Rural Hospital Network Summit Meeting

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NATIONAL RURAL HEALTH RESOURCE CENTER

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PURPOSE

The purpose of the Summit was to tap the collective wisdom of experienced rural hospital network leaders regarding productive network activities, critical success factors and lessons learned. The Summit was seen as an important step in building a national knowledge center on rural health networks and creating national learning communities of rural health networks.

Sponsorship: The meeting was sponsored by the National Rural Health Resource Center and the National Cooperative of Health Networks with funding from the Health Resources and Services Administration, Office of Rural Health Policy.

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BACKGROUND

As the American health care industry grows increasingly complex and costly, dramatic changes are being mandated by both payers and consumers. These abrupt changes will tax the resources, ingenuity, and resiliency of all health care organizations. Small, stand-alone rural hospitals, in particular, will be severely tested by these changes, and their survival may depend on their ability to collaborate and work together as networks. The Health Resources and Services Administration Office of Rural Health Policy has been funding rural health networks for more than a dozen years, and private foundations and state governments have also provided substantial financial support to network development across the country. Rural hospital networks were identified and inventoried in 2000 by the University of Minnesota Rural Health Research Center, and again in 2009, by the University of Minnesota and the National Rural Health Resource Center. The latest study profiled 141 rural hospital networks, which amounted to around eighty percent of the identified population.

The Summit meeting in Minneapolis was a facilitated key informant meeting of rural hospital network leaders. The participants were sent the questions in advance and were instructed to come prepared to address each of the topic areas. Over the two day meeting, participants related experiences, shared perspectives, and offered opinions on a variety of network topics. Highlights of the proceedings are included in this paper.

RURAL HOSPITAL NETWORK PURPOSES

Hospitals form networks for one or more of the following reasons:

- To create **economies of scale** and to obtain **discounts** through shared volume
- To gain access to federal, state, and private foundation **grants**
- To enhance the effectiveness of their **collective advocacy**
- To create **shared business ventures and products** to produce revenue
- To gain access to shared **technical expertise**
- To cooperatively address a **community need**
- To gain access to shared **education and information**
- To enable **peer support** among chief executive officers (CEOs), chief financial officers (CFOs), Directors of Nursing (DONs), quality coordinators, and other professional staff
- To **benchmark** performance and create network **learning collaborative**
- To build an organizational vehicle that can rapidly and collaboratively **address future challenges and opportunities**.

Common Areas of Focus: Summit participants discussed a number of common areas of rural hospital network focus, including: Quality Improvement, Health Information Technology (HIT), Workforce, Financial Sustainability, Network Governance, and Leadership. For each of these topic areas the participants addressed current activities, challenges and lessons learned, and then offered recommendations for state and national policy makers.

QUALITY IMPROVEMENT

Network activities noted by Summit participants included benchmarking quality outcomes, quality improvement education, peer support for quality coordinators, patient safety initiatives, shared network quality expertise, and advocacy.

Challenges in implementing network **quality initiatives** that were mentioned included:

- Gaining **full participation** by all the hospitals in the network
- Obtaining full **CEO support** for network quality initiatives in individual hospitals
- Gathering **too much quality data** in the hospitals, and using too little key data for strategic purposes
- Working with **small numbers** in rural hospital quality data that can undermine statistical significance
- Managing **multiple requests** for different sets of quality data from national, state, and insurance company source
- Continuing momentum through **turnover** of hospital quality improvement staff, resulting in loss of momentum and retraining needs.

Quality Lessons Learned by the Summit participants included the following:

- Hospital quality improvement personnel often feel isolated and therefore value **peer networking** and support.
- Rural hospitals should be **players in national quality initiatives** and reporting. Networks can encourage meaningful participation.

> *"Avoid data rich but information poor."*

- Avoid collecting information that isn't used to make improvements or drive strategy. Sometimes **less is more.**

- Networks provide opportunities to access **shared quality expertise** or consultation that might otherwise be unaffordable.

- It's important to **engage the hospital CEOs** in quality education to gain meaningful support for network quality initiatives.

- **Physicians** are important quality champions, and should be represented in both hospital and network quality initiatives.

- Hospitals learn best from each other. Profiling hospital successes and **best practices**, and using hospital staff in quality education workshops, improves collaboration and learning outcomes.

- Performance improvement in rural hospitals can be short-term if continuous improvement is not **imbedded in the hospital culture**. Focus on sustainable improvement and culture change.

- Sustainable performance improvement in rural hospitals can be enhanced by **performance frameworks** like Balanced Scorecard, Studer Pillars, and Lean Management. Networks can provide access to this important technology.

Recommendation: The Summit participants recommended that the disparate groups requesting quality information from small, rural hospitals agree on one, rurally sensitive group of measures. This would increase the utility of the information gathered and reduce the current duplication of effort.

HEALTH INFORMATION TECHNOLOGY

Network activities cited by participants included conducting HIT readiness assessments, HIT education and skill-building, grant writing, negotiated discounts from vendors, benchmarking of HIT adoption, and progress towards meaningful use. Other activities included shared HIT staff and expertise within the network, hospital HIT staff peer support and interaction, sharing models and successful approaches, and dissemination of HIT information and resources.

Challenges identified by the Summit participants regarding **HIT** included the following:

- Identifying a **common system** or platform for the entire network, or achieving interoperability between different systems or platforms
- **Engaging physicians** in hospital HIT planning and ensuring compatibility with practice management systems
- Overcoming the acute **shortage of skilled, experienced HIT workers**. Rural hospitals will experience great difficulties in recruiting and retaining staff that know both hospital operations and information technology
- Generating **capital** to purchase needed HIT equipment and software and maintaining operational costs of the HIT systems
- Finding trusted, affordable HIT **consultants** to advise and assist with HIT implementation in the hospitals
- Supporting rural hospitals to reach "**meaningful use**" of electronic health records (EHRs) by 2015, thereby avoiding reimbursement penalties and hampering physician and staff recruitment.

HIT Lessons Learned by the Summit participants included the following:

- It is important for network leaders to be **at the table** for state or regional HIT activities.

- Networks should find a reliable **go-to source** of credible HIT information and reliable consultants.

> *"Find your 'go-to' people."*

- **Telehealth** services can bring a valuable means of providing care in rural America. Networks can help to facilitate the expansion of both telemedicine and teleconferencing.

- Networks can help hospitals **focus on** the practical uses of HIT for **quality** and organizational improvement first, as well as articulate and communicate a vision of what is to be accomplished using the technology. Staff and physicians will need more than a "they're making us do it" mentality to provide meaningful support.

- Networks are ideal means of recruiting and retaining **shared HIT staff** and consulting expertise for rural hospital EHR implementation.

- Networks can convene **peer support** groups of hospital HIT staff, identify and share best HIT practices, and disseminate information about lessons learned.

- Networks can negotiate with **HIT vendors** to obtain discounts and common features and facilitate a dialog where all hospitals are given the same vendor information.

- Networks can collect similar reporting information from hospitals and create a **common data center**.

Recommendation: The Summit participants recommended that national and state policy makers consider making special HIT technical assistance and support available for rural hospitals, which, in general, are significantly behind their urban counterparts in HIT adoption. The recommended technical assistance would be provided most efficiently through existing network infrastructure.

FINANCIAL SUSTAINABILITY

Network activities to improve member hospitals' bottom lines included negotiating discounts through collective volume, educational boot camps for business office staff and fundraising training, developing network business products and services (with profits divided among members), benchmarking financial performance among hospitals, accessing grants to supplement hospital and network resources, CFO peer support groups, and finding ways to improve efficiency through economies of scale.

Challenges to improving **hospital financial performance** included:

- Ongoing need for **training** due to turnover of hospital business office staff
- Finding opportunities to bring reimbursement and coding **education** to staff that can't take time away from their jobs
- Developing profitable network **business ventures** with multiple partners
- Recruiting skilled grant writers to **maximize access** to public and private grants
- Identifying additional **sources of revenue** for hospitals to make up for growing uncompensated care, new unfunded mandates, long-term care financial losses, and cut-backs in public funding.

Challenges to the **financial viability** of rural hospital networks included the following:

- Acquiring **grants** and other sources of outside funding
- Accessing sufficient revenue from sources to support needed network **staff**
- **Diversifying** network revenue as not to create a reliance on any one source
- Determining type of **financial structure** (non-profit, cooperative, or for-profit corporation) to either attract grants or generate revenue for member benefit

- **Quantifying the value** of the network in terms of savings or additional revenue for the hospitals

- Establishing a network **dues** structure that is affordable to the hospitals but stretches them enough to take their membership seriously

> *"You have to have a business plan. Find a couple of things that are 'low hanging fruits'. You need to have a couple of early success stories."*

- Effectively **communicating** network value to the members in specific measures

- Creating a long range **business plan** that projects future activities and revenue sources.

Financial Lessons Learned identified by the Summit participants included the following:

- Networks should always focus on member **value** and return on investment.

- Member **needs** and network opportunities should be **assessed** at least annually and incorporated into an annual strategic plan.

- Network **value** should be **quantified** at least annually and communicated to the membership. There are currently tools that measure and report network return on investment (ROI).

- Network initiatives, particularly business ventures, require **trust** between hospital members. Meaningful sharing of money, information, and cooperative initiatives take time to be efficient and effective.

> *"The word 'trust' is a foundational concept, as is 'respect'. Trust will get you through hard times, but you have to earn it."*

- **Anti-trust** issues need to be considered, but can often be overcome with expert legal consultation.

- Developing roundtables and **peer support** groups for hospital CFOs is productive.

- **Benchmarking** member hospital financial performance can be valuable.

- It is important to have a network **business plan** that lays out **diversified sources** of future revenue, such as administrative fees, program fees, dues, grants, contracts, and sponsorships.

- Business office education and other types of **financial seminars** are beneficial and desired by network members.

- Rural hospital networks may have a variety of purposes, but improving the hospital members' **bottom lines** is usually near the top of the list.

Recommendation: The Summit participants recommended using grants from public and private funding sources that can most efficiently and effectively address rural health problems and issues through rural health networks.

WORKFORCE

Network activities pertaining to workforce include cooperative recruiting and retention, shared human resources expertise, peer support groups and roundtables, network employment of shared health care providers and technical staff. Other initiatives include workforce education, shared workforce data, and network arrangements with university and college health and medical education programs.

Challenges to network **workforce** development included the following:

- Establishing **trust** among members to enable cooperative recruitment and sharing of staff
- Providing ongoing, high quality **distance education** to busy providers
- Encouraging members to regularly **respond** to workforce surveys
- Creating strategies to **fill the short and long-term workforce needs** of hospital members, given the predicted shortages of various types of providers and the growing demand for health services in rural America, will ultimately be the biggest challenge.

Workforce Lessons Learned identified by the Summit participants included the following:

- Networks can develop productive relationships with health education institutions to provide **educational experiences** in rural hospital sites. They can become the portal for universities and colleges to plug in to the rural workforce.
- Peer to peer networking helps to **reduce the isolation** of key health providers and offers an excellent opportunity to share experiences and best practices.

> *"You can't underestimate the power of grassroots communication."*

- Networks can very effectively and efficiently provide **continuing education** to multiple hospitals and numerous types of providers, contributing to retention.

- **Shared staff** and consulting expertise is a cost effective way to gain access to expertise and services that individual hospitals might otherwise be unable to access.

- Networks can serve as **incubators** for new workforce models.

- Networks may be the only choice for independent hospitals to meet their **workforce** needs in the future. Growing shortages will dictate cooperative approaches.

Recommendation: The Summit participants recommended making networks a key part of national and state workforce strategies. They provide tremendous opportunities to obtain orchestrated provider input, and can be excellent rural laboratories for health provider education.

GOVERNANCE AND LEADERSHIP

Network activities in the areas of governance and leadership include hospital board education, leadership and management training, leadership peer support groups, shared use of leadership and management consultants, development of CEO leadership programs, and accessing grants for leadership and governance development.

Challenges to **governance and leadership** that were identified included:

- Creating and/or identifying **rurally-relevant education** on rural hospital governance, leadership, and management
- Managing instability due to **frequent turnover** of rural hospital leaders
- Working with rural hospital boards that have **ineffective board selection processes**, often run by cities or counties
- Imbedding **continuous improvement** in rural hospital culture
- Engaging and maintaining **physician involvement** in hospital leadership
- Addressing incomplete, and often ineffective, processes for **hiring** hospital CEOs
- Identifying **training** when there is a general shortage of good, readily available hospital network leader education
- Collaborating when there is **limited opportunities** for network leaders to get together, share best practices, and learn from each other.

Governance and Leadership Lessons Learned identified by the Summit participants included the following:

- Hospitals and networks should proactively create a leadership **succession plan** to prepare their boards for transition.

- Both network and hospital leaders learn best from their **peers**, therefore education should frequently use speakers and consultants who have led exemplary peer organizations.

"There is no way to underestimate the value of solid communication. The biggest key to success is alignment."

- Keep the **mission and vision** of the organization before both the board and the staff as much as possible.
- Complete periodic leadership and governance **self-assessments** and work to fill in any gaps or shortcomings.

"Remember that when you see one board, you've seen one board. There is a lot of diversity of network models."

- Use leadership and management **consultants** when necessary. Hire consultants that build self-sufficiency and independence rather that dependency.
- For new leaders, seek out an experienced **mentor** and interact as much as possible with experienced leaders in the field.
- Earning the trust of **boards** takes time. Build personal relationships, as much as possible, with each board member.

"When you meet with your board, you are meeting with your customers."

- Clearly state **annual objectives**, timetables and expected outcomes, and always be ready to "kick things up a notch."
- Use performance **management frameworks,** like Balanced Scorecard or Studer Pillars, to keep the big picture in mind, communicate strategy, and measure progress.

- The network is only as strong and vibrant as its members. It is important to grow network board leaders through **ongoing education**, self assessments and regular strategic planning.

- Advisory groups and special task forces can be useful in growing **member participation** in network activities and in enhancing member support for the network.

- Read leadership and management **books and articles** and keep up to date on the latest management technology.

- Work to create a change-oriented **culture** that can withstand the leaders' departure. It is the single best legacy of a departing leader.

Recommendation: The Summit participants identified that network effectiveness is dependent upon creating and sustaining relationships. Network leaders should strive to build personal relationships with key individuals in all member representatives, and especially with network board members.

CONCLUSION

Rural hospital networks have proven to be dynamic change agents in much of rural America. These networks are projected to become even more pervasive in the years ahead. The implementation of health information technology, for example, will require the formation of networks throughout the nation. Financial circumstances will likely drive the development of even more networks models as health care providers seek economies of scale and volume discounts. After considerable research on rural health networks in the 1990s, very little has been done in the first decade of the new century.

Given the future reliance on networks and networking, more research is needed on network formation, network leadership, network functions, and network cost effectiveness. Further sharing of successful network models and approaches is also needed. This paper summarizes the proceedings of an assembled group of key informant network leaders. Their shared wisdom will contribute to a growing learning community of rural hospital network leaders, policymakers, funders, health care providers, and their communities. The voice of rural hospital networks is growing, and will be increasingly relevant in an era of dynamic change.

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