA
Access	Medical Home	\$58K	\$125K	Grants
<b>Subtotal</b>		<b>\$58K</b>	<b>\$375K</b>	
Quality	Continuing Medical Education	X		HospSxRes
Quality	Medical Director	X		HospSxRes
Quality	Associate Medical Director – Pediatrics	X		HospSxRes
Quality	Access to CAH/EHR Records – Privileging	X		HospSxRes
<b>Subtotal</b>				
<b>Grand Total</b>		<b>\$133K</b>	<b>\$375K</b>	

\* Development Cost - Year 2000

\*\* HospSxRes means Berkshire Health Systems Resources

## SITE C

**Early Memorial Hospital (CAH), Blakely, Georgia**  
**John D. Archbold Memorial Hospital, Inc. (Managing Hospital), Thomasville, Georgia**  
**Primary Care of Southwest GA, Inc. (FQHC), Blakely, Georgia**

### **Background**

The communities addressed by this collaboration include two counties in southwest Georgia which have an estimated 90,000 residents. Health care-related collaborative activities for the uninsured and underserved in this area date back to the early 2000s and have involved several local agencies, most notably Early Memorial Hospital, a public hospital authority under management of John D. Archbold Memorial Hospital, Inc., the Georgia State District Public Health Office, Office of Rural Health and the Georgia Hospital and Primary Care Associations. Initial efforts resulted in the creation of a regional not-for-profit agency called Spring Creek which performed case management, Medicaid eligibility determination and pharmacy assistance for the medically needy in this area of the state. In 2006, the establishment of the FQHC, Primary Care of Southwest GA (PCSWG), Inc., in Blakely, GA was established largely as a result of the concerted action of these organizations in response to the general lack of primary care particularly among the uninsured and underinsured. At that time, Early Memorial Hospital closed its Rural Health Clinic in Blakely which in turn became the site for the FQHC. Considerable leadership and support was provided by the John D. Archbold Memorial Hospital, Inc., the hospital's management group, through a variety of community benefit mechanisms which addressed equipment, facilities and operational needs.

Need in the Blakely area has grown with the recent closure of several major agriculture-related businesses. The hospital's commitment to the expansion of FQHCs has broadened to another community with more extensive resources with renovation of a site for the FQHC Look-Alike to lease and community benefit funding support while the FQHC awaits Federal funding.

### **Summary**

In 2009, this collaboration has grown and enhanced the local health care system infrastructure, access to and quality of care, and cost parameters. Sixteen areas of collaboration were identified that positively impacted access to primary care, emergency department, inpatient services and specialty care in Early County. The financial implications of these joint ventures are equally impressive. Archbold, through community benefit support mechanisms, has provided the FQHC with an estimated \$100,000 to \$200,000 for start-up related costs associated with facilities, equipment and operational subsidies and significant in-kind of Archbold staff over the three-year period of 2006-2009.

Conversely, Archbold and Early Memorial have directly benefited from reduced costs for clinical coverage at the Early Memorial Emergency Department through expanded call coverage, elimination of potential costs to maintain staff physicians, and to a lesser

extent, absorb variable costs for services provided to the uninsured or underinsured in the hospital ER who now use the FQHC for non-emergent care. Indirectly, Early Memorial benefited from stabilized and increased use of inpatient, diagnostic and ancillary services, and specialty services associated with the doubling of primary care physician capacity in the community.

These successes have to no small extent resulted in a viable model for health care system improvements in other communities served by these types of organizations.

## **Major Areas of Collaboration**

### *Local System Infrastructure*

Several specific collaborative activities pertained to the strengthening of the local health care system infrastructure. First and foremost, administrative and board leadership from the community, the Early Memorial Hospital District Authority Board and Archbold was essential in developing plans and objectives for maintaining and expanding primary care capacity in the Blakely area. Leadership recognized the importance of both a CAH and FQHC as key components to a local system of care. Collaboration at the Board and especially senior staff levels provided a mechanism for accessing and sharing expertise essential to the successful implementation of this “joint” objective.

As the collaboration evolved, board overlap between Archbold and the FQHC, has expanded. As importantly, the local infrastructure was strengthened considerably through the formation of the FQHC which required a formal needs assessment and a formal application for FQHC designation. The needs assessment and designation application were funded by Archbold and developed by the same individual who facilitated the development of Archbold Memorial Hospital’s strategic plan.

That Archbold Board adopted plan referenced and reinforced the importance of maintaining and expanding primary care capacities in communities served by the Health System. The continuity in staff support between needs assessment, FQHC application and strategic plans was viewed to be a major factor contributing to the success of primary care related objectives. A third infrastructure development area addressed the collaborative development of grants related to obtaining funds for a variety of programs in which both organizations participated.

### *CAH OR FQHC Benefit*

The FQHC benefited considerably from the financial support of needs assessment, FQHC designation and strategic planning related expenses borne by Archbold. Indeed, the assessment and designation applications would not have been developed and had it not been for Archbold underwriting the cost of these efforts.

### *Access to Care*

Collaborative program or service enhancements were noted in a variety of areas. Perhaps the largest was community benefit assistance from Archbold to the FQHC to renovate and equip its primary care facilities in two different communities. The FQHC was unable to come up with the capital requirements associated with renovation and space costs

related to these two sites. Through a variety of mechanisms, Archbold developed financial parameters which were favorable to the FQHC. These services were provided by Archbold within the context of community benefit services and adjusted fair market values.

An additional area of collaboration addressed the stabilization of existing primary care capacity by reducing ER call requirements for existing practitioners at Early Memorial. The addition of two physicians to the FQHC staff who had admitting privileges at Early Memorial actually doubled ER physician call coverage capacity and reduced coverage demands on the two other primary care physicians from every second day to every fourth day. Extent of on-call responsibilities has been cited as a negative factor relative to physician recruitment and retention in rural communities.

The third area affected indirectly by the collaboration was the use of inpatient, laboratory, diagnostic, and telemedicine specialty services at Early Memorial. This was due to the needs of patients treated by the two PCSWG physicians in Blakely with privileges at Early Memorial.

#### *CAH OR FQHC Benefit*

Primary care capacity benefits for Early Memorial were related to costs Early Memorial would have had to absorb for staff primary care physicians. Early Memorial's "risk" for supporting primary care physician salaries was not included due to the speculative nature of such an assessment absent actual historical figures.

An additional program enhancement although minor in financial terms, is the provision of food services by Early Memorial at community events sponsored by the FQHC. Community participants consider it an expression of community interest on the part of Archbold management at Early Memorial.

#### *Quality of Care or Continuity of Care*

Due to privileging at Early Memorial, physicians at the PCSWG – Blakely, can access medical records at Early Memorial on computers located at the FQHC. This means that FQHC physicians can access, that is, see on the computer screen, in real time ER visit records and other information in the medical record at Early Memorial for their patients. Hence they do not have to call and wait for materials faxed over or sent otherwise in hard copy. They can get the information on the same computer terminal "simultaneously" as they access the FQHC medical record.

The FQHC can also receive laboratory results electronically from Early and add them to the patient's FQHC electronic record. This is a fully integrated exchange in that the results are directly input into the electronic health record of the FQHC rather than accessed through Early Memorial's medical record system.

The following chart provides a snapshot of the specific areas of collaboration and an indication of which organization benefits fiscally and the source of the benefit. The ultimate beneficiary though is the community as a whole.

FIGURE 8: Georgia Collaboration Summary

Area	Focus	Benefit To		Source or Mechanism
		FQHC	CAH	
Infrastructure	Administration Leadership	X		HospSxRes*
Infrastructure	Board Leadership	X		HospSxRes
Infrastructure	Facilitator/Planner/Strategist	X		HospSxRes
Infrastructure	FQHC development - formation - needs assessment, FQHC designation application	X		HospSxRes
Infrastructure	FQHC development - operational	X		HospSxRes
Infrastructure	Other Grants	X		Grants
Subtotal				
Access	Equipment	X		HospSxRes
Access	Facilities	X		HospSxRes
Access	Laboratory/Radiology/Inpatient/Telemedicine		X	Reimbursement
Access	Support Services - Food for Events	X		HospSxRes
Access	Recruit Primary Care Physicians		X	FTCA/HPSA
Access	Retain Primary Care Physicians		X	FTCA
Access	ER Coverage		X	FTCA
Subtotal				
Quality	Access to CAH/EHR Records - Privileging	X		HospSxRes
Quality	Laboratory Results	X	X	Grants
Subtotal				
Grand Total		\$33K to \$66K per year		

\* HospSxRes means John D. Archbold Health System Resources



## Footnote

---

<sup>i</sup> **FQHCs and Health Centers**, for the purposes of this manual, are interchangeable terms which differ primarily in the source of the term and its purpose. Technically, FQHC is a designation of the Center for Medicare & Medicaid Services (CMS) and entitles qualified organizations to special reimbursement rates controlled or influenced by CMS. FQHCs receive specific types of grant funding authorized under Section 330 of the Public Health Act and administered through the Health Resources and Services Administration, Bureau of Primary Health Care (BPHC) and are based on principles of community involvement and comprehensive primary health care and are sometimes referred to as Community Health Centers. A third term used in this manual – FQHC Look-Alike – is a Health Center that meets all of the statutory requirements of Section 330 and receives some of the FQHC benefits but does not receive a Federal operating grant.

FQHCs are those Health Centers that receive grant funding from the Health Center Program, as authorized in section 330 of the Public Health Services Act (42 U.S.C. 254b), as amended:

- Community Health Center (CHC) Programs, funded under section 330(e);
- Migrant Health Center (MHC) Programs, funded under section 330(g);
- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

FQHCs or health centers also meet CMS standards for FQHC.

The term **Critical Access Hospital** used herein is a formal designation conferred by the Federal Centers for Medicare & Medicaid Services (CMS) and state health departments. A facility that meets all of the following criteria may be designated by CMS as a CAH:

- Is located in a State that has established with CMS a Medicare rural hospital flexibility program
- Has been designated by the State as a CAH
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital
- Is located in a rural area or is treated as rural
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles)
- Maintains no more than 25 inpatient beds
- Maintains an annual average length of stay of 96 hours or less per patient for acute inpatient care
- Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services seven days per week

A CAH may also be granted "swing-bed" approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds. "Swing beds" programs are so named because the bed can be used for two purposes: as acute-care or post-hospital skilled nursing care depending upon the needs of the patient. CAH inpatients become eligible for swing-beds when their needs at the CAH swing from acute-care services to skilled nursing care. This is a dual licensure that permits the CAH to operate and bill accordingly.

<sup>ii</sup> Flex Tracking Project - 4/29/2009 listing

<sup>iii</sup> <http://datawarehouse.hrsa.gov> - Rural CHC sites as of April, 2009 both active and inactive.

<sup>iv</sup> Personal communication - Brock Slabach, NRHA - Rural Health Clinics (RHCs) have become an important part of the rural health care infrastructure. As of March 31, 2006, 3,673 RHCs were providing a wide range of primary care services to the rural residents of 46 states. Of this number, 2,000 are independent RHCs. The patient populations served by these RHCs include a high proportion of rural elderly and poor through the Medicare and Medicaid programs (Gale and Coburn, 2003). In addition, RHCs are increasingly looked upon as belonging to a class of providers that comprise the health care safety net (Gaston, 1997, Buto, 1997, Gage, 2000, Hartley and Gale, 2003), based on the requirement that they be located in rural areas that are designated as underserved.

<sup>v</sup> See note i. above

<sup>vi</sup> Frontier counties are defined as counties with fewer than six people per square mile.

- 
- vii Personal communication with Laverne Dallas, The Hopi Tribe, Kykotsmovi, AZ.
- viii BPHC Program Information Notice 99-08: Health Centers and the Federal Tort Claims Act. See <http://bphc.hrsa.gov/policy/pin9908.htm>
- ix See above note on Federal Tort Claims Coverage (FTCA)
- x Actual levels of growth of FQHCs and FQHC service sites located in rural communities were not available at this time.
- xi CAHs and FQHCs rarely define their service areas solely on a county basis. The county definition is used to provide an approximation of the number of CAHs and FQHCs which may have similar service areas and thereby have a high potential for collaborative programs and services.
- xii County assignment done by HMS Associates where not present in database.
- xiii <http://muafind.hrsa.gov/>
- xiv <http://bphc.hrsa.gov/about/requirements.htm>
- xv [http://www.raconline.org/info\\_guides/hc\\_providers/j1visa.php](http://www.raconline.org/info_guides/hc_providers/j1visa.php)
- xvi Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties. George Rust, MD, MPH, FAAFP, FACPM; Peter Baltrus, PhD; Jiali Ye, PhD; Elvan Daniels, MD; Alexander Quarshie, MD, MS; Paul Boumbulian, PhD; and Harry Strothers, MD, The Journal of Rural Health 16 Vol. 25, No. 1, Winter 2009
- xvii See [http://www.cms.hhs.gov/EMTALA/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/EMTALA/01_Overview.asp#TopOfPage)
- xix <http://www.cms.hhs.gov/emtala/>
- xx Personal communication, Mark Holmes, PhD, Co-Director of the Program on Healthcare Economics and Finance at the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill.
- xxi The Flex Program at 10 Years: Community Impact Lessons and Future Directions, Andrew Coburn, Ph.D and John Gale MS, Maine Rural Health Research Center, Muskie School of Public Service, University of Southern Maine, NRHA Annual Meeting, New Orleans, LA., May 8, 2008
- xxii Enhancing the Care Continuum in Rural Areas: Survey of Community Health Center–Rural Hospital Collaborations, Michael E. Samuels, DrPH; National Rural Health Association, Winter 2008, “Out of the 161 CAH respondents, 24 (14.9%) reported having a collaborative agreement with a CHC, and 2 indicated that they planned to develop a collaborative agreement.”
- xxiii Li, P., Schneider, J. E. & Ward, M. M., (2007) Effect of Critical Access Hospital Conversion on Patient Safety. Health Services Research, 42 (6): 2089-2108.
- xxiv Flex Monitoring Team Briefing Paper No. 5, Scope of Services Offered by Critical Access Hospitals: Results of the 2004 National CAH Survey, March 2005. This report was prepared by David Hartley, Ph.D., Research Professor and Stephenie Loux, M.S., Research Analyst, at the University of Southern Maine Rural Health Research Center.
- xxv Frontier counties are defined as counties with fewer than six people per square mile.

---

## **Manual Workgroup Membership and Collaborative Sites**

### **Workgroup**

Thomas Morris, Associate Administrator, HRSA, Office of Rural Health Policy

Jerry Coopey, Director of Strategic Planning, HRSA, Office of Rural Health Policy

Julia Bryan, Project Officer, HRSA, Office of Rural Health Policy

Cicely Nelson, Public Health Analyst, HRSA, Bureau of Primary Health Care

Amanda Reyes, Public Health Analyst, HRSA, Bureau of Primary Health Care

Pamela Byrnes, Director, Managed Growth Assistance Programs, National Association of Community Health Centers, Washington, DC

Patricia A. Carr, Director, Alaska Office of Rural Health, and Director, Health Planning and Systems Development, Department of Health and Social Services Juneau, Alaska

Bill Finerfrock, Executive Director, National Rural Health Clinic Association

Steven C. Hansen, CEO/President, Presbyterian Medical Services, Santa Fe, New Mexico

Wayne Hellerstedt, CEO, Helen Newberry Joy Hospital, Newberry, Michigan

Theodore J. Koler, Executive Director, Ohio Hills Health Services, Barnesville, Ohio

Ed Perlak, Vice President, Berkshire Health Systems - Hillcrest Campus, Pittsfield, Massachusetts

Kim Sibilsky, Executive Director, Michigan Primary care Association, Lansing Michigan

Brock Slabach, Sr. Vice-President for Member Services, National Rural Health Association, Kansas City, Kansas

Susan B. Walter, Associate Director of Resource Development & Regulatory Policy, National Association of Community Health Centers, Washington, DC

### **Collaborative Sites**

Site A: Minnie Hamilton Health System (Combined CAH and FQHC), Grantsville and Glenville, West Virginia – Principal Contact: Barbara Lay, CEO

Site B: Fairview Hospital (CAH), Great Barrington, Massachusetts, an affiliate of Berkshire Health Systems, Inc., Pittsfield, Massachusetts and Community Health Center of the Berkshires (FQHC), Great Barrington, Massachusetts – Principal Contact: Ed Perlak, Vice President, Berkshire Health Systems

Site C: Early Memorial Hospital (CAH), Blakely, Georgia & John D. Archbold Memorial Hospital, Inc. (Managing Hospital), Thomasville, Georgia - Principal Contact: Kevin Taylor; Primary Care of Southwest GA, Inc., Blakely, Georgia (FQHC) – Principal Contact: Ann Addison, CEO

Prepared by  
**HMS Associates, Getzville, NY**