Colorado State Rural Health Plan

2016

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Presented to:
The Federal Office of Rural Health Policy
5600 Fishers Lane
Rockville, MD
# Colorado State Rural Health Plan

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Executive Summary

The Colorado Rural Health Center (CRHC) in its role as the state’s grantee for the Medicare Rural Hospital Flexibility Program presents this plan to the Federal Office of Rural Health Policy (FORHP) as part of the state’s overall strategy to support rural health.

This State Rural Health Plan (SRHP) serves as a guide to address issues in rural healthcare throughout the state of Colorado and to measure improvement in rural healthcare. It also serves as a response to the grant guidance from the FORHP requesting a revised state plan from Flex Program grantees. This SRHP includes measurable objectives that will be developed over the next five years.

The needs discussed in this report are significant and include healthcare economics, resource constraints, and need for advocacy. CRHC is involved in multiple collaborative partnerships and statewide efforts that offer exciting, promising and proven solutions for the rural healthcare challenges throughout our state. While the challenges are ominous, vast, and continually changing, CRHC is committed to keeping a proactive pulse on the issues facing rural providers. CRHC’s extensive partnership network enables access to resources to readily offer solutions to problems with direct support activities, program development and creative community solutions.

While CRHC develops the content of the SRHP with input from partner organizations and rural providers in Colorado, the content presented is the sole responsibility of CRHC and does not necessarily reflect the views of organizations or individuals referenced in this report.
The Colorado Rural Health Center

History of CRHC

The Colorado Rural Health Center (CRHC) was established in 1991 by members of the Colorado Rural Health Consortium with start-up support from the Federal Office of Rural Health Policy (FORHP) and several other public and private organizations around the state. CRHC was developed as a non-profit organization and is one of three non-profit state offices of rural health (SORH) in the country. All 50 states have offices of rural health.

CRHC Organizational Overview

The CRHC is an independent, non-profit, membership-based organization that serves as the State Office of Rural Health (SORH) and Rural Health Association for Colorado. CRHC has a statewide constituency of over 3,500 people and organizations. It also serves as the state’s grantee for the federal Health Resources and Services Administration’s (HRSA) Medicare Rural Hospital Flexibility Program (Flex Program), the State Office of Rural Health (SORH) grant, as well as the Small Rural Hospital Improvement Program (SHIP) grant. CRHC is a diverse mix of people and programs located throughout the state of Colorado. The common thread is an interest in rural health – its delivery system, providers and people. CRHC administers programs and partners with many organizations to ensure rural communities have access to adequate healthcare and emergency medical services and to ensure healthcare delivery systems achieve financial stability.

CRHC advocates on behalf of the healthcare needs of rural Colorado. In order to assess the general landscape of rural health issues throughout the state, CRHC relies upon rural healthcare providers and consumers in helping shape CRHC policy and advocacy agenda. CRHC is considered to be the primary voice for rural residents of Colorado by tracking, analyzing, and influencing legislation and regulations that will impact the health of Colorado’s rural communities.

CRHC Mission

The mission of CRHC is enhancing healthcare services by providing information, education, linkages, tools and energy toward addressing rural healthcare issues.

Information: CRHC is a clearinghouse of information and resources on rural health issues in Colorado and the country. This information is available to healthcare consumers, advocates, facilities, programs and services.
**Education:** CRHC sponsors a variety of educational events including workshops, meetings, conferences, conference calls and webinars, which provide education about rural healthcare. In addition to educating those who live in rural communities, CRHC advocates for accessible, high quality healthcare services in rural Colorado by educating legislative decision-makers and keeping urban counterparts informed of current rural healthcare issues.

**Linkages:** Rural health issues can often be addressed by connecting federal and state, private and public resources with people and communities. CRHC identifies successful healthcare projects, activities and agencies, and links them together through formal and informal methods.

**Tools:** CRHC administers several grant programs and provides Rural Health Seed Grants for startup projects addressing rural health issues. Other tools include resources from state, federal and private agencies, education, and networking.

**CRHC Collaborative Partnerships**

CRHC takes a lead role for rural health in Colorado and is primarily responsible for the development of the State Rural Health Plan. CRHC partners with multiple organizations and stakeholders in the state to increase efficiencies and capitalize on existing resources and projects. Through partnerships and collaborative efforts, CRHC ensures that rural healthcare concerns are visible and addressed at the local and statewide level. CRHC’s major partnerships include, but are not limited to:

- American Heart Association, Colorado Chapter
- Caring for Colorado
- Centers for Medicare & Medicaid Services (CMS)
- Center for Improving Value in Health Care
- Centura Health
- Colorado Area Health Education Centers
- Colorado Children’s Immunization Coalition
- Colorado Community Health Network
- Colorado Department of Public Health and Environment
- Colorado Family Resource Center
- Colorado Health Institute
- Colorado Healthcare Extension Service
- Colorado Hospital Association
- Colorado Medical Society
- Colorado Patient Safety Coalition
- Colorado Prevention Center
• Community Resource Center
• COPIC Companies
• Exempla St. Joseph Hospital
• Health Care Policy and Finance
• HealthONE
• HealthTeamWorks
• Telligen
• The Colorado Health Foundation
• The Colorado Trust
Rural Healthcare Overview

National Overview

The major focus of rural health policy has traditionally been on accessibility of healthcare services in rural areas. However, research has found other “determinants of health,” including socioeconomic factors and personal behaviors, are also important in understanding and addressing the health status and well-being of selected populations. The Centers for Disease Control (CDC) issued a report entitled, *Health, United States 2001*, which set a precedent for documenting the disparities in health among urban and rural communities. The CDC report showed that rural areas, with their distinctly different demographic, social and economic characteristics, present a unique set of challenges that future disease prevention and health promotion programs will need to address.

The National Rural Health Association (NRHA) mirrors these findings in their advocacy work for rural healthcare providers. Rural America is a vital component of American society. Representing nearly 20 percent of the population, rural communities, like urban landscapes, are rich in cultural diversity. However, the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services. According to NRHA, “Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the sheer isolation of living in remote rural areas all conspire to impede rural Americans in their struggle to lead a normal, healthy life.”

Analysis of comprehensive data from the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS) shows that health status is generally worse among rural residents compared to urban residents.

Rural areas are vulnerable to workforce shortages, in part because small population size and scale often means that the loss of just one physician can have profound effects on a community’s ability to ensure reasonable access to care. As the number

1 2008 R Report to the Secretary: Rural Health and Human Services Issues
of shortage areas has increased over the past 20 years, so have the issues of provider shortages in all areas, physicians, dentists and nursing professions.

Across the U.S., the number of hospitals and hospital beds has decreased over the last 20 years, reflecting a national trend toward shorter lengths of stay and movement of services to outpatient facilities. As of March 2016, there are a total number of 5,627 registered hospitals in the United States with 1,331 of those being Critical Access Hospitals (CAHs).

Rural hospitals have struggled to remain financially viable. According to the National Rural Health Association, the rate of rural hospital closure has increased between 2010 and 2015 since sequestration and bad debt cuts went into effect with 68 rural hospitals closing nationwide and another 673 rural hospitals considered vulnerable to closure representing 1/3 of rural hospitals. At one time all hospitals, both rural and urban, were paid under the Medicare Inpatient Prospective Payment System (IPPS), whereas many rural hospitals are now paid under a variety of alternative reimbursement methodologies that emerged to address rural hospital viability under IPPS methodology. The most significant of these methodologies is the CAH status which provides cost-based Medicare reimbursement.

The CAH program has come under scrutiny over the past few years as articles have emerged questioning the quality of care delivered at these hospitals, as well as suggested reimbursement and funding cuts and modifications to CAH mileage criteria have been proposed. In response, there is more emphasis on CAHs submitting data measures to CMS Hospital Compare and more focus on initiatives such as FORHP’s Medicare Beneficiary Quality Improvement Project (MBQIP) as a vehicle for CAHs to demonstrate their quality and commitment to patient safety and for Flex programs to demonstrate the benefits of the CAH program.

Access to Emergency Medical Services (EMS) is also an important issue for rural communities given the realities of geographic isolation and travel time to care. Half of the nation’s ambulance services provide care to the 75 percent of Medicare beneficiaries living in urban areas while the other half of services provide care to the 25 percent living in rural areas.

In 2007, the IOM published *The Future of Emergency Care in the United States Health System*. The report notes that while there have been some advances, such as broadened 911 coverage, there was an abrupt decline in Federal funding and leadership in the early 1980s. Since then, “the push to develop more organized systems of EMS delivery has diminished, and EMS systems have been left to develop haphazardly across the United States.”
In its role as the SORH for Colorado, CRHC has worked over the years to raise awareness and provide education about Colorado’s rural health environment. CRHC developed the Healthcare Awareness for Rural Communities (HARC) databank, compiling over 400 demographic and population health indicators for every rural county in the state. CRHC uses this information to inform its work and to create an Annual Snapshot of the state’s rural health landscape. Over 73% of Colorado’s geographic area is rural or frontier, and almost one-sixth of the state’s population lives in this area. Of Colorado’s 64 counties, 24 are considered rural and 23 are considered frontier (a rural county having six or fewer people per square mile).

All but six of Colorado’s 64 counties are designated as Health Professional Shortage Areas (HPSAs), or Medically Underserved Areas (MUAs). Colorado’s 47 rural and frontier counties tend to share certain characteristics including typically lower income populations, higher poverty, a higher percentage of elderly, a shortage of
healthcare providers, decreased access to healthcare services, fewer insurance carriers, and increased insurance costs, among others.

According to the U.S. Census Bureau, in 2015, the total population for Colorado was 5,268,637. According to the latest data reports from the Robert Wood Johnson Foundation, 1

7% of Coloradans are uninsured (equal to the national percentage) and 9% of Colorado’s children are uninsured (compared to 8% nationally).
Colorado Healthcare Reform

As previously referenced, the IOM report, *Crossing the Quality Chasm*, urged a national commitment to transforming care delivery to bridge the gap between current substandard care and optimal, achievable care. Additionally, federal proposals brought forward through the Patient Protection and Affordable Care Act (PPACA) emphasize care quality over the traditional fee-for-service payment models. Initiatives such as Accountable Care Organizations (ACOs) are launching in this new healthcare climate to push providers to form networks to lower overall healthcare costs and improve care quality through increased care coordination and improved communication amongst providers with the incentive of sharing in the savings achieved in lowering costs through improved quality. Federal initiatives, such as ACOs, are based on the concept of the Triple Aim whose 3 tenets are to: enhance the patient experience; improve the health of populations; and reduce/control the per capita cost of care. Colorado has recently taken significant steps towards addressing healthcare access and quality needs as this new healthcare environment is emerging.

The Center for Improving Value in Health Care (CIVHC) was established by Executive Order D00508 signed by Governor Bill Ritter on February 13, 2008, as part of the "Building Blocks to Health Care Reform" plan. CIVHC was created to establish an interdisciplinary, multi-stakeholder entity to identify and pursue strategies for quality improvement and cost containment based on the Triple Aim.
CRHC is one of six operating partner organizations for the statewide Healthy Transitions Colorado initiative convened by CIVHC and fully supports the current adopted principles and work to ensure rural providers are represented.

Many other initiatives are underway in Colorado as a result of the current healthcare landscape and proposed healthcare reform. The Colorado Healthcare Extension Service (CHES) is a collaborative group of healthcare organizations from across the state that began convening to discuss the variety of practice transformation activities and initiatives in Colorado with the aim of increasing awareness, encouraging collaboration, and reducing duplication of efforts. With oversight of the Governor’s office, the CHES group is coordinating the efforts of national funding awarded to Colorado in this area including: the CMS’ State Innovation Model (SIM), AHRQ’s Evidence Now Southwest, and the CMS’ Transforming Clinical Practice Initiative (TCPI). CRHC is involved in all of these efforts and is contracted as one of the organizations performing practice facilitation as well as clinical health information technology advising.

Several of CRHC’s current programs support the concepts promoted in the Triple Aim and are specifically geared towards rural hospitals and clinics. CRHC has begun work to engage entire communities to support workforce recruitment retention and supports the concepts of primary care redesign and medical home to address health needs in rural communities. Additionally, CRHC’s Improving Communication and Readmission (iCARE) program (discussed later in this report) incorporates many of the same principles by looking to reduce avoidable readmissions, improve communication in transitions of care, and improve clinical processes.

For CRHC, the Triple Aim is especially relevant in the area of primary care concept design. The redesign of primary care services and structures includes:

- Establish a team design for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
- Deliberately build an access platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
- Cooperate and coordinate with other specialties, hospitals, and the community

As part of this redesign, in recent years, there has been push in Colorado and across the country for the “medical home” concept which emphasizes the role of primary care providers in following, tracking and guiding their patients in accessing preventative, primary, and specialty care to reduce medical errors and provide cost
savings. While this concept shares the original goals of managed care models, medical homes are not necessarily financial models focused on managing risk. CRHC continues to advocate for rural participation in medical home development and expansion in rural Colorado along with the considerations and flexibility needed for rural providers given their unique challenges.

**Colorado Rural Healthcare Needs and Opportunities**

Colorado’s rural communities face many of the same healthcare challenges as rural communities across the nation. What sets Colorado rural healthcare apart is the infrastructure and design of statewide activities, state regulations and reimbursement, and a spirit of collaboration amongst providers and stakeholder organizations. While the strengths in Colorado are plentiful, there are several opportunities to improve the Colorado rural healthcare landscape.

**SWOT Analysis**

**Strengths**

- Spirit of collaboration amongst Colorado providers
- Common performance improvement challenges
- Focused effort on quality and patient safety
- Local funding support (The Colorado Trust, The Colorado Health Foundation, Caring for Colorado, COPIC)
- Engaged and willing to participate in innovative solutions
- Coordinated effort of statewide initiatives to improve healthcare
- Infrastructure, leadership and collaborative nature of CRHC

**Weaknesses**

- State’s geographic diversity (Western Slope, Mountainous, Eastern Plains)
- Competitive nature among some organizations
- Legislative regulations and misalignments (Medicaid in Colorado does not pay additional reimbursement for CAHs as do some other states)
- Economic challenges of small communities and economy
- Provider and professional education
- Provider recruitment and retention
- Administrative turnover
- Time constraints due to multiple job functions
- Multiple initiatives that pull resources

**Opportunities**

- Continued consolidation of performance and quality improvement efforts in a single effort for the state
• Interconnectivity of health information systems for data collection and extraction
• Community health models including medical homes
• Economic development for communities
• Partnership enhancement amongst support stakeholders
• Tele-medicine system development to address provider shortages
• Enhanced networks with urban partners to address gaps in care
• Streamline efficiencies using lean and six sigma methodologies to improve financial status and improve care
• Increase opportunities for local education of healthcare providers

Threats
• CMS Recovery Audit Contractors
• Inconsistent funding
• Competitiveness of partners undermine efforts
• Uninsured numbers in rural Colorado rising
• General healthcare system gaps
• Economic downturn
• Community-level challenges such as large employers leaving area

Overarching Challenges Being Addressed

Healthcare Economics – At the highest level, healthcare economics create significant challenges for small, rural hospitals. The high fixed cost of hospitals and increasing reimbursement pressures make it difficult for the Colorado CAHs to reach financial stability.

CRHC takes a multi-pronged approach to help address the current economic challenges in rural Colorado. On a national level, CRHC keeps current on proposed rules and changes in reimbursement and provides responses to the government on behalf of the rural facilities to encourage optimal changes to regulations. At the state and facility level, CRHC provides educational opportunities for facilities to learn optimal billing practices to enhance reimbursement. CRHC also assists facilities in assessing their current provider type and determining what options would enhance viability.

Workforce Constraints – Financial instability and resource constraints present overarching challenges for rural facilities. Specifically, staffing models and recruitment challenges place significant demands on hospitals and other rural health providers. This results in time and resource scarcity, and opportunities to integrate clinical and financial successful models are often lost.
CRHC has a devoted staff that continually promotes rural healthcare and recruits providers for rural areas. Colorado has the added benefit of having support for several loan repayment options and other programs to incentivize providers to practice in rural Colorado. CRHC administers several of these programs including CPR (Colorado Provider Recruitment), and Marva Jean Jackson Rural Community Health Scholarships. In addition, CRHC staff are application reviewers for the state loan repayment program; Colorado Health Service Corps.

**Leadership Support** – Strong leadership and governance provides rural facilities with the opportunity to achieve financial stability and a sense of security. CRHC offers education to support and enhance boards and internal leadership. With improved financial performance, rural providers can enhance their status within communities, systems and state agencies. Solid and visionary leadership infrastructure provides operational leeway so that facilities can focus on long-term goals.

**Health Information Technology** – The national push towards incorporating Health Information Technology (HIT) and Electronic Health Records (EHRs) is especially daunting for rural healthcare providers given their lack of access to technical, workforce, and financial resources needed for HIT adoption, implementation, and sustainability. In response to this need, CRHC formed the Technology for Healthcare Excellence (THE) Consortium to provide education and access to trusted resources for rural hospitals and clinics in the pursuit of HIT. Additionally, under funding from the Federal Stimulus bill, CRHC served as one of Colorado’s Regional Extension Centers (REC) to assist rural providers in adopting, implementing and becoming meaningful users of electronic health record (EHR) systems to qualify for federal stimulus funds. Over the past year, CRHC has continued to develop and expand services to HIT in order to meet the needs of Colorado’s rural facilities. Assistance includes HIT support services, business analytic and business intelligence services, as well as facilitating discussions between rural hospitals and clinics and their EHR vendors through user groups to address common challenges in optimizing EHR functionality.

**Emergency Medical Services (EMS)** – EMS continues to be a challenge for Colorado’s rural areas because of the vast territory involved, limited workforce, and funding. Currently 24 of Colorado’s 29 CAHs are trauma designated. CRHC continues to champion rural EMS issues through assistance, working with the Colorado Department of Public Health and Environment, and supporting innovative models, such as Community Paramedicine, which allows the underutilized resource of rural EMS workers to provide health services where access
to physicians, clinics and/or hospitals is difficult or may not exist.

Advocacy – Too often the rural voice is unheard as the urban providers outnumber the rural providers. CRHC advocates on behalf of the healthcare needs of rural Colorado. In order to assess the general landscape of rural health issues throughout the state, CRHC relies upon rural healthcare providers and healthcare consumers to help shape CRHC’s policy and advocacy agenda. CRHC serves as the voice for rural residents of Colorado by tracking, analyzing, and influencing legislation and regulatory issues that will impact Colorado’s rural communities.

CRHC understands that working independently is not a competitive strategy; rather, it increases isolation. An effective state network of hospitals and rural providers working together ensures sharing resources and learning best strategies. Pooling and coordinating scarce resources results in improved performance and additional opportunities to develop programs and services that respond to common areas of need and interest.

CRHC will continue to facilitate networking amongst rural communities and advocate the value that rural Colorado communities provide to our state and the nation.
Colorado Rural Hospital Medicare Flexibility (Flex) Program

The Flex Program was authorized by section 4201 of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. The Flex Program provides funding to states for the designation and support of CAHs in rural communities and the development of networks to improve access to care in these communities. The mission of this federally funded program is to “strengthen rural health care by encouraging states to take a holistic approach, and is charged with promoting a process for improving rural health care using the CAHs.” The Flex Program is administered by FORHP.

Colorado Critical Access Hospitals (2016)
<table>
<thead>
<tr>
<th>City</th>
<th>Critical Access Hospital</th>
<th>Certification Date</th>
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</thead>
<tbody>
<tr>
<td>Aspen</td>
<td>Aspen Valley Hospital</td>
<td>9/1/2004</td>
</tr>
<tr>
<td>Brush</td>
<td>East Morgan County Hospital</td>
<td>1/1/1997</td>
</tr>
<tr>
<td>Burlington</td>
<td>Kit Carson County Memorial Hospital</td>
<td>1/1/2002</td>
</tr>
<tr>
<td>Cortez</td>
<td>Southwest Memorial Hospital</td>
<td>8/22/2008</td>
</tr>
<tr>
<td>Craig</td>
<td>The Memorial Hospital</td>
<td>3/1/2002</td>
</tr>
<tr>
<td>Del Norte</td>
<td>Rio Grande Hospital</td>
<td>1/1/1997</td>
</tr>
<tr>
<td>Eads</td>
<td>Weisbrod Memorial Hospital</td>
<td>7/1/2002</td>
</tr>
<tr>
<td>Estes Park</td>
<td>Estes Park Medical Center</td>
<td>6/1/2001</td>
</tr>
<tr>
<td>Fruita</td>
<td>Family Health West</td>
<td>1/1/1997</td>
</tr>
<tr>
<td>Gunnison</td>
<td>Gunnison Valley Hospital</td>
<td>10/1/2003</td>
</tr>
<tr>
<td>Haxtun</td>
<td>Haxtun Hospital</td>
<td>7/18/2000</td>
</tr>
<tr>
<td>Holyoke</td>
<td>Melissa Memorial Hospital</td>
<td>8/3/2000</td>
</tr>
<tr>
<td>Hugo</td>
<td>Lincoln Community Hospital</td>
<td>8/24/2000</td>
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<tr>
<td>Julesburg</td>
<td>Sedgwick County Health Center</td>
<td>4/1/2001</td>
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<tr>
<td>Kremmling</td>
<td>Kremmling Memorial Hospital District</td>
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<tr>
<td>La Jara</td>
<td>Conejos County Hospital</td>
<td>11/14/2000</td>
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<tr>
<td>Lamar</td>
<td>Prowers Medical Center</td>
<td>8/1/2004</td>
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<tr>
<td>Leadville</td>
<td>St. Vincent General Hospital District</td>
<td>5/1/2003</td>
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<tr>
<td>Meeker</td>
<td>Pioneers Hospital of Rio Blanco County</td>
<td>1/1/2008</td>
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<tr>
<td>Pagosa Springs</td>
<td>Pagosa Springs Mountain Hospital</td>
<td>9/15/2008</td>
</tr>
<tr>
<td>Rangely</td>
<td>Rangely District Hospital</td>
<td>9/28/2000</td>
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<tr>
<td>Rifle</td>
<td>Grand River Hospital District</td>
<td>1/1/2003</td>
</tr>
<tr>
<td>Salida</td>
<td>Heart of the Rockies Regional Medical Center</td>
<td>5/1/2004</td>
</tr>
<tr>
<td>Springfield</td>
<td>Southeast Colorado Hospital</td>
<td>3/1/2001</td>
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<td>Trinidad</td>
<td>Mt. San Rafael Hospital</td>
<td>1/1/2004</td>
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<td>Walsenburg</td>
<td>Spanish Peaks Regional Health Center</td>
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<td>Woodland Park</td>
<td>Pikes Peak Regional Hospital</td>
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<tr>
<td>Wray</td>
<td>Wray Community District Hospital</td>
<td>1/1/2001</td>
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<tr>
<td>Yuma</td>
<td>Yuma District Hospital</td>
<td>7/1/2002</td>
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Specific Flex grantee core areas include:

- Quality Improvement
- Financial and Operational Improvement
- Population Health Management and EMS Integration
- Designation of CAHs in the State
- Integration of Innovative Health Care Models

Flex Grant Program Highlights (1997-2016)

The following table highlights Flex Grant Program Activities in Colorado from the inception of the program in 2000, and includes CAH conversions as of 1997.

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitals Converted to CAH/ New CAH Facilities</th>
<th>Flex Program Highlights</th>
</tr>
</thead>
</table>
| 1997 | • East Morgan County Hospital  
• Rio Grande Hospital  
• Family Health West | • Hired CAH Program Director and received first Flex grant |
| 2000 | • Haxtun Hospital  
• Melissa Memorial Hospital  
• Lincoln Community Hospital  
• Conejos County Hospital  
• Rangely District Hospital | • Colorado Rural Health Council Formed by CRHC  
• CAH Conversion Technical Assistance |
| 2001 | • Estes Park Medical Center  
• Sedgwick County Health Center  
• Southeast Colorado Hospital  
• Wray Community District Hospital | • CAH Conversion Technical Assistance  
• Colorado Provider Recruitment Program  
Developed to address workforce shortage and retention issues  
• Regional HIPAA Compliance Trainings offered for CAHs and RHCs |
| 2002 | • Kit Carson County Memorial Hospital  
• The Memorial Hospital  
• Weisbrod Memorial Hospital  
• Spanish Peaks Regional Health Center  
• Yuma District Hospital | • Implemented a Statewide CAH Quality and Performance Improvement Program  
• Created CAH Swing Bed Manual  
• Developed CAH Profiles  
• HIPAA Training and Education  
• Coordinated two statewide technical assistance grant programs (EMS and QI focused)  
• Expansion of the CAH website, newsletter and hosting of annual statewide workshops to facilitate communication and education  
• Oversight of Colorado Provider Recruitment (CPR), the statewide recruitment and retention program  
• Regular site visits to CAHs and their communities to monitor progress, provide education, resources, and general support.  
• Developed CAH Technical Assistance Grant Program to support infrastructure of CAHs |
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<thead>
<tr>
<th>Year</th>
<th>CAHs Created</th>
<th>CAHs Converted</th>
<th>Initiatives</th>
</tr>
</thead>
</table>
| 2003 | Gunnison Valley Hospital  
  Kremmling Memorial Hospital District  
  St. Vincent General Hospital District  
  Grand River Hospital District |  | Developed and enhanced rural health networks  
  Supported programs to improve and integrate emergency medical services (EMS), and  
  Expanded local health system quality improvement (QI) activities  
  Hosted Regional Quality Improvement Trainings  
  CAH EMS Grants Offered to strengthen EMS services |
| 2004 | Aspen Valley Hospital  
  Prowers Medical Center  
  Heart of the Rockies Regional Medical Center  
  Mt. San Rafael Hospital |  | Peer Review Network Developed  
  Statewide Balanced Scorecard Implementation |
| 2005 | No new or converted CAHs |  | Statewide Collaborative for Pneumonia/CHF patients in rural hospitals  
  Financial impact study of CAHs in Colorado conducted  
  Swing Bed Trainings conducted onsite for CAH staff  
  CMS Conditions of Participation and compliance training held  
  Cost Reporting and Billing Training held  
  Held meeting with urban and rural case managers and discharge planners to discuss transfer needs |
| 2006 | No new or converted CAHs |  | Developed CAH IT Network to discuss IT challenges and solutions  
  Distributed $30,000 in EMS grants  
  EMS funding developed with support from local foundation to recruit EMS providers |
| 2007 | No new or converted CAHs |  | EMS Budget Tool Training available to EMS programs |
| 2008 | Southwest Memorial Hospital  
  Pioneers Hospital of Rio Blanco County  
  Pagosa Springs Mountain Hospital  
  Pikes Peak Regional Hospital |  | Trauma Assistance and Consultation Program developed  
  Board Training and Development Program  
  State Rural Health Plan update activities underway |
| 2009 | No new or converted CAHs |  | CRHC’s Colorado Rural Credentialing Network formed  
  CRHC develops Utilization Management Resource Guide for CAHs |
| 2010 | No new or converted CAHs |  | Improving Communication and Readmission (iCARE) project begins in September – 11 CAHs participate |
| 2011 | No new or converted CAHs |  | iCARE’s Second Year begins in September – 14 CAHs participate  
  ORHP’s MBQIP Program begins in September – 13 CAHs participate  
  CRHC exhibits iCARE Storyboard at IHI’s National Forum |
| 2012 | No new or converted CAHs |  | CAH Financial Workgroup formed  
  CRHC offers CAH Quality System Assessments |
| 2013 | No new or converted CAHs |  | iCAREs 4th year began in September – 14 CAHs participate |
| 2014 | No new or converted CAHs |  | iCARE’s 5th year begins in September – 19 CAHs participate  
  CRHC and iCARE Hospital present breakout session at NRHA CAH Conference  
  CRHC exhibits iCARE Storyboard at IHI’s |
| 2015 | • No new or converted CAHs | • iCARE’s 6th year begins in September – 21 CAHs participate |

### Flex Grant current year

In response to current needs as identified through evaluations and strategic priorities discussed at CRHC’s Annual CAH Workshop, CRHC is offering an array of programs and services for the Flex grant year cycles. Activities include regional CAH Quality Improvement Workshops, iCARE, Swing Bed and Utilization Management training, CAH Peer Review Network, and a CAH Financial Workgroup.

### Improving Communication and Readmission

In its sixth year, CRHC’s Improving Communication and Readmission (iCARE) program has engaged 21 Colorado CAHs looking at goals relating to:

- Reducing readmissions
- Improving communication in transitions of care
- Improving clinical processes that contribute to readmissions, particularly for heart failure and pneumonia patients

CRHC offers participating hospitals access to free technical assistance to help them achieve their iCARE goals. CRHC offers monthly educational webinars focused on quality improvement practices, data analysis, and peer learning. The CRHC iCARE team follows up with hospitals to provide individualized assistance in helping move their projects forward. In 2013 CRHC was awarded funding through the CDPHE which allowed iCARE to expand to include hospitals’ clinics in the project, looking at the care continuum and improved communication through extended reach to the community’s diabetic patient population. Along with the hospitals, 30 clinics are participating in the program to-date.

### Colorado Peer Review Network

The CAH Peer Review Network was developed by CRHC to provide a cost-effective way for rural hospitals to conduct objective external peer reviews to evaluate appropriate medical care. Currently, 20 of Colorado’s 29 CAHs participate in the Peer Review network.
Operational Improvement Assistance

CRHC provides services to assist CAHs in various aspects of their operations. Every year, CRHC provides customized CAH Swing Bed and Utilization Management Manuals and presents corresponding educational webinars to assist facilities in proper utilization of services and accurate application of regulations and documentation to help them maximize resources and reimbursement while providing quality and appropriate patient care.

CAH Financial Workgroup

In response to the need expressed by CAHs for a network for sharing financial issues and concerns facing Colorado’s CAHs, CRHC convened the CAH Financial Workgroup. The group examines CAH Financial data, shares information on opportunities to maximize funding and viability, and discusses the current financial landscape and pending legislation and reforms that could impact CAH reimbursement.

CRHC Quality Improvement Assistance

Colorado CAHs receive assistance in quality improvement through CRHC’s Flex Grant funding through a variety of mechanisms. Through partnership with Telligen, Colorado’s Quality Improvement Organization (QIO), CRHC facilitates the CAH Quality Directors Network including bi-monthly educational webinars and a listserv to connect CAHs for information sharing. CRHC hosts annual regional quality improvement workshops that include training for hospital staff on current quality improvement strategies and data analysis.
Colorado Rural Health Clinics

As of March 2016, Colorado has 49 federally certified Rural Health Clinics (RHCs) and another 50 rural clinics that do not have federally certified RHC designation, but that also provide vital access points in their communities.

Colorado’s RHCs are located in rural communities throughout the state (see table below). Approximately half of the clinics are provider-based to a rural hospital and the remainder are independent, free standing clinics. Rural Health Clinics are required by federal regulation to accept Medicare and Medicaid patients. Additionally, RHCs care for the uninsured and underserved populations in their communities. Many clinics accept managed care and private pay patients; however, these payer types comprise a small percentage of the patient population in rural Colorado.

CRHC serves the leaders, administrators, managers, healthcare providers and staff of Colorado’s certified RHCs. CRHC receives communication from RHCs regularly with questions related to policy and program regulations (i.e., Medicare and Medicaid) and requests for information, such as sample policies and procedures, guidelines for compliance with HIPAA and OSHA, human resources, board of directors development and strategic planning.
Rural Health Clinic Programs

CRHC developed a rural health clinic technical assistance program in 2005. The program currently offers technical assistance services for clinics and private practices in rural and underserved areas. Activities include quality improvement, assessments of basic business operations, compliance, billing/reimbursement, cost reporting, customer service, financial feasibility studies and policies & procedures. CRHC also works annually to compile information from all RHCs on topics including demographics, providers, and payer mix. This information is used to help inform CRHC’s programs and services as well as to educate and advocate for the work and impact RHCs have in communities statewide.

Future Objectives

- Identify additional organizations and consultants who are available and qualified to serve a variety of technical assistance needs.
- Assist RHCs with education, resources and support services for practice transformation.
- Expand the services available to new and existing RHCs.
- Continue to establish relationships and partnerships with RHCs and assess clinic needs through onsite visitation. CRHC’s onsite presence is the primary means through which clinics have access and receive the most RHC technical assistance services. As a result of these clinic visits CRHC is seeing increased demand for RHC technical assistance services.
Performance Improvement in Colorado

CRHC assists rural hospitals and clinics to improve performance based on current and anticipated needs. CRHC convenes an annual CAH Workshop for Colorado CAHs, an Annual Rural Health Conference, and an Annual Forum for RHCs to discuss top priorities and issues that can be addressed through CRHC’s programs and services.

The importance of data and measuring outcomes and impacts has grown over the past few years. Many hospitals and clinics have been challenged by initiatives that have multiple, competing data needs along with issues in abstracting data from EHRs and generating reports to measure progress. CRHC has also been working to synthesize the various sets of data such as quality, population health, financial, and operational, to provide facilities with in-depth snapshots and analyses of how their work correlates to the health of their communities. Below is an example of these efforts through CRHC’s iCARE program.
Colorado in National Efforts

National Organization of State Offices of Rural Health (NOSORH) – Several CRHC staff members are involved in the National Organization of State Offices of Rural Health which provides forums and information for state offices of rural health (SORHs) in multiple areas including Flex, RHCs, HIT, and Policy.

National Rural Health Association (NRHA) – CRHC staff members participate in several NRHA committees and group calls including the Rural Health Constituency Group, Policy Congress, NRHA CAH Leadership Group, and the Grassroots Policy Group.

Performance Measurement — Indicators

The following measures are intended to address a wide range of needs and opportunities and are supplemented in detail each year with CRHC’s grant application to FORHP and other grantors.

State Office of Rural Health

The SORH has introduced these areas for performance measure with the commitment to develop work plans annually that further detail and define specific measures. Presented here are general and broad areas in which CRHC works with stakeholders to develop.
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff time necessary to complete rural health activities</td>
<td>Fulfill planned activities, compare to prior months, year-end comparisons of activities planned &amp; activities completed</td>
</tr>
<tr>
<td>Percentage of activities planned and completed, measured quarterly</td>
<td>Fulfill planned activities &amp; year-end comparison of activities planned &amp; activities completed</td>
</tr>
<tr>
<td>Number of technical assistance offerings completed as measured annually</td>
<td>Respond proactively to state rural health issues; improve stakeholder through responsiveness; resource sharing; meet specific needs</td>
</tr>
<tr>
<td>Number of printed &amp; electronically disseminated rural health specific information shared as measure monthly</td>
<td>Share necessary data; timely response to TA requests; number of TA activities proactively presented; CRHC seen as a resource for convening stakeholders &amp; partners to address rural health issues</td>
</tr>
<tr>
<td>Number of hospitals eligible &amp; receiving SHIP funds</td>
<td>Fulfill planned activities, compare to prior reporting periods, year-end comparisons of activities planned &amp; activities completed</td>
</tr>
<tr>
<td>3:1 match</td>
<td>Continuous and ongoing: 1) short-term offer services to assist communities &amp; agencies in recruitment &amp; retention; 2) long range impact would be to development communities to grow their own, take the lead on recruiting, stabilize and/or grow community</td>
</tr>
<tr>
<td>Rural health funds received (outside sources)</td>
<td>Meet funding requirement</td>
</tr>
<tr>
<td>Rural health funds received by CRHC (sources in Colorado &amp; outside)</td>
<td>Continued support for programs</td>
</tr>
<tr>
<td>Strategic development of rural health plans, inclusive participation of partners</td>
<td>Evidence-based program implemented as a result of careful planning &amp; implementation – increase opportunity to meet needs</td>
</tr>
<tr>
<td>Staff time necessary to complete Flex grant activities as a percentage of the total number of staff hours as measured monthly</td>
<td>Fulfill planned activities, compare to prior reporting periods, year-end comparisons of activities planned &amp; activities completed</td>
</tr>
<tr>
<td>Number of research projects planned &amp; completed as measured annually through contracts &amp; partnerships</td>
<td>Work with partners to determine research opportunities &amp; obtain results to improve programs considered for implementation to meet needs</td>
</tr>
<tr>
<td>3:1 match</td>
<td>Continuous support for programs</td>
</tr>
<tr>
<td>Recruitment &amp; retention</td>
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<tr>
<td>Stakeholder relationships are varied, diverse, broad &amp; inclusive</td>
<td>Know trends, proactive stance on meeting needs; participate in state health care reform efforts</td>
</tr>
<tr>
<td>Increase national rural visibility &amp; unification on key issues</td>
<td>Well-rounded SORH connected with resources to address rural needs that impact health care including economics, population growth &amp; changes</td>
</tr>
<tr>
<td>Recruitment &amp; retention</td>
<td>Continuous and ongoing: 1) short-term offer services to assist communities &amp; agencies in recruitment &amp; retention; 2) long range impact would be to development communities to grow their own, take the lead on recruiting, stabilize and/or grow community</td>
</tr>
<tr>
<td>Number of hospitals eligible &amp; receiving SHIP funds</td>
<td>Accurate records for continued receipt of funding to support programs in rural areas</td>
</tr>
<tr>
<td>Recruitment &amp; retention</td>
<td>Continuous support for programs</td>
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**Future Work Plan Development**

CRHC is committed to proactively identify and address Colorado rural healthcare needs through personal connection and engagement at the state and national level. At its annual CAH Workshop, CRHC conducted a roundtable session with all attendees to discuss concerns, challenges, future endeavors, and successes with all CAHs in attendance. Below is a synopsis of the discussion.

- **What is your facility’s biggest concern/challenge?**
  - Staffing – turnover, retention providers and nurses
  - Technology – cost, struggles, security
  - Money
  - Staying open

- **What is on the horizon for your facility over the next year?**
  - New EMR
  - New buildings, remodel
  - Provider recruitment/retention

- **What is the biggest success your facility has achieved over the past year?**
  - Survived new EMR
  - Achieved various stages of meaningful use
  - Hired new providers
  - Community involvement

CRHC will utilize this information to inform its Flex work and collaborate with other program areas within the organization to continue to meet the needs of Colorado’s CAHs moving forward.

Collaborative partnerships with state and national organizations will continue to provide the solid infrastructure on which CRHC builds future projects to support rural Colorado. While multiple extensive partnerships already exist, CRHC will continue to explore new opportunities to partner with urban and rural constituents to enhance healthcare delivery in rural communities. With this solid infrastructure and support, the following activities will guide CRHC’s work as part of the Colorado State Rural Health Plan:

- Proactively research and respond actively to current interests and specific needs of Colorado rural health constituencies
- Prioritize activities to promote strong financial stability
- Promote immediate impact value producing activities that provide a “quick win” with long-term, sustainable strategies
• Establish expectations, indicators and targets and manage activities appropriately
• Engage rural providers and communities to support activities and follow through
• Encourage multi-level diverse participation within health organizations and within the community
• Establish individual responsibilities coupled with shared goals and strong leadership
• Continue to develop a cohort network of organizations that can offer support and expertise
• Continue to conduct annual CAH Workshop to develop annual work plan

For questions regarding the content of this report, contact The Colorado Rural Health Center (CRHC).

Colorado Rural Health Center | The State Office of Rural Health
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