

Data-driven Passion

What
Academics
and Activists
Need to
Know About
Rural
Healthcare

*Brought by our partners at
Southwest Virginia Graduate Medical Education*

<https://swvagmec.com/>





S W M M
G M E C



Tri-Area Community Health

Logistics

- Please silence your phones.
- When you speak, please state your name, organization and state.
- There will also be opportunities throughout the presentation for questions as well as a Q & A portion at the end of the panel discussions.
- Presenter contact information may be found on the last slide in the slide deck.



Howard Chapman



Tammy Norville

Today's Presenters

Beth O'Connor



Dale Clark

Learning Objectives

Following this session participants will be able to:

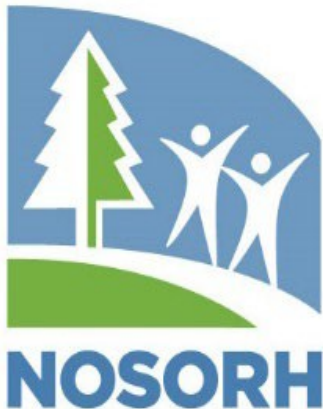
- ▶ Understand differences in Urban and Rural, describe the benefits of the Rural Health Clinic (RHC) program and describe how to use the State Office of Rural Health (SORH) as your rural health subject matter experts (SMEs)
- ▶ Articulate the difference between a Federally Qualified Health Center (FQHC), a Community Health Clinic (CHC), and other rural provider types
- ▶ Describe the current rural hospital environment and the benefits of a Critical Access Hospital (CAH)
- ▶ Articulate the general principles of advocacy and education of policy makers and stakeholders

Today's Agenda

- ▶ Tammy Norville, National Organization of State Offices of Rural Health, “Rural Health is Different from Urban Health Because...”
- ▶ Howard Chapman, Tri-Area Health, “Alphabet Soup Mixed with Numbers: Sorting the Realities of Rural Healthcare into Common Sense”
- ▶ Dale M. Clark; COO, Indian Path Hospital; “What You Don't Know About Your Local Hospital Could Kill You”
- ▶ Beth O'Connor, Virginia Rural Health Association, “Advocacy 101: How to Get a Meeting and Make a Point with Legislators and Policy Leaders”

Rural is Different from Urban Because...

Tammy Norville
Technical Assistance
Director
Durham, NC



National Organization of
State Offices of Rural Health

Definitions of Urban & Rural

“Numerous federal and state-level **definitions of rural** have been created over the years for various programs and regulatory needs. However, there are three federal government agencies whose definitions of what is rural are in widest use:

- ▶ the U.S. Census Bureau
- ▶ the Office of Management and Budget
- ▶ the Economic Research Service of the U.S. Department of Agriculture (USDA)”

Definitions of Urban & Rural

“Census Bureau:

Urbanized Areas (UAs) are geographic areas of 50,000 or more people. Urban Clusters (UCs) are geographic areas of 2,500 to 50,000 people.

Office of Budget Management:

Metropolitan areas contain a core urban area population of 50,000 or more. Nonmetropolitan areas contain a population of less than 50,000.

Economic Research Service, U.S. Department of Agriculture

Rural Urban Commuting Areas (RUCAs) - Utilizes the U.S. Census Bureau’s UAs and UCs definitions with information on work commuting. Classification delineates metropolitan, micropolitan, small town and rural commuting areas...”

Definitions of Urban & Rural

Table 1. Comparison of Rural Definitions

For each definition, using 2010 Census data

Definition & Agency	Geographic Unit Used	What is Included in "Rural"	U.S. Rural Population
<p>Urban and Rural Areas U.S. Census Bureau</p> <p>Urbanized Areas (UAs) are geographic areas of 50,000 or more people. Urban Clusters (UCs) are geographic areas of 2,500 to 50,000 people.</p>	Census Blocks and Block Groups	Rural areas encompass all population, housing, and territory not included within an urban area. (Excludes P.R.)	<p>59,492,267</p> <p>Percent of Total Population: 19.3%</p>
<p>Core Based Statistical Areas (Metropolitan, Micropolitan, & Nonmetropolitan statistical areas) U.S. Office of Management & Budget</p> <p>Metropolitan areas contain a core urban area population of 50,000 or more. Nonmetropolitan areas contain a population of less than 50,000. This includes both micropolitan areas, with urban cluster populations of 10,000 to 50,000, and all counties that lack an urban core, which are referred to as noncore counties.</p>	County	All non-metropolitan areas (counties) including micropolitan and noncore counties	<p>46,293,406*</p> <p>Percent of Total Population: 14.99%</p>
<p>Rural-Urban Commuting Areas (RUCAs) Economic Research Service</p> <p>Utilizes the U.S. Census Bureau's UAs and UCs definitions with information on work commuting. Classification delineates metropolitan, micropolitan, small town and rural commuting areas with whole numbers 1-10 and further subdivides into 21 secondary codes based on commuting flows - local or to another census tract.</p>	Census Tract, ZIP Code approximation	Primary RUCA codes 4 and above (Micropolitan Area Core, population up to 49,999)	<p>51,112,552</p> <p>Percent of Total Population: 16.55%</p>

*Urban Influence Codes are based on the Office of Management and Budget's metropolitan- nonmetropolitan designations, and further subdivided by the USDA-Economic Research Service.. County-based metropolitan area definitions have been used for New England (New England County Metropolitan Areas or NECMAs).

Sources:
[2010 Census Urban and Rural Classification and Urban Area Criteria](https://www.census.gov/geo/reference/ua/urban-rural-2010.html), Urban, Urbanized Area, Urban Cluster, Rural Population, 2010 and 2000: United States. (https://www.census.gov/geo/reference/ua/urban-rural-2010.html), U.S. Census Bureau; [2010 Rural Urban Commuting Area Codes](https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx) (https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx), USDA-ERS; [Urban Influence Codes, Documentation, 2013](https://www.ers.usda.gov/data-products/urban-influence-codes/documentation.aspx) (https://www.ers.usda.gov/data-products/urban-influence-codes/documentation.aspx), USDA-ERS

Definitions of Urban & Rural

To find out about community specific
'rurality'...

Am I Rural? Tool

If Rural Populations Are...

Older
Poorer
Sicker

*How to we ensure access to quality healthcare
and other necessary services?*

What is a Rural Health Clinic?

“An RHC is a clinic that is located in a *rural area designated as a shortage area*, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR 405 and 491.”

[CMS Rural Health Clinics Center web page](#)

What is a Rural Health Clinic?

Wikipedia says...

[RHC Definition](#)

www.Wikipedia.com

What is a Rural Health Clinic?

“A rural health clinic (RHC) is a clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs. RHCs were established by the Rural Health Clinic Services Act of 1977 (P.L. 95-210), (Section 1905 of the Social Security Act). The RHC program increases access to health care in rural areas by

- ▶ creating special reimbursement mechanisms that allow clinicians to practice in rural, under-served areas
- ▶ increasing utilization of physician assistants (PA) and nurse practitioners (NP)
- ▶ As of 2018, there were approximately 4,300 RHCs across 44 states in the U.S.^[1] RHCs facilitate 35.7 million visits per year and provide services for millions of people, including 8 million Medicare beneficiaries.^[2]
- ▶ As primary care facilities, RHCs are essential to the health care safety net in rural America.^[3] Unlike FQHCs, RHCs are not legally mandated to provide care to patients who cannot pay but many of their patients are uninsured.^[4] Recent evidence shows that the presence of RHCs enables greater appointment availability for Medicaid patients.^[5]”

What is a Rural Health Clinic?

“The Rural Health Clinic (RHC) program is **intended to increase access to primary care services for patients in rural communities.** RHCs can be **public, nonprofit, or for-profit** healthcare facilities. To receive certification, they must be **located in rural, underserved areas.** They are required to use a team approach of **physicians working with non-physician providers** such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be **staffed at least 50% of the time with a NP, PA, or CNM.** RHCs are **required to provide outpatient primary care services and basic laboratory services.**”

Rural Health Information Hub (RHI-Hub)

www.ruralhealthinfo.org

RHC Fact Sheet

Everything you ever wanted to know about a Rural Health Clinic (RHC).

[CMS Rural Health Clinic Fact Sheet](#)

www.cms.gov



RURAL HEALTH CLINIC

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these Rural Health Clinic (RHC) topics:

- Background
- RHC services
- Medicare certification as an RHC
- RHC visits
- RHC payments
- Cost reports
- Annual reconciliation
- Resources
- Lists of helpful websites and Regional Office Rural Health Coordinators



BACKGROUND

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas. RHCs are paid an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner. Currently, about 4,100 RHCs nationwide furnish primary care and preventive health services in rural and underserved areas. For a State-by-State list of Medicare certified RHCs within each region, refer to the [Current Listing of Rural Health Clinics](#).

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RHC SERVICES

RHCs furnish:

- Physician services
- Services and supplies “incident to” the services of a physician
- NP, PA, certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services
- Services and supplies “incident to” the services of an NP, PA, CNM, and CP
- Medicare Part B-covered drugs furnished by and “incident to” services of an RHC practitioner and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there is a shortage of home health agencies

MEDICARE CERTIFICATION AS AN RHC

To qualify as an RHC, a clinic must be located in:

- A non-urbanized area, as defined by the U.S. Census Bureau
- An area currently designated within the previous 4 years by the Health Resources and Services Administration as **one** of these types of Federally designated or certified shortage areas:
 - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act
 - Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act
 - Medically Underserved Area under Section 330(b)(3) of the PHS Act or
 - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act of 1989

RHCs must:

- Employ an NP or PA (RHCs may contract with NPs, PAs, CNMs, CPs, and CSWs when at least one NP or PA is employed by the RHC)
- Have an NP, PA, or CNM working at the clinic at least 50 percent of the time the RHC operates
- Directly furnish routine diagnostic and laboratory services
- Have arrangements with one or more hospitals to furnish medically-necessary services that are not available at the RHC
- Have available drugs and biologicals necessary for treating emergencies
- Furnish all of these laboratory tests on site:
 - Chemical examination of urine by stick or tablet method or both
 - Hemoglobin or hematocrit

- Blood sugar
- Examination of stool specimens for occult blood
- Pregnancy tests and
- Primary culturing for transmittal to a certified laboratory
- Have a quality assessment and performance improvement program
- Post their days and hours of operation
- Not be a rehabilitation agency or a facility that is primarily for the treatment of mental disease
- Not be a Federally Qualified Health Center and
- Meet other applicable State and Federal requirements

RHC VISITS

RHC visits are medically-necessary face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, NP, PA, CNM, CP, or CSW during which a qualified RHC service is furnished. A Transitional Care Management (TCM) service can also be an RHC visit. In certain limited situations, RHC visits may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

RHC visits may take place:

- In the RHC
- At the patient's residence (including an assisted living facility)
- In a Medicare-covered Part A Skilled Nursing Facility or
- At the scene of an accident

RHC visits may not take place at:

- An inpatient or outpatient hospital (including a Critical Access Hospital) or
- A facility which has specific requirements that preclude RHC visits

Encounters with more than one RHC practitioner on the same day, regardless of the length or complexity of the visit, or multiple encounters with the same RHC practitioner on the same day, constitute a single visit, except when the patient has any of these:

- An illness or injury requiring additional diagnosis or treatment subsequent to the first encounter (for example, he or she sees the practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC)
- A qualified medical visit and a qualified mental health visit on the same day
- An Initial Preventive Physical Examination (IPPE) and a separate medical and/or mental health visit on the same day

RHC PAYMENTS

The AIR is subject to a maximum payment per visit that is established by Congress and updated annually based on the percentage change in the Medicare Economic Index and subject to annual reconciliation. The per-visit limit does not apply to RHCs determined to be an integral and subordinate part of a hospital with fewer than 50 beds. Laboratory tests (excluding venipuncture) and technical components of RHC services are paid separately.

The coinsurance for Medicare patients is 20 percent of total charges, except for certain preventive services. Patient cost-sharing requirements for most Medicare-covered preventive services are waived, and Medicare pays 100 percent of the costs for these services. No coinsurance or deductible is required for the IPPE, Annual Wellness Visit, and any covered preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force. For more information about preventive services, including coinsurance and deductible requirements, refer to the [Rural Health Clinic \(RHC\) Preventive Services Chart](#).

The Part B deductible applies to RHC services and is based on total charges. Non-covered expenses do not count toward the deductible. After the deductible has been satisfied, RHCs are paid 80 percent of the AIR for each RHC visit, with the exception of any preventive services reimbursed by Medicare at 100 percent of cost.

Effective January 1, 2018, RHCs can receive payment for:

- Chronic Care Management (CCM) or general Behavioral Health Integration (BHI) services when 20 minutes or more of CCM or general BHI services are furnished and RHCs bill HCPCS code G0511 either alone or with other payable services. For CCM services furnished on or before December 31, 2017, RHCs bill CPT code 99490 alone or with other payable services on an RHC claim.
- Psychiatric Collaborative Care Model (CoCM) services when 70 minutes or more of initial psychiatric CoCM services or 60 minutes or more of subsequent psychiatric CoCM services are furnished and RHCs bill HCPCS code G0512 either alone or with other payable services on an RHC claim.

Influenza and Pneumococcal Vaccine Administration and Payment

The costs of the influenza and pneumococcal vaccines and their administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the cost report to report the cost of these vaccines and their administration. These costs should not be reported on an RHC claim when billing for RHC services. The patient pays no Part B deductible or coinsurance for these services. When an RHC practitioner sees a patient for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the costs of the vaccines and their administration are included on the annual cost report and reimbursed at cost settlement.

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Hepatitis B Vaccine (HBV) Administration and Payment

The cost of the HBV and its administration are covered under the RHC's AIR. If other services that constitute a qualifying RHC visit are furnished on the same day as the HBV, the charges for the vaccine and its administration should be reported on a separate line item to ensure that the deductible and coinsurance are not applied. When an RHC practitioner sees a patient for the sole purpose of administering this vaccination, the RHC may not bill for a visit; however, the costs of the vaccine and its administration are included on the annual cost report. In this instance, the charges for the HBV may be included on a claim for the patient's subsequent RHC visit.

Payment for Telehealth Services

RHCs are authorized to serve as an originating site for telehealth services if the RHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. RHCs that serve as an originating site for telehealth services are paid an originating site facility fee. Charges for the originating site facility fee may be included on a claim, but the originating site facility fee may not be included on the cost report.

RHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished.

COST REPORTS

RHCs must file a cost report annually to determine their payment rate and reconcile interim payments, including adjustments for graduate medical education payments, bad debt, and influenza and pneumococcal vaccines and their administration. Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report.

Hospital-based RHCs must complete Worksheet M of Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report. Other provider-based RHCs must complete the appropriate set of RHC worksheets on the cost report filed by the parent provider.

To find more information about cost reports and forms, refer to the [Provider Reimbursement Manual – Part 2](#).

ANNUAL RECONCILIATION

At the end of the annual cost reporting period, the RHC submits a report to the Medicare Administrative Contractor (MAC) that includes total allowable costs and total visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the MAC divides allowable costs by the number of actual visits to determine a final rate for the period. The MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. Both the interim and final payment rate are reviewed for productivity, reasonableness, and payment limitations. Contact your [MAC](#) if you have questions about the Medicare Program.

RESOURCES

RHC Resources

For More Information About...	Resource
RHCs	<p>Rural Health Clinics Center</p> <p>CMS.gov/center/provider-type/rural-health-clinics-center.html</p> <p>Chapter 13 of the Medicare Benefit Policy Manual (Publication 100-02)</p> <p>Chapter 9 of the Medicare Claims Processing Manual (Publication 100-04)</p> <p>Appendix G of the State Operations Manual (Publication 100-07)</p>
All Available Medicare Learning Network® Products	MLN Catalog
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Current Listing of Rural Health Clinics	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf
Rural Health Clinic (RHC) Preventive Services Chart	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf
Provider Reimbursement Manual – Part 2	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
MAC	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Chapter 13 of the Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
Chapter 9 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
Appendix G of the State Operations Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c08.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

HELPFUL WEBSITES

American Hospital Association Rural Health Care

<https://www.aha.org/advocacy/small-or-rural>

Critical Access Hospitals Center

<https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html>

Disproportionate Share Hospitals

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>

Federally Qualified Health Centers Center

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

Health Resources and Services Administration

<https://www.hrsa.gov>

Hospital Center

<https://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

Medicare Learning Network®

<http://go.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<https://narhc.org>

National Rural Health Association

<https://www.ruralhealthweb.org>

Rural Health Clinics Center

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Rural Health Information Hub

<https://www.ruralhealthinfo.org>

Swing Bed Providers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html>

Telehealth

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

Telehealth Resource Centers

<https://www.telehealthresourcecenter.org>

U.S. Census Bureau

<https://www.census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to [CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf).

[Medicare Learning Network® Product Disclaimer](#)

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What is the difference between a provider-based RHC and an independent RHC?

- ▶ **Provider-based RHCs** are owned and operated as an “essential” part [or department of] of a hospital, nursing home, or home health agency participating in the Medicare program. RHCs operate under the license, governance, and professional supervision of that organization. Most are hospital-owned.
- ▶ **Independent RHCs** are free-standing clinics owned by a provider or a provider entity (for-profit or not-for-profit). They may be owned and/or operated by a larger healthcare system, but *do not qualify for, or have not pursued*, provider-based status. More than half of independent RHCs are owned by providers/clinicians.

What is the “enhanced reimbursement”?

MEDICARE -

“RHCs receive an interim all-inclusive rate (AIR) payment per visit throughout the clinic's fiscal year, which is then reconciled through cost reporting at the end of the year. According to CMS's Medicare Benefit Policy Manual - Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, the interim payment rate is determined by taking the total allowable costs for RHC services divided by the total number of visits provided to RHC patients receiving core RHC services. In addition, RHCs are subject to productivity, payment limits, and other factors which can affect payment.

- ▶ RHCs staff must meet traditional Medicare regulations for coding and documentation, as well as unique RHC billing requirements.”

Source: Rural Health Information Hub (RHI-Hub)

<https://www.ruralhealthinfo.org/topics/rural-health-clinics#medicare>

What is the “enhanced reimbursement”?

MEDICAID -

“All state Medicaid programs are required to recognize RHC services. The states may reimburse RHCs under one of two different methodologies as outlined in a [2016 CMS letter to state health officials](#).

- ▶ The first is a prospective payment system (PPS). Under this methodology, the state calculates a per visit rate based on the reasonable costs for an RHC's first two years of operation.
- ▶ The second methodology is an alternative payment methodology. Under this methodology, there are only two requirements: 1) the clinic must agree to the methodology, and 2) the payment must at least equal the payment it would have received under the prospective payment system. State Medicaid agencies should be contacted to determine how RHC rates are determined in their state.

You can contact [your state Medicaid Office](#) or [CMS Regional Office Rural Health Coordinator](#) for information on how Medicaid pays for RHC services in your state.”

What does it mean to have - or not - an RHC?

The main advantage of RHC status is enhanced reimbursement rates for providing Medicare and Medicaid services. (RHI-Hub)

Other Potential Benefits:

- **Financial Benefit**
 - If hospital is less than 50 beds Medicare reimbursement is not subject to the cap (2019 is \$84.70)
 - Some hospital costs can be reallocated to the RHC
 - Increased volume for the hospital (lab, x-rays and in-patient volume)

What does it mean to have - or not - an RHC?

- **Community Benefit**
 - Hospital is not limited to in-patient care
- **Caution!**
 - CAHs can only expand RHCs within 35 miles of the hospital. If they expand out-patient services (non-RHC) there is potential risk to maintaining the CAH designation. Make sure the state regulatory agency as well as the State Office of Rural Health is aware there is pursuit of RHC development

What about Regulations and Administrative Burden?

Thanks to our friends at NARHC - CMS had Proposed Rules out for comment in the fall (comments were due by November 19, 2018) -

Some of the RHC-specific changes were:

- ▶ Changing the annual review of patient care policies and program evaluations to an every-other-year requirement.
- ▶ Allowing facilities to review their Emergency Preparedness program every other year instead of every year.
- ▶ Eliminating the requirement that RHCs must document their communication with emergency preparedness officials.
- ▶ Allowing facilities to train their staff on emergency preparedness every other year.
- ▶ Reducing the number of emergency preparedness exercises required per year to one.

Other Burdens and Barriers to Rural Healthcare Service

- ▶ “In order for rural residents to have sufficient access, necessary and appropriate healthcare services must be available and obtainable in a timely manner. Even when an adequate supply of healthcare services exists in the community, there are other factors to consider in terms of healthcare access. For instance, to have good healthcare access, a rural resident must also have:
 - ▶ Financial means to pay for services, such as health or dental insurance that is accepted by the provider
 - ▶ Means to reach and use services, such as transportation to services that may be located at a distance, and the ability to take paid time off of work to use such services
 - ▶ Confidence in their ability to communicate with healthcare providers, particularly if the patient is not fluent in English or has poor health literacy
 - ▶ Trust that they can use services without compromising privacy
 - ▶ Belief that they will receive quality care”

Do You Have an RHC in Your Community?

National Association of Rural Health Clinics MAP
of RHCs in US
(NARHC)

<https://narhc.org/>

National Organization of State Offices of Rural Health



NOSORH promotes the capacity of State Offices of Rural Health to improve health care in rural America through leadership development, advocacy, education and partnerships.

The Role of SORH

- Neutral conveners
- Source for rural health data
- Expert at leveraging resources
- Connection to statewide and national partners



Power of Rural

Founded to bring attention to:



- Rural America is a great place to live and work and be a healthcare provider
- Quality and innovation are abundant in rural communities
- Disparities do exist and can be addressed through joint national, state and local efforts
- Growing beyond the day into a movement!

Visit PowerofRural.org

November 21, 2019

**National Rural
Health Day**
Celebrating the Power of Rural!



Power of Rural

Share information about the impact of Rural & RHCs in your state:

Nominate a Community Star

Plan an educational event

Make an award

Invite legislators to visit rural areas & RHCs

***Share the Power of Rural through -
Communication!
Education!
Collaboration!
Innovation!***

November 21, 2019



What can you do?

- Continue learning with us -
Coming TA education attractions!
- Tap into the State Office of Rural Health in your state - it is the “one-stop-shop” of Rural Health Expertise!
- Connect with state policy makers
- Build relationships and utilize “official” policy contacts in your state
- When you don’t know where to go - reach out to your State Office of Rural Health (SORH) or me!

That’s why I’m here!

(Contact information is at the end of slide deck!)



Rural Realities to Common Sense

Howard Chapman, Jr.
Director of Programs
and Development
UNC Asheville
Asheville, NC



Tri-Area Community Health



Tri-Area Community Health

- ▶ **Types of Primary Care Models (4 basic Models)**
 1. Private Practice, (solo or group) - Most common model of care, but no requirement for indigent care. **(Hospital owned groups or networks)**
 2. Rural Health Clinic, (RHC) - Receive Cost Based Reimbursement for Medicare and Medicaid patients, but have no requirement for indigent care. They do require a NP or PA 20 hours per week.
 3. Free Clinic, - Rely heavily on volunteer staffing and have limited hours of operation. Provide indigent care, but some require the patient or dependent be employed. Most do not serve those above 200% of the Federal Poverty Guidelines.
 4. Community Health Centers, - Receive federal funding to serve the indigent and uninsured and accept self pay and insured patients as well. (Access to all patients). Receive Cost Based Reimbursement as an FQHC for Medicare and Medicaid patients.

- ▶ **Other sources of Primary Care**
- ▶ **Emergency Rooms**
- ▶ **Health Departments**
- ▶ **Urgent Care Clinics**

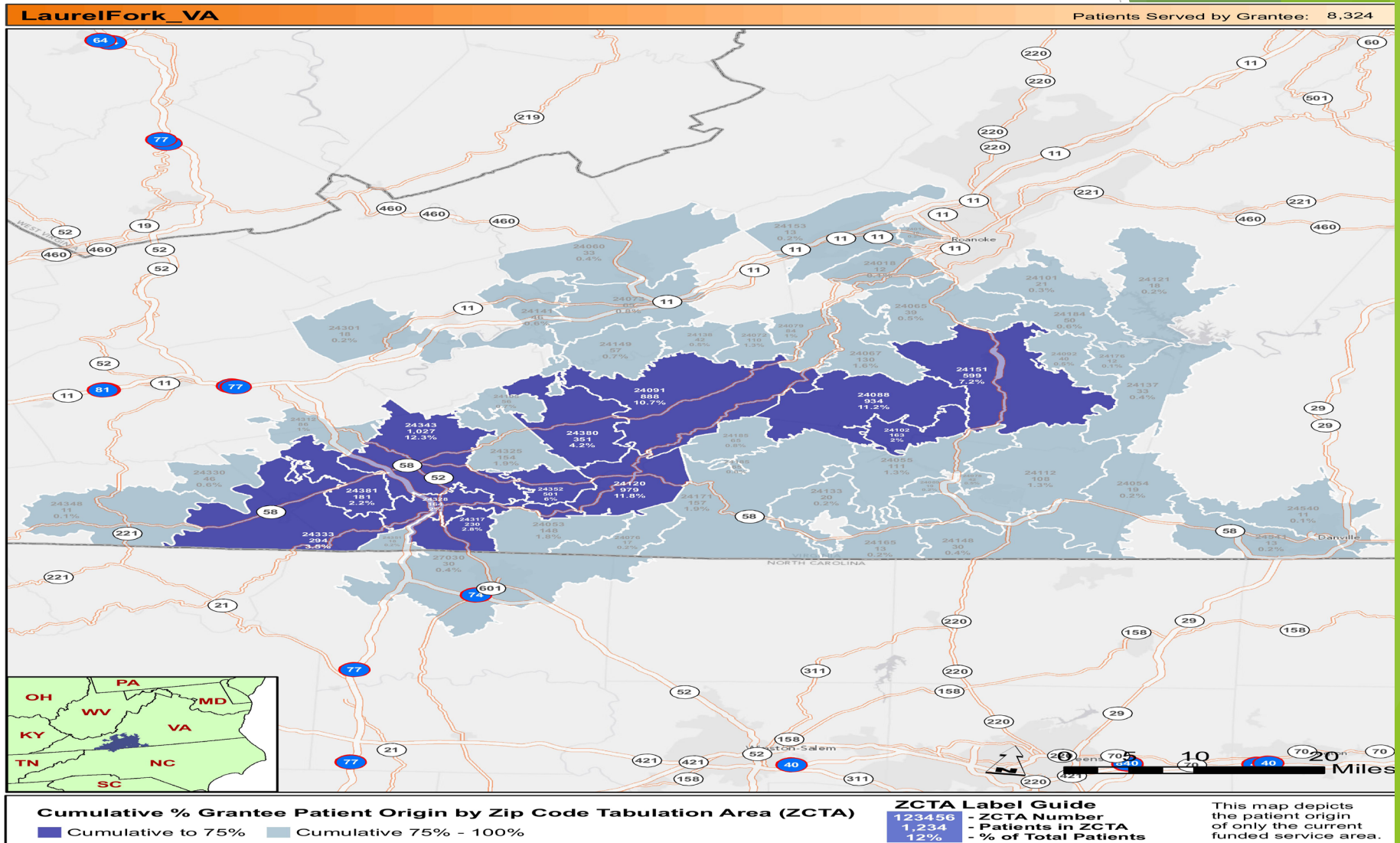
Bureau of Primary Health Care (BPHC) Section 330 Community Health Center Program

- ▶ Part of President Johnson's War on Poverty effort
- ▶ Public/Private Partnerships
- ▶ Governed by volunteer non-profit Board of Directors (51% must be users of the services by law)
- ▶ Addresses the health care needs of the local community
- ▶ Serve all regardless of the ability to pay
- ▶ Federal grant is used to underwrite the indigent care provided to qualified patients
- ▶ About 27% of our Total Budget comes from the Federal Grant and the other 73% we generate through Fee-for-Service and insurance contracts
- ▶ FQHC Provider status allows cost-based PPS reimbursement for CHCs for Medicare Patients
- ▶ Medicaid pays on a Perspective Payment System Rate (Based on established cost with annual 3.5% increase)

HRSA Program Requirements

1. **Needs Assessment (Annual)**
2. **Required and Additional Health Services (Scope of Service)**
3. **Clinical Staffing**
4. **Accessible Locations and Hours of Operation**
5. **Coverage for Medical Emergencies During and After Hours**
6. **Continuity Of Care and Hospital Admitting**
7. **Sliding Fee Program**
8. **Quality Improvement/Assurance**
10. **Key Management Staff**
11. **Contracts and Subawards**
12. **Conflict of Interest**
13. **Collaborative Relationships**
14. **Financial Management and Accounting Systems**
15. **Billing and Collections**
16. **Budget**
17. **Program Monitoring and Data Reporting Systems**
18. **Board Authority**
19. **Board Composition**

HRSA Service Area Map



Tri-Area Community Health



Tri-Area Community Health

- ▶ NCQA Level III Recognition as a Patient Centered Medical Home
- ▶ Provide Comprehensive Services that include Primary Care and Preventative Services
- ▶ Provide Mental Health Counseling on-site
- ▶ Full Retail Pharmacy at Laurel Fork and Ferrum sites (340-B Medications)
- ▶ Provide medication assistance through the Medication Assistance Program (MAP) with funding through the Virginia Health Care Foundation
- ▶ Network with private providers, health departments, hospitals, free clinics, and others for indigent patient care



Tri-Area Community Health Centers



Tri-Area Community
Health Center
AT FERRUM



Tri-Area Community
Health Center
AT FLOYD



Tri-Area Community
Health Center
AT LAUREL FORK

Humble Beginnings

Tory Creek Baptist Church

Meadows of Dan, VA

- 1979 - Laurel Fork Health Commission, a community owned, non-profit corporation was formed to bring healthcare to remote portions of Carroll, Floyd and Patrick Counties.
- 1982 - Tri-Area Health Clinic opened in the basement of Tory Creek Baptist Church in Meadows of Dan.





Tri-Area Community Health



- 1982 - Tri-Area Health Clinic opened in their new facility at 14168 Danville Pike in Laurel Fork.
- This new facility had
 - ✓ 5 Exam Rooms
 - ✓ 1 Treatment Room
 - ✓ Lab
 - ✓ X-ray
 - ✓ Administrative Space
- Private Pharmacy and Dental services were added in 1987.
- Tri-Area Pharmacy opened in 1993

Laurel Fork Site



June 2003
Tri-Area Community Health
Center
And Pharmacy Opens



Laurel Fork Services



12,500 Square Feet Site

- 12 Exam Rooms
- Treatment Room for emergencies
- Lab Services
- Meeting Rooms
- 5 Physician Offices
- Spacious Waiting Room
- Administrative Offices
- 2,000 Square Feet Pharmacy With Large OTC Area
- 27 employees including 2 FP's, 2 NP's, 1 pharmacist, Clinical Psychologist
- UVA Telemedicine Link (access to 24 specialties)



Ferrum Site



August 2006

Laurel Fork Health
Commission
began student health services
in the existing Student Health
Center at Ferrum College.

Construction was underway
for the new 5,000 sq. ft.
Ferrum Community Health
Center on the lower level of
Vaughn Chapel on the Ferrum
College Campus.

**New HRSA Funding - \$1
million grant for construction
of 16,300 sq. ft. facility.**



Ferrum College Chapel



Tri-Area Community Health



January 2007 Ferrum Community Health Center Opens

- 7 Exam Rooms
- Treatment Room for Emergencies
- Lab Services
- Administrative Offices
- Meeting Room
- Waiting Room
- Full Service Pharmacy
- 22 employees

Ferrum Site

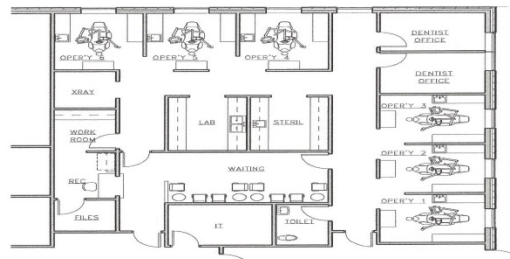
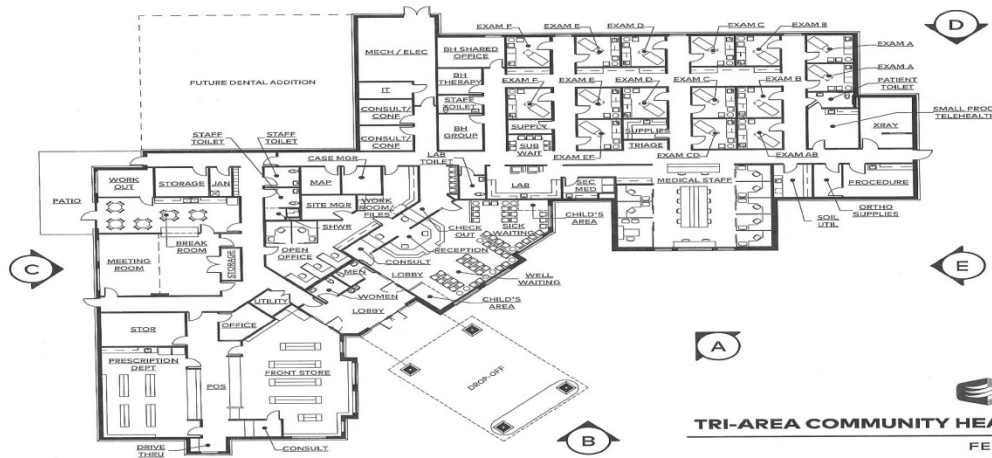


Services

- Digital X-Ray
- Lab Services
- Case Management
- Medication Assistance Program
- Minor Surgery
- EKG
- Family Health including Pediatrics, Geriatrics, Physicals and Disease Management
- Pharmacy
- Durable Medical Equipment
- Family Planning
- Student Health Services
- Treatment of Minor Emergencies
- UVA Telemedicine Link

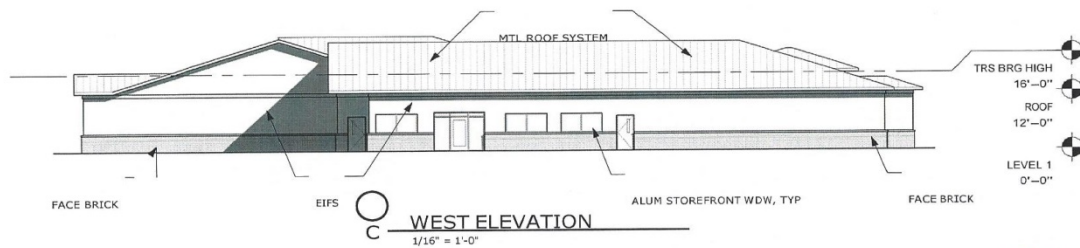
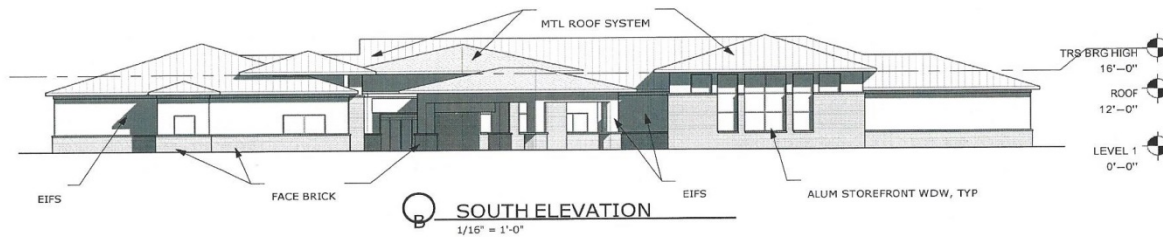
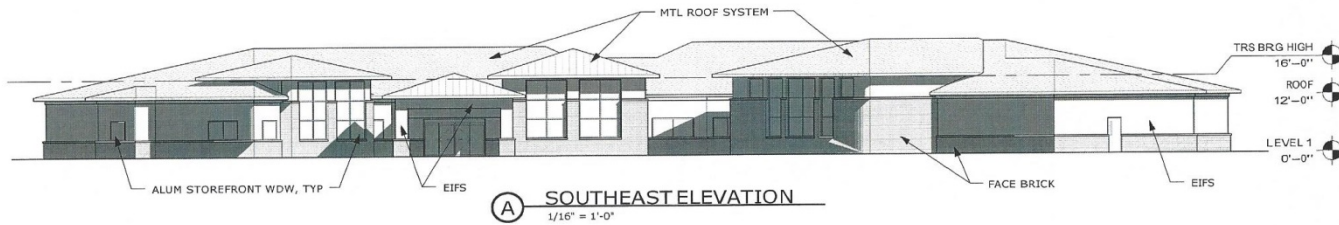


Proposed New Ferrum Site



DENTAL FLOOR PLAN
1/8" = 1'-0"

Concept Drawings



TRI-AREA COMMUNITY HEALTH CLINIC



Floyd County Site

It was a long hard winter but we finally opened
in March 2010



Tri-Area Community Health

Floyd Co. Site



8,000 Square Feet Site

- 8 Exam Rooms
- Treatment Room for emergencies
- Lab Services
- Meeting Room
- 4 Physician Offices
- Spacious Waiting Room
- Executive and Administrative Offices
- 11 employees with 2 Docs, 1 NP
- Clinical Psychologist & PT Psychiatrist



Floyd County Site



Services

- Digital X-Ray
- Lab Services
- Case Management
- Medication Assistance Program
- Minor Surgery
- EKG
- UVA Telemedicine Link
- Pediatrics, Geriatrics, Physicals and Disease Management
- Family Planning
- Colposcopy
- Treatment of Minor Emergencies





Tri-Area Community Health

2017 STATS

➤ Calendar Year 2017

- Patients = 9,840
- Medical/BH Provider Visits = 31,167
- Total Patient Visits including Enabling = 32,963
- Employees = 95 (83.12 FTE) Including 18 providers (14.82 FTE)

➤ Fiscal Year 2019

Budget = \$8,739,918

Federal Grant = \$2,356,394



Tri-Area Community Health

<u>Patient Mix</u>	<u>2017</u>
➤ Medicare -	23.1%
➤ Medicaid -	18.6%
➤ Private Insurance -	42.4%
➤ Uninsured -	15.9%
➤ Below 200% Poverty -	77.9%

Medication Assistance Program

- ▶ Virginia Health Care Foundation Grant - \$54,665
- ▶ October 2017 - September 2018
- ▶ Tri-Area Community Health helped a total of 714 patients
- ▶ receive 2,978 free prescriptions.
- ▶ Total Retail Value of Medication:

\$4.4 million

***Return on State Investment - \$80.64 per every \$1 invested**



Tri-Area Community Health

Integrated Behavioral Health

- ▶ New Program at Laurel Fork (March 2012)
- ▶ Virginia Health Care Foundation Grant \$98,250
- ▶ **HRSA Behavioral Health Integration (BHI) Grant - \$485,000/year**
- ▶ Brief counseling on problem solving and coping skills
- ▶ Coordination with the Primary Care Provider (Use the same medical record)
- ▶ Improved Outcomes
 - Local Radford Study of 251 patients noted 49.8% improved their PHQ-9 depression scores by 50% and 94.8% showed some improvement in their PHQ-9 scores
 - Patients continue to work and function with better control
 - Patients avoid long-term medications
 - 70% of behavioral health patients can be served in this model and 30% still need traditional mental health counseling

Collaboration

SPECIALTY CARE

University of Virginia Telemedicine Program

- 24 separate specialties available to our patients
- They have a Sliding Fee Scale for qualified patients
- Digital Mammography Van for screenings at our sites
- Digital Retinopathy Screenings for diabetic patients
*** Goal of reading within 20 minutes**
- Provide Patient Education through telemedicine
- Provider and staff CME



Tri-Area Community Health

- ▶ Franklin Memorial Hospital
 - HENI Program (Health Efficiency Navigation Initiative)
 - ✓ 62% of uncompensated care was through Emergency Services
 - ✓ 20% of a person's well-being is affected by access to care
 - Focus on established Patient Medical Home and reduced ER visits
 - Carilion has an Accountable Care Community Designation
- ▶ Ballad Health's Accountable Care Community Development
 - Tri-Area Community Health is one of 150 community partners working the Ballad Health ACC Strategic Plan

- ▶ **VA Choice Program for Outpatient Veteran's Care (Tri-Area was one of four FQHCs Nationwide in the "Pilot" for this program**
- ▶ **Diabetes Quality Improvement Program**
 - Endocrinologist to follow uncontrolled diabetic patients with a HbA1c of 8% or higher
 - Tied to the Certified Diabetes Education Classes through the UVA Office of Telemedicine and the digital retinopathy screenings
 - The use of "Home Monitoring" to collect daily measures on the patient and assure compliance with self-management goals
- ▶ **CMS Grant with Radford University - Training Clinical Psychologist in rural areas (post graduate Fellowships)**



Other Issues

- ▶ **Medicaid Managed Care Expansion - July 1, 2012 into southwest Virginia**
 - traditionally paid on a fee-for service basis (Medicaid patients doubled)
 - not enough primary care physicians to cover southwest Virginia in the past
 - Six (6) MCOs currently contracting in the southwest market
- ▶ **Patient Centered Medical Home - will provide an overall change in how medical care is delivered in this country (pay for performance by 2018)**
 - Focus on prevention and treating the whole patient
 - Coordination of Care among all providers treating the patient
 - Primary care driven
 - Potential for pay for performance through improved outcomes and shared savings
- ▶ **Fiscal Cliff and a possible 70% cut in FQHC Funding by October 1, 2019**



Other Needs in Our Service Area:

- **Transportation** - No mass transportation and only limited taxi service.
- **Dental/Oral Health** - A PEW Charities Report noted 48% of Medicaid covered children in Virginia in 2011 did not have a dental visit

Possible Cause:

- Shortage of dental providers in rural areas
- Lack of Virginia dentists who participate in Medicaid due to low reimbursement

National Health Service Corps



NHSC PROGRAMS PROVIDE FUNDING TO PRIMARY HEALTH CARE PROVIDERS IN EXCHANGE FOR SERVICE.

- ✓ **Students pursuing primary care careers:** The Scholarship Program pays for tuition and fees of future primary care providers, including physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants.
- ✓ **Primary care providers interested in serving communities in need:** The Loan Repayment Program provides up to \$50,000 for loans in primary care—medical, dental, or mental/behavioral health.
- ✓ **Students in the final year of medical or dental school pursuing primary care careers:** The Students to Service Program provides up to \$120,000 to students pursuing degrees in primary care and are in their final year of medical or dental school.

 VISIT [NHSC.HRSA.GOV](https://www.nhsc.hrsa.gov)

Rural Hospitals & Healthcare

*What you don't
know about
your local
hospital could
kill you ...*

Dale Clark, BS Pharm, MSHA, FACHE
Chief Operating Officer
Indian Path Community Hospital
Ballad Health
Kingsport, Tennessee

BalladHealth[™] 
It's your story. We're listening.

State-by-state breakdown of 93 rural hospital closures

Ayla Ellison (Twitter | Google+) - Tuesday, December 18th, 2018 [Print](#) | [Email](#)

[SHARE](#) [Tweet](#) [Share 39](#)

Of the 26 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program.

Seventeen hospitals in Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with nine hospitals closing since 2010. In third place is Georgia with seven closures.

Listed below are the 93 rural hospitals that closed between Jan. 1, 2010, and Dec. 17, 2018, as tracked by the NCRHRP. For the purposes of its analysis, the NCRHRP defined a hospital closure as the cessation in the provision of inpatient services. As of Dec. 17, 2018, all of the facilities listed below had stopped providing inpatient care. However, some of them still offered other services, including outpatient care, emergency care, urgent care or primary care.

Wellmont Health System closing Lee County hospital

Reasons cited include low use and cuts in Medicare reimbursements

BRISTOL HERALD COURIER Sep 11, 2013



[f](#) [t](#) [e](#) [b](#) [l](#)

Lee Regional Medical Center, a 70-bed hospital in Pennington Gap, Va., will close Oct. 1.

HEALTH NEWS [Fact Checked](#)

Rural Hospitals Closing at an Alarming Rate



When Terry Fulmer's 90-year-old aunt fell and tore her shoulder ligaments, she had surgery in Albany, a two-hour drive from her home in rural upstate New York.

REBUILDING A COMMUNITY

'The hospital was a force holding the community together. Without it, I think this community probably will disintegrate'

By Shelby Livingston

Rural Tennessee town feels the downstream effects of its only community provider shutting its doors.

Financial Management



1 in 5 rural hospitals at high risk of closing, analysis finds

Kelly Gooch - Wednesday, February 20th, 2019 [Print](#) | [Email](#)

[SHARE](#) [Tweet](#) [Share 120](#)

Twenty-one percent of U.S. rural hospitals are at high risk of closing unless their finances improve, according to an [analysis](#) from management consultancy firm Navigant.

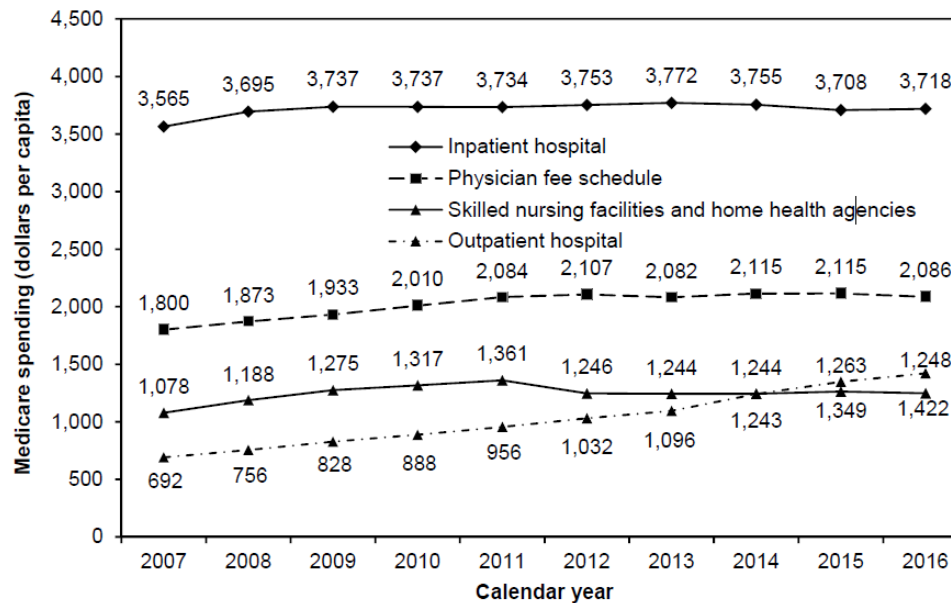
The study also found 64 percent, or 277, of high financial risk rural hospitals are considered essential to their communities.

What's happening . . .

- ▶ Reimbursement
 - ▶ Medicare
 - ▶ Medicaid
 - ▶ Commercial
 - ▶ Uninsured
- ▶ Rural Economy
- ▶ Rural Demographics
- ▶ Healthcare delivery

Reimbursement . . . Medicare

Chart 1-4. Per capita Medicare spending for FFS beneficiaries, by sector, 2007–2016



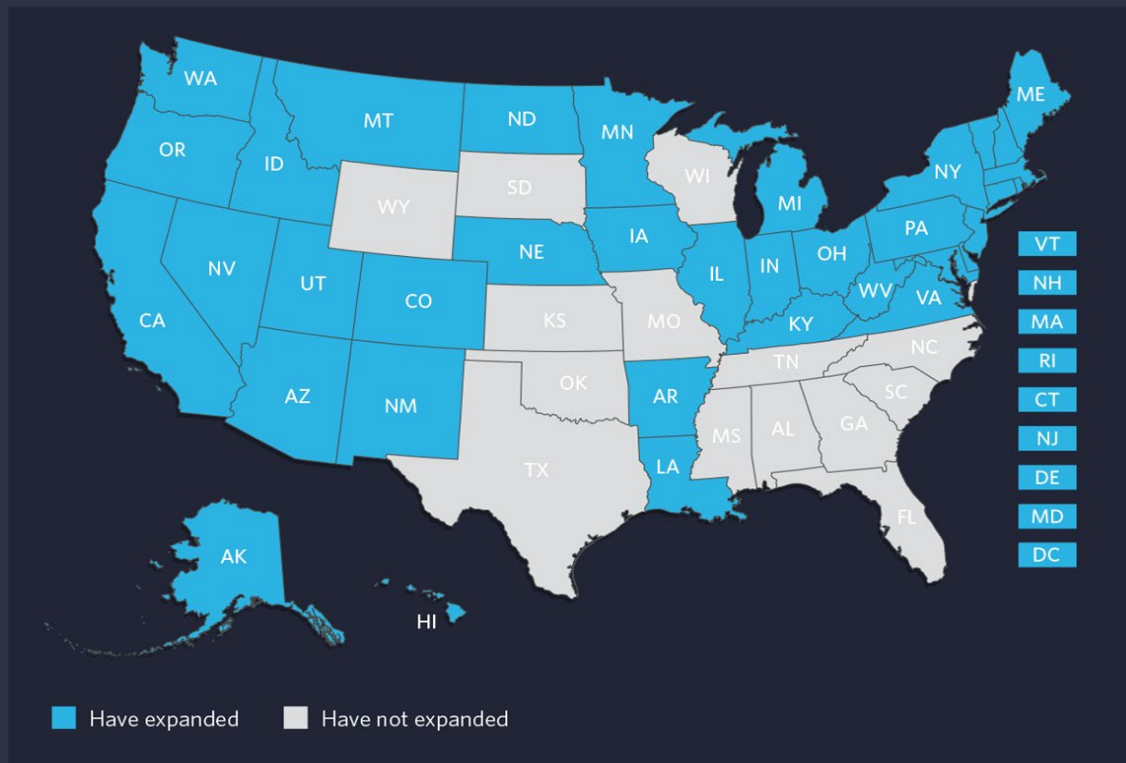
Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included. Spending per beneficiary for inpatient hospital services equals spending for the sector (see Chart 1-3) divided by FFS enrollment in Part A. Spending per beneficiary for physician fee schedule services and outpatient hospital services equals spending for the sector (see Chart 1-3) divided by FFS enrollment in Part B. Spending per beneficiary for skilled nursing facilities and home health agencies equals spending for those sectors (see Chart 1-3) divided by total FFS enrollment.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2017.

Reimbursement . . . Medicaid

Medicaid Expansion, 2019

Thirty-six states and the District of Columbia have expanded Medicaid to low-income adults.



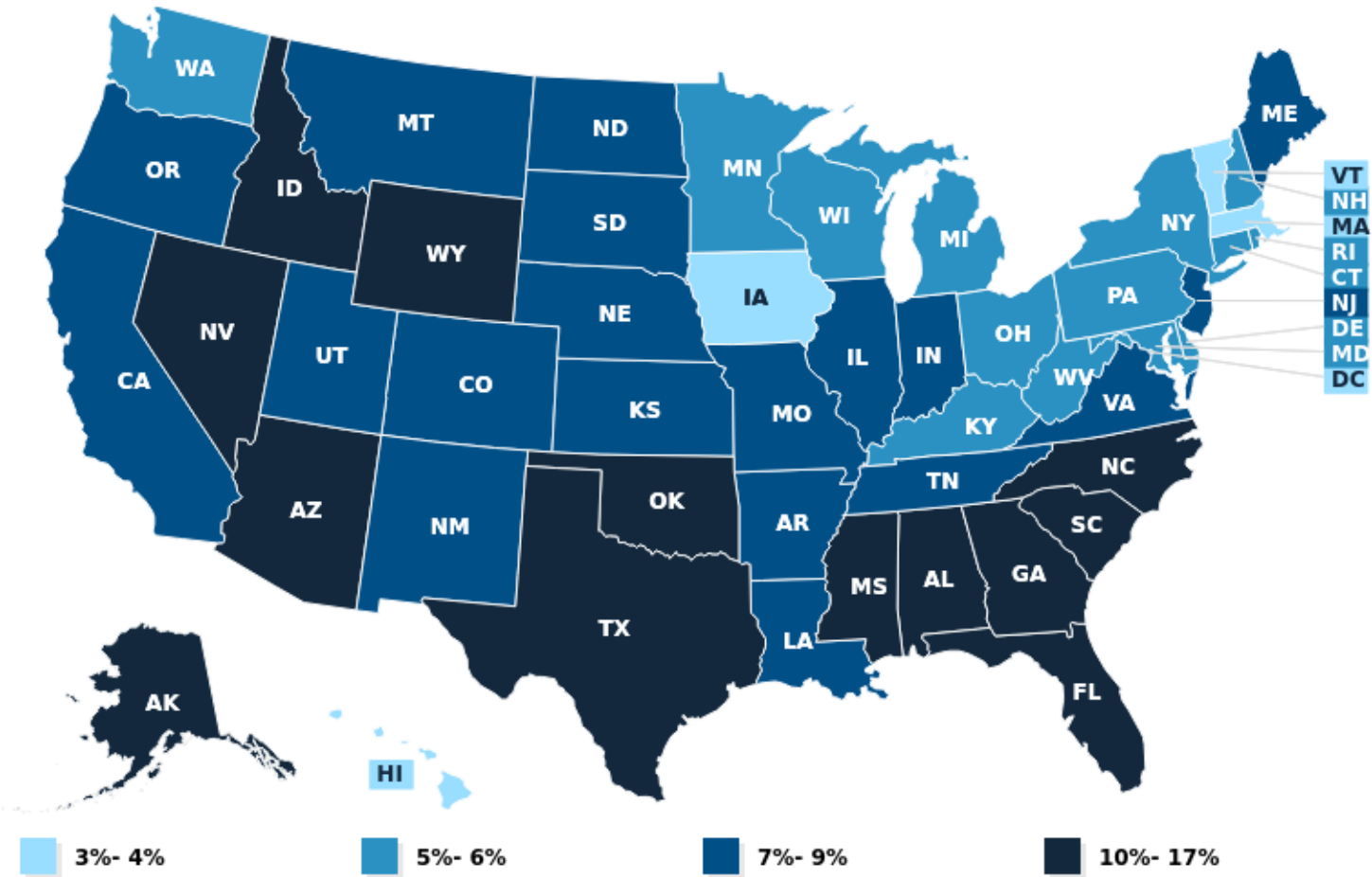
Source: *Stateline* research

© 2019 The Pew Charitable Trusts

Reimbursement . . .

Uninsured

Health Insurance Coverage of the Total Population: Uninsured, 2017



SOURCE: Kaiser Family Foundation's State Health Facts.

Rural Economy . . .

STATISTATS

Rural America Still Seeking Recovery

Rural America encompasses 72 percent of the country's land and is home to 46 million residents. But the quality of life in rural areas is not keeping pace with that in urban communities. While most urban areas, with highly educated workforces, have recovered from the Great Recession, rural, small-town America has not.

Rural America has been in recession since a period of growth in the 1990s—far longer than the nation as a whole, according to a report on rural poverty released in December by the Carsey School of Public Policy at the University of New Hampshire.

Since 2000, the economies of rural regions with less than 50,000 workers have grown by an average of 1.6 percent, compared with 9.1 percent in cities with workforces larger than 1 million. As jobs have dried up, especially in manufacturing (down 20 percent since 2000) and mining, rural residents have migrated to cities. Since 2010, the rural population has decreased by more than 462,000 people.

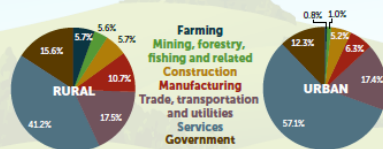
Reasons for the job losses include automation of blue collar jobs, giant online retailers undercutting mom-and-pop businesses and an over-reliance on a single industry or business. With the loss of jobs comes a spike in poverty. The portion of rural counties with a poverty rate greater than 20 percent jumped from one-fifth in 2000 to one-third in 2015. Since 2007, however, the median income of rural Americans has remained around 25 percent less than the urban median—\$45,295 compared with \$60,542 in 2016.

—Magazine staff

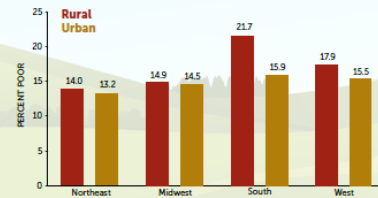
How Is Poverty Defined?

People are officially in poverty when their annual income is below a federally determined amount based on family size. In 2016, for example, the poverty line was \$12,486 for an adult under age 65; \$19,318 for a couple with one child; and \$28,643 for a couple with three children.

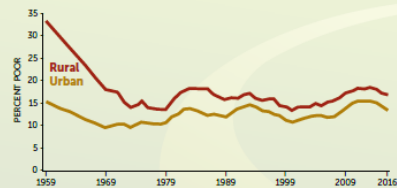
America's Employers, 2015



Average Poverty Rates by Region, 2011-15

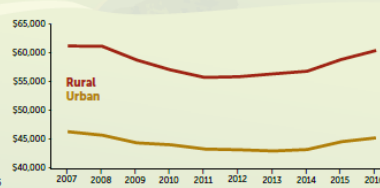


Poverty Rates Since 1959



Note: Some counties changed from rural to urban in 1984, 1994, 2004 and 2014.

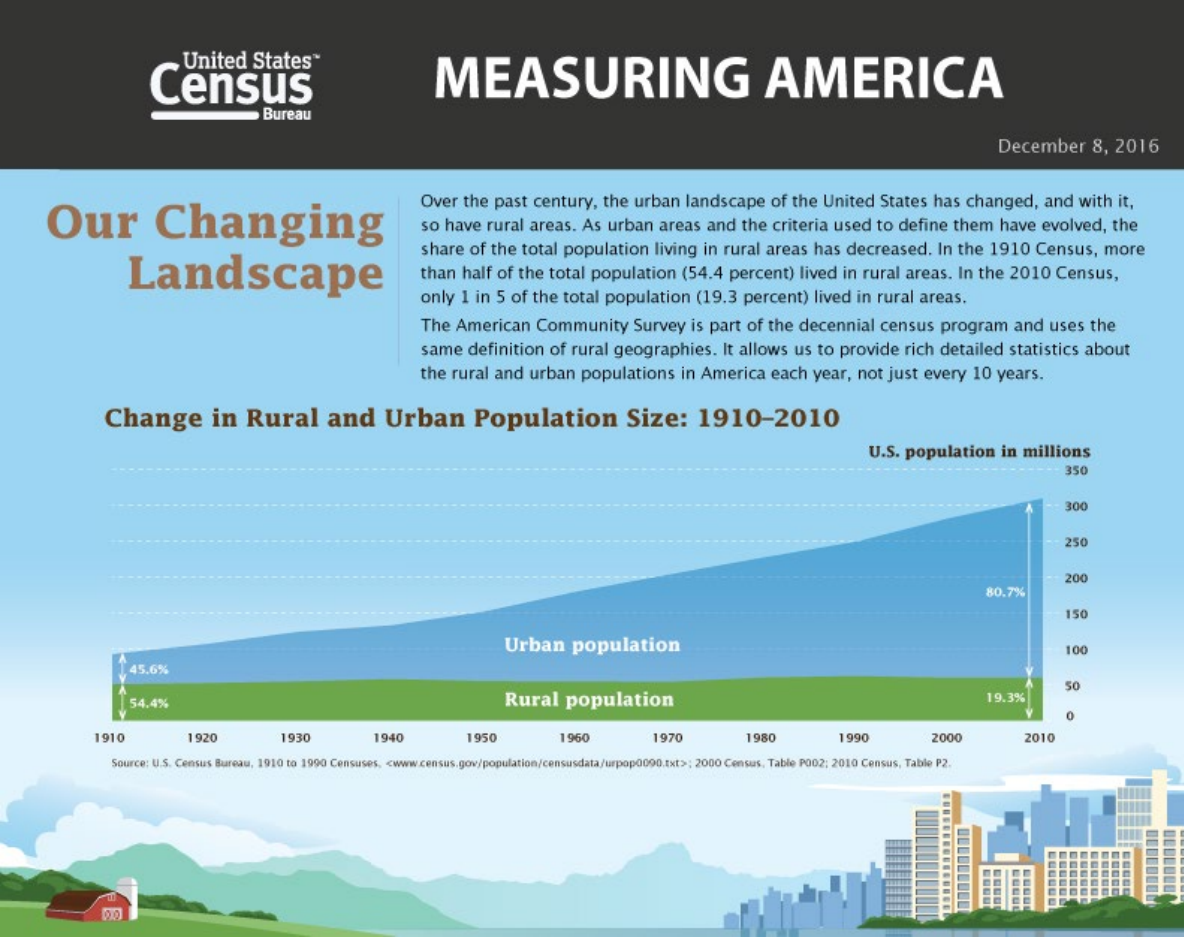
Mean Household Incomes, 2007-16



Note: The definition of metropolitan areas changed in 2013, reducing the number of rural households by 1.7 million.

Sources: U.S. Department of Agriculture, Economic Research Service; Bureau of Economic Analysis; Governing; U.S. Bureau of Labor Statistics; U.S. Census Bureau, U.S. Department of Commerce

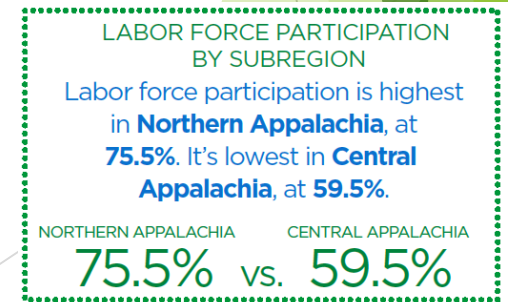
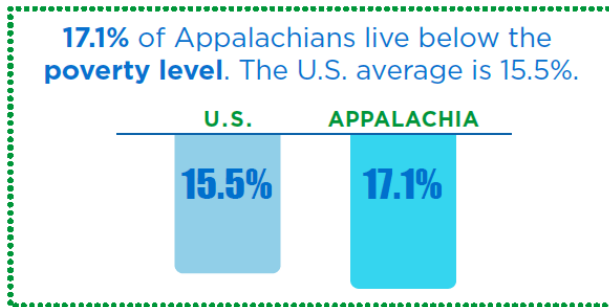
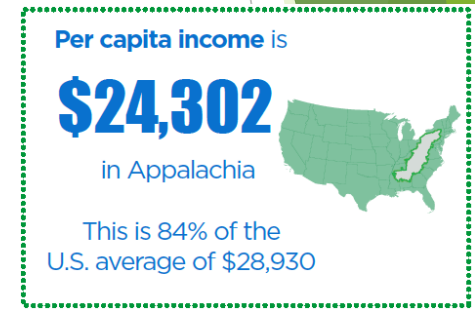
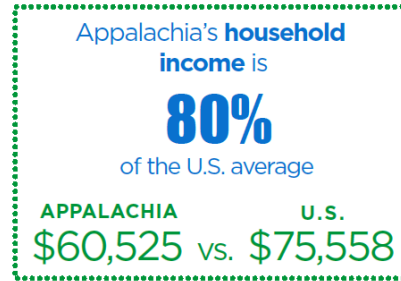
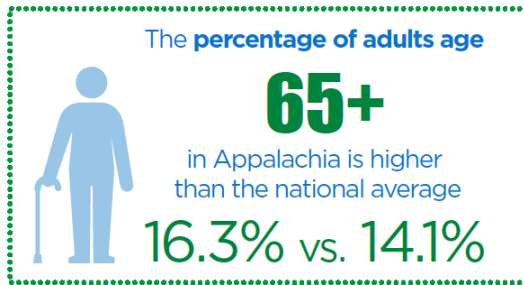
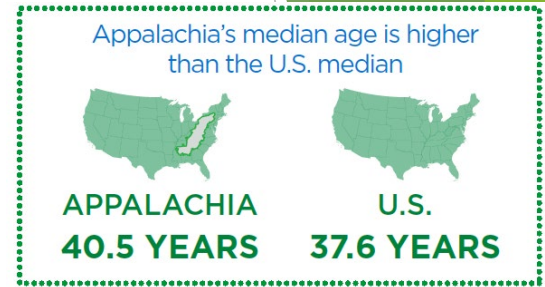
Rural Demographics. . .



Rural Demographics. . .



DATA SNAPSHOT APPALACHIA'S POPULATION

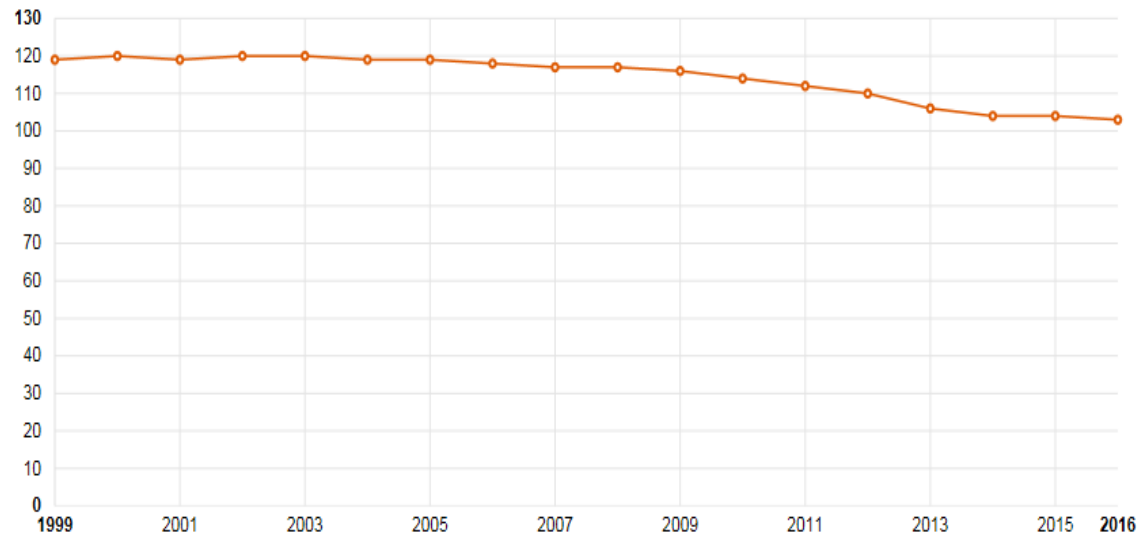


Healthcare Delivery . . .



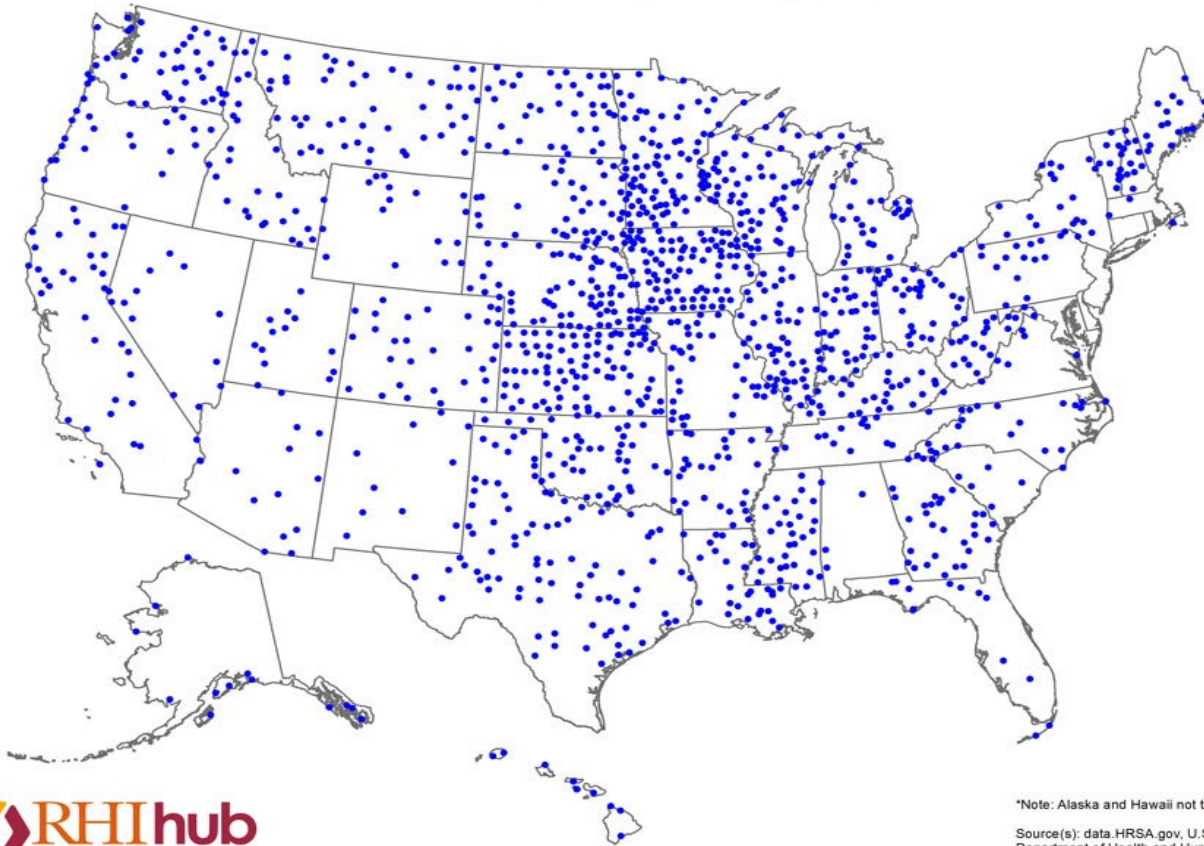
Hospital Admissions per 1,000 Population by Ownership Type | The Henry J. Kaiser Family Foundation

Timeframe: 1999 - 2016



Critical Access Hospital . . .

Critical Access Hospitals



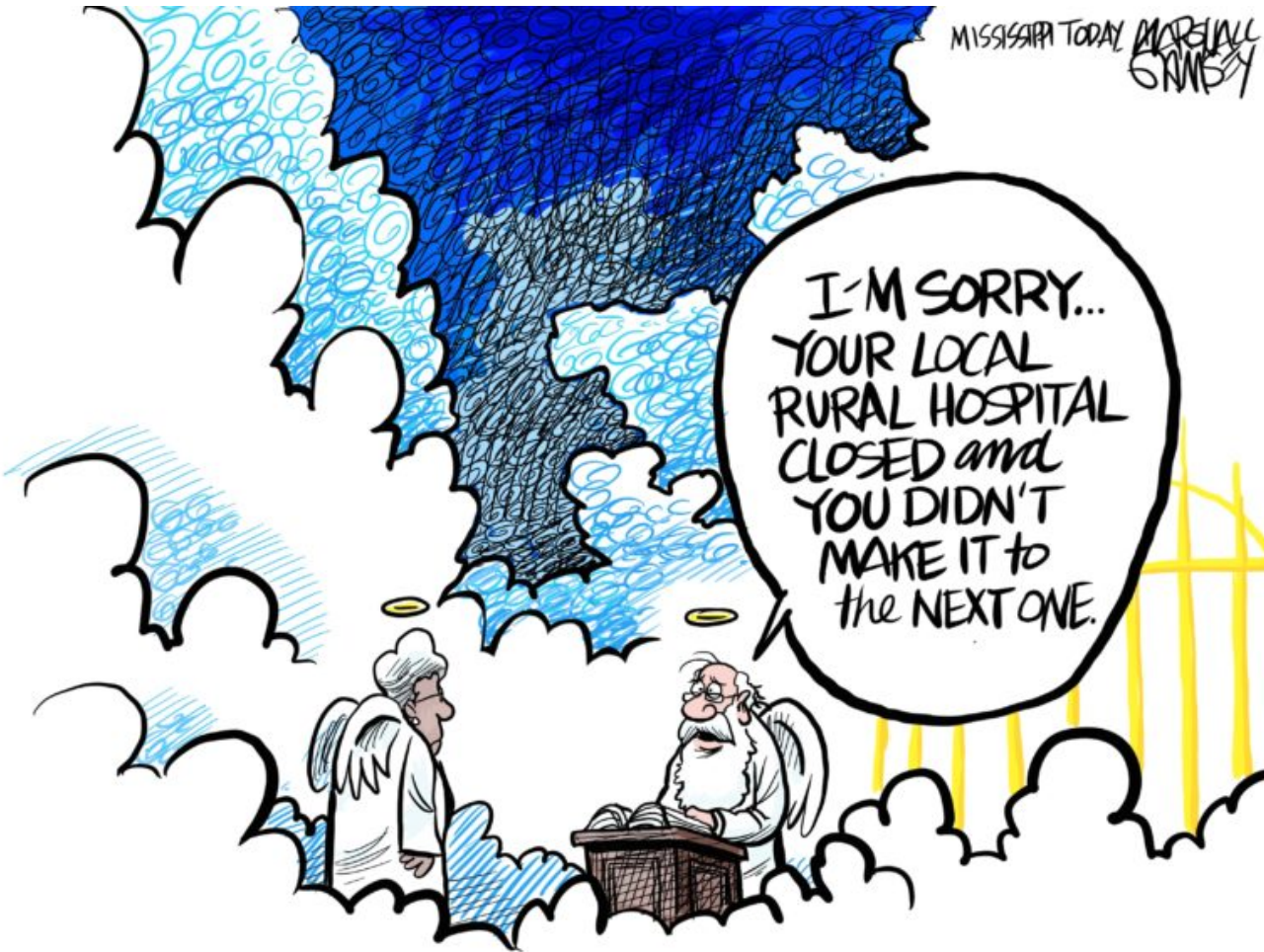
Critical Access Hospital . . .

- ▶ Eligible hospitals must meet the following conditions to obtain CAH designation:
 - ▶ Have 25 or fewer acute care inpatient beds
 - ▶ Be located more than 35 miles from another hospital (exceptions may apply)
 - ▶ Maintain an annual average length of stay of 96 hours or less for acute care patients
 - ▶ Provide 24/7 emergency care services

Critical Access Hospital . . .

- ▶ CAH status includes the following benefits:
 - ▶ Cost-based reimbursement from Medicare. As of January 1, 2004, CAHs are eligible for allowable cost plus 1% reimbursement. In some states CAHs may also receive cost-based reimbursement from Medicaid.
 - ▶ Flexible staffing and services, to the extent permitted under state licensure laws.
 - ▶ Capital improvement costs included in allowable costs for determining Medicare reimbursement.
 - ▶ Access to Flex Program educational resources, technical assistance, and/or grants.

Rural healthcare . . .



Policy & Rural Health Advocacy



Beth O'Connor,
M. Ed.

So what do we do??

ADVOCATE!



... tool
... our
... ring
... ments.



... e than
... vocate

If you can't advocate...

- ▶ Educate
- ▶ You'll hear lobby - think advocacy or go further and think educate
- ▶ All you are doing is asking elected officials and their staff to understand your situation - they can do the rest
- ▶ First Amendment rights

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cate?

your

d

tate

anyway

Lots of Issues

► What types of issues do elected officials discuss?

- Pacific Command
- Palau
- Pardon Attorney, Office of
- Parole Commission
- Peace Corps
- Pennsylvania
- Political Affairs
- Postal Regulatory Commission
- Postal Service
- Power Administrations
- Presidio Trust
- Public and Indian Housing
- Puerto Rico
- Pacific Northwest Electric Power and Conservation Planning Council
- Pension Benefit Guaranty Corporation
- Pentagon Force Protection Agency
- Pipeline and Hazardous Materials Safety Administration
- Policy Development and Research
- President's Council on Fitness, Sports and Nutrition
- Prisoner of War/Missing in Action Accounting Agency
- Privacy and Civil Liberties Oversight Board
- Public Diplomacy and Public Affairs

Lots of issues!

- ▶ You will know more about the issue you want to discuss than they do
- ▶ They will pretend they know what you are talking about
- ▶ You **MUST** explain acronyms & concepts

Time crunch

- ▶ You will not be the only meeting they have that day (or even that hour)
- ▶ Meetings are usually scheduled in 15-minute time slots and back to back
- ▶ Be concise
- ▶ Be flexible
- ▶ Be early

Pick a core topic!



Advocacy formats

- ▶ Office visit
- ▶ Phone calls
- ▶ ~~Fax~~
- ▶ E-mail
- ▶ Social media
- ▶ Greet at public events
- ▶ Invite to facility or event

NO LETTERS!!

6 Rules

- 1) Have an “ask”
- 2) Contact decision maker
- 3) Note importance to official’s area
- 4) Know who you are speaking to
- 5) Be concise
- 6) Follow up

1) Have an ask

- ▶ They like to say ‘yes’
- ▶ Will avoid saying ‘no’ - and are good at it
- ▶ Will talk about topics of interest to you, but won’t ask how they can help
- ▶ YOU must be specific about what you want from them!



Frame Your Message

- ▶ I'm here to talk about...
- ▶ No more than 3 'asks' per contact
 - ▶ Short term
 - ▶ Intermediate
 - ▶ Long term
- ▶ Use anecdotes and stories
- ▶ Imbed data when possible
- ▶ Stay on message

2) Contact Decision Maker

- ▶ Go to an event where elected official is and ask in person
- ▶ Get an e-mail or phone call to correct staff person
 - ▶ (DON'T leave a message with whoever answers the phone)
- ▶ For Congressional staffers:
 - ▶ john.doe@mail.house.gov
 - ▶ jane_doe @senator.senate.gov

3) Importance to Area

- ▶ How is your ask important to the official's state or district?
- ▶ Personalize it
- ▶ Give your experience
- ▶ They want to help!

4) Know who you are speaking to

- ▶ Most Congressional staffers are under 30
- ▶ They are making important decisions
- ▶ Be polite - they hear demands all day
- ▶ Where is the bill? What committee has it?
- ▶ Is the staffer new or experienced? Are they from your area? State?
- ▶ Don't assume anything!

How would I know all that?

- ▶ Advocacy Organization
 - ▶ National Rural Health Association
 - ▶ American Osteopathic Association
 - ▶ Society for Public Health Education
 - ▶ American Nurses Association
 - ▶ Association for Community Health Improvement
- ▶ Coordinate visits
- ▶ Action Alerts
- ▶ The more responses, the more likely Congress is to act!

5) Be Concise

- ▶ First impressions are important
- ▶ Have your ask condensed into a fact sheet
 - ▶ 1 page max per ask
- ▶ Walk through materials
- ▶ Don't pretend you know more than you do
- ▶ Understand time constraints
- ▶ Be yourself

6) Follow up

- ▶ Send e-mail (along with information you promised to get for them) no more than a week after a face to face meeting.
- ▶ If they act on your request, make sure you let them know how much it is appreciated!

What if?

- ▶ You know the politician will vote AGAINST what you want anyway?
- ▶ You know the politician will vote FOR what you want anyway?

The Phone Call

- ▶ Often will leave message
 - ▶ Don't leave it with receptionist
- ▶ Introduce yourself and explain your organization
- ▶ Keep it simple and brief
- ▶ Offer more info by e-mail
- ▶ Thank them



Meet & Greet

- ▶ No more than one ask
- ▶ Hand over information with the handshake
- ▶ Introduce self and explain organization
- ▶ Thank them
- ▶ Total encounter should last less than 30 seconds



The Office Visit

- ✓ Concise
- ✓ Factual
- ✓ Polite
- ✓ Punctual
- ✓ Understand their time constraint
- ✓ Give your experience!



Hollywood vs Reality

- ▶ Space
- ▶ Attention (yours & theirs)
- ▶ Knowledge



To Avoid

- ⊗ **Take their whole day**
- ⊗ **Make up things - if you don't know, tell them you'll get back to them**
- ⊗ **Be really late**
- ⊗ **Threaten to not vote for them**

Other tips

- ▶ Develop relationships
 - ▶ Send newsletters, event announcements, etc. Don't wait for a problem to arise before making contact
- ▶ Invite to your organization
 - ▶ They LOVE photo ops (ribbon cuttings, scholarship announcements, etc.)
 - ▶ They want to learn about your situation
 - ▶ They want to be seen doing good things
- ▶ Friends in high places
 - ▶ Low-level staffers won't be there for long
 - ▶ Find a way to connect with them

Indirect Advocacy

- ▶ Public gatherings
 - ▶ Media attention is key
- ▶ Letters to the Editor
- ▶ OpEd
 - ▶ Make sure you understand the newspaper guidelines

You - yes, YOU - can change DC

- ▶ Don't underestimate what you can do
- ▶ Realize that relationships you develop now will matter in the future
- ▶ Spending 5 minutes to send an e-mail or make a phone call can do a lot



“Senator, the American people, whom you often mention in your speeches, would like a word with you.”

Wrap Up & Conclusions



What are our take-aways?

- ▶ Name some general principles of advocacy and education of policy makers and stakeholders.
- ▶ Name a benefit of a Critical Access Hospital (CAH).
- ▶ What's the difference between a Federally Qualified Health Center (FQHC), a Community Health Clinic (CHC), and other rural provider types?
- ▶ Name a benefit of the Rural Health Clinic (RHC) program.
- ▶ How might you work with the State Office of Rural Health (SORH) in your state?

Questions?



Thanks so much!

We appreciate your participation!

*Brought to you by our partners at
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