



**NETWORKING
FOR RURAL HEALTH**

Using Rural Health Networks to Address Local Needs

Five Case Studies

By Ira Moscovice, Ph.D., and Walter Elias, Ph.D.
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About this Series

This collection of case studies is the final document in a series of eight written products created by the Networking for Rural Health project. Other monographs focus on the principles of rural network development, strategic planning, business planning, shared services, quality improvement, and legal issues for rural networks. For more information, visit www.academyhealth.com/ruralhealth/index.htm or contact Dan Campion at 202.292.6700.

Introduction

Rural health networks have captured the attention of health care providers and policymakers as an important strategy for improving access to health care services for rural populations, increasing the effectiveness of network member institutions, and aiding the diffusion of managed care in rural areas.

Networks bring together rural providers—and possibly other agencies, employers, or community organizations—to address health care problems that could not be solved by any single entity working alone.

The aim of the Networking for Rural Health project, a recently completed three-year initiative of The Robert Wood Johnson Foundation, was to strengthen the rural health care infrastructure by fostering development of rural health networks that seek to improve access to and the quality of health care services in rural communities.

The purpose of this monograph is to present five case studies of networks that used the resources provided by the Networking for Rural Health project to plan and implement activities to meet community needs. These case studies highlight a range of network sizes and compositions, service area characteristics, and relevant activities.

The networks profiled in this report are among 27 that received targeted consultation grants through the Networking for Rural Health project (see Appendix on p. 39 for a complete list of grantees). The networks used the funds to engage consultants, who provided assistance on legal, actuarial, communications, and procedural issues. Using Robert Wood Johnson Foundation funds, the project provided each network with up to \$40,000, which the network matched dollar-for-dollar.

The following networks were profiled in this report:

1. **The Dukes County Health Council** (p. 2) has 32 members representing the key health care stakeholders on Martha's Vineyard, Mass., including consumers, providers, businesses, elected officials, and the Wampanoag Tribe. The island has a year-round population of 16,000, which increases to 90,000 in the summer with tourism. The targeted consultation was used to support the planning and analyses for developing a health care plan, including a health insurance component, for low-income island residents.

2. **The Lac qui Parle Health Care Network** (p. 10) includes three hospital-based systems that provide services to the 15,000 residents of its three-county service area in the southwest central region of Minnesota. The targeted consultation assessed the feasibility of developing satellite primary clinics and implementing shared emergency room call coverage.

3. **The Maine Health Alliance** (p. 16) consists of 11 community hospitals and 350 medical practices in five northeastern counties of Maine. The network's service area has a population of 325,000 dispersed over 15,000 square miles. The targeted consultation was used to help develop the case management software needed to implement disease-management protocols.

4. **The Southwest Texas Network** (p. 22) consists of five non-profit, federally qualified health centers serving 10 medically underserved counties in south central and southwest Texas. The targeted consultation was used to develop the foundation for a corporate compliance program.

5. **The Upper Peninsula Health Care Network** (p. 35) includes a regional medical center, 13 community hospitals, a tribal health center, and a behavioral health provider network. The Upper Peninsula of Michigan spans 16,600 square miles with a population of 318,000 residents. The targeted consultation addressed the shortage of hospital coding personnel in the region.

For each case study, we used reports prepared by consultants, interim and final reports prepared by the network director, relevant secondary data provided by each site, and reports prepared by project staff. In addition, we conducted extensive phone interviews with the network director at each site.

Each case study includes the network's history and background, a description of the objective of the targeted consultation, and the progress the network has made in reaching their goals. The case studies also detail implementation challenges, post-grant activities, the potential for replicability, and lessons learned. We hope these case studies will interest rural health care leaders as they strive to improve their understanding of how the collaborative efforts can address local needs.

Dukes County Health Council: A Community-Based Health Plan for the Uninsured and Underinsured

Dukes County Health Council members

The Council is a broad-based coalition of consumers, health care practitioners, health care organizations or facilities, and government officials. As of June 2003, there were 35 active members.

- ◆ Practitioners include a family physician, a chiropractor, a psychiatrist, a psychologist, a mental health counselor, a dentist, and an emergency medical technician.
- ◆ Health care organizations represented include the local hospital, hospice, and visiting nurse service, and the Island Health Plan.
- ◆ Community organizations or social service agencies include an elder services organization, chronic care network, NAACP, AIDS alliance, and a local church.
- ◆ Government officials include the county commissioner, associate commissioner for elder affairs, associate commissioner for affairs concerning handicapped persons, chief of police, public schools representative, and an all-county selectman.
- ◆ Other members include a retired attorney, a high school student, and the executive director of The Foundation for Island Health.

Service Area

Dukes County, Mass.
(Martha's Vineyard)

History and Background of Network

The Dukes County Health Council is a 32-member group that was appointed by the Dukes County Commissioners in 1996. It represents the major health care constituencies on Martha's Vineyard, Mass., including health care consumers, providers, businesses, elected officials, and the Wampanoag tribe. The principal goal of the Council is to improve health care and wellness for all island residents, especially those who are uninsured or underinsured. With its economy based largely on tourism, Martha's Vineyard has one of the highest percentages of uninsured in Massachusetts, approximately 20 percent, compared to a statewide percentage of approximately 7 percent. The island has a population of 16,000 (90,000 from May to September).

Although Martha's Vineyard has an image of catering to the rich, many of its year-round residents are employees in the tourism industry who cannot afford health insurance. More than 80 percent of small businesses on the island do not provide coverage. Most island businesses have fewer than 10 employees and don't offer medical benefits. Median income is \$44,000, and the cost of living is 15 to 20 percent higher than on the mainland.

In 1998, the Council decided to concentrate its efforts on developing a health plan, including a health insurance component, that would improve residents' access to high quality, affordable health care. The Council envisioned a plan that would respond to the needs and preferences of island residents, was open to all those who chose to participate, and was planned and managed by the community. The decision to focus on health insurance as a mechanism to improve access was based on information that a large proportion of island residents were uninsured or underinsured.

Health Insurance Survey

In late 1998, Massachusetts conducted a statewide health insurance survey that was administered by the Center for Survey Research (CSR) at the University of Massachusetts. The Council was able to secure funding to supplement the University of Massachusetts survey by including 500 Martha's Vineyard households. The survey created a rich database about health insurance and health services needs of both insured and uninsured island residents. The results indicated that 3,000 (19 percent) of the 16,000 year-round residents had no health insurance, and 80 percent of the uninsured were employed.

This finding, coupled with the high cost of health insurance for small businesses on the island, became the key motivation for developing the Island Health Plan (IHP). Members of the Council generally agreed that the number of uninsured and underinsured people on the island was unacceptable, and that ways to improve their access to affordable, timely, and appropriate health services should be a priority for the network.

Consulting Project

In December 1998, the Council decided to engage the services of a consultant to assist in the development of the IHP. The network selected John Snow Inc. (JSI). The contract and project work began in July 1999. The consultant's goal was to help the Council to define and develop a health plan, including health insurance, for all residents of Martha's Vineyard. The project had three phases:

Phase I (Feasibility)—to determine whether it was realistic for the Council to proceed with its goal of developing the IHP, and, if so, to decide which options or models for the health plan were most attainable;

Phase II (Planning)—to determine the specific steps that the Council should take in developing the health plan; and

Phase III (Implementation)—to assist in making the health plan operational.

Phase I (Feasibility)

The feasibility phase of the project took place between July 20 and October 31, 1999. The specific objectives of this phase were to:

- ◆ Define critical health care and insurance issues on Martha’s Vineyard that affect the components of the IHP;
- ◆ Assess the willingness of various constituencies (consumers, providers, employers, and community leaders) to support and participate in the plan;
- ◆ Determine the number of people likely to enroll in the IHP, and describe their characteristics;
- ◆ Describe which benefits should be part of the plan;
- ◆ Define the cost of the plan and the potential for controlling costs;
- ◆ Describe key issues that could affect the success of the plan; and
- ◆ Provide recommendations on the design of the plan, including options.

The feasibility study phase included:

- ◆ Key informant interviews with constituencies, including members of the Council, consumers, health care and social service providers, elected and appointed officials, employers, insurers and insurance agents, and community leaders; and
- ◆ Data analysis, principally focusing on the Martha’s Vineyard Health Insurance Survey, census data, employer/employee data, and information on selected health insurance plans offered on the island.

Martha’s Vineyard Hospital (MVH) was foremost in people’s minds when issues of health care were raised. While opinions were diverse, everyone agreed that the plan would need to address perceived problems in the hospital as well as reinforce its positive attributes. Several years ago, the hospital fell into bankruptcy and had routinely posted significant Emergency Room (ER) losses. The ER sees about 14,500 patients per year, and the number has been growing with the influx of retirees and Brazilian immigrants to the island. To deal with the immediate ER deficit, \$500,000 were raised from local property taxes.

Managed care was not widely accepted as a reasonable means of providing quality, affordable health care. Health care providers were particularly resistant to this approach. Access to off-island health care services was an important priority for many island residents. Reasons that people seek services off-island include an expanded choice of providers, the need for services not offered on the island, confidentiality, requirements of their current insurance plan, and perceptions that quality is higher elsewhere.

Phase I was completed, and the following recommendations were presented to the Council in November 1999:

- ◆ The Council should play a leadership role in developing a health plan for the island.
- ◆ The Council should continue its multifaceted approach to improving access to quality, affordable health care to all island residents; and
- ◆ The Council should focus its initial efforts on developing a health insurance program that targets groups who are at a disadvantage in the current insurance market.

Phase II (Planning)

The goal of Phase II was to prepare the IHP for implementation through further planning using surveys and focus groups. The Council was awarded a targeted consultation grant under The Robert Wood Johnson Foundation's Networking for Rural Health Project. The award totaled \$32,500 to match funds already raised from the Massachusetts Medical Society, local banks, and foundations. These monies were used in part to pay for an additional year of consultation by JSI to implement Phase II (Planning) of the project.

JSI conducted four focus groups in March and April 2000. Participants included small employers, self-employed individuals, or uninsured people. The purpose of the groups was to:

- ◆ Determine reasons for not offering or purchasing health insurance;
- ◆ Assess what is considered an “affordable” premium;
- ◆ Determine which benefits and coverage were desired in an island health insurance plan;
- ◆ Assess providers’ and consumers’ receptivity to the concept of the IHP, and identify factors that would influence providers’ and consumers’ decision to participate in such a plan; and
- ◆ Determine the familiarity of participants with, and potential eligibility for, state-sponsored health coverage—in particular, the Insurance Partnership and Family Assistance Programs, which make state subsidies available to small employers and low-income workers.

Health Insurance Issues

Employers on Martha’s Vineyard offered a wide variety of health insurance plans to their employees. They used many methods

to keep down the cost of their plan, including self-funding and, especially among small employers, frequent switching of carriers to obtain the best price. The lowest monthly premium for a large employer on Martha’s Vineyard (used as a benchmark for the best premium possible under an island-sponsored health plan) was \$250 per individual and \$550 per family. Cost was the major reason that employers did not offer health insurance. Employers had little or no knowledge that state subsidies were available for some small businesses.

The majority of uninsured individuals were employed adults under age 65. With high health insurance rates, many islanders were left to pay more than their wages could support. This created a great deal of anger among employees who were working hard and paying taxes but struggling to be taken care of medically. The situation led to significant health care utilization by the uninsured, including costly emergency room visits. While nearly 90 percent of people who were uninsured said they could pay something toward the cost of coverage, most would need a significant subsidy.

Factors influencing employers’ decisions to not offer health insurance included:

- ◆ The seasonal nature of many jobs on the island;
- ◆ An inability to meet the eligibility and participation requirements of insurers; and
- ◆ The lack of a competitive disadvantage associated with failure to provide health insurance.

Most participants had no familiarity with the new state premium subsidy programs, suggesting the need for additional marketing to small employers. Although supportive of the concept of the IHP, employers said they would use the same criteria to

make decisions about whether to offer such a plan as those used by employers that now offer insurance, namely cost, scope of benefits, and provider network. In addition, support of the island's physicians was seen as critical to the success of any island health insurance plan.

A short written survey was mailed to randomly selected island businesses. The survey sought to identify whether employers were able to offer health insurance to their employees, and, if so, the details and cost of that coverage. It also inquired about barriers to furnishing coverage and employers' willingness and ability to fund this benefit.

Survey results showed that almost two-thirds of employers do not offer health insurance, with three-quarters of them employing fewer than five workers. Overall, small firms were less likely to offer health insurance. Businesses that offered health insurance usually made it available to full-time, year-round employees. However, only 20 percent of these employers offered health insurance to their part-time workers, and only 8 percent of them offered it to their seasonal workers.

As with the focus groups, most survey respondents identified cost as the major reason for not providing health insurance. Most significantly, almost two-thirds of employers were not willing or able to contribute a significant amount toward insurance premiums. Last, all employers appeared receptive to offering the IHP if it became available. Factors that would contribute to employers' decision to offer the IHP included: the plan's cost, the insurer's financial stability, as well as the covered benefits, including access to off-island providers.

Actuarial Analysis

Data collection efforts during Phases I and II focused on current health insurance coverage, insurance purchasing practices, and health care use patterns of island residents and employers. Reden and Anders, Ltd. (R&A), a nationally recognized health care actuarial firm, developed per member per month (PMPM) revenue requirements for the IHP, assuming two target populations:

- ◆ The "commercial" population comprised of those individuals who were employed (people with incomes above 200 percent of the federal poverty level [FPL]); and
- ◆ The "Medicaid-like" population comprised of those individuals who are unemployed but not eligible for state programs (people with incomes less than 200 percent FPL).

For the Council to make informed decisions about pricing the health plan premiums, R&A was asked to find a balance between premiums, reimbursement, and state subsidies for low-income residents. In an effort to make premiums for the IHP more affordable to enrollees who met income criteria, the Council proposed to reduce the provider fee schedule based on consumers' income level. The only difference between the two target populations was the level of reimbursement provided to individual physicians. PMPM revenue requirements obtained from R & A were translated into premium rates based on standard actuarial methods.

Survey and focus group results showed that 70 percent of consumers could only afford to pay \$100 each month for health insurance coverage. Only 35 percent of employers surveyed were willing to contribute anything toward employee coverage, with 50 percent of this group willing to pay less than \$100. Combining the lower physician reimbursement rates and state subsidies with the \$100 contribution from both consumers

and their employers closed the affordability gap for all individuals and for two-person contracts with incomes less than 400 percent FPL.

Still, a significant gap remained for family contracts at all income levels (for a family of four, 200 percent FPL = \$36,800; 400 percent FPL = \$73,600) and for two-person contracts for consumers with incomes greater than 400 percent FPL. Given the area's extremely high cost of living, low income is defined as up to 400 percent FPL. However, employees with families may not require a family contract, as their children may qualify for coverage under the Children's Medical Security Plan (CMSP). Although the CMSP does not offer inpatient coverage, the Council will attempt to structure a wrap-around policy for children covered under the CMSP, in the event that they are hospitalized. Whether the IHP can be made affordable depends on whether employers are willing to assume responsibility for at least half of the cost of employees' health insurance coverage, and whether the provider community is willing to accept discounted reimbursement rates.

An example of cooperation between the Council and MVH was their joint effort to seek a primary care Health Professionals Shortage Area (HPSA) designation, which the island received in fall 2002. Qualifying the Vineyard as a federally designated HPSA will create opportunities to improve primary care access. The HPSA designation makes the Vineyard eligible to recruit providers through the National Health Service Corps, which offers loan forgiveness to providers practicing in designated underserved areas. In addition, the HPSA designation allows providers who employ a nurse practitioner or a physician assistant to pursue certification as a Rural Health Clinic (RHC). This certification enables providers within the RHC to receive cost-based reimbursement from Medicare and Medicaid.

A regional consortium of groups from Cape Cod and Nantucket, including the Council and the Lighthouse Health Access Alliance (LHAA), applied for a Community Access Program (CAP) grant funded by the Health Resources and Services Administration. Over a three-year period, the LHAA was awarded approximately \$1.7 million that grew to \$2 million with local fundraising. These grant funds were used to fund one FTE working on development, two of four part-time employees, part of the Council office rent, and the use of JSI for Phase III of the IHP.

Supported and staffed by the LHAA starting in July 2002, the Island Health Plan, Inc., a newly formed 501(c)3 corporation, in cooperation with the Commonwealth of Massachusetts Division of Medical Assistance (Medicaid) and an insurance partner, the Neighborhood Health Plan of Boston, is preparing to launch a new health plan for low-income island residents in summer 2003.

Phase III (Implementation)

Phase III of the project was designed to implement the IHP. JSI developed a comprehensive business plan and budget for the implementation phase, which the Council approved.

Business Plan Development

The business plan had three components: strategy, analysis, and implementation.

The strategic and analytic components of the business plan included the short- and long-term goals of the IHP, the key components of the plan, and the structure of the insurance program, including definition of the relationships with insurance partners and/or TPA. The analytic component of the business plan included costs, utilization, and revenue projections for the IHP and any other proposed services. The estimates were based on the information collected in the focus groups, employer survey and analysis of the Massachusetts State Insurance Survey, and actuarial analysis of costs and utilization.

Progress to date in Phase III

The following progress has been made in the implementation phase of the project:

- ◆ A series of group and individual meetings with providers—particularly primary care physicians—was conducted to address questions and concerns about the IHP, elicit support, and lay the groundwork for developing participation contracts. A long-term goal of the IHP is to form a Community Health Clinic (CHC). Of the eight primary care physicians on the island, three are paid by the MVH, and five are independent. NHP has met with each of them individually. The physicians have agreed to join the IHP, and NHP will present them contracts shortly.
- ◆ The range of insurance benefit options and premium structures for the IHP were test marketed with potential purchasers (employers and individuals) and with insurance brokers.
- ◆ The benefit and premium rates and underwriting criteria were finalized. The Council's preferred benefit packages and premium assumptions were presented to two potential insurance partners, Blue Cross of Massachusetts and the Neighborhood Health Plan. Underwriting criteria, such as eligibility for the plan and cost-sharing, have been explored. The new plan's rates will be similar to those of other insurance plans available to islanders. It is estimated to cost approximately \$270 for an individual and \$750 for a family each month. However, employer contributions and outside subsidies will lower the cost that subscribers are paying.
- ◆ The Neighborhood Health Plan (a Boston-based affiliate of the Harvard Pilgrim Health Plan) was chosen as the insurance partner. A memo of agreement with NHP is being created. NHP will assume all financial risk and the Council will do the marketing and help maintain the support of island physicians. NHP, whose mission is to serve low-income populations, has 140,000 current members (100,000 Medicaid). Part of the decision to choose

NHP revolved around their experience working with CHCs around the state as well as their understanding and interest in the island's uninsured situation. With modest offices and "real staff," they were a natural fit for the Council.

- ◆ NHP also has a contract with the state Medicaid program with a negotiated capitation rate. Local physicians are likely to encourage islanders to enroll in NHP's Medicaid program since it means less paperwork for them and slightly better reimbursement.
- ◆ IHP subsidy sources are being assessed. The goal in developing the IHP was to have a premium that could be covered as much as possible through employer and consumer contributions, and by existing state subsidies. However, it is likely that the IHP will need additional subsidies to achieve 100 percent coverage of people wanting to participate.

Massachusetts Division of Medical Assistance (DMA) representatives suggested that the state might be willing to explore opportunities to use Martha's Vineyard and the IHP as a test site for making the Insurance Partnership Subsidy program more accessible by changing the subsidy amounts. As a result, IHP filed legislation to raise income eligibility to 300 percent FPL on a demonstration basis and expects to see passage by July 2003.
- ◆ MVH's HPSA designation, along with the Critical Access Hospital designation, make the Vineyard potentially eligible for federal programs to address the shortage of physicians as well as programs offering enhanced Medicaid and Medicare reimbursement. The LHAA will coordinate this activity.
- ◆ Physicians, brokers/agents, and employers are being kept informed about benefit, network, and marketing decisions related to the IHP.

- ◆ Meetings continue with providers to determine an acceptable level of reimbursement (i.e., sliding scale fees) to ensure provider support of the IHP. The IHP has received preliminary approval from the state Division of Insurance to conduct a demonstration project of a sliding scale co-pay that will meet local providers' reimbursement thresholds.
- ◆ The Healthwise Handbook, a self-care book, is being distributed at hospital health fairs.
- ◆ A Web site is under development.

Spillover Effects

The project is receiving national publicity and is potentially spreading to other parts of the country. For example:

- ◆ Articles about the IHP have appeared in the *Washington Post*, the *Boston Globe*, and other local newspapers.
- ◆ The LHAA has received inquiries from Florida, Indianapolis, as well as several other Massachusetts communities.
- ◆ The Community Health Leadership Network (CAP-affiliated) is profiling the project for national publicity.
- ◆ The Nantucket Council for Human Services invited the IHP to submit a funding proposal for Fiscal Year 2004 for island-wide health insurance on Nantucket. IHP was also awarded funding to begin a marketing/public relations effort and provider network formation.

Next Steps

The Council still needs to take some important steps prior to implementation, including:

- ◆ Determining methods for overcoming the affordability gap that exists for two-person and family contracts through:
 1. Local fund raising and eventually (over two to three years) some property tax funding;

2. Continued collaboration with the Division of Medical Assistance to increase the amount of subsidy paid and extending the eligibility up to 400 percent FPL; and

3. Passage of a \$1 million federal appropriation earmarked for IHP demonstration subsidy and core budget support.

- ◆ Exploring opportunities to formally designate providers as Rural Health Clinics—which would allow them to receive cost-based reimbursement for Medicare and Medicaid patients and thus reduce the potential impact of the proposed IHP fee schedules on net income.
- ◆ The IHP director will travel to health plan sites in Michigan and Minnesota to visit and learn from their CAP project experiences.
- ◆ As part of the LHAA's Year 3 work plan, consultants will help obtain additional federal and state designations that appear appropriate in terms of need and geographic/demographic criteria throughout the region (e.g., Medically Underserved Area, Medically Underserved Population, and Nantucket HPSA); and
- ◆ The Health Council is conducting a retreat to evaluate its future direction, and will subsequently decide what its relationship will be with the Island Health Plan.

Lessons Learned

The Council learned many lessons throughout its efforts to develop the IHP, including:

- ◆ All steps have taken longer than anticipated. The Council eventually became more realistic about the amount of time that certain activities would require. JSI was a major asset to the Council in technical matters (e.g., finding an actuarial firm, training the Council to negotiate with insurers).

- ◆ The Council was the driving force behind formation of the Health Plan. It successfully and collaboratively raised funds and was a very effective forum for issues regarding the uninsured and underinsured.
- ◆ Data from the University of Massachusetts survey were extremely helpful in highlighting the high cost of insurance to small businesses and the high percentage of working uninsured.
- ◆ As a rural, community-based health plan, the IHP has led to a possible redistribution of power. To date, most of the power has resided with physicians and the hospital. The Dukes County Health Council and the regional LHAA have created a “ground up” model in the IHP. Instead of the government providing universal coverage, these local organizations are forming partnerships among providers, hospitals, insurers, employers, and state and federal governments. The IHP was designed solely to meet community needs and preferences.
- ◆ There is, and will continue to be, a constant need to balance the financial aspects of running a business entity with a community health orientation that requires subsidies.
- ◆ Physician reaction ranges from reserved to cynical to enthusiastic. New models of delivery are being examined, such as incentivizing physician affiliation and participation in group practice or community health centers.
- ◆ The affordability of the plan depends largely on state and federal contributions, physician willingness to accept reduced reimbursement, and a potential tax subsidy. It also depends on attracting further funding from MassHealth if and when the Division of Medical Assistance agrees to lift patient financial eligibility to a full 400 percent FPL.
- ◆ Mental health practitioners are eager to work with the IHP, as their relationships with other managed care organizations have not been satisfactory. They are interested in putting the IHP’s provider advocacy commitment to the test.
- ◆ It is still unclear how many groups will sign up. Many businesses consider themselves seasonal and may not want to offer this benefit to off-season employees.

Summary

The IHP was built on a strong foundation. Through a rural network that represents a variety of stakeholders, a group of island residents joined together with an insurance partner, set up a network of local doctors and area specialists, reached out to employers and local hospitals, and sought a mix of funding streams, including the federal and state government, foundations, and local taxes. Communities elsewhere in the country have relied on government bodies to coordinate health care and subsidize affordable health insurance through existing funds or special taxes. But on the Vineyard, a close-knit community where most people know each other’s faces if not their names, residents organized a grassroots effort to create a solution. The IHP will be available to customers in summer 2003.

Lac qui Parle Health Care Network: Improving Local Access to Primary Care Services

Lac qui Parle Rural Health Network members

Madison Lutheran Home in Madison, Minn.

Johnson Memorial Health Services of Dawson, Minn.

Appleton Municipal Hospital and Nursing Home of Appleton, Minn.

Service area:

Lac qui Parle, Swift, and Yellow Medicine Counties in Minnesota

History and Background of Network

The Lac qui Parle Health Care Network (LqPHN) was formed as a Management Services Organization in 1998 to improve access to primary care services and technologies in the southwest central region of Minnesota. The three members of LqPHN include the Madison Lutheran Home in Madison, Minn.; Johnson Memorial Health Services of Dawson, Minn.; and the Appleton Municipal Hospital and Nursing Home of Appleton, Minn.

LqPHN members are similar in their structure, services, and service area populations. The Madison Lutheran Home health system includes a hospital, nursing home, rural health clinic, and attached housing. The hospital, which is licensed for 21 inpatient beds, has expanded its outpatient services in recent years. The nearest tertiary care center is 60 miles away in Willmar, Minn. Approximately 4,300 people live in the health system's service area, with the proportion of elderly increasing.

Johnson Memorial Health Service is a hospital district that includes a hospital, nursing home, rural health clinic, home health agency, and ambulance service. In 2001, the hospital was certified as a Critical Access Hospital. The population in its service area is similar to that in the region serving the Madison Hospital. Almost 75 percent of inpatient admissions were Medicare beneficiaries in 2000. The hospital has recently experienced a substantial increase in outpatient service use.

Appleton Municipal Hospital is a 23-bed facility that has an attached clinic, nursing home, dental clinic, and independent living facility. It is approximately 20 miles away from the other two hospitals and uses the same tertiary referral centers. Two thirds of its admissions are Medicare recipients, and the hospital serves a population of 4,500 people plus a prison population of 1,300.

In sum, the three-county service area of LqPHN (Lac qui Parle County and parts of

Swift and Yellow Medicine Counties) is characterized by:

- ◆ an aging population;
- ◆ an agricultural-based rural community;
- ◆ a group of small rural hospitals that provide a range of outpatient and long-term care services to meet the needs of the elderly; and
- ◆ challenges in maintaining access to primary and secondary care services for local residents.

LqPHN initially focused on providing professional services to its three members that would improve local access by adding a range of primary care services and technologies at an affordable cost. In its initial two years of operation, the network developed the following products, services, and programs:

- ◆ the group purchase, installation, and administration of a home health charting software program, which significantly reduced administrative time in processing reports, billing, and data analysis;
- ◆ the purchase and installation of a regional NOAA weather radio emergency broadcast transmitter;
- ◆ the development of an integrated schedule for a portable ultrasound to be purchased and shared between all three members; and
- ◆ the coordination of physician and other staff recruitment and retention efforts.

Through these early joint efforts, the network members built a sense of trust and tasted some financial success. This led to more ambitious efforts to improve local access to primary care services.

Targeted Consultation

In late 1999, LqPHN received a targeted consultation grant of \$15,000 from the Networking for Rural Health project to assess the feasibility of developing satellite primary care clinics in up to three sites, and implementing shared emer-

gency room call coverage between the network's members. These initiatives were identified by network members as central to improving access to primary care and emergency care services for the elderly population throughout the service area. LqPHN contracted with Larson, Allen, Welshair and Company (LAWCO) from Austin, Minn., to complete the feasibility analyses.

Feasibility of Satellite Clinics

The objective of the feasibility analysis was to assess the fiscal viability of satellite clinics in three sites, evaluate operating issues, and examine the potential impact of the satellite clinics on LqPHN members. The fiscal analysis included an assessment of volume, rev-

enues, expense, and capital requirements. The operation analysis provided information on days and hours of operation, staffing, and reimbursement implications.

Physician demand at the satellite clinics was estimated using assumptions and techniques developed in two prior studies, one by the Graduate Medical Education National Advisory Committee (GMENAC) and the other commissioned by the Duluth Clinic to assess physician-to-population needs. The three towns considered as sites for the satellite clinics were Milan, Boyd, and Marietta. Some highlights of the feasibility analyses are shown in Tables 1 and 2.

Table 1: Estimate of Primary Care Visits and Inpatient Admissions

	Milan	Boyd	Marietta
Population Projected	1,368	1,136	739
Total MD Visits	6,834	5,675	3,691
FP/IM	3,440	2,857	1,858
OB/GYN and Peds	1,122	932	607
Specialty Care	2,272	1,886	1,226
Projected MD Need (FTEs at 100% Market Share and Median MGMA Productivity)			
FP/IM	.82	.69	.44
OB/GYN and Peds	.26	.22	.14
Projected Inpatient Admissions	148	123	80
Primary Care	89	74	48
Specialty and Other	59	49	32
Estimated Net Revenues from Inpatient Admissions	\$621,000	\$516,000	\$336,000

Table 2: Projected Income Statement for One Day per Week Satellite Clinic with PA/NP

	Year 1	Year 2	Year 3
Net Patient Revenue, Professional Fees	\$21,840	\$43,680	\$58,240
Expenses			
Provider Costs	\$17,600	\$35,300	\$35,300
Nursing Staff	\$3,100	\$6,200	\$6,200
Space Costs	\$7,500	\$7,500	\$7,500
Other	\$4,700	\$9,400	\$12,500
Total	\$32,900	\$58,400	\$61,500
Potential Net Margins	(\$11,060)	(\$14,720)	(\$3,260)
Net Patient Revenue, Ancillary Services	\$12,500	\$25,000	\$33,300
Expenses	\$7,500	\$15,000	\$20,000
Potential Net Ancillary Margins	\$5,000	\$10,000	\$13,300
Combined Profitability—Professional Fees and Ancillaries	(\$6,060)	(\$4,720)	\$10,040

The feasibility analyses concluded that it was fiscally viable to run a satellite clinic that would be open two half-days per week and staffed with a physician's assistant, nurse practitioner, or physician. Based solely on professional fees and ancillary services, the clinic would have small losses for two years and become profitable in its third year of operation. The estimates listed in Table 2 do not include profits from additional inpatient admissions from the population in the service area of the satellite clinic.

Planning and Initial Operation of a Satellite Clinic

Network members decided to move forward with their plans to open a satellite clinic in Boyd. The town had been without a medical clinic for approximately 50 years, and the nearest primary care provider, Johnson Memorial Health Services, was 13 miles away. There was no local access to health services for the elderly and the uninsured living in the area.

The planning process for the satellite clinic included broad support from representatives of local residents and public officials; Johnson Memorial Health Services (JMHS); LqPHN; the state Department of Health; county public health and social service agencies; and the local EMS agency. The town donated a building on the main street of Boyd to house the satellite clinic. The executive director of LqPHN developed grant proposals to fund the renovation and start-up costs for the clinic. The U.S. Department of Agriculture provided a grant of \$112,000 to renovate the building into the satellite clinic. The Southwest Minnesota Foundation provided funds to paint the building and the Minnesota Department of Health provided grants to support planning and start-up costs (e.g., equipment, lighting, and furniture) associated with initial clinic operations.

The satellite clinic opened its doors in August 2002 and is staffed two mornings per week by JMHS (one morning by a nurse practitioner, one morning by a physician).

LqPHN provides management services by coordinating the responsibilities of the local governing board and stimulating program development in wellness and preventive health programs. The clinic has three exam rooms, a lab, a nurses' station, and a waiting area. The clinic provides primary care services and coordinates immunization and prenatal screening programs with local public health and social service agencies. One to three days' worth of most common prescriptions can be filled at the clinic. When necessary, clinic personnel assist with public transportation arrangements. In its initial quarter of operation, clinic staff saw four patients per half day.

Feasibility of Shared Emergency Room Call Coverage

Emergency care is an important function for rural hospitals that often distinguishes one institution from another. The rural EMS environment has special issues to cope with, including:

- ◆ long transport times;
- ◆ subsidies of EMS, often by financially struggling rural hospitals;
- ◆ EMS personnel shortages; and
- ◆ small volume, leading to limited experience with specific types of emergencies and high per capita EMS costs.

These issues highlight the importance of the feasibility analysis, which assesses potential models for sharing emergency room physician coverage among LqPHN's three hospital members. From 1996 to 1998, Madison Lutheran Home and JMHS spent on average close to \$100,000 per year. Appleton Municipal Hospital spent approximately \$20,000 per year on outside ER physician coverage. In 1999, Madison spent \$33,000 and JMHS spent \$47,000. Appleton did not spend any money on ER physician coverage. The largest determinant of these costs has been the availability of local staff providers. Table 3 shows ER physician coverage by LqPHN member hospitals in 2000.

Table 3: Emergency Room Physician Coverage in 2000

<p>Johnson</p> <ul style="list-style-type: none"> – Staff MD coverage: 52 weekdays per year (approx. one week/month) + 13 weekends per year (approx. one weekend/month) + backup for PA/NP – PA/NP coverage: 48 weekdays (one week/month) + no weekends – Locums cover 13 to 14 weekends/year (assuming 3 staff MDs)
<p>Madison</p> <ul style="list-style-type: none"> – Staff MD coverage: 80 weekdays per year (every other week) + 13 weekends per year (approx. one weekend/month) + backup for PA/NP – PA coverage: one PA covers 48 weekdays (one week/month) + 13 weekends per year (approx. one weekend/month) – Locums cover 13 to 14 weekends/year (assuming two staff MDs + one PA covering ER)
<p>Appleton</p> <ul style="list-style-type: none"> – Staff MD coverage: 70 weekdays per year (every third week) + 17 weekends per year (every third weekend) – PA coverage: None – No locum coverage needed

The consultant held interviews with local physicians and nurses to discuss the current ER physician call coverage situation and alternative models for sharing ER coverage. The models for shared ER coverage assumed that call coverage during clinic hours would remain the same and during weekday nights and weekends would be shared among facilities. The interviews suggested that reductions in call coverage commitments was important to physicians. The Madison and Johnson physicians and all DONs were generally supportive of the concept of a shared ER model. However, Appleton physicians expressed some reservations due to their distance from the other facilities.

The interviews also identified the following key operating issues related to shared ER call:

- ◆ availability of patient records when M.D.s from other hospitals were on call;
- ◆ impact of Saturday morning clinics on availability for call;
- ◆ timeliness of M.D. response;
- ◆ “turf” issues related to caring for patients of M.D.s from another site;
- ◆ lack of common clinical protocols across ERs; and

- ◆ implications of difficult winter travel between sites.

Using ER logs from each hospital, the network completed analyses of the overlap in ER services. When considering Madison and Johnson only, there was service overlap (i.e., patients in two ERs at the same time) 1.5 percent of the time, with a corresponding figure of 3.7 percent when considering all three hospitals. Service overlap across all three ERs occurred only 0.5 percent of the time. Service overlap occurred rarely for major cases (i.e., among patients who were admitted to the hospital or were transferred). Most service overlap occurred on Saturday mornings and other times of the weekend rather than during clinic hours or weekday nights. It does not appear that service overlap is a major issue.

The analyses found significant potential savings in ER locum coverage costs from a shared ER call coverage model based on the costs and number of locum hours required and backup PA/NP hours required (see Table 4). These savings could be realized without reducing coverage. ER call coverage sharing models also provide some protection against increased locum provider costs that may occur as physician supply changes in local communities.

Table 4: Potential Financial Benefits of ER Call Sharing

Hospital	Based on Actual FY 1999 Coverage	Based on FY 1999 with “Standard”* M.D. Coverage
Madison	\$33,200	\$67,000
Johnson	\$45,700	\$67,000
Appleton	\$0	\$86,000

*“Standard” M.D. coverage = 52 weekdays + 13 weekends per provider—which represents reductions from current M.D. coverage levels.

However, the network could not reach consensus about how to implement shared ER physician call coverage. The barriers identified earlier (e.g., distance impact on timeliness of response, physician “turf” issues) and variation in existing physician call coverage contracts precluded short-term progress in implementing a new shared call model for the ERs of LqPHN’s hospital members. The network director is hopeful that this issue will be addressed in the future as the network matures.

Additional Grant Activities

In addition to the two feasibility analyses, LqPHN was able to use a small portion of the remaining funds from the targeted consultation grant to hire an outside facilitator from Teamworks International Consulting. The facilitator conducted a strategic planning retreat with network member medical staff, administrative staff, and boards of directors in June 2000. The group developed a strategic plan for the next two years. They identified the following new areas for the network to pursue:

- ◆ a medical and professional staff case study/journal review group;
- ◆ development of a Web site for marketing and staff recruitment;
- ◆ cross-coverage staffing; and
- ◆ coordinated scheduling of specialty provider groups.

LqPHN members also agreed to support the fiscal viability of the network by charging annual membership dues of \$7,500.

Activities that the network has initiated as a result of their strategic plan include:

- ◆ a monthly noon luncheon case study review series to bring network physicians together, discuss clinical issues, and attract new providers;
- ◆ monthly health information management team meetings with department heads from each member organization; and
- ◆ the addition of a new dues-paying associate member hospital and the submission of new grant applications.

Post-Grant Development

The targeted consultation supported development and operation of the satellite clinic in Boyd. This experience facilitated, either directly or indirectly, completion of a planning process for community health centers in two other communities in the network service area. Both of these health centers have become operational.

LqPHN has also assisted with grant writing for the two Critical Access Hospitals in the network. One grant was received from the Minnesota Rural Flex Grant Program of the state health department to improve patient care through better communication between local medical staffs and regional radiologists. The grant helped network members with the group purchase of digital dictation software and equipment, the development of a coordinated schedule between network members designed to handle increased volumes of dictation, and the design of new policies and protocols to

administer the new system for managing transcription staffing. These accomplishments were important first steps toward standardizing medical records, staffing procedures, and protocols across network members.

Although the anticipated transcription volume increase has not materialized due to a shift in policy by the regional radiology group, the Flex grant provided an opportunity for collaboration among network members. This led to another collaborative application for Flex grant support for staff training of coders at JMHS.

Lessons Learned

A major lesson that LqPHN learned throughout this project is that rural health networks cannot be developed quickly and need a substantial amount of time to mature. LqPHN had some initial successes with limited-risk activities such as the group purchase and use of a home health charting software program and a portable ultrasound machine. The targeted consultation led to the successful development and opening of a satellite clinic in a small rural community.

The clinic improves access to primary care services for the elderly in the area, although patient volume is lower than the projections used by the consultants in the feasibility analysis. Two other satellite clinics have since opened in the service area. Although these clinics may yield modest economic return for their host institutions, their principal benefit is improved primary care access.

On the other hand, the sharing of emergency room call coverage is a riskier activity. It involves clinical issues related to caring for the patients of other physicians, the comparison of clinical protocols, and coordination of patient records. It is not surprising that a shared ER call model was not implemented, even though the feasibility analysis estimated that there would be significant savings in locum physicians' coverage costs. The network was not mature enough in its development to sustain that type of activity. In addition, with the advent of cost-based reimbursement for the two Critical Access Hospitals in the network, the environmental context for these facilities was relatively positive in the short-term.

What, then, will it take for the members of LqPHN to reach a level of integration that will include core clinical activities? Key factors will likely include strong network leadership, continued building of social capital among local providers and residents by completing ongoing activities, physicians who understand the costs and benefits associated with network participation, environmental threats posed by weakened federal, state, and local economies, and population declines. Rural health professionals, institutional leaders, and policymakers clearly need to make a long-term personal and financial commitment to networks like LqPHN if they want such entities to address community and provider needs.

Maine Health Alliance: Fostering Care Management in the Rural Environment

Maine Health Alliance members

Calais Regional Hospital
Calais, Maine

Cary Medical Center
Caribou, Maine

Down East Community Hospital
Machias, Maine

Houlton Regional Hospital
Houlton, Maine

Maine Coast Memorial Hospital
Ellsworth, Maine

Mayo Regional Hospital
Dover-Foxcroft, Maine

Millinocket Regional Hospital
Millinocket, Maine

Mount Desert Island Hospital
Bar Harbor, Maine

Northern Maine Medical Center
Fort Kent, Maine

Penobscot Valley Hospital
Lincoln, Maine

St. Joseph Hospital
Bangor, Maine

Plus 350 medical practices

Service Area

Aroostook, Hancock, Penobscot,
Piscataquis, and Washington counties

History and Background of Network

In 1995, representatives from 11 community hospitals in northern Maine formed the Maine Health Alliance (MHA) in an effort to prepare themselves for an increase in managed care penetration in the state. In addition to the 11 community hospitals, the network includes 350 medical practices. Its service area spans the five most northeastern counties of Maine (Aroostook, Hancock, Penobscot, Piscataquis, and Washington), with a population of 325,000 spread over 15,000 square miles. The median age in the Alliance's service area is older, and the population's health status worse, than that of both Maine and the United States. Medicare represents approximately 50 percent of patient-care revenues of community hospitals in northern Maine (Medicaid represents another 10 to 15 percent).

The MHA aims to preserve local access to health care by helping its members maintain financial viability, avoid contract exclusion, and provide the highest quality care to consumers. Governance in the Alliance is shared equally between hospitals and physicians. Approximately 60 percent of Alliance doctors are primary care physicians. The MHA holds 21 payer contracts and is included by all significant payers. It plans to continue to promote the financial viability of its members through payer contracting and joint cost-containment efforts. The network is developing care management capabilities in order to perform better under risk-based contracts through the provision of disease management programs.

Care Management Program

Patients with chronic conditions living in rural areas of Maine often must cope with limited access, inadequate transportation, and financial constraints. As a result, existing resources are often manipulated to meet their health care needs, such as ambulance service for non-emergent transport to emergency rooms when primary care providers

are not available. In addition, current reimbursement strategies do not provide for the post-discharge health care services that are necessary for optimal recovery. This pattern of resource utilization greatly escalates the cost of health care.

A care management initiative was designed to:

- 1) Coordinate and manage health care services for patients with chronic health conditions;
- 2) Achieve better outcomes;
- 3) Reduce utilization of emergency department and inpatient services; and
- 4) Improve patient satisfaction and compliance.

In 1999, the MHA was awarded a Federal Office of Rural Health Policy Outreach grant to secure care management personnel, equipment, and supplies for the three hospitals in Aroostook County. Houlton Regional Hospital had administrative authority over the project. Houlton, along with Cary Medical Center in Caribou and Northern Maine Medical Center in Fort Kent, provided care managers, patient referrals, and clinical services. The MHA, as a provider network PPO, provided a link between these Aroostook County network providers and providers of specialty and tertiary services in Bangor.

The project lacked the care management software needed to implement disease management protocols. The network found that commercially available software was either too expensive and/or did not address the unique needs of the rural patient population. To address this, the network sought a targeted consultation to help develop the necessary software. It was awarded \$35,000 from the Networking for Rural Health project for planning and initial implementation.

Several consultants were engaged for this work, including:

- ◆ Providia Healthcare Group (general contractor, strategic planning);
- ◆ Kelsey Healthcare Solutions (consulting nurse for disease and case management);
- ◆ VeARD Computer Research, Inc. (development, testing, implementation, training, and maintenance of Web-resident disease management software); and
- ◆ Lisa Clark, Esq., of Duane, Morris & Heckscher, LLP (analysis of HIPAA regulations).

Web-based software was created for an outpatient care management program addressing chronic health care problems such as chronic obstructive pulmonary disorder, diabetes, asthma, and heart disease. The population to be served included the elderly, minorities, children, and people with disabilities. Currently, four hospitals in the network are using the software and one is in training. Three of the 11 hospitals began providing care management services under an outreach grant from the 1999 Federal Office of Rural Health Policy. Two of these were providing this service prior to the 1999 initiation of the federal grant. They did so based on the belief of leading local physicians that care management would improve care. The hospitals were motivated to do so especially for their Medicare population because of high readmission rates before these chronic care patients' DRG would "reload" (i.e., be authorized for a new payment).

Two community-based disease management/care management applications are currently operational. The first uses Pfizer's disease management software from the Maine Cardiac Health Committee's (MECares) program on congestive heart failure. The second stems from the Office of Federal Rural Health Policy outreach grant targeting specific patients with chronic diseases. Patients who physicians believe could benefit from outpatient care management were the targets. This program is using the software developed by MHA with the assistance of AcademyHealth.

The development of rural-oriented care management software allowed care managers to systematically monitor high-risk or high-utilization patients on a prescribed basis using uniform care management processes.

Diagnosis-specific protocols, developed as part of the software, are being employed, but the software provides the capacity to tailor protocols to the needs of specific patients, physicians, or medical staff. Rather than having fixed protocols, the care manager has the discretion to modify a particular care management plan based on unique circumstances. The software was specifically created to extend beyond "silo" disease management, since 40 percent of people with the top seven major chronic illnesses have three or more diagnoses.

Referrals began coming into the program from physicians who wanted care management follow-up for patients upon hospital discharge. Not long into the project, the physicians began referring to care management services from emergency rooms. As a result, care managers are now receiving referrals directly from physicians' offices. This has been a major accomplishment with the intent to apply services to appropriate patients well before they require inpatient services. The incentive for physicians to use the program (all admissions to the program require a physician's order) is clearly a motivation toward improved medical care. Others in the community can refer patients to the care management program, but, as noted, admission requires a physician's order. Fundamental to the program is the intent that a referral to care management will improve patient care, most notably through improved patient compliance with physician orders.

Due to better pharmaceutical control, many of the issues that the care managers deal with are psychosocial rather than clinical. It is important for care managers to be in the community so that they are aware of local community resources and can better deal with the psychosocial issues people in a given area face. Local care managers have an appreciation for what it is like to live in an isolated community in rural Maine, while a disease manager from an urban area may lack this understanding. In

one example, a man in respiratory distress was burning treated wood that he took from a local lumberyard. Because his care managers understood the local environment, they were able to identify the treated wood as the cause of the condition.

Another important factor is the multi-generational nature of Maine's rural workforce. It is not uncommon for three generations of a family to be employed in the mills. If the grandfather and the father had a history of heart disease, the care manager will most likely already know about it.

RNs and social workers work as a coordinated team to cover both the medical and social aspects of care management. This facilitates a smooth referral and follow-up process. Care managers are available for a wide variety of services depending on a patient's individual needs. For very difficult or complicated cases, care managers are available to attend medical appointments to assist patients in understanding and complying with their physician's orders. In some cases, the care manager is also available to act as an interpreter for patients who speak limited English.

The care management services provided by this project became a cooperative effort among health care providers, patients, and community support services. This joint effort facilitated patient education and compliance by encouraging patients to take more control and responsibility for their personal health care. Because of this sense of participation, patients felt more secure knowing they had a hospital contact to call when questions came up or resources were needed. Patients felt that the hospital sincerely cared about them and how they were doing. Family members who were not living close-by were relieved to know that someone was checking in on their loved one.

Management, Operation, and Implementation Issues

The oversight committee met on a quarterly basis with the project director and staff to review, evaluate, and modify activities or procedures as necessary. Care managers from the three hospitals met on a monthly basis at the beginning of the project. The care managers and a representative of the MHA met

on a quarterly basis for the remainder of the grant period.

The collection of baseline information was difficult due to the use of a wide variety of data collection approaches among the participating hospitals. Agreement on uniform data collection methods was reached while developing the content for the care management software. The consortium provided a mechanism to compare, share, evaluate, and modify its disease management model in different hospital settings.

The need for a physician champion became evident when comparing provider participation in care management services between facilities with and without strong physician advocates. This issue was addressed through ongoing physician contact and education efforts and, as the project demonstrated its value, through patient successes. Strong physician support was also critical to the continuation of the care management project after the grant ended.

Internet connectivity is a problem in rural areas without access to dedicated cable lines. To help address this problem, the MHA secured local foundation funding that helped rural member hospitals to significantly improve Internet connectivity by the end of 2002.

The division of one FTE care manager position between more than one person created a problem with lack of staff continuity and availability to patients. There was a significant amount of unexpected patient contact. If a care manager was not available when a problem arose, a lack of service continuity resulted. In addition, the patient-care manager relationship is critical for ongoing support and medical compliance.

Patient satisfaction data were inadequate for pre- and post-service comparison. The MHA director reported that, rather than asking for a rating of current level of satisfaction, both surveys should have asked patients to identify their expectations for care management services and then asked for opinions on how well their expectations were met. Data should have been collected to track how often patients contacted the care manager, in addition to how frequently the care manager contacted the patients.

Results

System-wide outpatient care management proved effective in maximizing preventive care, controlling utilization of emergency and inpatient services, and effectively coordinating the utilization of care for a chronic disease population with complex medical and social needs. The successful implementation of this project demonstrated the need to establish and expand care management services to a broad rural population.

The care management software and related Web site were a huge success. The capacity to compile and analyze data, run reports, and produce outcome data has great potential for demonstrating to local industry and insurance carriers the ability to improve patient care while reducing unnecessary utilization.

The hospitals worked together very well. Innovative ideas and creative problem-solving strategies were shared to the benefit of all. A cooperative alliance was formed and is expected to foster good working relationships between the organizations and care managers for years to come.

One of the fallacies of managed care was the physician gatekeeper. Under the managed care system, physicians had little oversight or follow-up of chronically ill patients between office visits. A systematic tracking of these patients by care managers improved patients' compliance with doctors' orders, leading to better management of various disease processes, and less reliance on emergency room and inpatient services.

Participating physicians were very satisfied. The doctors appreciated having non-clinical issues addressed by a trusted staff member who would alert them to important patient issues and concerns. The doctors also noticed a significant decrease in patient-related social issues demanding their attention. The care managers often handled these issues even before the physician sought their assistance.

Care management services had a significant impact on hospital readmissions and emergency department visits for the target population (see Tables 5 and 6).

It is possible that reductions in admissions, hospital days, and emergency room visits were due to regression to the mean rather than care management. There was no control group in this project. However, all results tend to be in the same direction toward a reduction in utilization.

Lessons Learned

The new care management software and Web site have integrated the collection of statistical data into the care management process. The data component needed to be computerized. Manual collection of data is given to misinterpretation by care managers and is very time consuming. Evaluation statistics are critical for marketing the project to doctors for program referrals and for promoting care management to payers for potential reimbursement.

Physician education efforts were more effective once the project could demonstrate positive results. Physician reluctance to refer to the care management project was addressed on a physician-to-physician level.

Limited support resources in rural Northern Maine was a serious problem, especially in the first year of the project. A shortage of nursing home beds and home care providers was critical. This issue was addressed through group and individual meetings to inform area providers of the program and its services. When new care managers were hired, they were introduced to community organizations. The relationships formed through these efforts resulted in a much more proactive and mutually beneficial collaboration, such as nursing homes with open beds contacting care managers.

The MHA director reported on some additional lessons learned after going through this software development effort. He advised others taking on such software development projects to double their original cost estimates. He also felt it was critical to hire an intermediary to facilitate communication between clinicians and data staff, who have differing languages and cultures. The most obvious lesson, he said, was to let the people who will ultimately use the software for patient care guide its development.

Table 5: Services/Utilization Data for the Management Project

The timeframe for this services/utilization data is from September 1999 through August 2002.

	Combined Hospital Total	Percent Decrease
Original caseload *	59	
Number of new cases	485	
Cases discharged	295	
New referrals	885	
Number of patient/family contacts	9,810	
Number of physician contacts	1,586	
Hospital admits baseline	326	
Hospital admits post-care management	156	52%
Hospital days baseline	1,115	
Hospital days post-care management	525	53%
ED visits baseline	269	
ED visits post-care management	210	22%

*The original caseload is in reference to the pre-existence of case managers with caseloads at two of the Alliance hospitals before the federal grant.

Table 6

Hospital Readmissions For Same Diagnosis	Within 15 Days	Within 31 Days
Baseline	5.7%	9.6%
Post-care management	2.3%	2.8%

MHA began providing care management services in some of their hospitals for two primary reasons. First, the physicians felt that it was common sense that these activities would improve patient care. Second, these capacities were developed in anticipation of managed care risk contracts. It seemed illogical that providers should take on actuarial risks without developing community-based capacities that could be relied on to affect utilization. The full-blown risk contracts never materialized, but the Alliance's efforts have strongly improved patient care and patient compliance and, thus, clinical outcomes.

Application to Other Rural Areas

The MHA's care management model should work well in rural settings where there is a commitment to its success by the hospital's physicians and administration. The care management software, because of its flexibility and Web site usage, makes this project especially appropriate to rural settings.

Diminished reimbursement for home care-related services is one crucial consideration for the replication of this project in other rural communities. In recent years, third-party reimbursements have focused on reducing home health care costs, making it difficult for small rural hospitals to finance care manager positions.

A community's unique political climate should be considered when setting up a care management program. Community-based service providers were needed to provide support such as transportation, Meals on Wheels, and visiting nurses, but some community agencies were concerned that the care managers would cross service boundaries to impact their funding or service area.

Project leaders can expect results to look more impressive in the beginning. Once the program has a good track record with seriously ill patients, physicians will start refer-

ring patients with less severe problems. There will be less opportunity for cost savings with these patients.

The care management software product is replicable in other rural environments. Other hospitals within the Alliance have begun using the software. The MHA would be interested in selling the software to another provider. However, much of the software content belongs to the company that helped create the application. The Alliance has not established a fee for using the software, but, if the request came from outside of the Alliance, they would respond. As the Alliance is not in the software sales business, their price would be minimal. (This represents the point of view of the MHA and not the software developer.)

Post-Grant Activity

All three hospitals have funded positions to continue care management services to targeted patient populations. Reimbursement for these services will be provided through the state ME-Cares program for Medicare patients. In addition, one of the largest insurance providers in the state, Cigna Healthcare of Maine, has committed to buying care management services from all 11 MHA hospitals, which includes the three grant participants.

A fundamental issue with care management is ongoing funding for these services. Few if any payers at this time directly reimburse for care management services. CIGNA is one exception. Medicare has a five-year demon-

stration project, ME-Cares, in the state of Maine. The MHA believes that care management may someday become a reimbursable service under Medicare. In the meantime, they will struggle to find known sources of payment for these services.

Anthem Blue Cross in Maine has begun to focus on the 5 percent of their enrollees who use 55 percent of their premium revenues. They are considering community-based disease management offered by the Alliance. They currently have two national disease management vendors in place. MHA is reimbursed under the ME Cares program on a per member per month basis. CIGNA reimburses on a per member per month basis for their commercial patients enrolled in the ME-Cares program.

Looking Ahead

The MHA's challenges going forward are based on industry conditions outside of their immediate purview. The most important questions to be answered for the MHA will be:

- ◆ Will care management responsibilities and expenses reside at the payer/carrier level, or will they be delegated to community-level providers?
- ◆ Is community-based delivery more costly for the payer/carrier?
- ◆ Is community-based delivery of care management more effective for the payer/carrier?

Southwest Texas Network: Conquering Compliance in a HIPAA-Dominated World

Southwest Texas Network members

Atascosa Community Health Center
Pleasanton, Texas

Barrio Comprehensive Family Health
Care Center, San Antonio, Texas

Community Health Development
Uvalde, Texas

Service Area (counties)

Atascosa
Real
Uvalde
Val Verde
Zavala
Maverick
Bexar
Dimmit
Edwards
Kinney

History and Background of Network

The Southwest Texas Network (STN) was established in 1998 as a practice management network based in San Antonio. The network consists of five non-profit, federally qualified health centers (four rural, one urban) in southwest Texas. Its service area includes 10 medically underserved counties in South Central and Southwest Texas. Faced with growing numbers of uninsured and underinsured, changes in Medicaid reimbursement, and shifting needs for specialty services, early network members solidified their organization and formed the STN.

Early collaboration between some of the network members began in the late 1980s and early 1990s. Funding came from the Bureau of Primary Health Care's Integrated Services Development Initiative and partnership contributions. The STN aims to help the five centers develop individual infrastructures that support the services necessary to serve the uninsured and underinsured people in the network's service area.

Originally, the STN set the following goals:

- ◆ To improve coordination of services;
- ◆ To promote trust and effective communication;
- ◆ To set priorities for their limited resources; and
- ◆ To share information to enable compliance and continued performance improvement at each center.

During its first year, the Texas Health and Human Services Commission awarded a Children's Health Insurance Plan Community Based Outreach (CBO) Services Contract to the STN. In addition, the STN engaged consultant services to analyze fiscal management, improve reporting mechanisms, and begin to develop software systems to capture productivity, com-

pliance, and utilization data. A major barrier to success was the lack of internal resources to implement comprehensive corporate compliance programs in adherence to guidelines published by the Office of the Inspector General (OIG).

STN sought a targeted consultation from the Networking for Rural Health project to lay the foundation for a comprehensive corporate compliance program. Corporate compliance refers to the need for health care providers to comply with federal and state regulations regarding the control of waste, fraud, and abuse of reimbursement dollars mostly within the Medicare and Medicaid systems.

A compliance plan is preventive. It identifies what kinds of activities are illegal under federal and state law and determines how they can be avoided in order to prevent prosecution.

The following are the high-risk areas that are most often included in compliance programs, and the problems they aim to prevent:

- ◆ Coding and billing: using the wrong coding or modifiers;
- ◆ Reasonable and necessary services: failing to obtain approval for services before providing them;
- ◆ Documentation: failing to record relevant information on a patient's medical record;
- ◆ Referrals: kickbacks;
- ◆ Record retention: inappropriate length of time to retain records;
- ◆ Certification: inappropriate certification, typically of medical suppliers or home health services; and
- ◆ Professional courtesy: no collection of co-pays.

With the help of consultants, the STN developed the following compliance-related materials and activities:

- ◆ Two coding training sessions and a documentation training session;
- ◆ Training on data analysis from a financial specialist;
- ◆ Video orientation tape;
- ◆ Compliance manual;
- ◆ Toll-free compliance hotline;
- ◆ Contract with a network compliance officer; and
- ◆ Legal counsel for policy reviews.

The following consultants were engaged as part of this effort:

- ◆ Cox & Smith, Inc. (seminar on medical documentation to improve patient care and avoid liability, compliance video);
- ◆ Bonnie Lewis-Brown & Associates (coding workshops);

- ◆ National Association of Community Health Centers (training and compliance guidelines);
- ◆ Healthcare Management Advisors (compliance hotline); and
- ◆ Ronda Hajduk, MBA, RHIT (network compliance officer).

The network believes that it positively influenced the compliance program process for the centers. It used a hybrid form of Ernst and Young's Leading Practices Survey to identify and benchmark best practices for compliance, and establish a baseline for future tracking. This form is used throughout this case study.

Overall, 100 percent of the centers agreed that the network was effective at establishing compliance standards and procedures that are believed to reduce misconduct. (See Table 7.) All of the centers have developed a code of conduct that communicates the centers' objectives and fosters a corporate culture that not only detects, but also prevents, misconduct.

Essential Elements of the Corporate Compliance Program

Table 7: Establishing Compliance Standards and Procedures

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
A code of conduct that is designed to prevent and detect misconduct	100%		100%			
Multilingual versions of the code of conduct	100%			75%	25%	
Standards and procedures that are easy to comprehend	100%		100%			
A code of conduct that promotes a "compliance culture" within the organization	100%		100%			
A code of conduct that provides appropriate references and contacts regarding the organization's compliance-related policies, procedures, and reporting systems	100%		100%			

Table 8: Creating a Compliance Infrastructure

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
Upper management demonstrates commitment to ethical conduct (the tone for ethical conduct is set "at the top").	100%		100%			
The organization has a compliance officer or team leader.	100%		100%			
Compliance oversight is assigned to the compliance committee or equivalent.	100%		100%			
There is high-level oversight of compliance, legal, and regulatory matters; there is a network compliance officer.	100%		100%			
The compliance officer is "dedicated" (i.e., does not have additional duties other than the oversight of the compliance program).		100%				100%
The compliance officer has direct access to the CEO and/or the board.	100%		100%			
The compliance committee addresses compliance matters on a regular basis.	100%		100%			
The organization's budget for compliance-related matters adequately reflects its commitment to good corporate conduct.	50%	50%		100%		

The centers understand the importance of issuing standards that are easy to comprehend. However, the necessity for multi-lingual versions of the code of conduct was felt to be only slightly to moderately essential. The guidance is written at a level that can be understood by employees of varying education levels, reading, and comprehension skills. In addition to written policies, codes, and standards, training ses-

sions have widened employees' access to compliance information and understanding.

Networking for Rural Health funding made it possible for the network to secure full legal review of the code of conduct and policy templates by an independent law firm specializing in health care law and health system compliance.

Overall, the network has been very effective at creating a compliance infrastructure for each of the centers. (See Table 8.) While there is upper management buy-in and support, the centers each have a compliance representative. There are assigned compliance teams and high-level oversight of compliance matters. Only moderate financial appropriations have been set aside at the center level for the compliance program. For this reason, each center's compliance officer has additional duties within his or her organization, and none of the current year budgets for the centers appropriate direct funding for compliance-related expenses. The network consolidates certain costs that enable the centers' part-time compliance officers to do an excellent job.

Expenses are viewed as the responsibility of the network and are governed by the network's ability to attract and maintain additional grant funding for the continuation of the compliance project.

The centers have been moderately to very effective in conducting due diligence. (See Table 9.) While effective internal control structures were in place prior to the compliance programs, the centers now have heightened awareness through internal system strengths that extend beyond compliance and positively affect financial and clinical performance. Although no studies have been conducted to quantify the impact, the compliance concentration has enabled the centers to encourage productivity and efficiency by linking the internal control structure with performance measurements that are in part based on compliance objectives. An important activity was a "secret shopper" program, in which consultants present themselves as patients to network providers. The purpose was to give the centers a view of their service delivery from a customer's perspective.

Table 9: Conducting Due Diligence

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
The centers screen new hires, agents, and business partners.	100%		100%			
"Know your customer" policies and procedures	100%			100%		
A system to verify potential employee credentials and review their backgrounds	100%		100%			
Documents adequately consider related risks and incorporate appropriate safeguards regarding commercial relationships with vendors and agents.	100%		100%			

Table 10: Communicating Standards and Procedures

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
Required compliance training for all subcontractors, agents	100%		100%			
A center "hotline" or reporting system where employees can report misconduct without fear of retribution	100%		100%			
Consequences of failure to comply with the code of conduct and center standards and procedures is communicated to all employees.	100%		100%			
High visibility of references and contacts regarding how to obtain compliance information and report misconduct	100%		100%			
All employees, including new hires, are required to have compliance-related training.	100%		100%			
Contractors are informed about the center's commitment to ethical and lawful conduct and directed to behave consistently with the company's relevant policies and procedures.	100%		100%			
When appropriate, training programs are offered.	100%		100%			

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
Information received from the "hotline" or internal reporting systems accurately reflects potential problems within the center.	100%		100%			
Employees are encouraged to report misconduct without fear of retribution.	100%		100%			
Training materials and information pertaining to compliance-related standards and procedures are easily accessible.	100%		100%			

The centers have been very effective at communicating standards and procedures to all employees and other agents through training programs and other mechanisms. (See Table 10.) The network was able to succeed at this effort in large part because of project funding, which made it possible to produce a training video for new employee orientation and staff re-orientation, and to purchase a toll-free hotline service to serve as an objective and anonymous access point for employee reporting. Project funds also allowed the network to develop a policy resource manual and compliance-related training materials, and to outsource sanction check services for each of the centers through a reputable provider. A sanction check is a screening of individuals and businesses barred from participation in government-funded programs against government databases.

Heightened awareness of compliance issues, the ramifications of fraud and abuse, and the availability of more sophisticated management

information systems have played a critical role in the network's decision to purchase an integrated practice management system. (See Table 11.) While funding for the purchase was not directly associated with the project, the network and centers' willingness to voluntarily police their internal processes and to gather, store, and maintain information using advanced technology came largely from compliance and financial educational opportunities facilitated by the project.

In preparation for extended responsibilities for billing and HIPAA compliance, the STN is taking the next step toward securing a fully integrated practice management system. As they implement this system, the centers will take a detailed look at auditing and monitoring systems that are in place and extend systems that do not encompass compliance areas efficiently.

In addition to auditing and monitoring standards, the network and its participating centers are working to standardize internal controls for enforcing compliance standards.

Table 11: Establishing and Maintaining Internal Controls, Books, and Records

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
A policy that requires the center to maintain an effective system of internal controls as well as books and records that accurately reflect its transactions and disposition of assets	100%		100%			
The policy clearly and concisely prohibits "off the books" accounts, inadequately identified transactions, and false entries.	100%		100%			
The center has established accountability for enforcing these prohibitions throughout the organization (e.g., departments, sites/locations).	100%		100%			
Independent outside auditors oversee the structure of internal controls, the financial reporting process, and related functions.	100%		100%			

At this point, the number of employee and patient reports to the centers is insignificant. Two reports have occurred over the course of the project; both were clearly not compliance issues and subsequently were handled outside of the parameters of the compliance program. The independent hotline service provider logged all calls and, while the content was not disclosed to the STN (as contractor for the centers), there is a full listing of all calls. Lack of quantifiable data demonstrates that there is an insignificant volume of violations, due largely to the network's efforts to develop corporate

culture, education, and staff awareness. While it is difficult to measure the effectiveness of the response of the centers and their ability to take steps to prevent further offenses, it is reassuring that the need to use these measures has not been necessary. (See Tables 13 and 14.)

Despite the small number of reports, the presence of the compliance program fosters the compliance culture of each center and creates an awareness of the boundaries of acceptable behaviors within the organization.

Ancillary Outcomes of Compliance Program Implementation

The main purpose of a corporate compliance program is to ensure compliance with all federal and state law and regulations, but there are other benefits of equal importance. An effective compliance program demonstrates to employees, clients, and the community that the center has a strong commitment to fair and responsible corporate conduct, that it values the quality of patient care and customer satisfaction, and that it understands the importance of reducing waste.

Problems within the centers are perceived as being resolved more quickly and trust is enhanced because the mechanisms, procedures, and culture for exposing fraud and abuse are structured and straightforward. Everyone inside and outside of each center knows the type of behavior that is acceptable to that organization and the ramifications of violating these standards.

While the centers are well aware of the legal advantages of having a compliance program, they do not yet know how such a program will affect the internal staff and operations or patient satisfaction. This will be the topic of extended studies within the organization.

Table 12: Implementing Auditing and Monitoring Systems

Develop auditing and monitoring systems to include:	Next Steps
Procedures for regularly auditing compliance to determine whether each element of the program is functioning as appropriate	<p>Next steps for the compliance program include development of internal and external auditing devices to ensure implementation of the objective measurements necessary for performance evaluations and management feedback on the program's success and barriers to success.</p> <p>The network recognizes that, without some form of auditing, the compliance function cannot provide measurement and feedback and will not allow the centers to identify and maintain controls effectively in high-risk areas.</p>
<p>Audits, internal audits, or compliance functions that perform the following:</p> <ul style="list-style-type: none"> ◆ Interview employees and third-party representatives; ◆ Examine "due diligence" files, agreements, and other documents associated with third-party relationships; and ◆ Examine accounts pertaining to revenue received from patient accounts. 	
A mechanism to report and correct any weaknesses or deficiencies noted in the audits in a timely manner	
Auditing and monitoring systems designed to detect misconduct within outside vendors, affiliates, and agents	
Risk-related auditing and monitoring systems reviewed by an outside entity	

Table 13: Enforcing Compliance Standards

Develop auditing and monitoring systems to assure:	Next Steps
Compliance matters are considered in performance evaluations.	While each center has internal controls, there are no formal mechanisms in place to measure how effective the centers have been at enforcing compliance standards consistently through disciplinary mechanisms. These steps are taken from the Ernst and Young model and will be replicated to enforce compliance standards across the STN.
Sanctions are proportionate to the violation and serve as a deterrent.	
Disciplinary action for compliance infractions is consistently enforced at all levels of the organization.	
There is an established protocol for handling misconduct once it is reported or detected.	
Commercial relationships with outside entities, including customers, are terminated once unethical or unlawful conduct is detected.	

As STN integrates new techniques and business office efficiencies, it stands to reduce debt and reimbursement barriers. Through eligibility and referral upgrades as well as privacy and security measures, patient relations should improve. The collaborative relationship with key partners should enhance the overall product of health care services and delivery for patients. STN should achieve reasonable compliance with federal and state regulations, and it should carry through many of the goals of the compliance program.

Plans for HIPAA Compliance

Unlike the STN’s compliance program, HIPAA compliance is not voluntary—it is the law. HIPAA involves:

1. Standardizing electronic patient health, administrative, and financial data;
2. Unique health identifiers for individuals, employers, health plans, and health care providers;
3. Security standards protecting the confidentiality and integrity of past, present, or future “individually identifiable health information.”

Preparation of a compliance plan can be viewed as a preparation for HIPAA compliance. Because HIPAA focuses on privacy, accuracy, and confidentiality of patients’ medical records, any knowledge gained about how services are translated into coding would enhance the accuracy of patient information.

Definitive implementation and compliance deadlines will be met to ensure that all of the network’s centers are functioning within state and federal laws. Compliance with HIPAA will improve the efficiency and effectiveness of the delivery system by standardizing the electronic exchange of administrative and financial data. In addition, the centers will take all measures to protect the security and privacy of individually identifiable health information.

STN anticipates that preparation for HIPAA compliance will allow centers to achieve efficiencies in the following areas:

- ◆ Claim submission/coordination of benefits;
- ◆ Remittance;
- ◆ Patient eligibility;
- ◆ Referrals and authorizations; and
- ◆ Claims status.

Table 14: Responding to Violations and Taking Steps to Prevent Future Offenses

Program Element	Does the Center's Compliance Program Include this Element?		How Important Is this Element to a Corporate Compliance Program?			
	Yes	No	Extremely	Moderately	Slightly	Not
Program is revised to reflect changes in laws, regulations, and policies.	100%		100%			
When misconduct is detected, standards and procedures are reviewed and revised as needed to prevent similar behavior in the future.	100%		100%			
The center periodically reviews compliance and risk-related standards and procedures to analyze efficacy.		100%	100%			
There is an ongoing effort to keep the compliance program a vital part of the center's culture and infrastructure.	100%		100%			

Prior to HIPAA, claim submission required hundreds of payer-specific data elements in multiple formats. Over 60 percent of patient claims were sent on paper, and it took many days to pay “clean” claims. Post-HIPAA, there will be standard code sets and one standard claim format. Moreover, 95 percent of claims will be handled electronically, and “clean” claims are anticipated to be paid within 30 days.

Claims payment will be simplified under HIPAA to allow for automatic posting of payments. Previously, centers were required to determine insurance eligibility only by inquiry and to copy the insurance card, send the claim, and wait for the payment. If the claim was rejected, centers had to verify insurance, resend the claim, and wait again for the payment. Post-HIPAA eligibility will eliminate the claims rejection, verification, resending, and waiting functions.

STN will be able to use the following standardized code sets:

- ◆ ICD-9-CM (diagnosis and procedures);
- ◆ CPT-4 (services of physicians, other professionals);
- ◆ HCPCS (products, supplies, and services); and
- ◆ CDT (dental services).

There will be no local codes, and National Drug Codes will be retracted. National Drug Codes, developed by the U.S. Food and Drug Administration, are used in reporting prescription drugs in pharmacy transactions. Everyone will be on the current code version.

HIPAA compliance will be implemented through the following steps:

- ◆ Education (HIPAA orientation tape, videoconferences, meetings, and the posting of HIPAA articles on the STN Web site);

- ◆ Executive support (awareness presentations to governing board members);
- ◆ Identification and inventory (surveys and exercises to identify and inventory patient information flow, storage, and access);
- ◆ Vendor contacts (establishment of business agreements to ensure electronic data exchange efficiencies);
- ◆ Gap analysis (map the HIPAA security requirements against the center environment to identify gaps in the security infrastructure);
- ◆ Contacting health plans (contact health plans that process electronic claims for assurance of HIPAA compliance); and
- ◆ Testing of systems (a series of internal and external surveys and audits to ensure compliance with HIPAA standards).

In addition to modifications of transaction codes and datasets, the STN was required to be in full compliance with privacy standards by April 14, 2003, and has until April 14, 2004, to modify existing business associate contracts. The STN must designate a privacy officer at each of the centers, provide privacy training to their workforce, implement safeguards to protect health information from intentional or accidental misuse, and provide individuals with a means to lodge complaints about the center's information practices.

STN must also develop a system of sanctions for staff and business partners who violate their policies and further establish contracts with business associates that ensure that they will exercise an appropriate level of care related to Protected Health Information (PHI). All of their policies and practices must be documented and followed.

There are new patient rights that will be addressed:

- ◆ To inspect, copy, and amend the medical record;
- ◆ To appeal amendment decisions;
- ◆ To be given copies of notice of privacy policies and procedures;
- ◆ To be given signed authorizations for the release of PHI; and

- ◆ To lodge complaints regarding PHI.

Many additional issues are anticipated in this implementation process as the centers consider everything from fax machine locations to the types of shredders they should use to answering machines, to sign-in sheets.

The HIPAA implementation process will allow the centers to detail current health information policies and procedures and list the organizations that receive health information from them. STN will collect examples of current consent forms, notices of privacy practices, and authorizations, and ensure that all contracts with "business associates" meet compliance review standards. They will spend additional research time on state laws to ensure that the standards they impose not only comply with federal regulations but meet their own standards as well. STN will work with the centers to designate a health information privacy official who will be responsible for developing and implementing privacy policies and procedures.

In summary, the HIPAA security elements that have been developed include:

- ◆ Technical security mechanisms to guard data integrity, confidentiality, and availability;
- ◆ Technical security service process that must be put into place to protect, control, and monitor information access;
- ◆ Physical safeguards in the form of policies and procedures for ensuring authorized physical access; and
- ◆ Administrative policies, procedures, and organizational practices dealing with the behavioral side of security.

Net gains from the privacy elements of the HIPAA program include:

- ◆ Standard set of policies and procedures;
- ◆ Standard set of patient expectations;
- ◆ Protection from federal fines or prison time;
- ◆ Protection from state-level action; and
- ◆ Compliance with accreditation bodies;

Lessons Learned

The CEO of STN points out that success starts at the top. Compliance was not a top priority at all facilities. Getting good participation in conference calls with compliance officers became a problem. She suggests doing a comprehensive review with all stakeholders to communicate what is necessary to implement a program and what the desired outcomes are. Getting the board “on board” was key. She needed the endorsement of the board to bolster the authority of the network compliance officers. If the board didn’t understand its responsibility, then they were re-educated. This required CEO-to-CEO communication in some instances. The administrative staff also needed to understand what compliance meant and what their role in achieving it was. The video was invaluable because it could be used at all facilities and updates could be added to it.

Variation in the level of skill among designated compliance officers was an issue. A billing officer with only a high school education was a compliance officer at one center, while a person with more education and knowledge about coding and billing took on that role at another. Yet another center designated their COO. Some compliance officers who were asked to report to their board had never attended a board meeting before. None of the centers had had a seasoned compliance person at the start of the grant period.

Post-Grant Activity

Since the time when the network was awarded its grant from the Networking for Rural Health project, its funding has increased significantly—from \$280,000 to more than \$1 million annually. Project funding helped to strengthen and integrate the systems needed to obtain additional funding.

Table 15: Network Funding

Integrated Service Development Initiative (ISDI) Grant – To facilitate the integration of delivery systems as well as for planning activities.	\$65,000
TexCare (CHIP) Grant – To provide application assistance and educational outreach to parents of qualified children in nine South Central and Southwest Texas counties.	\$101,000
Community Access Program Grant – To provide the infrastructure necessary to fully develop or strengthen integrated health care systems that coordinate health services for the uninsured.	\$627,000
Shared Integrated Management Information System (SIMIS) – To strategically align health center information systems with business objectives in an effort to meet demands driven by competition in the marketplace.	\$350,000
Partner/Membership Contributions – Annual membership fees that help to support network operations and staff salaries.	\$21,000
	Total: \$1,164,000

Summary

Funding through the Networking for Rural Health project has played a significant role in enabling the STN to mount a significant, impressive, and ongoing compliance program. The executive director of the STN reports that the network is well ahead of the rest of Texas in their compliance implementation and have:

- ◆ Established compliance standards and procedures that are effective in reducing misconduct;
- ◆ Held training sessions to increase employee access to compliance information and understanding;
- ◆ Been able to fund full legal review of the code of conduct and policy templates by an independent law firm specializing in health care law and health system compliance;
- ◆ Implemented a “secret shopper” program to get an objective outside view of service delivery;
- ◆ Been effective at communicating standards and procedures to all employees and other agents through a policy resource manual, a training program with materials, a toll-free hotline for anonymous staff reporting, and an orientation video;
- ◆ Purchased an integrated practice management system;
- ◆ Made plans to take a detailed look at auditing and monitoring systems that are in place and extend systems that do not efficiently encompass compliance areas;
- ◆ Made plans using an Ernst & Young model for enforcing compliance standards;

- ◆ Incurred only a small number of reports of violations; and
- ◆ Completed detailed plans to address and comply with HIPAA standards.

However, several areas need additional work. For example:

- ◆ The internal staff and operational benefits as well as patient satisfaction outcomes of compliance efforts remain somewhat unknown.
- ◆ None of the centers have dedicated compliance officers; all compliance officers have additional duties. Pooling of resources is an important contribution of the network. However, as each center’s needs grow, full-time compliance officers may be necessary.
- ◆ Center participation in ongoing audio-conferences continues to be a problem. The centers are short staffed and on tight budgets. Time spent attending audio-conferences takes away from patient service time.
- ◆ Continued compliance efforts are dependent on new grant funding.

Replicability

Both the manual and the video could be adapted for use by other networks, although neither has been developed for use outside the STN so far. The STN would need to obtain the consent of its attorney, who is the presenter of the compliance workshop, before distributing the videotape.

Upper Peninsula Health Care Network: Using Local Resources to Overcome Personnel Shortages

History and Background of Network

The remoteness, sparse population, and severe winter weather of the Upper Peninsula (UP) of Michigan make access to medical services a serious problem. Many rural communities throughout the UP lack primary health care or easy access to health services, and thus fall under the federal and state guidelines of Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA). Retention and recruitment of physicians and other health professionals is a constant challenge because of professional isolation, distance from specialists, and limited continuing education.

The UP is located in one of the northernmost sections of the Midwestern United States. Lakes Superior, Michigan, and Huron are natural boundaries, limiting access to the Upper UP. According to 2000 Census data, the UP is home to 318,000 residents. It spans 16,600 square miles, with an average of 19 people per square mile.

The Upper Peninsula Health Care Network (UPHCN) in Marquette, Mich., was formally incorporated as a non-profit in June 1995, with 501(c)(3) status received in April 1996. With an original membership of 14, the network now has 16 members: a regional medical center, 13 community hospitals, a tribal health center, and a behavioral health provider network. All 16 members of the network are private or public non-profit organizations.

The original focus of the UPHCN was to serve the residents of the Upper Peninsula of Michigan through:

- ◆ Promotion of managed care networks;
- ◆ Cooperative hospital services;
- ◆ Availability of education;
- ◆ Access to health care;
- ◆ Assurance of professional standards; and
- ◆ Dissemination of information on current legislative and economic issues.

In 2000, the UPHCN's budgeted revenues were \$353,000. The 2003 budget submitted and approved at the UPHCN board of trustees meeting in December 2002 projects revenues of \$1.6 million for the year. The most significant component for this large increase was the addition of a mobile MRI that provides service to five hospitals in the UP.

The network wrestled with assessing which services should be selected to increase access to care and improve quality of care. They wanted to identify the program that could benefit the largest number of communities with the most efficient use of resources. To deal with these issues, the network board decided to develop a needs assessment and a business plan, and then to design and implement an appropriate program.

Targeted Consultation

The network sought a targeted consultation to help develop the needs assessment and follow-up planning. It was awarded \$40,000 from the Networking for Rural Health project. The original goal of the targeted consultation was to:

- ◆ Conduct an assessment of the community needs;
- ◆ Determine the market;
- ◆ Determine available resources; and
- ◆ Develop a business plan.

The network engaged the Northland Health Group (South Portland, Maine) for this targeted consultation.

The first step was to survey the board of trustees and conduct a board retreat to review the results and discuss options and opportunities. After the Northland Health Group conducted an initial needs assessment, the board of the UPHCN instructed the network director to focus only on personnel shortages—an issue of paramount importance to the membership and the board. Part of the reason for this was staffing. The executive director and an adminis-

Upper Peninsula Health Care Network members

Baraga County Memorial Hospital
L'Anse, Mich.

Bell Memorial Hospital
Ishpeming, Mich.

Dickinson County Healthcare System
Iron Mountain, Mich.

Grand View Health System
Ironwood, Mich.

Great Lakes Behavioral Health, Munising
Escanaba, Newberry, Marquette, Mich.

Helen Newberry Joy Hospital
Newberry, Mich.

Iron County Community Hospitals
Iron River, Mich.

Keweenaw Memorial Medical Center
Laurium, Mich.

Mackinac Straits Hospital
St. Ignace, Mich.

Marquette General Health System
Marquette, Mich.

Munising Memorial Hospital
Munising, Mich.

Ontonagon Memorial Hospital
Ontonagon, Mich.

Portage Health System
Hancock, Mich.

Schoolcraft Memorial Hospital
Manistique, Mich.

Sault Ste. Marie Tribal Health Center
Sault Ste. Marie, Mich.

War Memorial Hospital
Sault Ste. Marie, Mich.

Service Area (counties)

Baraga
Marquette
Dickinson
Gogebic
Luce
Iron
Keweenaw
Mackinac
Alger
Ontonagon
Houghton
Chippewa
Schoolcraft

trative assistant had little time for long-term strategic planning, because they were busy managing eight network committees and organizing a new group purchasing program. After the decision was made to forgo a larger planning effort, the relationship between the Northland Group and the UPHCN was amicably terminated.

Focus on Personnel Shortages

The UPHCN decided to focus on the crucial shortage of coding personnel because the shortage was having a major impact on hospitals, and the network had a good chance of succeeding in addressing this issue.

The shortage of coding personnel is part of a global problem of attracting health professionals to a rural area. Although it is often very expensive, agencies can provide nurses and radiology technicians. However, the availability of coders is very limited.

Qualified coding personnel are in great demand in the UP and nationwide. Coders are critical to hospitals and physicians' offices. Sufficient coding staff permit a faster turnaround of patient bills and consequently improve cash balances by reducing days in accounts receivable to these organizations. By increasing the institutions' cash flow, each member will have a varying degree of return on investment depending on whether they choose to purchase investments, buy equipment, or reduce debt. Rural hospitals generally have difficulty recruiting staff and the industry-wide shortage of coders makes the situation even worse. Knowing this, the board of trustees decided to take a "grow your own" approach.

Initial Collaborative Attempts

Unsuccessful initial attempts were made with a local university to expand its staff and resources to develop and implement a suitable training program. The UPHCN then began studying other alternatives to increase the number of qualified coders in the UP. After initially planning to develop a classroom-based curriculum, they discovered that there were very credible training programs for these positions that could be taken over the Internet. Word had spread that the network was trying to address the issue of coders, and the executive director received a letter from the dean of Gogebic

Community College in Ironwood, Mich., indicating that his school had developed a coding program but had no students.

At the same time, an organization called Michigan Works: The Job Force (formerly, the Michigan Employment Security Commission) also contacted the network's executive director to express interest in working with the UPHCN to improve awareness of jobs available in health care and specifically in coding positions.

These discussions led to two main initiatives, one short-term and the other long-term, that were pursued through the combined efforts of Michigan Works, Gogebic College, and the UPHCN.

The short-term initiative was to seek continuing education for coders currently on staff at member hospitals. The longer-term initiative was to design a curriculum for a coding certificate program to train new coders. The UPHCN negotiated the cost for two workshops available to coders and management staff within the network, which were conducted by Gogebic faculty and staff. Basic coder education was a one-day seminar available to department managers to bring basic coding knowledge to the hospital departments. The other workshop was conducted over lunch once a week for six weeks. It was designed specifically for coders, and provided continuing education credits for maintaining certification.

Both of these workshops took place outside of the network and were transmitted over the UPHCN's video conferencing system. Individuals attending these workshops were given the option of attending via video-conference or live attendance at the instructor's location. The American Health Information Management Association (AHIMA) approved both of these courses for credit.

For the long-term initiative, the network decided to develop a one-year certificate program rather than a two-year associate program because of the pressing need. At the time of the initiation of this effort, there were 16 coder vacancies in the network hospitals. The first students started the program in fall 2001. Medical records staff felt it was important for

the Gogebic program to be accredited to help with the recruiting process locally but also to allow Gogebic to market the program regionally. Accreditation through AHIMA or another organization is under consideration.

Students will be able to sit for certification exams after six months work experience. Position profiles are being developed by Michigan Works to determine the minimum requirements for students entering the program to ensure that it attracts high quality enrollees and has a high completion rate. A unique feature of the Gogebic program is that it uses local mentors. Local hospital employees mentor students who train online.

Students are recruited out of high schools and other health professions such as nursing. A coding career may be attractive to nurses who are under significant work pressure because of nursing shortages.

Programs exist within network hospitals for tuition forgiveness. In other words, hospitals will pay tuition if students work at the hospital for two years following their training. If the student doesn't work for the entire period of the contract, he or she must pay tuition on a pro-rated basis. In addition, a new scholarship program has been discussed, but not finalized.

Post-Grant Developments

The coding program has advanced beyond the network's original expectations. It allows 20 students to enter each year in the fall. Twenty students entered in fall 2001, another 20 in fall 2002, and six students are already scheduled to begin in fall 2003. The program is expected to take two years to complete but can be finished sooner if some pre-requisites are waived for experienced students and if circumstances regarding class sequence allow.

As the program is new, there have not been any graduates as of this writing. There have been no dropouts either. According to Gogebic staff, four hospitals in eastern Wisconsin and five hospitals in the UP have committed to a mentorship program. In this program, practicing coders pair up with students online, help students with classwork as needed, and share real-life experiences from their coding positions.

Implementation Issues

One issue that was a real dilemma was how to set up the sequence of classes with students entering the program who had different levels of educational experience. Some advanced nurses didn't need training in anatomy and physiology, for example. Without sufficient numbers of students for a particular course, it was not cost-effective to hire an instructor. How do you set up a continuum of classes in order to keep a full contingent of students? The executive director reports that Gogebic started the entire first half of the curriculum in the first semester after consulting with medical records staff in network hospitals.

Application to Other Personnel Shortages

The "grow your own" approach of addressing industry personnel shortages has drawn interest from network hospital administrators. The UPHCN Radiology Committee is now exploring a modified strategy to address the shortage of radiology technicians.

The shortage of radiology technicians is a major national problem. Marquette General Hospital's (MGH) radiology school accepts six applicants per year. Radiology departments are financially advantageous for hospitals. The UPHCN has started working with MGH to expand its program from six to ten positions per year. The plan is to provide incentives or have the network take some equity out and invest in expanding the program.

Another issue was whether the school should take on another radiology instructor and additional training sites around the UP. At about the time when the network was conducting a financial analysis, a large radiology practice with offices at MGH disbanded. Students are required to perform a number of procedures every year to pass certain competencies. It was felt that some of the hospitals didn't have sufficient volume to warrant a site for students to meet their competency requirements.

After the radiology group disbanded, Marquette General took over their site at the medical center, thus providing a large volume of procedures for students. They were able to achieve this without hiring an additional instructor, leading to savings of \$50,000 to \$80,000 a year.

Lessons Learned

The most important lesson learned from the consultation was that the network needed to perform more formal planning. In the past, the executive director would have ideas funnel in from board members intermittently. The ideas often were not developed further after presentation to the full board. It was difficult to gain consensus because of the wide diversity of network members' needs. Members of the network placed their institutional needs ahead of network decisions. Being able to gain buy-in from members required an expensive business planning process for each proposed project that included documenting the costs and benefits to the member institution as well as to the network as a whole. To some extent, board members realized this problem; however, the Northland Health Group helped the UPHCN identify that a more formal planning process was necessary if new programs were to be initiated.

Indirect Effects

The original intent of the grant was to identify opportunities and develop business plans for implementation. The first initiative evolved around a particular issue—personnel shortages—and coders in particular. An added benefit of the Northland Health Group's consultation was the board's realization that the network was undertaking too many activities with too few staff. To address this, the board funded a new operations position in the executive director's office in August 2002 to assist with all committees and analyze the costs and benefits of various network initiatives.

Replicability in Other Networks

Several elements came together at the right place and the right time to enable this effort to succeed. The network was fortunate to have come across a coder training program in need of students just as it had embarked on a search for one. However, coder training is available online, and therefore replicable almost anywhere. Mentorship programs can be developed through member hospitals. Since rural networks have shortages of key medical personnel, the UPHCN model of working with local institutions of higher learning, state employment agencies, and network hospitals to create training programs in key areas should be replicable in many rural settings.

Summary

The network is well on its way to relieving the shortage through its ongoing education of quality coders. However, the health care industry overall is experiencing extensive shortages of qualified personnel in many different areas, especially radiology technicians and nurses. The overall approach resulting from this grant was to “home grow” coders with incentives and utilization of local resources. There is already dialog among the board of trustees and various network committees to explore the same approach for radiology technicians.

The network has shown that it can build programs within the UP and make them attractive to its local community by addressing the problems that network members share. UPHCN has started to look at the next area to target. Using the model developed for personnel shortages, it will explore developing a network collection agency. Plans are being made to recruit people from local agencies or banks.

Further Information

Recent Grant History

- ◆ In July 2000, the network undertook a rural health initiative funded by the Michigan Department of Community Health, titled “Minimizing the Distances: Expanding Telecommunications Connectivity for the Upper Peninsula Health Care Network.” This \$200,000 grant was primarily an equipment grant that funded the purchase of an expanded, enhanced videoconference system.
- ◆ The network began a rural health initiative in 2001 funded by the Michigan Department of Community Health, titled “Building Collaboration and Efficiencies among Medical Control Authorities.” The network will use the \$86,000 grant to create a medical control authority network in 11 counties of the Upper Peninsula to collectively address the mandates recently published by the state. Medical control authorities are the responsibility of hospitals in Michigan and are the oversight body for emergency medical services in the counties for which they reside.
- ◆ Blue Cross Blue Shield of Michigan Community Health Agenda, through their preventive health program in August 2001, funded the full purchase of 10,000 residential smoke detectors at a cost of \$47,000.

Appendix: Targeted Consultation Grantees*

State	Network/ Location	Amount Awarded	Composition	Service Area	Grant Objectives
Colorado	Frontier Health Network 242 South 14th St. Burlington, CO 80807	\$10,000	12 members, including hospitals, clinics, long-term care, home care, and other social service agencies	Kit Carson County (7,300 pop.)	Develop collaborative strategy for suicide prevention. Review existing data, educate members, assess network and community resources, and recommend action plan.
Florida	Lake Okeechobee Rural Health Network 185 U.S. Hwy 27 South South Bay, FL 33493	\$40,000	2 vertically integrated networks	Panhandle and south/central Fla.	To develop a locally owned and operated PPO product on a statewide basis.
Illinois	East Central Illinois Rural Health Network 1000 Health Center Drive Mattoon, IL 61938	\$10,000	25 members, including county health departments, hospitals, and social service agencies	7 counties in east central Ill. (144,735 pop.)	Assessment and prioritization of prevention strategies based on analysis of risk behaviors in service area.
Indiana	Heartland Regional Health Network 205 W. Sycamore Kokomo, IN 46901	\$12,500	4 hospitals	4 counties in north central Ind. (168,570 pop.)	Facilitate the implementation of a jointly sponsored regional home health care agency.
Iowa	Crossroads Health Partners 407 S. White St. Mt. Pleasant, IA 52641	\$40,000	3 hospitals	3 counties in southeast Iowa (58,000 pop.)	Assist in network organizational development and refinement and implementation of business plans.

* To read short profiles of all 27 targeted consultation grantees funded through the Networking for Rural Health project, please visit: www.academyhealth.org/ruralhealth/ruralgrantees.htm.

Appendix continued: Targeted Consultation Grantees

State	Network/ Location	Amount Awarded	Composition	Service Area	Grant Objectives
Iowa (cont.)	Iowa Health System Community Network 1200 Pleasant St. Des Moines, IA 50309	\$40,000	12 rural hospitals and Iowa Health System	12 counties across rural Iowa	Create a network of interactive Web sites that would reduce costs, increase revenue, and offer additional services to consumers.
Maine	Maine Health Alliance 18 Stillwater Ave. Bangor, ME 04401	\$35,000	11 community hospitals, 350 primary care providers	5 counties in northeastern Maine (350,000 pop.)	Develop, implement, and train staff on Web-resident disease management software.
	Mount Desert Island Community Health Plan P.O. Box 875 Mt. Desert, ME 04660	\$22,500	9 organizations: health care providers, chamber of commerce, social services	Hancock County, 108 sq. miles (10,000 year-round pop.)	Design, implement, and evaluate a mental health services component of the health plan in order to be responsive to the community's needs.
Massachusetts	Dukes County Health Council P.O. Box 1298 West Tisbury, MA 02575	\$32,500	32 providers, social service agencies, physicians, consumers	Martha's Vineyard (14,000 pop. in 100 sq. miles)	Implement phase 2 of a 3-phase project to develop a health plan in order to increase access to services for low-income and uninsured persons.
Michigan	Upper Peninsula Health Care Network 710 Chippewa Square, Ste. 206 Marquette, MI 49855	\$35,000	16 providers: 1 med center, 13 hospitals, tribal health center, behavioral health	Upper Peninsula of Mich. (314,000 pop. in 16,600 sq. miles)	Conduct an assessment of the community needs, the market, and available resources and use that information to develop a business plan for implementing project(s) that will increase access or improve services.

Appendix continued: Targeted Consultation Grantees

State	Network/ Location	Amount Awarded	Composition	Service Area	Grant Objectives
Minnesota	La qui Parle Health Network 900 2nd Ave. Madison, MN 52656	\$15,000	3 hospitals	3 counties (2 in Minnesota, 1 in SD)	Conduct a financial analysis of two potential ventures: 1) development of a satellite clinic, and 2) shared staffing of emergency room call coverage.
	Northern Healthcare Partnership c/o Fairview Health Services 2450 Riverside Avenue, 6a West Minneapolis, MN 55454	\$12,200	14 providers: 3 hospitals, 10 clinics, 1 regional health system	6 counties in northern Minn.	Develop an integrated care delivery system of specialty services: select which services to integrate, determine how the service lines should be organized/function, and address related legal issues.
	North Region Health Alliance 109 S. Minnesota Warren, MN 56762	\$22,000	9 health care systems: 8 hospital/medical clinics, 1 mental health center	Northwestern Minn.; northeastern N.D.	Develop a reimbursement model and process to be used by 8 independent member organizations when negotiating contracts with third party payer organizations.
	Northwest Minnesota Health Care Purchasing Alliance 121 East Seventh Place, Suite 400 St. Paul, MN 55101	\$40,000	Alliance of small employers and individual community members	7 counties in northwest Minn. (70,250 pop.)	Identify and develop specifications for new group insurance option
	PrimeWest Health System 305 8th Ave., West Douglas County Courthouse Alexandria, MN 56308	\$40,000	10 counties that provide public health, mental health, and chemical dependency services.	10 counties in central Minn. (154,000 pop.)	Assess operational readiness for Medicaid managed care contracts.

Appendix continued: Targeted Consultation Grantees

State	Network/ Location	Amount Awarded	Composition	Service Area	Grant Objectives
Montana	Montana Health Network 11 S. 7th Ave. Suite 160 Miles City, MT 59301	\$29,500	23 hospitals, 3 nursing homes, 1 mental health facility	50 percent of Montana	Understand the risks, underwriting issues, and project scope associated with expanding the health plan; develop provider network; and establish a disease management program.
New York	Health Community Alliance 26 Jamestown St. P.O. Box 27 Gowanda, NY 14070	\$10,000	3 hospitals	4 counties in western N.Y. (100,000 pop.)	Develop recruitment and retention process (especially for surgeons, psychiatrists, pharmacists, OB/GYN); create a plan to attract LPNs, CNAs, and dental hygienists.
	Thompson Health 3170 West St. Suite 150 Canandaigua, NY 45133	\$35,000	1 health system, 1 IPA, 1 payer	3 counties in western N.Y. (120,000 pop.)	Improve information systems and analytical capacity by focusing on specific services, practice patterns, and clinical data to improve managed care readiness.
North Carolina	Graham Children's Health Services of Toe River P.O. Box 1298 Burnsville, NC 28714	\$6,000	21 community organizations	Yancey and Mitchell counties	Conduct an in-depth data collection effort in order to better address the gaps in services or needs for children and youth in a 2-county area.

Appendix continued: Targeted Consultation Grantees

State	Network/ Location	Amount Awarded	Composition	Service Area	Grant Objectives
North Dakota	Northland Healthcare Alliance 400 E. Broadway Suite 300 Bismarck, ND 58103	\$40,000	Hospitals, physicians, and nursing homes in 13 communities	32 rural counties, 2 urban counties, 2/3 of N.D.	Determine how to develop patient care systems, protocols, and procedures in order to develop a medical management plan.
Ohio	Rural Health Cooperative of Southern Ohio 1275 N. High St. Hillsboro, OH 45133	\$20,000	3 hospitals, 1 FQHC	3 counties in southern Ohio	Evaluate managed care readiness and develop strategic/ competitive response options.
Oregon	Pathways to Care 820 N.E. 7th St. Grants Pass, OR 97526	\$12,500	1 hospital, 1 physician practice, 3 health depts., 5 social service agencies	Josephine County (73,000 pop.)	Determine how to integrate behavioral health services with primary health care services and use appropriate measures of patient outcomes.
Pennsylvania	Community Integrated Services Network of Pennsylvania 1017 Mumma Rd. Suite 209-B Wormleysburg, PA 17043	\$25,000	20 FQHCs	Rural Pa.	Assess compliance and impact of existing clinical protocols and disease management for high-cost chronic conditions.
Texas	Uvalde County Clinic 201 S. Evans St. Uvalde, TX 78801	\$16,000	5 FQHCs	10 counties in south central and southwest Texas	Develop a comprehensive compliance program and educate and train staff in order to comply with standards for practice-based care.

Appendix continued: Targeted Consultation Grantees

State	Network/ Location	Amount Awarded	Composition	Service Area	Grant Objectives
Vermont	Lamoille Valley Long Term Care Team 11 Court St. Morrisville, VT 05661	\$20,000	12 community service providers	Northern Vt.; 700 sq. miles	Establish an integrated management information system to improve and target service delivery by sharing data/information across organizations.
Washington	Choice Regional Health Network P.O. Box 3466 Olympia, WA 98509	\$40,000	7 hospitals, 6 health depts., 4 clinics, 3 other entities	5 counties (440,000 pop.)	Improve access to services through chronic disease management and an uncompensated care pilot program.
Wisconsin	Rural Wisconsin Health Cooperative 880 Independence Lane Sauk City, WI 53583	\$30,000	25 hospitals	19 counties in central and south central Wis.	Assess feasibility of establishing virtual computer network for 25- hospital network.
	Total Amount Awarded	\$690,700			



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