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Innovations in Rural Health System Development: Governance

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Rapid changes in health care payment and delivery systems are driving health care providers, payers, and other stakeholders to consider how the current delivery system might evolve.

This series of briefs profiles innovative rural health system transformation models and strategies from Maine and other parts of the United States. The aim is to assist rural communities and regions to proactively envision and develop strategies for transforming rural health in the state. In preparing these briefs we consulted experts, interviewed key informants, and reviewed the professional and research literature to find robust and innovative models and strategies that could be replicated in rural Maine.

PROMISING STRATEGIES:

INTRODUCTION

Health system transformations often involve organizational and service system re-structuring within and across organizations in the community. These changes are often driven by new payment arrangements and/or by community-led initiatives that require greater collaboration across health care provider and other community organizations. As new organizational structures and service systems emerge, new management and governance structures are required, especially if financial and other resources are shared across multiple organizations. The organization and governance of new health system arrangements is central to their effectiveness and sustainability.

Innovations in governance run the gambit in scope and complexity from hospitals and health care systems collaborating to share services and cut costs to multi-sector population health improvement initiatives. In many of the emerging and innovative models, hospitals or health systems are providing leadership and resources and are serving a

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central coordinating role. Other initiatives are rooted in strong governmental or public health structures. New models of health care governance are helping to transition local health resources away from their often hospital-centric, legacy configurations towards new, collaborative delivery systems that reflect the evolving needs of rural communities.[1] Innovations in governance are an important means toward improving service delivery, quality, and reducing costs for the organizations involved.

In Maine, many of the examples of innovations in governance are rooted in hospitals, which is not surprising given the state's limited local public health and county government systems. In their role as community hospitals, rural hospitals need to leverage their existing ties to their communities to build consensus for new models. They also need to work well with local and regional partners such as Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), physician groups, and social service providers, sharing leadership, information, and ownership of outcomes. Collaboration with these and other partners can help build a more coordinated and integrated system of care in the future that will benefit rural residents and communities.

PROMISING STRATEGIES

Hospital/Health System Collaborations

Hospitals and health systems are partnering with primary care and other providers to create new organizational and governance structures in Maine and across the country. The following examples illustrate a few of the approaches underway in Maine.

COASTAL HEALTHCARE ALLIANCE:
Sharing Leadership and Clinical Services

Established December, 2015, Coastal Healthcare Alliance is a "system within a system" consisting of MaineHealth's Pen Bay Medical Center, a 109 bed hospital in Rockport, and Waldo County General Hospital, a 25 bed Critical Access Hospital (CAH) in Belfast. The two hospitals operate in a unified governance and management system, with a shared Board of Trustees. Both hospitals retain their own subsidiary boards; meetings of all three boards are held concurrently. Shared leadership, administration, and clinical services create opportunities for significant cost savings: the senior teams from each hospital have been almost completely combined, as has the leadership at the hospital-affiliated long term care entities. The sharing of clinical services has enhanced revenue for each hospital as new services become available, drawing on providers from both affiliated facilities.

William Caron, CEO of MaineHealth, notes that the challenge with a model like Coastal Healthcare Alliance lies in getting the hospital boards to think about a broader, regional service area and strategy; they need to care as much about health care in a neighboring community as they do in their own. According to Caron, it takes time and patience to get this "greater good" buy-in. The loss of complete local control, especially around assets, decision making, and philanthropy, can be a significant adjustment. The model's success depends on the boards becoming convinced of the benefits of operating on a larger, regional scale. In Waldo and Knox counties, the leadership of the two hospitals listened to donors and transitioned carefully to joint fundraising, helping people to feel invested in the "other" community.

At the moment, there is no plan to merge the hospitals, so as not to jeopardize Waldo's status as a CAH. Losing the special CAH reimbursement could cost the hospital $15 million a year in revenue. Medicare allows a parent company to hold multiple facility

licenses (with separate cost accounting but operating as the same corporate entity), and Maine's Department of Health and Humans Services has indicated to MaineHealth that they are willing to allow a single parent company to hold two different non-profit licenses without losing their distinctive statuses. Such arrangements are possible in other states and might permit Coastal Healthcare Alliance to explore merging subsidiaries at some future point.

MAINE RURAL HEALTH COLLABORATIVE:
Joint Purchasing and Contracting

The Maine Rural Health Collaborative (MRHC) consists of five member hospitals: Houlton Regional Hospital, Cary Medical Center (Caribou), Northern Maine Medical Center (Fort Kent), St. Joseph Hospital (Bangor), and Mount Desert Island Hospital (Bar Harbor). Three are independently owned and operated; St. Joseph is a member of Covenant Health; and Houlton is a strategic partner with Eastern Maine Health Systems (EMHS). Northern Maine Medical Center recently entered into a Strategic Network Partnership Agreement with EMHS.

The MRHC LLC was established in February of 2015, and builds on prior discussions by a large group of independent hospitals regarding potential efficiencies that could be gained through collaboration and resource sharing. The MRHC has a board of managers with representatives from all the members, as well as an operations committee with the CEO and CFO of each hospital. There is also a part-time executive director, whose role is to help implement the strategic plan, organize the MRHC's strategic initiatives, and work on the development of by-laws and other governance and management agreements. All the members contribute funds to support the executive director and any consultants.

The MRHC's goal is to maintain the systems and services that work well for the hospitals' communities, with an eye to preserving and enhancing health care in the communities they serve. As stated in the 2015 strategic plan, the purpose is to pursue collaborative activities aimed at promoting the effective, efficient, and rational expenditure of their resources in order to preserve and enhance future access to essential primary and preventive health services within their communities.

MRHC's initiatives focus on shared savings through joint purchases and contracting, including collection and denials management, common employee benefits, and the development of common standards and approaches for coding. Work in 2016 will continue many of these programs and will implement a telemedicine grant that the MRHC recently received.

CARY MEDICAL CENTER AND PINES HEALTH SYSTEM:
Sharing Financial Resources and Specialists

Cary Medical Center (Cary), a 65-bed acute care hospital in Caribou, Maine, and Pines Health Services (Pines), a community-based, multi-specialty physician practice and FQHC serving Aroostook County, have a long-standing, mutually beneficial relationship in which they share resources to ensure that the community and the hospital have adequate primary care and specialty staff to maintain a sustainable health system. According to Pines CEO James Davis, each organization is made stronger by serving the community together.

Pines was founded by Cary 31 years ago, in an era when hospitals were looking to add non-acute care entities to offer a wider range of services. Over time, Pines has become a large multi-specialty physician group with more than 40 providers divided about evenly between primary care and specialists. Although it is unusual for an FQHC to have specialists, their

presence (technically outside the FQHC grant) allows patients to access needed services quickly within the same system. This arrangement functions well due to the strong ongoing relationship with Cary, which maintains an agreement to exchange services and staff. Pines' status as an FQHC allows for better reimbursement for publicly insured and uninsured clients, and has allowed Pines to be less financially dependent on Cary.

Reflecting Cary's role in its founding, the Pines board has two members appointed by the Cary board: the Cary CEO and one additional Cary board member. The Pines and Cary boards interact frequently, with a monthly board member exchange (i.e., a member of one board attends the other organization's board meeting), and a joint board strategic planning retreat every other year. The latter gives them a chance to talk about strengths and opportunities for serving their communities. Cary's CEO, Kris Doody and Pines' CEO James Davis work very closely together.

Cary and Pines collaborate to create workable budgets for Pines. Pines' providers generate about 80-85% of Cary's revenues. In return, Cary provides Pines $2 million annually in community benefit payments to support primary care, and an additional $5 million that enables Pines to recruit specialists. In rural Maine, it would be very difficult for a specialist to be successful with a purely office-based practice, but the relationship with Cary offers specialists access to a hospital-based practice as well. Pines currently employs specialists in areas such as ophthalmology, urology, gynecology, and general surgical services.

Ongoing financial pressure on hospitals to improve quality and reduce costs creates challenges and opportunities in this arrangement. Capitalizing on its primary care resources, Pines is working closely with the hospital to decrease emergency room use; Davis estimates that a third to a half of all emergency department visits could be dealt with in primary care settings, where patients would get more comprehensive, ongoing care at a lower cost to the system. The hospital, in turn, works with MaineCare patients to enroll them in Pines or other practices so they have a medical home and continuity of care.

Maine is not alone in offering new models for organizing and governing hospital, primary care and other health services. The following examples highlight innovative strategies from around the country.

THE WESTERN NORTH CAROLINA (WNC) HEALTH NETWORK:
Hospitals Collaborating to Improve Population Health

WNC Health Network, a 501(c)3 in Western North Carolina, is a collaboration of 17 hospitals that "exist[s] to convene stakeholders and provide support for our members and partners to improve health and healthcare across our region." Founded in 1995, WNC Health Network's continued focus is to provide backbone support for regional health improvement, convene and support workgroups tied to strategic initiatives, and partner to address access and workforce needs. Current initiatives include: WNC Healthy Impact, a partnership between hospitals and health departments working towards a vision of improved community health; WNC Healthy Kids, a population health program designed to reduce and prevent childhood obesity; Director Workgroups, for key personnel such as emergency department directors, Infection Prevention and Control ("The Bug Club"), and Chief Medical Officer (CMO)/Chief of Staff (COS); and priority area workgroups around topics such as mental health/substance use disorders, access to care, and workforce. Past successes include a group purchasing program that has grown to become its own entity, Capstone Health Alliance, and WNC Data Link (2006-2014), the first regional health information exchange in North Carolina. For more information: **http://www.wnchn.org/**

THE RURAL WISCONSIN HEALTH COOPERATIVE (RWHC):
Collaborative Technical Assistance Efforts

Founded in 1979, the RWHC is one of the earliest rural hospital network models. RWHC is owned and operated by 40 rural, acute, general medical-surgical hospitals, and maintains affiliate memberships with additional hospitals and healthcare systems. With a vision of rural Wisconsin communities becoming the healthiest in America, the RWHC's mission focuses on being a strong and innovative cooperative of diversified rural hospitals, and on being the advocate of choice for its rural members. The RWHC emphasizes the development of a collaborative network among both freestanding and system affiliated rural hospitals. It offers programs in the areas of professional services (such as coding consultation, legal services, and financial consulting); educational services (such as professional roundtables, leadership series, and a clinical education series); quality improvement services (such as the CAHPS hospital survey, meaningful use, and a quality indicators program); and technology services (such as data center services and a technology management program). Together these are more affordable and higher quality than they would be if each individual hospital were handling them alone. For more information: **http://www.rwhc.com/**

SPRINGFIELD MEDICAL CARE SYSTEMS (SMCS):
FQHC-Hospital Collaboration

SMCS in Vermont is an integrated health system, serving southeastern Vermont and southwestern New Hampshire that includes Springfield Hospital and a large, multi-site FQHC. SMCS is structured as a non-profit FQHC, governed by an FQHC-compliant board of directors, with the hospital operating as a fully owned subsidiary corporation with its own board. There is a single executive team, and the boards of the FQHC and the hospital collaborate with each other. This unusual structure places preventive and primary care, rather than acute care, as the focus of the delivery system. At the time of the integration (completed in 2012), it was one of the first approved FQHC-hospital collaborative models. Springfield Hospital offers inpatient and outpatient care, 24-hour emergency care, adult day care, and a broad array of specialty care services, with inpatient and outpatient mental health services provided at a satellite facility. Five of the FQHC locations are currently participating in the National Committee for Quality Assurance Medical Homes program. For more information: **http://www.springfieldmed.org/**

WILDERNESS HEALTH:
CAH Collaboration

Wilderness Health is a collaborative of independent health care providers, primarily CAHs, in Northeastern Minnesota and Northwestern Wisconsin. The hospitals work together to advance patient and community health outcomes, improve the patient experience, and lower costs, with an emphasis on rural health issues that affect their communities. The Wilderness Health board includes representatives from each member organization; each member has one vote. Network revenue to fund programs comes from member dues, which are based on organization size and revenue, and some grant funding. Wilderness Health holds roundtables and issue-focused groups for its members, including a human resources roundtable and a CFO roundtable. Shared initiatives include an opioid management program which is implementing consistent practices across members for supporting chronic opioid patients; a data integration initiative to enable better care coordination and care planning for patients; and work with key community stakeholders to improve the continuum of care and identify gaps in care.[2] For more information: **http://wildernesshealthmn.org/**

Considerations for Application in Maine

- Maine has many small communities and providers that lack the capacity and volume to engage in value-based payment and delivery system initiatives. Partnerships among health care providers can be helpful in getting to scale, but they require agreements among diverse organizations. Clear and strong governance structures and systems that give all parties a voice at the table are critical to success.

- Shared governance models entail risks to participating organizations, with benefits that are not guaranteed. They require an ability to embrace a regional perspective, a long-term strategy, and an appreciation that positive outcomes will benefit a wider community than the organization has previously supported.

- Maine has a robust and diverse primary care system, including hospital-owned and independent practices, FQHCs, and Rural Health Clinics, that offer opportunities for innovation. Linking primary care, other providers, and hospitals in new structures and governance arrangements holds promise for creating a better coordinated system of care that is more sustainable in the current environment of value-based payment.

- Policy initiatives, such as Maine's Accountable Care initiatives, create opportunities for innovation in governance but may require organization and state level policy changes to allow for different structure and governance models.

PROMISING STRATEGIES

Population Health Improvement

Increasingly, governance structures are extending beyond hospitals and physician practices to include other community partners. While aiming to improve care management for hospital and primary care patients, these initiatives also seek to better connect healthcare, public health, and social services to address the long-term health of the communities they serve. The following example illustrates one approach in Maine's Somerset County.

SOMERSET PUBLIC HEALTH-REDINGTON-FAIRVIEW GENERAL HOSPITAL (RFGH): Hospital-Sponsored Public Health Partnership

RFGH, an independent CAH in Skowhegan, ME, spearheaded the development of Somerset Public Health (SPH), a local public health partnership funded by the hospital as well as federal, state, foundation, and other sources. RFGH serves as the organizational home for SPH, partially funding and employing SPH's executive director and an administrative assistant. It also provides human resources support, pays for the agency's office space, and serves as the fiscal agent for grants and other funding. The director of SPH reports to the hospital's director of education, and a hospital board member sits on SPH's advisory board. SPH emerged from prior work done by clinicians based at RFGH in developing a cardiac wellness and outreach program, whose program director was able to develop a broad-based partnership of municipal, business, and community organizations throughout the county to undertake wide-ranging health improvement initiatives.

The governance structure set up between RFGH and SPH has allowed RFGH to secure funding for a wide variety of SPH's health initiatives, including the Somerset Explorer Bus Service, a local public transportation system development of SPH in partnership with the

Kennebec Valley Community Action Program, local businesses, municipalities, and New Balance to improve community access to health and recreational facilities, grocery stores, and other vital services; and the regional Partnerships to Improve Community Health (PICH) initiative in which SPH collaborates with Eastern Maine Medical Center, MaineGeneral Hospital, and Health Reach Community Health Centers providing support for SPH's evidence-based chronic disease prevention programs. RFGH's support of SPH's activities is crucial to its ongoing success, and helps it to build key partnerships with stakeholders and other healthcare organizations.[3] For more information: **http://www.somersetpublichealth.org/**

In addition, a number of states, like Vermont and Minnesota have adopted policies that specifically target the development of new delivery systems and accompanying governance structures. Some examples from other parts of the country follow.

MT ASCUTNEY HOSPITAL AND HEALTH CENTER, VERMONT:
Hospital Supported Community Organizations

Mt. Ascutney Hospital and Health Center (Mt. Ascutney) is a non-profit entity affiliated with the Dartmouth-Hitchcock system located in Windsor, Vermont. Mt. Ascutney provides leadership, staffing, and resource support for several community initiatives, most of which are built around local partnerships involving diverse community organizations. In its role as a convener, the hospital has sought to build and maintain relationships among community providers and agencies and widely shares credit for the success of these initiatives among participants. The hospital has also played a leadership role in securing grant and other funding for many initiatives, again distributing that funding to participating partners. These include the Windsor Area Community Partnership, a coalition of community agencies and providers, convened by Mt. Ascutney, that facilitates strategic planning, ongoing communication, and local oversight in promoting the health of the community; the Mt. Ascutney Prevention Partnership (MAPP) and the Windsor Area Drug Task Force, substance abuse initiatives focusing on policy and environmental strategies to shift community attitudes and norms regarding alcohol, tobacco, and drug use; and the Windsor Health Service Area Coordinated Care Committee, an interagency leadership collaborative dedicated to the triple aim, whose key priority areas include emergency department readmissions, quality of life, and best practice approaches.[3] Staff from the hospital, especially the director of community outreach and the chief of nursing, provide leadership for many of these initiatives, and the hospital serves as a fiscal sponsor in some cases (such as MAPP). For more information: **http://www.mtascutneyhospital.org/**

SOUTHERN PRAIRIE, MINNESOTA:
Accountable Care Organizations

Southern Prairie refers broadly to a collaboration among 12 counties in southern Minnesota with a common goal: to enhance the quality of life and health of their citizens by facilitating the integration of services and supports provided throughout their communities. It includes two complimentary organizations, Southern Prairie Community Care (SPCC) and Southern Prairie Center for Community Health Improvement (CCHI). SPCC is a joint powers organization formed in 2012 by the counties in the Southern Prairie region, and has evolved to be a virtual network, focused on achieving improved clinical quality, lower total cost of care, and enhanced patient experience. The organization operates as an accountable care organization that contracts with Minnesota's Medicaid program, part of a state demonstration project designed to support and encourage improved patient health at lower cost by agreeing to a set payment for the treatment of the entire population. SPCC

has 27 member providers, including clinics, hospitals, mental health centers, public health, and area human service agencies. The board is comprised of the county commissioners from each county. According to the collaborative, a key strength of the organization is SPCC's ability to mobilize community services around those with the highest needs, and to leverage connections between the governance of SPCC and that of health and human service agencies, mental health centers, and county hospitals in the region.

CCHI convenes community partners interested in making measurable and sustainable improvements in the health of the residents in southwestern Minnesota. The governance structure includes a charter agreement that details the relationship between the two organizations (SPCC and CCHI) and specifically defines the role of CCHI in furthering the Southern Prairie mission. Local stakeholders make up the CCHI board of directors, delivering services in the region and working to advance the goals of the Triple Aim. The CCHI board has equal representation from the SPCC board and operations representatives, public and private providers of care and services, and consumers — each playing a key role in advising SPCC on the best approaches to achieve the organization's priority goals.[4] For example, health care providers assist CCHI in reviewing major health trends in their communities, and recommending action to address issues of concern, while SPCC representatives serve as liaisons to CCHI to promote transparency, ensure alignment with the mission, and facilitate ongoing communications between the partner organizations. CCHI provides recommendations to SPCC on quality improvement efforts and programs to address issues that require a collaborative evidence based improvement effort in areas such as health information technology, environmental public health, and gaps in the health care system. For more information: **http://www.southernprairie.org/**

ALIGNING FORCES HUMBOLDT, CALIFORNIA: County-based Initiatives Improving Care Coordination through Community Organizations

Aligning Forces Humboldt was an initiative in rural Humboldt County, the northern-most county in California. Launched with funding from the Robert Wood Johnson Foundation, Aligning Forces Humboldt developed a network of health care stakeholders, including providers, consumers, employers, and community leaders to develop a coordinated approach to health promotion, disease prevention, and early treatment by engaging the local community, and partnering with area health and human services organizations. In Humboldt County, health and human services operate through an integrated county-wide system. Community-based health care systems, in turn, were looking for opportunities to better coordinate programs and improve partnerships. Aligning Forces Humboldt's three programs included a patient engagement model to support patients in better managing their own care and becoming peer leaders and better informed patients; a surgical rate project to reduce rates of surgical variation; and a super-utilizers project, aimed at coordinating care to reduce overutilization of the emergency department. The projects were chosen with an eye towards system redesign opportunities, particularly ones that intended to include both patients and the community in healthcare decision-making.[5] Aligning Forces Humboldt built on the county's longstanding integrated community partnership, based in a client-centered model of health care service delivery that combines both health care and social services, with close ties to education and other community resources.[6] For more information: **http://cph.uiowa.edu/ruralhealthvalue/files/HumboldtCounty.pdf**

Considerations for Application in Maine

- Creative, practical thinking about traditional health care system structures can lead to better integration of population health and community health improvement initiatives with traditional primary and acute care structures and systems.

- The fact that Maine lacks a formal, county-based public health system may provide opportunities for hospital-public health collaboration.

- Although financing of population and community health improvement remains challenging, communities throughout Maine have the potential to use a combination of institutional, hospital support, and external grant funding to jump-start population health initiatives. Hospital-based leadership and infrastructure support provides a crucial backbone to many community population health initiatives.

- A fully integrated system of care, without the usual silos between health care delivery and social services, can take broader aim at some of the social determinants of health that lead to poor health and worse outcomes for the population.

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