

CAH/FLEX

National Tracking Project

FINDINGS FROM THE FIELD

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State Office of Rural Health and Hospital Association Partnerships: An Important Ingredient for Success

What is the strategy?

A minimum requirement for participation in the Medicare Rural Hospital Flexibility Program (RHFP) is the inclusion of the State Office of Rural Health (SORH) and the State Hospital Association (SHA) in program planning and implementation processes. This requirement is one of many retained from the predecessor program of the RHFP, the Essential Access Community Hospital Program (EACH/PCH). Experiences during the EACH/PCH Program demonstrated that a strong working relationship between the SORH and the SHA was often a key ingredient for program success. Our experiences with the twelve states visited by the National Tracking Project have also supported this contention. Implementation of the RHFP, with limited exceptions, has been slower in states where the relationship between the SORH and the SHA has been weak.

Many states visited by the project team benefitted from a solid working relationship between the SORH and the SHA, and those states with EACH/PCH experience tended to have the strongest connections. Of the two states (from among the 12 states visited) that demonstrated weak SORH/SHA relationships, one had a history of poor relations and the other resulted from a difference of opinion on how to implement the program.

Several of the states were working on a limited service hospital program of their own before the creation of the RHFP. In each case, the prime movers for these states included both the SORH and the SHA. This early experience allowed the states to "hit the ground running" once HCFA approved their state plan.

Previous Findings from the Field

- Vol. 1, No. 1: From Idaho: The CAH Start-Up Kit
- Vol. 1, No. 2: From North Carolina: Strengthening Billing Systems for Rural Emergency Medical Services
- Vol. 1, No. 3: From North Carolina and Wisconsin: The RHFP as a Vehicle for State Policy
- Vol. 1, No. 4: From Oklahoma and Wisconsin: "Right Sizing" – Matching the Scope of Services to the Population

Project Website: <http://www.rupri.org/srhf-eval/>

What are the benefits of a stronger relationship between the SORH and the SHA?

The SORH and the SHA can provide a synergistic boost for the RHFP because of their different constituencies and the overlap in strategies for achieving their separate but compatible organizational goals. SORHs, through their links at the state executive level, can provide a bridge to federal as well as state policy and regulatory arenas. They are also in a better position to work with those agencies responsible for the program's operations such as: HCFA regional offices, Peer Review Organizations and Medicare fiscal intermediaries.

SHAs, on the other hand, have a stronger link with individual hospitals and often much greater flexibility to advocate on behalf of the program with state legislatures and Congress. An important strategy for developing a stronger and more effective relationship between SORHs and SHAs involves identifying a common goal (such as stabilizing the rural hospital sector) where the partners can satisfy their separate but mutual needs.

In many states visited by the project team, the SORH lacked a critical mass of staff and other resources, as well as the time to work in and outside of state government to educate and build support for the program. In several of these states the SHA provided a counterbalance, mustering needed resources to make the difference, especially in cases where there was only one person staffing the SORH.

Some examples of successful partnerships:

- In Idaho the SHA took the lead in disseminating information, coaching hospitals about the survey (for certification) and conversion process, and providing valuable technical assistance on a continuous basis.
- The strong relationship between the Kansas Hospital Association (KHA) and the SORH helped to facilitate the distribution and use of grant funds as well as the provision of technical assistance including a comprehensive application packet developed by the KHA.
- In Minnesota, the Minnesota Hospital and Healthcare Partnership provided technical assistance in the form of financial feasibility studies, provided information on the program to its member hospitals, and served on the state's Rural Flexibility Advisory Committee.
- In Maine, the SHA served as the catalyst for the state's rural hospital plan and opened a new role for the SORH that traditionally had been focused on personnel recruitment and retention issues.

The benefits of such a partnership also accrue to the SHAs. For example, in cases where the ability of an SHA to address rural hospital issues is overshadowed by urban provider issues, the partnership can position the SHA to better connect with and benefit its smaller rural hospital members without compromising its advocacy relationship with those members that provide most of the Association's income. Collaboration with the SORH can also lead to opportunities for further dialogue on other rural health issues that extend beyond the scope of the RHFP.

How have states used the approach?

SORHs and SHAs have worked collaboratively to:

- make joint presentations at town meetings and individual hospital board sessions to clarify the program and to foster a rapport and image as an advocate for hospitals and communities;
- develop and distribute application packets including eligibility certification forms, model network agreements, Critical Access Hospital (CAH) conditions of participation and survey tasks;
- be sure the appropriate partner leads on certain tasks, such as the SHA taking on a stronger advocate role for rural health programs in the legislature, including state-funded grant and reimbursement initiatives;
- facilitate the distribution of grants and the general provision of technical assistance; and
- build broader coalitions of stakeholders to support the program.

What are the barriers to a strong relationship? How do SORHs move past them?

Many SORHs enjoy a strong relationship with their SHAs because of previous collaborative efforts such as the EACH/PCH Program. Others have had weak or antagonistic relationships. A history of a directive or a strong regulatory role on the part of the state is perhaps one of the most common reasons for such a relationship. To a degree, the ability to move beyond such unproductive relationships will depend upon the personalities involved. In other cases, it may be more effective to nest the partnership within a larger coalition or planning group so that individual issues don't have as much opportunity to dominate the program's agenda.

What are the potential benefits?

Effective partnerships reach the broadest possible audience with more accurate program information, and a broad range of technical assistance. The partners can advocate for rural providers and communities, and serve as the basis from which to build a larger rural health policy agenda for your state. The achievements noted in *Findings from the Field Vol. 1, No. 3* on state rural policy were largely possible because of the paired support of the SORH and the SHA. In several other states, an SORH/SHA team served as the core for building a broader coalition with significant potential to implement the RHFP and achieve greater synergies in rural policy reform.

Where Can I Get More Information?

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About this project: Check our website: <http://www.rupri.org/srhf-eval/>

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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