

## Rural Innovation Profile

### *Rural Health Network Thrives on Innovation in Whole-Person Care*

**What:** A rural health network works collaboratively using a person-centered approach to simultaneously meet health care and community needs.

**Why:** To meet the health and social services needs of uninsured and underinsured citizens.

**Who:** Health Care Collaborative (HCC) of Rural Missouri, a rural health network comprised of more than 55 member organizations, wraps social service support around the patients who receive care at four HCC health care clinics that serve Lafayette County and surrounding areas.

**How:** Centralize coordination of efforts to ensure health and social services are available and benefit the public.

#### Key Points

- HCC's origin as a rural health network addressing social factors and access related to health drives a unique perspective, philosophy, and culture, as the organization grew to deliver clinical care.
- Leadership believes the community owns the programs and services.
- Diverse board leadership—from the local public health department, critical access hospital, community mental health center, dental school, and nursing school—brings different perspectives to projects.
- Acting collectively through the network, board members are not afraid to take calculated risks.
- Staff are encouraged to try things and to be okay with failure. When efforts are not successful, they either modify them and try again, or decide not to continue.





**“Just trying new things is really where a lot of energy comes from.”**

***Toniann Richard,  
Chief Executive Officer***

## **OVERVIEW**

The Health Care Collaborative (HCC) of Rural Missouri is a vertically integrated rural health network, comprised of more than 55 member organizations that serve Lafayette County and surrounding areas and operates four federally qualified health centers (FQHCs). HCC serves a large portion of the poorest residents in its rural geographic service area, which covers more than 88,000 people, with 34 percent who live below 200 percent of the federal poverty level. HCC member organizations provide their own distinct products and services, while working together to meet the needs of the community. HCC directly employs 75 people. It advocates for improvements related to medical, dental, and behavioral health; overall health and wellness; and health care workforce recruitment.

## **FROM SOCIAL SERVICES TO HEALTH CARE**

Initially started as a community-based social services network with state grant funding in 2004, HCC addressed issues including transportation, dental access, psychiatric care, and primary care. In 2006, HCC became a 501(c)3 nonprofit organization. To ensure medical care, dental care, and mental health care would be provided in its communities, in 2013, HCC took over management of two struggling rural health clinics and converted them into FQHCs. The change to FQHC status provides access to different funding streams that better fit the needs of their communities and allows the clinics to be financially sustainable. HCC later opened two additional FQHCs to deliver care in shortage areas.

HCC’s origins as a grassroots network addressing social factors in health drive a unique perspective, philosophy, and culture, as it moved into the clinical care delivery space. Over the past decade HCC’s community-based programs have grown to include case management, counseling and assessment, health education, transportation, translation services, rural health professional recruitment, and health insurance enrollment.

The HCC board—with representation from the local public health department, critical access hospital, community mental health center, dental school, and nursing school—brings different perspectives to projects while taking the position that the community owns the programs and services.

## **SUSTAINABILITY**

With about 60 percent of HCC-clinic patients on Medicaid or uninsured, financial stability and sustainability for the network are significant challenges. To ensure sustainability, HCC works to diversify its funding with a combination of grants and fee for service programs. HCC’s network funding sources are split relatively evenly between fee-for-service revenue from programs offered on a sliding-fee scale, and grants and donations. HCC’s clinics have a payer mix of 30 percent Medicaid, 26 percent Medicare, 26 percent self-pay, and 18 percent commercial insurance. In addition, the HCC FQHC clinics became part of the Caravan Medicare Accountable Care Organization in 2018 to gain access to better data which enables improved care coordination, especially as HCC-clinic patients transition in and out of the hospital. HCC



hopes that improved care coordination leads to cost savings, which can be reinvested in the network and the clinics.

**CULTURE OF INNOVATION**

HCC nurtures a culture of innovation. In the ongoing search for ways to deliver quality health care and social services, HCC looks for new, untried approaches to push innovation. Network organization members are expected to work on issues with different organizations and communities and to try new approaches, learn, and improve together. Acting collectively through the network, board members are not afraid to approve of calculated risks.

Leaders across the network are expected to bring new ideas to the HCC board. HCC intentionally hires staff who are good at listening to what the community says it needs and are willing to explore various ways to address those needs. HCC’s culture supports everyone to gather ideas from other communities and adapt them for local needs. Staff are encouraged to try new approaches and to be okay with failure. When efforts are not successful, they either modify and try again, or decide not to continue with them. HCC uses the plan-do-study-act (PDSA) model for its innovative approaches. Detailed work plans are tied to the PDSA model, which builds in benchmarks for measuring progress.

Many ideas come from HCC’s peer networks of clinicians and social service staff. A large share of HCC’s innovation has come from crisis management, with others stemming from preventive strategic planning. New ideas are initially proposed informally through conversations. The HCC board discusses an idea’s potential economic impact, affordability, and influence on unmet community needs. Ideas are assessed for alignment with quality goals, vetted for clinical appropriateness, and reviewed from a financial perspective to determine whether they need grant or HCC agency funding.

**WORKING TOGETHER TO MEET WHOLE-PERSON NEEDS**

HCC is addressing social factors and community needs in a patient-centered, community-based, collaborative approach to deliver value. It has committees addressing key areas, such as homelessness, food access, transportation, and newly released incarcerated individuals. HCC identifies common issues that impact the communities it serves. Below is a selection of HCC’s innovative approaches to address community needs.

Issue	Innovative Approach
Behavioral health needs	<ul style="list-style-type: none"> <li>• Hire a psychiatrist and lease services back to the local hospitals.</li> <li>• Increase psychiatric care access at FQHC sites.</li> <li>• Hire licensed social workers at each health center to focus on therapy and case management</li> </ul>





Issue	Innovative Approach
Care access	<ul style="list-style-type: none"> <li>• Hold a one-day public health event, <a href="#">Project Connect</a>, three times a year where underserved adults can access free public health and human services in a one-stop-shop. The range of services include insurance and WIC (Women, Infant and Children) enrollment, dental extractions, mammograms, pregnancy tests, flu and tetanus shots, blood pressure check, basic vision screening, behavioral health screening, GED information, photo identification cards, utility assistance, and haircuts.</li> <li>• Provide clinical care in the community—in migrant camps, at two school-based clinics, and via mobile dental unit visits to 18 schools.</li> <li>• Share clinical staff, such as a nurse midwife, family practice OB, and other nurses to maximize local capacity.</li> <li>• Help people enroll in the federal health insurance marketplace.</li> </ul>
Health disparities	<ul style="list-style-type: none"> <li>• Hire a community health worker at each FQHC clinic site.</li> <li>• Hire community health workers positioned in the community to focus on transportation, housing, food access, and care coordination.</li> <li>• Implement <a href="#">Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences</a> (PRAPARE) tools to collect and act on social determinates of health data.</li> </ul>
Homelessness, temporary and long-term	<ul style="list-style-type: none"> <li>• Conduct homeless count every two years.</li> <li>• Assign homeless individuals to a community care team that determines their eligibility for temporary housing, food stamps, and child care.</li> </ul>
Food access and obesity	<ul style="list-style-type: none"> <li>• Work with school districts to install salad bars to reduce obesity in middle school kids.</li> <li>• Purchase commercial-grade freezers and refrigerators for local food pantries.</li> <li>• Help farmers markets develop business plans, by-laws, and safe food handling policies and procedures.</li> <li>• Promote community walking programs.</li> </ul>
Recidivism	<ul style="list-style-type: none"> <li>• Work with people on medications newly released from prison.</li> <li>• Assign formerly incarcerated individuals to a registered nurse who serves as their community health worker. The nurse makes sure the patient has a plan to manage their health and medications. They are followed for 30 to 45 days, depending on diagnosis.</li> </ul>
Service navigation	<ul style="list-style-type: none"> <li>• Through person-to-person referrals, connect individuals to appropriate resources to support social determinant needs.</li> <li>• Identify patients who frequently use the emergency department for primary care and help them to find a primary care doctor, dentist, or behavioral health professional.</li> <li>• Coach Medicaid patients on how to appropriately use the hospital ED.</li> <li>• Provide Medicaid patients with a list of facilities that accept Medicaid.</li> </ul>



Issue	Innovative Approach
Substance misuse	<ul style="list-style-type: none"><li>• Implement a suboxone program.</li><li>• Employ a psychiatrist and doctor of osteopathic medicine to facilitate detox programs in tandem with therapy by licensed social workers.</li></ul>
Transportation	<ul style="list-style-type: none"><li>• Establish <a href="#">HealthTran</a>, a medical transportation service model, to provide free rides to patients in Lafayette County.</li></ul>

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For more information about the Rural Health Value project, contact:  
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