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Rural Health: Collaborating to Improve Local Healthcare Access

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I live in a small, rural community. My community has lost their long-time healthcare provider, and we are having trouble recruiting a provider. What now?

This report provides information on specific rural health strategies and an example of a service model for the entrepreneurial nurse practitioner. Primary health care is essential for everyone, but obtaining high-quality health care can be difficult in rural areas. Many rural communities have experienced the struggles with recruiting and retaining primary healthcare providers. Currently, a common element in recruiting healthcare professionals is to “grow your own.” Individuals who have grown up in a rural area are more likely to return or live in a rural area than their urban counterparts (Chan et al. 2005). Rural community leaders should continue to work with local schools and the community to identify their healthcare workforce. Recruiting rural healthcare professionals is a challenge even for experienced and successful hospitals, making efforts even more complicated for a small community searching for a

local provider. Communities exploring these efforts without a hospital presence face additional issues, including provision of adequate time dedicated to recruitment efforts and having limited financial resources to provide incentives and competitive packages. They often lack an awareness of possible healthcare delivery options.

Over the years, the healthcare delivery model has changed from having a hometown doctor to a more centralized service delivery model, with services being provided in a larger, more populated area. Many rural programs have been implemented to maintain a local presence, but funding and resources are limited. Currently, 20 percent of the U.S. population resides in rural areas; however, only 9 percent of physicians practice there, and only 3 percent of recent medical school graduates plan to establish a rural practice (McIlvaine-Newsad and Clark 2003). Thus, this paper provides a rationale for rural areas to begin examining their community’s healthcare needs and identifying an appropriate service delivery model.

Rural Health Reality

Rural areas are facing healthcare professional shortages because of having more elderly residents at the same time that many healthcare professionals are retiring (McIlvaine-Newsad and Clark 2003). *The Urban and Rural Health Chartbook* also notes additional health disparities facing rural residents (Glasser et al. 2003). Rural children and young adults have the highest death rates, and rural residents have the highest death rates for unintentional and automobile-related injuries. Rural men have the highest death rates for suicide and heart disease; rural residents have the highest

smoking levels; and rural women report the highest rates of obesity (Glasser et al. 2003). People in rural areas often must travel longer distances to access health care. This is especially significant for elderly residents who may not have access to transportation. Fifteen percent of the population in nonmetropolitan areas are 65 years of age or older, compared to 12 percent in urban areas (Glasser et al. 2003). As Lindeke (2005) notes, “Approximately 1 in 3 rural adults is in poor to fair health, nearly one-half have at least one major chronic illness, and only 64.5% have private health

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insurance” (p. 178). Lack of insurance along with geographic isolation, poor health, and chronic disease, leads to limited access to providers and poor health outcomes. The access problem is compounded when fewer providers accept new patients or specific types of coverage because of medical

liability insurance, adequacy of reimbursement, or other concerns. While access to health care can be difficult in urban areas, it can be even more difficult for rural individuals and families.

Improving Access to Care

With an aging population and limited access to health care, rural areas must identify innovative and creative solutions for improving access. This report provides information on the role of mid-level practitioners in a rural community, the value of a rural health clinic, and an example of a service model for the entrepreneurial nurse practitioner.

Mid-Level Practitioner’s Role in Providing Primary Care. Nurses or mid-level practitioners are a valuable resource in bridging the gap between rural patients and access to health care. Nurse practitioners can work either independently or with limited supervision from physicians in all but seven states, and typically these practitioners have lower office fees than physicians (Kaiser Network 2006). The scope of practice for a nurse practitioner includes emphasizing health promotion and disease prevention, as well as diagnosing and managing acute illnesses/injuries and stable chronic diseases. They have the knowledge and authority to order, conduct, and interpret diagnostic and laboratory tests, and prescribe medications, treatments, and therapies (Sherwood, Brown, Fay, and Wardell 1997). Brown and Grimes (1993) identified that patients demonstrated greater satisfaction and treatment compliance with nurse practitioner-provided care, and providers spent more time with patients per visit than physicians (Sherwood et al. 1997).

Nurse practitioners and nurse-managed clinics that are providing for underserved populations in rural areas work to minimize the health disparities that exist among rural residents. Nurse practitioners have taken an active role in providing primary care to patients and, nationally, there are 250 nurse-managed primary care centers (Kaiser Network 2006). Nurse practitioners, along with other healthcare professionals and organizations, have worked collaboratively to help state and federal policymakers understand the healthcare disparities in rural areas.

Rural Health Clinics’ Role in Improving Access. In response to the healthcare disparities in rural areas, state and federal initiatives have been implemented to address the quality of life in small communities. One such initiative was the establishment of Rural Health Clinics (RHCs). RHCs were created to help meet the needs of underserved areas by providing incentives to participating providers serving Medicare and Medicaid patients, thus retaining elderly residents on the RHC rolls who require access to health services. RHCs address quality-of-life issues by improving access to care. They provide services in areas with lagging economic development, low-paying jobs, numerous Medicare and Medicaid participants, and/or scarcity of providers or of providers willing to accept Medicare and Medicaid coverage. An RHC can stand alone, be a part of another building, or be a mobile unit, as well as be for-profit or not-for-profit, public, or private (Rural Assistance Center 2005, para 5).

The RHC model provides cost-based Medicare and Medicaid reimbursements that allow for medical providers to better serve the needs of these patients. Many, if not most, medical offices limit the number of Medicare and Medicaid recipients treated to effectively cost shift² and meet overhead demands because reimbursements for Medicare and Medicaid patients are typically insufficient to cover costs (Tucker 2002). A disproportionate number of these recipients live in rural areas, placing greater stress on medical offices to cost shift (Size 2006, para 10).

To assist healthcare providers in caring for these patients, RHCs provide financial incentives. Some of the financial benefits include a higher reimbursement rate and incentives for the use of mid-level providers. The enhanced reimbursement rate for Medicare and Medicaid is understood to be “all-inclusive” and encourages RHC providers to serve these populations.³ All services

²Dobson, DaVanzo, and Sen (2006) define cost shift as “systematically higher prices (above cost) paid by one payer group to offset lower prices (below cost) paid by another . . . cost shift is the allocation of unpaid costs of care delivered to one patient population through above-cost payments collected from other patient populations” (23).

³The Medicare RHC model is a federal program, while Medicaid reimbursement levels are established at the state level. Providers receive a higher maximum reimbursement rate for Medicare visits (Rural Assistance Center 2005, para. 2), and the State of Illinois offers a higher reimbursement rate on Medicaid visits.

provided during the visit are included in one rate whether the treatment includes sutures, bronchitis, or procedures, but all visits that are billed must also meet federal program criteria. RHC status provides reimbursement based on the cost of services provided, supplies for those services, hours of operation, and number of staff receiving benefits. In rural health, costs of services rather than number of patients served are the justification for the higher reimbursement rate. RHCs also provide provisions for collaborative care by using nurse practitioners and physician's assistants with physician oversight. Patients must request the visit and a face-to-face consultation with the mid-level provider or the physician. Providers must understand both state and federal reimbursement rates for Medicare and Medicaid, as well as the specific program guidelines for RHCs.

Specific RHC program guidelines require an agency to meet other criteria, including documenting need in the community. Eligibility for an existing medical practice can be determined based on location or profile of the practice such as being in a Health Care Provider Shortage Area (HPSA) as designated by the Illinois Department of Public Health (IDPH) and the federal government (Bureau of

Health Professions 2007). Once community eligibility has been established, communities or providers can work with various state organizations to complete the application process for an RHC. A formalized needs assessment should be conducted in collaboration with area partners. Additional information for developing an RHC can be found on the Centers for Medicare and Medicaid Services website (www.cms.hhs.gov) as well as on the Rural Assistance Center website (www.raconline.org).

The establishment of RHCs has been a successful tool in improving access to health care for rural residents. The increased role of the nurse practitioner in providing primary health care along with alternative funding mechanisms has increased opportunities for developing creative service delivery models. New models provide potential strategies for rural community leaders to continue to enhance access to health care for their residents. This report provides an example of a nurse practitioner who owns and manages an RHC in Illinois along with detailed information on the role of the "collaborative agreement," practical information for establishing a nurse practitioner-owned RHC, and potential strategies for avoiding obstacles.

Collaborative Agreements

When the Nursing and Advanced Practice Nursing Act (P.A. 91-0414) was rewritten and revised in Illinois to define nurse practitioners and their scope of practice, it created an opportunity for individual practice (private practice) by nurse practitioners. Collaboration with a physician is the key to success. The physician must support nurse practitioners, understand their role, and have confidence in their skills. These essential elements make nurse-practitioner ownership of a clinic plausible.

Section 15-15 of the Illinois Nursing and Advanced Practice Nursing Act (Illinois General Assembly 2007) explains the criteria for collaborative agreements between a physician and a nurse practitioner. The agreement must describe the working relationship between a physician and a nurse practitioner; however, the Act states that, "collaboration does not require an employment relationship between the collaborating physician and advance practice nurse" (Section 15-15b).

Under federal RHC regulations, a physician need not be present at all times; however, methods for communication between the nurse practitioner and physician must be spelled out in the written agreement. The "physician medical direction" as outlined in the agreement is considered adequate if a collaborating physician . . .

- participates in the joint formulation and joint approval of orders or guidelines with the advanced practice nurse, and the physician periodically reviews such orders and the services provided patients under such orders in accordance with accepted standards of medical practice and advanced practice nursing practice.
- is on-site at least every two weeks to provide medical direction, consultation, and patient visits (this is a federal requirement and may differ in various states).
- is available through telecommunications for consultation on medical problems, complications, or emergencies or patient referrals. (Section 15-15c)

Collaborative agreements create a framework that supports nurse practitioner autonomy and role extension beyond that of traditional health services hierarchies. Mid-level providers can serve rural areas that suffer from provider scarcity, thereby improving the health and quality of life of residents. Reimbursement incentive programs, such as the designation of RHC status, further encourage nurse practitioners to provide services to underserved areas.

Rural Health Clinic Case Study: Implementation, Strategies, and Obstacles

One clinic that has met the specific RHC program guidelines is Family Rural Health of La Harpe, PC, in La Harpe, Illinois. This nurse practitioner-owned RHC is a primary family practice serving a town of 1,385 as well as individuals within a 30-mile radius. It employs one full-time receptionist/biller, one part-time receptionist, one part-time medical assistant, and a full-time nurse, plus the nurse practitioner and physician. The nurse practitioner sees an average of 24 patients per day, and the physician visits with patients one afternoon once every two weeks.

The first step in creating the clinic was to assess the community's needs and capabilities. An RHC already existed in La Harpe, but in 2001, the owner and operating entity decided to discontinue it. The board wanted the practice to remain open and invited offers to purchase the clinic. After a financial review of the clinic and a basic understanding of the operational system of an RHC, a nurse practitioner made an offer to purchase the clinic. Prior to meeting with the clinic board, the interested nurse practitioner hired an accountant familiar with rural health and medical billing and discussed financial feasibility, leasing, pricing, and billing aspects. Next, a business plan was prepared with help from loan officers at a local lending institution.

The prospective owner also engaged an attorney familiar with clinic operations who was recommended by another rural health institution. The attorney helped shape the business to suit the nurse practitioner's needs, developed the purchasing agreement and lease agreement for space and equipment, and prepared the written collaborative agreement with a physician. The initial lease was for three years, and a transition date was set for one month in advance.

The former facility allowed the new owner to turn over money collected from dates of service prior to the purchase date and continue billing and collecting revenues for three months, after which those accounts were closed to old billing. Any money from dates of service after the purchase date became operational funds for the new facility. This arrangement kept the initial cost of the practice to a minimum but did not include money from accounts receivable in the former practice.

To meet legal restrictions within Illinois, the La Harpe clinic was formed as a professional corporation to provide nurse practitioner services. The physician was provided space in which to practice at the clinical site and an

office/area to review charts. In return for the space and billing services, the physician provides the clinic with 50 percent of the revenue generated from his services. The physician receives the remaining 50 percent. The rate of pay is negotiated between each nurse practitioner and the collaborative physician. Another option is to contract with a hospital to provide a collaborating physician. There are several ways to execute a contract between a nurse practitioner and a physician, but it is important that an attorney familiar with healthcare regulations be closely involved in the process.

When starting a practice or clinic without having an established RHC in the area, several issues should be investigated such as assessing costs for building renovation, handicap accessibility, and other issues specific to RHC status. A feasibility study and market share analysis should be conducted before the practice site is selected. The practice must develop aggressive marketing strategies, including identifying partners, resources, and referral patterns.

Once the RHC has been established, all start-up costs are allowable on the cost report, including meeting time, mileage, equipment, real estate, supplies, contract services, renovations, and other expenses. Often, start-up costs can be defrayed by purchasing equipment or space from a retiring physician. Contacting local hospitals for information on equipment may help, as well as establishing contacts and potential collaborative options. Critical access hospitals in rural areas can provide services and ideas on funding options. Small business loans and rural business organizations can advise and provide needed funding. If the clinic is nonprofit, grant programs exist to assist with start-up costs.

If RHC status is not established, financial considerations such as payments and reimbursements differ, although a clinic can be initially created without such status. Reimbursement from private pay or insured individuals will not be affected; however, the reimbursement rate for practitioners from Medicare and Medicaid in Illinois will not be at the enhanced RHC rates. These rules apply until RHC status is granted and the higher rate is established. If the RHC site is approved, the reimbursement rates for Medicare and Medicaid are retroactive to the date on the application.

Establishing an RHC or changing ownership involves considerable paperwork. A change of ownership form

(CMS855) must be on file with Medicare. Other forms also must be completed and filed correctly so as not to impede the process. The Medicare claims for service are filed through a Centers for Medicare and Medicaid Services (CMS) claims processing entity. A CMS representative or personnel from the Center for Rural Health in the Illinois Department of Public Health can assist in explaining the application process, form distribution, time considerations, and responsibilities of a clinic.

RHC Certification Rules and Guidelines. Another critical step in the RHC certification process requires clinics to maintain a current *Policies and Procedures Manual* as well as an *Employee Handbook*. Much of this information is available electronically, through communications with similar clinics, or from partner organizations. Many agencies have conferences regarding RHC rules, regulations, and procedures. It is advisable for the clinic owner as well as billing personnel to attend at least one of these meetings that discusses policy issues for RHCs, billing considerations, financial information on Medicare reimbursement specific to rural health, and developing a policy and procedure manual.

A rural health certification group will inspect the RHC prior to certification and annually thereafter. This professional review is always unannounced. The clinic needs to be prepared for this review, which also includes a general health inspection. The clinic's guidelines should be outlined in the clinic's *Policies and Procedures Manual*. If a clinic is not in compliance, Medicare reimbursements can be withheld until the deficiencies are resolved.

RHC Logistics. Establishing an RHC takes six months to a year from time of purchase to organize clinic requirements, complete the forms, and begin receiving reimbursements. When purchasing a clinic that is already rural health certified, it is necessary to allow six months for approval of the change in ownership and reimbursements from Medicare and public aid. Establishing the initial rural health status takes longer than six months to complete. The healthcare provider may choose to bill Medicare with the lower reimbursement prior to rural health status in order to generate clinic revenue.

An important component in rural health financial management involves hiring someone well-versed in preparing and filing an annual cost report. This report is based on the expenses of the previous year and secures the reimbursement rate for the next year. Not all expenses

listed on the cost report are utilized to determine the reimbursement rate. Both allowable and unallowable expenses are included in the cost report, and filing incorrect reports can cost the clinic a substantial sum of money. Leasing space or equipment, or not paying enough for space, can also have a negative effect on the cost report. It may be better to purchase a building to increase expenses to maintain the cap rate⁴ from Medicare. Mortgages and bills related to maintenance and renovation are considered part of the allowable expense.

Various firms and organizations, such as Rural Health America and North American Healthcare Management Services, can help complete the annual cost report. The expense for this assistance varies based on specific services required. Quarterly reviews are advisable to stay current on changes throughout the year, and to budget for purchases and identify projects under consideration. Within the first 60 days of a new year, a window of opportunity exists to increase expenses on the annual report. These additional expenses can increase the cost per visit, which ultimately determines the reimbursement rate for Medicare patients.

Another important clinic expenditure is the requirement for software to facilitate billing services. Many clinics have found it more cost effective to hire an agency for billing rather than to do it internally. Choosing an agency with expertise in the billing processes for Medicare and public aid within the rural health system is critical. One option is to partner with a local hospital to contract billing services through an agency, thereby sharing the expense with other providers.

Clinics submitting claims need a software program specific to rural health needs and cost-based reimbursement procedures. These programs range from \$5,000-\$17,000, although they can be leased. The total cost plus interest is allowable on the annual cost report. If a clinic is to submit claims, it will also need experienced staff. This is one of the most important functions for timely reimbursements. The biggest roadblocks to success in establishing a nurse practitioner-owned clinic are the legal procedures involved; however, once procedures are understood and knowledgeable individuals are in place to assist, these roadblocks can be overcome.

Designing a practice improvement plan both for personnel and equipment needs is important from the beginning. Meeting with the accountant on a semi-annual basis to

⁴The RHC programs include a cost containment device: an upper limit (cap) on the All Inclusive Reimbursement Rate (AIRR). The Medicare AIRR is calculated by dividing allowable costs by RHC visits (Health Resources and Services Administration 2006, 34)

discuss loan repayment and other financial issues is recommended. Individuals and organizations who work in rural areas often serve as key resources as do consultations with other RHC owners with similar operations. The Illinois Rural Health Association provides contacts and resources from state agencies, private and group practices, hospitals, healthcare facilities, and health departments. Currently, only

three practices owned by nurse practitioners with rural health designation exist in Illinois. These healthcare providers are a useful resource for guidance and mentorship. A useful text is *The Business of Medicine* by Julie Silver, M.D. This book has several recommendations for the business of providing health care. Many people are available to assist in improving health care in the community, region, and state.

Summary

Innovative approaches in health care, such as the nurse practitioner-managed Rural Health Clinic described in this report, can enhance the health of rural populations and foster economic development within communities. Nurse practitioner ownership of RHCs involves entrepreneurship, perseverance, a network of knowledgeable individuals, and a community in need. Any advanced practice nurse considering ownership of a clinic should investigate applicable municipal, county, state, and federal regulatory standards. Discussions with a collaborative physician, accountants, bankers, lawyers, and insurers are a must. Quality assurance and risk management programs should be considered. A nurse practitioner may need to educate other healthcare providers and the general public on the scope of practice and services available from an advanced practice nurse. Once these considerations have been addressed, mid-level practitioners can become successful owners of healthcare facilities that enhance the quality of life of rural residents.

In moving toward improving local healthcare access, communities can begin to create an environment which attracts and supports healthcare providers. The community should be open to exploring a variety of healthcare service

models to extend services to the entire population. Combining current rural programs with a creative approach to health care can lead to increased access and availability of services.

Additional recruitment strategies in which communities can engage include fostering a “grow your own” model, recruiting the family of a potential provider, and developing a community marketing strategy to identify regional resources and opportunities. Communities should be working with their local schools to identify the healthcare workforce, as well as consider community residents with an interest in entering the healthcare field. Communities can develop scholarship programs and work with area hospitals to engage professional-level students in clinical rotations. When recruiting healthcare professionals, communities should consider the needs of their family. Is there an interest in local churches, schools, day care, employment for spouse, and quality housing? The community should be prepared to market their local community and discuss cultural and recreational opportunities in the area (Rourke 1993). Remember someone from the community already understands the values of community spirit and the quality of life.

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