A Guide for Rural Health Care Collaboration and Coordination

August 2019

U.S. Department of Health and Human Services | Health Resources and Services Administration

HRSA
Health Resources & Services Administration

The publication was produced for the U.S. Department of Health and Human Services, Health Resources and Services Administration, under Task Order No. HHSH25034002T.

This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Neither HHS nor HRSA endorses the products or services of the listed resources.

Suggested Citation: U.S. Department of Health and Human Services, Health Resources and Services Administration, *A Guide for Rural Health Care Collaboration*. Rockville, Maryland: U.S. Department of Health and Human Services, 2019.

Table of Contents

List of Exhibits, Tables, and Figures

Appendix III. Case Studies

Case Study 1 | Missouri

Case Study 2 | North Dakota

Foreword

The Health Resources and Services Administration (HRSA), the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable, is proud to present this *Guide to Rural Health Care Collaboration and Coordination*.

Rural areas face a myriad of challenges to building healthy communities, from provider shortages and low health care reimbursement rates to small patient volumes and older, sicker, and poorer populations. Safety net providers, such as health centers, rural health clinics, Critical Access Hospitals, public health departments, and others, can play a key role helping to meet the needs of so many rural communities. However, with limited economies of scale and heavy dependence on public payers, providers may feel they have to compete with each other, resulting in potential unnecessary duplication of services and additional strains on already-fragile finances. Collaboration among rural providers can actually enhance service delivery and improve coordination by building economies of scale and leveraging the strengths of each individual organization.

The Guide to Rural Health Care Collaboration and Coordination discusses how rural providers can work together to identify the health needs in their communities, create partnerships to address those needs, and develop a "community-minded" approach to health care. It illustrates through case studies how providers in two communities created networks and partnerships to improve the efficiency of care, optimize resources, and improve the lives of their residents. Finally, it includes links throughout and resources in the Appendix for readers to access up-to-date information on relevant policies and regulations not otherwise covered in the Guide.

As one rural provider told us, "In an environment as rural as we are, it just doesn't make sense to have duplication. We need to capitalize on the limited resources we have."

We could not agree more. It is our hope that this Guide can be an important resource for rural communities.

Thomas J. Engels
Acting Administrator, Health Resources and Services Administration

Executive Summary

Safety net health care providers in rural communities (see Exhibit 1) face a unique combination of challenges, including limited economies of scale, heavy dependence on public payers, low patient volume, and unnecessary duplication of services among providers. Given these circumstances, rural providers like Health Centers/Federally Qualified Health Centers (FQHCs), small rural hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and local public health departments may perceive some level of competition with each other for limited resources, staff, and patients, which can put key services at risk. This Guide discusses and illustrates through case studies how collaboration and coordination among rural providers can address these issues and improve care for these communities.

A Guide for Rural Health Care Collaboration and Coordination was developed in cooperation with local, state, and national level leaders representing various rural health care organizations (see Appendix IV). Below are key lessons learned from efforts these leaders have pursued in their own rural communities. These lessons are discussed in more depth later in the Guide.

Key Lessons Learned from Rural Health Leaders on Implementing Collaboration and Coordination Strategies

1. Leverage use of existing data sources to inform meaningful collaboration and coordination

- Organizations can use existing information, such as needs assessments and electronic health record (EHR) data, to identify the needs of the patient population and the organizations that can best meet those needs.
- Reviewing public information sources (e.g., strategic plans, regulatory filings, needs assessments, and technical reports) can help deepen the understanding of other organizations in the community and identify shared priorities.

2. Engage potential partners

- The community health needs assessment process can be an opportunity to engage with potential partners.
- Organizations with no prior history of collaboration might start with a small-scale project to establish a working relationship for larger projects.
- Taking a "community-minded" approach can encourage engagement with other potential partner organizations, recognizing that no single organization can address all of the community's needs.

3. Develop a collective strategy

- Collaborations are more effective when designed collectively by all participating organizations, rather than being initiated and dominated by a single organization.

4. Commit to transparency and honest communication

- Candid and honest conversations among potential partner organizations can result in clear expectations and role delineations.
- When a relationship between two organizations has a strong foundation of trust, sharing board members can be an effective way to increase transparency and enhance collaboration/coordination.

5. Set realistic expectations and prepare for potential changes

- Not every strategy will be successful; failed strategies and partnerships can provide valuable learning experiences that enhance the success of future partnerships.
- Leaders are important to establishing and maintaining collaboration and coordination; however, leaders will likely change. Formally document partnerships through memoranda of agreement (MOA) or memoranda of understanding (MOU) so that collaboration and coordination efforts can survive the departure of the leaders who initiated them.

6. Identify measures to monitor progress and performance

- Identifying meaningful measures helps guide improvement and performance of collaboration/coordination efforts.
- Use of performance measures data can help garner sustainability support from others in the community.

7. Complete due diligence before committing to a strategy

- All organizations involved in a collaboration/coordination strategy must first ensure that the strategy complies with all of their programmatic and regulatory requirements.

Exhibit 1. Rural Health Safety Net Providers

The National Academy of Medicine describes the rural health safety net as a complex web of public and private professionals and institutions that provide a majority of care to the uninsured, underinsured, low-income, or Medicare and Medicaid recipients. They fill this role because of legal requirements or out of a sense of charity and duty. Prominent safety net providers for rural areas are:

Rural Health Clinics (RHC). Created by the Rural Health Clinics Act of 1977, RHCs are certified by CMS to provide primary care services in non-urbanized areas that have been designated by HRSA as a shortage area within the last four years. RHCs must have a physician as the medical director, but they also must employ at least one nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) to be onsite for half the time the clinic is open. They may be independent clinics, similar to a doctor's office or other outpatient/ambulatory clinic, or provider-based as an integral and subordinate unit of a hospital, nursing home, or home health agency.

The Health Center Program and Federally Qualified Health Centers (FQHC). The terms "health center" and "FQHC" are often used interchangeably because the two are intertwined. In 1975, the Health Center Program was authorized under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b). The Omnibus Budget Reconciliation Act of 1990 created the Federally Qualified Health Center (FQHC) provider type to allow entities in the federal Health Center Program to receive FQHC-specific Medicare and Medicaid payments for services. Eligible entities must apply to the Health Resources and Services Administration (HRSA) to receive Health Center Program grant or look-alike designation before applying to CMS for FQHC certification. Health centers are required to provide services regardless of patients' ability to pay and charge for services on a sliding fee scale. The HRSA Health Center Program website provides additional information on health centers and Section 330 requirements.

Only certain organizations are eligible to enroll in Medicare and Medicaid as FQHCs:

- Health Center Program award recipients: Organizations receiving grants under Section 330 of the PHS Act. Health Center Program grant funding is awarded competitively, based on funding availability.
- Health Center Program look-alikes (LAL): Organizations that meet the requirements of the Health Center Program, but that do not receive grant funding under Section 330. Entities may apply at any time for look-alike designation.
- Tribal entities that operate an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991. Tribal entities apply directly to CMS for certification.

For the purposes of this Guide, the term health center(s) refers to either HRSA Health Center Program award recipients or Health Center Program look-alikes.

Rural Hospitals. Recognizing the vital role that hospitals play in rural areas, Congress and CMS instituted several formal rural hospital safety net authorities, including Critical Access Hospitals (CAHs); Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH); Medicare and Medicaid Disproportionate Share Hospital (DSH) payment adjustments; and the low-volume payment adjustment. The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 ensures that the public can receive emergency services regardless of their ability to pay, and Section 1867 of the Social Security Act requires that Medicare-participating hospitals with emergency services provide a medical screening examination when requested or treatment for an emergency medical condition regardless of an individual's ability to pay.

How to Use This Guide

This Guide provides the following information for rural health care organization leaders to consider as they explore collaboration and coordination* strategies:

- An overview of relevant changes in the current health care environment, which expands collaboration and coordination opportunities
- Factors to consider for effective and meaningful health care collaboration and coordination
- Examples of rural health care collaboration and coordination

The Guide is divided into three sections:

Section 1	**Why Is Rural Health Care Provider Collaboration and Coordination Important Today?** This section provides an overview of potential benefits of collaboration and coordination among rural health care organizations.
Section 2	**Rural Health Care Provider Collaboration and Coordination: Key Elements to Consider.** This section outlines factors to consider for new and existing collaboration and coordination efforts. This section draws from the experience of rural health care leaders who have implemented collaboration and coordination strategies.
Section 3	**Examples of Current Rural Collaboration and Coordination.** This section presents two collaboration and coordination case studies that illustrate the key elements presented in the Guide.

Throughout Sections 1 through 3, live links will help you navigate the Guide and access information resources outside of the Guide. The Guide also includes Appendices that contain additional tools and resources:

Appendix I	**Acronyms.** List of acronyms used in the Guide.
Appendix II	**Useful Tools & Resources.** Additional tools and resources relevant to Section 2 are provided.
Appendix III	**Collaboration and Coordination Examples.** Expanded versions of the case studies discussed in Section 3 are included, so rural health stakeholders can print and share these examples to help kick off discussions about collaboration and coordination.
Appendix IV	**Guide Contributors.** List of experts who provided guidance and lessons learned for this Guide.

* NOTE: *For the purposes of this Guide,* ***collaboration*** is defined as activities in which providers work together through various vehicles (e.g., contracts, formal memoranda of understanding, and data use agreements etc.) to maximize resources and efficiencies, with a common goal of ensuring access and provision of services to rural populations. ***Coordination*** is the deliberate organization of and communication about patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of quality health care and social services.

Section 1. Why Rural Health Care Provider Collaboration and Coordination is Important Today

Safety net health care providers in rural communities face a unique combination of challenges, including limited economies of scale, heavy dependence on public payers, low patient volume, and sometimes unnecessary duplication of services among providers. Given these circumstances, lack of collaboration can put key services at risk given the often-fragile economic status of rural providers like Health Centers, small rural hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and local public health departments. The Guide includes case studies on how collaboration and coordination among rural providers can address these issues and improve care for these communities.

The U.S. health care delivery system continues to undergo rapid transformation. The shift from a volume-based, fee-for-service payment system to one based on value has prompted exploration of new service delivery and reimbursement models that focus attention on health outcomes and population health. At the same time, there is growing interest in patient-centered approaches to care and in encouraging patients to take a more active role in their health and their care. These transformations reward organizations that can demonstrate improved outcomes by coordinating care and treating patients holistically, taking into account not only their immediate medical needs but also their physical environment and social and economic situations (often referred to collectively as “social determinants of health”).

Collaboration and coordination can offer solutions to problems that commonly affect rural areas:

- ***Financial Viability.*** Public payers account for a large share of the overall payer mix in rural areas.[1] Their relatively low reimbursement rates, combined with a limited private insurance base, often put a financial strain on rural providers. **Pursuing collaboration and coordination with other organizations in their service areas can strengthen the financial position of rural providers by allowing them to participate in value-based payment models and creating opportunities to share resources.**
- ***Health Workforce.*** Health workforce shortages in rural areas can limit access, hitting primary care and mental health services hardest. Over half of primary care medical health professional shortage areas (HPSAs) are located in rural areas.[2] Approximately 65 percent of rural counties do not have access to a psychiatrist, and 47 percent do not have access to a psychologist.[3] **Collaboration and coordination among providers can lead to more effective and efficient service delivery implementation, which can assist in recruitment and retention of health care professionals.**
- ***Health Care Access.*** Some rural hospitals are at risk for closure or for closing service lines (e.g. obstetrics units) due to financial viability challenges,[4,5] jeopardizing access to emergency and other important services. **Collaboration and coordination can help maintain and enhance health care access through reducing duplication of services.**

- ***Social Determinants of Health.*** A variety of non-medical factors influence how patients interact with the health care system and how well they are able to manage their health. These include education level, income, employment, housing quality and stability, the strength or weakness of social relationships, access to transportation, and availability of nutritious and affordable food. Problems in any of these areas can contribute to increased chronic conditions, substance abuse disorders, and shorter life expectancy in rural areas.[6] **Working with other community-based organizations allows health care providers to address the social determinants of health.**

For the purposes of this Guide, collaboration is defined as activities in which providers work together through various vehicles (e.g., contracts, formal memoranda of understanding, data use agreements, etc.) to maximize resources and efficiencies, with a common goal of ensuring access and providing services to rural populations. Coordination is the deliberate organization of and communication about patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of quality health care and social services.

Section 2. Rural Health Care Provider Collaboration and Coordination: Areas for Consideration

No single organization can address all needs of its community. However, by collaborating and coordinating with other organizations, rural health care providers can extend their reach and capabilities, which can lead to healthier communities and more vibrant, relevant, and financially stable organizations. Based on a review of current rural health care efforts across the country and interviews with rural health care stakeholders (see Appendix IV), this section presents "elements" of rural collaboration and coordination that leaders of rural health organizations can use to inform new *or* enhance existing collaboration and coordination efforts. Figure 1 illustrates the elements and outlines their key characteristics. While each element builds on the others and ideally organizations would address each element in sequence, organizations can—and should—focus on element areas based on their own needs and situations in their communities.

Figure 1. Rural Health Care Collaboration and Coordination: Areas for Consideration

Element 1 | Analyze the Environment

Element 1 | Key Takeaways

- Leverage existing information sources to identify community needs.
- Begin to develop an in-depth understanding of existing and future potential partners to address those needs.
- Be aware of national, state and local trends that may affect your collaboration and coordination efforts.

  See Appendix II, Element 1 for additional information resources.

The first step is to identify potential areas of need in the community that could be addressed through collaboration/coordination with new or existing partners.

Leverage Existing Information Sources

Start by reviewing existing information sources already accessible to your organization to identify community needs.

For example, electronic health record (EHR) data, community surveillance systems (e.g., condition-specific patient registries) can contain valuable insight on health care utilization, gaps in services, and areas in need of improvement among your patient population. Comparing the most recent community health needs assessments for all organizations in your community can reveal which needs have been identified by multiple partners and should be prioritized in any collaboration.

Public health departments, health centers[*, †] and non-profit hospitals are all required by federal law or accreditation requirements to produce community needs assessments regularly (see Figure 2).

Potential Partner Organization Inventory

Consider developing a potential partner organization inventory (e.g., a table or spreadsheet) that is grouped according to your organization's patient population health needs. Next to each patient population need, make a list of potential provider organizations that you might consider working with to help address each need. A document outlining this information may be useful to share with your organization's board to inform discussions or plans for future collaboration and coordination with others in your community. This document could also be useful when preparing for discussions with potential partners. See Appendix II for a sample template from the North Dakota State Office of Rural Health that was slightly modified for this Guide.

[*] "As part of Health Center Program requirements established under Section 330 of the Public Health Service (PHS) Act and through regulations, health centers are required to regularly complete a community needs assessment."
[†] For the purpose of this Guide the term health center(s) refers to either HRSA Health Center Program award recipients or Health Center Program look-alikes.

Figure 2. Community Needs Assessment Requirements

Safety Net Organization	Planning Requirement	Planning Frequency
Health Departments[7]	Community Health Assessment; Community Health Improvement Plan (conducted to obtain/maintain public health accreditation)	At least 1x every 3-5 yrs.
Non-profit Rural Hospitals; Critical Access Hospital[8]; PPS Rural Hospitals	Community Health Needs Assessment; Implementation Strategy	At least 1x every 3 yrs.
Health Centers[9]	Needs Assessment	At least 1x every 3 yrs.

Public Health Departments. Public health plays a vital role in addressing population health in rural communities, particularly prevention activities. State health departments must produce a State Health Assessment, State Health Improvement Plan, and Health Department Strategic Plan to earn accreditation from the Public Health Accreditation Board (PHAB). On the local level, PHAB requires local health departments to complete a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) every three to five years.[10] Reviewing these documents can reveal potential new partners to work with, and existing collaboration and coordination occurring in your community to potentially leverage. To learn more about these requirements, access the PHAB website.

Nonprofit Rural Hospitals. In 2015, the Internal Revenue Service (IRS) began requiring nonprofit hospitals to complete a Community Health Needs Assessment (CHNA) and an Implementation Strategy every three years to identify and prioritize health or social needs to invest their community benefit dollars. CHNAs must reflect input from the community, including those with special knowledge of or expertise in public health. The IRS requires hospitals to consider social, behavioral, and environmental factors that influence health in the community. More information about CHNAs and Implementation Strategy requirements are available on the IRS website.

Health Centers. As part of Health Center Program Requirements established under Section 330 of the Public Health Service (PHS) Act and through regulations, health centers are required to regularly complete a community needs assessment.

Please see Element 2 and Element 3 sections for further information on how to leverage a community health needs assessment to meaningfully engage potential partners in collaboration/coordination.

After reviewing existing data sources and identifying the most urgent needs among your patient population, analyze what assets, capabilities, and resources are available to address these needs. Next, consider the assets, capabilities, and resources of other state, regional or local organizations that might augment or improve your organization's effectiveness in addressing these needs. Refer to Figure 3 for a list of provider types and programs that may be potential partners. Also, see Appendix II for useful tools and resources to inform your efforts to identify potential partners.

Understand Your Partners

After you identify your patient population's needs, the next step is to create a list of organizations in your community, either current or potential partners that may be able to help you address those needs. Then, identify the organizational relationships that you may need to cultivate in order to develop meaningful collaboration/ coordination to address a shared need.

An in-depth understanding of other organizations in your community can help identify similarities and differences that may affect your working relationship, organizational issues that may need to be resolved, and areas where you may need to address other organizations' concerns about your own organization.

In addition to the needs assessments described above, it is useful to review other sources of information that are often publically available (e.g., mission statements, strategic plans, programmatic and regulatory requirements) about the organizations you identify. These materials can offer insight on what drives the culture and governance of these organizations. Additional information sources on various types of safety-net provider organizations are provided in Appendix II, Element 1.

Figure 3. Types of Organizations to Learn More About In Your Rural Community

Type	Examples
Behavioral Health and Substance Abuse	• Community Mental Health Center (CMHC) • Private Mental Health Provider
Long- Term and End-of-Life Care	• Palliative Care • Home Health Agency • Swing beds • Skilled Nursing Facility (SNF) • Hospice
Primary Care	• Rural Health Clinic (RHC) • Health Center/FQHC • Private clinic
Acute and Tertiary Care	• Critical Access Hospital (CAH) • Rural Referral Center (RRC) • Sole Community Hospital (SCH) • Medicare-Dependent Hospital (MDH) • Disproportionate Share Hospital (DSH) • Regional Tertiary Hospital
Public Health	• State Health Department • Local Health Department/Unit • Rural Cooperative Extension
Law Enforcement	• Juvenile Justice • Law Enforcement
Economic Development	• Community Development Financial Institution (CDFI) • Academic Health Department
Housing	• Public Housing Agency (PHA)
Community-based Organizations	• Faith-based Organization • Senior Citizen Center
Education	• Trade schools, colleges/universities, etc.
Other	• Foundations • Charitable organizations • Local businesses

Be Aware of Environmental Trends and Changes

As you process the information described above, also take note of recent changes to provider requirements, as well as emerging health care trends and changes at national, state, and local levels that can affect your collaboration/coordination efforts. Relevant changes and trends to consider at the national level include:

- ***Collaborative Relationship Requirements***

  Updates to HRSA's Health Center Program requirements further recognize the value of collaboration and coordination by calling for health centers "to make every reasonable effort to establish and maintain collaborative relationships including with other health care providers that provide care within the catchment area [service area], local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments."[11] The program also requires health centers to "coordinate and integrate their project activities with other federally-funded state and local health services delivery projects and programs serving the same population" and to document these efforts.[12] To learn more about HRSA Health Center Program requirements, see the HRSA Health Center Compliance Manual.

  The **North Dakota** case study illustrates how two provider organizations examined their respective programmatic and regulatory requirements to strategically plan for collaboration and coordination. For more information about this case study, see Section 3 and Appendix III.

- ***Value-based Health Care Models***

  Value-based health care models recognize that meeting the needs of complex patient populations requires support from multiple systems of care (health, behavioral health, social services, public health, and other enabling services). The following models provide opportunities for rural health organizations to work collaboratively with others.

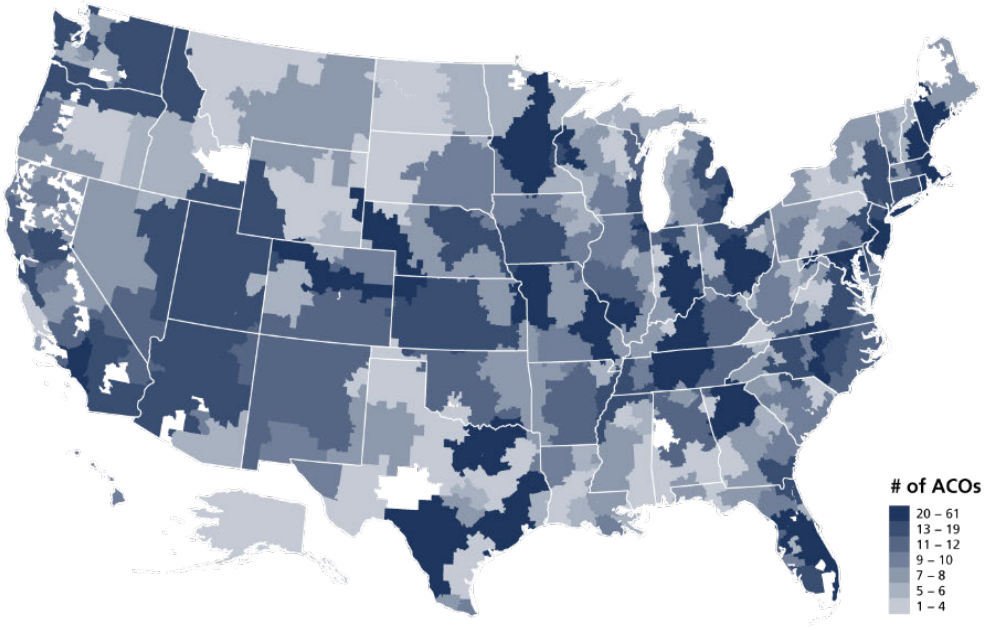
  Patient- Centered Medical Homes (PCMHs). This health care service delivery model has been widely implemented to transform the delivery of primary care. The model aims to deliver whole-person care that is coordinated and tracked by the patient's primary care provider or "medical home." A PCMH coordinates care across a broad health care system that includes specialty care, hospitals, home health, and other community services and related supports. Care coordination is a key function of a PCMH and is especially important during care transitions, such as hospital discharge. Rural Health Clinics, health centers, and rural private practices may become PCMH accredited. Health care organizations that are not PCMHs can assist in the effort to spread patient-centered care by reaching out to PCMH providers in their community and inquire how they might support implementation of the model (e.g., care coordination, data sharing).

  Missouri and **North Dakota** case studies illustrate how they optimized their PCMH capabilities by collaborating with other local community providers. For more information about these case studies see Section 3 and Appendix III.

  Accountable Care Organizations (ACOs). An ACO is a value-based arrangement that generally includes a network of physicians and hospitals that voluntarily share financial and clinical responsibility for a defined patient population and are held accountable to third-party payers. These clinical networks are formalized by an agreement between the payer and providers involved; the agreement stipulates how care will be provided and how

financial incentives will be disbursed. While ACOs vary and continue to evolve, overall they provide opportunities for providers to work closely together to provide highly coordinated care to reduce unnecessary health care costs and improve health outcomes. Public and private payers continue to invest in ACO models and continue to examine the lessons learned from this model. As of 2018,* there were approximately 1,011 active private and public sector ACOs across the country with service areas in all 50 States and the District of Columbia (see Figure 4).[13] Both rural and urban hospital referral regions have similar ACO penetration.[14]

Figure 4. Total Number of ACOs by Hospital Referral Region (2018)



Source: "Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018," Health Affairs Blog, August 14, 2018.

* As of 2019, CMS restructured the Medicare Shared Savings Program (SSP) ACO program and renamed it to Pathways to Success program. https://www.cms.gov/newsroom/press-releases/cms-finalizes-pathways-success-overhaul-medicares-national-aco-program

Element 2 | Engage with Potential Partners

Element 2 | Key Takeaways

- Use a broad stakeholder approach on your next needs assessment to engage potential partners.
- Strengthen existing partner organization relationships.
- Use a community-minded leadership approach.

  See Appendix II, Element 2 for related information and resources to support your efforts to engage partners.

After you have acquired as much information and insight as possible from the public information sources described above, it is time to engage with potential partners directly and to explore expanding your relationships with any existing partners. First-hand interaction will give you a deeper understanding of the organizations you have studied and may also lead to identifying other potential partner organizations. Consider the following areas as you prepare to meaningfully engage potential new and/or existing partners.

Use the Needs Assessment Process to Engage Potential Partners

Consider engaging a broad set of organizations to participate in your next needs assessment. Sharing this process with a diverse set of stakeholder community organizations can provide unique opportunities to network, leverage resources, and create community buy-in. The result will be a more comprehensive understanding of your shared needs. You can use the following discussion questions to identify potential collaborators when planning for your next community health needs assessment:

Missouri and **North Dakota** case studies illustrate how to strategically use community health needs assessments to engage community health organizations. For more information see Section 3 and Appendix III.

- Are there any organizations, coalitions, or stakeholder groups we should involve that have not been involved in previous community health needs assessments?
- Are there any organization(s) that specialize in a particular need area that we are currently addressing alone that would benefit from their assistance/involvement?
- What is the best way to ensure productive exchange with stakeholders? Would involving a facilitator encourage a more effective needs assessment process?

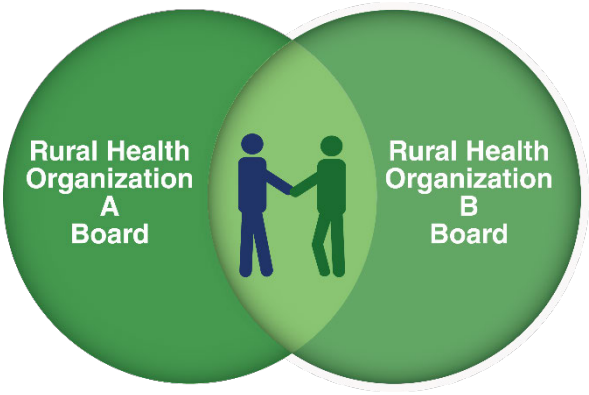
Also, see Appendix II, Element 2 for related information resources.

If your organization is not required to conduct a community needs assessment, consider reaching out to organizations that do these assessments to make them aware of your organization's services and resources, as well as the needs of your patient population. Sharing this information can open the door to potential partnerships.

Technical Assistance. Implementing a comprehensive community needs assessment requires extensive time and logistical coordination. A facilitator can handle this coordination and serve as a neutral third party to navigate any historical or emerging tensions between organizations. State Offices of Rural Health (SORHs) often offer technical assistance on community health needs assessments. To learn more, contact the SORH for your state or the National Organization of State Offices of Rural Health, the membership organization representing all 50 SORHs.

Strengthen Existing Partnerships

To strengthen an existing partner organization relationship, consider asking a partner representative to join your organization's board. This step can further enhance your shared commitment to work together on addressing community needs, but it requires a heightened level of transparency and trust between the organizations. Board members often have access or exposure to organizational level information (e.g., financials, performance data) that provides insight into an organization's culture (attitudes, shared values and expectations) and functions (programmatic structure or regulatory requirements). Board participation can facilitate a deeper understanding that enhances collaboration and coordination efforts when organizations have an open and trusting relationship. Most rural collaborations examined for this Guide included shared board members, which facilitated an increased understanding of each other's organizational processes and helped to identify areas for collaboration and coordination and related implementation to support collaboration/coordination.



Use a Community-Minded Leadership Approach

The value of a community-minded approach to collaboration was often mentioned by those involved with the rural collaboration and coordination activities described in this Guide. A *community-minded leader* addresses community needs in the most appropriate and effective manner possible, without unnecessarily duplicating efforts of other provider organizations. A community-minded leader recognizes that no single organization in the community can address all the needs of their patient population and that it is vital to leverage the strengths and capabilities of other community organizations in order to comprehensively address a patient population's health needs. Leading in this way can help your organization strengthen the collaboration and coordination process and help reduce (or eliminate) unproductive provider-level competition.

Element 3 | Develop a Collective Strategy

During the needs assessment process and other collective conversations with provider organizations, it is useful to identify areas where collaboration and coordination can address community needs, lead to more efficient use of resources, and minimize unproductive duplication of services. As rural providers face a low volume of patients and heavy dependence on Medicare and Medicaid with less private insurance, potential partners may perceive some level of competition for limited insurance reimbursement and limited numbers of insured individuals. The questions in Table 1 can help guide collective brainstorming discussions with potential partners (during the needs assessment process or for other purposes); this table is also provided in Appendix II of the Guide to print and use.

Multi-stakeholder discussions should take place in an environment that encourages an exchange of diverse opinions, concepts, or ideas in a collegial and respectful manner.[15] A trained facilitator can help promote open dialogue in which participants feel comfortable conveying areas of concerns or differences. As referenced earlier, you may consider accessing support from your State Office of Rural Health (SORH) in planning these discussions and/or for recommendations for a facilitator.

For all rural collaboration and coordination strategies that were examined to inform the development of this Guide, measuring success was not usually a priority or focus until after implementation of collaboration and coordination strategies. However, all of the organizations recognized the value of metrics to help guide their process of collaboration and coordination. Given the importance of transparency, accountability, and results in the current health care environment, metrics ideally can be identified before implementing a selected collaboration and coordination strategy. Measures (of process, outcome, and impact) can guide performance improvement, allocation of resources, and sustainability. Consider using evidence-base metrics that you may already be reporting on for other purposes to help reduce data collection and reporting burden.

See the **Missouri** and **North Dakota** case studies for measures that describe the impact of their collaboration and coordination strategies. For more information, see Appendix III.

See Appendix II, Element 3 for a list of other relevant information resources.

Table 1. Questions to Facilitate Collective Discussions with Potential Partners

Topic Area	Discussion Questions
Needs Better Addressed through Collaboration/ Coordination	Are there any identified needs that would be best addressed through collaboration and/or coordination with other organizations? *If yes:* • What are these needs? Why would it be more appropriate to collaborate/coordinate on these needs? • What partners should be involved (to address these needs) and why? • Are there additional organizations that need to be engaged? • What is/are the most appropriate solution(s) to address this community need(s)?
Unproductive Duplication of Efforts	Are there any unproductive duplication of efforts that any of us might be involved in that could be best addressed through collaboration and coordination to improve efficiencies (e.g., better use of resources) and better serve needs of our shared community/shared patient populations? *If yes:* • What are these areas? • In what ways could we collaborate and coordinate to reduce duplication?
Leveraging Strategies and Existing Resources	Are there existing resources (e.g., fiscal and/or non-fiscal, programmatic strengths, technical capabilities) among the collaborating organizations that could be leveraged to better address our shared patient population's needs? *If yes:* • What are these areas? • In what ways could we collaborate/coordinate?
Expected Partner Benefits	• What benefits can prospective partners expect from participating in potential collaborative or coordinative strategies (identified as a result of discussing previous questions listed above)?
Shared Goals, Objectives	• If we work together to address any identified need(s), what are our shared goals and objectives?
Local Strategy, Solutions	• What strategy(ies) or solution(s) do we agree to implement? • Are there any evidence-based strategies or solutions that can be modified or adapted to address the identified need(s)?
Measurement	• How can we measure success of the selected collaborative/coordinative strategy(ies) or solution(s)? • What measures (e.g., process, outcome, impact) can help us monitor and inform implementation of strategies? Are there any measures already in use that can be leveraged? • How often should organizations monitor and track performance? • What level of effort is involved in reporting on these measures? • Who will be responsible for data collection and reporting?
Resources	• Are there any resources (fiscal or non-fiscal) that can be leveraged to support implementation of the identified strategy(ies) or solution(s)? • Do we need to apply for external resources (e.g., grants)? If yes, what is the application process and level of effort required? Who will lead and manage this?
Implementation Structure and Management	• How should implementation of strategies be structured? Who will be involved? How will it be managed and by whom? • What will be the process for guiding continuous improvement?

Element 4 | Review Requirements and Seek Technical Assistance

Element 4 | Key Takeaways

- Before formally agreeing to participate in a collaboration and coordination strategy, ensure your organization's programmatic and/or regulatory compliance will not be compromised. If relevant, identify what additional steps must be taken to ensure compliance.
- Seek Technical Assistance.

  See Appendix II, Element 4 for related technical assistance resources.

Before committing to implement any type of collaboration or coordination, each participating organization should review its own programmatic requirements, regulatory requirements, organizational policies, and procedures, to ensure that the proposed collaboration/coordination strategy aligns with respective organizational requirements. This due diligence can save time and resources for all partners involved by ensuring that a given strategy is consistent with all existing requirements.

During this process, organizations can research and access relevant technical assistance resources specific to the selected strategy to determine how it may affect compliance and what additional measures need to be taken to ensure compliance. See Appendix II, Element 4 for related information resources.

The **North Dakota** case study illustrates a due diligence process that engaged legal counsel and a grant project officer to ensure organizational compliance before formal implementation of a collaboration and coordination strategy. For more information, see Appendix III.

Not every collaboration and coordination strategy implemented will be successful every time. However, each experience of working with other organizations in your community builds your organization's capacity for future partnerships. The organizations interviewed for this Guide reported that each partnership or attempt at partnership taught them new skills for working with others that helped prepare them for their next joint venture in collaboration and coordination.

Section 3. Examples of Rural Collaboration and Coordination

Two case studies representing provider organizations in Missouri and North Dakota are summarized in this section to illustrate examples of rural collaboration and coordination. These case studies were selected primarily due to their diversity in certain areas. For example, one used collaboration and coordination to repair an adversarial provider organization relationship between a Critical Access Hospital (CAH) and a Federally Qualified Health Center (FQHC) to better serve their shared patient populations, and the other used it as a tool to efficiently address a wide array of health and non-health needs. These contextual differences are reflected in their prior history of collaboration and coordination; one had no history and the other had an extensive history of collaboration and coordination fostered by a local health department. Another difference is the number of partners involved; one case study involves up to eight partners, and the other involves up to 50 partners. While these case studies are unique, they also share similarities. They share the collective will of stakeholders to work together despite challenges faced, community-minded leadership, strategic use of community health needs assessments to inform collaboration and coordination, and use of measures to monitor the impact of collaboration and coordination. Comprehensive case studies can be found in Appendix III to print and share with others in your community to kick off discussions (e.g., board member discussions) focused on exploring use of collaboration and coordination as a strategy to address community need(s).

MISSOURI CASE STUDY 1:
Implementing a Rural Health Network to Address Health Care Access and Social Determinants of Health Needs

STRATEGY: Create a Rural Health Network‡

During 2003, Care Connection for Aging Services, a non-profit Area Agency on Aging (AAA) serving 13 west-central Missouri counties, began planning for a senior center. In connection with this effort, the Lafayette County Health Department established an informal coalition to identify community needs that could be addressed by the senior center. The coalition included organizations representing economic development, public health, health care, behavioral health, social services, and local school districts.

Coalition members quickly realized the needs identified (e.g., provider shortages, oral health, transportation, disease prevention, and health needs across the lifespan) exceeded what a senior center could address.

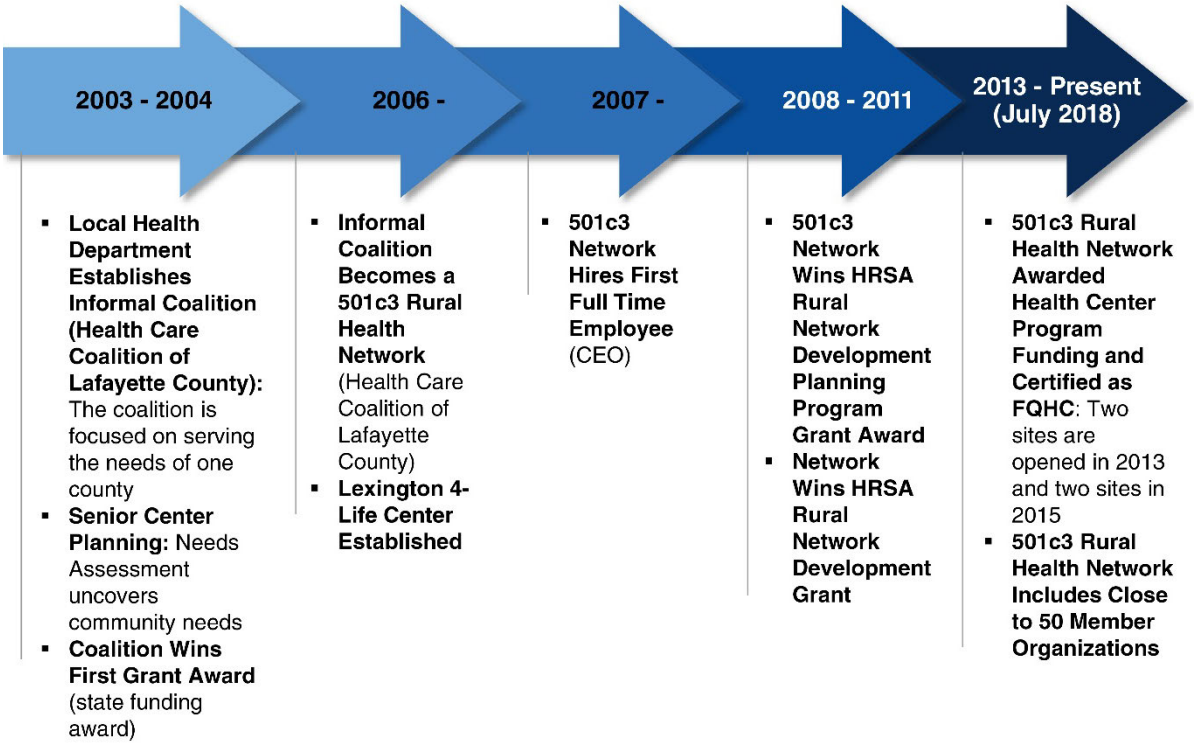
The informal coalition began serving one county with one part-time employee and has since formalized itself into a not-for-profit corporation serving four rural counties and the rural portion of another county with approximately 50 partner organizations and 40 staff.[17] The network's evolution (see Figure 6) was driven by its efforts to understand and address its patients' needs and by the community's interest in working together to address those needs.

Figure 5. Missouri Case Study Key Features

Key Features	Case Study 1 (Missouri)
Geography:	Northwestern Missouri Multi-county (n=5)
Catchment Area Population:	≈133,035[16]
Collaboration and Coordination Strategies:	**STRATEGY 1:** Create a Rural Health Network **STRATEGY 2*:** Collaboratively Address Social Determinants of Health
Timeline for Strategy Development Planning and Implementation:	2003–Present
Motives for Collaboration and Coordination:	**STRATEGY 1 & 2:** Address an array of health and social determinants of health needs.
Partner Types Involved:	**STRATEGY 1:** CAH (n=2); HD; AAA; CMHC; Economic Development; Domestic Abuse; FQHC **STRATEGY 2:** Rural Health Network (including 50 member organizations and community-based organization partners)
Prior History of Collaboration Coordination†:	Yes
Outcomes:	• Clinical • Workforce • Organizational • Community • Financial

* Information about Missouri's Strategy 2 can be found in Appendix III of this Guide.
† Prior history of collaboration and coordination: Refers to any prior history of partners collectively working together prior to implementing the strategies discussed in this Guide.
‡ Health Care Coalition of Lafayette County (HCC) is referred to as the "Rural Health Network" or "the network."

Figure 6. Rural Health Network's Incremental Development (2003-Present)



The network's ability to generate funding support for community focused projects and to participate in the planning of the senior center generated synergy among coalition members and solidified the need for maintaining the coalition, which led the group to formalize itself as a not-for-profit organization, referred to as the Health Care Coalition of Lafayette County (HCC). For the purposes of this case study summary, the Health Care Coalition of Lafayette County (HCC) is referred to as the "Rural Health Network." Obtaining 501c3 status allowed the network to pursue other funding opportunities to support its growth and development.

Designing the Network's Blueprint. After the coalition agreed to incorporate, it continued to pursue funding that required collaborative approaches to address local needs. Two HRSA grants were instrumental in the Coalition's early development; the Rural Health Network Development Planning Program and the Rural Health Network Development Grant Program. These grants helped to develop the Rural Health Network and to hire its first full-time employee, a Chief Executive Officer (CEO). Hiring a CEO accelerated implementation of the Rural Health Network.

"Needs were varied, we knew none of us could do it all, and if we didn't come together, there'd be unmet need. We knew it wasn't always going to be fair. It wasn't going to be like going out to dinner and splitting the bill six ways down to the penny. That's not the kind of relationship that was going to be successful."

— Founding Rural Health Network member, and CEO of a Rural Provider Organization, reflecting on the origins for developing the Rural Health Network

After the network expanded its geographic reach to four counties and the rural part of a fifth county, it filed for a "doing business as"

(dba)* to be referred to as the Health Care Collaborative (HCC) of Rural Missouri. The network's CEO attributed growth to changes in the health care landscape focused on value-based health care and expanded interest in the social determinants of health. As network membership grew, so did the network's capacity to bring in new funding streams to support new programs. For example, from 2007 to 2016, the network was awarded more than $3.5M in HRSA grant funding in addition to funding from private health care foundations and other local organizations. The additional funding strengthened the network's progress. One board member said every health care provider organization in the community is seated at the network's board table and, as a result, decisions can be made quickly.

After the network expanded, it completed an overall needs assessment of its five-county service area primarily using the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System (BRFSS) data. Findings uncovered extensive health care and non-health care needs, which led network members to implement a strategy to apply for Health Center Program funding and become an FQHC. The coalition determined that establishing a health center operating a number of sites was a scalable, long-term solution to implement and sustain the network's programs. The network, as the Health Care Coalition of Lafayette County (HCC), was awarded a Health Center Program grant in 2013, which enabled the organization to become an FQHC. Implementation of the coalition's FQHC strategy required support from member organizations. For example, one of the network's founding members, Lafayette Regional Health Center (a Critical Access Hospital), transferred ownership of two of its hospital-based RHCs to be included in the network's initial Health Center Program grant application through a New Access Point funding opportunity. The CEO of the CAH believed these two clinics could make more of a community impact as part of an FQHC than as RHCs. Later in 2015, the network was awarded additional Health Center Program grant funding through a New Access Point funding opportunity. They added two more sites, one of which had previously been a hospital-based RHC with the Carrol County Memorial Hospital (a CAH and a Rural Health Network member organization), to address overutilization of its ER for primary care services.

Figure 7. Rural Health Network's Key Components.

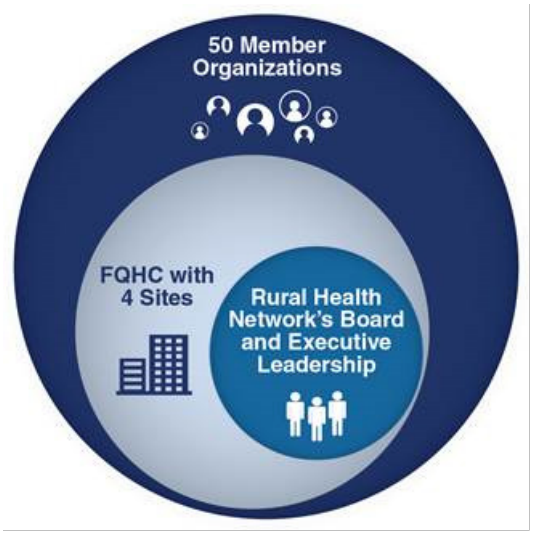


Figure 7 illustrates the current structure and organization of the Rural Health Network. Its leadership describes it as a living cell with three layers. Its mission is to cultivate partnerships and deliver quality health care to strengthen its rural communities, and the focus is to develop and implement programs that are innovative, integrated, and responsive to the health care needs of its local residents.[18] The nucleus is the network's leadership and 10-member executive

* The Rural Health Network's legal name is Health Care Coalition of Lafayette County and its "doing business as" name is Health Care Collaborative of Rural Missouri.

board, who represent health care and other non-health care sectors in the community.* The second layer is the FQHC with its four sites, which supports implementation of the network's programs. As an FQHC, the HCC improves access to care and addresses the social determinants of health needs for its patients in the five-county service area. Two of the four sites are National Committee of Quality Assurance (NCQA) accredited patient- centered medical homes (PCMHs), which aligns with the network's focus on comprehensive and coordinated care for its patients. The external layer comprises more than 50 provider and community-based member organizations that complement and support the network's provision of health care and social services.

When discussing with network members how the network accomplishes its goals, one member credited the culture of transparency that exists among the group. In the beginning, transparent discussions—known as the "What's in it for me?" discussions—were useful because they helped network members uncover differences in opinion rather than gloss over them. These discussions helped solidify a collective belief that no single organization can address all the needs of their community and that they can make more of an impact when working together.

A couple of the members also credited the network's strategic use of needs assessments to determine what services are needed and the appropriate structure for implementing services. For example, needs assessments helped bring to bear the network's three flagship programs – Warehouse Resources Hub, Connectors Program, and Project Connect – so they could be implemented collaboratively with other health organizations in the community, that focus on addressing the needs of the network's patient populations that are associated with social determinants of health. These social determinants of health programs are integrated in all of the network's clinical services.

Another factor helping the network stay focused and make progress is that when they attend network meetings, the member organizations "leave their organization hat at the door" and focus on the best interest of the community.

NOTE: See Appendix III for more information about the Rural Health Network's collaborative efforts to establish and implement services to address the social determinants of health needs of its service area.

Outcomes

The Rural Health Network's membership grew substantially after the establishment of the four FQHCs. As a result, the network has focused on monitoring its outcomes and performance to inform improvement and demonstrate its value to members and the larger community. The network has used tools, such as the Baldrige Excellence Framework, an evidence-based model, to facilitate organizational performance improvement. The Rural Health Network's board, with support from an external evaluator consultant, developed key performance indicators (KPIs) to reflect a collective vision of expected network outcomes (see Exhibit 2). These KPIs reflect an

* Rural Health Network Board activities are separate from the Health Center Board to ensure compliance with Health Center Program requirements.

array of community, financial, organizational, and clinical outcomes. A dashboard of the KPIs is updated monthly and presented at network board meetings.

Exhibit 2. Rural Health Network's Key Performance Indicators and Outcomes[19]

Goals	Key Performance Indicator Brief Description	Outcome Measures and Outcomes (as of 2016)*
Market & Strategy Driven	• Intentional Collaborative Relationships • Increased Community Resources	• # of co-locations (1 in 2016 to 2 in 2018) • # of network member interactions to support delivery of Network services • # of unique website page views
Fiscally Responsible Organization	• Clinical Services • Network Membership	• 59 days cash on hand • 20 NET Days in Receivables • 2.8 Net Asset Ratio (GOALS)†
Excellent Place to Work	• Staff Retention & Recruitment • Increased Voluntary Retention • Increased Employee Satisfaction	• Retained 80% of staff • 85% of staff reported satisfaction on annual survey
Valued & Competent Health care Provider	• Patient Satisfaction Survey • Medicaid Encounters • Uniform Data System (UDS) Encounters	• 80% Patient Satisfaction on annual survey • 20% increase in 2016 Medicaid encounters • 25% Increase in UDS encounters
Rural Health Network Leader	• National Leadership	• Number of leadership roles held by staff and board in community, state, regional, and national organizations • Recognized as leader locally, regionally, and nationally

Peer Advice

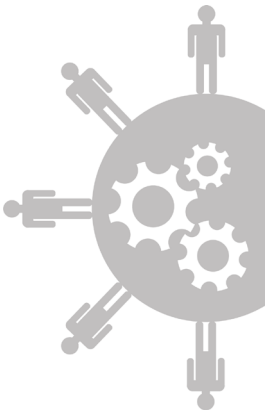
Case Study 1 stakeholders' advice to rural stakeholders interested in their collaborative efforts:

"It will be challenging, but don't give up, and ask for help. You need at least two people to help with operations and management in order for this to work. We started out with one part-time staff person, though things improved dramatically after hiring one full-time staff person [referring to the CEO] who was personally invested in the mission of the network."

— Rural Health Network Leadership

"Look forward and focus on the best interests of your community. This is what helped us get through any collaborative hurdles we encountered along the way."

— Rural Health Network Leadership



* Outcomes described reflect the Rural Health Network's 2016 data except for number of co-locations; these data are from 2018. Data were not available (at the time this Guide was developed) for certain measures listed under the *Market & Strategy Driven* and *Rural Health Network Leader* Goals.
† The Rural Health Network's goal for 2016.

NORTH DAKOTA CASE STUDY 2:
Transforming Competition into Collaboration to Help Streamline Health Care Delivery

STRATEGY 1: Sharing Resources to Better Serve the Community

This case study illustrates how an adversarial relationship between a Critical Access Hospital (CAH) and a Federally Qualified Health Center (FQHC) transformed into a collaborative relationship that benefits the organizations' communities. The FQHC (a HRSA Health Center Program grantee) and the CAH had competed for several years. Leadership of both organizations often engaged in misguided initiatives in an effort to increase their own market share. During 2011, competition between the organizations came to a head; duplication of services was causing financial strain for both organizations, and staff morale was at an all-time low. In the midst of all this, the FQHC experienced leadership turnover, leaving the organization without a Chief Executive Officer (CEO). These factors precipitated the need to do something different. Two key leaders, the FQHC's Medical Director and the CAH's CEO, helped chart a new solution.

Figure 8. North Dakota Case Study Key Features

Key Features	Case Study 2 (North Dakota)
Geography:	West Central North Dakota • Multi-county (n=3) • Multi-city (n=3)
Catchment Area Population:	≈ 13,800[20]
Collaboration and Coordination Strategies:	**STRATEGY 1:** Share Resources to Better Serve the Community **STRATEGY 2:** Implement a Multi-Stakeholder Community Health Needs Assessment
Timeline for Strategy Development Planning and Implementation:	2011–Present
Motives for Collaboration and Coordination:	**STRATEGY 1 & 2:** Address unproductive CAH and FQHC provider relationship rooted in competition.
Partner Types Involved:	**STRATEGY 1:** CAH; FQHC **STRAGEGY 2:** CAH, FQHC, HD (n=2); LTC (n=2); EMS; SORH
Prior History of Collaboration Coordination*:	No
Outcomes:	• Clinical • Workforce • Organizational • Community • Financial

The CAH CEO began his tenure in 2009 and brought years of executive level experience working collaboratively with health care organizations in rural areas. The FQHC's Medical Director had been with the organization for several years and helped to build the FQHC's quality improvement technical capabilities. The FQHC was involved in two pioneering quality improvement programs:

* Prior history of collaboration and coordination: Refers to any prior history of partners collectively working together prior to implementing the strategies discussed in this Guide.

- HRSA's Health Disparities Collaboratives,[21] a quality improvement initiative.
- The CMS Innovation Center's Advanced Primary Care Practice Demonstration* which focused on FQHC implementation of the Patient-Centered Medical Home (PCMH). Technical assistance was provided to participating health centers involved in the demonstration.

"I don't think any of us would want to ever go back to how we were before. We all love knowing that we're one team serving our community."

— Rural Health Care Provider Staff, reflecting on the adversarial CAH and FQHC relationship that once existed

Around the time the relationship between the CAH and FQHC reached an impasse, the FQHC was working to earn PCMH accreditation through the National Committee for Quality Assurance (NCQA). As part of the CMS demonstration, the FQHC received technical assistance grounded in the Safety Net Medical Home Initiative's change concepts, which were previously developed and established in partnership with health centers. *Engaged leadership* is one of the change concepts considered essential to the PCMH transformation process. Engaged leaders allocate the necessary resources (time, dollars, staffing, equipment, and technology) to enable the PCMH transformation and set the tone for cultural change.

Influenced by the PCMH model and by the need to address the unproductive CAH-FQHC relationship, the FQHC medical director reached out to the CAH CEO to see if he would be willing to also serve as the FQHC's CEO. He agreed, and the FQHC medical director recommended the change to his board. While sharing a CEO was an unconventional solution, it showed promise in addressing three pressing issues:

Limited Resources: Identifying and retaining high caliber executive leadership in rural health care organizations is especially challenging when these organizations compete for limited resources. Paying one CEO rather than two represented significant savings in both salary and recruitment costs for both organizations.

Reduce Unnecessary Duplication: Sharing a CEO could help neutralize competition between the organizations and facilitate efforts to leverage services and resources between the organizations.

Improve Care Coordination: With a trend toward value-based models of care, a shared CEO could help establish better continuity of care between the organizations and optimize the FQHC's PCMH efforts to benefit the shared populations the FQHC and CAH serves.

* HRSA was a partner on the CMS Innovation Center Advanced Primary Care Practice Demonstration.

Extensive due diligence was necessary for both organizations to complete prior to implementing the shared CEO leadership structure to ensure that each organization was in compliance with its programmatic requirements. In recognition of the FQHC and CAH's prior acrimonious relationship, the organizations chose to involve a neutral third-party consultant to help facilitate planning for the shared CEO leadership structure. Planning was guided by three areas (supporting functional alignment, establishing contracts/agreements, and enhancing organizational structure):

1. ***Functional:*** The organizations agreed to work towards clinical and operational alignment to guide identification and elimination of duplication of efforts between the organizations. This alignment effort helped the organizations identify additional resources to share, such as health information technology (HIT) and human resources staff.

2. ***Contractual:*** Formal agreements were established to define the terms and conditions of the relationship. The organizations established two agreements with support from legal counsel.

    - An *Executive Management Consulting Services Agreement* was developed to assure there was no conflict of interest in the shared CEO arrangement and established that the CEO is employed by the health center. Health Center Program requirements stipulate specific requirements regarding key personnel, key management, and conflict of interest, which includes CEOs.
    - *A Coordination of Services and Capacity Agreement* defined how the organizations would share HIT and human resources staff to optimize limited resources.

> **"In an environment as rural as we are, it just doesn't make sense to have duplication. We need to capitalize on the limited resources we have."**
>
> *— Board Chairperson*

3. ***Structural:*** The organizations believed it was essential to have overlapping board members to serve as added checks and balances between the organizations. Board by-laws for the CAH and FQHC were revised to include reciprocity of board governance representation.

After due diligence was completed, the FQHC received permission from its program fiduciary, HRSA, to implement the shared CEO solution temporarily. The shared CEO structure led the CAH CEO to develop a deeper understanding of the interconnection between the mission of health centers and their programmatic requirements, and value of the PCMH model for the broader community. The CEO's in-depth understanding has facilitated the CAH's strong support of PCMH, which has enhanced the FQHC's efforts to optimize implementation of PCMH beyond its four walls. As a result, both organizations now share an aspirational goal to build a PCMH "neighborhood of care" for their community. After two years of testing the shared CEO concept, the two organizations made the arrangement permanent with approval from HRSA. The CAH and FQHC continue to be separate organizations that are financially independent and operate in compliance with their respective programmatic requirements.

STRATEGY 2: Multi-Stakeholder Community Health Needs Assessment

The shared CEO leadership structure for the FQHC and CAH led to additional collaboration and coordination in the community. The organizations decided to work together to complete their needs assessment activities. The North Dakota State Office of Rural Health (ND SORH) provided technical and logistical support for the needs assessments through use of HRSA Medicare Rural Hospital Flexibility Program FLEX funds.

The assessment process engaged a wide variety of stakeholders including emergency management, economic development, long-term care, local public health departments (who used their involvement to satisfy their own community needs assessment requirements), faith-based organizations, educators, local businesses, and others. The process relied on a variety of data sources including focus groups, secondary data, and a community survey. Broad involvement of health organizations in the community led to a more comprehensive, complete needs assessment, according to reports from the organizations that used the process as part of their needs assessment requirements (e.g., local health departments). Key areas that contributed to the process were:

- *Leadership and Community Involvement:* Involvement by leaders of stakeholder organizations helped establish that the needs assessment was a priority, which facilitated community participation. To prepare for the needs assessment, the SORH conducted educational sessions with the community on the value of needs assessments and the significance of social determinants of health.
- *A Community-Developed Survey:* In addition to focus groups and review of secondary data, stakeholders developed a survey, with the SORH's support, to help understand residents' perceptions about current health services and their perspectives on needs. The resulting survey had a high response rate compared with past surveys. The survey data provided rich information that helped inform collaborative efforts to meet community needs.
- *Community Stakeholder Steering Committee:* A committee of diverse community stakeholders ensured the assessment was locally driven, comprehensive and meaningful. The committee informed the design of focus groups and the community survey as well as helped prioritize community needs.
- *Technical Assistance from the ND SORH:* The ND SORH supported the needs assessment technically and logistically, which freed the CAH and FQHC to focus on their substantive involvement in the process. The ND SORH office recommends identifying one point of contact from the organization(s) responsible for leading needs assessment efforts and creating dedicated time for these contacts to work with the SORH. In this case, two points of contact representing the CAH and FQHC worked with the SORH to help plan and implement the needs assessment.

Working together on the needs assessment informed how the CAH and FQHC could work together and work with other partners in the community to optimize implementation of the PCMH model. The CAH, the FQHC, and community stakeholders involved in the needs assessment continue to meet monthly to measure progress towards addressing the identified needs.

Outcomes

Collectively, the shared CEO leadership structure and multi-stakeholder community health needs assessment process has led to several positive outcomes for the FQHC, CAH, and their shared patient populations and community at various levels (e.g., organizational, clinical, financial).

Reduced Duplication of Services: The FQHC discontinued delivery of ancillary services (e.g., ultrasound, CT, bone density, stress testing). The CAH discontinued its delivery of primary care services through its RHC located just two blocks from the FQHC.

Established Inter-organizational Committees Focused on Care Coordination and Population Health: The shared needs assessment prompted establishment of two committees—a population health committee and a care coordination committee—to strengthen delivery and implementation of the PCMH model beyond the four walls of the FQHC. The population committee has hosted public screening events to prevent and identify chronic disease and conditions (e.g. cancer, obesity, diabetes). The care coordination committee includes cross-organizational discussions between FQHC and CAH clinicians to discuss hospital readmissions and emergency room use data, to improve care coordination for specific patients such as high ED utilizers.

Increased ACO Participation and Leadership: Collaborative strategies and related outcomes strengthened care coordination capabilities that led the FQHC and CAH organizations to consider participation in value-based payment and delivery models. In 2018, the organizations participated in two ACO programs. The first is the Medicare Shared Savings Program, led by the FQHC's clinical leadership. The second is the North Dakota Blue Cross Blue Shield Blue Alliance Rural ACO, a commercially-based program in which they have demonstrated cost savings and improved clinical outcomes.

Co-located Services: The FQHC and CAH decided to co-locate their services to enhance health care access and care coordination for its local residents. In 2017, the CAH opened a facility that co-locates the FQHC and CAH's services. Two USDA loans and community funding raised through the CAH's foundation helped to fund the new facility. The FQHC leases space at the facility.

New Co-located Facility
(Sakakawea Medical Center)

Increased Screening Rates: Screening rates have improved for breast, cervical and colorectal cancers. In 2016, the FQHC received the National Colorectal Cancer Roundtable '80% by 2018' National Achievement Award Grand Prize for its collaborative efforts to improve colorectal cancer screening rates.

Strengthened Financial Positions: Accrued cost savings between the CAH and FQHC were observed soon after implementation of the shared CEO structure. Over time, both organizations have strengthened their financial positions. As shown in Figure 9, the two organizations continue to experience overall improvement in net margins and cash-on-hand.

Figure 9. Financial Outcomes Associated with Collaboration and Coordination (Case Study 2)

	Before Collaboration (2011)	After Collaboration (2017)
Critical Access Hospital		
Cash-on-Hand	64 days	84 days
Net Margins	.8%	4.2%
Federally Qualified Health Center		
Cash-on-Hand	8 days	203 days
Net Margins	-11%	10.9%

Peer Advice

Case Study 2 stakeholder's advice to rural stakeholders interested in their collaborative efforts:

"Do what's in the best interest of your community and don't take "no" for an answer."

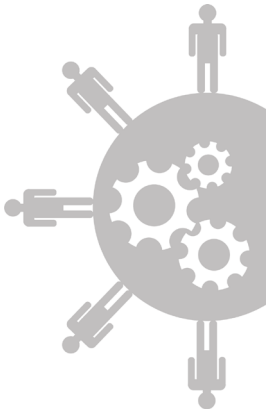
— CAH Leadership

"Understand and learn about your potential partner organization's requirements; don't let personalities get in the way."

— FQHC Leadership

On expanding PCMH outside the FQHC to involve other providers in the community: "Engaged leadership support and commitment is essential."

—FQHC and CAH Leadership



Appendix I. Acronyms List

AAA – Area Agency on Aging
ACO – Accountable Care Organization
CAH – Critical Access Hospital
CDFI – Community Development Financial Institution
CHA – Community Health Assessment
CEO – Chief Executive Officer
CHIP – Community Health Improvement Plan
CHNA – Community Health Needs Assessment
CHW – Community Health Worker
CMHC – Community Mental Health Center
CMO- Chief Medical Officer
CMS – Centers for Medicare & Medicaid Services
DSH – Disproportionate Share Hospital
ER/ED – Emergency Room/Emergency Department
EHR – Electronic Health Record
FQHC – Federally Qualified Health Center
HD – Health Department
HIT – Health Information Technology
HPSA – Health Professional Shortage Areas
HRSA – Health Resources and Services Administration
LHD – Local Health Department
MDH – Medicare-Dependent Hospital
MOU – Memorandum of Understanding
NCQA – National Committee for Quality Assurance
NP – Nurse Practitioner
PCMH – Patient-Centered Medical Home
PHA – Public Housing Authority
PHAB – Public Health Accreditation Board
PPS – Prospective Payment System
RHC – Rural Health Clinic
RRC – Rural Reference Center
SAMHSA – Substance Abuse and Mental Health Services Administration
SORH – State Office of Rural Health
SNF – Skilled Nursing Facility
T/TA – training and technical assistance
UDS – Uniform Data System

Appendix II. Information Resources

Brief Description: The following table lists publically available information resources organized by relevant Elements (1-4) that were described in Section 2 of the Guide.

Information Resources	Element 1	Element 2	Element 3	Element 4
Accountable Care Organizations				
Accountable Care Organizations: General Information *Source: Centers for Medicare & Medicaid Services* ACO Model Implementation Considerations *Source: Rural Health Information Hub*	✓			
Behavioral Health, Substance Abuse Programs, Providers, and Issues				
SAMHSA Behavioral Health Treatment Services Locator Substance Abuse Facilities Data (N-SSATS) Mental Health Facilities Data (NMHSS) Community Mental Health Services Block Program (MHBG) Substance Abuse Prevention and Treatment Block Grant (SABG) Block Grants Points of Contact (by State) Population Data/National Survey on Drug Use and Health (NSDUH) *Source: Substance Abuse and Mental Health Services Administration*	✓			
Community Mental Health Centers *Source: Centers for Medicare & Medicaid Services*	✓			
HRSA.data.gov: Mental Health Professional Shortage Areas *Source: Health Resources and Services Administration*	✓			
Rural Mental Health Substance Abuse in Rural Areas *Source: Rural Health Information Hub*	✓			
Long Term Care Facilities, Programs and Issues				
Find a Long-Term Care Hospital Find a Nursing Home Find a Hospice Agency Find Home Health Services Long Term Care Facilities Regulations and Guidance Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities Swing Bed Providers *Source: Centers for Medicare & Medicaid Services*	✓			
Rural Long-Term Care Facilities Rural Hospice and Palliative Care *Source: Rural Health Information Hub*	✓			

Information Resources	Element 1	Element 2	Element 3	Element 4
Primary Care Facilities, Programs, and Issues				
Health Center Program Compliance Manual Health Center Program Health Center Program Look-Alikes Health Professional Shortage Areas – Finder Tool *Source: Health Resources and Services Administration*	✓			
Federally Qualified Health Center *Source: Centers for Medicare & Medicaid Services* Additional Information (Federally Qualified Health Centers) *Source: Rural Health Information Hub*	✓			
Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care *Source: Agency for Healthcare Research and Quality*	✓			
PCMH Accreditation Programs: NCQA Patient-Centered Medical Home Recognition Program (NCQA) *Source: National Committee for Quality Assurance (NCQA)* AAAHC Medical Home accreditation (AAAHC) *Source: Accreditation Association for Ambulatory Care* The Joint Commission (TJC) *Source: The Joint Commission* State-specific PCMH Programs: Medical Home Collaborative (Idaho) MO HealthNet Primary Care Health Home Initiative (Missouri) Patient-Centered Primary Care Home Program (Oregon) Other PCMH Activities: HRSA Accreditation and Patient-Centered Medical Home Recognition Initiative *Source: Health Resources and Services Administration* Safety Net Medical Home Initiative's Change Concepts *Source: Safety Net Medical Home Initiative*	✓			
Rural Health Clinics *Source: Centers for Medicare & Medicaid Services* Rural Health Clinics *Source: Rural Health Information Hub*	✓			
Telehealth Services *Source: Centers for Medicare & Medicaid Services* Medicare Telehealth Payment Eligibility Analyzer *Source: Health Resources and Services Administration*	✓			

Information Resources	Element 1	Element 2	Element 3	Element 4
Hospitals				
Critical Access Hospitals Sole Community Hospitals Medicare Dependent Hospitals Disproportionate Share Hospitals *Source: Centers for Medicare & Medicaid Services* Additional Information (Critical Access Hospitals) Rural Hospitals *Source: Rural Health Information Hub*	✓			
Rural Referral Centers *Source: Health Resources and Services Administration*	✓			
Public Health				
Health Department Resources Behavioral Risk Factor Surveillance System – Survey Data and Documentation *Source: Centers for Disease Control and Prevention*	✓			
Directory of Local Health Departments *Source: National Association of County and City Health Officials* State Health & Human Services Finder *Source: HHS Office of Disease Prevention and Health Promotion*	✓			
Nationally Accredited Health Departments *Source: Public Health Accreditation Board*	✓			
Rural Public Health Agencies Health Extension Rural Offices *Source: Rural Health Information Hub*	✓			
Economic and Organizational Development				
Capital Funding for Rural Healthcare Community Vitality and Rural Healthcare *Source: Rural Health Information Hub* Rural Economic Development *Source: National Rural Health Association*	✓			
Academic Health Departments *Source: Public Health Foundation*	✓			
Rural Economic Development Loan & Grant Program Rural Community Development Initiative Grants *Source: U.S. Department of Agriculture*	✓			
Rural Economic Development Resource Directory Community Development Financial Institutions *Source: U.S. Department of the Treasury*	✓			
Housing				
Find your Local Public Housing Agency *Source: U.S. Department of Housing and Urban Development*	✓			
Rural Housing Service Single Family Housing Repair Loans & Grants *Source: U.S. Department of Agriculture*	✓			

Information Resources	Element 1	Element 2	Element 3	Element 4
Community-based Organizations				
National Rural Organizations with an Interest in Health Community and Faith-based Initiatives *Source: Rural Health Information Hub*	✓			
Sharing a Legacy of Caring: Partnerships between Health Care and Faith-Based Organizations *Source: Georgetown University; HRSA Bureau of Primary Health Care*	✓			
Eldercare Locator (includes Area Agencies on Aging) *Source: HHS Administration on Aging*	✓			
Community Needs Assessments				
Getting Started on Applying for PHAB Accreditation *Source: Public Health Accreditation Board*	✓	✓		
Community Health Assessments & Health Improvement Plans *Source: Centers for Disease Control and Prevention* Community Health Assessment Toolkit *Source: Association for Community Health Improvement* Community Health Needs Assessments *Source: Association of State and Territorial Health Officials*	✓	✓		
Conducting Community Health Needs Assessments in Rural Communities: Lessons Learned. Karin L. Becker, MA. Health Promotion Practice. Vol 16, Issue 1, pp. 15-19. October 17, 2014.	✓	✓		
Conducting Community Health Needs Assessments: A Ten- Step Process. *Source: Center for Rural Health, University of North Dakota School of Medicine & Health Sciences*	✓	✓		
Leadership				
Practical Playbook *Source: deBeaumont Foundation; Duke Community & Family Medicine; Centers for Disease Control and Prevention*		✓		
Lifelong Leadership Inventory *Source: National Center for Healthcare Leadership*		✓		
Strategy Development				
The Hospital Guide to Reducing Medicaid Readmissions Clinical-Community Linkages Integrating Primary Care Practices and Community-based Resources to Manage Obesity A Bridge-building Toolkit for Rural Primary Care Practices *Source: Agency for Healthcare Research and Quality*			✓	
Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries *Source: Centers for Medicare & Medicaid Services*			✓	
What Works? Strategies to Improve Rural Health *Source: Robert Wood Johnson Foundation*			✓	
Rural Care Coordination *Source: Rural Health Information Hub*			✓	

Information Resources	Element 1	Element 2	Element 3	Element 4
Measures				
Accountable Care Organization (ACO) 2018 Quality Measures: Narrative Specifications Document Quality Measures *Source: Centers for Medicare & Medicaid Services*			✓	
Emerging Trends in Care Coordination Measurement Care Coordination Measures Atlas Update Care Coordination Measures Database Types of Quality Measures Measures of Quality for Different Health Care Settings *Source: Agency for Healthcare Research and Quality*			✓	
Measures *Source: Institute for Healthcare Improvement*			✓	
Technical Assistance				
Centers for Medicare & Medicaid Services: Rural Health Open Door Forum CMS Regional Office Rural Health Coordinators				✓
Health Resources and Services Administration: Rural Health Research Gateway National Rural Health Resource Center National Cooperative Agreements State/ Regional Primary Care Association Health Center Controlled Network Office of Regional Operations				✓
National Association for Rural Mental Health				✓
National Rural Health Association				✓
National Organization of State Offices of Rural Health				✓
Association of State and Territorial Health Officials				✓
National Association of County and City Health Officials				✓
National Association of Community Health Centers				✓
National Council for Behavioral Health				✓
National Association of County Behavioral Health & Developmental Disability Directors				✓
National Association of Local Boards of Health				✓
Public Health Foundation				✓
The National Center for Complex Health and Social Needs				✓
United States Department of Agriculture Rural Development				✓
Substance Abuse and Mental Health Services Administration; **Health Resources and Services Administration:** SAMHSA – HRSA Center for Integrated Health Solutions				✓

Element 1 Tool: Potential Partner Organization Inventory (Sample Template)

Brief Description: The following is a sample template to help organize a list of potential partner organizations based on review of your current patient population need(s).

						Partner Organization Type													
No.	**Brief Title** *Identified Patient Population/ Community Health Need*	**Brief Description** *Identified Patient Population/ Community Health Need*	**Organization** *Potential partner to collaborate/ coordinate*	**Organization Point of Contact Name**	**Title/Role**	**Local Business**	**Education**	**Faith-Based Org.**	**Agriculture**	**Health care**	**Public health**	**Social service**	**SDOH***	**Law Enforcement**	**Econ. Dev.***	**Political leader**	**Consumer Org.**	**Other**	**Notes for Follow-Up**
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
13																			
14																			
15																			
16																			
17																			
18																			
19																			
20																			

* SDOH = Social Determinants of Health; Econ. Dev.= Economic Development

Element 3 Tool: Questions to Facilitate Collective Discussions with Potential Partners

Brief Description: These questions can help guide group brainstorm discussions with potential community partners (e.g., during the community health needs assessment process).

Topic Area	Discussion Questions
Needs Better Addressed through Collaboration/ Coordination	Are there any identified needs that would be best addressed through collaboration and/or coordination with other organizations? *If yes:* • What are these needs? Why would it be more appropriate to collaborate/coordinate on these needs? • What partners should be involved (to address these needs) and why? • Are there additional organizations that need to be engaged? • What is/are the most appropriate solution(s) to address this community need(s)?
Address Unproductive Duplication of Efforts	Are there any unproductive duplication of efforts that any of us might be involved in that could be best addressed through collaboration and coordination to improve efficiencies (e.g., better use of resources) and better serve needs of our shared community/shared patient populations? *If yes:* • What are these areas? • In what ways could we collaborate and coordinate?
Leveraging Strategies and Existing Resources	Are there existing resources (e.g., fiscal and/or non-fiscal, programmatic strengths, technical capabilities) among the collaborating organizations that could be leveraged to better address our shared patient population's needs? *If yes:* • What are these areas? • In what ways could we collaborate and coordinate?
Expected Partner Benefits	• What benefits can prospective partners expect to result from participating in potential collaborative or coordinative strategies (identified as a result of discussing previous questions listed above)?
Shared Goals, Objectives	• If we work together to address any identified need(s), what are our shared goals and objectives?
Local Strategy, Solutions	• What strategy(ies) or solution(s) do we agree to implement? • Are there any evidence-based strategies or solutions that can be modified or adapted to address the identified need(s)?
Measurement	• How can we measure success of the selected collaborative/coordinative strategy(ies) or solution(s)? • What measures (e.g., process, outcome, impact) can help us monitor and inform implementation of strategies? Are there any measures already in use that can be leveraged? • How often should organizations monitor and track performance? • What level of effort is involved in reporting on these measures? • Who will be responsible for data collection and reporting?
Resources	• Are there any resources (fiscal or non-fiscal) that can be leveraged to support implementation of the identified strategy(ies) or solution(s)? • Do we need to apply for external resources (e.g., grants)? If yes, what is the application process and level of effort required? Who will lead and manage this?
Implementation Structure and Management	• How should implementation of strategies be structured? Who will be involved? How will it be managed and by whom? • What will be the process for guiding continuous improvement?

Appendix III. Case Studies

NOTE: This section includes comprehensive information about each case study discussed in Section 3 of the Guide. These stand-alone case studies were developed for rural health leaders to print and share with other stakeholders in their respective communities to help kick off discussions focused on collaboration/coordination.

Case Study 1 | Missouri

Motivation for Collaboration and Coordination

Two main factors motivated collaboration and coordination in this rural Missouri community:

1. ***Local planning revealed unmet health care needs.*** In 2003, the planning for a senior center in Lafayette County identified an array of unmet health care needs (for example, provider shortages, oral health, transportation, and disease prevention) that exceeded what a senior center could address. These unmet needs served as the impetus for establishing a Rural Health Network.

2. ***State-funded study revealed gaps in social services.*** The Missouri Department of Health and Senior Services funded a county-level study using the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS). BRFSS findings revealed barriers to care and gaps in services in the network's five-county service area, which motivated the Rural Health Network to identify and implement programs to that address the social determinants of health needs of its patient population. Today, these programs are considered the network's core programs.

Provider and Partner Organizations Involved

For the purposes of this case study summary, the Health Care Coalition of Lafayette County (HCC) is referred to as the "Rural Health Network." The following provider and partner organizations were instrumental in the development of the Rural Health Network and/or in the Rural Health Network's efforts to address the social determinants of health needs of its patient population:

- ***Local Health Department (LHD):*** The Lafayette County Health Department (Lexington, MO), an independent local health department, provides 15 public health services programs. All programs work directly with the Missouri Department of Health and Senior Services through contracts to deliver public health services.[22]
- ***Critical Access Hospitals (CAHs):***
  Lafayette Regional Health Center *(LRHC)* (Lexington, MO), a for-profit 25-bed CAH, is part of Health Corporation of America (HCA) Midwest Health, a network of hospitals in Kansas City and surrounding areas. LRHC offers emergency care, imaging and testing services, a full range of general and laparoscopic surgeries, and more than 20 medical specialties.

  Carroll County Memorial Hospital *(CCMH)* (Carrolton, MO), is a not-for-profit 25-bed CAH offering a range of services including cardiac rehabilitation, cardiopulmonary, home health, laboratory, nursing (acute care services), nutrition, outpatient specialty services, pharmacy, pulmonary, radiology services, rehabilitation services, and a sleep laboratory.
- ***Behavioral Health:*** Compass Health-Pathways is a not-for-profit health care organization that provides a full continuum of behavioral health services as well as primary care and dental health services throughout Missouri and Louisiana. Its Pathways Community Health

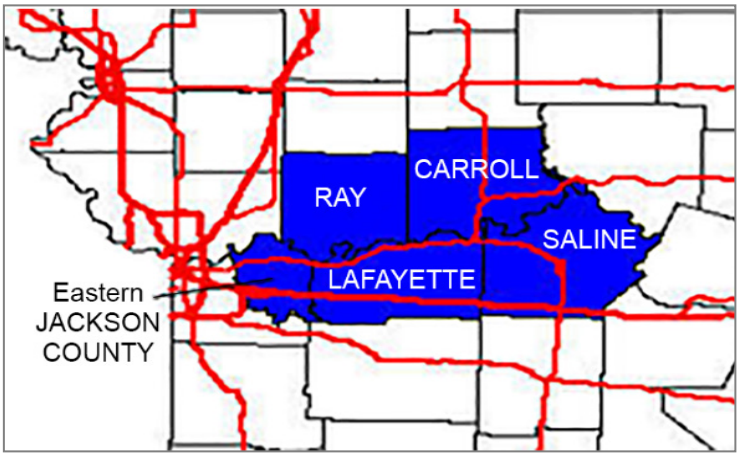
is a community mental health center and an FQHC, which has a 13-county catchment area that covers the Rural Health Network's service area.

- ***Aging Services:*** Care Connections for Aging Services, headquartered in Warrensburg, MO, is a not-for-profit local Area Agency on Aging (AAA) serving 13 west-central Missouri counties through 22 senior centers that provide services and resources to help seniors live with independence, respect, and dignity. CCAS operates the Margaret Gray Senior Center in Lexington, MO.

Geographical Reach

The Rural Health Network's service area covers approximately 2,700 square miles and 133,000 people (see Figure 1). The service area encompasses all or part of five counties: Lafayette (53 people/sq. mile), Carroll (13 people/sq. mile), Saline (40 people/sq. mile), Ray (40 people/sq. mile) and the eastern rural part of Jackson County.[23] Approximately 25,000 people, or 32 percent of the service area's residents, live at or below 200 percent of the Federal Poverty Level (FPL).[24] The most populous portion of the service area is Lexington, MO in Lafayette County, which is approximately 50 miles east of Kansas City, MO.

Figure 1. Geographical Service Area of Case Study 1



History of Collaboration

The collaboration and coordination activities in this community date back to a 2003 planning process for the senior center in Lexington, MO. This process included a thorough needs assessment (funded by the Missouri Department of Health and Senior Services and its State Office of Rural Health) that identified numerous unmet needs in Lafayette County. The needs assessment served as a catalyst for the local health department (Lafayette County Health Department) to develop an informal county coalition to improve health care access for residents. Founding member organizations of the coalition represented the following sectors:

- Economic development
- Public health
- Health care
- Behavioral health providers
- Social services
- Education

The coalition's members sought grant support to fund a variety of projects to address the health care needs of Lafayette County. The local AAA, Care Connection for Aging Services, led the initial planning for a senior center that eventually resulted in the establishment of the Lexington 4-Life Center, which combines a senior center, health center, and child day care center to address the health care needs of the community across the lifespan. The Lexington 4-Life Center provides health care and related services, early childhood education, senior services, transportation, and meal services. Today, a representative from the Center serves as part of the Rural Health Network's executive board.

Strategy #1: Create a Rural Health Network

WHO?

- ✓ CAHs (2)
- ✓ FQHC
- ✓ Local Health Department
- ✓ Local Area Agency on Aging
- ✓ Behavioral Health (CMHC)
- ✓ Economic Development
- ✓ Domestic Abuse Agency

WHAT?

- ✓ Development of a Rural Health Network to address unmet health care needs
- ✓ Needs assessments
- ✓ Network structure (501c3)
- ✓ FQHC designation with 4 clinic sites

WHY?

- ✓ Address unmet health care needs identified as a result of a needs assessment to plan a senior center.

Community-driven Collaboration and Coordination Strategies and Outcomes

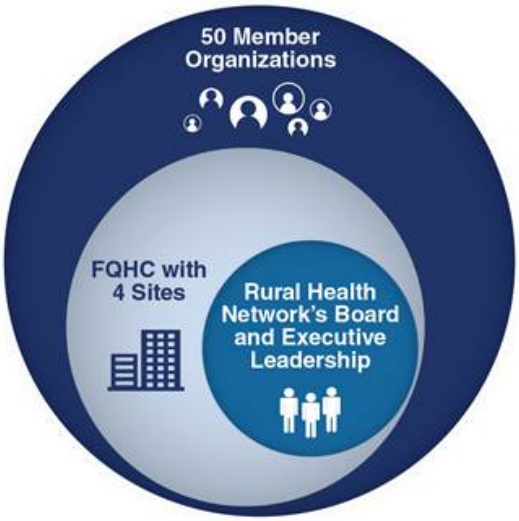
The two strategies used in this rural area of Missouri include creating a Rural Health Network (Strategy 1) and working collaboratively with others in the community to address social determinants of health needs of the Rural Health Network's patient population (Strategy 2).

STRATEGY 1: Create a Rural Health Network*

The Rural Health Network's mission is to cultivate partnerships and deliver quality health care to strengthen its rural communities. Its other primary focus is to develop and implement programs that are innovative, integrated, and responsive to the health care needs of its residents.[25]

The network's leadership describes the network as a living cell with three layers (see Figure 2). The nucleus is the network's leadership and 10-member executive board, who represent the health care and other non-health sectors in the community.† The second layer is the FQHC with its four sites, which supports implementation of the network's programs. As an FQHC, the HCC improves access to care and addresses the social determinants of health needs for its patients in the five-county service

Figure 2. Rural Health Network's Key Components



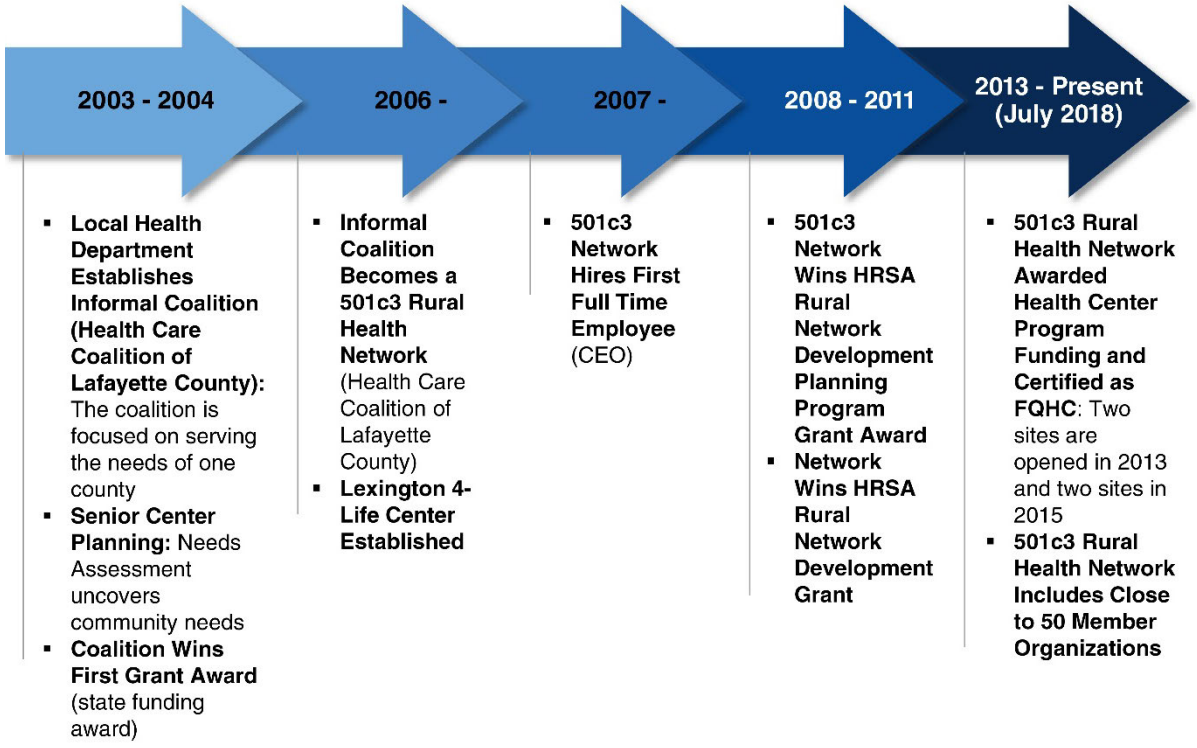
* The Health Care Coalition of Lafayette County (HCC) is referred to as the "Rural Health Network" or "the network."
† Rural Health Network Board activities are separate from the Health Center Board to ensure compliance with Health Center Program requirements.

area. The external layer comprises more than 50 provider and community-based member organizations that complement and support the network's provision of health care and social services.

The Rural Health Network's Incremental Development. The network's growth has been incremental, both organizationally and financially. Since 2003, it has evolved from a coalition with just under 10 members serving one county to a not-for-profit corporation covering five counties with approximately 50 partners and 70 staff members.[26] Each incremental step in the network's development has been strategic and motivated by community need. Figure 3 illustrates the network's major milestones in its development from an informal coalition to a 501c3 corporation. After planning for the senior center, the coalition applied for and received State grant program funding to support a collaborative approach in the consolidation of health care services at the county level (Primary Care Resources Initiative for Missouri, PRIMO). The coalition used the grant to address provider shortages and improve access to oral health care, which were previously identified as unmet needs in Lafayette County.

Between 2003 and 2006, the coalition increased its visibility and community involvement. The network's early success in obtaining funding (Lexington 4-Life Center, state grant) helped to generate synergy among the coalition members, which led to the coalition to formalize itself as a 501c3 not-for-profit organization so they could pursue other funding opportunities to help support the network's growth and sustainability.

Figure 3. Rural Health Network's Incremental Development (2003-Present)



The network members' commitment grew over time, facilitated by the network's culture of transparency and leadership involvement. An executive-level representative from each health care provider was seated at the board table. As a result, the group could make network decisions quickly and focus on the best interest of the community rather than their respective organizations. "What's in it for me?" conversations helped founding members uncover differences in opinion rather than gloss over them. These discussions helped solidify a collective belief among the group that no single organization can address the needs of its community more effectively than a unified group of organizations.

After the coalition incorporated, it continued to pursue funding that required collaborative approaches to address local needs, including two Health Resources and Services Administration (HRSA) grants that were instrumental in the network's early development: the Rural Health Network Development Planning Program and Rural Health Network Development Grant Program. These HRSA grants helped to develop the Rural Health Network and to hire its first full-time employee, a Chief Executive Officer (CEO). Hiring a CEO accelerated implementation of the network.

At about this time, the organizations outside of Lafayette County expressed interest in working with and joining the network. The network's CEO attributed the membership's growth to changes in the health care landscape that focused on value-based health care and expanded interest in the social determinants of health. The network went from serving one county (Lafayette County) to an additional four counties and filed for a "doing business as" (dba)* registration as the Health Care Collaborative of Rural Missouri to reflect its expanded service area. Support from private health care foundations helped cover initial operating costs for this larger network. As the network's membership grew, so did the network's capacity to bring in new funding streams to support implementation of programs. For example, from 2007 to 2016, the network received over $3.5M in HRSA grant funding in addition to consistent funding from private health care foundations and other local organizations.

Shortly after receipt of the first HRSA grant in 2007, a needs assessment for the network's five-county service area uncovered extensive health care needs. In response, the coalition determined that establishing a health center operating a number of sites was a scalable, long-term solution to help address the population health needs of the community. The network, as the Health Care Coalition of Lafayette County (HCC), was awarded a Health Center Program grant in 2013, which enabled the organization to become an FQHC. Implementation of the coalition's FQHC strategy required support from member organizations. For example, one of the network's founding members, Lafayette Regional Health Center (a Critical Access Hospital), transferred ownership of two of its hospital-based RHCs to be

Having transparent discussions with members on "what's in it for me?" were essential to establishing trust and commitment among members.

– Anonymous, Founding Member Organization, reflecting on the incremental growth of the Rural Health Network

* The Rural Health Network's legal name is *Health Care Coalition of Lafayette County* and its "doing business as" name is *Health Care Collaborative of Rural Missouri.*

included in the network's initial Health Center Program grant application through a HRSA New Access Point funding opportunity. The CEO of the CAH believed these two clinics could make more of a community impact as part of an FQHC than as RHCs. Later in 2015, the network was awarded additional Health Center Program grant funding through a HRSA New Access Point funding opportunity. They added two more sites, one of which had previously been a hospital-based RHC with the Carrol County Memorial Hospital (a CAH and also a Rural Health Network member organization), to address overutilization of its ER for primary care services.

Outcomes of Strategy 1 (Create a Rural Health Network): The network's membership grew substantially after establishing the FQHC. Having achieved some size and stability, the network is working to monitor outcomes and performance (see Exhibits 1 and 2) a various levels (e.g., clinical, financial, organizational, and workforce). The network hopes that by analyzing and sharing outcome data, it will demonstrate the network's value to its members and larger community and both strengthen existing partnerships and create new ones. For this purpose, the network has used tools like the Baldrige Excellence Framework, an evidence-based model that facilitates organizational performance improvement. The network's focus on improving its performance coincides with the health care landscape's heightened focus on reducing costs and improving clinical outcomes.

The Rural Health Network's board, with the support from an external evaluator consultant, developed key performance indicators (KPIs; see, Exhibit 1). KPIs are displayed in a dashboard updated monthly and presented at network board meetings.

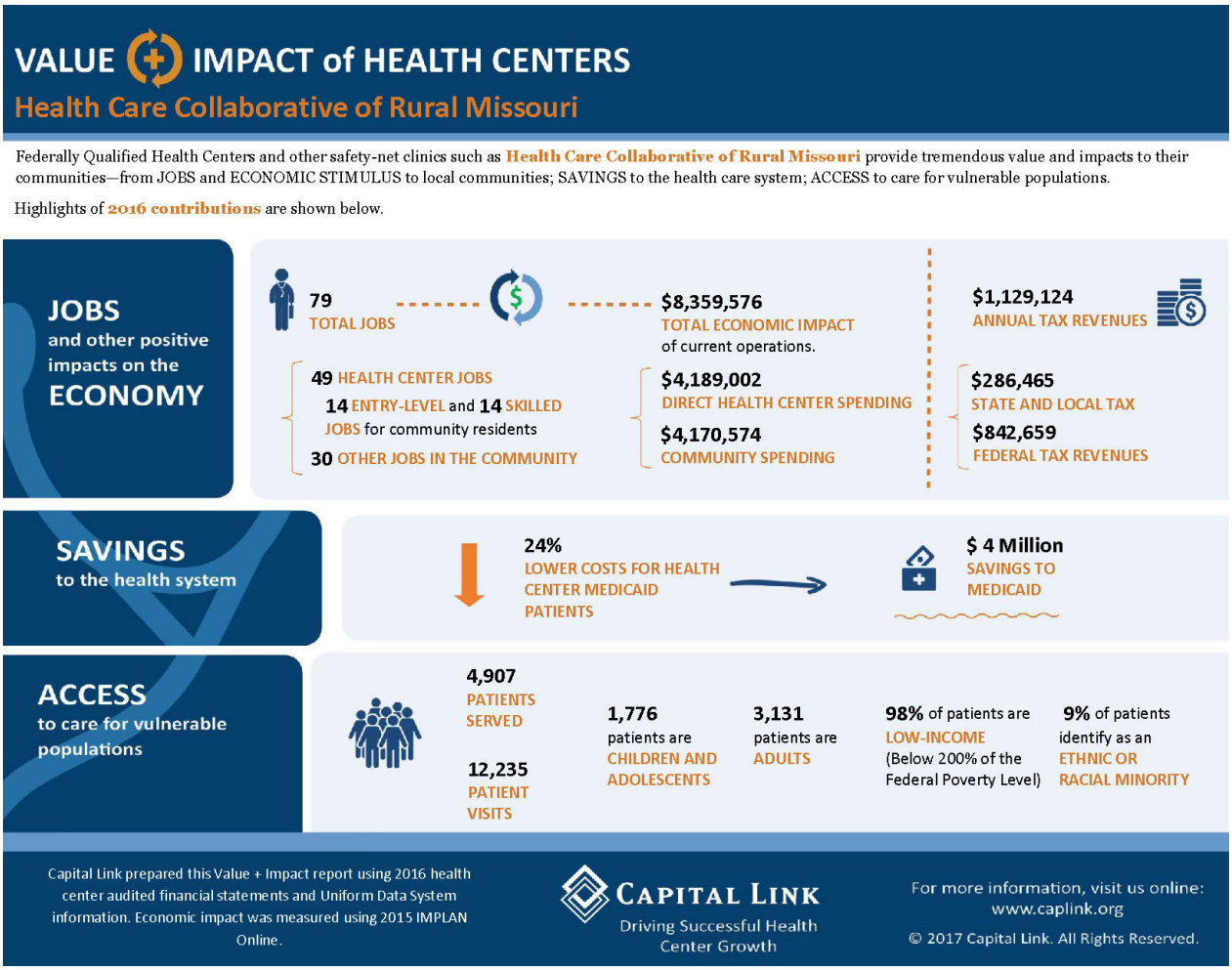
Exhibit 1. Rural Health Network's Key Performance Indicators and Outcomes[27]

Goals	Key Performance Indicator Brief Description	Outcome Measures and Outcomes (as of 2016)*
Market & Strategy Driven	• Intentional Collaborative Relationships • Increased Community Resources	• # of co-locations (1 in 2016 to 2 in 2018) • # of network member interactions to support delivery of Network services • # of unique website page views
Fiscally Responsible Organization	• Clinical Services • Network Membership	• 59 days cash on hand • 20 NET Days in Receivables • 2.8 Net Asset Ratio (GOALS)†
Excellent Place to Work	• Staff Retention & Recruitment • Increased Voluntary Retention • Increased Employee Satisfaction	• Retained 80% of staff • 85% of staff reported satisfaction on annual survey
Valued & Competent Health care Provider	• Patient Satisfaction Survey • Medicaid Encounters • Uniform Data System (UDS) Encounters	• 80% Patient Satisfaction on annual survey • 20% increase in 2016 Medicaid encounters • 25% Increase in UDS encounters
Rural Health Network Leader	• National Leadership	• Number of leadership roles held by staff and board in community, state, regional, and national organizations • Recognized as leader locally, regionally, and nationally

* Outcomes described reflect the Rural Health Network's 2016 data except for number of co-locations; these data are from 2018. Data were not available (at the time this Guide was developed) for certain measures listed under the *Market & Strategy Driven* and *Rural Health Network Leader* Goals.
† The Rural Health Network's goal for 2016.

The network annually studies its impact in the community with support from the Missouri State Primary Care Association and Capital Link. All health centers in Missouri have access to these reports (as shown in Exhibit 2). Capital Link provides training and technical assistance to support health centers in planning capital projects, financing growth and identifying ways to improve performance.

Exhibit 2. Impact Report: Health Care Coalition of Lafayette County[28]



STRATEGY 2: Collaboratively Address Social Determinants of Health

The Missouri Department of Health and Senior Services funded a state-wide county-level study using the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The network leveraged these data and identified gaps in services that focused on social determinants of health needs. These findings informed implementation of programs and services to help address these needs. Today, these programs are considered the network's core programs and are integrated in all services the network provides for its patients. The network's social determinants of health programs include:

Warehouse Resources Hub. The network rents a large warehouse space at a discount from one of its member organizations to store goods (e.g., medical supplies, laundry detergent, personal hygiene items, and mattresses). The warehouse receives in-kind donations from department stores and trucking companies. All goods are distributed to populations in need within 90 days through two network programs – the Connector's Program and Project Connect.

Strategy #2: Collaboratively Address Social Determinants of Health

WHO?

- ✓ Rural Health Network (including its 50 member organizations and community-based organization partners)
- ✓ Community volunteers
- ✓ Missouri Valley Community Action Agency (VCAA)

WHAT?

- ✓ Warehouse Resources Hub: Used to enhance delivery of services to address barriers to care and social determinants of health.
- ✓ Connector's Program: A workforce development program designed to support community–based care coordinators/case managers to effectively refer patients to social service supports and other services that address social determinants of health needs.
- ✓ Project Connect: One–day public health clinic events to address social determinants of health needs of the underserved and uninsured.

WHY?

- ✓ Address barriers to care identified via analysis of CDC's BRFSS data.

Connectors Program. The "Connectors Program" originated in Arkansas and was adapted by the network and two other community-based organizations in the network's service area: Missouri Valley Community Action Agency and Compass Health - Pathways (a community mental health center and FQHC). The program launched in 2014.

Through the program, patients identified by one of the network's clinics or member organizations as having social determinants of health needs are immediately linked to appropriate services with a warm hand-off. Services may include help to pay a utility bill, getting a mattress, or assistance with applying for food stamps. The program's approach is to meet the patient where he or she is. A network representative follows up within 30 days to ensure that the patient received the needed items or services and to see whether any additional services are needed.

The network trains case managers, care coordinators, and community health workers employed by the network's member organizations to be "Connectors" and provides tools and coaching to support them. Examples include:

- *Services Directory:* The network manages and regularly updates a directory for Connectors to connect patients with services to address any social determinants of health needs.
- *Monthly Connector Meetings*: The network conducts monthly Connectors' meetings to provide any training or updates on new services or changes to care coordination processes.

"The Connectors Program makes connectors' jobs easier by putting together the resource guides and the formalized follow-up process."

– Anonymous, Provider Staff, reflecting on the benefits of the Connector's Program

The Connectors Program has been well received by provider organizations because it helps streamline network member organizations' previous efforts to connect people to needed services. Before the program was established, member organizations had to conduct their own internet searches and make phone calls to connect patients with services.

The Connectors Program runs at minimal cost and entirely with existing staff. The primary costs include updating and printing the directory of services and the staff time of those who facilitate the program (scheduling and conducting meetings and compiling meeting notes). All other resources, such as meeting space, are in-kind donations by member organizations. Only network member organizations can participate in the Connectors Program.

Initial seed money for the Connectors Program came from a local health care foundation after the foundation revised its strategy for funding rural health programs and initiatives from funding prescribed projects to flexible funding opportunities, which allowed rural organizations to develop creative solutions to address locally identified needs. The foundation awarded the network approximately $225,000 over 3 years for the Connectors Program and continues to support the program as needed.

Project Connect. Project Connect is a public health clinic event that connects underserved and uninsured adults and families with needed resources and services (health care, enabling, and social services). This program complements the Connectors Program and uses the Warehouse Resources Hub, when necessary. All services are delivered at no cost to local residents in need. The project conducts at least three public health events each year in different communities located in the Rural Health Network's five-county service area.

At these events, attendees (guests) are paired with volunteers from the community who serve as guides. They ensure that guests receive appropriate care and services while at the event. To identify guests' social determinants of health needs, the network uses an instrument developed by and for health center stakeholders called the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). PRAPARE is used by volunteers to help gather information to understand guests' social determinants of health needs. The information collected is used to inform what care the guest should receive while at the Project Connect event. Depending on the guest's needs, they may receive vouchers to access services during or after the event, such as a flu shot, assistance in signing up for food stamps, or a state ID or driver's license from the local Department of Motor Vehicles. Guests can also sign up for health insurance coverage. Local governmental officials often attend these events to show their

support. After each event, the Rural Health Network staff follows up with all guests within 30 days to ensure they received the care and resources needed.

Key components and resources used to conduct these Project Connect events include:

- Links to network services:
  - *Clinical Staff*: A physician and nurse (from one of the network's clinics) provide health care services. The network's mobile dental unit provides oral health services.
  - *Community Organizations*: The Rural Health Network's 50 member organizations and other community-based organizations provide an array of in-kind services.
  - *Vouchers:* The vouchers are the largest expense associated with these events; sponsorships usually help cover these costs. Historically, local health care foundations have covered these costs, which have been approximately $5,000 per event.
- Guides: Community volunteers help guests obtain the care they need during an event.
- Planners: At least two network staff members are extensively involved in planning the event. The staff facilitates involvement of the local community that will be hosting the event to encourage community ownership of the event. The hosting community often has a planning committee as well.
- Lunch: All guests receive a free lunch at the event.

Outcomes of Strategy 2 (Collaboratively Address Social Determinants of Health): The network is still exploring what outcomes best reflect their efforts to address social determinants of health needs of their patients. The network plans to use PRAPARE data to inform further development of network programs similar to the way it uses needs assessment data. In addition, the PRAPARE data will support the Missouri Primary Care Association to describe the complexity of health center patients and their needs to relevant stakeholders. The following illustrates the impact of the network's programs to address the social determinants of health:

Warehouse Resources Hub:

- As of August 2017, the Rural Health Network donated $1,000,000 worth of goods and services to its patients.

Connectors Program:

- 2014: 60 local residents assisted with 130 patient encounters.
- 2017: 550 local residents assisted with 3,900 patient encounters.

Project Connect:

- An average of 125 people register for each event, and approximately 300 people receive services (includes adults registered and their families).

For Additional Information, Contact:

Case Study #1 (Missouri) | Point of Contact:
Toniann Richard, Executive Director, Health Care Coalition of Lafayette County
Email: toniann@hccnetwork.org

Case Study 2 | North Dakota

Motivation for Collaboration and Coordination

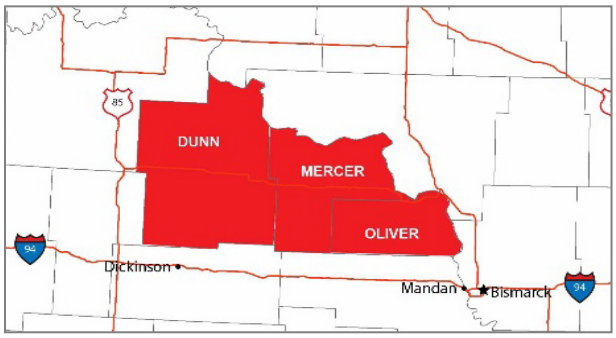
Organizational and national-level factors motivated provider organizations in this North Dakota community to thoughtfully consider collaboration and coordination to better serve their patient populations.

1. ***Ending a Long-Standing Competitive Relationship.*** Despite limited resources, a Critical Access Hospital (CAH) and a Federally Qualified Health Center (FQHC) in the same community had competed for many years with one another for patients, services, and workforce, leading to duplication of services, poor workforce morale, and financial inefficiencies. Both organizations provided primary care services, ancillary services (e.g., radiology, CT scan, physical therapy, ultrasound, bone density, and stress testing), wellness programs, and occupational health services for local businesses. Leaders at both organizations often engaged in misguided initiatives to increase market share. All of these efforts compounded over time and led to financial strain and animosity between the organizations. This situation eventually became too onerous for the organizations to manage. In 2011, acute financial and workforce-related challenges motivated the FQHC to reach out to the CAH for leadership support. The two organizations decided to work together to meet the health needs of the community, eliminate their unproductive competition, and position themselves for a health care environment focused on value-based care.
2. ***Collaborating to Conduct Community Health Needs Assessment.*** The Internal Revenue Service (IRS) implemented regulation revisions (effective March 2012) requiring 501c3 nonprofit hospitals to complete a community health needs assessment (CHNA) at least once every three years and adopt an implementation plan. Health Center Program grantees and health departments are also required to complete similar community-based needs assessment activities to be responsive to organizational requirements (see Figure 2 in Section 2). These regulation revisions complemented the shared aims of the CAH and FQHC to work together and collaborate with other providers in the community.

Geographical Reach

The health care service areas of the CAH and FQHC (see Figure 1) span three counties (Mercer, Oliver, and Dunn) and four cities (Beulah, Hazen, Killdeer, and Center) in west-central North Dakota. The cities of Beulah and Hazen are nine miles apart. The service area has a total population of 13,800 and covers about 3,900 square miles.[29] Two of the three counties are sparsely populated, with fewer than three people per square mile.[30] The

Figure 1. Geographical Service Area of Case Study 2



service area is bordered to the north by Lake Sakakawea and to the south by Interstate 94. The closest major population center is Bismarck, ND, which has a population of 72,000 people and is approximately 100 miles from the center of the service area.[31]

Provider and Partner Organizations Involved

The origins of collaboration and coordination in this North Dakota area began with the CAH (Sakakawea Medical Center) and the FQHC (Coal Country Community Health Center). The collaborative efforts of these two organizations flourished and led to meaningful collaboration with other local area providers. The organizations relevant to this case study are:

- **Critical Access Hospital (CAH)**: Sakakawea Medical Center (SMC), a 13-bed CAH, is an independent not-for-profit organization located in Hazen with 130 employees. SMC was designated as a CAH in 2001. The facility also operates a hospice and basic care facility with 34 beds. The CAH has an average daily census of two patients.
- **Federally Qualified Health Center (FQHC)**: Coal Country Community Health Center, a HRSA Health Center Program grantee designated as an FQHC in 2003, is a not-for-profit corporation located in Beulah, with primary care service delivery sites in Beulah, Center, Killdeer, and Hazen. The FQHC employs approximately 130 people, including five physicians and 10 advanced practice practitioners and behavioral health professionals. The FQHC has an extensive history and organizational capacity in clinical quality improvement. It is a National Committee for Quality Assurance (NCQA) accredited patient-centered medical home (PCMH) with support from the HRSA Accreditation and PCMH Recognition Initiative and has participated in several federal quality improvement initiatives, including HRSA's Health Disparities Collaboratives[32] and the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Advanced Primary Care Practice Demonstration program (in which HRSA was a partner).
- **Long-Term Care (LTC)**: Knife River Care Center is an 86-bed skilled nursing facility in Beulah. Hill Top Home of Comfort is a 55-bed skilled nursing facility in Killdeer. Both facilities are not-for-profit.
- **Local Health Department (LHD)**: Custer Health is a multi-district local public health unit that serves five counties, including Mercer and Oliver Counties, both of which are part of the CAH and FQHC's service area. Southwestern District Health Unit is a multi-district health unit that spans eight counties; one county (Dunn) overlaps with the CAH and FQHC service areas.
- **Emergency Medical Services (EMS)**: Mercer County Ambulance, based in Beulah and Hazen, is a four-ambulance unit servicing 1,000 square miles.
- **State Office of Rural Health (SORH)**: The North Dakota State Office of Rural Health/University of North Dakota Center for Rural Health, located in Grand Forks, helps rural communities build their health care services through collaborations and initiatives with a wide range of partners across the state.

History of Collaboration

The provider organizations in this community did not have an extensive history of collaboration prior to implementing the collaborative strategies that began in 2011.

Community-Driven Collaboration and Coordination Strategies

The collaboration effort involved two interlinked strategies involving organizational changes and community-based planning.

STRATEGY 1: Share Resources to Better Serve the Community

During 2011, the FQHC experienced financial challenges, and employee morale was a major concern. During this time, the FQHC was also working to earn PCMH accreditation through the NCQA. As part of the CMS Innovation Center's demonstration, the FQHC received technical assistance grounded in the Safety Net Medical Home Initiative's change concepts, which were previously developed and established in partnership with health centers. *Engaged leadership* is one of the change concepts considered essential to the PCMH transformation process. Engaged leaders allocate the necessary resources (time, dollars, staffing, equipment, and technology) to enable the PCMH transformation and set the tone for cultural change.

Strategy #1: Share Resources to Better Serve the Community

WHO?

- ✓ FQHC
- ✓ CAH
- ✓ HRSA
- ✓ Legal counsel
- ✓ Consultant

WHAT?

Share Resources:

- ✓ Key Personnel (Chief Executive Officer)
- ✓ Human Resources
- ✓ Health Information Technology
- ✓ Board Membership

WHY?

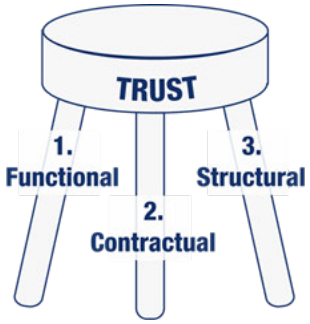
- ✓ Optimize limited resources (fiscal and non-fiscal)
- ✓ Improve continuity of care

Influenced by the PCMH model and by the need to address the unproductive CAH-FQHC relationship, the FQHC medical director reached out to the CAH CEO to see if he would be willing to also serve as the FQHC's CEO (after the departure of the FQHC's CEO). Because identifying and retaining high-caliber executive leadership was challenging, and the CAH and FQHC often competed for talent, the FQHC's clinical leadership proposed that the FQHC share the CAH's CEO. The FQHC's board and leadership recognized that the CAH CEO had a history of successful collaboration with other provider organizations, which made them comfortable with a shared CEO strategy. They determined that having a shared CEO could:

- *Leverage limited resources (fiscal and non-fiscal) to better serve the patient population:* The shared CEO structure would free up CEO salary and overhead, and save the FQHC the expense and challenge of recruiting another CEO.
- *Reduce unnecessary duplication*: Sharing a CEO could help neutralize competition between the organizations and facilitate efforts to leverage services and resources between the organizations.
- *Improve care coordination and continuity of care:* The FQHC and CAH leadership knew it was in their best interest to explore ways to operate differently to prepare for a new health

care environment focused on value-based care. The shared CEO structure would provide continuity in leadership for both organizations (and the community), minimize unnecessary duplication of efforts, and move toward aligning services. This structure also showed potential in helping the FQHC optimize its PCMH efforts.

Creating an environment of transparency was also important for both organizations. To support this shared aim, a consultant was hired as an objective third party to guide next steps to support implementation of the shared CEO structure and identify additional strategies to rebuild the CAH and FQHC relationship. As a result, the following three areas were identified to solidify and enhance collaboration between the organizations. Key informants for this case study refer to these areas as components of a three – legged stool to establish trust between the organizations:



1. **Functional.** The organizations agreed to align operationally and clinically to better serve their community while maintaining themselves as independent provider organizations with separate finances and budgets. "Operational" alignment covered sharing of resources and elimination of duplicated services. "Clinical" alignment ensured that primary care services continued to be delivered by the FQHC and all hospital inpatient and outpatient care delivered by the CAH. The two organizations synchronized their care coordination procedures and protocols so that they could work together more seamlessly. The FQHC and the CAH worked together on a community health needs assessment (discussed later in this summary, see Strategy 2) which helped to inform their efforts to be more functionally aligned.

2. **Contractual.** Appropriately implementing a shared CEO structure for separate CAH and FQHC organizations required extensive due diligence to comply with both organizations' internal rules as well as external legal and regulatory requirements. Legal counsel was hired to ensure the FQHC's compliance with Health Center Program requirements regarding key management staff as well as compliance with regulatory requirements governing CAHs and hospitals. The CAH and FQHC created a formal contractual relationship that defined: 1) the legal basis of the relationship, 2) the roles and responsibilities of each organization, and 3) the terms and conditions of the relationship. Legal counsel helped develop two agreements:

   - *Executive Management Consulting Services Agreement:* This agreement was developed to ensure there was no conflict of interest in the shared CEO arrangement and established that the CEO is employed by the health center. Health Center Program requirements stipulate specific requirements regarding key personnel, key management, and conflict of interest, which includes CEOs. Under this agreement, the CEO is a full-time employee of the FQHC, and the allocated CAH CEO portion is paid by the CAH to the FQHC. The CEO reports independently to the respective FQHC and CAH boards of directors, and each board of directors conducts a performance evaluation of the shared CEO staffing structure. Management teams from the FQHC and CAH organization report to the shared CEO. The FQHC medical director and the CAH chief of staff work together to facilitate

implementation of the PCMH. The CAH's director of patient care and the FQHC's director of patient care and innovation work together to align all aspects of care.

- *Coordination of Services and Capacity Agreement:* A Memorandum of Understanding (MOU) between the two organizations defines the operational relationship and services shared between the organizations along with associated terms and conditions. Both organizations agreed to share staffing where possible (for example, for IT and human resources) to save money and reduce recruitment needs.

  Both agreements include provisions for either provider organization to terminate the relationship.

"When considering partnering with organizations, you need to have a good understanding about what each organization is about."

CEO, Local Provider, on understanding regulatory, programmatic requirements and how providers are reimbursed

3. **Structural.** To establish transparency and trust, the two organizations made the following changes to their governance structures:

   - *Shared Board Membership:* Two board members from the CAH and FQHC's respective boards attend each other's board meetings and have voting membership.
   - *Board Bylaw Revisions:* Figure 2 illustrates the revised board bylaws for the CAH and FQHC, which formally support overlapping board membership. The CAH selects representation to serve on the FQHC board and the FQHC votes to approve the two board members, and vice versa.

Figure 2. Sample of Board Bylaw Language Supportive of Overlapping FQHC and CAH Board Members

FQHC Board Bylaw

There shall be two members of the Board who are also current members of the Sakakawea Medical Center Board of Directors. Such members shall be recommended by the SMC Board annually to the CCCHC Board and approved by a majority vote of the CCCHC Board present. In no event shall any other party(ies), individually or collectively, select or appoint a majority of the entire Board or a majority of the Non-Patient Members of the Board, nor shall any other party(ies) preclude the selection of members not selected or appointed by such party.

CAH Board Bylaw

Section 1. Number; Qualifications. The business and affairs of the Corporation shall be managed by or under the direction of a Board of Directors. Directors shall be natural persons, at least eighteen (18) years of age, must be members of the corporation and shall reside in the service area of Sakakawea Medical Center. The number of persons on the Board shall be no less than nine (9), and no more that fifteen (15). There shall be two members of the Board who are also current members of the Coal Country Community Health Center Board of Directors. Such members shall be recommended by the CCCHC Board annually to the SMC Board and approved by a majority vote of the SMC Board present.

After two years of testing the shared CEO concept, the two organizations made the arrangement permanent with approval from HRSA. The CAH and FQHC continue to be separate organizations that are financially independent and operate in compliance with their respective programmatic requirements.

Outcomes of Strategy 1 (Share Resources to Better Serve the Community):

Common Mission and Vision Statements. As opportunities presented themselves, the organizations expanded their sharing of resources, such as PCMH expertise and care coordination staff. They developed common mission and vision statements that reflected their collaborative efforts towards creating a coordinated, patient-centered "neighborhood of care" (see Figure 3)

Figure 3. FQHC and CAH Common Mission and Vision Statements

Mission Statement
Working together as partners to enhance the lives of area residents by providing a neighborhood of patient-centered healthcare services that promote wellness, prevention and care coordination.

Vision Statement
To be the preeminent providers of innovative and collaborative healthcare services.

Reduced Duplication of Services between the CAH and FQHC. Duplicative services, such as primary care and ancillary services provided by both organizations, were evaluated to determine appropriateness and profitability at each organization and to identify the locations where those services would best meet the community's needs. These efforts were conducted by the hired consultant with guidance from the CEO. Based on this evaluation, the following recommendations were made and approved by the respective boards of the CAH and FQHC. These changes led to positive financial impacts for the organizations (later discussed in this case study):

- *Ancillary Services:* The FQHC discontinued delivery of ultrasound, CT, bone density, and stress testing services.
- *Primary Care Services:* Primary care services provided by the CAH's provider-based Rural Health Clinic (RHC) located two blocks from the FQHC were discontinued, and staff from the RHC were hired by the FQHC. The former RHC building was sold to the FQHC and now serves as a facility to provide behavioral health and substance abuse services. Additionally, the local public health unit (Custer Health) leases space at this location.

The new shared aim of the FQHC and CAH—to deliver patient-centered care along with solidifying transparency between the organizations—had cascading effects in how these two organizations were willing to work together. To ease access in the winter months for all patients, particularly patients with walkers and wheelchairs, the CAH opened a new facility in 2017 that houses both the CAH and FQHC's services in one location. The CAH raised funding to build the facility through its foundation and secured two loans at very low interest rates from the United States Department of Agriculture (USDA) and infrastructure loan funds through the Bank of North Dakota. The FQHC site leases space from the CAH. The patients are now able to access primary care and ancillary services in one location, which has improved the patient experience. *NOTE: While both organizations (CAH and FQHC) are co-located, they function as two separate independent organizations that maintain separate financial systems and their own respective compliance standards.*

STRATEGY 2: Implement a Multi-Stakeholder Community Health Needs Assessment

During 2011 and 2012, the CAH and the FQHC recruited the local health department (Custer Health), EMS (Mercer County Ambulance), and a skilled long-term care nursing facility (Knife River Care Center) to participate in a joint community health needs assessment (CHNA). In addition, the FQHC invited Custer Health to supply a representative to serve on its board to ensure a public health perspective in the governance of the organization. These provider organizations also all participated in a subsequent CHNA conducted in 2016 and expanded participation to an additional local health department (Southwestern District Unit) and skilled nursing facility (Hill Top Home of Comfort). *NOTE: The local public health units (Custer Health and Southwestern District Unit) also conduct their own needs assessments to maintain public health accreditation. These needs assessments cover different service regions.*

Strategy #2: Implement a Multi-Stakeholder Community Health Needs Assessment

WHO?

- ✓ CAH
- ✓ FQHC
- ✓ LHD
- ✓ LTC
- ✓ EMS
- ✓ SORH

WHAT?

- ✓ CAH Community Health Needs Assessment [*]

WHY?

- ✓ Strategic approach to identify meaningful provider-level collaboration and coordination to benefit the community.

The CAH enlisted the support of the North Dakota State Office of Rural Health (University of North Dakota Center for Rural Health, ND SORH), through use of Medicare Rural Hospital Flexibility Program FLEX funds, to support CHNA planning and implementation. The NDSORH is a trusted entity in this community; it provides CHNA technical assistance to at least half of the CAHs in the state. The NDSORH has supported the CAH on two CHNAs (in 2012 and 2016) since the assessments became a regulatory requirement. The CAH and FQHC assessed community health needs through a variety of data sources:

- Community survey
- Focus groups and interviews with community leaders
- Secondary data (for example, County Health Rankings)

The following are peer-identified areas that made the CHNA process a success:

- *Technical Assistance from the North Dakota State Office of Rural Health*. Technical assistance from the NDSORH helped with logistics and allowed the CAH's leadership and board to focus on substance.
- *Community-Developed Survey to Assess Needs*. A survey, developed by the provider organizations, collected data on residents' perceived needs, evaluated assets, and assessed awareness of and attitudes toward local health services. The questions included ones recommended by NDSORH to ensure that both CAHs and health departments benefit from the survey, such as those required by public health units to attain or maintain public health accreditation. The survey was administered electronically and on paper, using

[*] Health Center Program grantees and look-alikes and health departments are also required to complete similar community-based needs assessment as non-profit hospitals to be responsive to organizational requirements.

distribution channels such as local newspapers, church bulletins, and schools. The NDSORH facilitated community meetings to educate the public on the importance of CHNAs and to distribute and collect surveys from local residents. For this community, the most recent CHNA survey focused on social determinants of health and, the NDSORH spent time orienting community members on the social determinants of health and its relevance to health and health care.

- *Individual Points of Contact*. One individual each from the CAH and the FQHC served as points of contact to support the CHNA process and work closely with the NDSORH.
- *Community Stakeholder Steering Committee.* This committee included representatives from non-health sectors (e.g., social services, faith-based organizations, economic development, transit authority, school systems, law enforcement, and local businesses and government) and kept the CHNA from becoming a hospital market study by providing diverse community perspectives and information used to develop focus group protocols. The committee was also responsible for prioritizing community health needs after reviewing the data gathered for the CHNA.
- *Leadership Involvement of Provider Organizations*. Involving leaders from all provider organizations is essential to the success of the CHNA. The NDSORH recommends including board members and community champions who understand the value and importance of these assessments for the community. The CHNA developed for the CAH also satisfies the FQHC's requirements for completing a needs assessment every few years.

The CHNA and Strategic Plan can be found at http://www.smcnd.org or http://www.coalcountryhealth.com. An interactive map illustrating the needs of Oliver, Dunn, and Mercer Counties can be found at: https://ruralhealth.und.edu/projects/community-health-needs-assessment.

Outcomes of Strategy 2 (Implement a Multi-Stakeholder Community Health Needs Assessment): The CHNA process strengthened provider and community relationships. The assessment informed the development of a Community Health Improvement Plan (CHIP), and partners who participated in the initial multi-provider CHNA (from 2012) continue to meet monthly to measure progress toward addressing needs identified by the assessment and adjust priorities for the CHIP.

In addition, the multi-provider approach improved the community's response rate. Providers and programs involved in the survey noted the response rate was better than when they had conducted surveys on their own. Participating programs and providers received richer feedback than in past surveys. Partners involved commented on how the assessment process was a "true community needs assessment and not a market survey."

Population Health Committee. A population health committee was established with representation from all providers involved in the CHNA process, including home health, hospice care, and the North Dakota State University Extension Office. The group meets monthly to improve population health through innovative and educational activities that engage local community residents. The population health committee has spearheaded several community

events about chronic diseases such as obesity, cancer, and diabetes. These events have contributed to an increase in screenings for breast cancer, cervical cancer, and colorectal cancer.

Figure 4. Multi-Provider Care Coordination Committee Membership

Provider Organization Type	Staff Title/Role
Federally Qualified Health Center	• Director of Patient Care and Innovation • Clinic Operations Director • Care Coordinators • Behavioral Health Care Coordinator • Community Health Worker
Critical Access Hospital	• Director of Nursing • Care Coordinator • Home Health • Hospice and Community Care Coordinator
Long-Term Care	• Director of Nursing • Director of Social Services • Case Manager
Public Health Unit	• Public Health Nurse

Multi-Provider Care Coordination Committee. A care coordination committee meets monthly. Committee members include clinical staff representing the FQHC, CAH, an LTC provider organization, a public health unit, and community care coordinators employed by the FQHC and CAH (see Figure 4). The group uses hospital readmissions and repeat emergency room data to examine areas for improvement. This committee originally formed as an extension of the population health committee prior to the FQHC and CAH's involvement in Accountable Care Organizations (ACOs, discussed later this in this summary). The efforts of the committee enhanced the FQHC and CAH's participation in ACO-related activities (discussed in the Long-Term Outcomes section) that focused on preventable emergency room visits and inpatient visits.

The needs assessment identified the challenge of filling health care positions in the community. The following initiatives were developed to create educational opportunities for local students and youth interested in pursuing health care careers:

Dakota Nursing Program. The CAH, the FQHC, and an LTC allocated funds to Bismarck State College to support the college's Dakota Nursing Program. The CAH dedicated a classroom and skills lab designed to replicate a patient room. Students participate in the Dakota Nursing Program via an interactive video classroom setting and are able to complete their Licensed Practical Nurse (LPN) clinical rotations in the CAH, FQHC, and LTC facilities. This structure allows students to become familiar with area providers, staff, and the EMR systems in place at each organization. Since the start of the program in 2011, 25 students have graduated, and half are pursuing a Registered Nursing (RN) degree. More than half the graduates joined the local community's clinical workforce.

Youth Health Sciences Program. Since 2011, the CAH and FQHC have participated in a program of the UND Center for Rural Health and Area Health Education Center (AHEC) that provides opportunities for middle school and high school students to explore careers in the health sciences. The program engages local health care providers and local school districts, targeting eighth-grade students. Collaborating partners include the CAH, FQHC, EMS, an LTC,

public health, a local youth organization (Mercer-Oliver County Youth Bureau), and a community development organization (Hazen Community Development). During 2017, the program included approximately 40 health care professionals interacting with 140 eighth grade students from four school districts.

Improved Access to Quality Mental Health Services. The CHNA revealed a great need for improved access to behavioral health services across all age groups. The FQHC increased the overall availability of visiting psychologist services from two days per month to three days per week. The FQHC has also implemented a Medication Assisted Treatment (MAT) program in response to the opioid epidemic. Through the Drug Addiction Treatment Act (DATA) of 2000, providers trained in addiction treatment have worked with the FQHC to build a robust addiction medicine program as part of primary care. In addition, both the FQHC and CAH have implemented a behavioral health screening and follow-up program for all primary care and emergency room (ER) visits. Depression screenings are now conducted for every patient who presents at the CAH's ER and the FQHC. The CAH and the FQHC are also working with the school district to improve access to behavioral health services for children and young adults and address mental health and substance use issues throughout the school district.

Long-Term Outcomes for Strategies 1 and 2: The willingness of both the CAH and FQHC to put provider competition aside allowed them to build on each other's strengths and the strengths of their community-based partners. This strengths-based approach to collaboration and coordination entailed optimizing the FQHC's PCMH and quality improvement technical capacities to improve care coordination between the two organizations and other partner organizations such as nursing homes and hospice care. These efforts led to positive outcomes at clinical, organizational, and financial levels. Though the partner organizations did not identify specific expected outcomes in advance, the collaboration yielded the following outcomes:

"The challenges a rural community faces require local solutions developed by local people, because nobody is going to come in and do it for you. The CHNA helped us identify our need and develop solutions which facilitated meaningful collaboration with providers."

Anonymous, Leadership of a Local Provider, describing the value of CHNAs

- Improved cancer screening rate (76 percent of total female patients at the FQHC during 2017; compared with 65 percent during 2015).[33]
- High cervical cancer screening rate (78.4 percent of female patients compared with 51.8 percent ND average and 54.4 percent national average).[34]
- Improved colorectal cancer screening rate (from 29 percent in 2012 to 76.7 percent in 2016). The 2016 rate exceeds the state average (52.7 percent) and the national average (39.9 percent).[35]

In 2016, the FQHC received the National Colorectal Cancer Roundtable '80% by 2018' National Achievement Award for its collaborative efforts to improve colorectal cancer screening rates. This award would not have been possible without the strong collaboration between the CAH, FQHC, the local public health unit (Custer Health), and annual FluFIT campaigns. The FQHC staff have been asked to speak at several national forums regarding the comprehensive collaborative model employed.

The work of the CAH and the FQHC to improve care coordination using the FQHC's PCMH capacity helped to lay the foundation for these organizations to participate in alternative payment models that reward successful care coordination, including:

- *ACO Participation.* During 2015, the CAH and the FQHC submitted an application to participate in a Medicare ACO and an application to receive CMS ACO Investment Model (AIM)[*] funding; both applications were awarded. As of 2018, the FQHC and CAH were both part of the Medicare Shared Savings Program. Both organizations have implemented a comprehensive care coordination model and are working to address avoidable readmissions. The FQHC's clinical leadership also leads the ACO; specifically, the FQHC's medical director serves as the medical director of the ACO.

  The CAH and the FQHC also participate in the Blue Cross Blue Shield of North Dakota's (NDBCBS) Blue Alliance Rural ACO program, a commercial value-based initiative that includes a shared savings program. Both provider organizations have attained financial cost savings and improved clinical quality outcomes for NDBCBS patients.

Reduced:

- Avoidable hospital readmissions (decreased readmissions by 14 percent in 2015 and by 40 percent in 2016).
- Preventable ER visits (decreased ER visits by 16 percent in 2015 and by 26 percent in 2016).

Improved/increased:

- FQHC and CAH breast cancer screening rates (81 percent in 2016 compared with a 73 percent ACO peer group average).
- FQHC well child visit completion rates (61 percent in 2017 compared with 41 percent in 2015 for all children 0-15 months[36]).

Children Day Care Center. The 2012 and 2016 CHNAs identified access to day care services as an issue: for the 2016 CHNA, it was identified as the number one need. Residents were quitting their jobs and moving out of the area due to the lack of day care services, creating a workforce recruitment and retention challenge for local businesses. One of the businesses directly affected was the local power cooperative. The cooperative reached out to the community to gauge interest in an initiative to address the lack of available childcare. Local businesses, banks,

[*] Sakakawea Medical Center (CAH) is the Principal Participant and Coal Country Community Health Center (FQHC) is the sub-Principal Participant for the CMS ACO Investment Model (AIM) program.

school districts, and all CHNA partner organizations participated in the initiative. Within a year, the initiative established a board of directors, adopted articles of incorporation and bylaws, and purchased a building. The facility was remodeled, and the day care center started operations in 2017.

Financial Outcomes. The financial outcomes shown in Figure 5 are a testament to the CAH and QHC's proactive efforts to minimize duplication of services.

Figure 5. Financial Outcomes Associated with Collaboration and Coordination [37]

	Before Collaboration (2011)	After Collaboration (2017)
Critical Access Hospital		
Cash-on-Hand	64 days	84 days
Net Margins	0.8%	4.2%
Federally Qualified Health Center		
Cash-on-Hand	8 days	203 days
Net Margins	-11.0%	10.9%

For Additional Information, Contact:
Case Study 2 (North Dakota) | Point of Contact:
Chief Executive Officer, Sakakawea Medical Center, Coal Country Community Health Center, Darrold Bertsch; Email: dbertsch@smcnd.org

Appendix IV: Guide Contributors

This publication was prepared by the Health Resources & Services Administration (HRSA) in collaboration with the following subject matter experts who generously shared their expertise and lessons learned from their applied experience relevant to the topics covered in this Guide.

- Suzanne Alewine, MPA
  Community Asset Builders LLC
- Lynn Barr, MPH
  Caravan Health
- Darrold Bertsch
  Sakakawea Medical Center/Coal Country Community Health Center
- Laurie Francis, RN, MPH
  Partnership Health Center
- Aaron Garman, MD
  Coal Country Community Health Center
- Carla Gibson
  REACH Healthcare Foundation
- Suzanne Gladney
  Migrant Farmworker Assistance Fund
- Vance Jackson
  FACHE; Davis Health System
- Keith Johnson
  Custer Health
- Toniann Richard
  Health Care Collaborative of Rural Missouri
- Eric Ruf
  Belington Community Medical Services Association
- Marcie Schulz, MBA, MSN, RN
  Sakakawea Medical Center
- Eric Shell, CPA, MBA
  Stroudwater Associates, Inc.
- Renae Snyder
  Sakakawea Medical Center
- John Supplitt, MPA, MBA
  American Hospital Association

References

[1] American Hospital Association. Rural report: Challenges facing rural communities and the roadmap to ensure local access to high-quality, affordable care. https://www.aha.org/system/files/2019-02/rural-report-2019.pdf. Published February 2019.

[2] Designated Health Professional Shortage Areas Statistics. Bureau of Health Workforce Health Resources and Services Administration (HRSA). https://datawarehouse.hrsa.gov/tools/hdwreports/Reports.aspx.

[3] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. *American Journal of Preventive Medicine* 2018; 54(6 Suppl 3): S199-S207.

[4] 104 rural hospital closures: January 2010 to present. Cecil G. Sheps Center for Health Services Research. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[5] Chartis Group. Rural relevance—Vulnerability to value: A Hospital Strength INDEX Study. Chartis Group. https://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf. Published 2016.

[6] Social Determinants of Health for Rural People. Rural Health Information Hub. https://www.ruralhealthinfo.org/topics/social-determinants-of-health.

[7] What is a community health assessment? Centers for Disease Control and Prevention. https://www.cdc.gov/stltpublichealth/cha/plan.html . Accessed January 2018.

[8] Requirements for 501(c)(3) hospitals under the Affordable Care Act: Section 501(r). Internal Revenue Services. https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act.

[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. HRSA Health Center Program Compliance Manual. https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf. Published 2017.

[10] Guide to National Public Health Department Initial Accreditation. Public Health Accreditation Board. https://www.phaboard.org/wp-content/uploads/2018/11/Guide-to-Accreditation-final_LR2.pdf. Published 2015.

[11] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Chapter 14: Collaborative relationships. In: HRSA Health Center Program Compliance Manual.

https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-14.html#titletop. Published 2017.

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Chapter 14: Collaborative relationships. In: HRSA Health Center Program Compliance Manual. https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-14.html#titletop. Published 2017.

[13] Muhlestein D, Saunders RS, Richards R, McClellan MB. Recent progress in the value journey: Growth of ACOs and value-based payment models in 2018. Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/. Published 14 Aug 2018.

[14] Muhlestein D, Saunders RS, Richards R, McClellan MB. Recent progress in the value journey: Growth of ACOs and value-based payment models in 2018. Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/. Published 14 Aug 2018.

[15] Becker KL. Conducting Community Health Needs Assessments in Rural Communities: Lessons Learned. *Health Promotion Practice* 2014; 16(1): 15-19.

[16] Case Study 1 (Missouri) Key Informant. Uniform Data System (UDS) Defined Service Area, population below 200% Federal Poverty Level. Accessed August 2018.

[17] Capital Link, Health Care Collaborative of Rural Missouri. 2016 Economic Impact Study: Value + Impact Report. Published 2017.

[18] About HCC. Health Care Collaborative of Rural Missouri. http://hccnetwork.org/about-us.

[19] Health Care Collaborative of Rural Missouri. 2016 Key Performance Indicators.

[20] Hall K, Hall SLW. 2016 Community health needs assessment: Dunn, Mercer, and Oliver counties, North Dakota. https://www.smcnd.org/assets/docs/community_health.pdf.

[21] Stevens, D. Health centers after fifty years: lessons from the Health Disparities Collaboratives. *Journal of Health Care for the Poor and Underserved* 2016; 27: 1621–1631.

[22] Local public health agencies (LPHA). Missouri Department of Health & Senior Services. https://health.mo.gov/living/lpha/.

[23] U.S. Census Bureau. QuickFacts. “Jackson county, Missouri”. https://www.census.gov/quickfacts/fact/table/US/PST045218.

[24] About HCC. Health Care Collaborative of Rural Missouri. http://hccnetwork.org/about-us.

[25] About HCC. Health Care Collaborative of Rural Missouri. http://hccnetwork.org/about-us.

[26] Health Care Collaborative of Rural Missouri. 2015-2016 Annual Report. http://hccnetwork.org/files/AnnualReport2015.pdf.

[27] Health Care Collaborative of Rural Missouri. 2016 Key Performance Indicators.

[28] Capital Link, Health Care Collaborative of Rural Missouri. 2016 Economic Impact Study: Value + Impact Report. Published 2017.

[29] American FactFinder. U.S. Census Bureau. https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed December 2017.

[30] American FactFinder. U.S. Census Bureau. https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml. Accessed January 2018.

[31] U.S. Census Bureau. QuickFacts. "Bismarck city, North Dakota." https://www.census.gov/quickfacts/fact/table/bismarckcitynorthdakota/PST045216. Accessed January 2018.

[32] Stevens, D. Health centers after fifty years: lessons from the Health Disparities Collaboratives. *Journal of Health Care for the Poor and Underserved* 2016; 27: 1621–1631.

[33] Blue Cross Blue Shield of North Dakota Accountable Care Organization Blue Alliance program. (2015 and 2017). Well child visit completion rates performance data.

[34] Uniform Data System. U.S. Department of Health and Human Services, Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx. Accessed March 2018.

[35] Uniform Data System. U.S. Department of Health and Human Services, Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx.

[36] Blue Cross Blue Shield of North Dakota Accountable Care Organization Blue Alliance program. (2015 and 2017). Well child visit completion rates performance data.

[37] Case Study 2 (North Dakota) Key Informant. Critical Access Hospital and Federally Qualified Health Center. Accessed August 2018.