State Offices of Rural Health

Grant Number: H95RH00100

Organization: ALABAMA DEPARTMENT OF PUBLIC HEALTH

Start Date: 07/01/2017 **End Date:** 06/30/2018 **Report Due Date:** 08/30/2018

Submitted Date: 08/24/2018

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Total number of technical assistance (TA) encounters provided directly to clients within your State by SORH: 1342

Examples of Different Types of TA Provided

	Types of TA Provided	Number	Description
R	In-Depth Telephone and email interactions	1029	Frequent email and telephone communications were held with rural health clinics and community health centers, community health centers, Area Health Education Centers (AHECs) and the Primary Care Association (PCA) regarding the establishment and staffing of health care safety nets in rural and medically underserved communities. Examples of these communications included an overview of a 3RNet webinar series called “3RNet Academy” which provided in-depth information and strategy to improve recruitment and retention of health care professionals, and an extensive phone interaction with Phyllis McCain, a pharmacist in Hurtsboro, AL, regarding establishing a rural health clinic.
R	Webinar Technology	69	A wide array of webinars were supported, through both attendance and dissemination to rural health providers and stakeholders. These webinars included coverage on a wide array of topics, from the current opioid epidemic to stabilizing the financial and operational viability of small rural hospitals. Specific webinars were developed and hosted for rural safety net providers, including a joint webinar with 3RNet on recruitment and retention, and a webinar on emergency preparedness with The Compliance Team staff to address new federal rural health clinic regulations.

R	Thru Teleconference	27	Frequent teleconferences were held with partners and stakeholders on matters of common interest to the rural health community, and in the development of new relationships and venues. Examples of outcomes include a new partnership between the Alabama Hospital Association and a consulting firm to assist rural hospitals in addressing population health needs; a consulting relationship with the rural hospital program in another state on a new "Global Payment" model for financially vulnerable hospitals; and, dialogue with the state's medical schools on a partnership to sensitize community leaders and health care providers to their specific health care deficiencies and resources which are available to address those needs.
R	Face to Face	93	Collaborative meetings were held with the state's three regional Area Health Education Center (AHEC) Directors to share information and resources; with the Alabama Medicaid Agency and ADPH Office of Community Affairs to collaborate on information dissemination for a billing/coding procedure change for independent rural health clinics; and with the Alabama Rural Health Association (ARHA) to organize and promote an in person training event regarding Medicaid billing procedures. Other meetings included presentations to the newly appointed State Health Officer on rural health issues and concerns, with the Alabama Hospital Association on hospital stabilization activities, with ARHA board members on future rural health priorities, and with the State Committee of Public Health on policy changes for the recruitment of foreign medical graduates.
R	Other	124	The SORH worked in close concert with the department's Chronic Disease Division to address community health needs in the ten counties which have been identified as having the greatest health disparities. This initiative will involve the development of a community report card, with data highlighting each community's specific health care issues, and recommended actions the community can take to address those issues. The report will also identify resources that are available within the ADPH to assist the community

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Total number of clients within your State that received TA directly from SORH: 508

Examples of Different Types of Clients that Received TA

	Types of Clients that Received TA	Number	Description
R	Communities	33	An annual rural health conference was sponsored in collaboration with ARHA, to provide updated information and networking opportunities for the state's rural hospitals and health care professionals. The agenda included national and rural policy updates, and separate tracts devoted to the informational needs of RHCs, small rural hospitals, and community leaders. Emphasis was placed on heightening community interest and action to address the causes of health disparities at the grass roots level.
R	Government Officials	127	SORH participated in a regional collaborative with the Centers for Disease Control (CDC), Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), and other stakeholders, to address the high incidence of health disparities and chronic disease within the southeast. This has resulted in a closer working relationship with these entities to target the root causes of these health problems. The SORH is now working closely with the ADPH Chronic Disease Division to identify community level initiatives and partners to address these root causes, such as obesity and substance abuse.

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R	Academic Institutions	30	The plight or rural hospital closures was brought to the attention of state legislators and policy makers, resulting in legislation to create a new Rural Hospital Resource Center (RHRC) within the University of Alabama at Birmingham. This crisis was highlighted with the recent closure of a major regional medical center and a rural hospital, and circulation of a financial analysis report by a national consulting entity that depicted a negative operating margin among the majority of the state's small, rural hospitals. The academic freedom of the RHRC will be leveraged to develop and promote innovative practices, such as the employment of insurance-exempt FQHC providers in hospital emergency departments to minimize the financial burden of providing health care to uninsured patients.
R	Associations	42	The absence of a stateside Rural Clinic Association was addressed with the newly appointed executive director of ARHA. The ARHA will continue to represent interests which are common to both ARHA and RHCs, before such organizations as the state legislature and other policy making bodies. SORH continued to identify and provide for the RHC's training, educational, and workforce needs by leveraging resources of national associations such as Association of State and Territorial Health Officials (ASTHO), National Organization of State Offices of Rural Health (NOSORH), Alabama Public Health Association (ALPHA), and Primary Care Association (PCA).
R	Agencies	1	SORH worked in close coordination with the Alabama Medicaid Agency, State Health Officer, State Committee of Public Health, and Alabama Board of Medical Examiners to establish a more accurate database of the state's primary care and mental health workforce. This database will be useful in planning and preparing for the state's future workforce needs, and will serve as a community-level point of contact for substance abuse initiatives.

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R	Networks	13	Networking opportunities were established with the creation of a Rural Hospital Resource Center within the University of Alabama Birmingham, and renewed partnerships with the Medical Association of Alabama, Pennsylvania Office of Rural Health, and ADPH Division of Emergency Medical Services (EMS). As a result, EMS collaborated on a joint grant application to increase training of first responders in the treatment of opioid overdoses, and activities have begun to plan the extension the state's formal trauma system to include the state's rural hospitals.
R	Emergency Medical Service	1	A needs assessment identified one of the state's six EMS regions as having a minimal EMS personnel pool, and a high incidence of toxicological emergencies, including deaths from opioid abuse, over the previous five or more years. The assessment also discovered that the region, consisting of ten rural counties, were underserved by volunteer fire rescue agencies which typically provide rapid first response on emergency calls such as drug overdoses. Based on this assessment, a project was developed to provide specialized continuing education training to all EMS providers in the region, including first responders, Emergency Medical Technicians (EMTs) and paramedics.
R	Clinics	171	Continual technical assistance was provided to rural health providers in underserved areas to assist in their conversion to more sustainable payment models, such as CMS-certified RHCs and FQHC Look-a-likes. These models provide a higher reimbursement rate for treatment of the large numbers of medically indigent and uninsured patients that are prevalent throughout each of the state's rural communities. This technical assistance resulted in one clinic submitting a formal request for conversion to Look-a-like status, and three other clinics requesting conversion to RHCs.

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R	Hospitals	47	Emphasis on the desperate financial situation among the state's rural hospitals was accentuated by the recent closure of a major regional medical center and another small community hospital. In addition, two other small hospitals were narrowly saved by being taken over by a large tertiary care center. These closures and takeovers accentuated the plight of virtually all small, rural hospitals throughout the state, and prompted the legislative creation of a new Rural Hospital Resource Center, hosted by the State's largest medical schools. Collaboration is ongoing with this new center to explore the development of alternate payment models, such as the global budgeting model being tested in Pennsylvania, and to develop technical resources that serve common needs.
R	Providers	42	Collaboration with the state medical association produced a venue for outreach to all member physicians, which comprise the vast majority all physicians throughout the state. As part of this venue, the association provided a database with a list of each County Medical Society, and the name and contact information for the physician who serves as the society's president. This venue will enable timely dissemination of important information to providers, such as health alerts and grant opportunities, and will provide a means to affirm the need for additional physician placements through recruitment programs such as the J-1 Visa Waiver Program and national 3RNet.
R	Other	1	Being defined as 'rural' is important to health care providers since this is one of the major qualifiers to apply for more sustainable payment models, such as RHCs. CMS recognizes federally-defined rural areas, and also recognizes areas that are so defined by state law or regulation. Accordingly, a hospital located on the fringe of an urban area petitioned the State Health Officer to have its area decreed as being 'rural.' Exhaustive research and coordination with other state entities revealed that a state definition of 'rural' had been embodied in a bill recently approved by the state legislature. This bill essentially extended the federal census definition of 'urban cluster' to be to be one and the same as rural.

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Any Comments About this Form or the Data You Entered:

Efforts are ongoing to streamline the means by which information is collected and disseminated to rural providers and other stakeholders. This is essential in light of the exponential growth in data, programs, and rural health initiatives flowing from governmental agencies, educational institutions, and research organizations. Information is standardized and disseminated through website posts and other media to the extent feasible. This greater efficiency in dissemination has tended to diminish the number of direct encounters between staff and clients, as reflected in this report.

Is this Form Complete? Yes

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