

# Improving the Health and Well-Being of Rural Communities Through Collaboration – 8/15/19

**Kristine Sande:**

Hello everyone. I'm Kristine Sande and I'm the Program Director of the Rural Health Information Hub. I'd like to welcome you to today's Webinar, Improving the Health and Well-Being of Rural Communities Through Collaboration. We have a few housekeeping items to cover before we get started.

We do hope to have time at the end of the Webinar for your questions. If you do have questions for the presenters, please submit those towards the end of the Webinar using the Q&A section that will appear on the lower right hand corner of the screen. That will happen at the end of the presentations.

We have provided a PDF copy of the presentation in the Webinar's section of the RHHub website and that's accessible through the URL that's showing on your screen right now. If you do have technical issues during today's Webinar, we ask that you call WebEx support at 866-229-3239.

Now, it is my pleasure to introduce our great speakers for today's Webinar. First, we will hear from Alana Knudson and Grace Gonzalez from the NORC Walsh Center for Rural Health Analysis about the new product from the Federal Office of Rural Health Policy, A Guide for Rural Health Care Collaboration and Coordination.

Alana Knudson, PhD, serves as the Program Area Director in the Public Health Department at NORC at the University of Chicago and is the Co-Director for NORC Walsh Center for Rural Health Analysis. Dr. Knudson has over 25 years of experience implementing and directing public health programs, leading health services and health policy research projects and evaluating program effectiveness. Her research and policy project findings have informed state, tribal and federal health policy.

She also has State and National Public Health experience having worked at the North Dakota Department of Health and for the Association of State and Territorial Health Officials. Dr. Knudson serves on the board of trustees for the National Rural Health Resource Center and the National Rural Health Association and the Board of Directors for the Maryland Rural Health Association and the Rural Health Foundation. She's also a member of the RUPRI, Rural Health Panel.

Grace Gonzalez, MPH is a Public Health Researcher with 14 years of experience in Health and Human Services Systems Research and Evaluation to support Department of Health and Human Services funded programs and initiatives focused on health and social services, a social service systems transformation currently at NORC.

She primarily works on projects focused on evaluation and evaluation technical assistance to support effective delivery and implementation of enabling social and health care services for vulnerable populations.

Previous to her current role, she supported the National Association of Community Health Centers, design and delivery of training and technical assistance focused on clinical quality improvement. She previously supported public communications and educational campaigns for the National Institute of Mental Health, Office of Science, Policy Planning and Communications.

We will then hear from Amanda Arnold and Suzanne Smith from the Health Care Collaborative of Rural Missouri. Amanda Arnold is the Director of Quality and Risk Management for the Health Care Collaborative (HCC) of Rural Missouri. Amanda is in charge of HCC's Care Coordination Efforts and it's Patient Centered Medical Home Initiative. She works heavily on the network side helping to bridge the gap between the network and the clinic as well as helping to promote available services in the community.

Amanda has been a registered nurse for eight years and loves being a part of an organization that helps to address all aspects of a person's care.

Suzanne Smith is the Director of Network Development for the Health Care Collaborative of Rural Missouri. Over the past five years, she has worked to develop the HCC network and has engaged more than 60 organizations to cooperate and collaborate in the HCC rural network. She has a strong leadership development background having spent 18 years with the YMCA in Saline County as the CEO.

Suzanne currently oversees the network including the community health worker program. She has expanded the network's programs to include 12 project connect events that have taken place, has put together a resource guide for each county that is served, has started a warehouse to address the social determinants of health needs of patients and network clients and is in charge of the Health Plan Transportation Initiative.

Suzanne is also on the CHW Hub Echo Team through the Missouri Telehealth Network and serves on the CHW advisory committee, and as a board member for the newly formed CHW Association for the State of Missouri.

Our final speaker will be Christie Obenauer. Christie was born and raised in Hazen, North Dakota. She lived in many other places in her career as a banker before moving back to Hazen in 2002. Christie is the CEO and President of Union State Bank and is the Board Chair for Sakakawea Medical Center in Hazen.

She began serving on the board in 2003 and thus has had the privilege of being deeply involved in the evolution of the collaboration between their Critical Access Hospital and the Federally Qualified Health Center, Coal Country Community Health Center in their community. With that, I will turn it over to Alana.

**Alana Knudson:**

Great. Thank you. Thank you so much for joining us this afternoon. I would like to first acknowledge our funders, the Federal Office of Rural Health Policy for making this project possible. I would also like to thank the many rural subject matter experts from across the country that we talk to and who so generously shared their expertise with us that helped inform this guide. Lastly, I would like to thank my NORC Walsh Center colleagues and also our colleagues at HMS Associates.

This guide was recently released. In fact, it was released just this week. This guide was developed to provide information to rural community leaders, all stakeholders from cross cutting areas in rural communities and rural health care provider organizations. As I mentioned, this guide was informed by local, state, and national rural health provider organizations. The link to this guide is provided on this slide.

The guide to health care collaboration and coordination was developed to address a number of important issues. First and foremost, we know that rural providers today are facing some very unique challenges. There are some issues with limited economies of scale, dependent on Medicare and Medicaid and in some instances some very low volumes.

We also are faced with having workforce shortages in some of our rural communities and looking at how to maintain financial viability. We also know that lack of collaboration can put some of these key services at risk given the fragile economies of some of our rural communities. We know it is far better to collaborate than to compete.

There's also been a shift from volume to value with regard to payment and reimbursement. A case in point, our accountable care organizations. We know that when we're looking at delivering services, we are looking much more at the holistic needs of our patient population to help maintain their health and make sure they have the central services they need to remain healthy and viable in their communities.

Lastly, there's a growing interest and looking at how patients centered approaches to care also address important social determinants of health such as transportation, housing, and access to food.

The guide has been created to address some different key features that you may find helpful as you and your partners are looking at different types of collaboration and care coordination efforts. This guide has first a section on elements of rural collaboration and coordination that my colleague, Grace will share in more detail. These really provide some building blocks that will help new collaborations or perhaps strengthen existing collaboration.

We also feature two very innovative case studies from Missouri and North Dakota and both of those case studies will be presented by the implementers of those efforts.

Lastly, we include tools and resources. In this section, there are links and examples of different tools and resources that may help your organization as you look to expand your collaboration and care coordination efforts.

We specifically developed this work using two distinct definitions. The collaboration definition is defined as activities in which providers work together through various vehicles, formal live, through contracts, memorandums of understanding, and data use agreements to maximize resources and efficiencies with a common goal of ensuring access and provision of services for rural populations.

When we look at coordination, we are looking at the deliberate organization and communication about patient care activities between two or more participants involving patient's care to facilitate the appropriate delivery of quality healthcare and social services. Again, we're looking at addressing the whole needs of the person.

Lastly, we provide information about the different rural health safety net providers. In this guide, we referenced rural health clinics, our health centers, also known as FQHCs and the different types of rural hospitals including Critical Access Hospitals, Sole Community Hospitals, Medicare Dependent Hospitals and Medicare and Medicaid Disproportionate Share Hospital.

With that, I will turn it over to Grace to share more details about the sections that are included in the elements.

**Grace Gonzalez:**

Thank you, Alana. I'm going to now go over the elements. In the guide, collaboration and coordination is presented as a tool or strategy to efficiently and effectively address patient population needs. As you all know, there's growing recognition in the current landscape that addressing complex patient needs often requires multiple supports from multiple systems of care, which plays in favor with strongly considering collaboration coordination as a strategy.

The slide that you're now viewing briefly summarizes four elements. These elements are presented for leaders of rural health organizations to help you or to help inform new and enhance existing collaboration coordination. These elements were informed by examining success factors and lessons learned from current rural collaboration coordination efforts across the country. The guide includes, as Alana shared, relevant tools and resources. There are relevant tools and resources associated with each one of these elements in the guide, and these elements are further illustrated by the case studies in the guide.

These elements build upon one another and ideally rural health provider organizations would address each element in sequence. However, organizations should tailor how they focus on each of these elements based on what their community context is and what their needs are. So now, I'm going to go through each element.

Element one is, analyze the environment. This element discusses how to lay the foundation for successful collaboration and coordination. Laying that foundation involves developing a deepened understanding of your patient populations' needs through use of existing data sources and review of these needs with an eye of potential partnering with others in your community.

It also involves developing a deep understanding of the provider organizations in your community to help identify shared priorities. This element suggest use of preexisting data sources that are easily accessible to understand your patient populations needs. These are data sources that you probably are you using such as EHR data and Community Health Surveillance data.

Other sources highlighted are Community Health Needs Assessments, not just your own, but review of other provider organization's needs assessments. These needs assessments are often found under the public domain. The guide highlights which organizations are required to complete these needs assessments and how often.

With regard to developing a deeper understanding of provider organizations in your community, the guide references data sources such as review of organizational strategic plans, programmatic and regulatory requirements about the organizations that you might partner with and for the organizations you already have an existing relationship with. These materials can offer insight on what drives the culture and governance of these organizations, which is key to understand.

Review of these data sources that I just touched upon collectively can help you prioritize and identify cross cutting needs where it might make sense to partner and it can also help inform who to consider partnering with. The guide features a tool to help identify potential partner organizations to consider partnering with.

This element also highlights the importance of being aware of national state and local trends that could potentially affect your collaboration and coordination efforts. In the guide, national trends such as value based healthcare models are highlighted.

The next element is element two, engagement with potential partners. For this element, approaches to engaging existing partners or new partners are discussed. One of the approaches highlighted is the community health needs assessment process. This is a great opportunity to explore new partnerships and strengthen existing ones.

As you prepare to engage in collaboration coordination efforts, consider participating in leading these efforts using a community minded approach. Based on examination of successful rural

collaboration coordination efforts, a common theme and thread we found among leadership, was that these leaders lead with a community minded approach.

You're probably wondering what is a community minded approach or a leader? A community minded leader addresses community needs in the most appropriate and effective manner possible and without unnecessarily duplicating the efforts of other organizations. This leader believes that no single organization in the community can address all the needs of their patient population. That it's vital to leverage the strengths and capabilities of other communities organizations in order to comprehensively address patient population needs.

The value of leading in this manner was discussed by rural health organization leaders is helping to strengthen the collaboration coordination process and also it can help with reducing or eliminating unproductive provider level competition.

Element three, developing a collective strategy. This element highlights the importance of collective discussions among rural provider organizations and stakeholders to discuss complex patient needs. Multi-stakeholder discussions are often valuable and can lead to effective design of collaboration and coordination strategies.

Having these types of discussions are important for relationship building, level setting, getting buy-in and strengthening the general will to address a common patient population need. As you prepare and plan for these collective discussions, whether it be part of your community health needs assessment process or something else, consider hiring a trained facilitator to help facilitate these discussions.

Multi-stakeholder discussions should take place in an environment that encourages diverse exchange of ideas, opinions, and it should be done in a collegial and respectful manner. A trained facilitator can help with that. A facilitator can serve as that neutral third party to help navigate any historical tensions that they exist or any emerging ones that might present.

So another area highlighted in this element are metrics. Identifying a personal need assessment of meaningful measures can help with guiding improvement and performance of your collaboration coordination efforts. Use of performance measures can demonstrate value of your collaboration and coordination, which can help with garnering sustainability support from others in the community.

The final element, element four, review requirements and seek technical assistance. This element highlights the importance of completing your due diligence before committing to a collaboration coordination strategy. All organizations involved in a collaboration coordination strategy must first ensure that the strategy complies with their programmatic and regulatory requirements.

During this due diligence process, it's recommended that organizations research and access relevant technical assistance resources specific to the selected strategy being contemplated before actually engaging. This can help determine how the strategy may affect compliance and what additional measures need to be taken to ensure that compliance.

The guide highlights various technical resources to this end. The consistent message we learned from rural health leaders involved in collaboration and coordination efforts we examined is not every collaboration coordination strategy implemented will be successful every time. But each journey is worth it because you've learned from these experiences and it builds an organization's capacity for future partnerships.

I'm going to turn things over to the next presenter.

**Amanda Arnold:**

Hi, my name is Amanda Arnold. So this first slide, this case study, the focus of the case study was implementing a rural health network to address healthcare access and social determinants of health need. So during 2003, the Care Connection for Aging Services, which was a nonprofit area agency on aging, served 13 west Central Missouri Counties, and they began planning for a senior center.

During this time, all this was taking place, the Lafayette County Health Department, worked together to make an informal coalition to look at some community needs that could be addressed by the senior center that they were working on.

Some of the people that were identified were individual and economic development, public health, health care, behavioral health, social service agencies and some local school districts. The numbers quickly realized though that the needs identified such as providers shortages, oral health, transportation, disease prevention, and health needs across the lifespan exceeded what a senior center could address.

So on this slide, the individuals that were identified, they were informal members, began serving one county, which was the Lafayette County, in the blue, with one part-time employee. They were attempting to address all of the identified needs at that time.

We can definitely tell you that there were many failures during this time, such as where the patients would be served, who owned the patient, HIPAA compliance, and the continuity of care where the records were stored, the referral process. We didn't have access to specialists when we were doing the referrals, money, who was going to pay for it when a patient didn't have the money. At that time there was no grant funds around it to cover that.

But truly it was the unknown. We didn't know what we didn't know and we were working really hard to establish that. But it took a lot of people sitting together at the table and truly working through these things that we didn't know what would happen next.

So since this time, the network has since formalized itself into a not for profit, which serves all four of those rural counties in blue, as well as the rural portion of the other county, which is the Eastern Jackson County that it points to right there.

HTC now has approximately 60 network partner organizations, approximately 80 staff members for SQHCs, two school based clinics, a mobile dental unit, transportation initiative, a discount drug program and a warehouse that helps the network to address social determinants of health.

One thing that the network has always focused on is working to understand and address these patient's needs and by assessing the community's interest in working together to address those needs.

So after the coalition agreed to incorporate, it continued to pursue funding that required collaborative efforts to meet those local needs. There were two grants specifically. They were both HRSA grants that were really instrumental in the early developments.

One of those was the Rural Network Development Planning Program. The second was the Rural Health Network Development Grant. The purpose of that planning grant was to assist in the development of an integrated health care network, specifically for entities that did not have a history of formal collaborations. The Rural Health Network Development Grant supported

established health oriented networks with a history of collaboration to develop and maintain collaborative relationships.

So as you can see with the progression that the relationships came first. It was always about that initially without the right people at the table, the networks are really difficult to sustain. HCC's board knew that it was more important to look at the long-term outcomes as opposed to grant and program driven sustainability. We wanted to ensure that we would survive and outlast any single grant proposal.

So this slide really reflects the drivers of the organization. The nucleus obviously being the most important piece. It is focusing on the strong development of a Community Based Organization. The health centers are the economic engine of the organization and the outermost ring focuses on all of the external relationships within the communities that trust us to provide that good patient centered care for their clients, families and friends.

These external relationships continue to be a very important part of how the network functions today. Not only do we care for these referrals within our FQHC and on our mobile dental unit and in our school based clinics, but we oftentimes go to the other organizations for problem solving around things such as resource development for the lower income individuals. We can honestly say that without these partnerships, our patients wouldn't have as much of an easy access to that care, and access to that holistic patient centered care.

Then this slide, this tool is really used to help us validate our strategic plan as well as the success of our organization. This slide is often used when forming new relationships and cultivating existing relationships within the community. Rural communities are always strapped for resources.

So to be able to show something, to show an economic footprint around things such as financial growth and job creation and sustainability, as well as show that, we're a strong service provider. It's critical in finding ways that communities can invest in what we're doing. It shows the ability for people to get behind us and our mission and vision and values and truly providing that good holistic patient centered care.

**Suzanne Smith:**

Okay. This is Suzanne Smith. I am the Director of Network Development for the Health Care Collaborative. So through our collaborative, we address the social determinants of health of all of our patients and then all of our clients that are members of our network. So we try and address any barriers to care that are identified through the Centers for Disease Control and Prevention, behavioral risk factor surveillance system.

So our Rural Health Network, which has grown, it is over 60 members now, and our community based partners. Our member organizations include, Critical Access Hospital, clinics, Faith Based Organizations, Social Service Organizations, food pantries and anyone that serves folks in our communities that want to come to the table to talk about how we can wrap our arms around the patients and clients of our communities to provide that whole person care.

We also collaborate very closely with the Missouri Valley Community Action Agency, which has action agencies offices in all of the different counties that we serve.

So how do we exactly utilize these resources and then how do we assess the determinants of health of our patients and clients? We utilize the prepare form, which is a protocol for responding to and assessing patients, assets, risks and experiences.

So every patient that comes into one of our federally qualified health centers fills out a prepare form and if they are a patient that is seen in one of our school based clinics, if they're 12 and over, they fill out a prepare form.

What that prepare form does is it allows us to see if they are at risk of needing resources. Maybe they are at risk of being homeless or they don't have food in their home or their utilities have been shut off or they're coming in with chronic bronchitis every month because they're sleeping on the floor with no mattress because they can't afford one.

So when we get those prepare forms, we have community health workers that are in all of our clinics. Then we also have four community health workers that work on our network side. Then there are two community health workers, one in each school based clinic that we have.

When they received those prepare forms and identify that there are patients that need resources, then they reach out and work with those patients directly to give them a hand up, not a hand out to access the resources that they need.

We started a warehouse in 2016 which is a 7,500 square foot warehouse located directly across the parking lot, from our administrative office where we are able to glean items, and resources that would otherwise go on the land sale, such as laundry detergent, personal hygiene items, body wash, shampoo, sheets, blankets, mattresses, anything that folks cannot buy with food stamps that as we all know costs a great deal of money.

We work with the 60 different organizations that are a part of our network to get those resources back out to the people that are in need in the communities. Everything that comes in is free and everything that goes out is free. We also do our prepare form on any of the clients that are clients of our organizational network that come in that need resources as well. We say we don't serve individuals, but we serve the organizations because we want to build a capacity within our communities.

We also have what's called our connectors program, which we have over a hundred people in our community that are trained on how to connect folks in their community to resources that are needed, whether it be through their church organization or through their workplace. They learn how to find the resources that someone might need if they got a shutoff notice for their utilities or again, if they found out that someone just moved in and has no food in their home.

We also host three project connect events per year and those events are a one-day public health event that are geared towards adults that are under served and uninsured. We target those folks by offering services that are free. We have around 50 different social service organizations that come in and provide services including haircuts. We have high schoolers that come in that we'll paint fingernails for folks. We offer vouchers for free for folks to be able to get a photo ID or to renew their driver's license or to be able to obtain a birth or death certificate in the State of Missouri. We also take our mobile dental unit and we do free dental extractions for adults as well.

What we also do is we have a person from the community that is a volunteer that guides our guests that come in that day for services throughout their experience. So not only is that guest that needs those research resources learning what is available in their community, also, the guide, who was a volunteer is learning what resources are also there in case they know other folks that might need these resources.

At the end of the event, there's a short exit survey that is filled out and then the guests get to receive an exit bag that has about \$15 worth of personal hygiene items in it, such as body wash,



shampoo, toilet paper, toothbrush, and then they get to select other items that we have there to give out, such as OxiClean, blankets, coats, whatever, the time of the year is we try and gear out additional resources towards that.

So, the outcomes that we have experienced in August of 2017, our rural health network had donated over a million dollars worth of goods and services to its patients and clients in our community through the warehouse. So that means everything that comes in is tracked and everything that goes out is tracked so that we can put a dollar amount on it.

Our connectors program, in 2014 we had 60 local residents that were assisted with 130 patient encounters. In 2017 we had 550 local residents assisted with over 3,900 patient encounters. Since that connector's program, we have really increased our community health workers. So our patient encounters are growing significantly as we speak.

Our project connect event, we have an average of 125 people that present for each event and approximately 300 people received services. That includes the adults registered and their families that come along with them for the day.

So advice or lessons learned from our collaboration and coordination. Never leave anyone behind. Always include anyone in your community that wants to help, whether they be from a large organization or a small organization. If they have the passion to help people, then be sure that you give them that opportunity to come to your table and be able to do the great work that is needed in all of our communities.

I will turn this over to our next presenter.

**Christie Obenauer:**

This is Christie Obenauer. That was such a great story to hear both Suzanne and Amanda spoke with. It's inspiring to hear what others are doing across those country. You're doing great work. My perspective is going to be a little bit different in that, as you could tell from my bio, my paid job is a banker. My volunteer job is the Sakakawea Medical Center Board Chair.

So my perspective on the collaboration journey that we have been traversing is a little bit higher level and certainly from the perspective of governance. So I hope I can share something that is worthy of you listeners out there. I'm speaking actually because our hospital community health center CEO is unavailable at the moment, so you get to tolerate me.

So, as I said, I'm the Board Chair for Sakakawea Medical Center, which is a Critical Access Hospital, 501(c)(3) organization we've had in our community since 1941. We're licensed for 13 beds and also have a 34 beds basic care facility that is attached to the hospital as well.

I'll also be talking about Coal Country Community Health Center, which is an FQHC, that our story is just about how we managed to get on the same page and formally collaborate, and Coal Country Community Health Center has been in existence since 2003.

Our community is in western North Dakota. We serve collectively about three counties that the service area equates to a population of about 13,000 people. So we are quite rural. Our sector of our economy is, as you can expect, ink based and then we have quite a bit of energy production here in western North Dakota as well. So that's the community that we serve.

The backstory behind our collaboration is that the Sakakawea Medical Center had an adversarial relationship with Coal Country, with our FQHC. When our Coal Country came into existence, there was just a lot of miscommunication or simple lack of communication.

We have great people that served on both of those boards, Coal Countries and Sakakawea Medical Centers boards, and certainly great staff at all organizations that just were not in a position to be communicating. There was some lack of trust on the leadership for both organizations. So it just created a lot of antagonism.

Unfortunately, ultimately created an environment where we were competing with one another with services and all taking care of the same small rural space of population and it just made absolutely no sense. So I often say to my board and without trying to wax poetic that we would never want to go back to the way it was before we started this formal collaboration. However, we wouldn't appreciate where we are today without having been where we were.

I think the quote on this, the slide that you're looking at, speaks to that, just that we're one team serving the community and that says it should be in any rural space.

I've often said, just to connect the dots to the statement I've just made, that in a rural marketplace like ours, we are doing a disservice to our communities if we're not pulling our resources and putting more than one grain on the table and collaborating. We can do so much more together than we can trying to go it alone. That's certainly been our experience doing what we're doing today for our community.

So the map that you're looking at is just a representation of the area that we serve. SMC, the Critical Access Hospitals serve that entire area. As I mentioned, just a little bit over 13,000 people Coal Country, which is our FQHC has four clinic locations, Beulah and Hazen, in this center our largest community and in the center of Mercer County, where our energy sectors are centered from coal and oil and lots of high per capita income area for us in North Dakota.

Our Coal Country also has clinical center which is also in the backyard of Coal Country and is a smaller community than Beulah/Hazen is. Then they also have a clinic in Killdeer, which is Dunn County and that's a little bit closer to the oil patch. So we have a variety of areas that we serve that represents an economic diversity. All of those areas of our, of course also are quite oil based.

So the services that SNC provide, it's still today. Obviously we're a hospital and I mentioned that we have a basic care facility. We also have ancillary services and a lab. We have hospice, we have physical therapy, and before we were collaborating Coal Country was duplicating some of that. At one point, both organizations had a CT, which makes absolutely no sense for a small community, our collective size. We're duplicating some other things too. So we're competing for the same small band of population.

Over that period of time that we began to get together, the Coal Country Community Health Center opened a clinic in Hazen and SNC closed our rural health clinic in Hazen and Beulah in order to allow for that to take place. That really just made a lot of sense for our communities.

In terms of how the collaboration took place or how we got started together, there's a change of leadership at Coal Country that afforded the opportunity for the boards to have a conversation led by our CEO Darrold Bertsch and the Medical Director at Coal Country. We basically just said, "We've got to figure out how to do this together."

Ultimately, we ended up getting HRSA involved to help with the process of getting on the same page together. I'll talk a little bit about that more in a moment. That began the journey of a more formalized relationship. I'm going to flip this slide here.

This three legged stool is a reference that we use quite a bit when we're afforded the opportunity to talk about this road that we have traversed. We look at three lengths, as you can see, in the slide. The functional end of the stool is just basically about the fact that we sat down and figured out, "Okay, how can we start to do this more formally, create a short term arrangement between the hospital and the health center?"

As I mentioned, we worked with HRSA bureau primary health care in that initial collaboration to get something set up that they would approve and that worked for us and for the communities that we served.

So the functional piece, of course, involves sharing a CEO. So the hospital and the health center, we share a CEO between the two of us and we have a formalized agreement that represents that of sharing. Then we also have formalized agreement for sharing other services, from physical therapy to lab to ancillary services like CT and all of those pieces.

The contractual leg. We have that in place just to make sure that what we're doing is aligned with the regulations and the standards that are in place both to regulate Critical Access Hospitals and also FQHC. That is certainly where we engaged our legal counsel and help from HRSA to make sure that as we relate to this new trail of formalizing a relationship between a Critical Access Hospital and an FQHC, that we were getting it right and following the rules and regulations that were already in place to govern those types of, two types of entities.

It also, even though, as I mentioned earlier, we never want to slip backwards, but we also are trying to be conscientious of the fact that we are two separate organizations, two separate entities with two separate boards. That if we needed to unravel that relationship, we can do so in a way that was outlined in a contract. So that's part of that second contractual leg.

The third leg about the structural perspective was primarily about creating in a model for integrated governance that afforded complete transparency and just in alignment of our strategic planning. So, as I mentioned, we share the CEO that's employed by Coal Country and we have this shared service agreement that FNC have back from Coal Countries for Darrold.

Two of our hospital board members serve on the Coal Country board and two of the Coal Country board members serve on the hospital board. Of course, our CEO attends all of those boards meetings too. We do all of our strategic planning and any of those high level conversations, we do those meetings together. That really works well for us.

The outcomes. Again, I am not well positioned to provide minutia because I'm not employed in the healthcare industry, but just from a governance perspective, and certainly the community member, the thing that I get approached about the most here over the last number of years that we've been doing this is just about the fact that we're efficient and we are representative of what the communities needs.

So we're no longer duplicating services. As I mentioned, there was both an RHC and a community health center in both the communities that Hazen and Beulah, that made no sense. So we're not doing that anymore. We don't duplicate ancillary services, so we don't duplicate routine, stress testing, bone density, ultrasound, those kinds of things.

As you could see from the table that Gerald's prepared for this slide, from an economic standpoint, it's made a huge difference in the financial success of both organizations. With financial success, we are simply afforded the opportunity to do more for our community, which is our explicit purpose. So it's a great position to be in. We know that we're making a difference when things are going well.

The other point I wanted to make an addition to the things that are listed. We have a Community Health Improvement Plan, we have a Population Health Committee. We're a member of NCO, and Coal Country did a really great job of facilitating our patient centered medical movers and program for all of our organizations.

I've been most heavily involved with our community health needs assessment. We conduct that needs assessment for our greater community, the whole area that was on the map a couple of slides ago, every three years. We just finished our latest one this past spring of this year. We survey our community and our healthcare professionals from our whole service area. Then we also conduct individual interviews with a variety of community leaders.

Then we ultimately meet together, face to face and about a half a day, just going through all of the things that we've identified that our community needs. That's, from my perspective, really about listening to our community, listening to our neighbors, paying attention and staying engaged.

Then we have an opportunity to share our thoughts collectively when we have this meeting about what things are the most important that we're hearing our community say that they need.

Some great results we've had from that countable results are like this past spring, mental health was at the top of the list that we are going to be focused on and have been focused on that with a little bit more laser like intent. Drug and alcohol addiction is at the top of the list and in the Community Health Needs Assessment that we conducted the last time, daycare, interesting enough leads at the top of the list.

We just simply are in an environment where everyone's working. You don't have enough people to fill jobs and we don't have enough people who were interested in doing daycare to take care of the kids. That's really the problem our working parents have.

So short story is, from that Community Health Needs Assessment, we're all of the people in our community, all from Public Health to the Community Health Center to the long-term care facility in our area, to the hospital, to our Mercer County Ambulance, and all of the people that represent organizations that take care of our community.

We're at the table and said, "We got to figure out how to handle this daycare thing," and we put together a new daycare facility for our community and that has gone really well.

So back to the last slide that I have here, just in terms of lessons learned. I mentioned it earlier, but I often say be a good listener, stay engaged, step back and look at the greater good and the big picture. As I often say in our boardroom, if we make decisions through the lens of what's in the best interest of the community we serve, we'll make the right decision every time.

Sometimes we have to blaze new trails for the greater good, which is what we did here, and be willing to push the envelope. Again, to get the right thing done for our community.

Thank you for the opportunity to share our story with you. I will hand it back to Alana, I think.

**Kristine Sande:**

All right. This is Kristine. At this point we will open up the Webinar for questions. Down in the right hand corner, we have opened up the Q&A section. So go ahead and type your questions in there for our presenters. We have a few minutes for questions. We do ask that when you enter those questions that you select the option to send the question to all the panelists so that we don't miss your question.

We do have one question that already came in. This is for Amanda and Suzanne. The question is, do the various network partners have a common electronic record and is the prepare form part of that EMR?

**Suzanne Smith:** So this is Suzanne. Can you hear me?

**Kristine Sande:** Yes.

**Suzanne Smith:** So there is no common electronic medical record across the board for us. So we're not able to share that, but the prepare form does go directly into our electronic medical record so that our providers can see that. We use eClinicalWork.

**Kristine Sande:** Great. Thank you. Another question for you. I'm wondering if you could describe some of the challenges that you face bringing organizations into the network.

**Suzanne Smith:** To be honest with you, we really don't face many challenges at all. If anything, it is getting their MOU's is collected back in a good time is probably the biggest challenge that we have. But they tell other organizations that they work with about us and then they want to be a part of us. So the recruitment is pretty easy. It's basically word of mouth.

**Amanda Arnold:** I can tell you that from a patient perspective, I think that as long as all of us continue to focus on our specific patient population and the specialists that we have in place, the wires don't get crossed near as easily. So what I'm meaning by that is, the hospital has a specific set of things that they can do. Our mental health, our CCBHC, or our Community Mental Health Center, they have a specific set of things that they can perform and the FQHC as well.

So by us all knowing our own roles and where we can refer to each other, it helps our patients get the best care and it helps us all be able to meet our metrics and keep our patient numbers where they're supposed to be. So that's been the only thing that has really required additional discussion, but by bringing us all to the table at the same time and discussing those things, really mitigates that problem.

**Kristine Sande:** All right. Thank you. A question for Christie. When you brought the two centers together, was there any loss of jobs by the workers in the community? Because, this person says that often it seems to be the scare that stops those types of mergers.

**Christie Obenauer:** Sure, that's understandable. There wasn't for us, and in fact, we ended up collectively hiring more people, not gobs of people, but we collectively between both organizations ended up hiring more people just because we are economically doing well, we can expand some services. So no loss of job.

**Kristine Sande:** All right. Another question for you, Christie. What level of help was HRSA able to provide in helping create the collaboration between Coal Country and Sakakawea Medical Center?

**Christie Obenauer:** Another great question. I know we pushed them. When I say we pushed the envelope, we pushed HRSA because no one had been doing... Nobody had done this before. So we spent some time in Washington, DC just telling our story and why we thought it was important for us to be able to create a formalized relationship for collaboration. But they were great listeners and when they understood what it was we were trying to accomplish and why, because it was for the benefit of our community, they were of a big help.

I think just seeing this guide that we're talking about today, that has ours and Amanda and Suzanne's examples in there, it's a great representation of HRSA's willingness to say, "This can be done and this is how it looks and it can be of benefit to the community."

**Kristine Sande:** Great. So for both of you or both organizations, what are preferred in efficient ways of sharing information on an ongoing basis to facilitate that full engagement in collaboration?

**Christie Obenauer:** I can start answering that and then turn it over to Amanda and Suzanne. I mentioned just communication. I worked hard at the outset of this to make sure everyone was on the same page. So that was conversations in boardroom, it was taking people out for dinner, it was meeting with them in their office, being a good listener, sharing information, just to make sure everyone felt comfortable with where we were going and why.

Today, now with our formal relationship, we are very conscientious about doing our strategic planning together. Coal Country and SNC board have meetings together, several times throughout the year and we're going into a board retreat this fall. We want to do some strategic planning. We do those things together. So there's transparency and a unified approach about where we're going.

**Suzanne Smith:** Hi, this is Suzanne and we have a monthly network membership meeting, it's a luncheon where we have a different guest speaker that comes in every month that has a topic of interest to the network members. Then everyone that is in attendance has an opportunity to give an update on what is going on in their organization. Then we send those minutes and any flyers that they may have out to all of the network members in the network via email. So there's about a hundred folks that get that update and can share.

Then we also have our social services connectors meeting once a month as well, that has a different guest speaker that comes in. Again, it's the same format. They all get the minutes sent out to them, but that group focuses on what is an immediate need in our communities that we can work together on to help maybe fulfill the gap.

**Kristine Sande:** Great. Thank you. It looks like we have a few questions around working with other types of entities. So, including Indian health service, universities in public health. So can you comment on the extent to which you have partnered with those types of organizations?

**Suzanne Smith:** This is Suzanne and yes, we work with the University of Missouri Extension. They are a part of our network where they come in and we'll do cooking classes or finance classes, different times of classes like that that will help benefit the clients in our community. Then we work very closely with our Public Health Department and actually the director of that department is on our board of directors. So we work hand in hand with them.

**Amanda Arnold:** This is Amanda. I think it's important to just say, any opportunity that comes your way, it's every new opportunity, we've been able to identify a success out of it. There have been so many things that haven't succeeded like I was talking about earlier with those, you don't know what you don't know, but it's just important that if anybody comes to you with the solution to be... With a suggestion to work together for how it will impact the patients and how it will impact the community.

Because there's been some things that we most definitely did not think would work that ended up, us working together and found a great solution on a better way to serve or a better way to collaborate on a specific service.

- Kristine Sande:** All right. Let's see. Related to Christie's presentation, what struggles did you have in getting patients directed to the most appropriate place? So when both places didn't have a CT anymore were there struggles with directing people to the right place.
- Christie Obenauer:** I think what was the most frustrating for us, as boards and inside each of the organization, definitely being in Coal Country and certainly what was the most frustrating for the community was just not knowing where they should go. So when there was that span of timing, each had a CT, I had many people come to my office from the community to say, "Why is there two? Where am I going to be best served?" So it just created confusion.
- I simply tried to be a good listener. We all tried to be good listener then and work our way through those concerns. When we got to the point where we were no longer duplicating, it makes it pretty easy. So community health centers clinic is inside the hospital. We just built a new hospital year and a half ago and Coal Country clinic is inside our hospitals.
- So we've come in and there's care coordination between all the organizations and with their patient centered medical homes, a setup or parameters, patients knew where they're supposed to go, who can they be directed by the collective staff between MPP. So it was confusing for our community and our patients before we managed to get onto the same page.
- Kristine Sande:** All right. A question related to the HCC connector program. How did you go about identifying the low income individuals and families that you would invite to attend?
- Amanda Arnold:** This is Amanda? We don't turn anybody away, especially with the project connect events, if they come to us, and they see that they need services, we will serve them. I think that it's really important to note that, we don't know what their specific situation is on that specific day or that month or whatever. Sometimes people just fall on hard times, and it's unexpected. So we want to make sure that that's open to anybody that needs that.
- As far as low income individuals in our clinics, there are many mandatory requirements being an FQHC, and having to identify things such as the annual income and applying for a slide C and the hardship forms. So every patient, is asked those questions at every visit, and then the needs are addressed or assessed based on what has been identified.
- Kristine Sande:** All right. Do you struggle with certain partners being unequally committed to the work and how do you handle that?
- Suzanne Smith:** There are some organizations and partners that bring more to the table than others, but they get more out of it. If they're active, then they get more out of it, if they're inactive then unfortunately, it's typically the loss to their patients and their organization. But we treat them all the same and there's not a certain requirement that they have to be able to participate in any of that stuff.
- Kristine Sande:** All right. Another question for you, what strategies did you identify that worked well in obtaining the community needs for that needs assessment since your area is so rural?
- Christie Obenauer:** We utilize the Center for Rural Health in Grand Forks to get that to help us facilitate that community health needs assessment. So we sent out a survey electronically and all of us, board members and the staff at both organizations just really talked it up with our neighbors, our friends, the people that we work with in our community. We say, "Please, take a few minutes to fill it out," and we got really great engagement from that.

So using an electronic survey makes it easy and efficient to fill out. Then the Center for Rural Health then just helped us identify community leaders to arrange from one-on-one interviews. That was just done face to face having conversation, and our community was very willing to be engaged, continued to be very willing to be engaged in that needs assessment because they do see tangible results that come from there.

**Kristine Sande:**

Great. Thank you. Since we're about five minutes over time, I think we will wrap it up at this point. I apologize to those folks that we weren't able to get to your questions. The presenter's email addresses were included in the presentation, so if you have a questions for them directly, you do have those email addresses.

So I would like to take this opportunity to thank our speakers for their great presentations and the insights that they've shared with us today. Thank you to all our participants for joining us. A survey will automatically open at the end of the Webinar and we encourage you to take the few minutes to complete that survey, to give us your feedback so that we can do even better with Webinars in the future.

The slides used in today's webinars are currently available at [www.ruralhealthinfo.org/webinars](http://www.ruralhealthinfo.org/webinars). In addition, a recording and transcript of today's Webinar will be made available on the RHlhub website and sent to you by email in the near future. So you can listen to the Webinar again and share the presentation with your colleagues. Thanks so much for joining us and have a great day.