
# Collaboration and Rural Health Care Delivery: Reflections and Lessons Learned

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## Presentation Overview

- About Northern Sierra Rural Health Network
- Reflections about collaboration
- The Art and Science of Rural Health Networks
- Growing NSRHN - lessons learned

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## NSRHN Geographic Area


- 435,900 residents
- 30,000 square miles

80% of residents live in rural or frontier communities

## Key Challenges for Rural Health Care Providers - 1995

- Difficulty recruiting and retaining all types of health care providers
- Large numbers of uninsured and low income patients
- Specialty and tertiary care located many miles away
- Shrinking local, state and federal support for rural facilities

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## 1995 Challenges – con't

- Higher income insured patients traveling to urban areas for primary care
- Difficulty providing continuing education opportunities
- Concern about managed care and its impact on rural areas




## NSRHN Structure

- Incorporated in 1996 as non-profit, tax exempt corporation
- 16-member board representing primary care clinics, rural hospitals and other health care providers in 9-county region
- Six employees in two offices



## NSRHN Structure (con't)

- Total membership is currently 40 health care providers consisting of 100% of primary care clinics in region, 70% of rural hospitals, half of the public health departments, and the two regional tertiary hospitals
- Network structure aggregates need, designs regional solutions, and provides vehicle for funding




## NSRHN Mission Statement

To promote the health and well-being of residents in rural Northeastern California through:

- comprehensive health care planning
- integrated health care delivery systems
- educational services
- programs and services that expand access to care for all residents regardless of ability to pay



## Key Focus Areas

- Promote the use of technology to improve community health through regional technology solutions
  - Coordinate regional Telemedicine System consisting of 25 rural and urban hub sites in the North State
  - Building Virtual Private Network to support healthcare information exchange
  - Using technology at the point of care to improve health outcomes

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## Key Focus Areas (con't)

- Provide support services and technical assistance to safety net providers and vehicle for regional policy/advocacy efforts
- Promote integration of mental health services into primary care practices to improve mental health services

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## Financial Support

- Current budget of $1.5 million financed by:
  - Private California health care foundations
  - Federal Office of Rural Health Policy
  - Technical assistance contracts for service delivery
  - Membership dues and other revenue




## Impact of Network – 1996-2004

- Telemedicine links patients with needed specialty care (over 1,600 clinical consults conducted to date)
- Video conferencing expands educational opportunities for isolated providers, helps with retention (over 450 continuing medical education events completed)



## Impact of Network – 1996-2004 (con't)

- Increased private, state, and federal support for rural health providers (over $3 million distributed to members and network since 2001)
- Regional rural voice to impact policy agendas (changed state law on billing for tele-psychiatry services)




## Impact of Network – 1996-2004 (con't)

- Helped members achieve HIPAA compliance
- Developing shared regional IT services to reduce costs/expand connectivity
- Generating business service projects as outlined in new business plan




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## Reflections on Collaboration

- Material adapted from "Collaboration for a Change" (revised April 2004) by Arthur T. Himmelman (ArthurTHimmelman@aol.com used by permission)
- Defines strategies for overcoming the three main barriers to collaboration:

  - **Time**

  - **Trust**

  - **Turf**

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## Four Strategies for Working Together

- Networking
- Coordinating
- Cooperating
- Collaboration




## Networking

- Exchange of information for mutual benefit
- Most informal level of working together
- Reflective of early stages of linkage: small level of trust, limited time availability, reluctance to share turf
- Example: public health department and community health center share information about how they each support early child development



## Coordinating

- Exchange information and alter activities for mutual benefit and to achieve a common purpose
- Requires more organizational involvement than networking, including more time, more trust, but little or no access to turf
- Example: public health department and community clinic share information and decide to alter service schedules so their services are more accessible to clients




## Cooperating

- Exchange information, alter activities, and share resources for mutual benefit and to achieve a common purpose
- Requires greater organizational commitment, including written agreements to share resources such as knowledge, staffing, space, access to people, money, etc.
- Requires substantial amount of time, high levels of trust, and significant access to turf



## Cooperating - example

- Public health department and community clinic share information, alter service schedules and agree to share neighborhood outreach resources to increase the effectiveness of their programs.
- Other examples of cooperating?




## Collaborating

- Exchange information, alter activities, share resources and enhance the capacity of another for mutual benefit and to achieve a common purpose
- Key concept: each organization wants to help its partners become the best at what they do
- Assumes organizations share risks, responsibilities and rewards
- Assumes substantial time commitments, very high levels of trust, and extensive areas of common turf



## Collaborating - Example

- Public health department and community clinic share information, alter schedules, share outreach resources and provide skill development training for each other's staff to enhance each other's capacity to support healthy early childhood development
- Other examples of collaborating?




## Notes on these Strategies

- They are developmental – assumes previous strategy is embedded in next strategy
- No strategy is "better" than another – different strategies are appropriate at different times for different purposes
- Collaboration is more an art than a science



## Organizational Roles in the Collaborative Process

- Convener
- Catalyst
- Conduit
- Funder
- Advocate
- Partner
- Facilitator

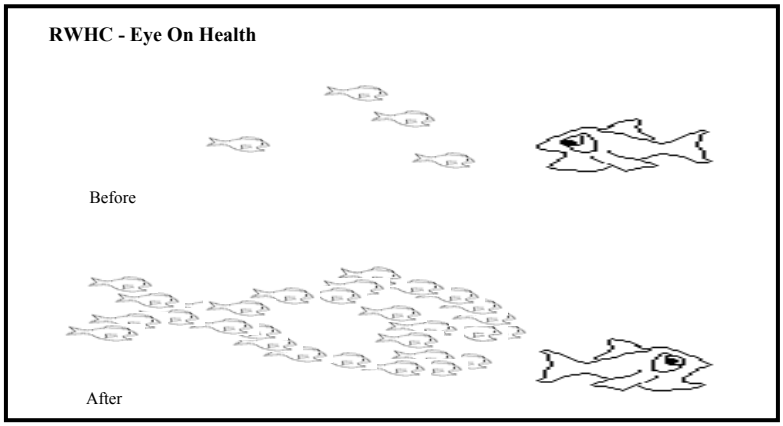



## The Art and Science of Rural Health Networks

- Excerpted and adapted, with permission, from presentation by Tim Size, Rural Wisconsin Health Cooperative (www.rwhc.com)



# In a Competitive World, Cooperation with a Bite



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# Belief #1: Not Every Group is a Network

- A rural health network has a written agreement that defines the roles and responsibilities of the members and the purposes of the network
- It performs collaborative activities according to an explicit plan of action
- It is not owned or controlled by one entity



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## Belief #2: It's about non-profit entrepreneurship

Network development is an entrepreneurial activity and as such success is not certain. But the odds can be increased if all participants understand that networks are businesses, albeit "non-profit."




## Belief #3: Rural Networks are Rural Advocates

- Networks are well positioned to advocate for their communities in both private and public sectors.
- The governance and management of network advocacy and shared services use largely the same organizational structure and skill sets.
- Advocacy, particularly against a common "foe" is a powerful glue to hold a network together as it develops concrete shared services and deals with other day to day pressures.



## Networks as Advocates – con't

Advocacy is both external and internal; network leaders, while subordinate to their board also have the obligation to challenge the board with information and expectations from the "outside."





## Belief #4 – Network Leadership Needs to Be Developed

- Traditional vertical organizational structures do not usually train successful network leaders
- The "natural" administrative response will frequently come out of traditions that may be inconsistent with the actions needed to support networking – e.g "top-down" vs. "bottom-up"
- Network development can look easy, but collaborative processes require more time up front to build trust.
- Enlightened self-interest is necessary for members to begin and continue working together.

## Network Leadership: Relationship Principles

- Make Yourself a Partner Who Can Be Trusted
- Respect the Need to Effect One's Own Future
- Involve All in the Planning Process
- Assure All Participants Know They Are Needed
- Share Your Big Picture
- Agree on Methods of Accountability Up Front
- Assure that a Fair System of Arbitration is Available
- Participation Must Makes Sense

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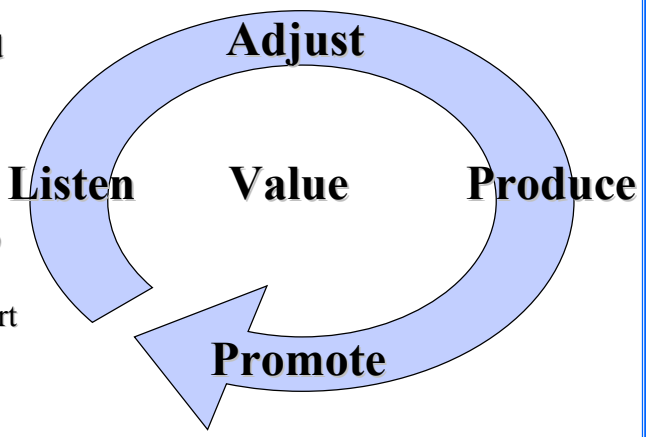
## Strategically Adding Value Requires Art & Science

Strategy:
"The science and art of employing the political, economic and psychological forces of a group to afford the maximum support to adopted policies."

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## Seek A Mixed Portfolio Of Developing Services

- Networks have multiple opportunities to invest scarce resources.
- When developing new services, it is useful to think in terms of maintaining a degree of "portfolio" diversification.
- Some low risk, low return products/services to maintain network member interest in the short run and some higher risk, higher return initiatives to provide substantive value over the long run.



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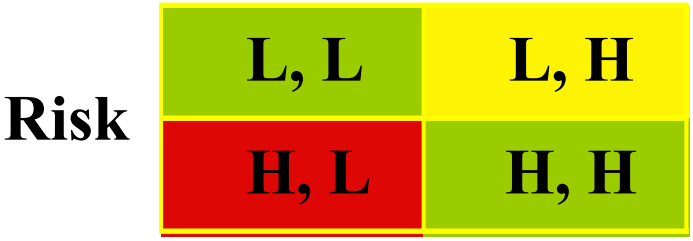
## A Mixed Portfolio of Services



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## Network Services: General Principles

- Network goals frequently satisfied by shared services.
- They must produce real member benefit.
- Member and "network" perspectives may differ.
- They are shaped by the environment (market, technology, member proximity and relationships).




## Network Services: con't

- Successful services help to builds trust to build service.
- The decision to offer a service and the decision to use a service are determined by financial & other criteria.
- More complex services require more complex structures.
- Shared services increase network cohesion.

From *Networking For Rural Health* by Anthony Wellever
available at http://www.ahsrhp.org/ruralhealth/ruralpubs.htm



## Growing NSRHN – Lessons Learned

- Be clear on vision and mission and re-visit them through regular strategic planning
- Do real things to keep people interested and engaged – and do them well
- Be nimble and respond to the needs of your members and changes in the environment




## Lessons Learned (con't)

- Approach non-traditional partners to develop "win-win" propositions
- Think strategically and for the long-term – successful programs take 12-24 months to be implemented
- Develop strong management systems and use evaluation as your friend, not your enemy



## Lessons Learned (con't)

- Maintain visibility of organization through web-site, publications, conferences, etc.
- Build and maintain strong relationships –both internally and externally to the organization
- Be the "partner of choice"…..and choose your partners carefully
- Diversity is our greatest asset…..and our greatest challenge



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