2021 Rural Health Conference

Rural Resilience and the Road to Recovery

November 18th, 2021 | 9:00 am – 3:30 pm
Housekeeping

• Today’s session will be recorded & posted to the ORH Rural Health Centers program website

• Please keep your lines muted when not speaking

• Submit questions in the chat box or use the raise hand feature during designated Q&A sections (click 3 dots on lower panel)

• Use the call-in feature to improve sound quality
  – This can be found in your event registration or if you click the ⏎️ button on the top left

• Use the active speaker view for best view of panelists

• Take breaks as needed
Agenda

• Welcome & ORH Updates
  – Maggie Sauer

• Lead the Way in 5 Minutes a Day: Sparking High Performance in Yourself and Your Teams
  – Jo Anne Preston, Rural Wisconsin Health Cooperative

10:30 – 10:45 Break

• How Are You Prepared for What’s Now and What’s Next?
  – Michelle Rathman, Impact! Communications

• Integrated Care Panel Session
  – Lisa Tyndall, FHLI Center of Excellence for Integrated Care
  – Alysia Hoover-Thompson, High Country Community Health
  – Regina Dickens, Rural Health Group

12:30 -1:15 Lunch – Celebration of YOU

• Rural Health Clinic Best Practices and Benchmarks
  – Jonathan Pantenburg, Stroudwater Associates

• RHC COVID-19 Initiatives & FHLI CDC Funds
  – Shannon Chambers, SC Office of Rural Health
  – Carla Obiol, Foundation for Health Leadership and Innovation

• Closing
  – Victor Armstrong, DHHS Chief Health Equity Officer
Objectives

• Recognize how to spark high performance in yourself and your teams

• Understand roles that strategy, communication, advocacy, and vulnerability play in meaningful collaboration, innovation, and capacity building.

• Increase knowledge of benefits of Integrated Care in rural communities

• Recognize best practices and benchmarks for Rural Health Clinics

• Increase knowledge of COVID-19 initiatives for Rural Health Clinics
North Carolina Office of Rural Health
SFY 2020 Rural Health Clinic and Rural Health Center Sites

Rural Health Clinic or Rural Health Center (80 Sites Covering 39 Counties)
- Rural County (70 Counties)
- Urban County (30 Counties)

*Numbers inside symbols indicate the number of sites within respective county.
ORH Supported Rural Health center data: last updated on June 30, 2020
Federal CMS Certified Rural Health Clinic data: last updated on May 5, 2020

Dorothea Brock – Program Manager
Beth Blaise – South Central
Kim McNeil – East
Thank you to our planning team!

• Carla Obiol, Foundation for Health Leadership and Innovation
• Katherine Parker Lucas, Hometown Strong
• Kevin Meese, Office of Rural Health
• Nick Galvez, Office of Rural Health
• Oluanda Green, NC Rural Center
• Renee Clark, Office of Rural Health
• Shawanda Fields, Office of Rural Health
• Brandon Washington, NC Community Health Center Association
NC Department of Health and Human Services
Office of Rural Health - Update

Maggie Sauer
November 18, 2021
CELEBRATING THE POWER OF RURAL

National Rural Health Day

Since 2011, the National Organization of State Offices of Rural Health, the 50 State Offices of Rural Health, and rural health stakeholders from across the country have set aside the third Thursday of November to celebrate National Rural Health Day (NRHD).

#POWEROFRURAL
National Rural Health Day (NRHD) is an opportunity to “Celebrate the Power of Rural” by honoring the selfless, community-minded spirit that prevails in rural America. NRHD showcases the efforts to address the unique healthcare challenges that rural citizens face today and into the future.
Thank You!
NC COVID Relief Funds

NC Rural Health Centers and Rural Health Clinics (RHCs) make up a key part of the rural health care infrastructure and help address health equity gaps in medically underserved rural communities to improve health outcomes for rural residents.

- Testing & Mitigation
- Ensuring Equitable Distribution of Vaccines in Rural Areas
- Building Vaccine Confidence
Office of Rural Health (ORH) & Mission

- First state office (1973) in the nation created to focus on the needs of rural and underserved communities
- ORH Mission Statement: The North Carolina Office of Rural Health (ORH) supports equitable access to health in rural and underserved communities.
- To achieve its mission, ORH works collaboratively to provide:
  - Funding
  - Training
  - Technical assistance
- For high quality, innovative, accessible, cost-effective services that support the maintenance and growth of the State’s safety net and rural communities.
- State Fiscal Year 2020 Office Facts:
  - Administered 216 contracts
  - $33.9 million available grant funding from state, federal, and philanthropic sources
  - Returned 84% of its budget directly to NC communities
  - Provided 2,778 technical assistance activities
  - 72 staff (including temporary)

** While we do not provide direct care, our programs support numerous health care safety net organizations throughout North Carolina.
ORH Profile

Programs at ORH

- **Placement and HPSA Services**
  Recruit providers and designates health professional shortage areas

- **NC Rural Health Centers**
  Supports state designated rural health centers that serve the entire community

- **NC Community Health Grants**
  Supports the primary care safety net system with increasing access to health care for vulnerable populations

- **NC Farmworker Health Program**
  Supports medical, dental and educational services for members of the North Carolina agricultural labor force and their families

- **Rural Health Information Technology Program**
  Provides technical assistance to improve the use of Electronic Health Record (EHR) Systems and the use of health information exchange

- **NC Rural Hospital Program**
  Funds operational improvement projects for the benefit of all critical access hospitals and eligible small rural hospitals

- **NC Medication Assistance Program**
  Provides free and low-cost medications donated by pharmaceutical manufacturers to patients who cannot afford them

- **NC Statewide Telepsychiatry Program**
  Supports psychiatric evaluation of patients through videoconferencing technology in emergency departments

- **NC Analytics & Innovations**
  Support data analytics, shortage designations, and pioneering efforts to improve health

- **Community Health Worker Program**
  Provide support to disadvantaged individuals and families in North Carolina communities by connecting them to medical and social support resources
Community Health Worker Program

Catawba County Public Health (1 county)
El Centro Hispano (10 counties)
KEPRO (25 counties)
Mount Calvary Center (9 counties)
One to One with Youth (3 counties)
Southeastern Healthcare (23 counties)
UNETE (5 counties)
Vidant (24 counties)

Counties where CBOs are working
# of Healthier Together Priority Counties
Food Bank of Central & Eastern North Carolina Counties
North Carolina Social Determinants of Health by Regions

NC Social Determinants of Health - Local Health Departments Region 8

- Percent of Households Speaking Limited English
- Percent Single Parent Households
- Low Access to Healthy Foods
- Food Deserts
- Education
  - An estimated 88,175 (14.8%) adult
Statewide Resource Platform: NCCARE360

Network Model: No Wrong Door Approach

- **Investing in connections**: Statewide coordinated network to connect citizens, healthcare providers, and human service providers
- **Strong public-private partnership** to create foundation for healthy opportunities
ORH COVID-19 Efforts

- Telehealth Technical Assistance
- Critical Hospital Assistance
- Community Health Worker and Support Services Program
- Migrant Farmworker Support
- Staffing Stakeholder calls
- NCDHHS Historically Marginalized Population
- Uninsured Portal
- Primary Care Survey
- CVMS support
- NCCARE 360 Support
Lead the Way in Five Minutes a Day:  
*Sparking High Performance in Yourself and Your Teams*

Jo Anne Preston  
RWHC Workforce & Organizational Development Sr Mgr

*2021 Rural Health Conference*  
*Rural Resilience and the Road to Recovery*  
North Carolina Office of Rural Health  
November 18, 2021
ROUNDING
Find the good
Find the good

Be intentional

Do it first

Destination

RELATIONSHIPS

RECOGNIZING

ROUNDING

RESILIENCE

RETENTION

RWHC
RETENTION

Do people want to go where you are going?
Find the good
Do it first
Be intentional
Authenticity
Destination
Resilience
Recognizing
Rounding
Relationships
Leadership is “authentic self-expression that adds value” Kevin Cashman

Small Group Breakout discussion:
• Introduce yourselves
• Discuss in a round-robin sharing, 1-2 minutes per person:
  – What are some ways that you demonstrate “authentic self-expression” in the way that you lead? And,
  – How does this build others’ trust in you?
RETENTION

Are you a learning organization?
RESILIENCE

When can you walk, not just talk?
Find the good

Be intentional
Do it first

Find the good

Be intentional
Do it first

RELATIONSHIPS

RECOGNIZING

Brain, body, heart
Walking Meetings

Brain, body, heart
Walking Meetings

ROUNDING

Authenticity
Prioritize Education

Authenticity
Prioritize Education

RESILIENCE

Destination

Destination

RETENTION
RESILIENCE

1. Move your body
2. Stimulate your brain
3. Engage your heart
Find the good

Be intentional
Do it first

Destination
Authenticity
Prioritize Education
Walking Meetings
Brain, body, heart
From coping to transforming

RELATIONSHIPS
RESILIENCE

➢ Center
➢ Enter
➢ Add Value
Recognizing...

WHAT'S YOUR STORY
RECOGNIZING
Your stories
Your Impact

WARDING
Be intentional
Do it first
Find the good

RELATIONSHIPS

RESILIENCE
From coping to transforming
Brain, body, heart
Walking Meetings

RETENTION
Prioritize Education
Authenticity
Destination

RWHC
Recognizing
Your Impact
Find the good
Your Stories
From coping to transforming
Brain, body, heart
Walking Meetings

Your Impact
Prioritize Education
Authenticity

Your Approach
Be intentional
Do it first

Destination

RELATIONSHIPS

RECOGNIZING

ROUNDING

RESILIENCE

RETENTION
Recognizing Your Go-To Approach

Does the situation call for:

* Acceleration?*
* Brakes?*
* Steering?*
* Lubricant?*
Pay attention…

“The negative screams at us; the positive only whispers.”

Barbara Frederickson
GOT 5 MINUTES?
BUILD YOUR LEADERSHIP LEGACY!

Jo Anne Preston
Jpreston@rwhc.com
608-644-3261
Resources

• Lead the Way in Five Minutes a Day: Sparking High Performance in Yourself and Your Teams, Jo Anne Preston
• http://www.rwhc.com/News/Leadership-Insights-Newsletter
• Duke Resilience Resources https://www.hsq.dukehealth.org/tools/
• Positivity, Barbara Frederickson
• The Zen Leader, and Resonate, Ginny Whitelaw
• Switch: How to Change When Change is Hard, Chip and Dan Heath
• No Ego, Cy Wakeman
Break until 10:45
How Are You Prepared for What’s Now and What’s Next?

Michelle Rathman
Impact! Communications
Are you prepared for what’s now and what’s next?

RURAL RESILIENCE & THE ROAD TO RECOVERY
What’s Now?

Where does your workforce stand?

Where will your organization land?

What’s your plan to manage what’s next?
Health Care in America is a Never-Ending Relay for Sustainability

- Still challenged with pre-pandemic industry burdens
- Continuing your quest to Identify the drivers for safety
- Working to improve organizational culture
- Removing the roadblocks to achieving High-Reliability
- Mustering up the courage to have the strategic conversations that accelerate change
- Preparing for leadership readiness
- Searching for resiliency in chaos
- Recruitment for retention

Do you have a finish line in your sights?
How do we manage population health without a workforce to do the hard and necessary work?
Opportunity.

The year **2020** was an urgent invitation to rethink our individual roles in the contribution of the population health disparities and inequities before us. (Reflection)

**2021** further amplified the challenges and the opportunities to put what we learned during the previous year in action, and work to understand the big picture, putting into place the pieces we need to solve this gigantic puzzle. (Collaboration)

**2022** is bigger than you and me and it begins with **COMMUNICATION, CULTURE & RESILIENCY**.
2021 Theme

4R’s of the #PowerofRural

The way forward. In your hands?
Resiliency

How do you nurture it?
Put People First

Developing Talent on the Path to High-Reliability (Think Retention)
HIGH RISK, DYNAMIC, TURBULENT, YET OPERATE NEARLY ERROR-FREE...
even though human beings are involved.
HROs are nimble, they have increased capacity for resourcefulness, they highlight the importance of communication, and encourage creative solutions to respond to unique problems.
Commitment to Resilience

How do they get nimble?

HROs spend disproportionately on development (in addition to training*) for individuals and teams:

- Problem Solving
- Conflict Resolution
- Coping
- Rebounding
- Social Support
- Determination
- Adaptability
- Recuperability
- Hardiness
Developing Resiliency

Rebounding from setbacks and adversity when facing difficult situations. Specific development focused on:

- Developing confidence under pressure
- Managing and handling crisis effectively and rationally
- Maintaining a positive attitude despite adversity
- Processing emotions after a setback
- Growing from negative experiences
- Conducting and constructing “Courageous Conversations”
- Using tools that will accelerate positive culture shifts
Today, there is an unfortunate and growing belief that it is more important to say what is on our minds rather than be mindful of what we say and how we deliver our message.
The difference between an emotionally intelligent conversation and one that is emotionally charged...everything.

You can be passionate without being punitive.
Manage vs. Deal With

WHO?
Identify

WHY?
Pinpoint

WHAT?
Result
Identify someone you have or are currently experiencing conflict, broken communication or a difficult challenge. Think about a person with whom you would like to reset the relationship or set it on a better path to achieve a common goal.
Pinpoint the reason behind the conversation. Is it motivated out of...

- Guilt on your part
- Feeling of injustice or hurt
- Disappointment or confusion
- Frustration or a roadblock
- Fear or concern
- Growth and healing
- Accountability
What could be the result of the conversation?

- A new understanding or awareness
- Resolve of a situation or condition
- Moving beyond an issue or forgiveness
- Needed shifts in behaviors
- Improved situation or productivity
- Heightened safety and satisfaction
**SHOULD** or **Shouldn’t?**

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<thead>
<tr>
<th>BEING ASSERTIVE</th>
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Be realistic and honest.
Relationships

How do you build and strengthen them?
Perform a comprehensive assessment of interpersonal relationships on the team.
CULTIVATING CULTURE
Emotionally Intelligent Communicators
Commitment to Healthy Workplace Relationships

• Building strong-identity teams that apply their diverse skills and perspectives to achieve common goals.

• Gaining the confidence of trust of others through honesty, integrity, and authenticity.

• Developing and delivering multi-mode communications that convey a clear understanding of the unique needs of different audiences.

• Working collaboratively with others to meet shared objectives.
Commitment to Healthy Workplace Relationships

Deference to Expertise

“When it comes to patient and employee safety, quality and high-reliability, any member of the team, with the skills to best manage the situation at hand, can assume a leadership role.”
Readiness

What’s your process and who else will you invite to the table?
Readiness is a test of endurance.

- Preoccupation with Failure
- Reluctance to Simplify
- Sensitivity to Operations
PREOCCUPATION WITH FAILURE
Focus on predicting and eliminating errors rather than being in the position of reacting to them.

Get preoccupied with ALL failures, including near misses and seemingly inconsequential errors because when you understand that when small things go wrong, they are often early warning signs of deepening trouble which provides insight into the health of the whole system.
Resist the temptation to simplify to achieve a faster result. Invite in-depth and diverse checks and balances, adversarial reviews, and the cultivation of multiple perspectives.

Build systems and process solutions to prevent human error proactively even though being ‘reactive’ is human nature.
Sensitivity to operations

Everyone values organizing and collaborating to maintain heightened and sustained situational awareness.

Making sense of complex, high-quantity, and sometimes conflicting information to solve problems.

- Ask the right questions
- Acquire data from multiple sources
- Uncover root causes of difficult problems
- Champion ideas with courage
Sensitivity to operations

To be ready for what’s next, answer these questions now:

1. What are conditions that might diminish situational awareness?

2. How do your teams (and you) practice mindfulness every day?
An organization’s strength are the people who build on its already strong foundation.
To inquire about having a skilled and certified facilitator for leadership development, administering and interpreting Emotional Intelligence Assessments, or for more information about the Impact! Journey to High-Reliability staff leadership and team education sessions, contact:

Recommended Leadership Development Tools:

- **Emotional Intelligence Assessments** as its resource for EQ-I 2.0 Assessments.

- **StrengthsFinder 2.0**
Integrated Care

Lisa Tyndall, PhD, LMFT
Regina Dickens Ed.D.
Alysia Hoover-Thompson, PsyD
National Definition of Behavioral Health and Primary Care Integration

Integrated care is “care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”

(Peek, 2013)
Benefits of Integrated Care in Rural Communities

• Improves “...availability, accessibility, affordability, and acceptability of behavioral health care for people in rural areas.” (SAMHSA-HRSA)

• Enhances access, lifts stigma and promotes respect of human rights (WHO, 2008)

• Increases provider comfort with talking about behavioral health needs with patients

• Support of the BH provider also protects against PC provider stress and attrition (Miller-Matero et al., 2016)

• BHC helps connect the patients to community referrals and resources.
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
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<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
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**Behavioral health, primary care and other healthcare providers work:**

- In separate facilities, where they:
  - Have separate systems
  - Communicate about cases only rarely and under compelling circumstances
  - Communicate, driven by provider need
  - May never meet in person
  - Have limited understanding of each other’s roles

- In separate facilities, where they:
  - Have separate systems
  - Communicate periodically about shared patients
  - Communicate, driven by specific patient issues
  - May meet as part of larger community
  - Appreciate each other’s roles as resources

- In same facility not necessarily same offices, where they:
  - Have separate systems
  - Communicate regularly about shared patients, by phone or e-mail
  - Collaborate, driven by need for each other’s services and more reliable referral
  - May meet occasionally to discuss proximity
  - Feel part of a larger yet ill-defined team

- In same space within the same facility, where they:
  - Share some systems, like scheduling or medical records
  - Communicate in person as needed
  - Collaborate, driven by need for consultation and coordinated plans for difficult patients
  - Have regular face-to-face interactions about some patients
  - Have a basic understanding of roles and culture

- In same space within the same facility (some shared space), where they:
  - Actively seek system solutions together or develop work-a-rounds
  - Communicate frequently in person
  - Collaborate, driven by desire to be a member of the care team
  - Have regular team meetings to discuss overall patient care and specific patient issues
  - Have an in-depth understanding of roles and culture

- In same space within the same facility, sharing all practice space, where they:
  - Have resolved most or all system issues, functioning as one integrated system
  - Communicate consistently at the system, team and individual levels
  - Collaborate, driven by shared concept of team care
  - Have formal and informal meetings to support integrated model of care
  - Have roles and cultures that blur or blend
<table>
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<tr>
<th>Primary Care Behavioral Health Model</th>
<th>Collaborative Care Model</th>
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<td><strong>LEVEL 5</strong></td>
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<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
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<tr>
<td><strong>Collaborate</strong> work:</td>
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<td>- Have roles and cultures that blur or blend</td>
</tr>
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</table>
Primary Care Behavioral Health Model

- Population based
- Goal is to improve and promote overall health within a population.
- BHC operates as a consultant and generalist – functional assessments.
- Team based with shared resources.
- Often a core model of a practice
Collaborative Care Model

- Registry driven approach
- Collaboration between primary care, case manager & consulting psychiatrist
- Use of medication and visit algorithms
- Team based care
- Behavioral Activation and Problem Solving Treatment (PST)
Special Considerations of the Rural Based BHC
(Selby-Nelson, Bradley, Schiefer, Hoover-Thompson, 2018)

- Often stretched across multiple clinics
- Need increased sense of flexibility and heterogeneity in how they practice
- Need to work harder to balance the outpatient needs due to lack of referral places
- BHC may consider taking new patients and reverse hand-off to medical provider if needed
- Dual relationships, conflicting roles, and recognizing scope of practice.
Content resumes at 1:15
North Carolina Rural Primary Care Providers

Introduction to POND® Webinar

November 18, 2021
Our Agenda

North Carolina Rural Primary Care Benchmarking Project Kickoff

01  02  03  04  05

Context
The relevance of rural primary care and RHCs

Taking Stock
North Carolina RHCs at-a-glance

POND®
Benchmarking system for rural primary care practices

20 Questions
Understanding RHC performance priorities

Next Steps
Building the POND database for North Carolina
Context

The relevance of rural primary care and RHCs
In 2019, there were approximately 1,350 Critical Access Hospitals in the US. Among those organizations, 890 owned and operated at least one Provider-based Rural Health Clinic. Collectively, these CAHs owned 1,649 PB-RHCs. The distribution of PB-RHCs largely reflected the distribution of CAHs across rural America, with a large percentage of PB-RHCs located in the Midwest.

North Carolina has 13 CAHs with Provider-based RHCs Representing 45 of 72 RHCs (63%)

Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.
RHC Cost Per Visit Rate Bands

Chart A displays cohorts based on cost per visit rates calculated as Total Costs divided by Total Visits. We constructed 13 bands based on the cost per visit rates for all RHCs for FY 2019. This analysis includes all RHCs (Independent and Hospital-owned) and excludes those clinics whose Medicare cost reports contained material errors, omissions or irregularities (n=293). For each band we calculated its percentage of total RHCs.

In FY 2019 for the 4,254 RHCs that had complete, reliable and traceable Medicare cost report submissions, 90% of RHCs report a Cost per Visit rate lower than $325.

Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.
192

110 of the 192 RHCs are Provider-based while 21 RHCs are operated by hospitals with greater than 50 beds. 61 RHCs are Independent.

<table>
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<th>&lt;50 STAC</th>
<th>&gt;50 STAC</th>
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Data Source: September 2021 CMS Provider of Services (POS) data file.
Hello NRHA members,

We want to provide a few updates on legislative packages making their way through Congress and inform you of NRHA’s newest advocacy campaign.

The House of Representatives is expected to return to Washington, D.C. next week to begin consideration of the $1 trillion bipartisan infrastructure package. Timeline for final passage of the bipartisan legislation is still unsure in the House of Representatives, but NRHA will keep members apprised of any developments.

Additionally, Congress has begun negotiating the details of the $3.5 trillion Build Back Better (BBB) reconciliation package, and NRHA is advocating Congress include funding and support for rural health care providers and patients within the legislation. We believe support for rural health workforce and rural health safety net providers should be an integral part of any legislation.

NRHA is advocating Congress include provisions within the BBB to:

- Provide capital funding to improve rural health care infrastructure using the framework provided within the Lift America Act (H.R. 1968), which includes $10 billion for hospital infrastructure. Congress must include a 20 percent carveout for rural hospitals.
- Make substantial changes to rural Medicare GME policies and other rural workforce programs through inclusion of the Rural Physician Workforce Protection Act of 2021 (H.R. 3853).
- Improve rural maternal health and health care access through inclusion of the Rural Maternal and Obstetric Modernization of Services Act (H.R. 709 - S. 1487).
- Permanently extend CARES Act telehealth flexibilities for rural health clinics and federally qualified health centers and increase their reimbursements for telehealth services, as done through the Protecting Rural Telehealth Access Act (H.R. 3400).

For our advocacy campaign to succeed, it is critical that our advocates contact their Members of Congress to include rural health providers within the BBB reconciliation package. By using the campaign, you can reach your members of Congress with one click, while customizing content as needed, to allow you to maintain your unique voice.

Sincerely,

NRHA Grassroots Update

“Modernize and improve the rural health clinic program by removing the cap for provider-based rural health clinics in exchange for voluntarily submitting to quality measure reporting.”

Thursday, August 19, 2021 at 2:54 PM
Taking Stock
North Carolina RHCs at-a-glance
North Carolina RHC Scorecard

Count of RHCs
- Provider-based: 45 (63%)
- Independent: 27
- Total MO RHCs: 72

Meeting Productivity
- Provider-based: 57%
- Independent: 65%

Cost per Visit
- Provider-based: $255
- Independent: $132

Capped Rate Visits
- Provider-based: 16,725
- Independent: 3,744

Physician Visits/FTE
- Provider-based: 2,965
- Independent: 2,750

APP Visits/FTE
- Provider-based: 2,398
- Independent: $632k

Cost per PCP FTE
- Provider-based: $730k

Regional Benchmarks
- Total MO RHCs: 1,223
- Contributes to $5.7 million loss in potential Medicare reimbursements
POND®
Benchmarking system for rural primary care practices
Our Current States
How Does It Work?

To gain access to these reports and tools the required data must be entered into the POND web application.
Our Reports

Lilypad’s flagship report, the **POND Summary Report** includes RHC-specific financial, staffing, provider compensation, productivity and clinical metrics with customized peer group and national benchmarks.

The **Cost Report Scorecard** includes multi-year trended volume, financial, cost and staffing ratios as well as state, regional and national benchmarks from all US RHCs based on current Medicare Cost Reports.

The **Site Audit** combines data from multiple public sources to provide summary statistics as well as a proprietary Medicare Cost Report integrity analysis and an evaluation of the out-of-pocket obligations for Medicare patients.

The **Lilypad Award Ranking Report** displays your RHC’s annual performance in five weighted rural-relevant performance metrics according to the industry’s only comprehensive RHC ranking and ratings program.
Online Training Tutorial

We created a simple 30-minute training webinar with chapters that enables viewers to watch how to enroll, enter data, generate reports and view benchmarks.

https://vimeo.com/466246995/0ebde8b506
20 Questions

Understanding RHC performance Priorities
Why Hospital CFOs Should Use POND®

Focus on the Right Metrics
POND features the most relevant RHC financial, staffing, and provider metrics

Benchmark your Clinic(s)
POND is the only national database focused on small rural practices

Validate Provider Compensation Plans
POND provides RHC-specific compensation and productivity benchmarks

Evaluate RHC Performance
POND helps you elevate primary care in your hospital QI program

Access Peer Learning
POND is your ticket to collaborate with other CFOs who face similar challenges
1. Why do visit volumes matter so much?
2. What is the right mix of physicians and APPs?
3. Are our providers “busy”?
4. What is the difference between gross charges and net revenue?
5. How come our clinic does not make money?
6. What quality measures should we track?
7. Are our providers appropriately compensated?
8. Do we have the right number of support staff?
9. How can we control our cost per visit?
10. Why is important to track “new patients”?
11. **What is most important? Managing visits, revenue or expenses?**
12. What is the right mix of clinical and non-clinical staff?
13. What level of performance should we expect for quality measures?
14. How do we increase our profit margin per patient visit?
15. Should performance standards be different for PA and NPs?
16. How does patient panel factor into overall performance?
17. What is the best model to compensate physicians?
18. How does visit volume relate to Work RVUs?
19. Why are our productivity scores low?
20. Do we need to hire more providers?
Gross Charges and Net Revenue

**Gross Charges** are the retail prices assigned to all medical services and procedures via the hospital or clinic Chargemaster.

**Net Revenue** is the amount of actual income (dollars) generated by the hospital or clinic.

Why does this matter for an RHC?
Gross Charges and Net Revenue

Example: Medicare PB-RHC Visit

<table>
<thead>
<tr>
<th>Cost</th>
<th>Charge</th>
<th>Commercial</th>
<th>20% Cost</th>
<th>20% Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200</td>
<td>$20</td>
<td>$20</td>
<td>$40</td>
<td>$80</td>
</tr>
</tbody>
</table>

The fully-allocated cost for a single visit according to the hospital Medicare cost report.

The “retail price” of the visit according to the hospital’s Chargemaster.

A typical co-payment for a primary care visit under a commercial policy.

Medicare beneficiary out-of-pocket obligation based on a “percent of charges” methodology for provider-based RHCs.

Out-of-Pocket Expenses

An inflated CAH chargemaster passes on cost to your Medicare patients.
Next Steps
Let’s be North Carolina RHC leaders:

1. View the Online Tutorial
2. Enroll your RHC(s)
3. Enter data
4. Generate reports
5. Spread findings
Lilypad is a Maine-based analytics firm that provides mobile and web-based applications for rural primary care practices. We adhere to a core business principle that accountable physicians/clinical leaders and administrators require sound data and simple, innovative tools to be successful in their roles within the emerging value-based care delivery environment.

Gregory Wolf, President
gwolf@lilypad207.com
Data Sources and Management


Lilypad warehouses Medicare Cost Reports for every Rural Health Clinic (RHC) in the United States and analyzes both provider-based and independent clinic reports.

As part of the data management process, we evaluate the integrity of each Cost Report to determine if the data furnished by CMS are complete and accurate. Cost Reports that violate our 29 proprietary integrity checks are handled separately to prevent erroneous data from corrupting the final analyses. As a result, each organization’s Cost Report data are evaluated on a field-by-field basis and data sourcing for our analyses are selected only if our integrity analysis confirms that the data are valid and reliable.

Cost Reports with omissions or errors for integral data elements are considered “Incomplete” and may not be included in certain analyses. Some selected data from these incomplete Cost Reports may be used in our analyses, or depending upon our assessment, they may be excluded entirely.

Medicare Cost Report Data Files
Provider of Services Data Files
Data Considerations

Source Data Integrity. Both the CMS Provider of Services (POS) and Medicare Cost Report data files contain raw data that are made publicly available for the purpose of research and analysis. These data files reflect the source data submitted to CMS by hospitals and clinics, and are subject to data errors, omissions and inconsistencies. In all instances Lilypad has made efforts to identify, resolve, eliminate and document material errors. This may result in some RHCs being excluded from this report’s analyses.

Timing and Synchronicity. RHCs operate with a range of fiscal year start dates. Designations and re-designations occur continuously. To harmonize these phenomena, Lilypad uses the fiscal year date on the Medicare Cost report as the time frame basis; in the case of this analysis, we used FY 2019 for every RHC. As indicated, Lilypad aggregates multiple cost reports for RHCs representing more than one parent organization. This may result in certain summary values differing from other publicly-available findings.

Cost Report Preparation and Compliance. The quality and completeness of Medicare cost report preparation is highly variable across different organizations. To address this variation, Lilypad implements 29 data integrity checks on every electronic cost report. Material data integrity check errors may result in some RHC cost reports being excluded from certain analyses. In addition, organizations may elect to consolidate multiple RHCs yet fail to report the identities of each RHC. Lilypad attempts to establish RHC relationships between the POS and Medicare cost report data files. This may result in non-material variances in RHC counts and aggregated reimbursement values across different analyses in this report.
The Current State

• Almost 70 Rural Health Clinics in North Carolina
• Still under a PHE until January 2022. PHE renews every 90 days if needed. Last renewed October 18th, 2021.
• Can still serve as the Distant site for telehealth since we are under the PHE.
• Several Telehealth bills that will permanently change the RHC telehealth model.
RHC COVID 19 Testing Funds
RHC COVID Testing Funds

• Eligible RHCs received $49,461.42
• Those funds must be spent out by December 31st, 2021
• You must continue to submit the total number of monthly tests performed and the total number of positive tests results.

www.rhccovidreporting.com
RHC COVID 19 Testing and Mitigation Funds
RHC CTM

- Eligible RHCs received $100,000
- The funds must be used by December 31st, 2022
- Must continue to report total number of monthly tests and total number of positives until January 31st, 2023
- New mitigation question coming in the portal
- These funds include expenses for mitigation as well as testing
  - There are 4 eligible categories for these expenses: COVID19 Testing Expenses, COVID 19 Mitigation Expenses, COVID 19 Testing-Related Expenses, and COVID 19 Mitigation-Related Expenses

Allowable Expenses | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)
Allowable Expenses

• Hand Sanitizing Stations
• Replacing carpet
• Replacing cloth chairs
• Adding to your waiting room to allow for Social Distancing
• Ensuring Water systems are safe
• Ensuring Heating and Air systems are safe
• Retention payments to staff
• Hiring Bonuses for new employees for COVID testing
• PPE
• Digital Technologies
RHC Vaccine Confidence and Hesitancy Grant
RHC Vax Confidence

• NOSORH is the TA provider and will meet with Rural Health Clinics directly to discuss workplans, budget review, and answer any questions.
• Works with the HRSA team on any outstanding issues.
• Period of performance is **July 1st, 2021 to June 30th, 2022**
• Dedicated email address: rhcvaxconfidenceinfo@nosorh.org
• 17 South Carolina RHCs applied for and received grant

Rural Health Clinic Vaccine Confidence (RHCVC) Program | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)
Fighting Vaccine Hesitancy

• Have a provider champion for those patients that might need additional conversations about the vaccine and myths.
• Pull the top myths and then debunk them!
• Create a social media campaign!
  o I got my vaccine for my mother
  o Hashtags
Vaccine Distribution
Vaccine Distribution

• This wonderful opportunity allows RHCs to receive direct shipments to their clinics!
• You can request all 3 vaccines
• Ordering is simple!
• Order this week and receive next week after registration is completed.

Rural Health Clinic COVID-19 Vaccine Distribution (RHCVD) Program | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)
Shannon Chambers  
Director of Provider Solutions  
chambers@scorh.net

Text SCRURALHEALTH to 66866 to subscribe to our “Rural Focus” newsletter!

Social:

Website:  
scorh.net

Address:  
107 Saluda Pointe Drive Lexington,  
SC 29072

Phone:  
803-454-3850
Engaging Rural Health Stakeholders: CDC Health Equity Focus

Carla Obiol, VP of Community Voice & Advocacy
Foundation for Health Leadership & Innovation
North Carolina Rural Health Leadership Alliance (NCRHLA)

• NCRHLA is a program of the Foundation for Health Leadership and Innovation (FHLI) and is a coordinated network of leaders and practitioners representing more than 25 organizations with a rural health interest.

• NCRHLA serves as a hub, a single organizer whose role it is to **convene**, **foster**, **share**, **advocate** and **offer a unified voice** that promotes better rural health for our state.

• The NCRHLA emphasizes three activities: engagement, collaboration, and education.
A partnership to promote an equitable response to the pandemic and recovery
NCRHLA’s work includes the NC Rural Coalition Fighting COVID-19 (NCRCFC) and other FHLI programs.

The NCRCFC includes leaders from rural-focused organizations, including the FHLI, NC Rural Center, Hometown Strong, and AHEC. This coalition partners with the NC DHHS Office of Rural Health to extend the ORH’s reach in disseminating vital resources and messaging to rural communities.
NC Rural Coalition Fighting COVID-19 convenes regularly to:

• Host subject matter experts.

• Host regular conversations between rural organizations, county officials, elected officials, care providers, community leaders, and the public.

• Collect real-time feedback about what’s working and what’s not working.

• Provide and share tools and resources.

• Facilitate connections!
Our Objective:

As part of the CDC Health Equity grant, the NC Rural Health Leadership Alliance (NCRHLA) will partner with the Office of Rural Health to build community infrastructures that both address disparities in the current COVID-19 pandemic and set the foundation to address health equity in NC communities and among historically marginalized populations for years to come.
Our Goals:

• Increase vaccine uptake in rural communities and among vulnerable populations in counties with low vaccination rates.

• Connect communities, local leaders, providers, public health, and organizations around response ideas and share those ideas to help communities respond faster.

• Build a foundation for equitable future recovery efforts among vulnerable populations and rural communities.
NCRHLA’s Approach to Achieve Success

• Start with **TRUST**.

• All work must be **community-led** and will vary in different regions of the state and among different populations.

• A **multi-pronged approach is necessary**, including enrolling a wide range of groups, organizations and leaders (i.e., CHWs, health department workers, county officials, church members and civic leaders).

• Leveraging and following the data is **essential**.

• Augmenting DHHS rural approach, communications, and work of the Community Health Workers Program and Healthier Together.
How we’ll do it:

- **Strategy One:** Assess and Map
- **Strategy Two:** Convene, Collaborate, and Educate
- **Strategy Three:** Mobilize and Activate
Strategy One: Assess and Map

• Develop a mapping matrix based on assessment of existing data sets, including:
  • Counties with low vaccine rates
  • Zip codes within counties with low vaccine rates (social vulnerabilities database)
  • Layer counties with highest rates of chronic conditions
  • Identification of cultural nuances based on populations in mapped areas

• Pair this with a local trust assessment: Who is trusted in the community (individuals and groups)? What are the messages that will resonate and how should these messages be delivered?

• Output: Defined locations and populations for launching and targeting efforts
Strategy Two: Convene, Collaborate, and Educate

• Convene and facilitate a coalition of multi-sector rural health stakeholders that include members of underserved communities and organizations that serve the community. The workgroup will collect input on gaps in access and delivery of rural health services and identify strategies for bridging the identified gaps.

• Lead a leadership-level health equity workgroup that will provide advice, guidance, and recommendations that will address COVID-19 response and advance health equity in underserved, high-risk communities.

• Leverage the data gathered during the local trust assessment to enroll leaders and key organizations that will support and serve as conduits for the local, on-the-ground work.
Strategy Three: Mobilize and Activate

• Absorb the convening and facilitation of meetings of North Carolina Rural Coalition Fighting COVID-19 to highlight, discuss, and provide rural-oriented tools, training, guidance, and messaging to community leaders who are visible and trusted in their communities.

• Enhance existing website landing page to serve as the digital space for this work.

• Launch content that supports all outreach and programming efforts.

• NCRHLA Director of Community Voice leads the work of the CDC Grant
NCRHLA - CDC Work Groups

Health Equity
Chair: Bridgett Luckey MHA, Manager of Uninsured Programs, Vidant Health
First meeting: December 1, 2021, 9:00am-10:30am
Registration link: https://bit.ly/healthequitydec21

NC Rural Coalition Fighting COVID-19
Chair: Donald Hughes, MPA, Director of Community Voice, FHLI
First meeting: December 8, 2021, 9:00am-10:00am
Registration link: https://bit.ly/ncrcfcdec21
Next Steps for NCRHLA

• CDC Health Equity Focus
• NC Rural Coalition Fighting COVID-19
• Rural Health Snapshot Report
• Membership Drive for 2022
• Rural Health Issues Legislative Agenda
• Advocacy Expansion
Invitation to Join NCRHLA

• NCRHLA convenes diverse stakeholders, leads action-oriented workgroups, organizes educational events, and fosters collaborative rural health solutions through best practices and strategies.

• We need your expertise to help improve the health of our rural communities in North Carolina!

• If you have questions or are interested in joining the NCRHLA or any of these workgroups, please email Donald Hughes, FHLI Director of Community Voice at donald.hughes@foundationhli.org.
To be rather than to seem

Victor Armstrong, MSW
Chief Health Equity Director
November 18, 2021
NC’s motto

Esse Quam Videri
To be rather than to seem
Closing Remarks

• **Resiliency**
  • You will find a unique endurance quality in those who choose rural health as their career path.

• **Resolve**
  • Although resources are often constrained, you’ll find rural health professionals are masterfully skilled at securing solutions.

• **Relationships**
  • Behind the story of rural health heroes are extraordinary people collaborating to make rural life better.

• **Readiness**
  • The work of those committed to rural vitality is never-ending. The challenges they encounter are met with determination.
Thank You For Attending!

Today’s recording & exit survey will be emailed to you