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Innovations in Rural Health System Development: Federally Qualified Health Center Initiatives

Sara Kahn-Troster MPH

University of Southern Maine, Maine Rural Health Research Center

Amanda Burgess MPPM

University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

Andrew F. Coburn PhD

University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

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Innovations in Rural Health System Development

Federally Qualified Health Center Initiatives

Sara Kahn-Troster, MPH
Amanda Burgess, MPPM
Andrew Coburn, PhD

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Muskie School of Public Service
Maine Rural Health Research Center



Rapid changes in health care payment and delivery systems are driving health care providers, payers, and other stakeholders to consider how the current delivery system might evolve.

This series of briefs profiles innovative rural health system transformation models and strategies from Maine and other parts of the United States. The aim is to assist rural communities and regions to proactively envision and develop strategies for transforming rural health in the state. In preparing these briefs we consulted experts, interviewed key informants, and reviewed the professional and research literature to find robust and innovative models and strategies that could be replicated in rural Maine.

PROMISING STRATEGIES:

- Workforce Recruitment and Retention Initiatives..... 2
- Approaches to Serving High-Need Patient Populations..... 6
- Services to Address Critical Community Needs Such as the Opioid Crisis and Dental Care..... 7
- Innovations in Providing Enabling Services that Address the Social Determinants of Health 10

INTRODUCTION

Federally Qualified Health Centers (FQHCs), also known as community health centers, are an essential source of primary care and other services for medically underserved communities and populations. Patients of FQHCs are disproportionately uninsured or publicly insured, and low income.¹ A large share of Maine’s FQHC patients is low income: 44 percent of health center patients live at or below 100 percent of the federal poverty level (FPL) and 72 percent live at or below 200 percent of the FPL.² Nationally, over half of FQHCs are located in rural areas.³ In Maine over 65 percent of FQHC service sites are located in a rural areas,⁴ and two thirds of Maine’s FQHC patients are served by a health center located in a rural area.⁵

WHAT IS AN FQHC?

FQHCs are outpatient clinics that receive federal funding under Section 330 of the *Public Health Service Act*⁶ and qualify for specific reimbursement systems under Medicaid and Medicare. To qualify, FQHCs must fulfill a set of Health Center Program requirements, including:

- Provision of comprehensive primary and preventive care, enabling services, and additional health services as appropriate;
- Sliding fee discounts based on a patient's ability to pay;
- Location in a Medically Underserved Area or Health Professional Shortage Area (HPSA), or a focus on serving a high-risk target population such as migrant workers or individuals who are experiencing homelessness;
- An ongoing quality improvement/quality assurance program; and
- A governing board of which patients of the health center make up a majority.

An FQHC look-alike is an outpatient clinic that the federal government has certified meets the FQHC requirements, but that does not receive Health Center Program funding under Section 330. Look-alikes are eligible to apply for reimbursement under FQHC Medicare and Medicaid payment methodologies, and access other FQHC benefits, such as eligibility to purchase discounted drugs through the 340B Drug Discount Program.

FQHCs are a key component of Maine's health delivery system. According to the Maine Primary Care Association (K. Hess, e-mail communication, August 2017), the state is home to 18 FQHCs and one FQHC look-alike (Community Clinical Services in Lewiston) that operate 70-80 delivery sites across the state. In 2015, these sites—which are located in every county in Maine—served 187,269 patients⁵ (roughly 14 percent of Maine's population) and had over 815,700 patient encounters.⁷ According to data from the National Association of Community Health Centers, 16 percent of Maine's FQHC patients were uninsured in 2015 (the most recent year for which data are available), while 24 percent were covered by Medicaid, 21 percent were covered by Medicare, and the remaining 39 percent of patients had private insurance, some other type of public insurance, or were self-pay.⁵ The percentage of Maine FQHC patients with Medicare is considerably higher than the national average of 14 percent; likewise, the percent of patients with Medicaid is higher than the national average of 20 percent, and the percent of uninsured patients is higher than the national average of nine percent.⁵

PROMISING STRATEGIES

Workforce Recruitment and Retention Initiatives

A recent, national survey of FQHCs found that workforce recruitment and retention were the most challenging issues identified by respondents.³ Competitive salaries and benefit packages, community amenities, and other health center location factors were the top specific recruitment and retention challenges that FQHCs identified.⁸ Nationally, nearly all FQHCs have at least one clinical vacancy—with 69 percent recruiting for a family physician, 56 percent recruiting for a behavioral health staff member, and half recruiting for a nurse practitioner.⁸ On average, FQHCs have 13 percent of their clinical staff positions vacant.⁸

Efforts to address workforce shortages include new staffing models and the use of pipeline programs. Staffing models that support all health providers to work at the top of their licenses are increasingly widespread. Nationally, between 2007 and 2012, the number of physician assistants, nurse practitioners, and certified nurse midwives working in FQHCs increased by 61 percent, compared with an increase of 31 percent for physician full-time equivalents.⁹

FQHCs also use health professional training programs to create a pipeline of staff—58 percent of health centers reported that they had hired a health professional who trained at their health center in the past two years.⁸ The National Health Service Corps (NHSC) loan repayment and scholarship program is a key resource for recruiting clinicians to health centers. The program is particularly helpful in recruiting dental professionals into underserved areas—79 percent of dentists in the NHSC program and 78 percent of registered dental hygienists in the program are practicing at FQHCs.⁸

FQHCs are increasingly seeking financial support for their training activities from the Health Resources and Services Administration's (HRSA's) Teaching Health Center Graduate Medical Education Program, which supports primary care and dental residency programs in community-based ambulatory patient care settings, with an emphasis on underserved communities and vulnerable populations. During the 2014-15 academic year, 22 percent of residents in the program trained in a rural setting.¹⁰

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

A Health Professional Shortage Area (HPSA) is a federally designated geographic area which has been determined to have care provider shortages in primary care, mental health, or dental health. The designation is based primarily on provider to population ratios and the population's need for services.

Maine has 68 areas designated as primary care HPSAs and 52 designated as mental health care HPSAs.¹¹

Maine has 74 dental care HPSAs—48 additional dentists would be needed in these areas to remove the HPSA designations.¹¹

KEY FACTS about Maine's FQHC workforce:

In 2015, Maine's FQHCs employed a total of 1,589 full time-equivalent employees, including:

- 83 physicians;
- 135 nurse practitioners, physician assistants, and certified nurse midwives;
- 28 dentists;
- 27 dental hygienists;
- 83 behavioral health specialists; and
- 115 staff dedicated to enabling services such as case management and eligibility assistance.⁵

Example: Penobscot Community Health Care

Penobscot Community Health Care (PCHC) is the largest FQHC in Maine and the second largest in New England, with 16 sites that collectively provide comprehensive primary care, mental health, and dental services, along with ancillary services such as pharmacy and audiology. PCHC provides job shadowing opportunities, internships and externships, and residencies to students at all levels, from high school to undergraduate and graduate medical education. The programs focus on a wide range of health professions, including physicians, physician assistants, nurses, dental assistants, medical assistants, social workers, occupational therapists, dentists, and pharmacists. PCHC hosted more than 300 students last fiscal year. The organization believes that these programs fit with their mission, and are a part of their culture of "organizational citizenship" which includes training the next generation of providers. This is exemplified by the training given to students from the University of New England College of Osteopathic Medicine who complete a community health rotation at PCHC. The students work with all levels of health care providers, from care managers and medical assistants to receptionists and outreach coordinators, so that the increased work associated with being a preceptor is shared across the staff and students are exposed to all aspects of medical practice operations and understand how a comprehensive care team functions. Megan Sanders, PCHC's vice president of human resources, notes that they work to recruit physicians who are interested in teaching, and who understand the value it brings to their own work and to the community.

Although Bangor is the heart of a Metropolitan Statistical Area, many perceive Bangor as a rural place. This poses challenges with recruitment. The dental residency program in particular has faced issues recruiting their top candidates due to PCHC's location, despite a competitive salary and a well-regarded program. The pharmacy residency has worked to overcome this challenge by having current residents participate in recruiting the next class, reaching out to students at their alma maters to describe their experiences and answer questions about PCHC and living in Bangor. This strategy has led to consistently high numbers of applicants for the pharmacy residency program, representing 10-12 schools of pharmacy from around the country.

According to Sanders, the residency and rotation programs play an important role in recruiting providers. PCHC hires a considerable number of their students, recently including physician assistants, dental assistants, and pharmacists. She notes that even when students do not choose to pursue further work at an FQHC, they bring their experience in community-connected care and their understanding of community health to other practices. To encourage the health professions pipeline, PCHC also works with high school students to show them, through job shadowing and other programs, the wide range of available health professions.

In addition to this focus on recruiting new providers, PCHC is also committed to improving job quality to retain existing staff. Recognizing that provider burnout represents a significant challenge to the organization, PCHC is building an initiative addressing burnout into its 2018 budget. In early 2017, PCHC leadership convened a series of meetings with primary care providers to discuss what led them to go into primary care, barriers to them being fully engaged with their patients, and job satisfaction, including feeling fulfilled and having a sense of purpose in the workplace. Meeting participants also discussed solutions to burnout, such as ensuring that providers have meaningful interactions with patients (including adjusting workflow to give them more time with patients), streamlining the electronic health record system, hiring scribes to reduce provider administrative tasks, and building in both time and financial support for professional development and peer collaboration. Sanders notes that these efforts are worth the cost to the practice if they reduce turnover and burnout.

Example: Katahdin Valley Health Center

Katahdin Valley Health Center (KVHC) is a six-site FQHC in Aroostook County, Maine. KVHC has long been known for its health professions mentoring and teaching activities. The organization sees operating clinical training programs as a fundamental part of its mission. This is true even though KVHC is a small and sometimes short-staffed FQHC in a very rural part of the state.

To support its training programs with a small staff, a human resources coordinator handles most of the administrative work and assists with much of the data collection required by program partners, allowing clinical staff to focus on working with the students. Michelle Lefay, KVHC's chief operating officer, and Linda McGee, the director of human resources, note that when they are short-staffed it can be harder to add more students into the mix; in particular, they have not had any medical students for several years due to a small number of physicians available to serve as preceptors, and limited time availability for remaining staff. Although they receive Continuing Medical Education credits for their work as preceptors, physician preceptors must fulfill their teaching responsibilities in addition to their usual workload.

KVHC usually has between 5-8 students doing clinical rotations over the course of a year, in a variety of health professions. Although KVHC does not currently have any medical students, they have worked with the Tufts University School of Medicine and the Geisel School of Medicine at Dartmouth in the past, and are working to develop a partnership with the University of New England College of Osteopathic Medicine. They have worked with a variety of other colleges and universities in the state, including Husson University's family nurse practitioner program, the University of Maine at Augusta's dental assistant program, the University of New England College of Dental Medicine, and Northern Maine Community College's medical assistant training program. KVHC is potentially looking to add students from the University of New England's physician assistant program and Husson University's pharmacy program. According to Lefay, clinical rotations serve as a valuable recruitment tool—several current staff members completed a training program at KVHC. According to Lefay and McGee, KVHC is often approached by students from the area who are looking to do their clinical rotation closer to home; the hope is that, in turn, these students are more likely to stay in the area after graduation if they do their rotations at KVHC.

Example: Stone Mountain Health Services

Stone Mountain Health Services (SMHS) is a 12-site FQHC in rural southwestern Virginia.¹² In order to address a chronic shortage of behavioral health providers, SMHS launched a partnership with two local universities to create a behavioral health internship program. Students in social work and psychology from Radford University and East Tennessee State University are able to use SMHS sites for clinical internships, with SMHS staff providing supervision. SMHS uses an integrated behavioral health model, with the interns serving as part of the primary care team to address behavioral health issues, plus concerns such as obesity, tobacco use, and substance use disorders (SUDs). Without the interns, SMHS would not have been able to implement the integrated model. Many of the interns have remained with SMHS after graduation, serving as supervisors for future interns.¹² Other interns have gone on to work in similarly underserved rural areas. The program has helped to improve access to behavioral health care throughout the region, with services now available in all seven counties of the SMHS service area.

Example: High Plains Community Health Center

The High Plains Community Health Center (High Plains), located in rural southeastern Colorado, transformed its practice by embracing a team-based approach to care, with a special focus on the role that medical assistants play in the practice.¹³ With the help of a HRSA system redesign grant 15 years ago, High Plains transitioned their medical assistants to become patient facilitators (PFs). The PF job description includes processing medical records, answering phones, greeting patients, triage, and clinical support. High Plains also created care teams that have a ratio of three dedicated PFs for every medical provider. The support of the PFs allows the providers to focus on patient care, improving their morale and leading to higher productivity levels (i.e., more patient visits per day).^{13,14,15} Patient outcomes and satisfaction improved, especially for those with chronic illness, as did clinic finances.¹⁵ High Plains provides bonuses for teams that see more patients while maintaining quality and patient satisfaction. Changes in workflow and communication helped to ease the transition to this approach, which has allowed High Plains to do well in a rural area.¹⁴

KEY CONSIDERATIONS for application:

- Smaller FQHCs can successfully serve as training sites, especially if they are able to use the entire care team to assist with instruction and mentorship. Smaller FQHCs can also leverage non-clinical staff to assist with administrative work associated with training students, freeing clinical staff to focus on teaching and evaluation.
- FQHCs that develop a culture of mentorship, with staff seeing training programs as essential to the organization's mission, generally experience greater buy-in from employees even when they are short-staffed.
- FQHCs report that current students in training (interns, externs, residents, etc.) can enhance their recruiting efforts. Positive experiences shared by current students can potentially overcome applicants' concerns about working in a rural area and/or a smaller practice.

PROMISING STRATEGIES

Approaches to Serving High-Need Patient Population

Some FQHCs are structured to focus their work on one of three statutorily recognized special populations: persons experiencing homelessness, migrant and seasonal farm workers and their families, or residents of public housing. Nationally, FQHCs serve over 25 million patients, including 1.2 million people experiencing homelessness, and 900,000 migrant and seasonal farmworkers.¹⁶

KEY FACT about serving complex high need patients in Maine:

- In 2015, nine percent of patients seen at FQHCs in Maine were members of vulnerable populations, including migrant/seasonal farm workers (2,557), veterans (9,426), and people experiencing homelessness (5,689).⁵ Together, these vulnerable populations accounted for nine percent of the patients seen at FQHCs.

Example: Nasson Health Care

Nasson Health Care (Nasson) is an FQHC in Springvale, Maine that is one of the only rural FQHCs in the country to focus on people experiencing homelessness. Nasson has five locations, including one school-based health center. Patient volume is growing; there were about 14,000 visits in 2016, up from 11,000 visits in 2014. Among Nasson's patients in 2016, 34 percent were uninsured, 35 percent had Medicaid, 11 percent had Medicare, and the rest (20 percent) had private insurance. Nasson has succeeded for more than twelve years despite the financial challenges of providing services to a population that is generally uninsured or on public insurance—80 percent versus the statewide health center average of 61 percent.⁵

Nasson's director of health services, Martin Sabol, notes that the population they serve is highly transient, which makes care for chronic illnesses especially challenging. Nasson relies on a broad but informal referral network to get potential patients in for care, but often has no way to find patients once they leave the clinic. In order to coordinate services when patients return, Nasson has an integrated electronic health record system, with all branches of care (primary, dental, behavioral health) able to see records for each patient. This allows them to share treatment plans and track which medications have been prescribed.

Current innovative work at Nasson is focused on the social determinants of health, particularly working to capture more data on issues such as food insecurity, sexual orientation/gender identity, and transportation needs. Questions about food insecurity are being asked formally of all clients and in all interventions, in order to link clients with appropriate food resources. Nasson has also been working to improve its support for lesbian, gay, bisexual, and transgender clients, including those who are transitioning, who may have different needs and risk behaviors than other Nasson clients.

Example: Maine Mobile Health Program

The Maine Mobile Health Program (MMHP) is funded through HRSA's Office of Special Population Health within the Bureau of Primary Health Care, under Section 330(g) of the Public Health Services Act. MMHP saw more than 1,500 patients in 2016, out of the estimated 3,000 migrant and seasonal workers in Maine. MMHP Executive Director Lisa Tapert notes that the number of migrant and seasonal workers in Maine is small compared to other states, but the agriculture industry in Maine relies heavily on this workforce.

Most migrant health centers are brick and mortar health centers, either stand-alone or integrated with services for other patient populations. MMHP instead uses four mobile health units to bring health care to clients in the fields where they work, and the camps and homes where they live. The mobile units provide basic primary care and have bilingual behavioral health specialists onboard, but rely on community health workers (CHWs) to help connect clients to other health providers (including FQHCs) in Maine for specialty services, dental care, and vision care. The CHWs arrange for transportation to and from the point of care, help with translation at the visits, and facilitate follow-up for the patients. MMHP relies on contracts with external providers to provide services, and furnishes clients with vouchers that help pay for care; MMHP reimburses providers at the same rate as MaineCare. For example, Pines Health Services (Pines) sees broccoli and potato workers in Aroostook County. A Pines provider serves part-time on the mobile unit, and many patients are then referred for care at the health center itself. Harrington Family Health Center, near the heart of the blueberry barrens, has both a primary care partnership and a dental partnership with MMHP. Harrington makes block appointment times available in the evenings, when workers are available after their shifts, and treats 6-7 workers in an evening (they have often been triaged in the field by Harrington dentists first).

KEY CONSIDERATIONS for application:

- As a part of efforts to provide care to high need populations, FQHCs must seek to create welcoming and hospitable spaces for these patient groups consistent with their unique needs, such as flexibility and understanding around the scheduling and cancellation of appointments.
- Expanding availability of and providing easy access to interpretation services is critical for many high need patients, including migrant workers and immigrants.
- As for many other patient populations across Maine, accessing care can be very challenging for high need populations if they do not have access to transportation. Working to ease transportation barriers for all patients benefits high need patients as well.

PROMISING STRATEGIES

Services to Address Critical Community Needs such as the Opioid Crisis and Dental Care

Nationally, in 2014, FQHCs provided Substance Use Disorder (SUD) treatment to more than half a million patients, representing more than 2.2 million encounters.¹⁷ In Maine, the need for greater capacity to provide SUD treatment is urgent—in 2016 there were 376 drug-related deaths in the state, a 38 percent increase from 2015.¹⁸ The problem is statewide—ten counties and five cities across the state had 10 or more drug-related deaths in 2016.¹⁸

Access to dentists and dental care is also a significant concern across the state. Maine has fewer dentists per capita than the U.S.; in 2009, Maine had 0.5 dentists per 10,000 population while the U.S. had 0.6. Maine's dental workforce is aging, and is poorly distributed across the state.¹⁹ In 2016, more than 300,000 Mainers lived in dental health professional shortage areas.²⁰ In addition, few dentists practicing outside FQHCs provide care to individuals covered by MaineCare.²¹

FQHCs play an important role in rural communities, where they may serve as a hub of activity around health care and wellness, as well as leading the front line response to public health crises, such as the Zika virus or the opioid epidemic. This may be especially true if there is no local hospital to take a leadership role on population health care. The community

may feel a real sense of investment in the FQHC and its providers, who in turn may help set the community's direction for providing support for underserved populations, including linking health care initiatives with social services, housing, and other services. These services are increasingly recognized as addressing the “social determinants of health”—conditions in the social, physical, and economic environment in which people are born, live, work, and age—such as the availability of resources to meet basic daily needs, and the natural and built environment.²² Because FQHCs have governing boards with majority representation from their patient population, they are typically engaged in their community and have a culture of community ownership. Programs for engaging the community in the FQHC help communities grow stronger together. They can also help build community capacity to respond to challenges.

KEY FACTS about new services to address critical community needs in Maine:

- FQHCs are playing an increasing role in SUD treatment and prevention. In 2014, Maine's health centers had 50,443 patient visits for SUD services.²
- FQHCs are also a key component of the behavioral health system in Maine. 75.3 FTE mental health specialists were employed in Maine FQHCs in 2014. That year, these specialists conducted 89,112 patient visits. Across all provider types, FQHCs had 81,428 patient visits for depression and other mood disorders, 68,008 visits for anxiety and PTSD, and 44,241 visits for other mental disorders.²
- FQHCs are an important source of dental care in underserved areas and with underserved populations. Fourteen of Maine's FQHCs (77 percent) provide preventive dental care at 21 sites located in 10 counties.²³
- Health centers in Maine employ 27 FTE dentists and 28 FTE dental hygienists.²
- 28,176 patients received dental exams at Maine FQHCs in 2014—accounting for 15 percent of all patients at FQHCs.²

Example: Health Access Network

Health Access Network (HAN) is a six-site FQHC in Penobscot County that is investing significant resources, relative to its size, in behavioral health and SUD treatment. In the face of the opioid crisis, HAN has invested in the workforce necessary to help people combat SUDs. HAN employs three licensed clinical social workers, three psychologists, and two physicians to work as a team to treat SUDs through counseling and medication-assisted treatment (MAT) with Suboxone; an additional two medical providers (a nurse practitioner and a physician assistant) are currently being certified to prescribe Suboxone. The team receives assistance from a case manager and a dedicated care coordinator, who is responsible for patient recruitment and initial intake, arranging for prior authorizations of medications, and keeping the MAT practice organized and efficient. Former HAN CEO William Diggins noted that this is a notable number of behavioral health-focused staff for a small rural clinic (HAN employs 26 clinicians overall), but that it is crucial to providing comprehensive treatment. Expansion of SUD treatment and MAT, including strengthening the care coordination function, has been supported by sources including a 2015 HRSA grant and a recent Maine Health Access Foundation (MeHAF) grant program. HAN is investigating the creation of in-patient behavioral health care treatment beds at a nearby hospital to complement the outpatient care HAN provides.

According to Dr. Marco Cornelio, HAN's medical director, HAN is the “only game in town” for MAT—patients would otherwise need to drive to Bangor or Houlton for treatment. HAN provides MAT for about 40-50 patients in its primary care practice. Because the clinicians cover many aspects of primary care, they are able to reach patients in a convenient setting. HAN's providers do combined prenatal care and MAT for patients who need it,

identifying them through a urine drug screen administered to all prenatal patients. All MAT patients undergo regular drug screens and pill counts, although Dr. Cornelio notes that some uninsured patients under-dose their Suboxone because the cost is very high, and that some people with SUD may not seek MAT because they cannot afford it. With the help of the care coordinator, Dr. Cornelio hopes that HAN will soon be able to start addressing some of the social determinants of health for MAT patients, looking at stable temporary housing and job placement assistance.

HAN also works to heighten awareness of MAT and reduce stigma around SUDs, engaging with an organization called Save A Life, a coalition of concerned citizens, people in recovery, faith communities, the school superintendent, health care providers, police, mental health agencies, and town officials in Lincoln, Maine. Dr. Cornelio explained that when HAN decided to provide MAT in 2014, there were initial concerns among Lincoln's town leaders about the possible impact of running the program, but that the fears were allayed through effective communication with the town council.

Example: Fish River Rural Health

Fish River Rural Health (Fish River) is an FQHC with four locations in northern Aroostook County that provide services to more than 3,000 people in the St. John River Valley. Over the past five years, Fish River has invested significant time and resources providing dental services as local dentists have moved away or retired. Fish River received practice improvement consultation with grant support from MeHAF, to develop processes and procedures to make their dental practices more efficient and effective. Fish River's first dental clinic opened in 2011, and within two years the dental practice was causing financial strain on the overall medical practice and patient volume was dropping. In 2013, with the help of Safety Net Solutions, Fish River revamped the program by implementing a practice improvement plan. Fish River has also worked proactively with retiring dentists to ensure the continuation of services. According to key informants, productivity has improved, patients are happier and more likely to return, and the providers are more satisfied.²⁴ Since 2012, the dental clinic has gone from one site serving 663 unique users to two sites (as of December, 2016) serving more than 3,700 unique users. A third dental site opened in Madawaska in early 2017. Fish River employs a full time oral health coordinator, supported by grants, and has entered into agreements with the Tufts University School of Dental Medicine and the University of New England College of Dental Medicine to create rotations for dental students interested in rural practice. Based on the positive turnaround of their dental practices, Fish River is exploring expanding into optometry services, another crucial service that is often challenging to provide in smaller rural communities.

Example: Eastport Health Care

Eastport Health Care (EHC), an FQHC with three locations in Washington County, uses a community engagement model known as Community Circles to facilitate conversations, listen to patients and their families, and support change in the local health system. Holly Gartmayer-DeYoung, EHC's CEO since 2010, created the Community Circles concept in 2011 in response to major changes at EHC, including significant turnover in the clinical staff. Inspired by a number of books that discussed creating sacred conversation, multigenerational culture and experiences, and the value of peer voices and positive change, Gartmayer-DeYoung designed a model that honors patient experiences and emphasizes positive and creative energy. The first Circle focused on responding to the community's health care needs and engaging residents in recruiting new providers. Since then, Circles have been used for a variety of conversations and topics, including strategic planning, food insecurity, and the patient-centered medical home model. EHC has convened 129 circles since 2011, with more than 400 individuals participating. Currently, Circles convene around

caregivers (with a focus on palliative care), a gay-straight-trans alliance (GSTA), and SUD. Sometimes a Circle will only meet once or for a brief period, while others have met regularly for years. Circles have had a tangible impact on the community; the GSTA Community Circle, for example, has created standardized educational posters, participated in teacher and provider workshops, and influenced the development of GSTAs in three local high schools.

According to Gartmayer-DeYoung, Community Circles can be an effective way to engage a community and take action around a variety of needs and issues. They have helped move the health system in Eastport from being reactive to being responsive, collaborating with patients and families, and listening to them as individuals and as communities. They have helped to create a culture shift around health care in Eastport in a short time, and to bring the community together.

KEY CONSIDERATIONS for application:

- A comprehensive community-based strategy for treatment and prevention of opioid use disorder includes the promotion of evidence-based prescribing guidelines, screening tools and protocols across health care providers, and the expansion of access to treatment, harm reduction, prevention, recovery, and other support services.²⁵
- FQHCs across the state can take a lead role in addressing the opioid crisis from both a medical perspective and by taking the lead in building relationships and addressing the key factors that may contribute to SUDs in their areas.
- Partnerships between FQHCs and the new University of New England College of Dental Medicine will expose more dental students to working in rural areas. The expectation is that this will make them more likely to consider practicing in rural parts of Maine or in other rural settings once they graduate.

PROMISING STRATEGIES

Innovations in Providing Enabling Services that Address the Social Determinants of Health

FQHCs are required to provide enabling services necessary to support adequate patient care. These are non-clinical services that support individuals in accessing care and improving health outcomes. Specific services include transportation, translation services, health education, eligibility assistance and financial counseling, and case management. Many FQHCs are also engaged in aiding their patients with other social determinants of health, particularly around issues of food insecurity and stable housing.

KEY FACTS about FQHC-provided enabling services and the social determinants of health in Maine:

- The Maine Primary Care Association has made the social determinants of health a priority for Maine's FQHCs, and is helping many of them adopt PREPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences), a template that helps integrate screening questions around housing, financial resources, social and emotional health, access to food, and safety into all patient encounters.
- Most of Maine's health centers offer case management and eligibility assistance services onsite (89 percent and 84 percent respectively).
- Although few FQHCs offer transportation services or interpretation/translation services onsite,² they frequently partner with regional transportation services for low income individuals.

Example: Finger Lakes Community Health

Finger Lakes Community Health (FLCH) is an FQHC in upstate New York, with ten sites located between the cities of Rochester, Syracuse, and Ithaca. Originally founded as a Migrant Health Clinic, FLCH now offers comprehensive care for all individuals in the region. Many local providers are unable or unwilling to treat migrant workers, who are often uninsured and have specific cultural and translation needs. FLCH has worked to build trust with the migrant workers through concerted outreach and culturally and linguistically appropriate care. A team of staff members at FLCH are “champions for the patient,” serving as bilingual patient advocates who help patients with a range of enabling services, including transportation, housing assistance, and financial advocacy, and patient navigators and insurance enrollers who can help patients with a range of health care and insurance issues.

With limited public transportation in the region, and long distances between many of FLCH’s sites, telehealth has taken on an especially important role in facilitating access to specialty care. A video-equipped robot, known as “Ruby,” can be moved remotely via joystick through a clinic, allowing providers to treat patients at multiple sites and allowing a translator to be present over video if they are not available onsite at that time. Patients can be connected to remote providers without having to travel long distances, and receive care such as dental consults, behavioral health treatment, and retinopathy screenings for diabetes. Migrant workers may be especially at risk for depression and other mental illnesses, due to the trauma of immigration and the separation from communities and family that often accompanies it. Telehealth allows them, via video conferencing, to access providers who may not be otherwise available in rural areas. A report about FLCH notes that accessing remote providers allows migrant workers “a sense of anonymity,” as they may be reluctant to disclose mental health concerns to members of their own community.²⁶

FLCH offers many of its clinical services through telehealth, including child and adult teledentistry and telepsychiatry, HIV/AIDS care, TeleRD (registered dietician, certified diabetic counseling), interpretation services, and pulmonology. FLCH also utilizes telehealth technology for staff education, peer-to-peer learning collaboratives, board of directors training, and staff meetings.²⁷

Example: HealthReach Community Health Centers

HealthReach Community Health Centers (HealthReach), an FQHC with 11 sites that serve people in seven counties in western and central Maine, is partnering with Good Shepherd Food Bank (GSFB) to combat food insecurity among its patients. GSFB began the initiative in 2014 by bringing its Food Mobile to HealthReach’s Bingham location on a regular basis, a community that, at the time, had no local food pantry. The Food Mobile now regularly visits four rural HealthReach locations, serving around 100-125 clients at each visit. The Rangeley clinic in particular subsidizes a visit by the Food Mobile every other month, in response to community need.

Beginning in 2016, the collaboration expanded to address food insecurity more broadly. GSFB staff are training HealthReach clinical staff to screen clients for food insecurity. Many health centers already asked about food insecurity but not in a systematic or integrated way, and without a plan to connect people with identified needs to resources such as food pantries and federal programs, such as the Supplemental Nutrition Assistance Program. With GSFB’s support HealthReach is piloting a project to screen every patient using the brief Hunger Vital Sign questionnaire and, if needed, connect them to social services. With the approval of HealthReach’s leadership, GSFB has been reaching out to practice managers to establish relationships and bring the program to new sites. Three clinics—Bingham Area Health Center, Belgrade Regional Health Center, and Strong Area Health Center—are currently

participating in the pilot. Another location in Kingfield (Mt. Abram Health Center), which already had a small food closet on-site, has expanded the range and amount of healthy food that can be given out immediately to clients with identified needs, bridging any gaps before the appropriate ongoing support can be set up.

Funding for these initiatives has come from small grants and foundations, and overall costs for GSFH have been low. GSFH is aiming to double the number of partner sites in the next year, and the hope is that some of the sites will be able to self-fund the projects, so that they can continue past the initial pilot phase.

Example: Aroostook County Health Network

The Aroostook County Health Network (ACHN) is a partnership between three FQHCs—Pines Health Services, Katahdin Valley Health Center, and Fish River Rural Health—as well as the Aroostook County Action Program (ACAP) and the Aroostook Agency on Aging (AAA)—to integrate social services and health care in the county and to develop and improve programs around the social determinants of health. They are looking to develop a single form that any of the organizations can use to connect patients to the services they need, without the need for patients to resubmit the same information to multiple organizations. ACHN is supported by a number of grants, including a HRSA rural network development grant.

ACHN has implemented a number of initiatives around the social determinants of health, with each member organization taking the lead where appropriate, with the partner organizations providing support. For example, recognizing that people may not be able to access food pantries due to limited hours of operation or limited means to transport food home, ACHN is planning to have one Community Cupboard in the town of each network member established by spring 2018, where you “give what you can, take what you need.” These cupboards will be stocked by members of the community and available for use any time of day. Pines has used grants and program funds to ease transportation concerns, providing gas cards for patients referred to Portland or Bangor for specialty services, arranging peer rides through AAA, and even coordinating Angel Flights for referrals to Boston. As Pines CEO Jim Davis noted, ACHN’s members never want patients to have to worry about money for gas, money that might otherwise be used to heat their homes, put food on the table, or pay for prescriptions. ACHN wants to take the cost of transportation out of the equation when it comes to medical care. All of the FQHCs also screen their patients for concerns about food, housing, or heating oil, and make referrals to ACAP. ACHN is currently developing a screening tool around the social determinants of health.

ACHN and the four county hospitals are currently working on streamlining care coordination by reducing duplication across programs, so that each patient is only contacted once, rather than repeatedly by multiple member organizations. This can be especially confusing for senior citizens, who might be concerned about being scammed or about their safety if someone they don’t know contacts them for a home visit. This effort is funded in part through MeHAF’s rural transformation grant program.

Example: Community Health Partners of Montana

Community Health Partners of Montana (CHP) is an FQHC with seven sites located in Park and Gallatin Counties, Montana, a rural, mountainous, and sparsely populated area in the southern part of the state. CHP recognized that low levels of educational attainment in adults was a contributing factor in generational poverty and poor educational achievement in children, and developed a robust program to address this key social determinant of health. Since 1999, CHP has looked to improve the health of its patient population by providing on-site educational programming, an initiative known as Learning Partners (LP).²⁸

This family literacy program is seamlessly integrated into CHP. It is housed in the same building as the dental and medical clinic, which allows families to access literacy support and educational services at the same time as their other appointments. LP's website notes that it "integrates educational programs and support services within the medical clinics, which empower individuals and families to become self-reliant, life-long learners."²⁸ Educational services include GED courses, Adult Basic Education, parenting classes, financial literacy, courses for English language learners, and workforce development, while early childhood education programs include soft skills training, home visits, one-on-one tutors, and technology education. In 2015 alone, LP provided over 600 home visits, and served an average of 17 families accessing Temporary Assistance for Needy Families per month. LP is also home to the Reach Out and Read Program, which gives out more than 2,000 new books a year to young children. LP is funded through a combination of federal grants, patient revenue, private grants, and donations. These programs were about 3.4 percent of CHP's total operating budget in 2010.²⁹

KEY CONSIDERATIONS for application:

- The examples featured here indicate the importance of starting small with manageable initiatives. They provide the building blocks for more ambitious efforts that are likely to require more time and resources.
- Capturing critical information on food security, housing, and other social factors patients face is a critical first step. Developing and implementing mechanisms to share information/data across organizations supports effective care management.
- While grants are helpful to get initiatives started and engage stakeholders, building deep and meaningful partnerships with community organizations is essential for the long-term success of these programs. Some of the strategies and models outlined in this brief—like EHC's Community Circles—offer frameworks for creating and strengthening partnerships within a community.
- While adequate, sustainable funding is a challenge, the projects featured here demonstrate the value of community-based efforts to use existing funding to address the social determinants of health.
- Participation in Accountable Care and other value-based payment arrangements (e.g. Accountable Care Organizations and Accountable Communities) offer potential opportunities for FQHCs to build capacity and offer innovative services to address the social determinants of health.

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