

Rural Health Clinic Survey

Office of Rural Health

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**Wyoming Department of Health
Rural and Frontier Health Division
Office of Rural Health**

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The Wyoming Office of Rural Health surveyed the 16 certified Rural Health Clinics in Wyoming and consolidated the information into this report. In some areas, a Rural Health Clinic may be the only source of outpatient primary care within the entire county, or for several thousand square miles. This information may help other clinics understand why becoming a certified Rural Health Clinic may be in their best interest.



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Background

“Rural Health Clinic” is a Centers for Medicare and Medicaid Services (CMS) designation that qualifies clinics for an increased Medicare and Medicaid reimbursement of approximately \$20 per visit. While Wyoming has numerous clinics in rural areas, only 16 have been approved for RHC status. The Rural Health Clinic (RHC) Program was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualifying clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain non-physician services. For RHC purposes, any area that is not defined by the U.S. Census Bureau as urbanized is considered non-urbanized. RHCs are located in areas that are designated or certified by the Secretary of the Department of Health and Human Services (HHS) as Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA), including the Wyoming Governor’s HPSA designation that was approved by HHS in 2009. A clinic cannot be Medicare approved concurrently as an RHC and a Federally Qualified Health Center (FQHC).

The Wyoming Office of Rural Health (ORH) conducted this survey to learn more about Wyoming’s RHCs. ORH developed 66 questions designed to educate ORH, policy makers, and the RHCs themselves on RHC specific information. Wyoming does not currently have an association dedicated to RHCs; therefore, this survey may provide each RHC with some basic information about how they may compare to their peers.

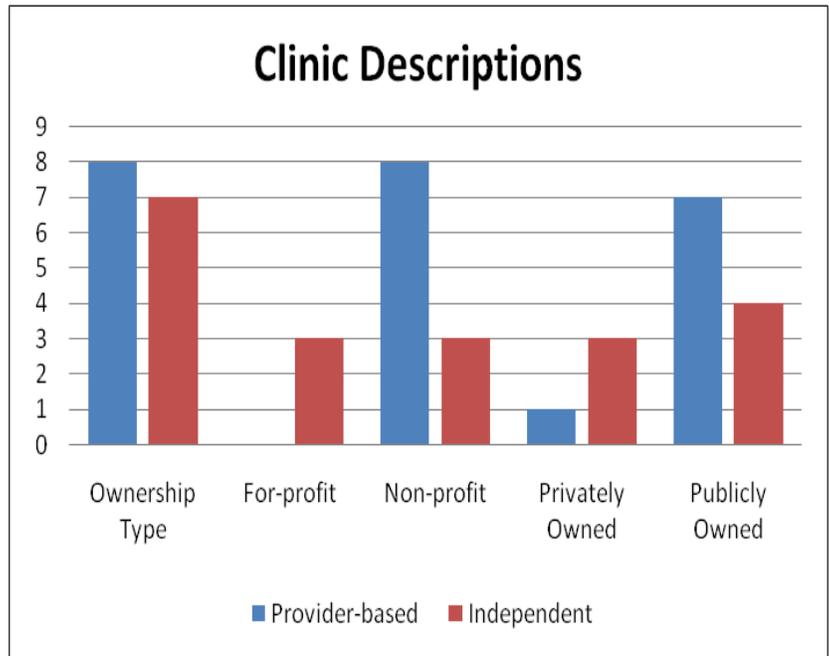
Methodology

ORH mailed letters to each of the 16 certified RHCs in Wyoming identifying the SurveyMonkey.com website address and projected timeline. ORH did not include clinics pursuing RHC status, only those clinics presently certified as an RHC. ORH conducted follow-up via e-mail three weeks later and by telephone at four weeks. Additional follow-up was not required as all existing RHCs completed the survey. One survey response incorporated information from two clinics owned by the same entity. As a result, there are 15 total responses. Not every clinic responded to every question; therefore, responses to some questions do not total 15.

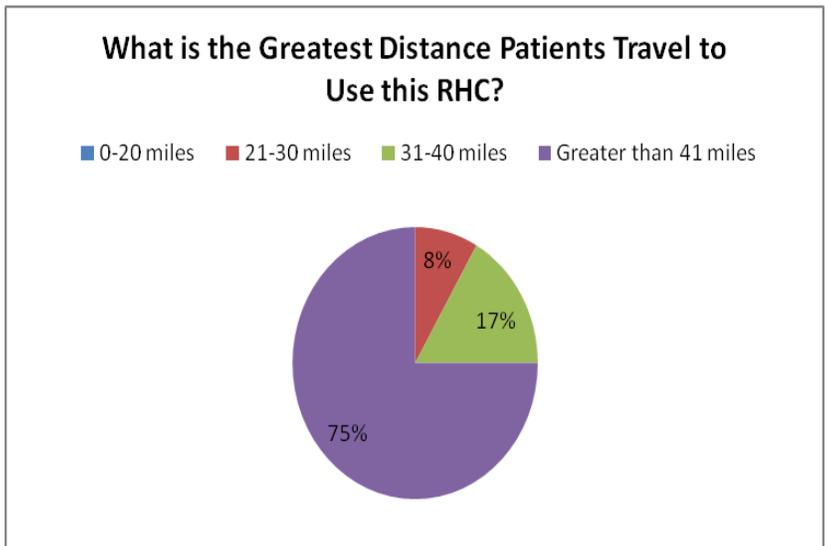
Clinic Descriptions

There were two RHC ownership types easily recognizable in this survey: Provider-based (hospital owned, n=8), and Independent (not hospital owned, n=7). All of the Provider-based clinics are part of a Critical Access Hospital (25 beds or less). Throughout the report, clinics will be referred to as All, Provider-based, and Independent. There are 4 privately owned RHCs and 11 publicly owned RHCs; 11 are non-profit, 4 are for-profit.

RHCs are located in Newcastle, Upton, Baggs, Thermopolis, Moorcroft, Sundance, Hulett, Guernsey, Glenrock, Basin, Lusk, Green River, Saratoga, Lovell, and Medicine Bow. Most of these towns are small remote communities where the RHCs are often the only primary care access point for many miles.



Some of these clinics are the sole source of healthcare within literally thousands of square miles.

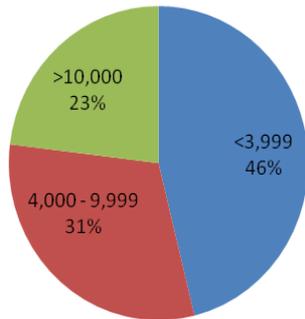


The community remoteness is evident with 9 of 12 Rural Health Clinics stating some of their patients travel greater than 41 miles, one way, for care (3 clinics did not respond to this question). Considering winter road conditions and generally non-interstate travel, this is quite challenging for several months of the year.

The size of the communities served by RHCs is highlighted by the number of patient encounters RHCs reported. Centers for Medicare and Medicaid Services (CMS) identifies 4,200 annual patient encounters as one physician full-time equivalent; 46% of the RHCs did not exceed 3,999 patient encounters in 2009. *Nearly half the RHCs are in communities so small that a physician would receive a reduced reimbursement from CMS for not treating enough patients.* Of the 10 non-profit RHCs which responded to this question, 60% had 3,999 or fewer patient encounters.

Patient Encounters per RHC in 2009

CMS: 1 physician
FTE has 4,200
encounters
annually



Because so many locations are unable to generate enough patient encounters to fully utilize a physician, only four RHCs are staffed by a full-time physician; nine are staffed by a full-time physician assistant; three by a nurse practitioner.

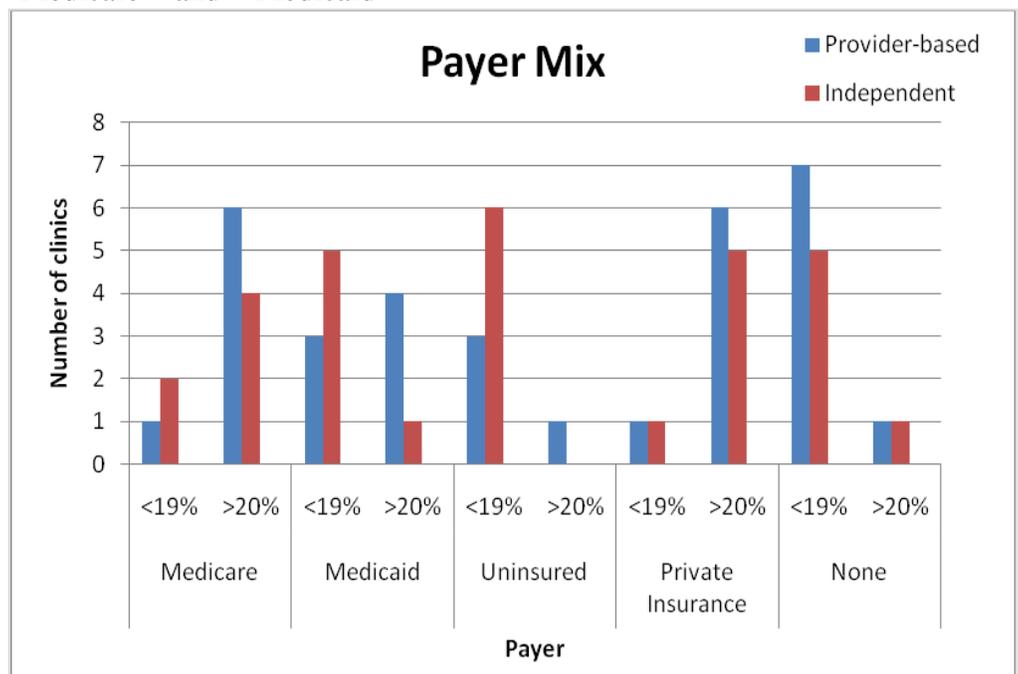
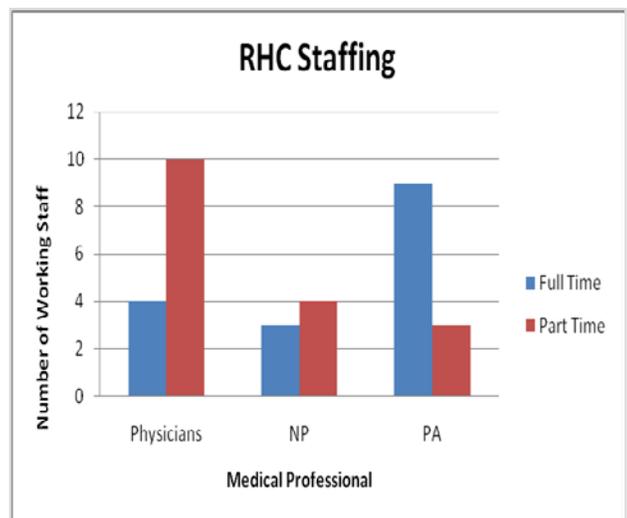
Healthcare Professionals

Wyoming's RHCs employ a variety of other healthcare professionals including: RNs (9 clinics), receptionists (11 clinics), office managers (7 clinics), medical technicians (5 clinics), and billing clerks (5 clinics). Only one clinic had a coding specialist; and only one mental health professional is employed by or working with an RHC. CMS does allow mental health professionals to bill for services while

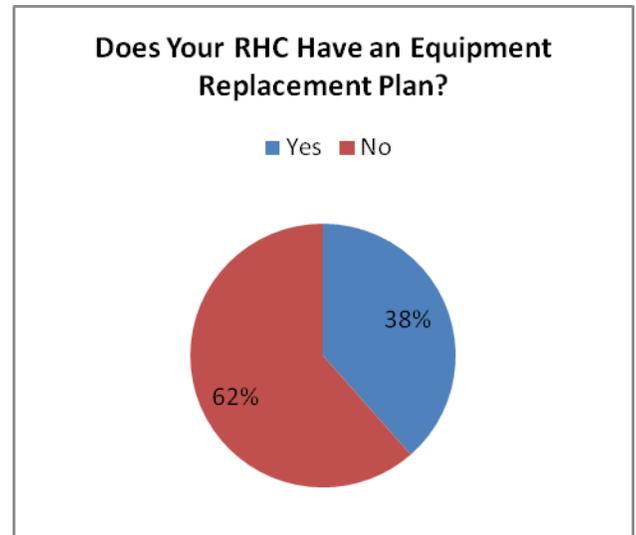
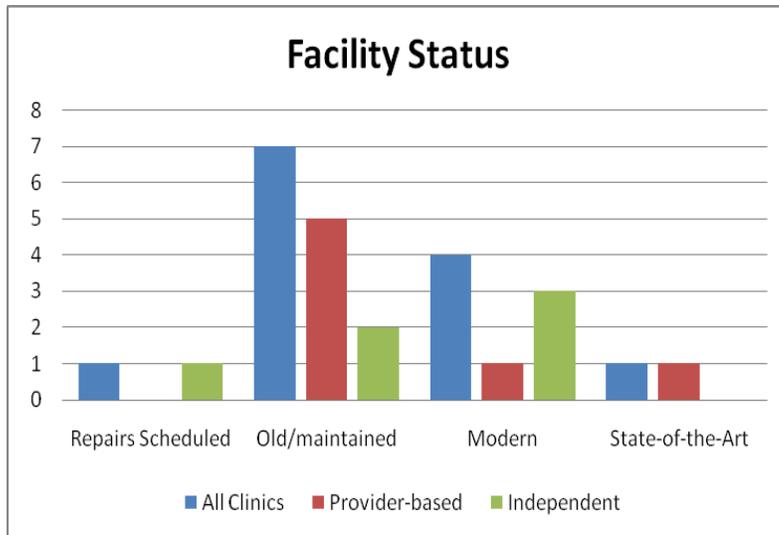
working in RHCs. The RHCs may bill both a regular visit and a mental health visit on the same day. CMS does not allow this billing practice in other clinic models.

Insurance

RHCs require that a profit be earned or at the very least break financially even, to continue serving in their rural community. RHCs are not required to have a sliding fee schedule for low-income patients and do not receive federal funding to offset healthcare provided without reimbursement. RHCs receive a higher reimbursement from Medicare and Medicaid than a 'regular' clinic (approximately \$20 per Medicare/Medicaid visit); Provider-based (owned by a hospital) RHCs may receive substantially higher Medicare and Medicaid reimbursement than an Independent RHC. This may explain why RHCs care for fairly high percentages of Medicare and Medicaid patients, while other providers express disappointment about low Medicare and Medicaid reimbursement.



Facilities and Equipment



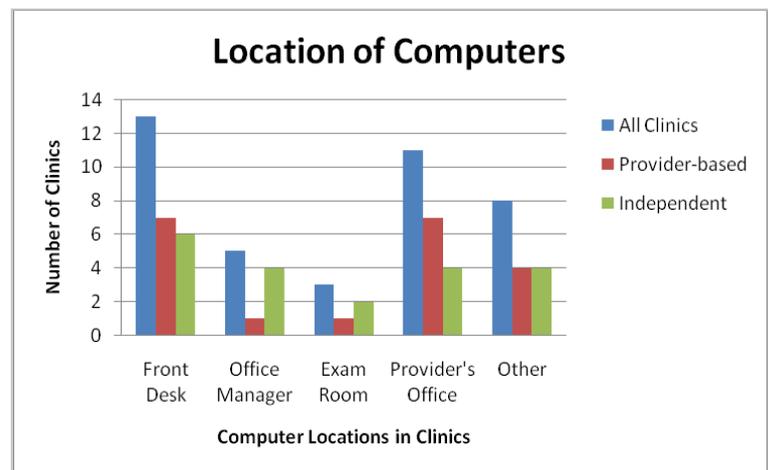
Parity regarding facility status seemed to exist between the Provider-based and Independent clinics. The most common responses to the facility status survey question were old but well maintained, followed by modern. Four clinics, two of each clinic type, do not have facility maintenance plans. The lack of a plan could be problematic due to building age and remote locations.

The majority of RHCs identified equipment as serviceable, but becoming dated (61.5%), and half do not have equipment replacement plans. Every manufacturer has an estimated life span for their equipment. A simple spreadsheet with date purchased, life expectancy, and projected year of replacement can prevent a work stoppage due to equipment downtime. An equipment replacement plan for Provider-based clinics can assist with business decisions, such as replacing equipment in the hospital and filtering older/serviceable equipment to the RHC which may be included on the annual cost report.

Facility maintenance and equipment replacement are often viewed as an expense that can wait. However, a good business decision is based on fact and a facility maintenance plan and equipment replacement plan would allow for fact-based decisions regardless of clinics being privately or publicly owned.

Computers and Electronic Media

Every responding clinic indicated the RHC had at least one computer and some type of high speed internet capability. Over half the clinics reported computers were less than one year old. Independent clinics (66.7%; 4 clinics) were ahead of Provider-based clinics (14.3%; 1 clinic) in the use of electronic medical records (EMR). Prescribing medicine electronically (e-prescribe) between the clinic and pharmacy followed the same results as EMR. Both clinic types used electronic billing with similar frequency. Over 30% of RHCs do not have e-mail capability, despite all reporting internet capability. The



Provider-based clinics fall behind the Independent clinics in electronic billing usage. There are four RHC web pages, split evenly between the two clinic types. Computers and electronic media seem to show a considerable disparity between the two clinic types; Independent RHCs have a substantially more favorable position than Provider-based clinics.

Funding

Billing practices continue to show a disparity between Provider-based and Independent RHCs. Eighty-six percent (86%) of Provider-based RHCs do not perform their own billing, compared to 33% for Independent RHCs. Both clinic types utilize electronic billing at nearly the same frequency (approximately 62% each).

Nearly 62% (8 RHCs; 4 each clinic type) of all RHCs receive funding from sources other than patient care. Of the eight clinics, five clinics reported receiving less than 10% of funding from sources other than patient care. Three Independent clinics identified 26% or more of clinic funding came from sources other than patient care. Seven clinics identified local tax as one source of the funding. There are multiple counties with Rural Healthcare Tax Districts which can be used to assist clinics.

Independent RHCs usually (83%; 5 of 6) hired a Certified Public Accountant (CPA) with RHC expertise to complete their CMS required cost report. One clinic had an office manager perform the task. Provider-based clinics worked on their own CMS cost report 40% of the time (2 of 5) and more frequently hired a local CPA. The only clinic not receiving the maximum reimbursement (\$76.76) had the office manager prepare the cost report; eleven of fifteen clinics responded to this question.

Miscellaneous

- All RHCs provide preventive care services.
- No RHCs provide transportation to or from appointments.
- All RHC staff receive adequate time off (Refer to bottom of Page 6).
- All non-provider staff in all RHCs are well-trained.
- Eighty-six percent (86%) of Provider-based clinics reported if their clinic did not exist, their patients would be required to travel 20-39 miles (one-way) for care; 67% of Independent clinics stated their patients would be required to travel over 40 miles (one-way) for care.
- Provider-based clinics are 100% Somewhat Confident to Confident in their clinics' ability to pass the RHC survey with few to no deficiencies. Independent clinics express higher confidence, as half responded they were Very Confident. CMS certification requires an RHC survey be conducted to verify the clinic complies with CMS requirements (i.e. a mid-level provider on duty 50% of clinic hours).

	Not Confident	Somewhat Confident	Confident	Very Confident
Provider-based	0%	28.6%	71.4%	0%
Independent	0%	16.7%	33.3%	50%

Barriers, Challenges, Opportunities

Clinics were asked the following questions and given a list of several barriers and challenges which could then be rated on a scale of one to five, with one being Least Critical and five being Most Critical.

“What healthcare needs does your clinic need assistance in providing?” From a list of 14 health issues that RHCs might need assistance providing in their community, the ones most frequently identified by RHCs as Most Critical were mental health related (5 responses) and substance abuse related (3 responses). One level down, the most frequently identified issue was nutrition/diet counseling (8 responses) followed by diabetes-related (6 responses). Not surprisingly, mental health and nutrition/diet counseling tied with the highest average rating of 3.83. Obesity ranked next with an average rating of 3.33, followed by diabetes and substance abuse with 3.25. Obviously, mental healthcare and diet/nutrition counseling are the most pressing health issues Wyoming’s Rural Health Clinics need assistance in providing.

“What are your community’s biggest barriers to healthcare?” From a list of 15 general barriers to healthcare, Wyoming’s RHCs identified the following as the three most common Most Critical barriers: 1) lack of 24 hour Emergency Room/Urgent Care Clinic (5 responses), 2) travel distance/time to specialist (4 responses), and 3) lack of local mental healthcare (4 responses). The next most critical level indicated travel distance/time to specialist (9 responses), lack of pediatrician (5 responses), and lack of internal medicine (5 responses) as the most frequently selected barriers. The highest average ratings were: 1) travel distance/time with an average rating of 4.31, 2) lack of in-home care with 3.50, and 3) lack of local mental health care, diet/nutritional counseling, and lack of 24 hour emergency Room/Urgent Care Clinic all tied with a 3.25 average rating. The greatest discrepancy between the two clinic types is that Independent clinics rated lack of in-home care as the second highest barrier with an average rating of 4.0; Provider-based clinics had it ranked 7th with 3.14.

“What do you consider barriers to meeting your patients’ healthcare needs?” From a list of 21 barriers to healthcare, Wyoming’s RHCs identified these as the most common Most Critical barriers: healthcare provider burnout/number of primary care providers in community was tied with locally available mental health outpatient care (4 responses each) followed by lack of back-up primary care provider for call and vacation time (3 responses). The highest average ratings were: 1) lack of locally available specialist (4.00), 2) lack of locally available OB/Gyn (3.77), and 3) healthcare provider burnout/number of primary care providers in community (3.75). The greatest discrepancy between the two clinic types is Provider-based clinics overwhelmingly identified healthcare provider burnout as the Most Critical barrier with a 4.57 average rating. Independent clinics ranked it 13th with a 2.60 average rating. This was somewhat contradicted in the Miscellaneous Section of this report (bottom of Page 5) as 100% of clinics responded staff received adequate time off, and generally, burnout is associated with inadequate time off.

Most desired training documented in the survey involved working with specialists, telemedicine, mental health/addiction counselors, diabetes, and nutrition/diet counseling.

Biggest challenges identified were: recruitment and retention of physicians, economic viability (low patient volume, Medicare/Trailblazers, lack of insured patients), staff turnover, shortage of healthcare providers, high number of self-pay patients/low revenue, public relations, and upgrading high cost medical equipment with limited budget due to low population.

Next Steps

Based on the survey findings, ORH will:

- Provide trainings via webinar, face-to-face, and/or video to address training needs;
- Provide stipends for RHC staff to attend continuing education opportunities;
- Advocate to create a consolidated voice for RHCs (i.e. Rural Health Association); and
- Educate clinics eligible to become RHCs on the benefits and requirements of conversion.



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