KANSAS
Rural Health Systems Improvement
PILOT PROJECT

AN INVITATION
for Requests for Participation as a Pilot Community

United Methodist Health Ministry Fund
June 2013

UNITED METHODIST HealthMINISTRYFund

Pilot Project funded in conjunction with
Sunflower Foundation: Health Care for Kansans
Kansas Health Foundation
Blue Cross and Blue Shield of Kansas Foundation
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Kansas Hospital Association

Additional information available at:
www.ruralhealthopportunity.org

KANSAS **RURAL HEALTH SYSTEMS IMPROVEMENT** PILOT PROJECT

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FORWARD

This solicitation is not a typical Request for Proposals but rather an invitation to interested communities to request participation in a pilot program through which they will develop proposals to improve rural health systems of care. Those proposals will be reviewed and funded for the second phase of the pilot, contingent upon the extent to which they intend to improve population health, access, quality, and cost in their respective communities.

Information contained herein is descriptive of concepts and approaches which will be utilized during the pilot to inform potential applicants about the nature of this request and the pilot program itself. Information sought from applicants at this time focuses on frontier communities' interest in pursuing change in the financial base and structure of local health care services and their experience in developing viable collaborative approaches to improving rural health service systems.

I. Intent of Project

Multiple factors are dramatically reshaping the rural health landscape in Kansas and the nation. However, little is known about how small rural communities can realistically improve the financial base of local health care systems and, as importantly, effectively improve those systems to better address population health and maintain essential health care services. Rather, than adopt a "hold-fast, wait-and-see" posture in the face of these multiple challenges, this Project offers opportunities to energetic, forward-thinking rural communities to design, test, and evaluate the risks and rewards of locally conceived or adjusted approaches to rural health systems improvement.

The Project has two major objectives:

1) **assist up to four rural communities in developing improved local health systems** and
2) **capturing knowledge and experience from each of the local projects for possible replication and for establishment of better informed national and state policies concerning rural health systems.**

The Project emphasizes system improvements through health service provider and payment restructuring or re-alignment rather than expanded or new service development. It is predicated upon the belief that health-related data provided directly by the communities themselves and associated analyses will enable communities to successfully grapple with and resolve "pushes and pulls" inherent in restructured roles of health care service providers.

The Project work will be done in two Phases. Phase One will last approximately one year and will be a very detailed information gathering process about the local community, an analysis of that information, and development of a proposal for transitional or transformational change (these terms are defined later) to be implemented in Phase Two. The proposals developed in Phase One will be considered for additional grant support and technical assistance in a two-year Phase Two. For communities moving into Phase Two, the primary task will be to implement the proposed system changes and evaluate those changes.

The work of a local project must occur within a specific geographic focus. A community will be defined as a hospital district, a county, an incorporated city, or multiples or combinations of hospital districts, counties, or cities. Multiple jurisdictional communities are highly desired and, in that event, an expanded Community Health Futures Taskforce would be expected beyond the normal limit of fifteen members. The geographically defined community generally ***must contain a Critical Access Hospital.***[1] The population of the defined community ***must be classified as a frontier area*** (defined in this RFP as ten people or fewer per square mile), except that, in multiple jurisdictional communities, at least half of the territory must be classified as frontier.

II. Phase One

The uniform planning process in each of the four communities during a one-year period will:

- Develop a detailed description of local health services and how they fit within regional structures;
- Compare local system performance with frontier community benchmarks from other Kansas rural communities which will help pinpoint significant variations and needed improvements;
- Depict financial and service utilization data for providers in the local rural health system;
- Determine what are essential health services for that community;
- Identify needed system improvements in the areas of:
  - Population Health
  - Access to Care
  - Quality
  - Cost
- Develop a plan for transitional or transformational change to meet the identified needs for a long-term, viable health system providing essential health services.

The planning phase terminates with the development of a transitional or transformational plan that flows from a definition of essential health care services, the identification of health system improvement objectives (information on these objectives can be found at www.ruralhealthopportunity.org), and desired approaches to change.

Regarding essential health care services, Community Health Futures Taskforces will be asked to rate services based upon several characteristics of essential care. A potential listing of health care services which will be considered is contained in Section VIII.

Potential health system improvement objectives which should be considered by all Taskforces are listed below to convey the fundamental intent of the pilot -- *systems change versus service development related needs assessments.*

POTENTIAL PILOT PROGRAM OBJECTIVES

Frontier Community Impacts

1. Higher levels of primary care services utilization by individual payer and all payer categories
2. Higher levels of care management and patient care navigators
3. Lower levels of need for direct financial operational support
4. Reduced or shared costs for essential health care services
5. Reduced transportation costs for both patient and family

National Health Care Impacts

1. Reduced rates and costs of avoidable inpatient care
2. Reduced rates and costs for hospital readmission within 30 days of discharge
3. Reduced ER use and costs for primary care treatable conditions
4. Improved rates for chronic disease management approaches
5. Reduced rates and costs of tertiary care readmissions
6. Reduced rates of duplicated laboratory tests and procedures

Two approaches to change have been highlighted by the Kansas Statewide Rural Health Group which has been advising this work since 2011. Those approaches include an ***Essential Services Project*** and a ***Frontier Community Care Collaborative*** (FCCC).

Other approaches will be examined during the planning phase and may include enhanced integration of primary care and preventive health services or shared clinical, administrative or financial services or mechanisms. Additional information on the Essential Services Project and Frontier Community Care Collaborative is contained in Section III, Phase Two.

The local work will be conducted with the efforts of :

A) a Community Health Futures Taskforce,
B) a Lead Organization and a Project Coordinator,
C) HMS Associates,
D) Kansas Leadership Center support, and
E) Financial Consultants.

A. Community Health Futures Taskforce

Each community will organize a group of individuals committed to actively participate in the Phase One work. The Taskforce ordinarily will be composed of not more than fifteen persons[2] and must contain representation of the local hospitals, medical providers, public health department and emergency medical services *(required group members)*. In addition, the Taskforce should have representatives of 1) other health care providers serving the community such as FQHCs, pharmacies, dental offices, optometry offices, mental health providers, long term care and other senior service organizations, home health agencies, etc. and 2) key community leaders, including public officials, likely to be necessary for connections and leadership to implement significant change (all referred to as optional group members). Out of area health service partners may be members, as the community desires. The required group members are mandatory data providers (see Data section) and, to the extent that other service providers are willing to provide data, the project will be perceived as having a stronger likelihood of success.

The Taskforce will attend a general Project kick-off currently scheduled for October 24-25 and held in Wichita. After that orientation and team organization event, the Taskforce will meet for six formal day-long sessions in the community and one or more half-day conference calls. The schedule for these meetings will be developed not later than the announcement of grant awards. The likely schedule and general substance of the meetings are outlined below:

1. ***Community Health Futures Taskforce established*** (pre-submission to the extent possible)
2. ***General Session "Kick-off"*** – October 24-25
3. ***Meeting #1*** - Orientation - late October, November
4. ***Meeting #2*** - Local services description and discussion of triple aim measures and community economic values – December
5. ***Meeting #3*** - Local services description, out of area use and discussion of essential health care services – February
6. ***Meeting #4*** - Local services description, out of area use, ranking of services and measures, and presentation of change strategies such as Essential Health Services Project and Frontier Community Care Collaborative – April
7. ***Meeting #5*** - Implementation strategy and plan – June
8. ***Conference Call*** - Initial draft of plan – July
9. ***Meeting #6*** - Final implementation plan - August

B. Lead Organization and Project Coordinator

Each community must designate an organization -- either a 50l(c)(3) organization or a governmental entity -- to serve as the Lead Organization. This Lead Organization will serve as the local fiscal agent and will most likely be the local hospital. The duties of the local fiscal agent will be to receive grant funding, apply the funding to approved budgetary items, issue any needed tax reporting, and provide financial reports to the Project Fiscal Agent. The Lead Organization will employ or contract for a Project Coordinator.

The Project Coordinator is the core community resource supported during Phase One of this Project. $40,000[3] is available to each approved community for use in securing a Project Coordinator to work an estimated 20 hours a week.

The responsibilities of a Project Coordinator are:

- Being the point of contact for project
- Maintaining community planning materials files
- Developing Taskforce membership contact list
- Scheduling Taskforce meetings and associated logistics – i.e., times, dates, locations, meeting room set-up and recording of minutes or summaries
- Gathering materials from partners as needed – i.e., local provider service descriptions including services offered, patients served by service, costs by cost category and by service category, revenue or other financial support by service category, patient mix by service category
- Developing knowledge of local capacities as contained in materials developed through the planning phase
- Participating in occasional pilot conference calls for all awardees, regular discussions with HMS and discussions as needed with team coach from Kansas Leadership Center
- Providing copies of project documents, including regular meeting minutes to Project leadership; each set of minutes will include a summarization by the Project Coordinator of progress to date (achievements, barriers identified, barriers overcome, immediate project plans, etc.)

Project Coordinators are viewed to be new vital community health resources who develop leadership and team building strengths and extensive knowledge about the local service system which can be used to guide implementation plans in Phase Two as well as interactions with other parties about the future of health care services in their communities.

C. HMS Associates -- Greg Bonk, principal

Communities will be materially assisted in the Phase One work by a technical assistance firm with experience in rural health care systems, HMS Associates, Getzvillle NY. HMS will work with the Project Coordinator in securing data from local providers. HMS will facilitate each local meeting with assistance in physical arrangements from the Project Coordinator. With some specific analytical products from the Financial Consultants, HMS will perform most of the data analysis and summarization of data for the Taskforce. HMS will explore rural system models from around the country and maintain information on policy developments to assist the Taskforce in making its decisions on potential health system changes. Additional information on HMS Associates and Greg Bonk, the principal, is available at www.ruralhealthopportunity.org.

D. Kansas Leadership Center

The Kansas Leadership Center will assist in the Kick-off event by providing team building and leadership development services for each community team. Each Project Coordinator will be assigned a coach from the Kansas Leadership Center to provide strategic advice on Taskforce functioning and any process or community issues which might develop during the process. It is anticipated that the KLC coach, Project Coordinator and HMS Associates will cooperate to improve the prospects of success in development of a meaningful community proposal for Phase Two work.

E. Financial Consultants

Certain issues which may develop during Phase One work may require particular financial or service utilization projections. There is a limited budget for each community to use -- with the approval of HMS Associates -- to secure these projections. In Phase Two, there is additional funding for communities to use in the same manner.

III. Phase Two

Work in Phase Two requires acceptance by the Project Administrative Board of the proposal developed by a community in Phase One. Funding is available to support four communities in implementation of accepted proposals in an average amount of $110,000 per community. The scope of Phase Two work will likely require significant local resources beyond grant support. Communities will continue to receive technical assistance from HMS Associates and financial consultation during the Phase Two work. Project monitoring and evaluation will be part of the services provided to the Project by HMS during this phase. The local leadership -- project manager, maintenance of Community Health Futures Taskforce, or otherwise -- will be proposed by the community in the proposal for Phase Two work.

A. Anticipated Phase Two Work -- General Description

The changes to be implemented in Phase Two can be either transitional or transformational.

Transitional approaches are those that employ incremental steps leading to improvement in the operation, financing and outcomes of local health systems. Compared to current systems, they will have more integration of structure, more coordination of services, selection of available services based on an understanding of essential services for that community, and a clearer eye toward long-term financial results based on the bundle of services. Transitional systems will have different -- some new, some eliminated, some re-packaged services -- compared to the services in that community today.

Transformational approaches are more thorough-going and shift the focus from type of provider, i.e., hospital, Rural Health

Clinic, to patient-centered service systems emanating from comprehensive primary care and preventive health care capacities financed through shared savings, improved efficiencies or outcome based funding mechanisms, and coordinated or administrated through a collaborative structure or multi-organizational rural health network structure.

The following two approaches (B. and C.) for change are provided only as examples and are not meant to limit the creativity of local communities in developing transitional or transformational approaches appropriate for their local communities.

B. Example One -- Transitional Approach: Essential Health Services Project

All communities in Phase One will determine essential health services for that community. In a Phase Two Essential Health Services Project, a community would implement the changes necessary to deliver as many as possible of those essential health services on a financially viable basis.

This implementation will require the community to squarely address what levels of funding are needed to sustain such programs regardless of volume, payer or payer mix. In communities with Critical Access Hospitals, it will be important to develop a new revenue capacity for maintaining essential services "negatively impacted" by the Medicare cost-based reimbursement mechanism where administrative and general cost recovery is lost for services not covered by Medicare or covered services used by non-Medicare patients *(the so-called CAH disincentive).* In a CAH community, the work of a Phase Two project (including preparations in Phase One) could include:

• Implement or modify information systems and collect and analyze data needed in Phase Two

• Provide the scope of essential health care services identified in Phase One

• Closely examine cost reports relative to essential health care service provision

• Identify where the actual negative effects occur both in terms of expenses, services, payer mix, profit or loss, etc.

• Refine and apply metrics identified in Phase One which assess the impact of an essential health services operation on population health, access, quality and cost to the community

• Propose new structures or sources of revenue for essential health care services maintenance

C. Example Two -- Transformational Approach: Frontier Community Care Collaborative (FCCC)

The FCCC is the gateway to significant rural health system restructuring. The FCCC requires that health care providers do business differently in a very cooperative manner. The extent of such cooperation will be a function of the benefits expected to accrue to both providers and the community and the extent to which such benefits are of significant or compelling value to motivate such change.

The actual design and function of the FCCC will be explored and determined by each pilot community interested in such a transformational approach. In effect, final FCCC designs will reflect a given community's interest in coordinating and integrating care between different providers in a way that ensures the best use of existing health resources and trends in health care services financing. It may also provide the translation of Accountable Care Organization concepts to small populations which may eventually be covered by regional capacities. Concepts guiding FCCC development are similar to a set of ground rules adopted by the National Rural Health Association in January 2013 for developing transformational programs. FCCCs should be:

• Based upon community needs identified through the assessment process [in our case Phase One]… to define the communities' most critically needed programs by the entire (not just underserved) community and a financial plan reflective of the respective model through which such services can be strengthened and maintained;

• Reimbursed through expanded or adjusted payments to providers, through an approved organization of their own planning and design;

• Built upon evidence-based practices and designed to test the relevance of urban evidence-based practices in a rural setting;

• Measured through proven, relevant benchmarks of quality and financial/ operational efficiency, comparable to those already required of FQHCs, established by the Office of Rural Health Policy and others; and

• Incentivized through shared downstream savings, projected utilizing CMS Innovation Center financial models, and gauged by per-beneficiary cost.

Implicit in each project is local prioritization of community resources for the health of its citizens. This prioritization work should inform decision-makers throughout the community.

D. Continuum of Phase Two Project Designs

The above two examples can be placed on a continuum of potential proposed work in Phase Two. *(See graphic at top of next page.)* The two identified points on the left of the continuum would be proposals which would not be funded in Phase Two because they are not within our understanding of transitional or transformational change. From the mid-point (Essential Services Projects) to the far right of the line ending with the FCCC project are a variety of approaches which a community may determine to implement which would qualify for Phase Two Work.

IV. Data

The theory of change for this Project is based in part on the assumption that community based planning is most effective when community leaders are engaged through a uniform plan development process informed by significant technical data and analysis specifically about their community. In Phase One, data will be accessed through a variety of sources and benchmarks developed for similar communities in Kansas, where possible, to develop comparative information about the impact of the local communities' health systems.

Access to several different data sets and information systems are critical to the success of the Project. Some information, such as payer organizations' and statewide hospital discharge abstracts, will address use of services by community residents regardless of location or provider of care. Other information provided by Taskforce members will describe what is provided locally. This section is meant to convey to potential applicants expectations about accessing a significant and probably unprecedented amount of local data essential to the success of the pilot and impress upon potential applicants the importance of their efforts in this regard.

It is the intent of this project to access this information through Taskforce members' existing databases and reporting mechanisms. Principal sources of such information include: Patient Registries, Clinical Records, Billing Systems, Cost Reports and Internal Management Reports. HMS will work with the sites to identify where this information is and how to best access it.

Communities not interested in granting access to such data should not apply for consideration as a pilot community.

DATA TYPES	REQUIRED PARTICIPANTS - POTENTIAL SOURCES				
	Patient Registry	Clinical Record	Billing System	Cost Report	Internal Reports
DEMOGRAPHIC					
Age	X				X
Sex	X				X
Race	X				X
Residence - preferably street address	X				X
CLINICAL					
Encrypted Patent Identifier	X	X	X		
Date of Service		X	X	X	
Diagnostic Groupers (DRG, etc.)		X	X		
ICD9 Diagnoses		X	X		
Major Service Type (inpt, ER, OPD, LTC, etc.)		X	X	X	X
Specific Service Type (see service listing)		X	X	X	X
Procedure Codes		X	X		
Personal Health Status (Phase 2 as needed)		X			
Diagnostic Results (Phase 2 as needed)		X			
FINANCIAL					
Payer			X	X	
Charges			X		
Reimbursement			X		X
Major Service Type (inpt, ER, OPD, LTC, etc.)			X		X
Specific Service Type (see service listing)			X		X
Other Revenue					X
Source					X
Purpose					X
Costs				X	X
Major Service Type (inpt, ER, OPD, LTC, etc.)				X	
Specific Service Type (see service listing)				X	

Essentially three types of data need to be accessed: demographic, clinical and financial.

• **Demographic data** is used to describe the population being served and includes information such as age, sex, race, and place of residence with street addresses for sub-county geo-coding.

• **Clinical data** describes medical problems through diagnostic related groups or other groupings, ICD9 diagnoses; aggregate, specific and procedure level service classifications; and health status measures such as personal health measures and various diagnostic test results.

• **Financial data** is two-fold and pertains to either billing data on charges, reimbursement levels by payer types, other revenue, or expenses or costs of care relative to cost categories and individual service type.

• *Encrypted patient identifier codes* are also needed for cross walks between various data elements.

This data is needed to examine and eventually measure four key impacts of health system performance. For Phase One, data will be analyzed primarily at the community level to provide a detailed picture of how the local system operates. Phase Two proposal analyses are expected to be far more detailed and examine impacts on specific patient target groups.

As stated above, access to data from local providers—required group members of the Taskforce and other cooperating providers —will be sought to provide a detailed picture of the local system. These required group members and other local cooperating data sources are asked to indicate in the letters described below (in Application Process) that they intend to provide access to data to HMS Associates, will cooperate with the Local Project Coordinator and HMS Associates in development of responses to access to data requests, recognize that some of the requested data may be proprietary or confidential, and understand that the success of the Project depends on the availability to key local data.

It is noted that the agreement to provide access to data, once pilot communities are selected, will be between each specific organization and HMS Associates and that any reference either verbal, written or electronic to information so disclosed will not be done without the explicit written consent of the organization providing the data. Of course, access to any potentially confidential data will comply with all statutory and regulatory requirements.

While recognizing that the specific details of access to data of local providers will need to be worked out on an individual basis, the statement of intent is expected to give a clear indication of a willingness to provide access to considerable data. Local providers are encouraged to exclude any specific data from the list below which they would not be willing to provide access to, although this is not a final, binding decision.

The inability to access local provider data as needed by the Project would be grounds for Project termination or curtailment.

Non-local provider sources are also extensive and will include, to the extent possible, demographic (census-like) data, vital statistics, FQHCs (where relevant), hospital inpatient and emergency department discharge abstract databases, behavioral risk factors, Medicare, Medicaid, commercial insurers, etc.

V. Statement of Interest/Readiness and Community Selection Criteria

Each community will submit a written statement of that community's interest and readiness to participate as a pilot community. The statement will contain the following materials, and the weight given to the various sections of the statement are indicated by the points shown for each section.

Applications will be submitted using an on-line tool (see VI.C below) and should not exceed twenty pages, single-spaced using a font size not smaller than 11 pt. This limit does not include letters of support and other materials. In determining the allocation of space within the page limit, local communities should consider the relative point values shown below.

A. Identifying information (15 points)

1. Community applicant name *[geographic descriptor such as Williams County]*
2. Lead Organization
    a. Name and contact information *(must be a governmental entity or a 50l(c)(3) organization)*
    b. Key personnel at the organization to be involved in the project *(paragraph resumes)*
3. Community Delineation *(see Definition section for more information)*
4. Proposed membership of the Community Health Futures Taskforce
    a. Required members *(hospitals, medical providers/ organizations, county health departments, and emergency medical services)*
    b. Other optional members *(see desired traits of these persons, Section II. A)*

This membership information should identify the names of persons who have agreed to serve; their places of employment, if any; other key associations in the community; and any specific leadership training they have received such as local chamber programs, Kansas Leadership Center programs, KARL, etc. If all members are not recruited, provide an indication of the associations and traits to be sought in the final members.

B. Description of Community (20 points)

1. Location
2. Demographics *(population, racial/ethnicity, insured/uninsured, age, etc.)*
3. List of incorporated cities and their populations

4. Local and regional health care services, include those adjacent to the community *(within 60 minutes travel time)*. This item should be an expanded narrative with clearly identified organizations and individual providers.

5. Current challenges faced by the community and how it is hoped restructuring will address those challenges in terms of:
    a. Population health status
    b. Access to care
    c. Cost
    d. Quality

C. Restructuring or re-alignment potential (readiness) (25 points)

1. Evidence of past or current major innovative, cooperative or collaborative actions in this community. *(These would include actions in health, economic development and other civic arenas.)*
    a. Current -- What is it? Who is involved? What challenges have been faced and how have they been dealt with? What are the expected benefits to the community for this effort?
    b. Past (for each example)-- What was it and when? Who was involved? What challenges were faced and how were they dealt with? Was it successful? Why or why not?

2. Why do you believe the community is ready to restructure its health care system? What are the factors affecting the community which could assist in overcoming the status quo?

3. Reference up to five meetings within the last year during which Taskforce members have discussed issues of common concern, the members present, the issue itself, and the outcome of the discussion.

D. Willingness to share critical information (20 points)

As discussed in the Data section, this project requires availability of considerable data from local providers and other sources. Describe your understanding of the project's data needs and how your community intends to provide that data. The required members of the Taskforce must provide written evidence of their willingness to provide data to the Project. Additional providers -- whether members of the Taskforce or not -- who agree to provide data to the Project should also provide written evidence of that fact. The breadth of the available locally provided data will be an important consideration in determining which communities can successfully engage in this pilot project. It is understood that all data will be subject to legal constraints related to confidentiality.

E. Letters of Support (5 points)

1. A letter of commitment should be obtained from each member of the Taskforce agreeing to serve in this capacity and acknowledging the considerable time and effort full participation at eight or more meetings will require. The letters related to Part D (Willingness to share critical information) can contain these participation assurances; there is no need to submit two different letters from the same person.

2. Key community organizations, whether represented through Taskforce membership or not, may submit letters of general support, including (in appropriate cases) their recognition that they are represented on the Taskforce through the participation of named persons.

F. Local Project Coordinator (10 points)

Our preference is that the prospective Local Project Coordinator be identified in this Statement of Interest. When that is possible, please provide detailed biographical information about that person. Also describe that person's 1) knowledge of local and regional health services, statewide and national trends; 2) prior work experience with Taskforce members; and 3) any leadership training (KARL, Kansas Leadership Center, Leadership Kansas, local chamber programs, etc).

When it is not possible to identify the prospective Local Project Coordinator, please provide a job description for the position and the estimated employment (or contracting) timeline.

In addition to the knowledge and experience listed above, communities are encouraged to identify a person for this position who has demonstrated self-starting characteristics, an ability to engage with diverse persons and listen to differing views, and consistency in meeting deadlines. Any evidence of these characteristics is also appropriate to include in the description of an identified person or, in the case of a job description, these characteristics should be included in desired attributes.

G. Budget/Local Matching Funding (5 points)

The funding provided to a local community in Phase One will be $37,500 in external grant funding. In addition, the local community is required to provide at least $2,500 to complete a $40,000 Phase One budget. Other Project support for the community – HMS and Financial Consultants -- will be provided at no cost to the local community. Costs of attendance at the Kick-off event, such as transportation, hotel accommodations and meals, for the Local Project Coordinator and Community Health Futures Taskforce members will be reimbursed to the local community.

In the Statement, a community should include a budget showing revenues of $37,500 from the Project and at least $2,500 from the local community (with the specific source identified and evidence of firm commitment). The local budget could cover the compensation of the Local Project Coordinator and any local expenses which the community does not think can be handled as in-kind contributions to the Project. These expenses might include meeting room, snacks,

meals, A/V, copies of materials, telephone expenses for the Coordinator and similar items related to the Taskforce meetings. A community may chose to provide these items in-kind and utilize the entire $40,000 for Local Project Coordinator compensation. The budget should contain line items detailing the expenditure plan.

H. Other Materials

A copy of the latest audit of the Lead Organization must be provided with the application.

A community may include newspaper clippings, short studies, etc. which illustrate other community change projects which have been described in C. 1. above.

VI. Application Process

A. Required Attendance for Explanation

Any interested community is required to attend one of the following webinars:

Webinar on July 9	10:00 - 11:30
Webinar on July 10	1:30 - 3:00
Webinar on July 11	3:30 - 5:00

Registration for these webinars can be handled on line at www. ruralhealthopportunity.org.

Communities must have an authorized representative of the Lead Organization in attendance and are encouraged to include other persons who will be involved in the project.

B. Letter of Interest

Interested communities are requested to submit a letter or email expressing interest in submitting a Statement of Interest. This expression of interest is not required, but is requested to be communicated by July 23rd to:

kmoore@healthfund.org
or
Kim Moore, President
United Methodist Health Ministry Fund
PO Box 1384
Hutchinson KS 67504-1384.

C. Actual submission

Interested communities must submit the Statement of Interest described above by midnight August 21, 2013 [*submission date]*. **Statements will be completed online using forms available at www.ruralhealthopportunity.org.** Attachments beyond the formal Statement of Interest such as *Other Materials* may be transmitted by mail or preferably electronically to United Methodist Health Ministry Fund, PO Box 1384, Hutchinson KS 67504-1384 or jgamber@ healthfund.org. These attachments will be treated as timely filed if postmarked by August 22nd or emailed by midnight August 21st. Any such attachments should be noted in the Statement filing so that they can be expected.

D. Submission supports

Answers to Frequently Asked Questions derived from the webinars and informal contacts of interested parties will be posted online from time to time by the Health Ministry Fund. Once a community requests a submission password in the on-line system, the designated representative of that community, as well as any other listed parties, will automatically be included in notices of updates in the FAQs.

D. Reservations

The Health Ministry Fund reserves the right to grant a specific community an extension of time to make its submission. This specific extension possibility will be utilized only under exigent circumstances or when an insufficient number of credible submissions has occurred or appears likely. The right to grant a general extension of the deadline is also reserved; in that event, all communities with a submission password will be notified as soon as reasonably possible.

Although funding has been committed to permit the anticipated project work for Phase One and Phase Two in four communities, the Health Ministry Fund reserves the right to make a lesser number of awards.

VII. Grant Reporting Requirements

HMS will provide updates to the Project leadership (and thereby to funders) on Project progress. Using on-line forms provided by the Project Administrative Board, Project Coordinators (or another designated local representative in Phase Two) will provide quarterly progress reports and financial reports to that Board.

A report on Phase One and a report covering the total Project will be prepared by HMS for dissemination to interested parties throughout the state and nation by HMS. It will include a compendium of data sets and analyses.

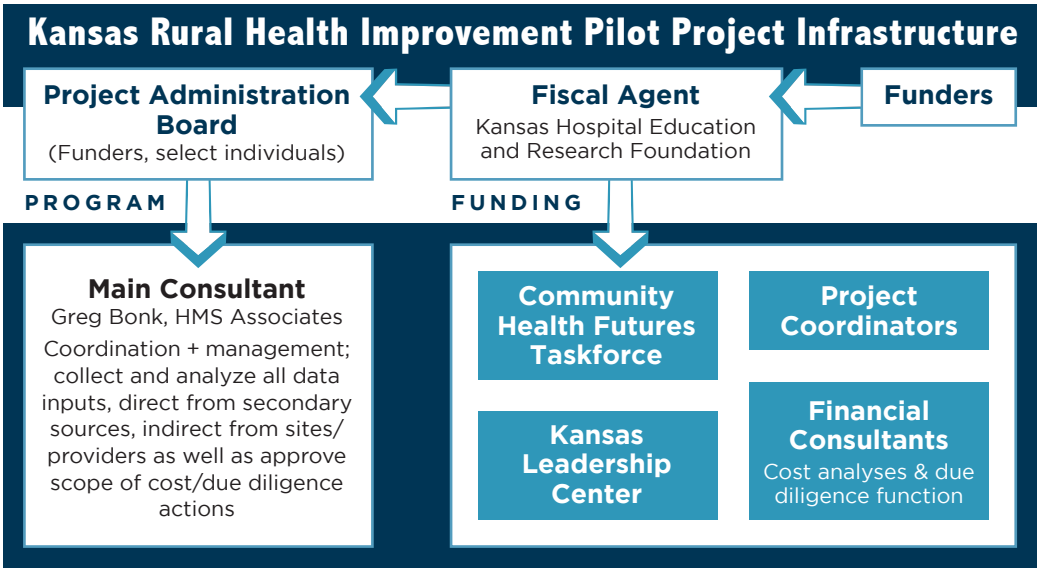
Communities are expected to cooperate with Project leadership in discussing their work with other participating communities and showcasing their work at meetings and conferences on an occasional basis (including post-grant period). Any additional expenses such as travel involved in these efforts will be at no cost to the local communities.

VIII. Definitions

A. ***Essential health services:***[4] These are the health care services (including supportive social services) determined by the community to be necessary for the health of the local population, the financial viability of the local health system and the livability of the community. A list of health care services from which essential services need to be selected include:

- *Primary Medical Care*
- *Primary Dental Care*
- *Laboratory Services*
- *Ancillary Therapist Services*
- *Emergency Medical Services*
- *Patient Advice & Screening Services*

- *Radiology Services*
- *Behavioral Health Services*
- *Pharmacy Services*
- *Extended Hospitalization*
- *Hospitalization*
- *Specialty Dental Services*
- *Long Term Care Services*
- *Extended Pharmacy Services*
- *Specialty Medical Services*
- *Complex Radiology Services*
- *Patient Care Management Services*
- *Complex Laboratory Services*
- *Care Transition Management Services*
- *Specialty Behavioral Health Services*
- *Emergency Department Services*
- *Community Health Promotion & Disease Prevention Services*



B. ***Community:*** The work of a local project must occur within a specific geographic focus. A community will be defined as a hospital district, a county, an incorporated city, or multiples or combinations of hospital districts, counties, or cities. Multiple jurisdictional communities are highly desired and, in that event, an expanded Community Health Futures Taskforce would be expected beyond the normal limit of fifteen members.

The geographically defined community generally must contain a Critical Access Hospital.[1] The population of the defined community must be classified as a frontier area *(ten people or fewer per square mile)*, or, in multiple jurisdictional communities, at least half of the territory must be classified as frontier.

C. **Coordinator:** Time demands on the coordinator will vary by community but the half-time coordinator's time may be utilized generally in the following way:

TASK	DAYS/MONTH
KLC Monthly Calls	0.5
HMS Biweekly Calls	1.0
Meeting Logistics	0.5
Community Tasks	
Local service system description	1.0
Knowledge of planning metrics	2.0
Knowledge of "models"	1.5
Leadership/coaching role	2.5
Total	**9.0**
Days per year (.50 FTE or 110 days)	108

IX. Description of Project Organization and Funders/Project Structure Diagram

This Project is funded by a combination of Kansas entities providing approximately $1,500,000 for the Project work:

Blue Cross and Blue Shield of Kansas Foundation

Kansas Health Foundation

Kansas Hospital Education and Research Foundation

Kansas Hospital Association

Sunflower Foundation:
Health Care for Kansans

United Methodist
Health Ministry Fund

Administration of the Project will be housed in the United Methodist Health Ministry Fund.

A Project Administrative Board will handle major project decisions such as determinations of selected communities, approval of Phase Two work, and major changes in the project. This Board will be composed of representatives from interested funders and some selected persons without conflicts of interest.

The fiscal affairs for the Project will be handled by Kansas Hospital Education and Research Foundation as the Project Fiscal Agent. That Project Fiscal Agent will issue grant agreements to communities, issue payments for local community grant awards and expenses *(kick-off event travel, etc.)*.

X. Additional Information

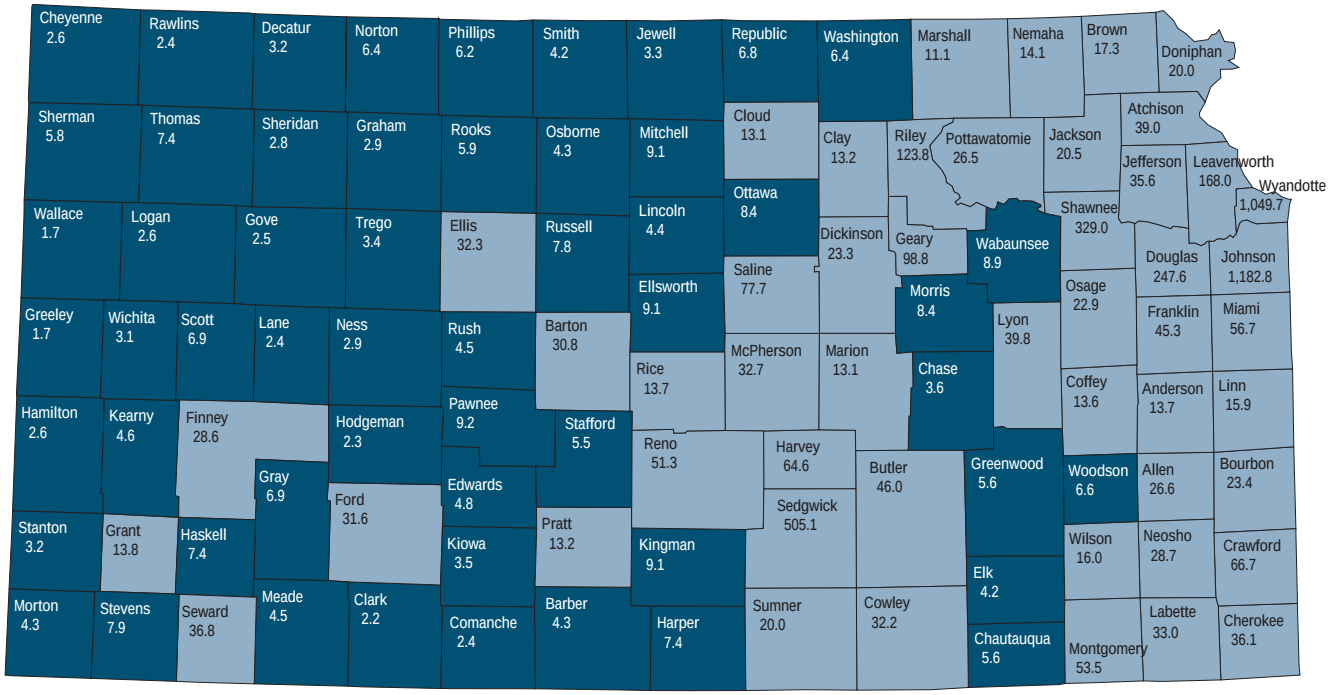
Questions about this Invitation may be addressed to Kim Moore, President, United Methodist Health Ministry Fund by email kmoore@healthfund.org or by phone 620.662.8586.

Additional information which may be helpful to interested communities can be found at www.ruralhealthopportunity.org:

- Background paper on Kansas rural health systems project (including list of Kansas Rural Health Advisory Group)
- Rural Health Care in Kansas, a summary of knowledge developed by the Kansas Rural Health Advisory Group
- Rural Health Care Services Listing for Selecting Essential Health Care Services
- Credentials of HMS Associates and Gregory Bonk
- Preliminary Ideas for Selection of Phase Two Projects

Population Density Classifications

IN KANSAS | BY COUNTY | 2012



Adapted from material produced by the Institute for Policy & Social Research, The University of Kansas; data from U.S. Census Bureau, Population Estimates, Vintage 2012.

Note: This Pilot Project uses a special definition for Frontier of 10 persons or fewer per square mile.

Qualifying Counties

Non-qualifying Counties

KANSAS
Rural Health Systems Improvement
PILOT PROJECT FUNDERS

United Methodist Health Ministry Fund

Sunflower Foundation
HEALTH CARE FOR KANSANS

Kansas Health Foundation

BlueCross BlueShield of Kansas Foundation
An Independent Licensee of the Blue Cross and Blue Shield Association.

Kansas Hospital KHERF Education & Research Foundation

Kansas Hospital KHA Association

RFP FOOTNOTES

1. The specific reimbursement problems of Critical Access Hospitals, commonly called the CAH disincentive, were motivating factors in the development of this Project. The Project wants to address the organizational and clinical issues facing low population and low volume frontier communities. A community otherwise meeting the definition for eligibility will not be eliminated from consideration solely because it does not contain a Critical Access Hospital but would be expected to clearly identify its payment and structural problems.

2. If the community is a multi-jurisdictional community (see Definition section), the team may need to be slightly larger than 15 to contain the required group members from all jurisdictions as well as some optional members.

3. $2500 in cash must be provided by a local resource developed by the community; the balance of $37,500 is provided by Project funders.

4. The term “essential health services” has been used in recent discussions of health care financing by MedPac and is consistent with work of the National Rural Health Association in forging new models of local health care. One interest of the Project is to apply this concept in communities where local people make the determination of what are their essential health services, with good data and the necessity of hard choices. There is no assurance that what is learned from the Project will lead to changes in reimbursement by payors, the Project intends to advocate for changes in reimbursement aimed at assuring viable rural health care systems which can support essential health services in the long-term.