SUSTAINING COMMUNITY HEALTH SERVICES OVER TIME: MODELS FROM THE RURAL HEALTH OUTREACH GRANT PROGRAM

Working Paper Series

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This monograph summarizes the results of site visits to three rural health consortia conducted during mid-summer and early fall of 2003 as part of an assessment of exemplary models from the Rural Health Outreach Grant Program that have sustained community health services over time. The three sites included a medical rehabilitation project, the Wyoming Rehabilitation Clinic in Sheridan, Wyoming; a prenatal outreach project, the Fassett-Magee Community Health Center in Cambridge, Maryland; and a community health center, the Providence Health Center in Shady Cove, Oregon.

The services and activities initially supported by RHOGP funding continued to be available in each of the projects for up to six and seven years following the expiration of the grant. All had demonstrated a post-grant expansion or development of services to meet new and growing community health needs. Each also relied on a strong business plan to balance their need for sustainability and a desire to provide necessary community services. This combination of compelling community service need and the inherent difficulty in being supported through existing reimbursement mechanisms contributed to the level of emphasis given to sustainable strategies and strong business plans.

In each case consortium members faced a clear and compelling need for action, were able to identify participant self-interests and benefits of collaborative action, and were able to rely upon strong leadership and a clear vision to pursue the identified course of action. Each engaged in preliminary efforts (e.g. identifying partners, developing a business plan that incorporates the goal of self-sustainability and community service) for as much as a year prior to submitting their grant application. An important factor in each project's success has been the presence of strong visionary leadership keeping each consortium on course and focused on its long-term goals.

Essential components of this leadership are: (1) the ability to understand the social and cultural context of the community and to use this knowledge to integrate the project into the community; (2) a willingness to do whatever it takes to make contact in the community and market the value of the consortium's role in the community; and (3) the ability to stimulate and maintain open communication and trust between consortium providers and between the providers and the community at-large. The case studies demonstrated that it is critical to maintain a degree of flexibility and adaptability to make the most of environmental changes. Few organizations can stand alone and those consortia that are able to identify external organizations to collaborate with will be more likely to survive and continue to serve their communities in the future.

INTRODUCTION

The Rural Health Outreach Grant Program (RHOGP) is a federal program that assists rural providers and the communities they serve to fill critical gaps in needed health care services and to meet growing health care needs in rural areas. Since its creation in 1991 the RHOGP has provided over $300 million in grants that support more than 600 consortia projects to expand access, coordinate resources, and improve the quality of essential health care services for rural America. A key condition of participation in the program requires grantees to actively pursue a post-grant capacity for self-sustainability. While many state and federal grant programs are premised on the assumption that program participation can lead to long-term changes, the RHOGP explicitly requires discussion of such strategies in the grant application process and pursuit of those strategies throughout the grant award period.

As typical of many grant programs, information concerning project operations exists but is limited to data collected during active grant funding. It is not surprising that post-grant operational experiences are typically missing from grant program evaluation efforts. The costs in tracking these experiences can be significant depending upon the number of grantees and the difficulty in locating key informants and obtaining information for projects that were funded years ago. Gaps in post-grant operational information can be particularly frustrating in the case of the RHOGP projects where grant-related reports indicate that significant success was accomplished. Questions of interest include: *Did the grantee consortia continue after the grant funds expired? Did their level of success in meeting local health care needs change over time because the grant support ended? Was momentum established that continued years after participation in the RHOGP ends?*

Answers to such questions can provide insights in to the strategies and circumstances that drive post-grant sustainability. The results can be used to educate current and future grantees of the RHOGP, fine tune program requirements and technical assistance as well as provide a basis for monitoring the major outcomes of the program. This monograph summarizes the results of three rural health consortia site visits conducted during mid-summer and early fall of 2003 as part of an assessment of exemplary models from the Rural Health Outreach Grant Program (RHOGP) projects that have sustained community health services over time.

THE RHOGP SUSTAINABILITY PROJECT

Phase I – The Survey

The core premise underlying the study is that the ability of rural consortia to survive following the expiration of RHOGP support is proportional to their ability to meet the needs of consortium members and the degree to which those members meet the needs and expectations of their target rural population.

The first phase of the project used a telephone survey to collect information on the scope of activities and services originally supported by RHOGP grant funds, the ability of projects to adapt to changing needs and demands, and the nature and effectiveness of strategies used to develop self-sustaining operations. The phone survey was conducted during the late fall and early winter of 2002.

Structured interviews lasting between 20-30 minutes were completed with 99 of the 104 directors of RHOGP grantee projects supported during two funding cycles, 1994-1997 and 1996-1999. The response rate was 95 percent. After an average of six years following the termination of RHOGP grant support, 86 percent of the RHOGP consortia were still operational. Approximately 60 percent of the surviving consortia exhibited at least two out of the three criteria identified for grantee success.[1] The vast majority (88%) of initial activities remained available to local populations and a variety of new and expanded efforts were initiated and stable funding was developed for 46 percent of the surviving consortia.

Phase II – The Site Visits

Eight prospective site visit locations were selected from the telephone survey respondents exhibiting characteristics of successful consortia such as the provision of a breadth and depth of services, an ability to acquire stable funding streams, and the continuation over time of their most important activities. Five of the candidates were from the 1994–1997 grants cycle and three of the candidates were from the 1996–1999 grants cycle. Most of the candidates provided direct clinical services (five provided primary care services and another provided medical rehabilitation services). Each consortium director was contacted to determine his or her likelihood of participating in an in-depth site visit. The final

[1] Three criteria for grantee success were identified and include: (1) continuing to provide the original set of services unless demonstrated need was satisfied; (2) expansion of existing or development of new activities and services to address needs that emerged since grant support; and (3) securing stable revenue sources to support important consortium activities.

three sites were selected based on the stability of their leadership and organizational structure, the availability of key informants, and their ability to schedule a timely site visit.

The three sites selected included a medical rehabilitation project, the Wyoming Rehabilitation Clinic in Sheridan, Wyoming; a prenatal outreach project, the Fassett-Magee Community Health Center in Cambridge, Maryland; and a community health center, the Providence Health Center in Shady Cove, Oregon. In preparation for the site visits, a series of interview protocols were developed and historical data were collected from grant applications, evaluation reports and public relations materials.

WYOMING REHABILITATION FOUNDATION, SHERIDAN, WY
Meeting the Medical Rehabilitation Needs of the Rural Elderly
Regardless of Ability to Pay

Doing business as the Wyoming Rehabilitation Clinic (WRC), the Wyoming Rehabilitation Foundation of Sheridan, Wyoming received funding from the Rural Health Outreach Grant Program between 1996 and 1999 to provide medical rehabilitative services in Sheridan and surrounding communities. The WRC was established in 1994 as a not-for-profit entity through the efforts of four community health and human services organizations; the Memorial Hospital of Sheridan County, the Sheridan County YMCA, the Sheridan County Senior Center, and the Sheridan Community College.

The consortium formed to address concerns about the availability and coordination of medical rehabilitative services for the region. Its core strategy focused on filling service gaps, where possible, with local resources and linking to more distant providers when necessary to meet the needs of community residents with significant functional limitations regardless of their ability to pay.

Background

Service Area

At the time of its award the service area of the WRC covered 11,684 square miles included three frontier counties (Sheridan and Johnson Counties, Wyoming and Big Horn County, Montana) and extended from north central Wyoming along the eastern slope of the Big Horn Mountains to south central Montana. Approximately 46,841 persons lived in the area with over half living in the city of Sheridan, the county seat and locus of rehabilitation services for the County with an overall population density of four persons per square mile.[2] In addition to being the second most populous county, almost two-thirds of the population of Big Horn County was Native American Indians (60%) in contrast with Sheridan County at 1.3 percent and Johnson County at 0.6 percent (Table 1).

Regional Providers of Rehabilitation Services

Prior to the formation of the WRC, rehabilitation services were limited to physical therapy (PT), speech pathology (SP), and occupational therapy (OT) mostly available in Sheridan. The local hospital provided inpatient and outpatient-based PT services as well as

[2] 2001 estimate U.S. Census Bureau accessed at http://quickfacts.census.gov/qfd/

contracted SP services on an as-needed basis while two local nursing homes provided both PT and OT services in outpatient and home health-based settings. A modest-sized, for-profit, therapist managed PT practice also was located in Sheridan County as well as a Veteran's Administration Medical Center (VAMC) providing PT and OT services. The former only served those who could pay while the latter served eligible veterans.

Johnson and Big Horn Counties each had a much lower rehabilitation service capacity than Sheridan County. Johnson County Memorial Hospital (JCMH), a small 25-bed facility with a 50-bed attached Skilled Nursing Facility (SNF) located in the town of Buffalo about one hour south of Sheridan, provided inpatient and outpatient PT, SP, and cardiac rehabilitation (CR) services. Residents of Big Horn County, Montana accessed PT services from one of two locations; the Crow Northern Cheyenne Hospital, a 24-bed Indian Health Service Hospital in Crow Agency about one hour north of the city of Sheridan and the Big Horn County Memorial Hospital (BHCMH) a 16-bed acute care facility located another half hour drive further north in Hardin, Montana. Additional services were located approximately 130 miles north in Billings, Montana (Saint Vincent's Health Care or Deaconess Billings Clinic) or almost 160 miles south in Casper, Wyoming (Wyoming Medical Center). Many people, especially the elderly and those with little financial resources, often faced a daunting choice – either find the means to travel out of the region to receive needed care, or do without services at all.

Barriers to Rehabilitation Services

The WRC service area is typical of many rural and frontier areas of the country. It's small communities are separated by great distances with few having ability to support even the most minimal health care services. Even in the most densely populated section of the service area (Sheridan County), only 4 out of 12 towns had more than 200 residents making it very difficult to support service points much beyond the city limits of Sheridan. Adding to the challenges of residents seeking care are the winding roads and rising peaks (up to 13,000 feet) of the Big Horn Mountains which separate parts of western Sheridan County and northwestern Johnson County from services in Sheridan. The arrival of winter with its typically severe weather further complicates matters with icy conditions and road closures including Interstate 90 which links Sheridan with Casper, Wyoming and Billings, Montana.

Table 1

WRC Service Area Characteristics

Characteristics	Sheridan County, WY	Johnson County, WY	State of Wyoming	Big Horn County MT	State of Montana
Population estimate, 2001	26,833	7,245	494,423	12,763	904,433
Population density (persons/square mile)	10.5	1.7	5.1	2.5	6.2
Population under 5 years, 2000	5.3%	5.2%	6.3%	9.3%	6.1%
Population under 18 years, 2000	24.1%	24.2%	26.1%	35.8%	25.5%
Population 65+ years, 2000	15.5%	18.0%	11.7%	8.6%	13.4%
American Indian, 2000	1.3%	0.6%	2.3%	59.7%	6.2%
Population with a disability, 5+ years old, 2000	16.4%	17.9%	15.6%	20.4%	16.1%
Population below federal poverty line, 1999	10.7%	10.1%	11.4%	29.2%	14.6%
Local government employment, 1997	6.0%	1.6%	100%	1.6%	100%

Source: U.S. Census Bureau, State and County QuickFacts, available at http://quickfacts.census.gov/qfd/states. Accessed on 1/21/04.

Catalyst for the RHOGP Application

Two developments in the early 1990's stood out as bellwether events for the necessary changes to rehabilitation services in Sheridan County, Wyoming. The first development was the realization that local rehabilitation capacity was unable to handle the needs of a newly established neurosurgery practice and the second was the failure of the local health care system to meet the needs of the medically indigent. Each development, while not the only factors behind the changes that would eventually transform health care delivery in Sheridan, exemplifies the major problems the community faced.

In 1992 a physician retiring from a successful neurosurgery practice in Denver, Colorado moved to Sheridan and decided to establish a practice. Soon he found that many of his post-surgery patients were unable to find the rehabilitation services they needed to complete their recovery. There not only were holes in the service continuum but the services available also were poorly coordinated, built around outdated delivery models, and staffed by personnel lacking needed training. The physician soon emerged as an energetic community leader who was able to elevate the needs of his patients to a public dialogue about access to care important for the community's well-being. His high visibility in the community coupled with the degree of respect he had from the provider community helped significantly in engaging key community stakeholders in this dialogue early in the process.

At about the same time, the staff and administration of the YMCA suddenly became aware of a significant number of post-cardiac patients using its popular cardiac exercise program. Cardiac exercises had been available to the general community since the 1980's when it started as a Phase III cardiac risk reduction and prevention program. Over the years the program had gained in popularity and prestige as a well-grounded and effective intervention to promote cardiac health. As local physicians began to find it hard to get their less fortunate patients into standard, medical model, rehabilitation programs they apparently began to point their patients to the YMCA's cardiac exercise program as an alternative source of physical therapy. With nurses to follow program participants and staff to develop individual programs for YMCA participants, it is understandable why some physicians considered the cardiac program a better alternative than having their patients sit at home with a stalled recovery and increased chances of another cardiac event. The lack of coordination of program participants with the physicians coupled with inadequately qualified staff to handle

post-cardiac patients put both the program participants and the YMCA at significant risk (i.e., for the health risks to participants and the increased liability to the YMCA).

With these and related events feeding into a community dialogue about change, a core strategy, initially proposed by the neurosurgeon, emerged and was rapidly accepted as the most logical course of action. The strategy involved the creation of a rehabilitation clinic "without walls." Essentially the strategy involved the creation of an umbrella corporation empowered by collaborating provider organizations as the responsible agency for coordinating and directing rehabilitative services for the region. It was referred to as a clinic "without walls" because existing rehabilitation service capacity would remain housed at their original locations while their operation and that of future services and locations would be the responsibility of another entity that was corporately separate from its supporting member organizations. The arrangement was expected to be more cost effective by reducing the current fixed costs while maximizing economies of operation and coordination important for reinvestment into service development and delivery.

A variety of factors made the strategy attractive both to providers and to key community stakeholders. The strategy grew naturally out of local experiences rather than being imported from outside the community, minimized threats to organizational and community autonomy, emphasized the value and role of local providers, required very little time or resources to launch, and provided a venue for consortium partners to identify redefined roles in the new delivery system.

Project Development and Overview of Operations

Almost two years after it originally took shape, the WRC submitted its application to the RHOGP in 1996. The proposed project built on earlier efforts focusing on staff recruitment and training, development of regional contracts to provide locally unavailable services in Billings and Casper, and community engagement and education activities to promote community involvement in the services that would be offered by the WRC. The plan included the creation of a prevention and wellness curriculum, community and patient support groups, targeted exercise programs, and support services such as case management and non-emergent transportation. Evaluation strategies were identified to monitor the project's implementation and impact on target populations. Project outcomes were defined using clear and unambiguous criteria simplifying data collection and analyses. For example, target

populations were clearly identified with capture rates established for each year of the project's operations to assess consortium success in engaging target groups and meeting their needs (i.e., 35 percent in year one, 45 percent in year two and 50 percent by year three, for a total of 1,885 persons). [3]

Contributions of Consortium Members

One component of the RHOGP application process requires applicants to describe the degree and nature of collaboration among the proposed consortium membership. The WRC exhibited a remarkable history of collaboration which, in retrospect, contributed significantly to its success under the RHOGP grant project. Two years prior to its formal application to the RHOGP, a mutual agreement was negotiated between the Memorial Hospital of Sheridan County, the Sheridan County YMCA, the County Senior Center and the Community College. The agreement led to the eventual incorporation of the WRC as a not-for-profit organization and its later designation as the consortium's lead agency.

Once the WRC was legally established the membership began turning over the administrative and supervisory responsibilities for various rehabilitative services capacity to the sponsored corporation. PT capacity - including staff, and equipment needed for the provision of inpatient and home health-based physical therapy, occupational therapy, and speech pathology services - was transferred to the WRC by the Memorial Hospital of Sheridan County under a leasing agreement.[4] The Sheridan YMCA turned over its available equipment and space for current services such as the cardiac exercise and mobility programs to the WRC and also provided space for a new aquatic therapy program. Staff from the YMCA staff also worked closely with WRC staff to develop and implement a series of disability-focused exercise programs. The Community College provided space for OT services on campus at a nominal cost and jointly developed a prevention and wellness curriculum with the WRC that targeted the community at-large. Finally, a pivotal transportation resource was provided by the County Senior Center to help link seniors and others without regular transportation with the various community-based rehabilitation services and to access out-of-area services available only in Billings and/or Casper when necessary.

[3] A capture rate is a measurement of the proportion of a program's target population that has been engaged and enlisted in available program activities.

[4] The amount of the lease agreement was based on a fair estimate of lost revenues expected to accrue to the hospital as a result of the transfer.

Consortium members continued to operate as autonomous organizations providing their regular scope of services and activities in addition to their overlapping roles as rehabilitation service partners.

Project Scope

As proposed in the initial grant application, the goal of the WRC project was to fill service gaps and strengthen system coordination in Sheridan County and then gradually implement similar measures in Johnson County, Wyoming and Big Horn County, Montana (e.g., discipline-specific clinical protocols, staff training to implement those protocols, and the expertise and resources to enhance the local infrastructure to sustain those efforts over time). Recognizing that care for the indigent was a significant issue throughout the service area, it was decided early on to base the consortium's decisions and goal setting on the premise that the responsibility for meeting the needs of the medically indigent would fall to those counties in which the persons resided. Sustaining project efforts, regardless of County, required that consortium planning and decision-making be driven by reliable information about internal operations and the evolving local market. Planning sessions were held and efforts were undertaken to forecast future service needs and reimbursement trends to identify how best to coordinate the development and delivery of consortium-related services. At this early stage of development the major assumptions shaping consortium strategic planning were expected increases in small rehabilitation provider contracting (on a regional scale); increased payor demands for accountability (e.g., efficacy, cost effectiveness and quality outcomes); continued growth in the case management services; increased standardization of patient and care management modalities; and decreased reliance on inpatient settings for the provision of rehabilitation services.

The year the WRC received its grant award from the RHOGP, its Executive Director, who had also authored the RHOGP application, resigned in order to relocate out of the area with her husband. Her replacement, the present Executive Director, was selected in early 1997. The new director brought a number of valuable resources to the consortium including knowledge of the local community and providers gained over the past four years managing psychological and occupational rehabilitation services and a strong background in management and business administration. As he began moving the project forward it became evident that efforts would be more successful if focused solely on the needs of Sheridan

County. Sheridan was always the first target for action, it was the home of the consortium membership, the other counties had made little commitment beyond their signatures on the RHOGP application, and there was a growing sense of threat on the part of providers in Johnson and Big Horn Counties regarding involvement with Sheridan services.

When asked about the decision to limit the consortium's service area to only one county a number of respondents noted that while not finalized until much later the decision to drop Johnson and Big Horn counties from the consortium's service area was not a unilateral decision. There apparently was little interest from these counties from the start. Speculation over the initial inclusion of Johnson and Big Horn Counties ranged from a desire to meet broad regional needs and the misunderstanding that multi-county and frontier service areas were a major focus of the RHOGP funding effort to the desire on the part of Johnson and Big Horn County providers to remain aware of system developments in their region. Considering the broader context of delivery system development in the region over the last few years, others have commented that key issues were the great physical separation between Sheridan County providers and those in Johnson and Big Horn Counties and the then emerging provider networks in Billings and Casper (the natural referral points for each county) who were beginning to exert their influence. This gave Johnson County and Big Horn County providers reason to consider all options before making a final decision to participate.

Accomplishments

During the course of its RHOGP grant support the WRC successfully accomplished all of its major project objectives. The project resulted in the creation and use of general clinical protocols, identification of quality indicators and implementation of protocols for specific medical rehabilitation areas, provision of on-going staff education and reached half of the target population as set for the third and final year of RHOGP support. The first and second year capture rate goals were achieved on time and the third year goal was accomplished ahead of schedule. Respondents attributed this increase in operational efficiency to the availability of Senior Center transportation resources and charitable contributions that made a sliding fee scale and charity care available to those in need. Paradoxically, by its third successful year the WRC had also developed physical walls with the establishment of a clinic in downtown Sheridan. Made possible through its many successes and expanding client base, additional service capacity was added under the direct assistance and collaboration of the four consortium members.

A model accomplishment of the consortium was the provision of transportation services to meet client needs to reach downtown services and those only available in either Billings or Casper. Thanks to the generous involvement of the Senior Center in providing the vehicles and the extensive outreach efforts made with the physician community it was possible to achieve some economies of scale while bridging critical gaps in necessary services for local residents. In the beginning, the proposed project was expected to cover half the costs from funds provided by the Wyoming Department of Transportation with the remainder coming from general contributions. However, due to a significant degree of pent up demand for such services it rapidly evolved into more of a quasi-public transport system. The service remained available only to those with severe functional limitations who needed help to reach points of care. An expansion in service to those without a significant functional limitation as well as those younger than sixty years of age made it necessary to modify the fee schedule to continue supporting people with significant limitations.

By 2002 the service was providing over 49,000 rides per year of which 70 percent were for people over sixty years of age. By 2003 the usage fee was $1.50 per ride for people 60 and older (including transport to Billings) and $3.50 for everyone else. This level of success would not have been possible without a significant degree of support from the physicians providing the care. Physician concerns over taking their patients to see a provider in Billings or Casper are understandable. The consortium addressed these concerns through mailings and, in some cases, personal discussions with local physicians to allay fears about lost patients and undermined practices. The physicians were assured that their patients were taken only to services that were unavailable locally.

The consortium's ability to develop outreach strategies and weave program activities and goals into everyday community life stands as a major strategic accomplishment that kept the community aware and engaged in consortium efforts. For example, the consortium broadened its scope of outreach services to include the provision of athletic training in the local schools and provided specific training for school assistant (student) coaches to recognize sports injuries, minimize further injury and future occurrence. This activity not only generated career interest on the part of some students but broadened the public's vision of the WRC's value to the community.

One event that stands out as an exemplary model of program design, engagement, implementation and follow-through is the development of what later came to be called "Lifetime Fitness." As the findings of a community needs assessment were reviewed, it became apparent to the consortium that a large number of area elders were undergoing a marked sense of alienation. Although not immediately clear, this spiraling poor mental health apparently was due largely to personal issues related to coping with aging. Many seniors felt that the time for them to make valuable contributions in their community was past and they were simply waiting out nature's course. Concerned about the obvious physical and psychological implications, the consortium leadership developed and launched a broad set of outreach and engagement strategies.

Taking a much broader role in the community than was previously envisioned in the grant application, the Consortium's approach incorporated a multi-level effort including the provision of skill building workshops, physical activity programs, and social support groups to enhance self-worth and to provide the tools for re-engaging with the community. The respondents related numerous success stories stemming from this effort including seniors that once again became involved in the community through participating in not-for-profit boards, taking active roles in consumer and civic advocacy efforts and engaging in physical activities that once were considered far beyond their capacity (i.e., seniors needing walkers were taking part in YMCA exercise programs).

When asked to explain how this could happen respondents replied that a big part was the tight relationship formed with the community at-large and the social connection that developed among the participants. Two former cardiac patients participating in the cardiac exercise program pointed out that while they could do the exercises at home it was far more fun at the YMCA and indicated that participants regularly reached out to support one another. Weaving programs into everyday community experience and integrating them within a larger social milieu increased their potential impact on participation rates and longevity. These accomplishments would not have been possible without WRC's well-grounded understanding of the community's issues and concerns.

Factors in Post-Grant Sustainability and Success

The consortium began preparations for post-grant operations before the RHOGP application was submitted. The WRC approached program development with a two-pronged strategy. First, they identified service needs that could be met through the development of

programs with pre-existing reimbursement streams and used grant funds to jump start the process (cover start-up costs) so that once they were up and running patient revenues would be sufficient to continue to provide the services. Projections of operational economies suggested a slight surplus during the fourth year of operations (i.e., the first year without grant support). Program development efforts incorporated the likely use of sliding fee scales and the provision of free care (subsidized by surplus revenues and/or charitable contributions) to help meet the needs of medically indigent residents, a major goal for the consortium. Second, they used charitable contributions and a reinvestment of revenue surpluses to launch programs specifically targeting the area's indigent population to address factors that can interfere with their participation in available programs. These programs included targeted outreach efforts to enlist their involvement in activities that could help integrate them further into the social life of the community.

During the initial project development phase when the vision included a three county service area the participating partners recognized that in order to pursue the difficult goal of providing indigent care it would be necessary to separate commitment to that population at the county level. If revenues and contributions fell short of covering indigent costs, consortium members intended to approach external funding sources already committed to the service needs in question (e.g., the State Lung Association for respiratory-related programs and the Heart Association for cardiac rehabilitation services).

This conservative approach of compartmentalizing program resources and liabilities, while unnecessary for the WRC because it ended up including only one county, represents a viable strategy for limiting the impact of one county missing project goals on the efforts of remaining counties to meet their goals. The consortium’s strong commitment to self-sufficiency and care for the indigent may have had added benefits in pursuing self-sustaining strategies by highlighting the risks involved in pursuing efforts that overreach member capacities.

Achieving the Post-Grant Sustainability Goal

A key factor behind the consortium's post-RHOGP success has been the strength of its business plan. It made it possible to stay focused on long-term goals and identify opportunities along the way. It provided a useful framework for identifying ways to maintain program accountability, fiscal responsibility and the ability to choose and follow a leadership strategy to

tackle the day-to-day issues important for program success. Regularly scheduled staff meetings initially designed to assess management strategies, operations and project impact proved to be valuable both for informing annual strategic planning retreats and for approaching charitable foundations for support. Using the information made available through these efforts, the consortium conducted a number of successful fund raising drives from 1998 through 1999 that secured sufficient funding to underwrite the first three years of post-RHOGP operations. Subsequent efforts have resulted in reserves to cover operational costs through the end of 2008.

Another factor that worked in tandem with their sound business plan was strong leadership. Clearly defined goals and able leadership make it more likely that a consortium can secure capable staff that not only adapt well to the goals and needs of the organization but also can be given latitude to adapt to client needs. Respondents singled out leadership as a particularly important quality needed to develop and nurture a supportive corporate culture that is sensitive to community needs, staffing limitations and the fiscal realities that drive provider and consumer relationships. Leadership and a strong bond with the community are considered critical for balancing the consortium's mission with its margin. It is also critical to not lose sight of the organizational needs and benefits that accrue to the participating providers and serve as the basis for their continued collaboration and not to misinterpret one member's success as another's risk. It is important to educate board members as well as key administrators that if one consortium member does well it is not necessarily a bad thing for the other members.

A Strategy for Long-Term Sustainability

The transition period from grant support to non-RHOGP support was reported by most to be a non-event, largely because they had a goal of achieving self-sustaining operations firmly in place at the very beginning of operations. The consortium's strategy for making the transition was straightforward, was pursued throughout the three year grant period and involved four components:

- Strengthening collaborative relationships among the consortium membership;
- Continuing to raise the community's awareness of quality of life and lifetime wellness issues and goals;
- Continuing the growth of the core business of the consortium; and

- Developing local sources of support (i.e., aggressively marketing the value and accomplishments of the consortium to local foundations).

The consortium leadership was responsible for the first three components while the board was primarily responsible for the fourth component.

Success would not have been possible without substantial support from local charitable foundations. There was no other way to provide for the care of the indigent and no other way to subsidize sliding fee scales. Three issues that were useful for making a successful case before charitable foundations included: 1) evidence of an effective collaboration of community organizations pulling together to provide needed services; 2) use of evidence-based proposals; and 3) framing the proposal within a logical, outcomes-based plan of business. One respondent noted that charitable foundations regularly use accountants and attorneys to sort through the many requests sent every year for support - accountants are looking for a good business plan and attorneys are looking for accountability and the logic behind the project being proposed.

The funding efforts initiated in 1997 and 1998 to approach charitable foundations were greatly strengthened by the development of a program specific outcomes management plan. Originally developed to meet accreditation criteria stipulated by the Commission for Accreditation of Rehabilitation Facilities (CARF),[5] the consortium found that it also provided a logical framework for portraying program activities and accomplishments and changes that were made in program design.

The strategies used to approach the general community for fund raising also involved integrative engagement and follow-through approaches. One of the better examples of this type of approach involves an event called "Hoop Jam." Popular among the young and the old, "Hoop Jam" involved setting up basketball goals up and down Main Street for the period of the fund raiser. An entire section of Main Street was closed forcing traffic to sort its way through downtown. On the surface it would seem that such an event would generate more stress than support since people had to bypass usual travel routes and the downtown merchants could not be directly reached by car. However, the disruption made the event all the more dramatic and notable in the public's eyes and the merchants soon recognized a spin-off benefit in setting-up sidewalk sales to meet the volume of pedestrians attending the event.

[5] WRC was the first rehabilitation entity in the United States to receive a three-year accreditation from CARF.

When talking about "Hoop Jam" a number of consortium partners expressed a strong interest to do it again. Consumers related experiences that suggested a sense of community pride in the efforts and in the principle behind the operation of the WRC. Although everyone knew of the existence of a free or sliding scale service, only the finance staff of the consortium knew who was benefiting from the service. One current client mentioned that he had told others they should use the service even if they were worried about finding care because of their financial problems. Reflecting on the role the WRC had grown to occupy in the community the respondent noted that there always seems to be a way to get people the care they need most.

Current Operations

Six years following the termination of the RHOGP grant support, all initially supported activities and services continue to be available and there also are a number of new and expanded services available that have been developed to meet the community's changing needs. Progress reports filed during the funding period attest to the growing sense of caution on the part of Johnson and Big Horn County providers. Providers in Big Horn County, Montana, primarily those in Hardin, chose to meet the needs of their county without the direct help of the consortium members and the large Native American population in that county appears to have been too distant and too different culturally/socially to consider Sheridan as a natural source of care. Recent events over the last few years suggest that the providers located in Billings and Casper are stretching beyond their accomplishments in Johnson and Big Horn Counties to place satellite providers in Sheridan County as well (e.g., the two Billings hospitals have set up a family practice and an internal medicine clinic in Sheridan). Although the consortium has maintained that the original offer of a partnership within the consortium remains open to Hardin and Buffalo providers, the likelihood of any significant linkage with those providers is limited. Both Big Horn County Memorial Hospital and Crow Northern Cheyenne Hospital have since decided to become Critical Access Hospitals with the likelihood of links to Billings' providers greater than ever.

Rehabilitation services in Sheridan County have grown significantly over the last several years with two consecutive years of an annual growth rate of 15 percent in the volume of outpatient and home health rehabilitation services and a sizable growth in the health enhancement program (adding almost 50 new participants a year and averaging 50

participants three times a week for specific activities). The former cardiac and pulmonary rehabilitation programs were broadened to include a lifetime fitness strategy for community seniors. Aquatic fitness programs from the YMCA and classes for life long learning offered by the Community College have also been included in the effort. The lifelong learning courses are available at a nominal cost due to Golden Age Grants provided through the College's Center for a Vital Community Program (started in 2002). Matching funds are provided by the WRC. The lifetime fitness program builds upon the earlier senior initiative launched in 1998 and includes multi-level and multi-provider components to integrate lifetime fitness activities with a more substantial focus on self-actualization as the means to energize and open options for seniors.

Social services and case management support shifted focus over the last few years to increasingly concentrate on meeting the needs of area veterans who lacked the means to obtain care and were not eligible for services from the Veterans Administration Medical Center (VAMC). Referrals to these services are regularly made from the VAMC to WRC. This development, largely the result of renewed efforts on the part of the VAMC to bridge with the community, has also led to the VAMC Medical Director becoming a member of the WRC Board of Directors. In addition the VAMC has turned over several non-essential buildings to the community including one for use as a homeless shelter and another for use as an alternative school. At this point in time there are no psychiatrists available in Sheridan but the VAMC has four practicing psychiatrists on staff and the local hospital continues to keep a dialogue about shared staffing with the VAMC to help address staff shortages.

The consortium continues to reach out to non-local sources to strengthen local rehabilitation capacity. Clinical affiliations have been established with a number of regional universities (e.g., University of Montana, University of North Dakota, University of Wyoming, University of South Dakota, and the University of St. Mary's in Nebraska). These efforts have resulted in the placement of six students in the rotation program at the WRC over the last two years.

Adaptation Continues Within the WRC

As the service delivery and financing environment surrounding consortium activities continue to evolve, key consortium stakeholders have decided to pursue a full asset merger between WRC and the local hospital. The idea surfaced during a consortium planning meeting

as members considered how to strengthen WRC's operations to meet future market challenges (largely sparked by concerns over Billings' providers setting up a clinic in town). Initially, a number of participants had difficulty seeing the merger as a logical step since it was almost a 180° turn from the initial model of a clinic "without walls." However, participants began to realize that good ideas, like the clinic "without walls" strategy, have a life span that eventually runs out as the environment changes. Recognizing that their essential principles would not change and that the walls are only going up physically and not functionally, they voted for the merger.

Many considered the merger decision to be good for the partnership and the community at large. The merger would be good for the partnership because of the added market strength to withstand incursions from the north and the south and good for the community because of the possibility that the valued WRC corporate culture might carry over to the hospital. The positive characteristics of the WRC's organizational culture include an entrepreneurial focus with interdependent and self-supporting co-workers, respect for staff and clients, working teams, and a patient-centered effort. Discussions are underway on next steps for the organization once the merger is completed and are initially focusing on the expansion of the rehabilitation outreach model for cancer patients and oncology services.

It remains to be seen how effective the consortium will be in continuing to successfully meet the needs of the indigent in the WRC service area. This represents at once the greatest achievement and the most vulnerable component of the overall strategic plan. The original projection for the contractual adjustments needed to provide indigent care was approximately $9,200 per month. At that level, it was hoped that losses would be covered by the third year by surplus revenues and charitable contributions. The assumptions were altered early in the project with adjustments for bad debt and charity care over the first five months reaching $13,500 per month and by year three approximately $16,500 per month, or 25 percent of all charges. Bad debt and paying for medical rehabilitation services for those who could not pay or whose coverage was inadequate quickly became a more substantial liability than originally projected.

By 2003 the payer mix of the WRC is 60 percent third party and 40 percent bad debt and charity care about half of which is funded and half written off. Foundation funding has been a major asset in enabling the WRC to continue its indigent services. Services for the

indigent currently are running about $150,000 annually; however, about three-quarters of this cost is directly related to specific outreach efforts targeting the indigent. Sheridan is fortunate to have a number of foundations in the area which generally is not the case in most rural communities. All of the eight major foundations are the result of local circumstances (i.e., locally amassed capital from long-standing homesteads and developments related to land and cattle). The success in obtaining support from these foundations was not dependent so much upon geographic proximity as on the strength of the funding request, the evidence of need and the likelihood of accomplishment backed by solid data.

Summary

A variety of important factors have been identified that contributed to the overall success of the WRC before, during and after its grant award from the RHOGP. Foremost is the early work completed by the consortium prior to submitting its application for RHOGP support. During the period prior to grant support the consortium membership developed its business plan, sorted out the unique roles and responsibilities of each of the consortium members necessary for the future delivery system envisioned in its strategic plan that provided a clear and logical frame for future goals, staffing needs, and potential external relationships in the region.

This clarity of mission and goal focus on the part of the consortium members was made possible because of the clear and compelling need to fill gaps in rehabilitation services and to identify alternatives for the faltering safety-net for the area's indigent population. An important factor has been the strong visionary leadership that has guided this process and kept the consortium on course and focused on its long-term goals.

A strong and clear commitment to achieving project self-sustainability was evident from the very beginning and has kept the membership focused on what is reasonable and practical given the need to balance mission and margin. The strong commitment of the membership to providing services to all in need regardless of their ability to pay heightened the awareness for planning alternative survival strategies to support on-going projects and services independent of the grant award. The adoption of the outcomes management plan required for accreditation as a rehabilitation facility proved helpful to the consortium. Accreditation was achieved and in the process the consortium gained a powerful tool for monitoring their program activities and providing the data needed for both strategic and

tactical decision-making. The availability of a rich body of outcomes data also was useful when approaching funding agencies to support new program ideas.

The usefulness of the management plan for strategic planning and program development was enhanced through the integration of current community needs assessment information, staff assessments of program operations and effectiveness, and the availability of external observations from providers and the community at-large. The richness of these data coupled with the effectiveness of the management and leadership styles with a patient-centered focus made it possible to develop multi-dimensional approaches for meeting community health needs in ways that engaged target populations and framed program outcomes within the context of community life rather than discrete medical interventions unrelated to other aspects of the patients personal and community life.

The WRC outreach strategy made it possible to focus on participant happiness and fulfillment rather than allowing it to be framed as it normally is as a conflict between self-interest and moral or ethical obligations (i.e., participants saw a different future stemming from their participation in the programs rather than what is more commonly experienced in exercise and behavioral change programs as a struggle between what a person could/couldn't or should/shouldn't do with their life). WRC's use of this strategy not only eased the transition of participating in a given program but also helped prepare those individuals and their families and close acquaintances for engagement and participation in future efforts.

The combination of a data collection and analytic capacity, strong leadership, member trust, and a mutual commitment to community values allowed the consortium to accomplish far more than any of the members could have accomplished independently. It also paved the way for a new phase in the area health care delivery system with the merger of WRC and the local hospital to facilitate adaptation to local market changes.

PRENATAL OUTREACH PROJECT – FASSETT-MAGEE COMMUNITY HEALTH CENTER, CAMBRIDGE, MD
Bringing Primary and Prenatal Care to Low Income Minority Women and Children in a Rural Service Area

The Prenatal Outreach Project was funded under the RHOGP to reduce the prevalence of infant mortality, low birthweight babies, teen pregnancies, and poor prenatal care for low income women in Dorchester County, Maryland. The RHOGP funding (1994-1997) helped equip treatment facilities, recruit needed health care personnel, and forge a partnership among regional providers along the Eastern Shore of the State. Consortium members included the Fassett-Magee Community Health Center (FMHC), as the lead agency, the Dorchester County Health Department (DCHD), and the private family practice offices of Fadden and Washington, PA. Although the partners were all located in the town of Cambridge (the county seat) the physician practice also operated in two other locations (Hurlock and Federalsburg). The Dorchester General Hospital (DGH), also in Cambridge, joined the consortium in late 1994.

By 1997 the FMHC had taken steps to continue long after the RHOGP support ended. Merging with the Caroline Health System, Inc. in January 1998 the FMHC stabilized finances and strengthened its operations. The new entity, the Choptank Community Health System, Inc. (CCHS) continues to operate today providing needed health care services to a wide range of patients including low income minority clients with limited ability to pay for services.

Background

Service Area

Dorchester County extends over almost six hundred square miles of the State's Eastern Shore along the border of Chesapeake Bay. Settled in the mid-1600s as the first of nine municipalities, the present County Seat of Cambridge was formed in 1793 and is one of the oldest towns in the State. Today the county is home to approximately 30,451 persons,[6] with approximately 30 percent African Americans. Dorchester County exhibits many of the characteristics (e.g. poverty rate, insurance coverage, education level) of rural underserved communities across America.[7,8] Although located less than two hours away from Baltimore and

[6] 2002 estimate U.S. Census Bureau accessed at http://fedstats.gov/qf/states

[7] Percentage of persons below federal poverty line in Dorchester County in 1999 was 13.8%, for the State of Maryland it was 8.5%.

Washington DC, the county remains the second poorest county in the state with long-standing designations as a HPSA and a MUA. Cambridge (population of 11,000) serves as the home for more than half of the African Americans residing in the county.

Regional Providers of Prenatal Care and Community Needs

Prior to the establishment of the FMHC in 1995 the availability of health care services for low income African American residents of Cambridge, Maryland was tenuous at best. The most stable source of medical care was the emergency room of the local hospital, Dorchester General. Prenatal care for low income minority women was available through the county health department; however, with no public, and poor personal, transportation, access was problematic for many residents of the area. There were no community health centers prior to the FMHC and there had not been a steady source of primary care services for at least a decade since the retirement of a private practitioner, Dr. J. Edwin Fassett, and a health department nurse, Maxine Magee in the 1980's.

By the early 1990s the uninsured rate ranged between 20 and 25 percent and a growing number of Cambridge residents were in need of primary and prenatal care services. Of the 17 primary care physicians practicing in the county (including 8 family practice physicians, 2 pediatricians, 2 obstetricians, and 5 internists) only twelve participated in the Maryland Medical Assistance (MA) Program and only two of those were accepting new patients. The minority population in Cambridge at the time numbered 11,000 – there was virtually no capacity to address the community's primary and prenatal care needs. Most of the prenatal patients on MA delivered locally at DGH. The majority of these patients were meeting their attending physician for the first time and the physician's knowledge about the mother's term of pregnancy and prenatal care was limited to the medical record. Approximately 30 percent of the expectant mothers coming into DGH for delivery had little or no prenatal care history.

The DCHD prenatal program was the only stable source of prenatal care for low income women (which comprised virtually half of the County's prenatal population). The program had struggled long and hard to secure enough providers but continuity of care and full time availability of services remained a serious problem. There was only one permanent ob/gyn nurse practitioner to manage the prenatal clinic and to provide routine care. Although the program

[8] Between 1990 and 1999, private non-farm employment dropped 6.8% and the overall unemployment rate for the county in 2000 was 8 percent.

rotated state employed nurse midwives and family practice physicians through the clinic, scheduling and funding issues forced the Health Department to limit clinic operations to only one day a week between the hours of 8:00 a.m. and 4:00 p.m. creating additional difficulties for working mothers to participate in the program. However, 60 percent of all Dorchester General Hospital births during this time were health department prenatal patients. At delivery, 94 percent of the patients received Medical Assistance.

During the mid-to-late 1980s, Maryland ranked among the ten worst states in the nation in infant mortality while Dorchester County ranked among the worst county rates in the state for both infant mortality and low birth weight babies. The County also had double the state's rate for teen pregnancy and the proportion of expectant mothers with late or no prenatal care. Of the 217 prenatal patients seen in the County Health Department's Prenatal Program in FY 93, 59 percent were African American , 76 percent were single, and 33 percent were under 20 years of age with over half of those under 17 years of age. There was a clear and compelling need for prenatal services in the county, particularly in the town of Cambridge.

Barriers to Prenatal Care Services

Efforts by the state to expand Medicaid eligibility for expectant mothers were blunted by a relative decline in Medicaid payments. In addition, transportation problems worsened when Cambridge residents, already without public transportation, were further isolated when Medicaid coverage for transportation services was cut.

The difficulties faced by the DCHD in scheduling state employed nurse midwives and physicians severely restricted the prenatal program's availability further complicating the efforts of working mothers to find a means and the time to attend important care sessions. The need to attend ongoing sessions was virtually impossible to meet for some because of the concomitant impact on their jobs and the threat of job loss. In addition, expectant mothers that could make it to the clinic hours were never certain of which provider they would see, with continuity of care suffering in the process.

Cultural differences between providers and clients compromised the outreach efforts at times and potentially clinical outcomes. The numbers of Haitian-Americans, Asian-Americans, and Mexican-Americans were steadily growing in the Cambridge area as people settled after following the seasonal truck crop cycle between April and early Fall. Between June and November, an additional 300 Mexican women usually came into the area as temporary hires of

the seafood industry to harvest crabs. These women were not officially eligible for the area services that had been gradually built up over the years by a regional migrant health project to serve the primary care needs of migrant farm workers.

Preparation for the RHOGP Application

Planning for the Fassett-Magee Community Health Center was underway before submitting the RHOGP application. Momentum for establishing a community clinic evolved through a grass-roots effort by the organizations with strong ties to the community – the Harriet Tubman Coalition, the Good Shepherds Association, and the Dorchester Community Development Corporation. The efforts of the DCHD and DGH were eventually joined by the Maternal and Child Health Division of the Maryland Department of Health and Mental Hygiene, the Mid-Atlantic Association of Community Health Centers, the Dorchester Health Planning Agency, and the Chesapeake Health Planning Agency among others. The magnitude of the task before them was not underestimated. Health care capacity had to be built from the ground up and needed to be designed to address many of the barriers that had compromised and challenged the efforts of even the most ardent providers. With the primary target population consisting of low income and uninsured women and children it was essential to develop an approach that secured sufficient operating capital to make sliding scale and free care a reality.

In addition to the RHOGP grant which totaled almost $600,000 over three years, they were successful in acquiring a $35,000 Section 330 Community Health Clinic Planning Grant and $430,000 from a Small Cities Community Development Block Grant available through the Maryland Department of Housing and Community Development to purchase and renovate physical space for the neighborhood clinic. Funds were now available to move forward with the prenatal care project, obtain physical space for providing services in the community, and plan for designation as a Section 330 Community Health Clinic. In July of 1995 the joint efforts of the consortium acquired grant funds for the DCHD from the Maryland Department of Health and Mental Hygiene's Office of Maternal Health and Family Planning to develop a Regional Perinatal Advisory Board and establish a Prenatal High Risk Clinic in association with the Department of Obstetrics and Gynecology at the University of Maryland School of Medicine. The Regional Perinatal Coordination Project provided a host of service supports for the Dorchester providers including continuing education for staff and a management information

system to handle multi-provider patient risk assessment, diagnosis, and treatment data among all area prenatal providers.

Project Development and Overview of Operations

The plan for improving the health and wellbeing of the low income population centered on a public/private partnership model to integrate the case management and outreach services currently provided by the DCHD using an interdisciplinary team located at the FMHC and the Fadden and Washington PA office in Hurlock. A core minority neighborhood in Cambridge was selected for the location of the new health center. Grant funds and donations from concerned citizens equipped the clinic and helped hire staff.

Contributions of Consortium Members

Initially clinic personnel were housed at the Harriett Tubman Coalition Headquarters. As clinic personnel were added they moved to temporary quarters in a medical office building donated by the DGH. The FMCH grand opening was held on December 8, 1995. Both Dr. Fassett and Nurse Magee were in attendance at the grand opening symbolizing the historic link between the current establishment and the philanthropic spirit of commitment to caring that had been so much a part of their practice for many years. The decision to establish the FMHC in the neighborhood was a response to the great need for a locally-centered, culturally relevant community-based health care center that firmly identified with the African Americans it would serve.

As the project got underway the FMHC took on its role as the lead agency for the Consortium. All were in agreement that the relationship between FMHC and DCHD was a natural partnership from the beginning and that the addition of DGH made sense given their shared services ventures with DCHD. The DCHD contributed services and personnel to the Prenatal Project, housing them at the community clinic while the private family practice and the local hospital assisted with the recruitment of an obstetrician to stabilize the continuum of care needed in the area. Functionally, the FMHC and DCHD shared an integrated clinical space for the nursing, laboratory, exam and waiting areas.

Fassett-Magee Community Health Center

The FMHC, Inc. is a private, non-profit organization serving low-income residents of Dorchester County that do not have health insurance coverage and those covered by MA. The health center provides culturally-sensitive services through a community-oriented model of

primary care. In partnership with the DCHD the clinic provides a range of programs under a one-stop-shopping model that overcame a number of barriers that had been problems for clients of the DCHD. A Maternal and Child Health (MCH) program provides care for expectant mothers through the term of their pregnancy. Services include home visits, family planning, lead screening and follow up, school age immunizations, HIV testing and referral assistance. Addiction counseling is also available through an intensive outpatient service offering individual and group counseling sessions. A variety of special services are also provided including prenatal assessment, DWI court assessment, family counseling, detox referral, child and adolescent programs and an after care program. In addition to the nutrition services provided through the WIC program, individual and group dietary counseling services are available for free from a registered/licensed dietitian. Related nutrition services cover group classes on weight control, blood pressure and cholesterol reduction, and food shopping habits.

Dorchester County Health Department

The DCHD is a publicly funded organization providing a variety of health care services in the County. Matching funds from the state and county support the operating budget for basic public health services. The role of the DCHD in the prenatal project involved the contribution of services and personnel including an ob/gyn nurse practitioner, community health nurses, and outreach workers. Participation in the consortium would make an obstetrician available to provide consistent and quality medical care for DCHD prenatal patients. Working as a group also helped to better focus staff time on case-management and outreach efforts without struggling, as in the past, with coordinating specialty and sub-specialty care for high risk patients. Its nursing staff would also have access to expanded in-service education and training.

Fadden and Washington, PA

The offices of Fadden and Washington, PA provided a wide variety of primary health services for all ages from three locations (Cambridge, Hurlock in northern Dorchester County, and Federalsburg in Caroline County). The founding physician came to Dorchester County in 1981 as a National Health Service Corps Scholar providing outreach services for the migrant health program in Hurlock. By the time the RHOGP grant was awarded, the practice had grown to include three office locations and five family physicians plus a physician's assistant. After several years of working with the DCDH on the migrant health program, the growing group practice began working in earnest with FMHC and the DCDH to identify more effective

strategies for meeting the needs of the low income population in the area. The obstetrician expected to be hired by the project would be placed in the Hurlock office of Fadden and Washington, PA. This placement was a strategic decision based on the non-existence of prenatal care services in the northern part of Dorchester County. In addition, the physician would provide back-up and help maintain continuity of care through the FMHC and DCHD prenatal program.

Dorchester General Hospital

At the time of the RHOGP award, Dorchester General Hospital (DGH) was a non-profit, 114 bed acute care hospital (94 acute care beds and 20 psychiatric beds). Involved in the early FMHC planning efforts, the DGH officially joined the consortium in late 1994. Its membership completed the partnership of all major providers of prenatal care in the county. DGH offers comprehensive inpatient and outpatient medical, surgical, and psychiatric services for the county. Initially the DGH provided clinical space for the FMHC in its medical office building. In the minds of the hospital leadership, partnering with Fassett-Magee was a win-win proposition for them as well as the community. As a well established provider in the community, the hospital helped to broker relationships between FMHC and local specialists (especially obstetricians) over a number of turf issues. Although the private practice Ob/Gyns did not provide many of services for the low-income and Medical Assistance patients helped by the DCHD, turf issues were a concern that was further heightened by the development of Fassett-Magee. In addition, working with FMHC provided an excellent entrée into the African American community that helped residents to become more aware of key health issues and solutions.

<u>Project Self-Sustainability</u>

At the time of the initial application, the Prenatal Outreach Project was confident that its efforts could be sustained past the RHOGP award. This confidence was based, in part, on the intention to continue pursuit of funding opportunities whenever they coincided with project goals. It was a common concern to keep efforts focused on the plan as originally detailed and not become bogged down in tangential efforts that might bring in funds but divert resources and efforts away from the main task at hand. It was also assumed that any new practitioners recruited to the community would be self-supporting by the time the RHOGP grant expired.

The four major project objectives as defined in the initial grant application set their target values for a three year period following the expiration of the grant funding (i.e., 1997 through 2000). The application stated that “The three major expenses of this grant will be assumed by

other mechanisms. The salaries for personnel will be generated through revenues or assumed by the PHS Section 330 grant. Major training supplies will have been purchased and health department staff trained as "trainers" for new staff. The costs of health education classes will be assumed by Dorchester General Hospital or FMHC." The costs associated with the project director, registered nurse, and a receptionist would be covered by a Community Health Center Grant.

Project Scope and Issues

The first year of the RHOGP grant progressed slower than expected. Hiring an obstetrician took much longer than anticipated. After months of recruiting, one letter of intent was received from 15 candidates. The interested candidate backed out of the arrangement with only two months to go before his start date leaving the consortium in a difficult recruiting position. The consortium was also having difficulty recruiting a family nurse practitioner and initially settled for a part-time FNP to begin the project until a permanent staff person could be signed.

As recruitment problems for the rural community continued, consortium members were informed that further Section 330 funding to build on the previous year's planning efforts would not be available. This was a major blow to the effort since further 330 funding for implementation would have covered a full-time family practice physician/Medical Director for the clinic. Later discussions with the ORHP made it possible for the consortium to redefine its search, recruiting a family practice physician with obstetrical training rather than an obstetrician. This change provided an opportunity for the FMHC to continue operations as a Community Health Center and increased its chances of finding a practitioner for placement.

However, the shift in staffing goals had a ripple effect on the role of the physician group practice within the consortium. The original plan placed the obstetrician part-time at FMHC and part-time in the private practice office at Hurlock. The family practice physician would be housed at FMHC working part-time with the prenatal program and part-time in family practice. Fadden and Washington PA lost an obstetrician and FMHC was now able to provide comprehensive services for all FMCH patients as well as assure continuity of care for prenatal patients. After receiving designation as a National Health Service Corps (NHSC) site for family practice physicians, the FMHC obtained a NHSC Scholar in May 1996. Although their

commitment to serving the needs of the less advantaged residents of Dorchester County remained, the active role previously taken by Fadden and Washington, PA began to fade.

Another challenge to the on-going operations of the consortium was the potential of Medicaid Managed Care on the horizon. In 1996 Maryland submitted its 1115 waiver to HCFA for mandatory managed care enrollment for Medicaid patients (a major proportion of FMHC clients). As hospital systems and independent providers began to form networks in an effort to better compete in the new market, FMCH's future was not as clear as it once was. It was also at this time that Dorchester General Hospital merged with Memorial Hospital 15 miles away in Easton to form Shore Health Systems. They had been competing with each other over the past several years for surgical and obstetric patients. Obstetrical services were moved from DGH to Memorial in July 1997 followed by the closing of one of the local obstetrician offices as he relocated to Easton. The remaining obstetrician discontinued services that same year. Memorial Hospital was the larger entity and as of 2003 had 132 licensed beds compared to Dorchester General with 66 beds.

Largely due to the comprehensiveness of the prenatal program established under the RHOGP, the new hospital system and the Maryland Department of Health and Mental Hygiene continued to support the prenatal program at FMHC. The hospital invested considerable time and capital to create a primary care network in anticipation of the move toward managed care as did other hospitals across the nation. However, the project did not reach fruition and constrained future efforts to integrate primary care services in the region. At about the same time, the FMHC decided to join with the Caroline Health System, Inc. to form a community health center network.

Accomplishments

Many individuals believed the single greatest accomplishment of the Prenatal Outreach Project was building a prenatal and general primary health care presence in the African American community in Cambridge. There had been a clear and compelling need for such services but without the RHOGP grant and subsequent resources through grants and contributions it would not have been possible. The ability to garner such an array of resources over an extended period of time attests to the vision and determination of the core consortium members as well as the diligence, skill and grace of the nurse practitioner who had started working with the Migrant Health Program and the DCHD and ended up serving as the first

Executive Director of the FMHC. Her combination of grant writing skills, vision and ability to reach out to the entire community and achieve the level of acceptance and trust needed was one of the best resources available from the consortium.

Had it not been for the emergence of a strong grass-roots effort by leaders of the African American community pushing through decades of racial, cultural and economic turmoil, those services and grant writing successes could not have been possible. In addition to mobilizing members of the minority community, the group generated the political, social and economic support and awareness of need within the non-minority community to forge the alliance needed to make the community health center a reality providing not only prenatal care but a broad spectrum of support services. These included services available from the health department's WIC program, general nutrition and diabetes education, drug screening and counseling services and family and health education.

Housing this host of services under one roof provided a one-stop-shopping opportunity that was a natural solution for the timing and travel barriers that had been facing many local residents. It also provided opportunities for cross-program referral and follow-up. The prenatal program was so effective that even though the Shore System had the ability to compete, it continued to support the efforts of FMHC. By 1996, FMHC provided services to 1,604 patients with a total of 3,987 encounters. Almost 65 percent of the patients were female and 66 percent had income under 200 percent of the federal poverty line.

Discussion of the consortium's accomplishments would not be complete without noting the accomplishments of the project's four major objectives – lowering infant mortality, the rate of low birthweight births, and teen pregnancies, and improving the delivery of prenatal care services for low income minority women. A comparison of the pre-grant period rates (1987–1990) with post-grant period rates (1997–2000) clearly demonstrates that significant progress was achieved among a population that previously had ranked among the lowest for these indicators of population health and well-being.

Minority infant mortality rates in Dorchester County decreased from 23.4/1000 to 10.8/1000 births while the rates for the entire population of the county dropped from 11.7/1000 to 6.2/1000 births. While Dorchester County rates for low birth weight dropped from 9.3 to 9 percent, the state rate rose from 7.6 to 8.7 percent. Although the Prenatal Project was unable to reach its year 2000 goal for teen pregnancies (i.e. not to exceed the state rate), its rate of decline

was greater (21.7% to 17.5%) than that for the state (11.1% to 10.2%). Finally, the percent of pregnant women in Dorchester County who received prenatal care within the first trimester of pregnancy rose from 72 percent in 1990 to 86 percent in 2000 (the project goal was 90 percent by 2000).

Factors in Post-Grant Sustainability and Success

Post-Grant Experiences

At the time of the initial RHOGP grant application the project was expected to be self-sustaining by the end of the funding period. With the shrinking possibility of Section 330 funding, the growing interest in Medicaid Managed Care and the impending termination of the RHOGP funding, the FMHC Board of Directors began reviewing their strategic options in earnest during the second year of the RHOGP grant. With the delays in project implementation and the recruitment and retention issues it was clear that they could not sustain all services under the current organizational structure. At the time they had only one family practice physician and one nurse practitioner providing less than 5000 visits a year.

After considering their options and the advice of a consultant hired specifically to help examine self-sustaining strategies, it was decided to explore merging with an existing community health center network operating in Caroline County, the next county north of Dorchester. Coincidentally, that network, Caroline Health Services (CHS), was also in the process of identifying additional providers to expand its network of community health centers. CHS had been regularly working with Memorial Hospital in Talbot County and by joining forces FMHC would have a voice in the prenatal and primary care services coordination at both hospitals. Initially the expansion discussion also involved a third health center, Delmarva Rural Ministries, but after a year of planning Delmarva dropped out of negotiations. It was engaged in migrant health care but had a growing interest in entering assisted housing and chose to pursue that avenue independently.

In time a joint proposal was submitted to the Public Health Service by FMHC and the Caroline Health Services (CHS) for Section 330 Expansion Grant funding to create a community health network. They were serving similar populations in the same geographic area, governed by community-based boards and had similar missions. It was a complete asset merger with the horizontal integration of FMHC and CHS serving the two counties of Dorchester and Caroline. The merger was a strategic move on the part of both entities to build financial and operational

strength to negotiate on a more competitive level with the private sector while at the same time maintaining a safety net for uninsured and vulnerable patients. While it was legally more of a take over than a merger since CHS retained its 501 (c)(3) status and FMHC surrendered its incorporation, CHS gave up some autonomy in the process as the new board was created with equal representation from FMHC and CHS. A Public Health Service Expansion Grant award was awarded in January 1998 creating the Choptank Community Health System (CCHS). By 1998 the CCHS accounted for more 30,000 health care visits and 10,000 patients with FMHC accounting for almost 7,000 of those patient encounters (an increase of almost fifty percent over the previous year).

This new phase in the development of FMHC resulted in the further coordination and expansion of primary and prenatal care services as well as dental care, school-based wellness and dental programs in three counties, a 340B drug pricing program (a discounted drug program providing lower cost medication for low income residents), reduced cost diagnostic laboratory services for uninsured patients, and increased services for migrant workers. Although the Fadden and Washington, PA group practice dissolved with the exit of Dr. Washington, the Federalsburg office is still open and is being used by CCHS to help meet community needs in the area. It is now a solo practice with a nurse practitioner and the physician sharing call with three other physicians in the area. The work of CCHS along with many of the original consortium members continues to provide comprehensive care throughout the north shore region (Table 2).

Achieving the Post-Grant Sustainability Goal and A Strategy for the Future

Achieving the Goal

The most significant event that secured the future operations of FMHC was its merger with CHS. This provided a broader base of operations, greater area and specialty expertise and increased advantage for obtaining the necessary capital to continue developing operations, and a stronger negotiating position. When discussing the factors behind the consortium's post-grant period success respondents readily identified the former Executive Director of FMHC as a pivotal person who made things happen and happen in a way that was inclusive and always with the community's interests in mind. In addition to being trained as a pediatric nurse practitioner, she had a firm background in public health which was considered critical for understanding how community outreach and consensus building was accomplished. All agreed that networking

Table 2

Choptank Community Health System, Inc. Program Expansion

Time Frame	Initiative
9/99	Healthy Schools/Health Community funding awarded to develop the Caroline County School-Based Wellness Program
4/00	Community Development Block Grant awarded to renovate and expand the Federalsburg Medical Center (one of the four clinic sites including FMHC)
6/00	MD Health Care Foundation funding to develop Oral Health Program
6/00	Caroline Human Services Council funding to pilot mental health program through the School-based Wellness Program
11/00	MD Office of Children, Youth and Families funding to develop School-based Dental Program
6/01	MD Health Care Foundation funding for Mid-Shore Medbank Program in coordination with DCHD.
8/01	National Library of Medicine funding to expand Internet access for providers.
9/01	MD State Department of Education funding to support mental health professional at Federalsburg Elementary School.
2/02	BPHC Service Expansion funding for Oral Health Services Program and to expand mental health services through the School-based Wellness Program.
5/02	Youth Strategies Grant to expand Mental Health Services in the School-based Wellness Program.
8/02	Medical Capacity funding to expand pediatric and family practice services in Cambridge and Denton.
11/02	Access Point funding to establish a new CHC site in St. Michaels, MD.
1/03	March of Dimes funding to implement a prenatal home visiting program for high-risk, Spanish-speaking prenatal patients who are not eligible for medical assistance.

within the community was a key to success – the clinic works within the community and provides support without thinking about the direct benefits for the clinic. A willingness to go to where the community residents are engaged in everyday roles (e.g., church events, shopping centers, stores and other community meeting places) rather than asking them to come to you at the clinic made all the difference. Such efforts instilled a sense of honesty and forthright purpose of effort in the minds of all participants and strengthened the providers' and eventually the clinic's credibility in the community.

Leadership is a significant resource particularly when it includes vision and adaptability. The Executive Director's approach was to recognize what needed to be done, persevere in the efforts to achieve necessary goals and objectives, and when necessary, develop a slightly different plan to overcome potential barriers. This requires getting out into the community and gauging sentiments within the context of local traditions and beliefs with the goal of providing culturally and socially relevant services.

The on-going success of the consortium and the CCHC also depended upon the effort of the network members and their Board representatives to keep communication channels open and maintain strong working relationships in which mutual benefit and value can be demonstrated for all participants. CHS had a broader mission working from the ground up since the 1970's to establish a physician presence in Caroline County and develop private practices for third party payer and self-pay patients. The development of FMHC was independent and originally focused on the uninsured minority population of the region. While CHS focused on a business plan set within the context of private sector health care, FMHC focused on a business plan set within the context of the public sector with subsidized and charity care. This required a reworking of bylaws, procedures and a thorough examination of all of their policies for consistency.

Board members seldom serve on just one board and have numerous opportunities to work with each other in rural communities. This also means they have multiple opportunities for organizational turf issues. Many respondents attributed the continued post-grant success of the consortium to efforts to remain aware of the "tipping points" where individual agency agendas could focus attention more on each other rather than on meeting the needs of clients.

A Strategy for the Future

The transition period from RHOGP grant support to other sources had been planned for since the beginning of the prenatal project. A series of events in the initial implementation

coupled with emerging market trends alerted the consortium leadership to move earlier than they had planned, eventually stimulating a major reorganization with the creation of the CCHS just months after the expiration of the RHOGP grant. The strategy for the transition was straightforward. In addition to merging with the CHS, efforts needed to be taken to educate Cambridge area residents that FMHC was more than a safety net provider for minority and low income populations. The level of care and quality of service provided by FMHC rivaled private providers in the county. When coupled with the network of services and the continual modernization of capacity through grants and collaborative ventures of the consortium, patients could expect as good or better care than they could receive elsewhere in the county.

Retaining a major role as primary care provider for the community continues to be a goal of FMHC. With recruitment still a challenge for rural areas such as Dorchester and Caroline Counties it is critical to balance the growth of the organization with meeting community needs. The clinic needs a solid financial base to succeed in the end. This may lead to the expansion of the network (e.g., some discussions have been started with Peninsula Regional Hospital Center, approximately 30 miles southeast of Cambridge) to develop a community-based OB system for the eastern shore of the state. This has become more of a necessity as malpractice costs have increasingly pressured physicians who provide obstetric services.

Current Operations

Six years after the expiration of the RHOGP grant the consortium continues to deliver the services originally supported by the grant and has expanded into a wide array of other services designed to meet the needs of low income and uninsured residents of the Eastern Shore. The core business remains primary and prenatal care services but capacity has expanded through the merger with CHS from one to four and now five medical offices (the most recently added office was in St. Michaels)[9] and provides continuous medical coverage 24 hours a day seven days a week. Most clinic sites have evening hours and the Denton clinic is open on Saturdays providing multiple opportunities for residents to obtain the care they need.

The merger enabled clinic sites to add migrant health services including a full range of family practice services for migrants of all ages. The migrant health project uses a nursing outreach model to compliment the existing clinical services offered at its four clinic sites. Outreach services are provided to the camp sites by two nursing/outreach teams and evening

[9] On Tilghman Island in the western part of Talbot County jutting out into the Chesapeake Bay.

clinics are available three times a week at the sites closest to the migrant camps. Services are provided to all regardless of their ability to pay. CCHS is also a participating provider with most major insurance companies and HMOs. In addition, a sliding fee scale is available for any patient without insurance.

School-based health services are provided by CCHS at four Caroline County schools, in partnership with Caroline County Public Schools and the University of Maryland, School of Nursing. Oral health services are available at the Dental Center in Federalsburg (a two dentist, five chair facility) and through school-based programs in three counties along the Eastern Shore. The network now has formal arrangements for reduced cost diagnostic laboratory services for uninsured patients and pharmacy assistance programs to provide access to discounted prescription drugs. Grant funding represents approximately one quarter of their budget at the present time. The organization has grown by 125 percent in total patient visits over the past five years. In 2002, the total patient visits in the medical and dental clinics, school-based wellness centers and migrant sites approached 60,000 visits. Program staff exceeds 80 persons including 15 full-time practitioners with two additional pediatricians expected for Dorchester County in 2003. During the 2002 fiscal year, total patient service revenues exceeded $5 million for the first time.

The biggest challenge currently is maintaining a stable business plan and operations while accomplishing service goals. There continues to be many health care disparities for women and children in the CCHS service area. One of the more exciting areas of development for the organization is the provision of affordable pharmaceuticals. A key future challenge pointed out during the site visit was the expected failure of employer-based health care coverage to address pharmacy-based solutions to chronic illnesses. One idea being considered is the further development of a medicine bank to provide medicines to individuals who can't afford them and using clinic personnel to serve as a broker between physicians and pharmacies. Interest is also focused on approaches to strengthen the network's infrastructure such as developing and implementing electronic medical records.

Finally, respondents noted that the RHOGP is much wider in scope and more flexible for meeting grantee and community needs than the Community Health Centers program. They liked the more open and adaptable qualities of the RHOGP especially for meeting their changing circumstances over the three year grant period. They considered the ORHP to be very helpful

and the technical assistance provided was right on target. They suggested that the CHC and RHOGP grantees increase the coordination of their activities.

Summary

The Prenatal Outreach Project offered through the Fassett-Magee Community Health Center was instrumental in reversing some of the worst maternal and child/infant health statistics in the Nation. At the core of this achievement was the overcoming of barriers created by severe poverty, divisive socio-cultural values and ideals, and a limited health care capacity for meeting local needs. The achievement reflects the dedication and compassion of the community leaders and local providers in making the project work.

Project leaders recognized at the very beginning that bringing lasting relief to the region meant that project activities must be self-sustaining. They also understood that their commitment to community service and the provision of care regardless of the ability to pay would require balancing a business plan against service commitments. Rigorous planning and an on-going process of assessment were critical to this effort. In time they found that doing business in this way not only benefited the consortium's internal operations but helped shore up its external alliances as well. For example, the efforts of regional stakeholders such as the new hospital system and the State Department of Health and Mental Hygiene to support and encourage the continued operation of the prenatal program long after the expiration of RHOGP funding.

In addition to winning the respect and appreciation of other regional providers, project leaders recognized the importance of developing strong working partnerships. As early as a year prior to the expiration of the grant funding, the FMCHC was conducting negotiations with the Caroline Health System, Inc. to establish a firm foundation for future operations. Without the merger with CHS it would have been far more difficult to have weathered the changing health care marketplace of the late 1990s. They likely would not have been able to continue to address their service goals at the current level of involvement.

The role of strong, visionary leadership cannot be overemphasized in the success of the FMCHC. Prior knowledge of the community allowed the leadership to swiftly integrate into the surrounding community and to approach community residents on their terms rather than on the provider's terms. Understanding the social and cultural milieu of the community and using this understanding to help build bridges between the community and providers was a

critical step for the project. Education was necessary on both the demand and on the supply side of issues to make community outreach efforts a success. Most importantly, these outreach efforts were implemented where residents were involved in everyday roles and activities (e.g., in the churches, schools, social gathering places). Lastly, the project leadership fostered a level of flexibility and adaptability in project operations that was one of the driving features behind the project's overall success.

PROVIDENCE HEALTH CENTER, SHADY COVE, OR
Re-establishing Primary and Preventive Health Services in a Rural Region

The Providence Health Center (PHC) located in Shady Cove, Oregon (now operating as the Providence Medical Group – Shady Cove (PMG-SC)) first received operational support under the Federal Rural Health Outreach Grant Program in 1994. At the end of the three year funding period in 1997 the Center, with the assistance of several Jackson County providers and community leaders had created the infrastructure for providing access to primary and preventive care services for the Upper Rogue region. The PHC first started taking shape in the early 1990s through the efforts of the Upper Rogue Community Center and the Upper Rogue Physician Search Committee. Following several unsuccessful years of recruitment, the Committee approached a Jackson County Commissioner for help. The County Commissioner along with the Director of the Community Health Center, Inc., located in Medford about twenty miles south of Shady Cove, facilitated the establishment of the Upper Rogue Health Care Coalition to improve access to health care services for area residents.

The member organizations of this Coalition included the Upper Rogue Community Center (URCC) located in Shady Cove, the Providence Medford Medical Center (PMMC) and the Jackson County Health Department (JCHD) located in Medford, and a physician group affiliated with the PMMC. The new strategy called for the PMMC to take a dominant role in project development and operation by hiring a full-time mid-level practitioner, a part-time physician as Medical Director, medical assistants, a patient care coordinator and a receptionist to staff the clinic in Shady Cove. The clinic officially opened in the summer of 1994 with PMMC's Emergency Department responsible for area emergency and after hours coverage, including the operation of the hospital's "Call a Nurse" telephone on-call system. Physicians associated with PMMC provided inpatient care for area residents requiring hospitalization. The Upper Rogue Community Center provided community education, promotion, and outreach services as well as non-emergent medical transportation for patients in need of specialty and other ancillary services in Medford or Ashland. The Community Center also served as the grant applicant for the RHOGP award and provided physical space for staff from the Jackson County Department of Health and Human Services (JCDHHS). The JCDHHS provided immunization, community education, WIC, well-child and home visiting services.

Background

Service Area

Jackson County is located in the southwestern part of Oregon. The Upper Rogue region is located in the northernmost part of the County. Although located within the Medford/Ashland Metropolitan Statistical Area, the Upper Rogue region is recognized as rural. The region includes the communities of Shady Cove, Prospect, Butte Falls, Trail, Union Creek, and portions of Sams Valley and Eagle Point with a population of approximately 26,000 in 1990. The geography of the region ranges from sparsely vegetated rolling hills to steep densely forested mountains.

Known as the "Jewel of the Upper Rogue," Shady Cove has long been world famous for record breaking salmon and steelhead fishing as well as white water rafting. The region is known for its dry moderate summers and moderate to severe winters which can include dense fog at lower elevations and significant snow packs at higher elevations. It is common for area residents to be located more than 75 miles away from primary care services. Some residents, especially those living in the communities of Union Creek within the Umpqua National Forest and the Cascade Mountains, face particularly difficult obstacles during the winter months as mountain roads become slick and dangerous from drifting snow.

The natural beauty of the region responsible for drawing tourists to the area (e.g., the Siskiyou, Rogue River, and Umpqua National Forests) has shaped the area's economy since the beginning of the last century. For decades Jackson County and its communities prospered from an economy dominated by the timber industry until changing demands for lumber, evolving industry technologies and environmental concerns over logging federal lands led to a tail spin. Between 1990 and 1994 receipts from timber harvests on federal lands, long the mainstay of many local economies, dropped precipitously.

In Jackson County alone, federal logging receipts dropped from $18 million in 1990 to $4 million in 1994. With the subsequent closing of two major timber mills in the area by 1994 the number of "working poor" within the region rose at unprecedented rates. More than 400 local residents lost their jobs from a single mill closing. Those able to find new employment seldom found wages that matched their former income. This upsurge in the ranks of the unemployed in an area already suffering from high levels of unemployment further strapped the fragile health and social service resources in the area. The secondary

impact of lost employer health insurance coverage further pressured local health care resources. Many of the area's residents classified as working poor lacked employer-based health insurance coverage but could not qualify for the Oregon Health Plan (i.e. Oregon's Medicaid program) because of the wages they received through their replacement jobs.[10]

Barriers to and Demand for Care

With the region's timber-based economy sliding into recession, the needs of the local population were rapidly outpacing local resources. The area's unemployment rate was already higher than the state average placing many residents among the ranks of the uninsured. Twenty percent of the population in the area lived below the federal poverty level. In addition to the growing demands created by rising unemployment rates and increased rates of the under-and-uninsured, local health care and human service capacity was stretched to address the most costly phases of the life cycle – the elderly and the very young. The proportion of Upper Rogue residents over the age of 65 and the area's birth rate were both higher than the state average.

An area needs assessment funded by the Oregon Office of Rural Health in 1991 found that the lack of primary care providers in the area was increasing emergency room use and forcing scarce local resources to be used inappropriately. The inadequate use of prenatal care services in the area was particularly disturbing. In the Upper Rogue region, 137 out of every 1,000 expectant mothers received inadequate prenatal care compared to the state average of 79 out of 1,000 expectant mothers. The infant mortality rate was 21.1 per 1,000 live births for the region compared to 8.8 per 1,000 live births for the state. Area residents were clearly bearing the consequences of inappropriate access to primary and prenatal care services.

Local residents had enjoyed access to two family practice physicians for decades prior to their loss in 1989. The physicians had contributed enormously to the needs of the local population together averaging 77 medical encounters per day and remaining on call 24 hours a day. One physician was a D.O. and the other an M.D. and also a National Health Service Corps (NHSC) physician. By November 1989 both the Shady Cove Clinic on Highway 62 as well as the Shady Cove Medical Center located on Erickson Street had closed. The first

[10] The Oregon Health Plan, implemented on February 1, 1994, provided health care insurance for "a limited set" of health care procedures to Oregon residents that lived at or below 100 percent of the federal poverty level. However, residents between 101 and 185 percent of the federal poverty level represent the bulk of the uninsured population of the Upper Rogue region.

closed because of physician burnout while the second closed due to a physician's long overdue retirement. At the time of the RHOGP application the area had been designated as a Health Professions Shortage Area (HPSA) and a Medically Underserved Area (MUA). However in time, both clinic sites would reopen to provide services to the residents of Shady Cove.

The Upper Rogue Physician Search Committee was formed in 1989 by concerned citizens and community leaders in order to fill the gap left by the exodus of their two family practice physicians. After many years of continued effort to recruit a physician, including working with the National Health Service Corps and producing a promotional video, the care gap remained unfilled. A number of candidates had demonstrated an interest in the area. Their main reasons for not deciding to settle in Shady Cove were the 24-hour per day call schedule and the lack of patient transportation to services available only in Medford or Ashland. These were the same issues that had complicated the practices of the previous two physicians. The main reason for the burnout of the Shady Cove Clinic physician was the constant need to transport patients to Medford and make rounds with residents that required hospitalization.

During their search for a physician the Committee became aware of a family nurse practitioner (FNP) practicing in Medford who was interested in establishing a practice in Shady Cove. However, the majority of the Search Committee membership felt that although the community could use a FNP it first needed a physician. The FNP eventually established a practice at the old Shady Cove Clinic site of one of the former physicians. She had been planning the move for almost two years. Her clinic eventually became a competing service against the PHC that would be established at the Shady Cove Medical Center's site of the other physician on Erickson Street across from the Community Center.

At its grand opening, the Providence Health Center was staffed by a physician's assistant (1.0 FTE) and a physician from PMMC for medical oversight (.10 FTE). The hospital initiated community education efforts to prepare the local population for the placement of a mid-level practitioner. At the time, many community members were unfamiliar with mid-level practitioner practice. In response to community concerns the hospital agreed to consider placing a physician if it was demonstrated that a physician's

practice could be supported through community-based use. The community agreed to a mid-level practitioner as a temporary measure and accepted the mid-level practice.

Catalyst for the RHOGP Application and Early Ground Work

The activities that would eventually be supported through grant funds under the RHOGP would not have been possible without the commitment of the key coalition members. Formal planning began as far back as late 1989 when members of the Physician Search Committee approached a County Commissioner for help. Through her vision and leadership as well, as that of the Executive Director of the Community Health Center, Inc. in Medford, a plan of action began to take shape. She immediately approached the major health care providers in the region and convened a series of meetings to discuss the issues and identify a reasonable strategy for meeting the community needs in the Upper Rogue Region. An early step in this process involved the formation of a community liaison committee that provided input and legitimacy to the process. The committee included nineteen members representing the local ranger district, Episcopal Church, pharmacy, newspaper, bank, the Mayor of a neighboring town, the County Commissioner, the Community Health Center, Inc. in Medford, and a variety of local residents.

In time, the meetings involved the Providence Medford Medical Center, Rogue Valley Medical Center, Ashland Community Hospital, Community Health Center in Medford, Jackson County Health Department, and the Upper Rogue Community Center in Shady Cove. Group discussions initially focused on the possibility of one or more of the region's hospitals working with the Shady Cove community to establish a clinical practice. As the talks continued, both the Rogue Valley Medical Center in Medford and the Ashland Community Hospital in Ashland decided not to participate leaving the Providence Medford Medical Center as the only hospital partner in the venture.

In addition to the drive and vision of the Shady Cove stakeholders a number of people pointed to the special interests and values of the hospital CEO as key to the partnership that developed with PHCM. Speaking about the developing arrangement between the hospital and the Shady Cove community she noted …"how could we say no to people who have such persistence." The clinic and outreach concept also fit well with the hospital physician integration strategies and Oregon's developing managed care environment which favored integrated delivery systems. In a number of ways, the decision for Providence Medford

Medical Center to link with Shady Cove was a strategic decision driven by assumptions regarding the evolution of managed care in the state and the establishment of physician-hospital linkages.

Similar service area issues (e.g. an earlier request by the Shady Cove community for the Community Health Center to open a clinic in Shady Cove) caused some concern on the part of the PMMC. The Director of CHC working with the Shady Cove stakeholders already managed the Medford clinic and the Ashland Health Center. With efforts taking shape in Shady Cove the hospital became concerned about the possibility of a redundant clinic being established in Shady Cove. The hospital agreed to collaborate with the project on the condition that the CHC would not seek to establish an independent clinic practice in Shady Cove. This was an acceptable condition for the Community Health Center. As a follow-up to Shady Cove's request, the CHC conducted a needs assessment and found that it was not in their best interests to pursue a new clinic in Shady Cove. The neighboring community of White City had also asked the Community Health Center to establish a clinic in its area and this location fit better into CHC's long-term strategy. It would be able to serve the bedroom communities of the Upper Rogue region including Shady Cove.

Community support for the Shady Cove project was significant from the very beginning. The central role played by the Upper Rogue Community Center was recognized by all coalition partners and was a direct reflection of the interest and commitment of several community leaders. One of these leaders invested a portion of his personal wealth to purchase the former Shady Cove Medical Center to make it a turn-key operation for the return of a clinical practice to Shady Cove. In addition to the creation of the Upper Rogue Physician Search Committee, the formation of a community liaison committee was an influential community force behind the creation of the Upper Rogue Health Care Coalition and the subsequent strategies used to fill the primary and preventive care gap. The committee included members from all walks of the community. Key community members were intimately involved in the interview and selection of important medical staff for the clinic site. This was also mentioned a number of times as being a key factor behind the committee's acceptance of the physician's assistant who would eventually move into the Erickson Street site.

The coalition's primary motivation behind pursuit of the RHOGP was to obtain the funds necessary to build capacity to serve the under-and-uninsured residents of the region. The funding was expected to support the critical first years of the clinic's operations as it strived to meet the needs of the local population. The members of the clinic project did not expect to continue in the absence of all grant awards. They desired to use the RHOGP to establish an on-going capacity to pursue other forms of financial support for serving the uninsured. The group viewed the federal support as seed funding essential for jumpstarting clinic development and operations.

The Upper Rogue Community Center (URCC) took the lead as the grantee agency by providing a location for health and human services other than clinical care, providing continuing education and outreach services for the community and making non-emergent transportation available for the community. The Providence Medford Medical Center acted as the fiscal agent for the project. The County Health Department located in Medford provided WIC, lead testing, well child examinations, and immunization programs in the URCC, and the CHC brought a vast amount of development and operational experience for establishing the community health clinic in Shady Cove.

Project Development and Overview of Operations

A renewed practitioner search organized by the PMMC located a physician assistant with rural experience and ties to the West Coast, who was willing to relocate to Shady Cove. The ultimate acceptance of the PA was in part due to the involvement of key community members in her interviews and selection as the practitioner for the Shady Cove site. Extra effort was made to reach out to the community through a series of meetings designed to educate the community and encourage a dialogue about the project's goals and the rationale behind some of the key decisions such as using a PA first followed by an MD/DO at a later date. In addition to the PA, the hospital also supported a registered nurse to manage the clinic operations and a receptionist that had worked with one of the previous family practitioners. Knowing the community thoroughly was a major key behind the Center's success.

The Providence Health Center was dedicated in July 1994 and officially opened its doors for business on August 18, 1994. At the opening the clinic was staffed by a physician's assistant and a part-time physician from PMMC as the Medical Director (available once a week). The remaining staff included an LPN and a receptionist. The Center provided limited

lab support, portable x-ray services along with primary care. Walk-ins were always welcome but appointments were encouraged and medical services were offered for "newborns to seniors." At the dedication ceremonies, the County Commissioner most responsible for facilitating the consortium partnership that supported a successful community health center praised the local providers and community members involved.

Contributions of Consortium Members

Although the members of the consortium were previously familiar with each other, no prior collaboration had occurred among them beyond that expected among regional providers of a rural area. The hospital, for instance, had been working with the public health department on a prenatal clinic and school-based health care. With the hospital CEO serving as the chairperson of the region's Public Health Advisory Board there was an open channel for the County Health Department and the Hospital to discuss community health issues and priorities as partners.

The Providence Medford Medical Center is a 168 bed not-for-profit community hospital that is a member of the Providence System, a not-for-profit organization including hospitals, clinics, physicians, and long term care facilities across the four states of Alaska, California, Oregon and Washington. PMMC took a lead role in the development of the RHOGP project from the very beginning working closely with the CHC Director. Throughout the process the PMMC demonstrated considerable diligence in sorting through issues crossing organizational boundaries in terms of their benefit/risks for the coalition as a group and the hospital as a separate entity. In this way the hospital helped set the standards for the coalition in terms of pursuing self-sustainable goals.

While making considerable material and in-kind contributions to the success of the clinic, the hospital also faced a number of serious financial decisions at the time. It was supportive of the effort for a number of reasons. However, the hospital found that it could only do so if it would also exercise considerable diligence to protect itself against undo risks. The hospital announced publicly that its investment in the clinic would be stable for one year. After that period it would reassess its position and commitment to the project. During this "trial period" the clinic would be staffed by a physician's assistant (PA) (also on a trial basis) with the option of adding a full-time physician once it became clear that the surrounding service area could support such a practice in Shady Cove. The RN assigned to be the

Center's manager was a key employee of the hospital and the current Director of its Physician Service Program. She was given a year to get the project off the ground and was provided with support from the hospital CFO and financial analysts. After that period of time she was expected to reduce her commitment to the clinic to part-time and resume her previous duties as Director of the Physician Service Program.

Her clinic responsibilities included developing outreach efforts, starting new programs, monitoring and improving patient satisfaction and sitting on the community board for the PHC. Serving also as a provider of care, the center manager also would be working with the PA to develop first response policies and procedures with the local fire district. The clinic manager and the Director of the hospital's Emergency Department worked to stabilize patients before arranging transport to an appropriate source of care. Originally an ambulance company in Eagle Point provided the services (located twenty miles south of Shady Cove). The service was eventually purchased by Mercy Flight which then provided both ground and air transport services. EMS coverage was offered on a per capita basis ($50 per family per year). Individuals did not have to buy into the service and could pay a per trip rate while others were transported at no extra charge. In addition to the clinic manager, CFO and financial planners, the hospital made $80,000 available for the project. Of that amount, $1,000 funded a feasibility study, $2,000 supported grant development services, and the remaining $77,000 was pledged in support of the first year of clinic operations.

The Shady Cove Community Center is a not-for-profit corporation with an average operating budget of approximately $77,000. It provides a number of programs including transportation assistance, after-school and summer programs for the community's youth, senior support activities, short-term emergency relief for community families, and an information and referral service. The mission of the Community Center is to attract, initiate, and maintain community services and activities which benefit the residents of the Upper Rogue Region. It was in this capacity that the Center headed the Physician Search Committee in 1989 and served as a catalyst for the formation of the Upper Rogue Health Care Coalition.

The Community Health Center in Medford is a non-federally funded primary health care clinic founded in 1986 and operates a second clinic in Ashland Oregon established in 1972. The sole governing mission of the CHC is to optimize the health status of low-income and working-poor persons in Jackson County, Oregon. The center fulfills its mission by

offering primary health care services, medication assistance, and a limited mental health counseling program. The center operates on a budget that is generated through patient fees, in-kind donations, fund raising, and public and private grants. It played a vital role in the development of the Upper Rogue Health Care Coalition and began undertaking a needs assessment and problem-solving process with the Upper Rogue community as early as 1990.

The Jackson County Department of Health and Human Services, a public, not-for-profit agency in the Jackson County government, offers services that are traditional to public health agencies: including school-based clinics, vital records maintenance, family planning, sexually-transmitted disease clinics, prenatal services, immunization programs, well child examinations, and maternal and child health services. Operations are supported largely through block grants which involve both federal and state funding. The agency has been successful in establishing a "one-stop shopping" service delivery system in White City, about fifteen miles south of Shady Cove. Through this project it has started to bring together the services necessary for establishing a similar capacity in Shady Cove, with the help of the three other Coalition members.

Clinic Operations

When the PA started she was on-call to support EMS services in coordination with the local Fire District. The Medical Director came to the clinic twice a month and remained supportive of the PA and her efforts to meet community needs. Following the opening of the clinic, it was initially used by people that had not had access to basic primary care for quite a while. One unexpected role they found themselves in was linking patients with the Oregon Health Plan.

Evaluations of the first year of operations revealed that while the productivity goals were reached, the number of unduplicated users was less than two thirds of the initially expected number. Patient acuity and complexity and trust issues were offered as potential explanations. For example, many patients had little or no prior access to primary and preventive care and had needs that were beyond the capacity of the center (e.g., extensive dental work, hospitalization to stabilize and normalize body systems). Much of the eventual success of the clinic rests with the PA. In addition to facing community members that were not sure of her credentials, she was also under the lens of the hospital that had informed her that she was on a year trial basis. Tapping into the strong community leadership in Shady

Cove was a key factor as well as conducting many public meetings on a face-to-face basis with the community.

Substantial work was necessary to strengthen the center's capacity for processing medical claims and patient billing. The Center also suffered many of the common maladies of new starts in terms of linkages with existing payers, making sure as many patients as possible are enrolled in the plans for which they are eligible, finding the right types of services to meet patient needs among those currently supported by existing programs such as the Oregon Health Plan, and being able to acquire the necessary capital to purchase items such as durable medical equipment.

Project Self-Sustainability

From the very beginning, key stakeholders were aware of the need to identify alternative means for supporting those aspects of the project initially made possible by the RHOGP award. A carefully designed business plan and performance schedule was developed to support clinic operations in the first full year following the expiration of the grant award. For Providence Health System, the logical corporate strategy for post-grant operations was to transfer the clinic's management to the Providence Medical Group-South. Traditionally, they used three organizational structures to support system efforts: (1) the hospital; (2) a medical group; and (3) a managed care company. As the latter faded with diminishing federal and state efforts, the process for service development remained the same (i.e., develop a service using the hospital's development and management expertise and resources and then transfer it to an external unit for ongoing operations).

Initially, the PHC was under the auspices of key hospital personnel including the Director of the Physician Service Program, the CFO, financial analysts and physicians affiliated with the hospital (Providence Medical Group-North), and to a degree the hospital CEO. With the end of the grant award and following some administrative changes in the PMMC it was decided to transfer the clinic to the hospital's for-profit arm. This shift and the accompanying policies issues that arose from the transfer stand in contrast to what the project had achieved to date. It had become a self-supporting entity with some added help to address the needs of the under-and-uninsured.

Accomplishments

The involvement of the Community Health Center Director in the project was a major advantage for the PMMC because of its prior lack of experience in establishing and running a community health clinic. The hospital was able to bring critical resources to bear on complex issues by using an individual with extensive experience in addressing these types of issues. The additional services provided by the County Health Department coupled with the transportation services provided by the Community Center further strengthened the clinic's position in the community. This led to the establishment of a core community role that would continue well into the future. The addition of a physician at the end of the grant period in 1997 settled the long debated issue within the community about the need for a physician in addition to a mid-level practitioner and nursing staff.

The most significant accomplishment of the project and benefit to the community has been the re-establishment of primary and preventive health care services to the Upper Rogue area. In addition, the service area has benefited from an increase in coordination and collaboration for meeting emergency medical needs, the provision of a diagnostic and laboratory services and the provision of a range of community health and social service supports including transportation services. The project presented an opportunity for Providence Medford Medical Center to become a more active community partner, created valuable bridges with the County Health Department and other regional providers, and educated the public on how to successfully meet community needs using a variety of strategies (e.g., including the use of mid-level practitioners and nurses).

Clinic volume grew from three to 30 patients a day. It has expanded lab and x-ray services (one person cross-trained), has restarted diabetic education which previously was provided by PMMC, and pastoral counseling services. The involvement of the Community Center and its shuttle services has been a significant contribution to the clinic's success. Starting with only one van in 1987 the service added another van after the RHOGP grant in 1994 and it now operates four vans. Travel expenses have been covered by a special state transportation fund which pays $9 per client and a per client charge of $4 for each ride to Medford. The PMMC has also played a key role in maintaining this transportation capacity by using social accountability funds each year to help subsidize the service.

Through the efforts of consortium members there has been a significant increase in the proportion of community residents receiving their necessary immunizations. Initially almost every child in the area lacked the required sequence of immunizations. Now with the significant involvement of community volunteers for immunization clinics these figures have been dramatically reduced. Volunteers are also available for other clinic-related activities such as a Thrift Store that helps underwrite the additional costs of providing services to those unable to pay the full costs of services.

The project has also been a significant benefit to consortium members. In addition to providing a feeder system for the PMMC, the delivery system linkages also created a buffer against an incursion by other regional hospitals into the area. The project allowed the CHC to fulfill its mission to the community based on a collaborative model among local and regional entities.

Factors in Post-Grant Sustainability and Success

Many of the key project stakeholders indicated that the vision of self-sustainable operations was an important focus since the beginning of the project. The project would not have been as successful without the significant contributions of the PMMC. Even with the significant commitments of cash and personnel, the hospital exercised due caution in assessing the benefits and risks of each of its actions. This enabled the hospital to maintain a steady internal commitment to the project.

The clinic stakeholders maintained a strong awareness of the need to contain costs and keep operations efficient. Since rural primary care clinics typically operate on very slim financial margins and the goal of servicing the Upper Rogue region involved providing services to many under-and-uninsured patients, the concept of self-sustainable operation was viewed as a significant challenge. Grant funds were seen as a vehicle to obtain start up costs for services for the working poor.

A number of finance strategies were considered in the development of the project including certification as a Rural Health Clinic (RHC) with the benefits of cost-based reimbursement, the possibility of the state creating public insurance under the Oregon Health Plan, and fee for service and sub-capitation payments from third-party payers for patients with private insurance who chose Providence Health Center as their primary care provider.

For the public health department, the key was to develop operations in a way that would allow grant supported activities to become part of routine operations. The activities needed to be absorbed within the normal scope of operations. In addition, the JCDHHS had its successful "one-stop-shopping" model in place in White City and had assessed the potential outcomes of a similar effort in Shady Cove. Operations would be more efficient, outreach activities more successful because of the multiple services provided in the same location, and a public health mission would be met with less effort and resource investment.

Post-Grant Operations

Managing the transitional period from grant support to self-sustaining operations brought a number of issues to the surface for the coalition. The issues were less the result of the direct transition from grant funding to other revenue support than from the changes in the organizational relationship between the Providence Health Center and the Providence Health System.

While seemingly a logical follow-up in the hospital's carefully gauged project development and implementation strategy, the shift from an internal "research and development" phase overseen by hospital personnel to external implementation by the hospital's for-profit medical group reflects the larger corporate strategy of PMMC rather than synchronization with Shady Cove needs. The Providence Corporation decision makers approved of the transition because, in their view, the Medical Group had far more experience running a community health clinic than the hospital personnel that had first developed the project.

The decision to transfer the PHC to the Providence Medical Group-South effectively undermined the ability of the PHC to continue to serve the needs of its community under its original social contract (i.e. caring for all regardless of ability to pay). In the early part of 1995, the clinic attained status as a participating Rural Health Act clinic. With that status and the assistance of federal Rural Health Outreach funds, the clinic accepted low-income and medically-uninsured patients on a sliding fee scale. When the outreach grant ended in 1997 the clinic continued to comply with Rural Health Act clinic regulations and accepted patients on a sliding fee scale.

The financial underwriting of clinic charity care was provided by the Sisters of Providence; however, patients were required to make application to the Sisters of Providence

for the discounted services. At the time the clinic was transferred to the Medical Group, its status as a participating Rural Health Act clinic was terminated. The loss of the hospital as a partner meant that the underwriting of charitable services by the Sisters of Providence was no longer available. Charity care and discounted services remained available, to the extent they were deemed appropriate by the administrators of the Medical Group, but were provided at a lower volume than prior to 2000. The majority of charity care for low-income and medically indigent patients in the area is now provided through referral from the Providence Shady Cove clinic to the Community Health Center located in White City.

The most important health care needs of the community remain primary and emergency care. The goal for the project was to become viable within three years and to continue to try to treat everyone regardless of his or her ability to pay. These goals were now more difficult to balance. For example, providers at PHC had provided free school physicals at the clinic, but have discontinued the practice after the shift to PMG because of legal concerns voiced by management.

In 2000, the organizational relationship between the PHC and Providence Health changed again. This time the oversight and support of the Providence Health Center was shifted from Providence Medical Group North to PMG-South. This affiliation has proven to be far more beneficial particularly in terms of the mission and philosophies concerning the use of nurse practitioners and physician's assistants.

Current Operations

The original configuration of the Upper Rogue Health Care Coalition as a closely coordinated and integrated unit has ceased to exist. The functional relationships that still exist among the former coalition partners continue to make important health and human service programs available to the residents of the Upper Rogue region. However, the PHC is clearly a component of Providence Health System. It is useful for a small community health clinic to be partnered with a larger entity capable of sharing its expertise, personnel and other resources to help the clinic function effectively and efficiently. The Providence Medical Group – Shady Cove has become fully integrated into the Providence System and relies on its own operational revenue to continue providing services. The project has been a resounding success in that regard.

The clinic provides the instrumental support necessary to maintain the availability of health and human services at the Upper Rogue Community Center by continuing to work with the Community Center and the County Health Department. However, while still a critical part of the local health care delivery system the clinic has become distanced from the pulse of the community. The continued provision of primary care services in Shady Cove is a major accomplishment for the project. However, the loss of provider collaboration with the community and the loss of synchronicity among providers in the assessment of priorities and allocation of resources needed to meet current and emerging community health needs could create barriers for future progress. Reimbursement issues also remain a major concern in terms of the level of reimbursement by Medicare, the high cost of self-pay patients and the subsequent delay of care by uninsured patients, unpaid counseling, and coding issues.

Changes and developments in the regional health care market and within the Providence Health System also will influence the clinic's future operations. For example, while the clinic works closely with Providence Medford Medical Center, information exchange with the Rogue Valley Medical Center (which is in the Asante System) is limited and not always timely. All patient information is handled by mail. The developing trend of physicians admitting to one hospital but not the other and the Rogue Valley Medical Center's offering of services not available at PMMC (e.g. cardiothoracic surgery, PICU, NICU) may influence the clinic's future ability to serve its patients.

Summary

The Shady Cove project was successful for a number of reasons. There was very strong community commitment to the project as evidenced by large turnouts at public meetings, the involvement and commitment of prominent community leaders, and the willingness of the community to support and use the existing clinic facility. The members of the Health Care Coalition shared many common values and a general philosophy that focused on meeting the needs of the local population while taking into account how the economic disadvantages of the area influenced the ability of the population to seek and pay for health care services. The process of establishing a community liaison committee and the involvement of a politically influential advocate for local health care was also critical to building collaborations among necessary partners.

The timing of the project also was fortunate. The goal of establishing a primary care clinic and enlisting the help of one of the hospitals in the area coincided with the widespread focus on developing integrated delivery systems to address managed care pressures.

Finally, a needs assessment funded by the SORH contributed to the success of the project. Data were collected that highlighted the implications of poor access to primary and prenatal care giving added urgency to the actions and accomplishments of the Upper Rogue Health Care Coalition.

The major future challenge facing the Coalition is how organizational relationships with the Providence Health System will affect the delicate balance of sustaining a feasible business plan with the ongoing desire of meeting the major health needs of all community residents.