

# Emerging Strategies to Ensure Access to Health Care Services

## Rural Hospital-Health Clinic Integration



The AHA Task Force on Ensuring Access in Vulnerable Communities examined ways in which the access to and delivery of care could be improved. This strategy – focused on cooperation and collaboration through integration of rural hospitals and health clinics – is a way for vulnerable rural areas to better meet community need and stabilize and expand services as those needs change. The specific type of relationship formed between a rural hospital and health clinic, such as a Federally Qualified Health Center (FQHC), Rural Health Clinic or Community Health Clinic, will vary based on the needs of the hospital, health clinic and community. However, integration may take the following forms:

- ➔ Contractual collaborations, such as referral and co-location arrangements, or an agreement for the purchase of clinical and/or administrative services between a rural hospital and health clinic;
- ➔ Formation of a consortium or network that allows for sharing of clinical and administrative functions, as well as facilitate the continuum of care; or
- ➔ Corporate integration (i.e., merging the rural hospital into the health clinic).

Regardless of the level of integration chosen, as depicted below, this strategy has the potential to significantly improve access to health care services in vulnerable communities.

### Benefits of Rural Hospital – Health Clinic Integration

- **Eliminate Duplication of Services.** Integration allows each entity to dedicate its resources to what it does best, thereby eliminating duplication in services and allowing a community to more efficiently use its limited resources. For example, the hospital may focus on providing acute inpatient services, diagnostic and lab services, outpatient surgery and therapeutic services, without having to maintain an outpatient primary care clinic. In contrast, the clinic would focus on providing primary care and behavioral health services, without having to maintain a full set of diagnostic or lab services.
- **Improve Synergy Through Shared Resources.** Rural hospitals and clinics may also be able to share access to patient records or quality improvement programs, which would allow for greater synergy and integration of primary care, behavioral health and oral health, as well as secondary and tertiary care.
- **Create Efficiencies of Scale.** Efficiencies of scale between both organizations may be accomplished by sharing administrative and medical leadership functions, consolidating capacity, or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.



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## Federal Policy Solutions to Pursue

No changes are needed at a legislative level to implement this model, and many rural hospitals and health clinics have already taken steps towards integration. However, there are federal legislative and regulatory changes that can be made to lead to greater adoption of this strategy. These include:

**Regulatory and reimbursement differences.** Rural hospitals and health clinics are required to meet separate and distinct regulatory requirements. In addition, each is paid under its own reimbursement structure, which has its own set of standards and expectations. More closely aligned payment structures would help to align incentives and, therefore, encourage rural hospitals and health clinics to integrate.

**FQHC ownership and governance requirements.** In order to promote integration between rural hospitals and FQHCs specifically, changes to FQHC ownership and governance regulatory requirements are necessary. For example, generally speaking, the Health Resources and Services Administration (HRSA) (which oversees the FQHC program) does not approve relationships for a hospital, municipality or 501(c)(3) corporation to own an FQHC. However the regulations could be modified to allow such ownership when the FQHC has its own independent board of directors. In addition, HRSA has promulgated strict regulations that set forth additional governance requirements for FQHCs, including that the governing board must have a majority (minimum of 51 percent) of members who are patients of the FQHC and who, as a group, reasonably represent the patient population. There also are restrictions on the percent of non-patient board members who earn 10 percent or more of their incomes from health care-related industries (including hospitals). Relaxation of these requirements would allow for more collaboration between rural hospitals and FQHCs through their governance boards.



## Hospital and Health System Actions to Deploy

As hospitals and health systems consider whether this integration is possible in their communities, it may be helpful to review examples of the types of relationships that exist today. The AHA has highlighted many examples in the task force's report, available at [www.aha.org/EnsuringAccess](http://www.aha.org/EnsuringAccess). In addition, the AHA conducted a [webinar](#) exploring additional case examples. The Federal Office of Rural Health Policy has also created a [manual](#) highlighting effective collaborations between critical access hospitals and FQHCs.

Hospitals and health system should also consider engaging their boards in conversations related to the amount and type of services currently offered by the hospital to the community. Hospitals may utilize [AHA's Discussion Guide for Health Care Boards and Leadership](#) to assist with these conversations. These discussions may then be expanded to key community stakeholders, including patients and clinicians. AHA has developed a [Community Conversations Toolkit](#) to help hospitals as they engage in discussions related to the services needed in their community.