Task Force on Ensuring Access in Vulnerable Communities

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American Hospital Association®

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Executive Summary

Millions of Americans living in vulnerable rural and inner city communities depend upon their hospital as an important, and often only, source of care.

However, these communities and their hospitals face many challenges. As the hospital field engages in its most significant transformation to date, many are fighting to survive – potentially leaving their communities at risk for losing access to health care services. The loss of such a critical health care access point could be devastating to the individuals living in these vulnerable communities, and the concern for them is only growing as significant pressures on the health care sector continue.

Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, approved the creation of this 29-member task force to address these challenges and examine ways in which hospitals can help ensure access to health care services in vulnerable rural and urban communities. We were charged with confirming the characteristics and parameters of vulnerable rural and urban communities; identifying emerging strategies for health care services in rural and urban areas; and identifying federal policies and issues that serve as barriers to implementation of the recommended emerging strategies.

In taking on this charge, we determined it was critical to also identify those essential health care services we believed should be maintained for individuals living in vulnerable rural and urban communities. We acknowledge that the range

of health care services needed and the ability of individuals to obtain access to health care services varies widely across communities. However, we believe that access to a baseline level of high-quality, safe and effective services must be protected and preserved. Some of these include primary care services, psychiatric and substance use treatment services and transportation.

In developing this report, we also examined the characteristics and parameters of vulnerable rural and urban communities. We determined that the reasons a population may be deemed vulnerable vary widely and there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. We also found that while there were unique characteristics and parameters for rural and urban communities, many of these characteristics and parameters were the same. As a result, we created a list of characteristics and parameters of which one or more may be necessary and sufficient to identify a vulnerable community. For example, lack of access to primary care services; poor economy, high unemployment rates and limited economic resources; cultural differences; and low education or health literacy levels.

We then considered integrated, comprehensive strategies to reform health care delivery and payment in vulnerable communities that would allow them to choose different options based on their needs, support structures and preferences. Our ultimate goal was to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential health care services they should strive to maintain locally, as well as with the delivery system options that will allow

them to do so. We identified nine emerging strategies that we believe can accomplish this. These include strategies that address the social determinants of health, adopt new and innovative virtual care technologies, build upon existing delivery models (these include inpatient-outpatient transformation, urgent care centers, integration between rural hospitals and health centers and strategies to address Indian Health Services) or allow for the creation of new delivery models (such as global budget payments, emergency medical center and a frontier health system). While our focus was on vulnerable communities, these strategies may have broader applicability and may serve as a roadmap for all communities as hospitals begin to redefine how they provide better, more integrated and more efficient care.

Finally, we examined federal policies that serve as a barrier to implementation of these strategies. We determined that the ability to successfully adopt many of the strategies is dependent on numerous federal policy changes. The options we set forth also will require a certain level of transformation and redefinition on the part of the hospital as well as collaboration between hospitals and a diverse group of community stakeholders.

Introduction

The millions of Americans living in vulnerable rural and inner city communities depend upon their hospital as an important, and often only, source of care. The nation's nearly 2,000 rural community hospitals and more than 2,000 urban community hospitals frequently serve as the anchor for their area's health-related services, often providing prevention and wellness services, community out-reach and employment opportunities. Many serve as cornerstones within their communities, working to advance population health and well-being, as well as serving as economic engines.

However, these communities and their hospitals face many challenges. Rural hospitals often struggle with their remote location, limited work-force and constrained resources. Inner-city urban hospitals strive to achieve financial stability while pursuing their charitable mission. As the hospital field engages in its most significant transformation to date, many of these hospitals are fighting to survive – potentially leaving their communities at risk for losing access to local health care services. The loss of such a critical health care access point could be devastating to the individuals living in these vulnerable communities, and the concern for them is only growing as significant pressures on the health care sector continue.

As communities grapple with the challenge of maintaining access to health care services, it will be necessary for payers and health care providers to work together to develop alternative payment and delivery strategies that support the preservation of health care services for Americans living in vulnerable communities. Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, approved the creation of this 29-member task force to address these challenges and examine ways in which hospitals can help

ensure access to health care services in vulnerable rural and urban communities. They charged us with the following:

- **Confirming the characteristics and parameters of vulnerable rural and urban communities** by analyzing hospital financial and operational data and other information from qualitative sources, where possible;

- **Identifying emerging strategies, delivery models and payment models** for health care services in rural and urban areas; and

- **Identifying policies and issues at the federal level that impede, or could create, an appropriate climate for transitioning** to a different payment model or model of care delivery, as well as identifying policies that should be maintained.

In taking on this charge, we determined it was critical to identify those essential health care services we believed should be maintained for individuals living in vulnerable rural and urban communities. In this report, we acknowledge that the range of health care services needed and the ability of individuals to obtain access to health care services varies widely across communities. We do, however, believe that access to a baseline level of high-quality, safe and effective services must be protected and preserved.

The AHA Board also made clear, and we wholeheartedly concur, that while the current special payment programs that attempt to account for the unique circumstances of vulnerable communities have their place, what is now needed are integrated, comprehensive strategies to reform health care delivery and payment within which vulnerable communities can make individual choices based on their needs, support structures and preferences. Therefore, in this report, we aim to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential health care services they should strive to maintain locally, as well as with the delivery system options that will allow them to do so.

The options we set forth will require a certain level of transformation on the part of the hospital. They will require them to begin defining the "H" by focusing on quality and population health management, and on providing more integrated, efficient and better coordinated care. In addition, they will require hospitals to continue evaluating how to provide patients with the right care, at the right time in the right setting. Improving the value of care will involve increased stewardship of resources and innovative ways to transform care for changing communities. In some cases, a hospital will need to redefine the services it offers or the facilities in which it offers those services in order to ensure essential health care services are available to individuals in that community.

We fully recognize and acknowledge that the choice to transform in such a manner is not easily made; however, pursuing such a path is certainly preferable to the only option that many of these communities have at the present time – hospital closure. As a hospital field, we must face these challenges by keeping the goal of ensuring access to health care in mind.

It is also more important than ever that hospitals build and maintain strong linkages with a diverse group of community stakeholders to ensure the needs of the community are supported in the future. Collaboration through community health needs assessments and other strategic endeavors will be vital as a foundation for planning and aligning health priorities. In addition, hospitals and stakeholders will need to work together to identify obstacles that exist to achieve good health, unite around shared goals and work collaboratively to implement changes that promote a healthier community, and do so while developing a sustainable business model.

Our report and recommendations are presented below.

Characteristics and Parameters of Vulnerable Communities

As a starting point for framing this issue, we defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. We then worked to identify the characteristics and parameters that would identify such vulnerable rural and urban communities. In doing so, we relied upon our personal experiences, as well as an analysis of financial data and other information from qualitative sources related to vulnerable rural and urban communities.

We found that the reasons a population may be deemed vulnerable vary widely and there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. Therefore, we created the following list of characteristics and parameters (listed in no particular order), of which one or more may be necessary and sufficient to identify a vulnerable community.

- **Lack of access to primary care services.** High-quality primary care involves health care providers offering a range of medical care (preventive, diagnostic, palliative, therapeutic, behavioral, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated.[1] A meaningful and sustained relationship between patients and their primary care health care providers can lead to greater patient trust in the provider, good patient-provider communication, and the increased likelihood that patients will receive, and comply with, appropriate care.[2]

Unfortunately, access to primary care services is unavailable for many Americans. Today, nearly 20 percent of Americans live in areas with an insufficient number of primary care physicians. These health professional shortage areas for primary care face clear recruitment and retention issues and have less than one physician for every 3,500 residents.[3] They also tend to be in remote rural towns and inner-city urban areas. Lack of access makes it difficult for millions of Americans to get preventive health care services, leaving them and their communities susceptible to fragmented, episodic care and poorer health outcomes.

- **Poor economy, high unemployment rates and limited economic resources.** The presence of a poor economy typically leads to high levels of unemployment and a limited amount of economic resources. These factors are linked to poor health outcomes. For example, poverty may result in individuals purchasing processed food instead of fresh produce, which over time could lead to hypertension, obesity and diabetes. This also may affect individuals' mental health and result in other health conditions, such as high blood pressure, high cholesterol, diabetes and obesity.[4]

Rural and inner city areas more often show the effects of a poor economy. For example, overall, rural areas have seen moderate growth in employment, but certain areas face losses in jobs (including much of the South, Appalachia, Northwest and the Mountain West).[5] Likewise, while urban areas of the United States have generally seen moderate employment growth over the last several years, inner cities have a higher rate of unemployment (14 percent) than the national average (9 percent).[6] Therefore, while not all rural or inner-city urban areas face

high levels of unemployment, those that do may be most vulnerable.

- **High rates of uninsurance or underinsurance.** High rates of uninsurance or underinsurance negatively impact health care delivery and access to quality care. Individuals without insurance coverage often go without needed medical care, including preventive services, and are at a higher risk for preventable hospitalizations and missed diagnoses.[7] In addition, when the rate of uninsurance is high, health care providers may restrict the provision of certain services or shorten hours.[8] As a result, even those with insurance are less likely to have a regular source of care, likely to report delaying or forgoing care, and less satisfied with the care that they receive.

- **Cultural differences.** Cultural differences, including ethnic heritage, nationality of family origin, religion, and the beliefs and practices that make up a patient's value system can pose challenges. For example, even when quality care is available, individuals that come from different cultural backgrounds may have difficulty trusting providers in a way that facilitates the acquisition of necessary care. Or, populations facing language barriers may have difficulty understanding the services offered by a health care provider. These individuals may not be able to accurately describe symptoms or read and understand items, such as discharge instructions. In addition, cultural differences cause concepts such as health, illness, suffering and care to mean different things to different people. Immigration status also can impact health – patients that are not in the United States legally may not seek care due to a fear of possible repercussions. A lack of culturally competent care can contribute to poor patient outcomes, including racial and ethnic disparities in care, reduced patient compliance and

increased health disparities, regardless of the health care services available.[9]

- **Low education or health literacy levels.** Given the complexity of today's health care system, communities with low education or health literacy levels are more often in poor health. Specifically, individuals with low education levels and/or limited health literacy skills are less likely to effectively manage chronic conditions, such as high blood pressure, diabetes, asthma or HIV/AIDS.[10] They also are more likely to skip important preventive measures, such as mammograms, Pap smears and annual flu shots.[11] As a result, studies have shown that those with low education and health literacy rates have a higher rate of hospitalization and use of emergency services.[12] Ultimately, individuals must be able to understand and use health information in order to choose a healthy lifestyle, know how to seek medical care and take advantage of preventive measures – making education and health literacy essential tools needed for making decisions that can lead to favorable health outcomes.

- **Environmental challenges.** Environmental challenges, including but not limited to, poor water and air quality, access to sewer lines, or the presence of lead, mold or asbestos can exacerbate illness and lead to poor health outcomes in a community. For example, air quality is often lower in urban environments, which can contribute to chronic illnesses, such as asthma.[13] In addition, challenges such as witnessing or experiencing trauma and violence or living in unstable housing conditions affects an individual's mental and emotional health and can lead to chronic behavioral health conditions.[14]

We also identified characteristics that vary between rural and urban communities and that, gen-

erally speaking, tend to be much more prevalent in one area than another. These characteristics and parameters are discussed separately below.

Unique Characteristics and Parameters of Vulnerable Rural Communities

- **Declining population, inability to attract new businesses and business closures.** Rural communities are challenged by declining populations because population growth from natural change (births minus deaths) is no longer sufficient to counter migration losses when they occur. According to the U.S. Department of Agriculture (USDA), from April 2010 to July 2012, the estimated population of non-metro counties as a whole fell by close to 44,000 people.[15] Although this may seem like a small decline, the USDA indicates that it is a sizeable downward shift from the 1.3 percent growth these counties experienced during 2004 - 2006.[16] From July 2012 to July 2013, the population in non-metro areas continued this three-year downward trend.[17]

  Such declines may have a ripple effect, leading to other negative impacts, such as business closures. They may change the health or needs of the community, which may in turn affect the viability of certain businesses. When businesses close or a community is unable to attract new businesses, it becomes more difficult for it to retain existing health care services and recruit new providers. As a result, these communities tend to have fewer active doctors and specialists and face difficulties in accessing care, which can complicate early detection and regular treatment of chronic illnesses.

- **Aging population.** Rural communities also tend to be older than non-rural communities. U.S. Census data indicates that close to 18 percent of rural counties' total population is aged 65 or older.[18] This is in contrast to the general average of 14.3 percent in large metropolitan statistical areas (MSAs) and 14.8 percent in other MSAs.[19] Given that older individuals are more likely to have one or more chronic diseases, these communities may face poorer health outcomes. This challenge can be exacerbated if access to health care services in the community is already limited.

Unique Characteristics and Parameters of Vulnerable Urban Communities

- **Lack of access to basic "life needs," such as food, shelter and clothing.** The level of an individual's health is closely connected to their ability to access food, shelter, clothing and other basic life needs. For example, homeless persons face barriers to receiving health care and have higher rates of emergency department (ED) use, inpatient hospitalization and longer hospital stays.[20] In addition, eating well, staying active, and having a safe home, neighborhood and community all influence health. When these social determinants of health are in poor condition or not present or available at all, it will have a negative effect on health outcomes.

- **High disease burden.** Inner cities have a disproportionately high disease burden, which puts them at higher risk of poor health outcomes. For example, they tend to have a high population of individuals living with chronic conditions, including hypertension, emphysema, chronic bronchitis, cancer, diabetes and cardiovascular disease.[21, 22] Vulnerable urban communities also may face stress resulting from their circumstances, such as witnessing or experiencing trauma and violence, which affects their mental and emotional health.[23] Therefore, these populations may have higher incidence of behavioral health conditions, including drug/alcohol abuse, depression, anxiety and recurrent trauma.

Essential Health Care Services

Before identifying emerging strategies that could better ensure access to health care services in vulnerable communities, we determined it was necessary to identify the essential health care services that should be maintained locally within a community. While acknowledging that the range of health care services needed and the ability of individuals to obtain access to health care services varies widely, access to a baseline of high-quality, safe and effective services must be preserved within vulnerable rural and urban communities.

While we discussed this issue separately for rural and urban communities, we felt strongly that one unified list should apply to both, and in fact all, communities. These essential health care services are listed below in no particular order.

Primary care services. As discussed above, primary care services include not only the diagnosis and treatment of acute and chronic conditions, but the provision of a continuum of services that include preventive, diagnostic, palliative, therapeutic, curative, counseling, rehabilitative and end-of-life services in a manner that is accessible, comprehensive and coordinated. Other emerging primary care models encompass population health initiatives and medical home services. These services could be provided to patients of all ages in many settings (e.g., urgent care clinics, pharmacy-based clinics, etc.) by physicians or other health care providers in the community. Further, primary care may take different forms for different patients. For example, primary care for children is typically provided by a pediatrician; for the elderly it may be through a geriatrician.

Psychiatric and substance use treatment services. These services include a spectrum of acute and chronic mental health and substance use disorder services, such as behavioral health treatment, counseling and psychotherapy. These services also include individual and group therapy sessions, occupational therapy services; services of social workers, trained psychiatric nurses and other professionals trained to work with psychiatric patients, drugs and biologicals furnished to outpatients for therapeutic services, activity therapies, family counseling services, patient education programs and certain diagnostic services.

Emergency and observation services. Emergency services include health care services provided to evaluate and/or treat medical conditions that require immediate and unscheduled medical care.[24] Observation services include hospital outpatient services that are provided in order to help a physician decide if the patient needs to be admitted as an inpatient or can be discharged. Both emergency and observation care services allow for health care providers to treat minor conditions and stabilize patients prior to additional treatment for more serious conditions.

Prenatal care. This includes preventive health care that allows for regular checkups to treat and prevent potential health problems throughout the course of the pregnancy and promotion of healthy lifestyles that benefit both mother and child.

Transportation. Transportation services include both medical and personal transportation to allow patients to access care at hospitals and other health care facilities. For example, transportation services could include ambulance services for individuals being transferred from a critical access hospital to a tertiary hospital or trauma center, transportation for patients from the hospital to a skilled-nursing facility for post-acute care services, as well as bus or car transportation for patients to travel to their doctor's appointments.

Diagnostic services. These include testing services that are necessary for the provision of primary health care and provide practitioners with information about the presence, severity and cause of illnesses and diseases in patients. Examples may include, but are not limited to, laboratory services and plain film X-rays.

Home care. Home health care includes a wide range of health care services that can be given for an illness or injury and allows patients to stay in their home. For example, home health care services could include, but would not be limited to, wound care for pressure sores or a surgical wound, patient and caregiver education and intravenous or nutrition therapy. The goal is to help patients regain their independence, and become as self-sufficient as possible.

Dentistry services. These services include, but are not limited to, preventive and basic dentistry services, including prophylactic cleanings and X-rays, for individuals of all ages.

Robust referral structure. In addition to the services listed above, communities should maintain a robust referral structure that customarily provides access to the full spectrum of health care services needed for individuals in the community. This would help promote efficiency by avoiding offering low-volume service, as well as unnecessary duplication of certain services. As an example, referrals to neighboring communities may be provided for specialty physicians (e.g., orthopedists, neurosurgeons or endocrinologists) or for specialized testing. This also would include referrals to entities that may provide access to medications for individuals living in vulnerable rural and urban communities. This referral structure should also include transfer agreements.

Range of Existing Affiliation Strategies

Many hospitals are affiliating or partnering with other providers to deliver care within their communities. These affiliations, in many instances, have allowed vulnerable communities to enhance or maintain access to essential health services. Below, we highlight these strategies because we believe they have value and could potentially serve as an option for communities to increase services offered, achieve greater economies of scale and financial stability, improve physician recruitment and retention, or increase access to capital and clinical and administrative expertise.

Regional Collaborative

Structure – A flexible, low-risk, low-investment affiliation that allows independent organizations, typically in the same geographic region, to partner on specific initiatives. Each organization remains fully independent, but they join to create a separate entity that manages the logistics of the regional collaborative.

Benefits – A regional collaborative may be used to share best practices related to clinical or operational issues, consolidate purchasing power to obtain more favorable prices on supplies and services, and/or share resources for large capital investments (e.g., information technology infrastructure). It also allows organizations to begin communications with other providers to enable additional affiliation opportunities in the future.

Management Agreement

Structure – Hospitals may enter into a management agreement with another provider to manage a specific service line – such as orthopedics, oncology or cardiology. The managing entity would oversee the service line and ensure it runs smoothly, effectively and provides high-quality services. Hospitals also may contract with another provider or management firm to assume responsibility for the day-to-day operations of the entire hospital. Here, the managing entity may provide budgeting, financial oversight, contracting and purchasing leadership.

Benefits – While the scope of these agreements will differ, in vulnerable communities, these arrangements could allow a hospital to benefit from the management entity's administrative, operational and clinical expertise. They may be able to improve quality and cost savings.

Clinical Affiliation

Structure – An opportunity for two or more entities to come together to jointly operate a specific program or service, without changing the ownership or management of either provider. It allows shared investment in costly resources and the potential to increase collaboration and the sharing of best practices for select specialties.

Benefits – Clinical affiliations have the potential to bring new services or specialty care to a community that may not otherwise have access to those services, while allowing the hospital to remain independent. This could include, for example, telemedicine, cancer care, stroke care, specialized surgery, neurology, cardiac or orthopedic services.

Joint Venture

Structure – Joint ventures allow hospitals to enter into partnerships that are limited to a certain line of business, similar to clinical affiliations. However, in a joint venture, the partners typically create a new governance entity that manages the new business and the parties share ownership in and governance of the new entity.

Benefits – Joint ventures may provide access to capital and shared financial risk, although typically both providers would contribute capital or in-kind contributions (e.g., contribution of real or personal property or intellectual property).

Merger/Acquisition

Structure – A merger or acquisition typically involves the formal purchase of one organization's assets by another or the combination of two organizations' assets into a single entity. They also involve significant costs, including legal costs to effectuate the deal and the administration costs of integrating the organizations together.

Benefits – Mergers and acquisitions may provide many benefits including the ability to jointly contract with private payers, consolidate financial statements and debt financing, improve borrowing power, streamline administrative functions or share administrative and support functions.

Essential Health Care Service

Table 1	Primary Care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
Addressing the Social Determinants of Health					X				X
Global Budget Payments	X	X	X	X	X	X	X		X
Inpatient/Outpatient Transformation Strategy	X	X	X	X		X			X
Emergency Medical Center	X		X		X	X			X
Urgent Care Center	X					X			X
Virtual Care Strategies	X	X	X						X
Frontier Health System	X	X	X	X	X	X	X		X
Rural Hospital-Health Clinic Strategy	X	X	X	X		X		X	X
Indian Health Services Strategies	X	X	X	X	X	X	X		X

Emerging Strategy (vertical axis label)

Emerging Strategies

Taking into account the characteristics and parameters of vulnerable communities, as well as the essential health care services set forth above, we identified and created the following strategies as the most promising for ensuring access to health care services in vulnerable communities. While these strategies will not apply to or work for every community, we are presenting a variety so that each community may choose one, or several, that are sustainable and compatible for its needs. Each of these strategies offers the opportunity for communities to ensure access to the essential services described above. Table 1 above, illustrates the essential services which may be maintained or enhanced by each recommended strategy.

Addressing the Social Determinants of Health

In the course of our discussions, we repeatedly grappled with the reality that, in vulnerable communities, even if quality care is available, social challenges often prevent community members from being able to access health care or achieve their health goals. In other words, we recognize that there is an important difference between "lack of presence" and "lack of access" – services may be present in a community, but patients may be unable or unwilling to utilize them as intended. For example, a lack of access to transportation may prevent patients from being able to obtain necessary care, or food insecurity may prevent the ability to adhere to specific diets dictated by certain conditions.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[25] These forces include

economic policies and systems, development agendas, social norms, social policies and political systems.[26] Although not a comprehensive list, we identified the following domains of common health-related social challenges:

- housing instability
- utility needs
- food insecurity
- interpersonal violence
- lack of transportation
- lack of adequate family and social support
- low levels of education
- lack of employment/low income
- risky or harmful health behaviors

We determined that addressing these challenges through enhanced clinical-community linkages would aid community members in more effectively accessing available health care services, which would, in turn, improve their health outcomes. Therefore, we set out to construct a model that would bridge the gap between clinical care and community services – those public health and social service supports that aim to address health-related social needs and include many home and community-based services. The model draws upon existing initiatives, including programs developed by Health Leads or the Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities Model.[27]

Health care provider efforts to date and capabilities in this area vary widely, therefore, this model provides several different paths that providers and their communities could take. While each of these paths generally builds upon the previous path, they may be utilized together or individually by a community. These include:

PATH 1: Screening and Information. Providers wishing to engage in this path would first focus on systematically screening their patients for health-re-

lated social needs. Doing so entails developing screening questions and creating an appropriate method to administer the screening. To create appropriate screening questions, providers should either conduct a new or consult an existing community health needs assessment to identify which of the challenges from the above bulleted list are present in their community. They would then create question(s) that correspond to each domain. Questions could be included as a prompt in their electronic health record (EHR) to ensure that all patients are screened.

Once patients' needs are identified, providers should give them information on community resources that might be able to address those needs. To do so, providers would need to compile an inventory of the available community resources and services that address each of the domains they identified as being present in their community. This inventory would include contact information, addresses, hours of operation and other relevant information that a patient would need to access the resources of an organization. It also would need to be updated periodically.

PATH 2: Navigation. Providers wishing to engage in this path of addressing health-related social challenges could build upon the Screening and Information step by providing navigation services to proactively assist patients in overcoming barriers to accessing community services. Specifically, after a provider identifies the resources a patient requires, it would determine what level of navigational support the patient needs. For example, some patients may need assistance gathering the documentation required to access a particular resource; others may require help contacting the organization; still others may feel comfortable without additional assistance. The provider would use this information to create a patient-centered action plan that delineates the patient's next steps, as well as the provider's next steps.

Next, a provider would track the outcome of these navigation efforts to determine whether the patient accessed the community services and, if so, what services were obtained. It also could track other information, such as how promptly the community services were provided and what the patient's satisfaction level was. This could be done for example, by conducting a follow-up assessment after the initial screening. Doing so yields data the provider can use to refine its program. For example, it would know which resources were able to be accessed most frequently, most promptly, and with what amount of patient satisfaction. These data will allow providers to identify "top performing" community resources, which could, in turn, dictate refinements of the community organizations to which they are referring their patients.

PATH 3: Alignment. Providers wishing to engage in this path of addressing health-related social challenges could build upon the prior two steps by partnering with community stakeholders to more closely align the services that are available with the needs of community members. This could entail creating a community board that includes all stakeholders or another framework for collaboration. If that is the route taken, the community board would conduct a gap analysis that compared available resources with the existing critical needs. Gaps may exist in the types of resources available, but also in the amount of each resource that is available. The data that the provider has been able to collect in the prior two steps will greatly inform this gap analysis – through these data providers will know what portion of their population faces each challenge and how many patients are able to successfully access the necessary resource. Finally, the community board would use the gap analysis to create an improvement plan to re-align available resources to meet the social service needs of the target population.

Federal Statutory and Regulatory Barriers to Implementation of Social Determinant Strategies

1. Limited federal funding. While many hospitals implement these types of services through their existing community benefit programs, increased federal funding would enhance the potential for these programs to address social challenges in vulnerable communities. Currently, there is little direct federal funding available to reimburse hospitals or their communities for these programs. For example, only limited grant funding is available from federal agencies to provide community social services. And, when they are available, those opportunities may be difficult to find. Further, providers in vulnerable communities may not have access to grant writers who would increase their chances of obtaining the award. In addition, federal programs designed to address the social determinants of health are limited in scope. For example, the Accountable Health Communities Model, which would address health-related social needs through enhanced clinical-community linkages that have the potential to increase health outcomes and reduce costs, is only open to 44 participants around the country. Finally, while many federal alternative payment models (i.e., global budgets or accountable care organizations) are built around the concept that providers are financially rewarded if they are able to drive down utilization, including if they do so by addressing social determinants of health, participation in these programs is limited in vulnerable communities.

2. Civil Monetary Penalty (CMP) law. The "beneficiary inducement" provisions in the CMP law are a barrier for health care providers that would like to provide community resources directly to Medicare and Medicaid patients. These provisions prohibit health care providers from offering inducements to a Medicare or Medicaid beneficiary that the provider knows or should know is likely to influence the selection of particular

providers, practitioners or suppliers. This prohibition also applies to providing assistance to beneficiaries, and while there are exceptions for providing support that promotes access to care or is based on financial need, there are no clear and readily applicable protections for encouraging a patient's follow-through on post-discharge treatment plans. In addition, while there have been some beneficiary inducement waivers included in certain Center for Medicare and Medicaid Innovation (CMMI) programs, they are limited in nature in that they contain restrictions on the type of item or service that may be offered, as well as the dollar value of that item. For example, hospitals have created farmers markets that provide free and healthy food to their communities; they have provided certain patients with air conditioners to help improve respiratory-related illnesses; and they have provided patients with refrigerators so they can keep their insulin cool. However, they are only able to provide these types of assistance to non-Medicare or Medicaid patients. A new legal safe zone would be needed to enable providers to offer the type of assistance beneficiaries need to realize the benefits of their discharge plan.

Global Budget Payments

Global budget payments shift reimbursement for health care services away from volume-based payments to a single payment that encompasses certain costs associated with caring for a patient. We believe global payments have the potential to provide financial certainty for hospitals in vulnerable rural and urban communities. In addition, they could offer communities incentives to contain health care cost growth and improve quality by allowing providers to focus on offering services that improve the health of their communities overall and decrease the need for hospital services.

Global Budget Requirements

In their most basic form, global budget payments provide a fixed amount of reimbursement for a fixed period of time for a specified population – rather than fixed rates for individual services or cases. Therefore, if a provider's costs are less than the budget, they retain the difference; if a provider's costs exceed the budget, the provider must absorb the difference. They may be designed in a way that allows each provider to create a unique plan to meet mandated budgets, thereby allowing vulnerable rural and urban communities autonomy and flexibility to create solutions that work best for their communities.

When designing these programs, many factors must be considered. For example, global payments should be made at a predictable, stable and sufficient level to allow providers to build the infrastructure and capability to redesign care delivery. For vulnerable communities, global payments may need to be inflated above historical payment levels to allow hospitals in these communities to offer services under this model.

Another factor to consider is what type of health care providers would be included in the global budget program. For example, participation may be limited to hospitals, or it could be expanded to include additional health care providers (e.g., physicians). The broader the participation, the more alignment between health care providers and accountability for the health care services offered within a community. In addition, consideration must be given to the payers participating in the global budget program. Participation by all commercial and government-funded health plans affords hospitals the most opportunity to focus their efforts on success, rather than attempting to simultaneously operate under fee-for-service and global budget payment models. However, this could be the most difficult factor to achieve.

There are many other considerations, including, but not limited to:

- The types of services that will be included in or excluded from the global budget;
- The details around timing and structure of payments and for participating providers, including the potential for up-front payments to providers that would cover the costs associated with building infrastructure and capabilities necessary to redesign care delivery;
- Ability to adjust payments to account for factors outside of a hospital's control;
- Selection of appropriate quality metrics; and
- Hospital access to claims and quality metric data.

Federal Statutory and Regulatory Barriers to Implementation of Global Budgets

1. Fraud and abuse laws. To allow hospitals to form the financial relationships necessary to succeed in a global budget, it is critical to obtain waivers of applicable fraud and abuse laws that inhibit care coordination. Specifically, the Physician Self-Referral Law and the Anti-kickback Statute may not be compatible with the financial arrangements that are necessary between hospitals and other health care providers to implement a global budget.

2. Waivers of current Medicare payment rules. Waivers of many existing Medicare payment rules also would be necessary to provide participating hospitals with maximum flexibility to identify and place beneficiaries in the clinical setting that best service their short- and long-term recovery goals. This includes, but is not limited to, the waiver of discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the skilled-nursing facility "three-day rule," and the inpatient rehabilitation facility "60% Rule." These waivers are essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time.

3. Access to timely data. Access to actionable information related to care, payment and cost is essential to the success of a global budget. For example, access to real-time data on patient utilization and spending for services across an episode of care would be necessary to actively manage care offered to patients. Currently, this information is offered to providers on a delayed basis, which prevents them from making necessary decisions to improve care delivery for their patients. Payers and other suppliers of claims and quality metric data must provide reliable, timely data to hospitals participating in global payment arrangements.

Inpatient/Outpatient Transformation Strategy

In recent years, hospitals have faced a decline in the volume of inpatient services, while also seeing an increase in the volume of outpatient services. The inpatient/outpatient transformation strategy (IOTS) would make this challenge work for the hospital and, ultimately, the community by reducing current inpatient capacity and shifting those resources to the delivery of outpatient care.

IOTS Requirements

The IOTS would vary by hospital and community; however, by utilizing this strategy, hospitals would do the following:

- Continue providing inpatient services, but at a capacity that is reduced (i.e., a reduced number of licensed beds) to a level that closely reflects the need of the community for inpatient services;

- Enhance the outpatient and primary care services offered to the community, which may include an increased focus on outcomes and prioritization of primary care, wellness and prevention; and
- Continue providing emergency services, which would be available to the public 24 hours a day, 7 days a week, 365 days per year.

Federal Statutory and Regulatory Barriers to Implementation of the IOTS

The IOTS could be implemented today and does not require changes to any federal statutory or regulatory provisions. Hospitals considering this option will continue to be subject to all federal statutory and regulatory requirements that apply to hospitals, including, but not limited to, quality requirements and the Medicare Conditions of Participation and other requirements related to the volume and type of inpatient services provided by the hospital.

There may, however, be other barriers that may prevent a hospital from making this transformation. These are described in more detail in the Barriers to Implementation section of this report, but may include a lack of access to resources to make the transition or lack of partnership, buy-in and acceptance from the community.

Emergency Medical Center

The emergency medical center (EMC) would allow existing facilities in vulnerable rural and urban communities to continue providing emergency medical services without having to maintain inpatient beds or provide inpatient acute care services. This would allow hospitals that may be struggling financially, for a variety of reasons, to meet the needs of the community for emergency and outpatient services. As discussed in more detail below, the EMC is different from existing freestanding EDs and would require a new designation at the federal level, and in most cases, at the state level as well.

EMC Requirements

EMCs would be required to provide the following services on an outpatient basis:

- Emergency services, which would be available to the public 24 hours a day, 7 days a week, 365 days a year; and
- Transportation services, either directly or through arrangements with transportation providers, that allow for the timely transfer of patients who require inpatient acute care services.

In addition to emergency and transportation services, EMCs would be able to offer additional health care services needed by a particular community. For example, EMCs would have the ability to provide outpatient services that may include primary care services, observation care, infusion services, hemodialysis, population health and telemedicine services. EMCs also could provide a variety of post-acute care services, including skilled-nursing facility care, home health, hospice and nursing home care. Regardless of the selection of services chosen, it would be necessary for each EMC to be transparent in its marketing so that the EMC clearly conveys to the community the services being offered.

Freestanding EDs exist today, primarily in the two structures described in the text box below. However, they may not be an option for vulnerable communities. For example, struggling hospitals in such communities may not be part of a system, which means they would not have the option of becoming a freestanding ED. In addition, the reimbursement limitations for independent freestanding EDs likely mean they would not be sustainable in vulnerable rural and urban communities.

The EMC seeks to solve these challenges. It would only be able to arise from a hospital conversion, but would not need to be part of a system, which would limit the number of EMCs to situations where a hospital already exists. Such hospitals would be required to rescind their current hospital license and certification upon conversion to an EMC and would remain separate from any existing hospital. This "conversion" aspect makes the EMC unlike either the FSED, which continues to be associated with an existing hospital, or an IFSED, which is a new provider that did not exist prior to being an IFSED. The EMC also would include the option for hospitals to revert back to their original status within a limited time period.

EMCs also would be required to meet any requirements set forth in state or federal law and would need a new reimbursement methodology to account for challenges that EMCs will face, including low volume.

Federal Statutory and Regulatory Barriers to Implementation of the EMC

1. No existing designation for EMCs. As indicated above, the EMC is a new designation and would need to be recognized at both the federal and state level. From a federal perspective, this will involve congressional action, as well as the creation of regulations to implement the EMC. More specifically, EMCs would need to meet any Conditions of Participation or other requirements set forth by CMS. This would include staffing requirements and it is anticipated that EMCs would be staffed with an appropriate combination of physicians, medical and nursing personnel that are trained in providing emergency services at a higher level than an urgent care or physician office. It also would include quality measures that each EMC must meet in order to ensure EMCs are providing high-quality health care.

At the state level, each state would need to create a licensure category and certification process for EMCs. While many states have a license designation for FSEDs, very few allow for IFSEDs. Specifically, in 2010, Texas became the first state to allow the operation of an ED without hospital affiliation. Other states have since followed, including Delaware and Rhode Island, and more recently Georgia established state regulations to allow IFSEDs in rural areas. Therefore, it is likely that state licensure and acceptance of the EMC could pose a significant barrier to nationwide implementation of the EMC.

2. Current reimbursement methodology. Federal reimbursement methodologies do not currently account for the low volume or other challenges EMCs would face in vulnerable rural and urban communities. Specifically, because an EMC is not tied to an existing hospital, it would not be able to obtain provider-based reimbursement as FSEDs do. Further, given the low volume EMCs may experience, the Part B payments that may be available to IFSEDs serving Medicare beneficia-

ries would likely not be sufficient to maintain the financial viability of an EMC.

Since current reimbursement methodologies are not sufficient to address this challenge, a new methodology would be needed to ensure that EMCs have adequate reimbursement to cover costs and create an adequate margin for capitalization. This issue was recently examined by the State of Georgia, through its Rural Hospital Stabilization Committee. This committee examined ED volume in 53 hospitals in counties with a population less than 35,000.[28] Through financial modeling and a series of assumptions, they found that the number of ED patient visits for these hospitals ranged from 11.2 and 27.2 visits per day.[29] This is far lower than the estimated break-even point used by the Urgent Care Association of America of between 35 and 40 visits per day for a free-standing ED.[30] As a result, the committee found that low volumes were one reason why IFSEDs would not be financially viable under the current reimbursement methodology.

Policy makers considering this type of model have proposed a variety of payment options to account for the potential low volumes at EMCs. For example,
the Rural Emergency Acute Care Hospital Act (S.1648), introduced by Sens. Chuck Grassley (R-IA) and Cory Gardner (R-CO), provides cost-based reimbursement for services provided by EMCs in rural settings at a rate of 110 percent of reasonable costs. The Medicare Payment Advisory Commission (MedPAC) has proposed a similar EMC model for rural communities that provides fee-for-service outpatient PPS reimbursement for services provided, as well as an additional fixed payment to cover extra costs and overhead expenses. MedPAC also is considering whether the community in which these emergency facilities are located should be responsible for providing additional funding to support access to emergency services in the community.

3. Staffing. Many states currently include staffing requirements for FSEDs that would be challenging if they also are applied to EMCs. For example, in North Carolina, FSEDs are required to have at least one physician and one nurse on-site at all times, regardless of patient volume.[31] However, this level of staffing is more than what is required for a fully functioning critical access hospital (CAH). When reviewing staffing from a federal regulatory perspective, policy makers would need to be balanced in order to contain costs while at the same time ensuring that the appropriate combination of physicians, medical and nursing personnel are available to provide emergency services.

Urgent Care Centers

In some instances, a vulnerable rural or urban community may only need an access point for urgent medical conditions to be treated on an outpatient basis. In those situations, we believe an urgent care center (UCC) could be a viable alternative – allowing a vulnerable rural or urban community to have a health care resource without having to maintain emergency medical services or inpatient acute care services.

UCC Requirements
UCCs are designed to assist patients with an illness or injury that does not appear to be life-threatening, but requires care within 24 hours. They also provide treatment for these conditions during the days and hours that primary care physician offices are closed. Key components of the UCC often include:

- Patients do not need to make or have an appointment in order to see a health care provider;
- UCCs are open in the evenings and on weekends;

- X-ray services are provided on-site; and
- UCCs have the capability to perform procedures like suturing and casting.[32]

Beyond this, services offered by a UCC can vary widely depending on a community's needs. Some examples of the types of urgent medical conditions that may be treated at a UCC include: accidents and falls; sprains and strains; moderate back problems; bleeding/cuts that are not bleeding profusely but still require stitches; diagnostic services (including X-rays and laboratory tests); fever or flu; vomiting, diarrhea or dehydration; severe sore throat or cough; or minor broken bones and fractures.

In some communities, UCCs also may function as the primary care practice for their patients by handling ongoing chronic conditions or serving as a formal "medical home" for patients.[33] In addition, the UCC could provide enhanced service lines, such as swing beds, observation, home care or therapy, depending on the needs of the community. As with the EMC, each UCC would need to be transparent in its marketing so that it clearly conveys to the community the services that it offers.

Federal Statutory and Regulatory Barriers to Implementation of the UCC

1. Current reimbursement methodology. Federal reimbursement methodologies may not be sufficient to account for the low volume or other challenges UCCs would face in vulnerable rural and urban communities. Specifically, UCCs bill for services similar to a primary care office and are reimbursed under applicable Medicare Part B payment systems, including the physician fee schedule. Reimbursement from commercial payers will vary based on the contracts negotiated between the UCC and those payers. Under these reimbursement methodologies, the Urgent Care Association of America estimates that the break-

even point for an urgent care clinic is approximately 25 visits per day.[34] In vulnerable rural and urban communities, UCCs may not be able to maintain this volume making additional financing necessary to ensure they have adequate reimbursement to cover costs and create an adequate margin for capitalization.

Virtual Care Strategies

We identified telehealth and virtual care strategies as very promising options to help maintain or supplement access to health care services in vulnerable rural and urban communities that have difficulty recruiting or retaining an adequate health care work force. It offers benefits such as immediate, 24/7 access to physicians and other health care providers that otherwise would not be located in these communities, the ability to perform high-tech monitoring without requiring patients to leave their homes and less expensive and more convenient care options for patients. Therefore, virtual care strategies have the potential to result in better access to care, better care and outcomes, lower costs and workforce stability.

Right now, health care providers are using telehealth technologies to fill the need for critical services in a variety of specialty areas and across diverse patient populations. Some of the most common conditions for which patients seek telehealth services are acute respiratory illnesses and skin problems, but the list of possible uses continues to grow. It has been used to provide access to emergency services through secure, interactive, high-definition video and audio equipment in locations that cannot secure board-certified, emergency physicians or critical care nurses. In some instances, a button is even installed at the remote hospital location that may be pushed at any time the hospital needs to connect with an

emergency physician or critical care nurse, guaranteeing immediate access to these much needed services. Telehealth also has been used to effectively monitor patients on the floors of hospitals or in the intensive care unit, and to provide pharmacy services, including real-time pharmacist reviews of all new hospital medication orders.

As technology advances, the modes in which telehealth services can be provided will increase. For examples, smartphones, tablets or computers may be used to connect patients and physicians directly. Patients can connect through their smartphone for a visit with a physician related to minor illnesses such as colds, flu, bronchitis, allergy problems or rashes.

Currently, reimbursement for telehealth services differs by payer and, for many, broader reimbursement policies would be needed to adequately compensate health care providers for the costs associated with developing and maintaining this model. For example, many state Medicaid programs cover telehealth services to some extent, although the criteria for coverage vary widely from state to state. On the private payer side, by contrast, there has been significant expansion, with many states passing laws requiring private payers to provide coverage for telehealth services. Medicare coverage for telehealth services is particularly restrictive as a result of the program's narrow definition and scope regarding telehealth:

- Telehealth services may be provided only to Medicare beneficiaries who live in, or who use telehealth systems in eligible facilities located in rural Health Professional Shortage Areas, either located outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy within the Health Resources and Services Administration (HRSA); or in a county outside of an MSA.
- Medicare does not cover telehealth services provided via store-and-forward technology,

except in Alaska and Hawaii.
- Telehealth services will be covered only if the beneficiary is seen at an approved "originating site" authorized by law (including physician offices, hospitals and skilled-nursing facilities).
- Only Medicare-eligible providers (such as physicians, nurse practitioners and clinical psychologists) can provide the services.
- Medicare provides coverage only for a small, defined set of services (including consultation, office visits, pharmacological management and individual and group diabetes self-management training services).[35]

Federal Statutory and Regulatory Barriers to Implementation of Virtual Care Strategies

1. Coverage and current reimbursement methodology. As explained above, coverage by public and private payers varies significantly and whether payers cover and adequately reimburse providers for telehealth services is complex and evolving issue. However, without adequate reimbursement and revenue streams, providers may face obstacles to investing in these technologies. This may be especially detrimental to hospitals that serve vulnerable rural and urban communities – where the need for these services may be the greatest. For Medicare specifically, more comprehensive coverage and payment policies for telehealth services that increase patient access to services in more convenient and efficient ways would likely be necessary to make these strategies work for vulnerable communities. This would include elimination of geographic and setting location requirements and expansion of the types of covered services.

2. Privacy and security laws. Virtual care strategies can facilitate the generation, transmission and storage of tremendous volumes of new electronic health information and, as a result, create some additional operational challenges for health

care providers in meeting their existing privacy and security obligations under the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and any relevant state privacy laws. When adopting these strategies, health care providers will need to understand how the existing legal and regulatory requirements for safeguarding the privacy and security of a patient's medical information and other data extend to the operation of telehealth programs. In addition, more uniformity among federal and state privacy laws would help facilitate adoption of the virtual care strategies.

3. Fraud and abuse laws. Telehealth relationships must comply with applicable federal health care fraud and abuse laws, such as the False Claims Act. Arrangements between independent providers (e.g., physician collaborations with institutional providers and/or technology companies) may be subject to the Anti-Kickback statute and/or the Stark Law physician self-referral prohibitions. As telehealth utilization and coverage for these services by Medicare, Medicaid and private carriers continues to grow, the potential for exposure to liability under various federal fraud and abuse laws will only increase. However, more uniformity among federal and state fraud and abuse standards would help facilitate adoption of the virtual care strategies.

4. Access to broadband. Many rural communities do not have sufficient and reliable broadband access, which significantly hinders their ability to utilize virtual care strategies. The Federal Communications Commission (FCC) is taking a large role in telehealth to address some of these inequities. Among other things, in 2013, the FCC allocated $400 million through the Healthcare Connect Fund to help rural providers access broadband services. More recently, the FCC announced the formation of a new task force,

the Connect2Health Task Force, that "will bring together the expertise of the FCC on the critical intersection of broadband, advanced technology, and health." The Connect2Health Task Force is considering ways to increase adoption of health care technology, including telehealth, by "identifying regulatory barriers and incentives and building stronger partnerships with stakeholders in the areas of telehealth, mobile applications, and telemedicine." These efforts are steps in the right direction to help create robust broadband networks that will facilitate meaningful telehealth utilization.

Frontier Health System (FHS)

We also explored the creation of a strategy to address the unique geographic challenges faced by frontier communities. Frontier communities face challenges similar to other vulnerable rural and urban communities, but many are exacerbated. For example, these communities are extremely geographically isolated and there are often physical barriers, such as mountain ranges or large bodies of water, which hinder the ability to access health care services. Access may be further challenged by weather events such as snowstorms, whiteouts, fog, heavy rains or floods, disparate road conditions or the sheer distance between a patient's home and the necessary health care provider. Frontier communities also have very low population density, resulting in very low patient volume and a weak reimbursement base for supporting necessary infrastructure.

FHS Requirements

As a starting point for creating this strategy, we examined two existing CMS demonstration programs: the Frontier Extended Stay Clinic Model

(FESC) and the Frontier Community Health Integration Project (F-CHIP). While both of these demonstrations are promising, by definition, their design and scope is narrow, allowing only a small number of hospitals to participate.

FESC and F-CHIP Explained

Frontier Community Health Integration Project. The Frontier Community Health Integration Project (F-CHIP) is a budget-neutral demonstration project, mandated by the Medicare Improvements for Patient and Providers Act of 2009 (MIPPA), that would develop and test new models for the delivery of health care services to Medicare beneficiaries in certain frontier communities. The purpose of the demonstration is to improve access and better integrate the delivery of acute care, extended care and other essential health care services for beneficiaries in frontier areas. This model is available to CAHs meeting certain geographic requirements in Alaska, Montana, North Dakota and Wyoming – at the time of its mandate, 71 hospitals met the criteria to participate. While stakeholders presented a variety of design options for this model, the final, CMS-approved model includes three policy changes that allow for enhanced reimbursement for telehealth services, expansion of swing bed capacity to 35 beds (versus 25) and enhanced ambulance reimbursements. Ultimately, 10 frontier CAHs in three states (Montana, North Dakota and Nevada) are participating in this demonstration program, which began in August 2016.

Frontier Extended Stay Clinic Model. The Frontier Extended Stay Clinic (FESC) demonstration, mandated by the Medicare Modernization Act, allowed remote clinics to treat patients for more extended periods of time, including overnight stays, than are entailed in routine clinic visits. It was designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, could not be transferred to acute care hospitals in a timely manner, as well as of patients who needed monitoring and observation for a limited period of time, but did not require hospitalization. Under this program, participating FESCs must have been located in a community that was at least 75 miles from the nearest acute care hospital or CAH, or that was inaccessible by public road. Medicare set the reimbursement rates for these services on a prospective basis for the five clinics that were certified as Medicare providers under this three-year program. This demonstration program ended in April 2013.

Therefore, we created a strategy, similar to an accountable care organization (ACO), to address the health care needs of a broader set of frontier communities, including the extremely low patient volume and the lengthy distance between providers. The FHS would allow for the creation of local, integrated health care organizations for very small, isolated frontier communities. It would serve as a medical home for all patients in its service area, including Medicare and Medicaid beneficiaries. These organizations would include frontier health care providers that join together to coordinate preventive and primary care, extended care, inpatient care and emergency services across local, secondary and tertiary settings.

Similar to ACOs, the primary role of the FHS would be to provide a framework for integrated and co-ordinated health care as individuals move through the primary and specialized segments of the medical system. However, unlike traditional ACOs, the FHS also would provide transportation services to patients – this would include transporting individuals living in frontier communities to specialized medical care outside of their community, but also enabling those individuals to return to their home town for follow-up care. In addition, the care provided by the FHS would include inpatient and outpatient, swing bed, rural health clinic, ambulance and expanded visiting nurse services. In order to survive and to maintain access to important services for their communities, FHSs would need to aggregate and more efficiently manage the delivery of health care services to reduce unit cost and re-invest savings in care coordination, as well as enhanced preventive and home-based care.

While frontier communities in many states could benefit from this strategy, certain states may face unique circumstances that must be accounted for in order to successfully implement this strategy. The FHS should be designed in a way that takes into account the differences between frontier states and allows for flexibility.

Federal Statutory and Regulatory Barriers to Implementation of the FHS

1. Current reimbursement methodology. Currently, the different providers within an FHS are paid under different payment methodologies, which does not support economies of scale or care coordination. For example, visiting nursing services are paid on a fee-for-service basis, while all inpatient and outpatient services provided by a CAH are paid based on cost. A new payment methodology would be needed that aligns the incentives of all providers in the FHS and accounts for low patient volume and the distance between providers. We believe that a reimbursement methodology that combines cost-based and pay-for-performance reimbursement would be appropriate for this strategy. Cost-based reimbursement would allow all health care providers to account for the costs of creating integrated FHS organizations and care coordination networks – this may include costs associated with health information technology, chronic disease management tools and education and training for current or new staff. The pay-for-performance element could be a value-based purchasing-like program that rewards the FHS for care coordination, reduced admissions and readmissions, improved quality outcomes and the reduction of health care costs.

2. Waivers of current Medicare payment rules. In addition, regulatory changes would need to be made for this strategy to be implemented. More specifically, the FHS would need a system of waivers that would only apply to services provided by an FHS and may include:

- Changing the CAH 25-bed limit to 35 beds, which would allow for expanded swing bed services;
- Allowing cost-based reimbursement for visiting nurse services (e.g., physical, occupational and speech therapy services as well as services delivered by a home health aide) when furnished in the frontier home setting;
- Waiving the 35-mile ambulance rule to allow FHSs to operate in their regional service areas, which often encompass hundreds or even thousands of square miles, even if another ambulance service is located within 35 miles; or
- Waiving telehealth restrictions.

3. Fraud and abuse laws. To allow health care providers to form the financial relationships necessary to succeed in the FHS, it is critical to obtain waivers of applicable fraud and abuse laws that inhibit care coordination. Specifically, the physician self-referral law and the Anti-kickback Statute with respect to financial arrangements formed by hospitals are not compatible with the FHS.

Rural Hospital-Health Clinic Integration

Currently, many rural hospitals have developed relationships with various types of health clinics in their communities to ensure and expand access to health care services. This is most often seen as a relationship between a rural hospital and a Federally Qualified Health Center (FQHC), which is what we have focused on below. However, we believe this model has the potential to be expanded to include relationships between rural hospitals and all types of health clinics including, but not limited to, Rural Health Clinics and Community Health Clinics.

We acknowledge that in many communities, rural hospitals and FQHCs have strained relationships

and a lack of trust resulting from years of conflict and competition for patients as well as health care practitioners. In addition, as a result of the regulations governing and operating rural hospitals and FQHCs, these facilities also often have different incentives when providing health care services to the community. Despite these challenges, however, we believe cooperation and collaboration through integration is a way for vulnerable rural communities to better meet community need and stabilize and expand services as those needs change.

FQHC and CAH Explained

FQHC. An FQHC is a community-based outpatient clinic that qualifies for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors.[36] FQHCs provide a range of services including comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

CAH. A CAH is a hospital, certified and structured under a different set of Medicare Conditions of Participation than acute care hospitals. They have a limited size (no more than 25 inpatient beds), short lengths of stays (annual average length of stay of no more than 96 hours for acute inpatient care) and meet certain location and distance requirements. CAHs also provide outpatient care and offer 24/7 emergency care. They receive cost-based reimbursement from Medicare, instead of fee-for-service or fixed reimbursement rates.

Rural Hospital-Health Clinic Requirements

Integration between rural hospitals and health clinics may take the form of a variety of relationships including:

- Contractual collaborations, such as referral and co-location arrangements, or an agreement for the purchase of clinical and/or administrative services between the FQHC and rural hospital;
- Formation of a consortium or network that allows for sharing of clinical and administrative functions, as well as facilitate the continuum of care; or
- Corporate integration (i.e., merging the rural hospital into the FQHC).

Regardless of the level of integration chosen, this strategy would allow each entity to dedicate its resources to a different set of services. For example, in a CAH-FQHC relationship, the CAH would generally continue to provide acute inpatient services, diagnostic and lab services, outpatient surgery and therapeutic services, without having to maintain an outpatient primary care clinic. In contrast, the FQHC would generally focus on providing primary care services, dental services and behavioral health services, without having to maintain a full set of diagnostic or lab services. With each entity focusing its resources on what it does best, the collaboration between a CAH and FQHC would eliminate duplication in services and allow a community to more efficiently use its limited resources.

While working together, rural hospitals and FQHCs also may be able to share access to patient care records or quality improvement programs, which would allow for greater synergy and integration of primary care, behavioral health and oral health, as well as secondary and tertiary care. This integration also could allow for efficiencies of scale between both organizations that may be accomplished by sharing administrative and management and medical leadership functions, consolidating capacity or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.

Federal Statutory and Regulatory Barriers to Implementation of Rural Hospital-Health Clinic Integration

1. Regulatory and reimbursement differences. Rural hospitals and health clinics are required to meet separate and distinct regulatory requirements. In addition, each is paid under its own reimbursement structure, as described above, which has its own set of standards and expectations. Both entities will need to understand the requirements associated with the other entity in order to implement this strategy. Likewise, both entities will need to educate and market the joint relationship in a way that is transparent and clearly conveys to regulators, health care providers and patients the nature of the relationship and services being offered.

2. FQHC regulatory requirements. For relationships between rural hospitals and FQHCs, it is important to note that the HRSA oversees the FQHC program and generally speaking, does not approve relationships where a hospital, municipality or 501(c)(3) corporation owns the FQHC. Historically, however, HRSA has made exceptions if the FQHC has its own independent board of directors. In addition, HRSA has promulgated regulations that set forth additional governance requirements for FQHCs, including that the governing board must have a majority (minimum of 51 percent) of members who are patients of the FQHC and who, as a group, reasonably represent the patient population. There also are restrictions on the percent of non-patient board members who earn 10 percent or more of their incomes from health care-related industries. It is important to take these requirements into consideration when developing any type of integration between a rural hospital and an FQHC.

Indian Health Services Strategies

While developing strategies for vulnerable rural and urban communities, we also reflected on ways in which the access to and delivery of care could be improved for those American Indian and Alaska Native Tribes that receive health care services from the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. While our task force did not dive deeply into the operations of the IHS program, we did gather feedback from states that are significantly impacted by its operations. As a result, we offer recommendations that may increase access to health care services for this population and improve the quality of care and coordination between the IHS facilities and other health care providers.

Background on IHS

The IHS program has been developed through several treaties and other agreements between the U.S. government and Indian Tribes and provides for medical services, the services of physicians, or the provision of hospitals for the care of Indian people. As a result, members of 567 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by IHS.

In total, IHS provides a comprehensive health service delivery system for approximately 2.2 million of the nation's estimated 3.7 million American Indians and Alaska Natives – a majority of which live on or near reservations and in rural communities, mostly in the western U.S. and Alaska.[37] It operates 28 hospitals, 62 health centers, 25 health stations and 33 urban Indian health projects.[38] American Indian Tribes and Alaska Native corporations administer an additional 18 hospitals, 282 health centers, 80 health stations and 150 Alaska village clinics.[39]

IHS provides two types of services:

- Direct care to tribal patients through IHS-operated heath care facilities, most of which are located on or near reservations. For tribal members who are covered by IHS health care programs, treatment at these facilities is free.

- Contract health services (CHS), which includes health care services provided by non-IHS facilities to tribal members eligible to receive CHS benefits. These heath care services are funded by annual, fixed appropriations from IHS that pays providers for these services at a Medicare-like rate. These services are only to be used when the treatment or services needed by the patient are not available at an IHS-operated facility.

While this system has had success at delivering care to these communities, American Indian and Alaska Native Tribes have long experienced lower health status when compared with other Americans. When compared to the general U.S. population, their life expectancy is more than four years lower and death rates are significantly higher, including deaths related to chronic liver disease and cirrhosis, diabetes, unintentional injuries, intentional self-harm/suicide and chronic lower respiratory disease.[40]

IHS Strategies

We believe the IHS system could be strengthened through the development of partnerships with non-IHS health care providers. These partnerships could take many forms, but would be made with the goals of increasing access to health care services for this population, improving the quality of care available and promoting coordination of care between the IHS facilities and other health care providers.

We developed a strategy to improve care coordination between IHS facilities and those providing contract health services to American Indians and Alaska Natives. As a first step in this process, IHS facilities would conduct an assessment of the services it currently offers and those available in surrounding communities. IHS services at each facility vary, but specialty services available through the IHS are generally limited. For example, IHS facilities are often unable to provide sufficient behavioral health, specialty dental care and treatment for non-urgent conditions, such as arthritis, allergies and chronic care.[41] In addition, IHS facilities often lack necessary equipment for ancillary services and have few medical specialists on site.[42] These service gaps could be filled by expanding relationships with non-IHS health care providers.

This assessment also should include an examination of which health care providers best allow the IHS system to most efficiently use its limited resources. In some situations, health care providers outside of IHS may be able to offer better quality services at a lower cost. In other cases, the IHS facility may prove to be a better option. The assessment also would include an analysis of

efficiencies that may be accomplished by sharing administrative and management and medical leadership functions, consolidating capacity or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.

Once this assessment is completed, the IHS system would work to develop the relationships needed to expand access to the needed services. This will include ensuring that financial resources are dedicated to the appropriate health care providers and that systems are in place to exchange information among the participants responsible for different aspects of care.

In addition, the IHS may benefit from the other strategies we recommend in this report. For example, IHS can work with non-IHS providers to expand virtual care at its facilities. This could increase access to many areas of health care, particularly specialty care that may be difficult to find in these vulnerable communities (i.e., emergency medical services or appointments with specialists in behavioral health, cardiology, maternal and child health, nephrology, pain management, pediatric behavioral health, rheumatology, wound care and dermatology).

IHS hospitals also could consider partnering with FQHCs in the community. That way, the IHS hospital can focus on providing acute inpatient services, diagnostic and lab services, outpatient surgery and therapeutic services, without having to maintain an outpatient primary care clinic. The FQHC could then focus on providing primary care, dental and behavioral health services, without having to maintain a full set of diagnostic or lab services. With each entity focusing its resources on what it does best, the collaboration between an IHS hospital and an FQHC would eliminate duplication in services and allow the IHS system to more efficiently use its limited resources.

Federal Statutory and Regulatory Barriers to Implementation of IHS Strategies

1. IHS funding. Adequate funding has been a continual challenge for the IHS program and CHS providers. IHS is an appropriated program rather than an entitlement program. That means that a majority of the federal funding available for IHS is appropriated in advance each year in fixed amounts that are then allocated among the different geographic areas and tribes served by the IHS.

These funds have been insufficient to cover the costs of providing health care services to all those eligible for IHS services. As a result, the program typically runs out of money well before the end of the year – creating financial issues for IHS facilities and hampering IHS's ability to reimburse for health care services provided by non-IHS facilities. And, while there are many health care providers that are willing and able to provide health care services to this population, there is little trust that they will be reimbursed for their efforts. Funding for the IHS program will need to be reevaluated to improve care coordination with non-IHS providers and ensure that the right providers are incentivized for providing necessary services. Policy makers may wish to examine funding of other governemnt operated health systems (e.g Veterans Health Administration and the Military Health System) as a part of that reevaluation process.

2. Technical assistance. In addition to the funding addressed above, IHS facilities may collect additional reimbursement for services provided to American Indians and Alaska Natives who are also eligible for other federal programs, including Medicare, Medicaid, the State Children's Health Insurance Program and Veterans Access Choice. Increased funding from these sources allows IHS facilities to expand services; however, they face challenges in collecting this funding because they often lack the technical expertise and assistance

necessary to bill and collect for these services. In addition, many American Indians and Alaska Natives are eligible for Medicaid but remain uninsured due to enrollment barriers (e.g., lack of knowledge about Medicaid, difficulty completing the enrollment process, language and literacy barriers, and geographic or transportation barriers). Technical assistance for IHS and its constituents would allow IHS facilities to improve the organization's operations.

3. IHS regulations. Currently, IHS hospitals are required to meet the hospital Conditions of Participation. This is onerous given that many IHS hospitals are comparable to small rural hospitals. Their location is often geographically remote and they see a very small volume of inpatient services. Transformation within IHS would be more easily facilitated if they were subject to less burdensome regulations and could meet Conditions of Participation more suited to their needs – e.g., Conditions of Participation similar to CAHs.

Barriers to Implementation

Throughout this report, we have identified specific federal statutory and regulatory barriers that would impede transitioning to or implementing our nine emerging strategies. However, there are many other barriers to implementation that may arise at the health care provider, community or state levels. While we cannot capture the full scale of those barriers, we have identified some consistent themes across each of these emerging strategies.

Health Care Provider Barriers

At the health care provider level, transitioning to these new strategies may take longer or require more significant investments of time, effort and finances in vulnerable communities. For example, certain hospitals in vulnerable communities have been unable to meaningfully participate in value-based payment programs or develop and sustain alternative payment models for a variety of reasons. Therefore, they lack experience participating in alternative payment models, such as global budget payments, and may require payment policies and technical assistance that bridges the gap between current fee-for-service and value-based reimbursement models.

In addition, for the virtual care model, credentialing and privileging at the health care provider level may be a barrier to implementation. Specifically, in an effort to ensure the highest quality of care possible for its patients, each health care facility takes steps to verify a health care provider's proficiency through the collection, verification and evaluation of data relevant to the practitioner's professional performance. These credentialing and privileging requirements are exacerbated in the telehealth context because the services provided usually involve two or more health care facilities, both of which credential and privilege each health care provider.

Community Barriers

At the community level, the ability to attract or retain health care providers will remain a challenge regardless of which of these strategies are selected. The AHA Board Committee on Performance Improvement (CPI) has undertaken the topic of workforce, specifically the need for hospitals and health systems to begin to integrate workforce planning and development with hospital strategy and operations. It is imperative that hospitals in vulnerable communities undertake this effort at the same time that they are planning their transformation strategies. The CPI also is formulating its own report that will be a resource for hospitals. That report will enable hospitals and health systems to assess their workforce needs and to commit to developing long-range workforce plans integrated with their new or existing strategies to operate in a very dynamic and evolving health care field.

Furthermore, this task force's report underscores the need for innovation in workforce planning and development to ensure providers are able to deliver care as they transition to these emerging strategies. Specifically, many in the current workforce are not adequately prepared to take on the variety of responsibilities outlined in this report, nor is the education system of the future workforce adequately preparing providers for new, expanded roles that are not hospital-based. For this reason, it is critical that workforce planning and development become integrated into discussions around developing new models of care, new collaborative relationships and new payment structures. Vulnerable communities will need a workforce that is well-educated, culturally competent, nimble and flexible to meet the needs of their populations.

Moreover, what we learned from our listening sessions around the country is that the concern from the community and its leaders may hinder transformation and implementation of these emerging strategies. Communities, and the community board that governs the hospital, typically do not want to lose their hospital because it serves as the anchor for and economic engine of the community. Conversations related to transformation will be challenging for many vulnerable communities, but community input, buy-in and acceptance are critical for success as hospitals transition to these new strategies.

State Statutory and Regulatory Barriers

State laws also will present barriers to implementation of these strategies. The best examples are the issues related to physician licensure across state lines that would be required for broad implementation of virtual care strategies. State licensure laws can be major obstacles for facilities wanting to provide telehealth services to patients in other states because of the current lack of portability of health professional licenses between states. The harmonization of state laws to foster increased physician licensure portability, greater licensure portability for nurse practitioners, physician assistants and other health professionals, increased flexibility of the physical examination requirement for online prescribing; and clarification of medical malpractice insurance rules for telehealth encounters would facilitate the adoption of virtual care strategies.

The Interstate Medical Licensure Compact (IMLC) and the Nurse Licensure Compact (NLC) are two promising avenues to address these state licensure issues. The IMLC offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states, increasing access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies. As of the date this report is published, 16 states have joined this Compact. The NLC offers a multi-state license to nurses to practice in their home state and in other Compact-participating states. Under this Compact, nurses have the opportunity to practice across state lines and it enables state boards of nursing to cooperate and coordinate standardization of requirements, resulting in safer, coordinated care. As of August 2016, 25 states have joined the NLC.

Advocacy Agenda and Assistance Strategy

In this report, we discuss specific federal policies and issues that could impede or create an appropriate climate for transitioning to a different payment model or model of care delivery in relation to each of our recommended strategies. Generally speaking, these barriers naturally lead to the development of an advocacy agenda, as well as a vulnerable community assistance strategy, that will help facilitate the adoption of the emerging strategies we set forth above.

Advocacy Agenda

The ability to successfully adopt many of the strategies we describe above is dependent on numerous federal policy changes. Therefore, we recommend that the AHA advocate for the:

- Modification of existing Medicare Conditions of Participation to allow for the formation of the strategies identified above, where necessary;

- Creation of new Medicare payment methodologies and transitional payments, as appropriate, that would allow for successful implementation of the strategies identified above, while covering necessary costs, promoting predictability and stability and aligning provider incentives to increase accountability for health care services offered within a community;

- Creation of new and expansion of existing demonstration projects being conducted by CMMI and other federal agencies that promote and fund opportunities for communities to maintain access to essential health care services;

- Modification of laws that prevent integration of health care providers and provision of services including, but not limited to, fraud and abuse (Anti-Kickback Law and Stark Law), antitrust and CMP laws and artificial barriers such as those that prevent a rural hospital from owning an FQHC.

- Modification of existing Medicare payment rules that stymie health care providers' ability to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals including, but not limited to, discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services and the inpatient rehabilitation facility "60% Rule;" and

- Expansion of Medicare coverage and payment for telehealth, including a more flexible approach to adding new telehealth services to Medicare.

We also note that while the above recommendations focus on a federal advocacy agenda, states will play an important role too, such as with physician licensure and credentialing across state lines required for telehealth services. Therefore, we also recommend that the AHA continue to work with the state hospital associations to address state-level issues, as appropriate.

Vulnerable Community Assistance Strategy

By their very nature, vulnerable communities and the hospitals that serve them may not have all the resources they need to successfully adopt one or more of the strategies set forth in this report. Therefore, we recommend that the AHA provide communities and health care providers, including hospitals, with operational tools to facilitate such adoption. For example, we believe the association could assist by:

- Providing assistance in analyzing financial data or conducting data analytics to determine the feasibility of adopting a particular model or the outcomes and efficacy of each model;

- Creating community relations toolkits to assist hospitals in creating opportunities

for community input, partnership, buy-in and acceptance of their transformation by their community;

- Providing information related to grants that may provide financial assistance for certain strategies;

- Facilitating the creation of learning networks to bring hospitals together for information and idea sharing; and

- Offering curricula, developed in partnership with third parties, to promote best practices, identify cutting-edge strategies, operationalize innovation activities and adapt successful approaches from elsewhere into hospitals' own organizations.

Conclusion

In this report, we have worked to identify and set forth characteristics and parameters, strategies and solutions can appropriately identify and account for the variation in access to health services in communities around the country. But, this is only the beginning. To fully ensure access to essential health care services, we will all need to do our part – vulnerable communities, the hospitals that serve them, and the association that serves us all. Vulnerable communities will need to make significant investments of time, effort and finances. Hospitals will need to build upon their current infrastructure for health information technology, patient and family education, care management and discharge planning. They will need to align in ways they have not before, which will involve forming new and different contractual relationships that build valuable partnerships and incentivize successful strategies. The AHA should advocate for policies that allow these transformations, and provide the tools that facilitate their occurrence.

Case Examples and Best Practices

Addressing the Social Determinants of Health: Lehigh Valley Health Network, Pa.

Lehigh Valley Health Network (LVHN) is working to help address one of the most prevalent health-related social needs in its community – homelessness. It became generally aware of the problem through its Community Health Needs Assessment (CHNA), but did not have information on the number or identity of the homeless patients it was serving. Therefore, with the goal of changing the way health care was delivered to the homeless in its area, LVHN founded the Street Medicine Program. The program is wide-ranging, but one facet is the recent completion of a research study that screened for homelessness in the ED using a newly developed screening tool. The tool screens ED patients using four questions based on the Departments of Health and Human Services, Housing and Urban Development, and Veterans Affairs definitions of homelessness. It is designed to be short and completed quickly, which facilitates compliance with completion. Through this screening tool, LVHN was able to quantify that, at all hospital sites, the prevalence of homelessness was far higher than anticipated. This has led to allocation of more and more targeted resources to address the problem.

When a patient answers affirmatively to any one of the four questions in the screening tool, several activities are triggered. First, the provider takes an in-depth social history to obtain more details on the barriers to care that the patient faces. In order to improve awareness and identification of barriers to care, the Street Medicine team has provided education on homelessness and health care to the ED and inpatient providers, nurses and case managers. Next, if the ED provider feels it is appropriate, the Street Medicine team is called for a consultation. They begin to establish a relationship with the patient, and use their social history, as well as other forthcoming information, to provide information on community resources that can help address the patient's needs, such as homeless shelters, food pantries, soup kitchens, food stamp programs, and health insurance. The team also provides both personalized assistance to help the patient obtain needed resources and provides certain resources themselves, such as access to free medications and lab tests needed to facilitate safe discharge from the hospital setting. They have put a particular emphasis on helping patients gather documentation and fill out the appropriate forms to obtain health insurance and, subsequently, connect with a primary care physician in a more traditional setting. As a result, they have seen a rise in the rate of insurance for their homeless population from 24 percent in February 2015 to 70 percent from January through May 2016.

The LVHN Street Medicine team also is working to identify and address the many disconnects it has identified between the needs of the homeless population and the resources available to help them, particularly with regard to their health care needs. Thus, in addition to the screening tool and hospital-based consultation services, it has established free clinics within homeless shelters and soup kitchens, and the team also delivers health care on the street for those that are unwilling or unable to visit the clinics.

> *"We developed a health care delivery system that put free clinics in homeless shelters and soup kitchens and a street team that seeks out those who live in the shadows of our society. This simple idea would change the trajectory of families we treat now and hopefully forever."*
>
> *Brett Feldman, Director of LVHN's Street Medicine Program*

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Addressing the Social Determinants of Health: ProMedica Health System, Ohio

ProMedica's efforts to address food insecurity in its community began with an initiative to battle obesity. It first identified this as an issue in its CHNA, finding that Toledo consistently ranked one of the most obese communities in the country. ProMedica determined that one of the root causes of the problem was food insecurity and, in particular, a lack of access to nutritious, affordable food. As such, they began providing educational programs at schools and to parents on nutrition, including recommendations for how families could purchase healthy food on very limited budgets.

In an effort to address food insecurity more directly, in 2014, ProMedica created a two-part screening tool that is embedded in its EHR and administered as part of the inpatient admission intake process. The questions are taken from a larger U.S. Department of Agriculture screening tool and focus on whether a patient is concerned that their food supply will run out before they are able to purchase more.

ProMedica asks patients to respond either "yes" or "no" to two statements:

1. Within the past 12 months, we worried whether our food would run out before we got money to buy more.

2. Within the past 12 months, the food we bought just did not last and we did not have money to get more.

ProMedica runs a daily report that indicates which patients answered either of the tool's questions affirmatively; hospital staff then confirm the positive screen with the patient. Then, upon discharge, the patient receives a care package that contains one day's worth of shelf-stable food, such as crackers, cereal and packaged fruit. ProMedica also provides him or her with a Community Resource Guide that includes information on food resources specific to the community in which the patient lives. They are currently developing a follow-up protocol to determine whether the patients successfully accessed any of the resources.

To further assist patients on an ongoing basis, ProMedica created the ProMedica Food Pharmacy, for which patients obtain a prescription through one of ProMedica's primary care physician practices. ProMedica believes that tying the prescription to a physician visit increases the likelihood of patient participation, as they know it is in their best health interest. In addition, if the physician is concerned about the patient's ability to access the Food Pharmacy in a timely manner, due to, for example, transportation challenges, or if they feel the patient is in immediate need, they are able to provide the patient with an "emergency food bag" that contains a day or so worth of shelf-stable food for their entire family.

The Food Pharmacy offers patients two to three days' worth of food for their entire household, per visit. Patients can return once per month for up to six months, at which time they can return to their physician for another prescription if they are still in need. In addition, the patient is offered nutrition counseling from a registered dietitian, healthy recipes and a connection to community resources. Patients are able to choose their own foods from the pantry with assistance from trained staff who consider the patient's needs and health conditions. From January through April 2016, the Pharmacy provided healthy, nutritious food to almost 5,000 individuals representing almost 2,000 households.

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Addressing the Social Determinants of Health: Kaiser Permanente, Calif.

Kaiser Permanente is working to address the social determinants of health for a targeted, high-cost portion of its members. To do so, Kaiser partnered with a social needs screening and referral vendor and aims to address all patients' basic resource needs as a standard part of quality care. One of the initiatives they are testing is a call center that proactively reaches out to members identified as being at the highest risk of becoming "super-utilizers" (i.e., in the top 1 percent of predicted utilization according to their illness burden).

Under this initiative, trained staff ask these members if they would like to participate in a phone-screening session about social needs. If the member agrees, they are asked a set of questions related to food insecurity, homelessness, transportation availability and financial difficulties. Members that screen positive are offered the opportunity to enroll in Kaiser's social needs program, which connects them with existing resources in the community, such as food banks and tenants' rights associations, or at Kaiser itself, such as medical financial assistance. In addition, Kaiser calls enrolled members every 10 to 14 days to further assist them until they connect with resources and to assess how well their needs are being met.

Currently, Kaiser has one call center serving three of its Southern California medical centers. Two of these locations are more urban in nature and one is rural; initial data have revealed important differences between the sites. Kaiser has determined that it is important for the call center employees to have knowledge of the communities in which the members live so the members feel that they have a greater connection to the community. In order to facilitate this, these call center employees have toured the areas where the targeted members live and met with community leaders.

Kaiser has found that 78 percent of screened members have at least one unmet social need, and the average screened member has 3.5. In addition, of the members with unmet needs, 74 percent agree to enroll in the social needs program. Kaiser is in the process of analyzing the success of referrals to outside agencies to identify top resources; better understand the resource gaps within a defined geography; develop a community-alignment strategy; and, ultimately, increase the number of successful resource connections.

> *"We believe that adopting a 'whole patient' perspective for our high-cost, high-need patients will give us the best chance of improving their health outcomes. To achieve this goal, we aim to partner with existing community resources, identify gaps in linking with those resources, and (in the process) demonstrate the value of addressing the social determinants of health."*
>
> *Dr. Nirav Shah, Senior Vice President and Chief Operating Officer for Clinical Operations, Kaiser*

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Addressing the Social Determinants of Health: Bon Secours Baltimore Health System

Bon Secours Hospital serves West Baltimore, a socioeconomically disadvantaged neighborhood in Maryland, which has a high prevalence of poverty, chronic disease and health disparities. Most of the patient population is on medical assistance or lacks health insurance. Bon Secours Baltimore Health System leads a wide variety of initiatives to affect the social determinants of health and foster a culture of health in West Baltimore.

They do this by partnering with community stakeholders to more closely align the services that are available with the needs of community members. For example, in 2010, Bon Secours Baltimore Health System took the lead in as the fiduciary organization, forming a coalition of 16 hospitals, health centers and other wellness, educational and community-based organizations that would address the health of this community. The coalition worked with the state of Maryland to have West Baltimore declared a Health Enterprise Zone (HEZ) – allowing the community to receive approximately $4 million from the Maryland Department of Health and Mental Hygiene to improve the health of the individuals living within this four/ZIP code community. The funds from the HEZ are used to attract additional primary care physicians, nurses, care coordinators and community health workers to augment preventive care for residents living in the designated ZIP codes. Additionally, community grants will fund fitness equipment in churches, and healthy eating and medication management initiatives to keep people healthy and out of the emergency room.

Initial results in the community have been positive. Care coordination has increased as a result of HEZ's efforts and providers were able to successfully connect over 7,200 patients to a Community Health Worker (CHW) and those CHWs have completed over 7,400 encounters through home visits, phone calls, health screenings and clinic visits. In addition, through the HEZ funding, 85 scholarships have been awarded to residents within the HEZ to pursue health careers. The coalition also offers free fitness classes each week, which reached 3,574 residents and resulted in an average weight decrease of 15 pounds and a decrease in body mass index of 1.5 for participants. The coalition also has been able to offer training classes to train CHWs and provide additional equipment for the community related to cooking, nutrition and chronic disease management.

This coalition continues to evolve and works to enact policy, create programming, and make ultimate decisions for the West Baltimore Health Enterprise Zone project. The coalition also maintains an Advisory Board that is enlisted to offer recommendations for, and insight into, programming and services related to improving cardiovascular and overall health in West Baltimore. Membership of that Advisory Board is primarily comprised of a cross-section of individuals who live, work, play, study, or worship in ZIP codes within the HEZ. Additional members may include representatives of corporations and organizations with particular disease focus interest in the community.

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Global Budgets: Maryland All-Payer Global Budget Revenue Program

In January 2014, the state of Maryland established a Global Budget Revenue Program (GBR) as its primary approach to moving Maryland hospitals away from the volume-driven, fee-for-service system and toward the value-driven approach of the new Maryland waiver. This model builds on Maryland's experience with its "Total Patient Revenue" system that established fixed global budgets for certain rural hospitals on the basis of historical trends in the cost of providing care for the specific populations they serve.

Under the GBR, Maryland hospitals receive a pre-established budget for all inpatient and outpatient services provided to all Maryland resident patients, regardless of payer, within a calendar year. Each hospital operating under the global payment budget receives annual adjustments for inflation, changes in payer mix, population/demographics and the impact of quality-based payment programs. There are no explicit adjustments for changes in patient volume or case mix/severity.

There are several commitments and benchmarks for financial success in Maryland's demonstration project. First, state-wide all-payer cost growth for included services is limited to 3.58 percent per capita per year. In addition, the cost growth per Maryland Medicare beneficiary for all Medicare services must be below the national Medicare per beneficiary average over five years, and may not exceed the national average by more than one percentage point in any given year. Finally, as part of the demonstration, the state also committed to create hospital savings of at least $330 million for Medicare over five years.

Maryland's hospitals also must meet enhanced quality benchmarks. Specifically, in aggregate, they must reduce their 30-day Medicare readmission rate to the national average within five years, after having the third-highest statewide average prior to the project's start, and reduce their potentially preventable complication rate by 30 percent over the five-year period.

Early results have been positive. Operating margins have increased from 3 to 5 percent for rural hospitals. In addition, the occurrence of hospital-acquired conditions declined by 25 percent in the first year of statewide participation in the demonstration.

However, there are characteristics that have contributed to the demonstration's success that may not be present in every state. For example, all payers participate in the global payment in Maryland, including commercial providers. This allows hospitals to focus their efforts on success under the global payment, rather than attempting to simultaneously operate under fee-for-service and global budget payment models. Another important factor is that average spending per beneficiary in Maryland has historically been higher than in most other states. Further, Medicare and Medicaid both pay an average of 94 percent of charges in Maryland, which is higher than what is observed on average nationally.

Despite a largely positive experience under the demonstration so far, Maryland's hospitals face potential challenges to continued success. A key metric of the project's success is the growth rate of total,

all provider (Parts A and B) Medicare spending per beneficiary; however, non-hospital providers are not included in the regulatory model even though they can significantly contribute to increased utilization and beneficiary spending through no fault of the hospitals. Additionally, Maryland's hospitals are responsible for meeting the demonstration's goals, regardless of factors that may shift the comparison to national benchmarks that they need to achieve. For example, Maryland's hospitals must reduce their readmissions rate to the national average or below; however, hospitals nationally also are incentivized to reduce their readmission rates through the Hospital Readmissions Reduction Program. Hospitals in Maryland also are concerned about the lack of a payment mechanism to account for needed capital reinvestment in hospital facilities.

Global Budgets: Pennsylvania Rural Health Transformation

Pennsylvania's rural hospitals face significant financial challenges, as payment pressures and volume fluctuations have negatively impacted their finances. Between 2013 and 2015, the median operating margin of rural hospitals declined from 2 percent to zero percent, and 20 percent of rural hospitals have reported negative operating margins for each of the last three years.

To help address this trend, Pennsylvania is considering a move to global budgets for rural hospitals, which would align payment incentives across payers and lessen incentives to focus on inpatient care. The Pennsylvania Department of Health has proposed that six hospitals fully participate in 2017, with an increase to 30 hospitals by 2019. To meet this timeline, the initial six hospitals will declare their interest in participating and develop their care transformation plans and budgets prior to the end of 2016.

Similar to the Maryland model, Pennsylvania hopes to engage all payers in global payment through a gainsharing model. In years one and two, hospitals would retain all savings created by the program, while in year three they may gain up to 75 percent of savings created. Thereafter, hospitals and payers would equally split shared programmatic savings created through global budgets.

It is anticipated that some of the proposed savings are to be created through reduced ED visits, hospital admissions and readmissions. Additional value, however, could to be created through more efficient management of administrative services, including supply chain, improved productivity, service redesign and utilization of care management services.

Inpatient Outpatient Transformation Strategy: Carolinas HealthCare System Anson, N.C.

Carolinas HealthCare System Anson recently transformed the services it offered, with the goal of improving health status in Anson County, which is challenged, both in terms of economics and health. For example, this community had a median household income of $33,870, far lower than the median household income of $51,939 nationwide.[44] This community also had an overall health ranking of 84 out of 100 counties in North Carolina. The hospital struggled, both financially and in its ability to improve the long-term health status of its community.

Carolinas HealthCare System (Carolinas) recognized that it would have to transform its model of delivering care in order for this hospital to remain viable. Carolinas was committed to creating a future state that included:

- Enhancing patient and community outcomes through personal and virtual connectivity of Carolinas' network of specialized services;
- Providing and supporting a team of health care professionals for primary and preventive care;
- Enhancing the availability of specialist physicians;
- Providing improved access to appropriate services through telemedicine and other services; and
- Developing a flexible, cost-effective new facility for the evolving care needed to serve the community.

The result of this work was a new facility that replaced the existing hospital, included a reduced inpatient capacity from 52 beds to 15 and allowed the hospital to offer enhanced outpatient and primary care services to the community. These services include a patient-centered medical home, increased ED capacity and increased behavioral health services. The hospital developed new patient flow and care coordination models that focus not only on improving outcomes, prioritizing primary care, wellness and prevention, but also on improving patient flow and screening so that each patient is treated in the most appropriate setting.

As part of this transformation, Carolinas proactively fostered relationships with community organizations focused on improving the health status of Anson County residents. It worked closely with the local county government (including the Anson County Manager and the Anson Board of Commissioners) and the Anson County School Board of Education throughout this process. The relationship with the Board of Education allowed the hospital to proactively plan initiatives important to education and health of the approximately 2,000 students in the school system, including an active partnership that prepares the next generation workforce through Carolinas' Youth Career Connect Partnership.

As Carolinas moves forward with this new model, it will continue to work with community health partners, including health departments, churches and schools, to coordinate care and increase the focus on health and wellness in the community. Largely as a result of this hands-on, active partnership with the community, early results of the transformation are positive. For example, ED visits have decreased and primary care volumes have increased. In addition, Carolinas has transitioned 2,631 patients into the new primary care/medical home model in the first year – which is significant given that the total population of the hospital's service area is only 25,765.

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Urgent Care Center: Doctors Medical Center, California

Doctors Medical Center (DMC) in San Pablo, CA had been struggling financially for many years, despite having received funds from two parcel taxes, neighboring community hospitals and the state. And, even though it was on the brink of closure for almost a decade, the consensus from the community was that everything should be done to stop a closure. By 2014, however, it was clear that this was no longer possible. At that point, DMC faced significant financial challenges. It had a high cost structure, but a poor payer mix that was dominated by Medicaid, Medicare and uninsured patients. In addition, its ED was being used primarily as a substitute for primary or urgent care – the hospital had approximately 40,000 ED visits each year, with only 11 percent requiring inpatient admission. And, DMC faced issues related to seismic compliance – an issue that is unique to California but would have required the hospital to expend $100 million to rebuild to be compliant with earthquake standards.

As a result, the Hospital Council and Contra Costa Health Services came together to form a Regional Planning Group (RPG) charged with developing and evaluating innovative strategies for providing sustainable health care services in the West Contra Costa County area. In addition to its lead organizations, the RPG included representatives from Doctors Medical Center, the West Contra Costa Health Care District, the Contra Costa County Board of Supervisors and area hospitals. To support the work of the RPG, member hospitals of the Hospital Council funded a technical advisory group (TAG) made up of experts in the fields of health care law, finance, and reimbursement.

In the short-term, the RPG discussed streamlining hospital services or converting DMC to a satellite ED with no inpatient beds. In the long-term, they discussed additional options of conversion to a basic or extended urgent care as well as a modified satellite ED that would include access to specialty services. The TAG conducted a financial and legal analysis of each model considered to determine which would be feasible. Ultimately, the RPG concluded that an urgent care center was the most financially sustainable option, and the only option supported under current California law. On April 21, 2015 DMC closed its doors. With support from area hospitals, an urgent care center opened the day before at a community health center located across the street.

While the urgent care center has provided an access point for care for those patients with non-life threatening injuries, the community is still adjusting to the impact of DMC's closure. For example, the remaining hospital in West Contra Costa County, Kaiser Richmond, has been overwhelmed with volume (it only has 50 beds and 15 ED stations). Hospitals further outside the service area have also been impacted because, as Kaiser Richmond fills, the overflow continues to go out of the county. This situation is occurring at the same time that hospitals in neighboring cities and counties are experiencing record ED and inpatient volumes, exacerbating ED wait times and patient transfers.

In addition, the community still has some challenges ahead as it works to ensure access to health care is fully addressed. The county is home to Chevron and other oil refineries and the community must work to ensure it is prepared for a mass casualty incident or other disaster. In addition, they must ensure they have the capacity to handle primary care needs.

Urgent Care Center: Our Lady of the Lake Regional Medical Center, La.

In 2012, Earl K. Long Medical Center (LMC), a state-run safety-net hospital and home to several clinical sites for the Louisiana State University School of Medicine, closed, reducing access to much needed health care services for Baton Rouge's most vulnerable residents. As a result of this closure, Our Lady of the Lake Regional Medical Center (OLOL) developed and implemented numerous strategies to sustain access to high-quality care for this community. They included:

- Taking on local graduate medical education training.
- Addressing the confusion and disruption in patient care stemming from the closure by reaching out to the community, primarily through churches and town hall-style gatherings, to let people know that even though LMC was closing, they could still go to OLOL clinics to receive ambulatory care. OLOL then made process changes and implemented enhanced staffing models at these clinics to decrease wait times for new patient appointments from an average of eight months to less than 30 days.
- Working to ensure that OLOL and other facilities in surrounding communities could absorb that volume. For example, OLOL added 25 beds to address this need, including a mixture of regular emergency beds, fast-track beds for patients with non-emergent conditions, trauma bays and treatment beds for people with minor-to-moderate illness.
- Building a separate pediatric ED.

In addition, recognizing that many of LMC's ED visits were for non-emergency conditions, OLOL immediately opened an urgent care clinic in north Baton Rouge at the time LMC closed. OLOL then opened a second urgent care center in its mid-city clinic when local hospital resources were further stressed by the closure of the ED at Baton Rouge General Medical Center's mid-city facility. Both urgent care centers provide services for non-emergency conditions including ear or eye infection, fever, cuts that may need stitches, possible broken bones or simple fractures, severe sore throat, sprains and strains, and vomiting and diarrhea.

These urgent care facilities had 29,419 visits in their first year; 29,521 visits in their second year; and are on track to have a total of 52,784 in their third year of operation. As a frame of reference, LMC had approximately 30,000 visits in its ED annually. Therefore OLOL's urgent care centers are proving to be a resource and significant access point to health care for this community.

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Virtual Care Strategies: Freeman Health System, Mo.

Freeman Health System is a locally owned, not-for-profit that includes Freeman Hospital West, Freeman Hospital East, Freeman Neosho Hospital and Ozark Center, as well as two urgent care clinics, dozens of physician clinics and a variety of specialty services. In an effort to improve access to health care services, Freeman has partnered with area schools to provide timely health care to students, faculty and staff in an easily accessible venue – the school health clinic program.

Freeman has established four separate programs to date, and while each is uniquely developed to suit the needs of the school, all of these programs allow school health clinics to improve the physical and mental health of students, increase access to health care and decrease the time lost from school to receive health care services through the use of telehealth.

Each program has three components:

- **Telecommunications** – By using digital technologies, Freeman is able to assist in the delivery of medical care, health education and public health services by connecting health care providers in its clinics to school nursing staff. Services that are offered to schools include: audiovisual conferencing between the school nurse and a nurse practitioner to determine whether a student is able to return to class or needs further evaluation or treatment; physical exam by a nurse practitioner, or physician, with diagnosis and treatment of illness and minor injuries; access to behavioral health professionals (on and off site); health and nutrition education, counseling and wellness promotion; and prescription for medications when necessary for treatment of acute illnesses or conditions.

- **Priority scheduling** – For students who need further treatment, the program offers priority scheduling. This allows students to get an appointment with a health care provider at a Freeman clinic immediately, provided the child's parent has given consent.

- **School transport** – In situations where parents have difficulties getting students to an appointment due to work or lack of transportation, some school districts elect to provide transportation from the school to a designated Freeman provider. The school will work with the student's parents to make these transportation arrangements.

Although these programs are relatively new, Freeman has already seen early successes in the Neosho School Disctrict school clinic program. In the first six months, 179 students and faculty utilized the Freeman school clinic program via telecommunication and/or priority access at Freeman Neosho Physician Group. Freeman hopes to expand these programs to include broader access to wellness promotion. In the meantime, however, they are focused on increasing utilization of these programs by educating parents, schools and local employers about these programs and the benefits they offer.

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Virtual Care Strategies: Copper Queen Community Hospital, Ariz.

Copper Queen Community Hospital (CQCH) is located in a geographically remote area of Arizona near the U.S. border with Mexico and has a service area of approximately 2,500 square miles. The 14-bed acute-care critical access hospital (CAH) is the largest non-government employer in the city of Bisbee, serving more than 6,000 Bisbee residents and many of Cochise County's 140,000 residents. The hospital's mission is to maintain and support access to basic primary care throughout southeastern Cochise County and to provide its patients with the highest quality services. One of the biggest challenges for CQCH, however, is providing care for patients who need specialty health care services. CQCH has chosen to meet this need of its community through the creation of a "hospital without walls" concept that makes care for specialty services available through virtual care strategies. These services are provided in collaboration with several tertiary care hospitals in Arizona and bring specialists to patient's bedsides, without having the actual physician on-site. Currently, CQCH offers virtual care services in the areas of trauma, endocrinology, neurology, cardiology, cardio pulmonology, burn and pediatrics.

In one of its newest telemedicine relationships, CQCH has teamed up with Tucson Medical Center to offer endocrinology services. CQCH will have a board-certified endocrinologist available for telemedicine endocrinology appointments. Patients will initially be seen by an on-site physician for a primary care visit, which will then be immediately followed by their telemedicine appointment with the endocrinologist. This relationship will increase access to critical services for the Cochise County community, including diagnosis and treatment of diabetes, thyroid disorders, adrenal and pituitary gland disorders, metabolic disorders, menstrual irregularities, osteoporosis and calcium disorders.

CQCH also offers burn services through a relationship with The Grossman Burn Center at St. Luke's Medical Center in Phoenix – a plastic surgery-based burn center that works to restore patients to as close to a pre-injury status as possible (functionally, emotionally and cosmetically). The tele-burn program allows the Grossman Burn Center's credentialed burn specialists to provide bedside care in CQCH's ED via a large telemedicine monitor. The on-site tele-burn team collaborates to give patients a physical examination using a stethoscope and a fiber optic camera connected to the telemedicine system. When more extensive care is needed, patients are transferred to St. Luke's Medical Center.

> *"I am a strong advocate of telemedicine services. Through them, we are able to bring specialty care directly to our patients without time consuming and costly transport out of town and away from their family. Our partnerships with other health care organizations are fundamental to bringing this level of expertise to our patients."*
>
> *Jim Dickson, Chief Executive Officer, Copper Queen Community Hospital*

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Virtual Care Strategies: The Medical Alumni Volunteer Expert Network, Calif.

The Medical Alumni Volunteer Expert Network (The MAVEN Project) is a California nonprofit organization created to address the unmet health care needs of underserved and vulnerable populations that seek health care services at safety-net clinics. This project recruits a team of semi-retired, retired and other experienced physicians from around the country to serve the specific needs of vulnerable patient populations that seek care at various types of health centers (e.g., FQHCs, free clinics and community health clinics).

Specialist and primary care volunteer physicians are matched with the physicians, nurse practitioners and physician assistants already working at the health centers. These volunteer physicians provide remote video consultations and evaluations for patients needing specialty care (together with health center providers), as well as teaching, mentoring and providing advice for local health care providers. Telehealth technology is used to link volunteers' laptops and desktops to health center equipment that enables medical data exchange, videoconferencing and message dialogue between volunteers and health center providers. As a result, patients enjoy enhanced access to expert specialists and primary care physicians while remaining in an environment where they feel comfortable and accompanied by a primary care provider they already trust.

Currently, The MAVEN Project has completed its initial three pilot programs – two in vulnerable rural communities (Western Massachusetts and Central Valley California) and one in a vulnerable urban community (Massachusetts). To date, The MAVEN Project's volunteer physicians have provided over 265 medical specialty consultations and conducted educational "lunch and learn" sessions for clinic providers.

The MAVEN Project has successfully overcome many challenges – including technology, credentialing of volunteers, and malpractice insurance for participating volunteers. Informed by the "lessons learned" from its pilots and the evaluation currently being completed by RAND Corporation, The MAVEN Project is focused on expanding and scaling within California and Massachusetts, in Florida and beyond. This involves additional volunteer recruitment, new sites and a focus on financial sustainability.

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Virtual Care Strategies: The North Carolina Telepsychiatry Network

In 2013, North Carolina faced a significant shortage of psychiatrists, which limited access to psychiatry services. Specifically, 28 counties did not have a psychiatrist and 18 counties had only one. In addition, only five counties had addiction psychiatrists and only 13 had physicians that specialize in addiction and chemical dependency.[45]

In an effort to improve access to psychiatry services, the North Carolina General Assembly established the North Carolina Statewide Telepsychiatry Program (NC-STeP), which was launched in January 2014 and appropriated $4 million to the program for fiscal years 2013-2015.

NC-STeP is administered by East Carolina University's Center for Telepsychiatry and e-Behavioral Health. By January 2015, 57 hospitals were participating in the network and NC-STeP was operating five clinical provider hubs. The program provides patients with face-to-face interaction with providers through real-time videoconferencing technology. Video conferencing is facilitated using mobile carts and desktop units. A web portal also has been designed and implemented that combines scheduling, EHRs, health information exchange functions and data management systems.[46]

NC-STeP was modeled after South Carolina's use of telepsychiatry, which has increased access to care for rural communities. A March 2014 study of that program by the North Carolina Center for Public Policy Research found that the use of telepsychiatry so far in South Carolina shows that patients spend less time waiting in hospital EDs and have a lower likelihood of returning for treatment. The study also found fewer involuntary commitments to state psychiatric hospitals and higher satisfaction for telepsychiatry patients. More specifically:

- The length of stay for patients in EDs waiting to be discharged to inpatient treatment declined from 48 hours to 22.5 hours.
- The percentage of patients who had to return for treatment within 30 days at one hospital declined from 20 percent to 8 percent.
- The number of involuntary commitments to local hospitals or state psychiatric hospitals decreased by 33 percent.
- Eighty-eight percent of patients agreed or strongly agreed that they were satisfied with the telepsychiatry services they received.

NC-STeP hopes to have similar results, as it rolls out this program and improves access to psychiatry services across the state. As of July 2016, NC-STeP has enabled over 21,000 patient encounters. EDs have seen short lengths of stay, fewer involuntary commitments and less recidivism. In addition, the program has generated measurable cost savings. According to Sy Saeed, M.D., the director of NC-STeP, the state has already generated $5 million to $6 million in cost savings simply by preventing unnecessary hospitalization with this program.[47]

Fully Integrated CAH-FQHC: Springfield Medical Care Systems Inc., Vt.

Today, Springfield Medical Care Systems (SMCS) Inc., is an FQHC that operates a fully integrated critical access hospital. SMCS serves nearly 25,000 individuals in 14 towns throughout Windsor and Windham Counties in Vermont, and Sullivan and Cheshire Counties in New Hampshire. SMCS currently operates 10 health center locations and Springfield Hospital (SH).

However, in 2009, SMCS was only the corporate entity that owned SH. At that time, SH was evaluating ways to improve access to primary care. In an effort to improve the delivery of primary care services, SH had employed all of the primary care practices in their service area – this situation was not financially sustainable. At the same time, with primary services incorporated under the SH umbrella, it was hard for management to operate an effective and efficient primary care strategy for the community. SH also was looking for ways to improve access to behavioral health services and affordable prescription drugs for its patients.

SH determined the best way to improve access to these services was to develop an FQHC that could focus directly on these services. In order to do this, SH and Springfield Medical Care Systems Inc., the parent-holding company for SH, underwent significant corporate and governance restructuring to satisfy the regulations governing FQHCs. This ultimately resulted in the following:

- SMCS is now the operating company for the FQHC and SH is a wholly owned subsidiary of SMCS and the FQHC.
- Specialty provider services remain as part of the SH operating structure.
- All primary care sites and outpatient behavioral health services were transferred from SH to SMCS.
- This structure has allowed SMCS to administer all primary care and acute care activities using a single executive team that is employed by the FQHC, avoiding duplication of costs and promoting a system-like feel.
- The FQHC and SH have separate boards with up to four members that overlap on both boards.
- The FQHC board has overall governing authority and retains certain reserved authorities over the SH board.
- A Community Advisory Board provides input to the FQHC board and increases the level of community and individual patient engagement in the ownership of this delivery system.

One of the biggest challenges associated with this transformation was changing the perspective from which SMCS leadership and the community viewed the delivery of health care services. Rather than the hospital-focused viewpoint they had in the past, it became important for the organization to examine ways in which the hospital could support the FQHC.

As a result of this relationship, SMCS has increased the number of residents in its medical home to 25,000 – a 25 percent increase – because the FQHC was better able to monitor these services. They also have created a process to make sure that individuals arriving at the SH ED without a primary care provider are directed to and given an appointment to see a primary care provider within five days of the

ED visit. They have seen significant success with this new process; approximately 95 percent of these individuals leave with primary care appointments, and 80 percent actually keep these appointments.

In addition, SMCS was able to dramatically increase access to behavioral health services, including integration of licensed independent clinical social workers into each primary care site and comprehensive substance abuse counseling. It also has launched two dental sites. The results on the community have been positive and health outcomes have improved significantly – in fact, according to Robert Wood Johnson Foundation County Health 2014 rankings, Windsor County, Vt., (from where a majority of SH's patients live) moved from ninth to fourth out of 14 in health outcomes.

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Fully Integrated CAH-FQHC: Gifford Medical Center, Vt.

Gifford Medical Center (Gifford) is a fully integrated CAH-FQHC developed in an effort to increase the primary care services offered to the city of Randolph and its surrounding community, and in particular for the uninsured, isolated and medically vulnerable. It also was interest of improving dental care and mental health services for Medicaid patients and the uninsured. The FQHC designation opened the door to federal dollars that could support these efforts.

Gifford underwent corporate and governance restructuring to satisfy the regulations governing FQHCs. And, like in the SMSC example above, now has separate boards for the FQHC and hospital that allows for some overlap of members between the boards. The FQHC board has overall governing authority and retains certain reserved authorities over the hospital board. The FQHC and hospital also share infrastructure, including billing, human resources, finance, information technology, administration, development and quality. This improves efficiency and provides the best use of existing resources.

The FQHC-CAH integrated structure also has allowed Gifford to enhance the services it offers, since the FQHC reimbursement structure better covers the costs of providing behavioral health services. Gifford has added both a psychiatrist and psychologist to its behavioral health team and has embedded two clinical social workers into its primary care practice at its FQHC. This offers patients the convenience of having psychological and substance abuse evaluations conducted at the time of their primary care visit. In addition, Gifford has entered into agreements with area dentists to provide care to Medicaid patients – a service it was not able to offer before creating an FQHC.

> *"This assistance from the federal government allows us to develop programs for dentistry, psychiatry, and mental health that are hugely important for the community,"* says Chief Operating Officer Barbara Quealy. *"It also allows us to place a bigger focus on primary care. It means we can take better care of our Medicaid patients, offering them services that we couldn't before, and that's huge."*
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> Barbara Quealy, Chief Operating Officer, Gifford Medical Center

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Partially Integrated CAH-FQHC: Coal County Community Health Center & Sakakawea Medical Center, N.D.

Coal County Community Health Center (CCCHC), an FQHC, and Sakakawea Medical Center (SMC) have implemented a successful relationship between an FQHC and a CAH, without full integration. This CAH-FQHC partnership has resulted in a more efficient allocation of resources and services between the organizations and improved patient care.

CCCHC operates three health center locations, including an FQHC located in Beulah. SMC is a 25-bed CAH located in Hazen. In addition to standard acute-care services, SMC provides hospice and home health services, along with senior Basic Care Services. CCCHC's FQHC in Beulah and SMC are located roughly 10 miles apart and serve a population of approximately 15,000 individuals. These facilities had a long history of conflict and competition for this limited market share.

Despite that history, in 2011, when CCCHC was experiencing significant financial challenges and had terminated its relationship with its CEO, it turned to SMC for assistance. At that time, SMC provided interim leadership and assistance with a variety of functions, including revenue cycle, operational issues and employee morale. This interim relationship helped mend the strained relationship between CCCHC and SMC. It also allowed for more efficient utilization of resources, which improved the financial position of both organizations. As a result, the two organizations decided to make this integration permanent.

This model and further collaboration has allowed the organizations to eliminate duplicate services, improve population health, enhance community awareness of local services, maintain adequate human and facility infrastructure, and better monitor and adapt to changes in health care delivery. Today, each organization maintains a separate structure and board governance. However, they share a CEO, other staff and resources, and had cross-representation on the other's governance board. The organizations also adopted a common mission: *"Working together as partners to enhance the lives of area residents by providing a neighborhood of patient-centered healthcare services that promote wellness, prevention, and care coordination."*

CCCHC providers staff the ED and provide care for their patients at SMC. Over the past year, SMC has converted its provider-based rural health clinic (RHC) to an FQHC service delivery site, and CCCHC has worked with another hospital to convert yet another provider-based RHC located in Killdeer to a CCCHC service delivery site. CCCHC and SMC also are working together as participants in a Medicare ACO and commercial insurance value-based contract, embracing population health and care coordination in the primary care, hospital and community settings.

In addition, today, CCCHC and SMC work together to conduct a collaborative CHNA that also involves the local nursing home, ambulance service and public health agency. These health care providers have collectively developed a collaborative strategic plan and health improvement plan and meet periodically to update each other on progress towards the individual organization initiatives. This cooperative planning has resulted in improved patient care and improved health for the community.

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The Collaboration Model: Cary Medical Center/Pines Health Services, Maine

Cary Medical Center, a small rural acute care hospital located in Caribou, Maine and Pines Health Services, an FQHC, have created a unique model of collaboration that has current and future advantages, including improving the health status of the population served and growing the long-term financial position of both entities.

While each entity remains independent with its own Board of Directors, the two work closely together in partnership. For example, representatives of the hospital board serve on the board of the FQHC; and members of the FQHC board serve on the hospital board. In addition, the leadership of the FQHC participates in the hospital's senior management team and meet weekly with the hospital's leadership group. The two organizations also conduct joint strategic planning every two years. The ability to partner strategically has led to many benefits for the community, including increased access to primary care, development of new services, access to medical specialists that are recruited to the community, and capital improvements that are able to be funded as a result of this partnership.

The overall impact of the partnership has been substantial in improving access to health care services for their communities. The hospital provides a 'Community Grant' to the FQHC that helps support its services. The two organizations also support the employment of non-FQHC specialty physicians (e.g. orthopedics, hematology/oncology, general and urologic surgery, ophthalmology, pathology and hospitalist medicine). The hospital and the FQHC work closely in managing patients who are struggling financially and may be in need of acute care including hospitalization or other hospital-based treatment. In addition, the FQHC has improved access to low income patients through a sliding fee scale – leading to a dramatic increase in the access to health care services for low income individuals.

By working together, both the hospital and the FQHC have made it possible to preserve and expand health care services in Northern Maine. The collaboration of the hospital's in-patient case management and the out-patient case managers of the FQHC enhance the health status of patients, particularly at time of hospital discharge. The FQHC case managers also help to address issues of patients with multiple ED visits, chronic diseases, and other needs related to the social determinants of health. In addition, the FQHC manages a highly effective Prescription Assistance Program for patients without prescription coverage, helping them to comply with their prescribed medication. The program has generated millions of dollars in savings by providing eligible patients with free or reduced cost prescription medication. The FQHC also has integrated behavioral health services in the primary care physician office setting.

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