PRINCIPLES OF RURAL HEALTH NETWORK DEVELOPMENT AND MANAGEMENT

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ALPHA CENTER

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PREFACE

This primer on the principles of rural health network development is part of a series of technical assistance reports produced under the *Networking for Rural Health Project*, an initiative to strengthen the rural health care delivery system by fostering the development of rural health networks. The Project is directed by the Alpha Center with grant support from The Robert Wood Johnson Foundation.

A primary goal of *Networking for Rural Health* is to provide a variety of technical assistance tools and services to support network leaders. These technical assistance tools will be made available to rural health networks throughout the nation. For more information about the Project or to make suggestions for future reports, workshops, or other ways to support rural communities, please contact the Alpha Center at 1350 Connecticut Avenue, N.W., Suite 1100, Washington, DC 20036; 202.296.1818 (phone); 202.296.1825 (fax); or www.rural@ac.org (e-mail).

Please note that all names of particular networks or network participants in this document are fictitious. Examples and appendices are for illustrative purposes only and are not specifically endorsed by the Alpha Center.

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TABLE OF CONTENTS

INTRODUCTION

Providing the right mix of health services in the right locations at the right price and with the requisite quality is extremely difficult for many rural communities. Inadequate resources, such as personnel and capital, may limit the supply of health services, and lack of coordination among health care providers may cause the limited resources that do exist in rural areas to be used inefficiently. Licensing laws and regulations for health care institutions and providers and the payment policies of third-party payers emphasize the uniqueness of various providers and may implicitly drive them apart.

With increasing frequency, rural communities are turning to networks to bring some order to their delivery systems. Certainly, rural health networks will not and cannot solve all problems in the rural health care environment, but they may help to improve the availability and quality of health care services or reduce their cost. They cannot, for example, change the Medicare payment system for hospitals, but they may be able to reduce the cost of providing care, making the payment system less of a problem.

Rural health networking is a collaborative strategy. It requires individual actors to come together voluntarily, agree on a course of action, and take action cooperatively. Because the individual goals of the actors may differ, it is not always easy to agree on common goals, let alone a common strategy for achieving goals. Rural health networking is not easy; it requires time, trust, will, and skills. Network members must have the ability to separate their individual goals from the common goals of the network and the vision to see the potential benefits of joint action.

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Networks are types of partnerships and as such they must respond to their members' compelling needs and must demonstrate benefits in order to prosper. Like all organizations, rural health networks prosper when they have clear goals and objectives, action plans, and control systems. Establishing and maintaining these organizational elements requires time and hard work.

PURPOSE OF THIS PUBLICATION

This document is intended to be a ready reference on network development and management. It informs individuals and networks about the challenge of networking, helps them to anticipate and overcome obstacles, and above all, allows them to develop and maintain a structure that fosters collaboration and win-win scenarios. Thus, the concepts contained herein are intended to help physicians, community leaders, health care service administrators, and network staff and board members develop successful rural health networks. This primer provides existing and potential rural health network leaders with perspectives, tools, and tips central to effective network development and operation. It is not meant to be prescriptive,

but rather illustrative, of options networks may employ. Case studies, based on actual experience, have been selected to convey the diversity of rural health networks and to provide concrete examples in the text.

The document begins with two real-world examples that illustrate the organization and management of rural health networks. The subsequent two chapters include a definition of rural health networks, a description of the characteristics of networks, a discussion of the organizational forms networks take, and an outline of the factors prospective network members should assess before proceeding to form a formal network. Chapters 4 and 5 concentrate on the skills necessary to manage networks successfully and include a discussion of how rural health networks set goals and organize to accomplish objectives.

This primer is not meant to be the definitive source on the topic of rural health networking. It is, instead, an introduction to the topic for those who think they may want to formalize their collaborative activities.

CHAPTER 1

Key Elements of Rural Health Networks

Rural health networks can vary considerably. Differences among rural communities in their culture, history, and geography, the personalities and skills of key participants, and perceptions of health care problems produce networks that are quite dissimilar. Even networks that form to solve similar problems may differ due to local circumstances. Despite these dissimilarities, all rural health networks share some common elements. In this chapter we highlight the common elements of rural health networks using short case studies of two hypothetical networks. Throughout the monograph we occasionally refer to these case studies to help illustrate a point about networks.

The experiences of the two case-study networks are diverse: the Mountain Area Advanced Life Support Network is a network of emergency medical advanced life support services, and the First Choice Health Network is an administrative service organization composed of a rural hospital and local physicians. Yet, four key elements of network development and operation are shared by both of these successful networks:

1. Compelling need - The network was formed in response to a compelling need that was mutually recognized by prospective network members.

2. Expected benefits - Expectations of network performance were clearly articulated by each key participant; the network was formed to provide benefits to members, the public, or both.

3. Network form and function - Network form was determined by expected network functions.

4. Key participants and actions - Network members were organizations or individuals whose resources were essential for success.

Successful networks respond to the needs of their members and the communities they serve. Ultimately benefits determine network viability. Networks produce benefits for their members, for example, when they increase member revenue or expand the market share of members. Rural communities benefit when rural health networks develop needed services or improve the health and well-being of the community. The following case studies illustrate key principles in rural health network development.

CASE STUDY

Mountain Areas Advanced Life Support Network

THE CHALLENGE:

Improving the Local Emergency Medical Services System

The service area is mountainous and sparsely populated; it encompasses 2,500 square miles and has 21,000 residents. The closest hospital is 90 miles away and travel can take up to two-and-a-half hours during winter months. Small, individual emergency medical service squads at volunteer fire departments in this region have only first responder capacity to perform traffic control, immobilize victims, and transport them to hospital emergency rooms. No active medical care is provided and, as a result, the community has a high rate of preventable deaths and disabilities. The squads do not have: 1) the capacity to train or retain advanced life services (ALS) technicians; 2) the financial resources for medical equipment; or 3) the administrative resources and expertise to monitor the quality of advanced life services. In addition, a proprietary ALS program, located in the closest neighboring urban area, has been approaching local government for financial support for a satellite ALS capacity in the area. The Mountain Areas Advanced Life Support Network is a private not-for-profit corporation composed of 12 self-selected representatives of 20 Emergency Medical Services (EMS) squads in the area.

COMPELLING NEED

This mountain area is a great place to live and a beautiful place for recreation, but it is not a place that readily lends itself to an efficient response to medical emergencies. The compelling need for the formation of the network was the lack of access to emergency medical services in this area. EMS access was impeded by: 1) distance, which is attenuated by inclement weather, mountainous topography, and rivers and lakes that must be circumnavigated; 2) irregularity in the availability of EMS personnel; and 3) limited ability to pay for services, made more expensive by the absence of economies of scale.

The region does not usually enjoy the development experienced by the rest of the nation or state and the population tends to like it that way. This means, however, that economic resources are limited. The most important sources of employment are tourism, forest products, government services, retail sales, and health care. Incomes are low to moderate by national standards. The population is widely dispersed and there is no public transportation. The area covers five counties.

The EMS squad network was formed due to the lack of ALS capacity and impending competition and loss of local control of ALS services. Volunteer EMS rescue squads operated by local fire departments had basic training through which they could immobilize accident victims, apply bandages if needed, and then transport them to the nearest emergency room. Most could not administer medication under the direction of a physician. In addition to this lack of training, the EMS squads were funded primarily through local fund raising events and could not afford medical equipment, such as defibrillators. The few squads that had advanced life support technicians had difficulty performing independent quality reviews because technicians would be reviewing their own cases.

EXPECTED BENEFITS

Each EMS squad expected benefits that were directly related to the compelling need for the net-

work. Specifically, the squads wanted:

- ALS-trained staff;
- defibrillators;
- formal communication and feedback systems with medical control provided by the hospital;
- assistance with quality assurance and quality improvement;
- a mutual aid system;
- start-up funds for new services; and input to the emergency dispatch system.

FORM AND FUNCTIONS

The Mountain Areas Advanced Life Support Network began in 1984 as an ad hoc committee of volunteer EMS providers. Because of size, intensity of interest, and the newness of the concept and organization, during its early years the Board functioned as the Planning and Development Committee. In 1988, the network became a not-for-profit (501(c)3) corporation. Incorporating improved the ability of the network to employ staff, apply for, receive, and administer grants, contract for services, and generate revenue. These functions were too diverse and time-consuming to be conducted on a decentralized basis by individual committee members. In addition, by developing a formal structure for the network, a more stable and long-term identity was established; the network was taken more seriously by external organizations such as non-member hospitals, governmental agencies, and funding bodies. The corporate identity also more truly represented the organizations as a network and reduced the potential that individual organizations might pursue individual agendas in the name of the network.

KEY PARTICIPANTS AND ACTIONS

Initially, the ad hoc network committee was a self-selected group of volunteer EMS providers who reflected the geography of the area and the skill levels of the EMS agencies in the service area. The concept behind committee selection was to have interested, dedicated participants rather than agency representatives who were "filling slots."

This ad hoc committee evolved into an incorporated structure and all ad hoc network committee members became members of the board of directors of the incorporated successor network. Other key participants, who were not ad hoc committee members but active in the network, included the network's medical director, who was also the emergency room director at the local hospital, the local hospital chief executive officer, emergency personnel from the county and regional organizations, and representatives of the local rural health network. All were essential because of their respective roles in the EMS system and the surrounding health care system to which it relates. The medical director was indispensable in the development and implementation of the program, especially in the establishment of protocols and the work of the Quality Improvement Committee, and in establishing respect and trust with physicians covering the emergency room. County and regional emergency services personnel provided links to governmental programs and oversight functions. A second local rural health network, which is composed of primary-care clinics, preventive health care service programs, and local hospitals, provided routine access to virtually all primary-care providers in the area and offered considerable expertise in planning, community development, and grant writing.

In 1998 board composition became more formalized due to state requirements. Each EMS squad in the area was required to designate a board member to deal with the issues of credentialing of squads and patient billing.

The primary accomplishment of the network is the routine sharing of skilled ALS providers among EMS agencies providing service within the local hospital service area and contiguous regions. The availability of locally controlled ALS services has also discouraged urban-based ALS services from taking advantage of market opportunities by expanding into the rural service area and competing with local EMS squads.

There is much that goes on behind the scenes that facilitates networking. The network has developed systems for dispatch, radio communications between ALS technicians and ambulance crews,

review of calls and quality improvement functions, original training and continuing medical education, regular re-credentialing and enhanced communication between EMS agencies.

Initially, 10 agencies were part of the quality improvement process. Other squads have joined the network because of these benefits. Twenty-five agencies now provide EMS services under the direction of the network medical director and the quality improvement committee. The network has recently begun to work with a cardiology group on patient outcomes in order to explore the relationship between the provision of cardiac care and mortality.

OUTCOMES

Community Benefit: Reduced Mortality

First and foremost, the network has saved lives. People experiencing heart attacks can now be defibrillated and receive cardiac medication within 20 minutes of contacting emergency services such as police, county sheriffs, or fire departments. Severe allergic reactions can be treated with appropriate medication within the same time frame. Accident victims experiencing severe uncontrollable bleeding can receive intravenous solutions. The number of individuals receiving pre-hospital care has more than tripled since the network's inception.

Network Member Benefits: Improved Staff Training and Competitive Position

Each network member wanted to improve its capacity to provide emergency response services and discourage the involvement of urban competitors in their service area. Because of the network, all squads in the area currently have defibrillators, as well as staff trained in ALS services (or can obtain network staff with that level of training). All participate in a centralized quality assurance/quality improvement process that routinely reviews all cases in which ALS services were required. In addition, communication between the squads, and between squads and the hospital emergency room supervising physicians, has been improved. Urban-based ALS providers have lost interest in expanding into the area due to the success of the network. By joining forces as a network, the EMS squads created an entity to obtain funds for EMS services and equipment and to provide training and supervision, which each operating on its own could not have accomplished.

Key features of this network are summarized in Exhibit 1.

EXHIBIT 1

KEY ELEMENTS OF THE MOUNTAIN AREA ADVANCED LIFE SUPPORT NETWORK

Compelling Need		Expected Benefits		Network Composition		
Community	Network	Community	Network	Form	Functions	Participants
Preventable deaths and disabilities caused by trauma	Lack of ALS equipment and training Loss of local control of EMS services	Saved lives Shorter and more complete rehabilitation of patients	ALS equipment and training Local control of EMS services Improved hospital medical control Improved overall quality	1984 - Informal	ALS training or linkage Obtaining funds for ALS equipment Developing pre-hospital treatment protocols	Selected volunteers
				1988 - Incorporated	Employ staff Coordination of complex programs Apply for and administer funds	All volunteer squads Medical Director, hospital CEO, governmental EMS, and rural health network

CASE STUDY

First Choice Community Health Network

THE CHALLENGE:

Providing Administrative Services to Rural Self-Insured Employers

Local employers were concerned about high health insurance premiums for their employees. The employers were paying community-rated premiums that were based upon the comparatively higher health service costs of urban communities approximately 100 miles away with whom they were "community" rated. The problem was compounded by the employers' interest in funding employee assistance and preventive health programs and their inability to justify the cost-effectiveness of such programs to corporate headquarters. The employers thought that self-insurance was a way to restrain the costs of benefits, to support preventive programs for reducing disabilities in the work force, and also to support local health care providers.

In response to the employers' interest, the First Choice Community Health Network was formed to provide administrative services to self-insured employers in rural communities. This for-profit network was formed by the local hospital and local independent physicians to help employers reduce employee health insurance costs without reducing benefits and to assist them in contracting with local providers for health care services.

COMPELLING NEED

The network service area has two major population centers approximately 30 miles apart. Two hospitals had been located in these communities until four years ago, when the hospital in the eastern region closed due to financial difficulties. Excluding these two centers, the area is made up of many small towns with sprawling green space, orchards, and lake shores, whose independent people are characterized by strong friendships, family ties, and values. When things need to be done, the movers and shakers of the community meet after church, for coffee in the local diner, or in their homes. Boardrooms, assistant vice presidents, and tortuous agendas are not part of these communities. Commerce and community enterprises are conducted face-to-face; owners deal directly with one another rather than through a cadre of subordinates. For example, the mayor might call the public health director to identify ways to publicize rabies vaccines. People prefer to handle things their own way and are skeptical of the involvement of the big cities to the east and west.

Two major urban areas with tertiary medical centers lie 45 miles from the area's eastern and western borders. Health care insurance companies and health maintenance organizations (HMOs) apply their community ratings for these urban areas to premiums sold in the network service area. With increasing frequency, their policies have limited choices of practitioners and have started to draw patients away from the existing hospital and specialists in the community to urban-based practitioners.

The compelling need for this community is more affordable health insurance costs. Local employers were unable to control the premiums that urban HMOs and health insurance plans charged for health care benefits. Small businesses, very much the fabric of these communities, were hesitant to reduce employee benefits because of the economic demands it would place on their neighbors and friends. The network was interested in helping employers develop self-insurance plans because they could generate revenue through providing administrative services and promote goodwill between the

network and local employers. Local providers were very much interested in potentially contracting with the local employers for health care services and maintaining or expanding market share.

EXPECTED BENEFITS

The network members — the hospital and physicians — expected increased net revenue for administrative services.

FORM AND FUNCTIONS

The network originated as a working committee composed of hospital administration, key primary care and specialist physicians, and consultants. Following a series of interviews with local employers, the immediate functions of the network were determined:

- Assess interested employers' health care benefits with specific attention to covered services, co-pay requirements, and premiums.
- Develop corresponding employer and preferred provider contracts, including scope of services, payment, and fee schedules.
- Assist employers in estimating potential financial risks and obtaining stop-loss and reinsurance coverage.
- Develop a method for distributing the administrative services profit to the network board of directors.
- Determine start-up costs for the program.

To conduct these functions the network established a new corporate presence. The local hospital could have carried out these functions, but the hospital was reluctant to blur its community health care service mission by possibly being seen as a "third-party administrator." Local physicians also wanted to be full participants in the enterprise. Consequently, a for-profit corporation was formed. It was the organizational form preferred by members because it allowed the board of directors to share excess revenues.

KEY PARTICIPANTS AND ACTIONS

The hospital's chairman of the board, chief executive officer, medical director, quality assurance director, management information service director, and director of community services all represented the hospital on the network board of directors. The physician composition of the network board included family practitioners from each of the area's four communities, a pediatrician, an obstetrician/gynecologist, an ophthalmologist, a cardiologist, and a general surgeon. The hospital constituted a majority of the board and was apportioned 12 votes, which are cast by the hospital chief executive officer. The physicians were apportioned eight votes, one for each physician. This ratio was also used to calculate each member's share of start-up costs and earnings, should revenues exceed expenses.

All administrative functions were conducted for the network by hospital appointees or consultative staff. Physicians were instrumental in determining the requirements of preferred provider panels with which the school boards could contract for medical services for their employees. The physicians were expected to assume the responsibility for utilization review as the network expanded into this function that would assist employers in reducing costs to a greater extent. As the network expands into that area, it will develop agreements on sharing portions of these cost savings with its self-insured clients.

After two years of operation, the network served five employers that have a total of 2,400 employees. These employers have experienced cost savings, but not to the extent originally envisioned. Cost increases for benefits, not covered by the preferred provider network, have cut into anticipated savings.

OUTCOME

Community Benefits: Lower Health Insurance Costs

The employers' budgets for health care benefits have been reduced for the last three years, yet the benefits available to their employees have not been compromised.

Network Benefits: Revenue Increases

The local hospital and physicians who are on the network's board of directors share in the profits that accrue to the corporation for administrative services and the local hospital and physician communities have generated goodwill with local employers for assisting them with this task.

Local Provider Benefits: Revenue and Market Share

Participating providers, as preferred providers of the employers, have experienced an increase in revenue for services, therefore increasing their financial viability.

The network has also helped ensure that health care services remain under local control; urban-based hospitals have been discouraged from locating primary-care physicians in the service area. An evolving network benefit is the community's growing recognition of the network and participating providers as community partners in efforts to make health care more affordable.

Key features of this network are summarized in Exhibit 2.

EXHIBIT 2

KEY ELEMENTS OF THE FIRST CHOICE COMMUNITY NETWORK

Compelling Need		Expected Benefits		Network Composition		
Community	Network	Community	Network	Form	Functions	Participants
Uncontrollable high health insurance premiums Lack of employee assistance programs	Surplus administrative capacity	Lower premiums Healthier more productive employees	Revenue producing administrative services	Incorporated	Review existing benefits Define service contracts, fees, terms, and scope of service Assist in negotiating preferred provider contracts Assist in obtaining stop loss insurance and reinsurance	Hospital administration and local physicians

Note: This network did not directly provide health care services. However, some of the network members became preferred providers of the local employers and hence also benefited through maintaining or expanding market share.

CHAPTER 2

Rural Health Networks: Definition and Concepts

Rural health networks have become more pervasive in recent years. Hospitals, community health centers, public health agencies, community coalitions, the federal and state governments, and philanthropic foundations consider rural health networks to be among the best strategies for maintaining scarce rural health resources in times of increased competition and decreasing operating margins. While these entities agree that rural health networks are a good thing, they do not all agree on what a rural health network is.

The Medicare Rural Hospital Flexibility Program (also known as the Critical Access Hospital program) created by the Balanced Budget Act of 1997 defines networks as consisting of at least two licensed hospitals, one of which is rural, and which meet a series of requirements for critical access hospital certification. The federal Office of Rural Health Policy's Rural Health Network Development Grant Program requires rural health networks to be composed of at least three independent providers of different service types. Other programs, such as the New York State Networking Program, are less restrictive and support generic "networking activity." All programs for rural communities, however, require networks to originate from locally determined needs and interests and to reflect local circumstances.

WHAT IS A RURAL HEALTH NETWORK?

The *Networking for Rural Health Project* defines a rural health network as a formal organizational arrangement among rural health care providers (and possibly insurers, social service providers, and other entities) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved (*Networking for Rural Health, Request for Applications,* May 1999).

This definition contains the following characteristics:

1. Multiple independent rural health care providers and possibly other members;
2. Documentation of participation by each network member;
3. Definition of the roles and responsibilities of network members;
4. Specification of expected short- and long-term benefits; and
5. Acquisition of resources to achieve expected benefits.

Characteristic 1: Multiple Independent Rural Health Care Service Providers

This characteristic emphasizes the nature of networking: *independent* organizations or practitioners *voluntarily* collaborating and sharing resources as a *means to an end.* The characteristic implicitly recognizes the shortage of technical resources in rural communities and the need to join forces to compete and prosper.

Large health systems owned by the same corporate parent are not considered to be networks within the context of this program. They may contain multiple health care service providers, but because they

are owned by a single entity, coordination among them is a corporate requirement rather than a self-determined way of doing business.

Corporately related entities are required to work together by their common owner; networks of independent agencies voluntarily choose to work together.

Characteristic 2: Documentation of Participation by Each Network Member

Written documents help to confirm that participation is real and significant. The availability of funding for network projects has encouraged the development of "name only" networks. In such networks, a lead organization may have the support of local programs for networking projects, but in fact, the lead organization is often the only entity that will benefit directly from the project. Partnering or networking in these arrangements likely will be minimal.

Characteristic 3: Definition of the Roles and Responsibilities of Network Members

Projects involving multiple organizations can get bogged down and become counterproductive if the roles of key participants are not determined early in the network development process. Defining members and their functions also pinpoints the contributions network members make and their corresponding importance to the network itself. Roles also differentiate between core members and interested parties. The greater the role, the more essential the commitment and level of participation. As network member interests wax and wane, shifts in roles and responsibilities should be expected. Also, all network members should not be expected to participate in all network objectives or programs. Network members should select and participate in those programs that provide them the greatest benefits. As with documentation of participation, the roles and responsibilities of network members should be outlined in a written document.

> Networking is independent organizations or practitioners voluntarily collaborating and sharing resources as a means to an end. Organizations implicitly recognize the shortage of technical resources in rural communities and the need to join forces to compete and prosper.

Characteristic 4: Specification of Short- and Long-Term Benefits

The specification of both short- and long-term benefits is essential. Short-term benefits are generally easy to accomplish and provide incentives for continued participation. They also help to keep the network moving and prevent inertia or lack of interest. Long-term benefits are generally more complicated to achieve, but may be ultimately more beneficial. However, they may take several years to accomplish and may be too broad to motivate organizations facing considerable challenges on a daily basis.

To whom do the benefits of networking accrue? Many rural health networks engage in activities that directly benefit their members. These benefits may improve the viability of local providers and also may indirectly benefit the community. Other rural health networks engage in activities that explicitly target community problems, which, if solved, will benefit the community at large.

Member Benefits

Some rural health networks exist primarily to produce benefits for their members, for example lowering operating costs or improving access to scarce operating resources. Network members should state the benefits they anticipate from participation both on a short- and long-term basis. This criterion can be met as network members answer the question: "What's in it for me?" These answers need to be shared openly with all network participants. The answer is a strong indicator of the commitment of participants: the more critical the benefit is to a member, the more energetic and resilient its participation likely will be. Further, by sharing expectations, network members may find synergy and the opportunity to achieve their collaborative goals.

Community Benefits

Rural health networks also exist to provide benefits to the communities they serve. They may provide benefits either directly or indirectly. Direct benefits to a community are those derived from specific network goals and plans. Examples of direct community benefits are improving local access to services and development of community health promotion and disease prevention programs. Indirect benefits are those that accrue to the community when network members pass on benefits that they have gained through participation, for example, lower costs or improved quality. Despite the distinction made here between member and community benefits, in practice many benefits are shared.

Characteristic 5: Acquisition of Resources to Achieve Expected Benefits

To achieve the benefits network members expect, networks must be able to marshal resources, which help turn plans into action. Resources may be made available to the network by the in-kind contributions of members, for example, the donation of staff time, office space, equipment, and so on. Network members may also provide money to the network in the form of dues, corporate shares, or contributions. These resources allow the network to purchase the means to accomplish their goals. Successful, mature networks are self-sustaining. Through the services they produce, they generate revenues sufficient to cover the costs of operating the network.

Successful, mature networks are self-sustaining. By providing services, they generate revenues sufficient to cover the costs of operating the network.

WHAT FORMS DO NETWORKS TAKE?

Networks can take many forms, the simplest of which may be characterized as an informal network. This arrangement consists of a casual group of interested parties convened to discuss issues of mutual concern and potentially to take action to ameliorate a problem. Participation in informal networks is ad hoc and decisions do not bind. Informal networks have no written agreements to define membership, outline member roles and responsibilities, and state the expected benefits of participation. These networks typically engage in information sharing, joint planning, and, to a limited degree, resource sharing (education, equipment, and staff). Within the limited scope of activities undertaken, these networks can be effective. Informal networks also may function as the base upon which formal networks are built. Informal networks allow participants to test various combinations of members, build trust, and identify common interests outside of a legal structure and without a large financial investment.

Formal rural health networks take one of two predominate forms: they are either governed by a written agreement, or they are incorporated as a legal entity. At a minimum, written agreements such as letters of agreement or memoranda of understanding describe the purpose of the network and list its members. Networks based upon a written agreement may elect officers, adopt operating procedures, form subcommittees, and implement programs. They are the preferred form when the network has a modest agenda, performs most of its responsibilities using in-kind resources, does not require employees, and cannot act on behalf of its members without explicit approval from all member organizations. Formal networks such as these may address a short-term problem and disband after the problem is solved or they may continue in operation for a number of years.

Incorporated networks may be operated as either not-for-profit or for-profit entities. They have articles of incorporation that describe their purposes, initial directors, and location of offices. Incorporated organizations have bylaws that define corporate officers, board members, voting rights and requirements, tenure of office, manner of election and removal of officers, and specific functions or committees. Bylaws of for-profit corporations may also outline the basis for distributions of profit to directors or shareholders. Incorporated networks tend to be "going concerns" and are considered more per-

manent than networks based only on written agreements. (See *Forming Rural Health Networks: A Legal Primer,* the first in a series of monographs available from *Networking for Rural Health,* for a more in-depth discussion of network organizational structures.)

The organizational form of rural health networks is fluid. A network that started out as an informal network may decide to execute a memorandum of understanding to obtain grant funding. If the network is successful, it may decide to incorporate. Not-for-profit networks may decide to engage in for-profit enterprises and establish subsidiary for-profit corporations. For-profit networks may establish not-for-profit corporations to provide charitable or education-related services.

WHY SHOULD ONE ORGANIZATIONAL FORM BE SELECTED OVER ANOTHER?

The more complicated the network programs and operating procedures, the greater the need for a corporate structure. Networks that engage in projects, which carry potential liabilities — medical or financial — should be incorporated to minimize personal liability of members.

The actions of incorporated networks are more likely to be construed as representative of the network as a whole rather than one or two agencies that perform leadership roles in informal networks or those governed merely by a written agreement. Additionally, network employees, especially the director or coordinator, are more clearly linked to the network and less open to claims of conflict of interest than staff who are on loan or leased from network members.

Exhibit 3 lists questions that network members should ask themselves when determining whether a network needs a separate legal organization.

WHO PARTICIPATES IN RURAL HEALTH NETWORKS?

With the exception of physicians, the members of networks, in most cases, will be organizations. However, the business of networking is accomplished by people and not organizations. The individuals who represent network members are as varied as the rural health landscape and may include physicians, nurse practitioners, hospital trustees, nursing home administrators, public health practitioners, and elected officials. Just as the form of the

EXHIBIT 3

FACTORS IN DETERMINING WHETHER A NETWORK NEEDS A SEPARATE LEGAL ORGANIZATION*

Organizational Considerations

- Does the network need a central authority that can act other than by consensus of members?
- Does the network plan to expand membership, possibly to the point where the number of members precludes decision-making by consensus of all members?
- Will the network engage in several types of activities or exist for an extended period of time?

Legal Considerations

- Will network activities generate revenue that must be reported and possibly taxed?
- Will the network own real or personal property?
- Will network activities require dedicated employees?
- Will network activities require the consortium to borrow money?
- Will network activities generate potential liabilities from which members should be protected?
- Can network activities be adequately insured without a separate organization?
- Will network activities require:
  - Licenses?
  - Significant contracts with non-members (e.g., leases or service contracts)?
- Will the network seek grants (e.g., from private foundations)?

* This list was created for the "Legal Issues and the Formation of Rural Health Networks Workshop" by Monte Dube, J.D., McDermott, Will & Emery, 227 West Monroe Street, Chicago, IL 60606-5096.

network is determined by the functions it performs, network participants are selected on the basis of their importance to the mission of the network. There is no list of appropriate network members. Networks attending to primary care issues require primary care providers; those addressing HMO development may need an insurance partner.

Considerable disagreement exists over the desired size of rural health networks. Some support an all-inclusive, come-one come-all approach, wherein no organization or individual can be denied participation. Others caution that unless participation is limited to key stakeholders, network efforts will become diluted and members will lose interest. The lack of empirical evidence showing that one network size and composition is superior to another fuels this debate. In general, rural health networks should be only as large and as complex as is necessary to achieve their goals, given the local political environment.

The membership of successful rural health networks may be expected to expand as organizations seeking the benefits of membership apply to join the network. Initial successes also provide positive momentum for the network, creating a base for expansion of membership as needs change.

> **Networks that engage in projects, which carry potential liabilities — medical or financial — should be incorporated to minimize personal liability of members.**

Like network structure, the membership of networks can be fluid. Depending on the internal policies of the network and the external demands of the environment, new members may join the network and established members may resign. The continuous review of objectives and work plans often identifies the need for new participants or capacities. Before parties interested in networking decide upon final membership composition, they should define their missions and, to the extent practical, their short-term objectives. In an ideal scenario, networks should include all organizations that are likely to make a significant contribution to the attainment of the network's objectives.

RURAL HEALTH NETWORKING CONCEPTS

Rural health networks offer promise as a means of restructuring and stabilizing health care programs in rural communities. Many community leaders and health care professionals consider networking as an option, but wonder if they are ready to develop a network.

Health care leaders who want to form a network should consider first the question of need. If a compelling need is present, the second step in forming the network is to make other health care professionals and community leaders aware of the compelling need. If the need is recognized and considered crucial by other leaders, the third step in the process is the examination of joint strategies for satisfying the need and the willingness of potential partners to collaborate. If these conditions are met, leaders need to develop a plan of action. What is a compelling need, what is sufficient recognition of the need, and how do you judge interest and willingness to partner?

Compelling Need

A compelling need is a substantial health problem that, if not solved, will dramatically affect the health and well-being of community residents, local providers, or both. Compelling needs for networks also have an additional characteristic: the problem cannot be solved by the action of only one actor in the community. In other words, the problem must not only be important, but also require collective action to solve.

Compelling need takes many forms, such as poor health status measures or high incidence of preventable disabilities, as those experienced in the Mountain Areas Advanced Life Support Network example. Compelling need can also take the form of economic circumstances, such as the high health insurance premiums paid by local employers as in the community served by the First Choice Network. Compelling needs are often identified intuitively without relying on special studies to identify problems; they emerge from the community's pain or provider's recognition of current or impending loss of revenue or market share. The impact of the problem is keenly felt locally, and community or local health care providers are anxious for solutions to the problem.

A mutually recognized compelling need is the magnet that draws network participants together. It is of sufficient strength to overcome historical antagonisms and the awkwardness participants who have not worked together previously may feel. The expectation of benefits — solving the problem — bonds members of the network together. Compelling need overcomes the fears that individual members may have of surrendering partial autonomy to the network. Compelling need, therefore, is very important to networks because it both brings and holds members together.

Needs change as successful networks solve their problems. Over time, a successful network may come to be viewed by its members as a platform for solving other problems. As part of a process of identifying new problems, the network may undertake formal needs assessments. Chapter IV pertains to needs assessment and provides information on methods rural leaders can employ to assess and determine local needs.

A mutually recognized compelling need is the magnet that draws network participants together.

Tip: Once the need is identified, ask the question, "What will happen if we do nothing?" Loss of lives, jobs, or institutions are compelling answers.

Recognition of Need

Compelling need may exist, whether members of the community recognize it or not. For compelling need to spark network formation it must first be recognized. A shared perception of need is the bedrock of network development. People and organizations will not work together meaningfully unless they are motivated to do so. If they do not share a view on the criticality of a problem, they are less likely to work together.

How do you know if the need is a sufficient motivator for collaboration and change? In the Mountain Area community, friends and neighbors were dying unnecessarily or becoming unnecessarily disabled. The local volunteer rescue squads helped the community in emergency situations, but they lacked the necessary skills and equipment to be effective. In the First Choice community, the local employers may have reduced some of the employee benefits in light of uncontrollable costs. Local providers saw an opportunity to prevent that.

Tip: Ask the community leaders and health care providers to list their top 10 priorities. If the need or a related issue is not in their listing, do not expect a significant level of participation.

When considering the importance of a local rural health network, rural leaders should examine whether local needs are sufficiently compelling that organizations will join forces and work together for both their own self-interest and the benefit of the communities they serve. The compelling need must be on the priority list of key community leaders and health care organizations.

Willingness to Collaborate

Interest in collaboration can be expressed in many ways. Perhaps first and foremost, key participants' track records for working jointly with other parties should be reviewed as an indicator of future behavior. Have the key parties been successful at joint ventures in the past? If so, what types of ventures were they? Who were the participants? Why were the joint ventures undertaken? Not surprisingly, when these questions are examined examples of successful collaboration are likely to emerge. The more similar successful past joint efforts are, the higher the likelihood of network success. If past collaborative successes occurred among similar organizations (for example, among a group of community health centers), and affiliations between hospitals and community health centers are required to satisfy the current compelling need, future success may be more difficult, but by no means impossible, to accomplish. If no relevant examples of prior collaboration among potential network partners emerge, key participants may lack the proper culture for collaboration among autonomous organizations.

Willingness to cooperate implies not only that participants share in the rewards of the collective enterprise, but that they also share resources in producing expected benefits. Therefore, willingness to cooperate means that participants agree with the goals of the network *and* that they pledge some of their resources to accomplish these goals. Pledging resources helps make participants stakeholders in the network; a member's interest in the success of the network grows as its stake in the network becomes greater.

Compelling need provides the framework for potential cooperation, but expected benefits determine the extent to which agencies will work together. As networks evolve, actual benefits ultimately determine their current and future viability. The stakes must be high enough initially to work together and the rewards of collaboration great enough to justify continued participation.

Joint Action

Recognition of a compelling need and a willingness to collaborate unite network members, but joint action of autonomous members is what distinguishes rural health networks from other organized entities. What networks do in the final analysis will determine whether they were worth the effort to form. Two examples will illustrate the importance of joint action.

Any one party could not meet the needs of the Mountain Area community and First Choice community. Families who lost loved ones have no ability to change things so that others will not have to experience that difficult circumstance. No single element of the health care system can bring about lower mortality and disability rates. A combined effort of EMS squads with appropriately trained and equipped technicians, working closely with hospital emergency room medical control, police, and other emergency personnel, can reduce traffic and other types of fatalities and related disabilities.

Employers cannot reduce the premiums they are charged and still maintain employee coverage. A small rural hospital cannot act like an administrative services organization and examine employee benefits of local businesses, or determine corresponding acceptable scope of service contracts and discounted fees. The hospital and local physicians know that they can provide those services together with some outside assistance.

Individual heath care providers cannot negotiate for market share if there are no self-insured plans with which to negotiate. As potential preferred providers, they act individually in accepting or rejecting the service contract offers. Together they can act as the employers' agent and assist them in self-insuring their employees.

Tip: Among the interested parties, develop a list of resources needed to remedy the problem and list local sources. If one local agency has all these resources and is willing to use them to address the problem, networking is not needed and therefore unlikely to succeed.

TAKE-AWAY POINTS

1. Network form follows expected functions.
2. Incorporated networks tend to be "going concerns" and more permanent than unincorporated networks.
3. Networking is synonymous with partnering. For partnerships to work, each party must be sufficiently motivated to collaborate. Such collaboration is predicated upon expected benefits.
4. The specification of short- and long-term benefits of the network is essential. By sharing expectations, network members agree on collaborative goals.
5. Network participants should include those organizations and individuals that have a role in the achievement of network goals.
6. Partners compliment rather than compete with each other within the scope of the network programs. Networks capitalize on the respective strengths of the members and share, rather than duplicate, existing capacities.
7. Defining "who does what" within the network pinpoints the contributions network members make and their corresponding importance to the network.
8. Networks are dynamic organizations; membership, goals, and functions may change over time.
9. Agencies lose some autonomy by networking. Compelling needs and expected benefits must be great enough to overcome the fundamental obstacle of working together.
10. Most communities and health care providers have an extensive list of unmet needs. Organizations will work together to the extent to which these compelling needs or expected benefits are among their top priorities.

CHAPTER 3

Organizational Structure of Rural Health Networks

Networks vary by community. In general, however, formal networks require the same structural elements as other organizations:

1. Statement of purpose
2. Statement of goals and objectives
3. List of participants
4. Written agreements
5. Business identity
6. Policies and procedures

Incorporated networks also require articles of incorporation, bylaws, committee assignments, composition descriptions, and reporting relationships. Formal networks also have a series of operational requirements. Depending upon the network's scope and resources, these requirements can be brief or very elaborate. The guiding principle is that the level of detail should correspond to the complexity and functions of the network. Documents should seek to clarify ideas and commitments to better ensure smooth operations.

Rural health networks should approach the task of determining and defining operational requirements with much deliberation. Missteps regarding operational matters can detract from the substantive work of the network. This is especially important in rural communities because networking resources are scarce.

A more extensive treatment of issues relating to network corporate structures is contained in *Forming Rural Health Networks: A Legal Primer* previously issued by the *Networking for Rural Health Program*. Portions of this chapter discussing legal issues should not be construed as legal advice. Rural network participants are urged to consult with their legal counsel about specific legal questions.

STATEMENT OF PURPOSE

Networks should have a statement that summarizes why the network exists. Statements of purpose should generally describe the functions the network performs and the target community. Statements of purpose should be concise. For example, the First Choice Network's purpose and function statement contains the following text: The First Choice Community Health Network is formed to provide administrative services regarding employee health care benefits to businesses in the southern region of the state.

STATEMENT OF GOALS AND OBJECTIVES

Goals and objectives identify the impact the network expects to have on its members and the community it serves. Goals are generally broad and represent a desired outcome, an expected benefit. Objectives are generally action-oriented, time-limited, quantifiable, and related to goals. Both goals and objectives flow from compelling provider and/or community needs.

For example, Exhibit 4 describes the stated goals and objectives for both the community and the network members of First Choice Network.

These goals and objectives focus on expected benefits, the bedrock of successful network development and operation. They define and set expecta-

tions both for the short and long term. In achieving these goals, the network satisfies the goals of the members and the community.

PARTICIPANTS

Participation is based upon the members' contributions to the successful accomplishment of network goals and objectives. Participants are the parties who are key stakeholders in a successful outcome and who expect to benefit significantly from participation. Participants can be anyone in the affected community or anyone who brings an essential capacity to the network. Networks that perform a variety of functions require a variety of participants. All network members rarely participate actively in all network programs; they select those in which they have the greatest interest and those that will yield the greatest potential benefit.

Broadly inclusive networks often fall victim to lack of focus and dilution of effort. Broadly inclusive networks should draw distinctions between various functions and related participants. If a network function is to operate a shared pediatric clinic in a remote area, for example, the local fire department, although a member of the local network, need not be involved in that network function; its efforts are needed elsewhere.

Neither the Mountain Area Network or the First Choice Network are broadly inclusive. Now that the First Choice Network has accomplished its initial objectives, however, it has identified the need to develop and coordinate charity care in the community. Because it has expanded its functions, it has broadened membership to include local clergy, community action programs, food banks, and shelters. These new members constitute a new class of members that do not share in corporate profits of the network. The constituents of these new members, however, benefit from the free care the network subsidizes.

WRITTEN AGREEMENT

Written agreements describe the structure of formal rural health networks. They define who is a mem-

EXHIBIT 4

GOALS AND OBJECTIVES OF FIRST CHOICE COMMUNITY NETWORK

Community Goal: Maintain local businesses' existing levels of employee health care benefits while reducing the cost of such benefits.

OBJECTIVE 1 – 1
By the end of Year One, three local employers will be self-insured and will reduce their employee health care benefit costs by an average of 5 percent in comparison to previous year premium costs.

OBJECTIVE 1 - 2
By the end of Year Three, six local employers will be self-insured and will reduce their employee health care benefit costs by an average of 5 percent in comparison to previous year premium costs.

OBJECTIVE 1 - 3
By the end of Year Five, 10 local employers will be self-insured and will reduce their employee health care benefit costs by an average of 5 percent in comparison to previous year premium costs.

Network Member Goal: Generate revenue for participating network members comparable to member risks.

OBJECTIVE 2 - 1
By the end of Year Three, participating network members will receive a return on investment of 20 percent.

OBJECTIVE 2 - 2
By the end of Year Five, participating network members will receive a return on investment of 40 percent.

The First Choice Network also has indirect goals for local health care service providers.

ber, the purpose of the network, and how decisions for the network are made. The written agreement used commonly by unincorporated networks is a memorandum of understanding (MOU). An MOU should provide information on the following areas:

1. General purpose(s) of network;
2. Operating principles, membership, officers and terms, committees, staff and resources, frequency of meetings; and
3. Endorsements of members.

The MOU should be amended when associated changes occur. A sample MOU addressing an unincorporated network illustrating these components is depicted in Appendix A.

Formal rural health networks may begin as unincorporated associations and move to higher levels of formality as members gain confidence in the ability of the network to achieve its current and future goals.

The participants of unincorporated associations can be held personally liable for the acts of the network. To limit the liability of members, some networks choose to incorporate, thereby obtaining the corporate shield afforded by state corporate law. The written agreements that describe the structure of incorporated rural health networks are articles of incorporation and corporate bylaws.

Articles of incorporation are legal papers that state the purposes of the network, its initial directors and officers, the location of the corporate office, and a contact person. Once approved by the appropriate state agency, they verify that the network is a corporate entity.

Incorporated networks are operated as either for-profit corporations or not-for-profit corporations. The tax status of a network will be determined largely by what a rural health network does. Other legal considerations affecting the tax-exempt status of network members also play a role in the decision whether a network should seek for-profit or not-for-profit status. (See *Forming Rural Health Networks: A Legal Primer* for a more detailed discussion.)

The First Choice Network was incorporated from its inception because its function required that the network entity bear the full responsibility for network actions. The hospital board also wanted a new corporate entity to operate as an administrative services organization. The Mountain Area Network initially functioned as an unincorporated consortium of interested parties. Grant funds were administered by the lead EMS squad. As it expanded and began contracting for services and interacting more frequently with medical control and emergency response agencies, a corporate presence became essential. No one agency could be accountable for other agencies on these matters. Accordingly, the unincorporated association became an incorporated entity.

Bylaws describe the network's organizational structure, its functions, and the basic responsibilities of its board of directors, officers, and standing committees. Most bylaws address the following areas:

1. Name of network
2. Geographic service area
3. Participating agencies
4. Functions of the network
5. Board of directors:
   a. description of duties
   b. number of directors
   c. qualifications
   d. terms of office
   e. mode of election and removal
   f. new directorship and vacancies
   g. conflict of interest
   h. compensation
   i. annual meeting
   j. schedules
   k. written notice requirements
   l. meeting minutes
   m. meeting quorum
   n. voting requirements
6. Officers of corporation:
   a. terms of remuneration
   b. election of officers
7. Committees:
   a. types of committees
   b. composition of committees
   c. selection of the chairs

d. responsibilities and reporting relationships

8. Miscellaneous: Many bylaws contain miscellaneous provisions that pertain to amendment, change, or interpretation of the bylaws in effect.

This list is extensive and may seem overwhelming at first glance. But two items, functions and committees, require the most customization to local circumstances and needs. The other sections are almost standard, but they need to be completed by all incorporated networks.[1]

BUSINESS IDENTITY

A formal rural health network is an organization of organizations. Its members are autonomous organizations, such as hospitals, clinics, and home health agencies. But the network is more than simply the sum of its members. It is its own organizational entity that engages in activities independently of its members. For example, the First Choice Community Health network provides local employers with administrative services to help control health care costs. None of the individual members of the network provide such administrative services, however, the members of the network are able to offer the services *through* the network. The business identity of the network is recognized when network members and consumers and beneficiaries of services view the network as an independent entity.

The network is more than simply the sum of its members. It is its own organizational entity that engages in activities independently of its members.

The business identity of a network is enhanced by naming the network and by defining goals, participants, and ways of doing business. Legal incorporation, establishing a place of business independent of members, and offering services to the public under the name of the network are ways of clearly establishing the network as an independent entity with its own business identity.

POLICIES AND PROCEDURES

Networks conduct business on a day-to-day basis. Policies and procedures describe specifically how the network will conduct its business and comply with its responsibilities. Two key types of policies and procedures are needed by networks: personnel and financial.

Personnel policies generally include:

1. Job descriptions;
2. Application processes;
3. Attendance policy;
4. Bereavement policy;
5. Civil practice laws and rules;
6. Disciplinary procedures;
7. Employee benefit and policy changes;
8. Equal employment opportunity;
9. Performance evaluations;
10. Personal leave of absence;
11. Personal records policies;
12. Smoking and substance abuse policies;
13. Vacation and sick time;
14. Wage and salary administration; and
15. Grievance and sexual harassment policy.

Financial policies cover:

1. General accounting and reporting terms;
2. Revenue accounting;
3. Expenditures accounting;
4. Budget procedures;
5. Program and project budgeting processes and requests; and
6. Financial procedures governing deposits, invoices, checks, assets, payroll, bank statements, and financial reports.

[1] See Appendix B for selected readings on resources for bylaws. Please note, however, that legislation governing bylaws varies from state to state.

A variety of publications are available that provide boilerplate for completing personnel and financial policies. Networks should also ask member organizations for samples of personnel and financial policies that can be modified as needed.[2]

HIRING THE NETWORK EXECUTIVE

One of the most critical decisions networks make is the selection of executive staff. Certain skills are mandatory: excellent communication, capacity to motivate people, and knowledge of health care systems and payers. Network executives should be powerful advocates for their networks; they will eventually come to represent the entire network in its dealings with other players in the environment.

What criteria should be used in selecting a network executive? Should networks favor candidates knowledgeable and experienced in health care programs in the area? Or is there a set of qualifications that must be met that recognize the importance of local knowledge, but balance it with requisite health care management skills? First and foremost, the skill set of the lead network staff must include experience in collaborative management practices. They should also have experience working with boards, communities, competitors, payers, regulators, and consultants. This means that they should have been in key health care leadership positions in the past. The more experience they have managing multi-organizational projects, the better. Second, they should have expertise in the health system components addressed by the network's goals and objectives. They need not be resident experts, but need to have had some direct experience in the work area or have been responsible for similar work areas.

The network executive should be selected by a committee of key network members, each of whom has the power to veto any potential candidate. In small networks, the entire board may be involved in the selection. The selection committee of the board should be as explicit as possible about its expectations for the performance of the network executive and the expectations of performance for the network as a whole. Executive performance should be evaluated at the end of the first six months of employment and regularly thereafter, but not less frequently than once a year.

Compensation for network executives should be consistent with their qualifications and the responsibilities of the position. Networks that attempt to save money by hiring poorly qualified executives at low rates of pay are apt to find either: 1) members are required to commit substantial resources (primarily time and staff) to accomplish network objectives; or 2) the objectives of the network are not fully achieved.

Tip: Avoid the easy decision. Do not automatically appoint an interested, likeable network member or network staff member as executive director. Familiarity may facilitate an initial decision, but it can contribute to a false start and eventually require considerable effort to undo if the person does not meet job requirements.

[2] See Appendix B for selected readings on resources for personnel and human resource management.

TAKE-AWAY POINTS

1. Operational requirements of rural health networks are similar to those of other organizations.
2. Particular attention needs to be placed on the description of functions and the identification and description of committee responsibilities and membership. These operational requirements flow from compelling needs and self-interests of network members. They should state explicitly the benefits that key members of the network expect to accrue as a result of network membership.
3. Memoranda of understanding (MOU), which govern the relationships between member organizations in unincorporated networks, are critical documents. They set the ground rules for network operation and also should specify expected benefits of each participant (see Appendix A for an example of an MOU). The specification of expected benefits is extremely useful and should be reviewed by network members every six months.
4. No operational requirements are carved in stone. They can and should be modified as the need arises. A hallmark characteristic of successful networks is their capacity to be flexible and introduce change to accommodate needs of their members and the external environment.
5. Legal assistance should be sought for the preparation of articles of incorporation, bylaws, and MOUs.
6. Broadly inclusive networks often fall victim to lack of focus and dilution of effort. Broadly inclusive networks should draw distinctions between various functions and related participants.
7. The business identity of the network is recognized when network members and consumers and beneficiaries of services view the network as an independent entity.

CHAPTER 4

Planning for Action:

How Rural Health Networks Set Goals and Accomplish Objectives

Strategic planning is a process in which organizational members and/or stakeholders envision a desired future and develop the means to achieve that future. Strategic planning plays an important role in the development of rural health networks because it is a way of identifying problems and opportunities, mapping out solutions, agreeing on goals, and reaffirming expected benefits. Members learn about each other through their participation in a strategic planning process as they express their values, assess their respective strengths and weaknesses, and agree on the activities that will be undertaken collectively. Participation in a planning process is one of the first substantive activities of a rural health network. The planning process builds trust among members because it necessitates their agreement on goals and action steps that define their relationship.

> A strategic planning process — an important on-going function for any organization — can revitalize a network by periodically re-assessing its role in the community.

Established networks should routinely engage in strategic planning in order to better understand the problems and opportunities they face and to determine how the network should approach them. An important ongoing function for any organization, a strategic planning process can revitalize a network by periodically re-assessing its role in the community. An iterative process for identifying problems that are common concerns and compelling needs and require joint action to solve, strategic planning is essential for success.

The context of strategic planning for rural health networks is somewhat different from its member organizations, specifically:

- Because rural health networks will have interests that are more expansive than those of any single member, they often will be concerned with health-related problems that potentially are broader than those of individual members.
- The problems that rural health networks identify should be limited to those that require the joint action of the network to solve. If a single member can solve a problem, it should not be subsumed by the network.
- Rural health networks are self-defined organizations. Most member organizations, such as hospitals, clinics, nursing homes, and public health agencies, are defined by custom and law. The activities they undertake are more circumscribed than those of a rural health network. The network is free to undertake a much wider array of activities than any of its individual members.

This chapter presents several techniques for assessing community needs, which is the first step in a strategic planning process. A method for setting priorities among identified problems and some ground rules for action plans are also discussed.

COMMUNITY-NEEDS ASSESSMENT

Most compelling needs are self-evident. The threatened closure of a rural hospital, loss of a key rural practitioner, high rates of teenage pregnancy, or the exclusion of key local providers from panels of major health care plans are events that seldom go unnoticed in rural communities. The magnitude of associated problems, such as loss of jobs, limited access to health care, and significant drains upon social programs, are frequently topics of conversation at meetings of health care providers, at local diners, and at church socials. They galvanize providers and communities to action.

In such cases, formal assessments are not necessary initially because the need for action is felt. These networks are "jump-started" and the networks move almost immediately into the implementation phase, attacking the well-defined problem. The immediate challenge to the network is to develop a collaborative, energetic response that satisfies the compelling need.

A compelling need may be only the most visible of a community's many unmet needs. In some rural communities, these other health needs may not be well-recognized or understood. Providers and the communities they serve can benefit, therefore, from a formal assessment of health needs. These assessments can identify trends that point to emerging or current problems, which are not as dramatically evident as hospital closure or teen pregnancies. Assessments of local health needs systematically review data and help providers, communities, and networks sift through the array of unmet needs and identify priorities.

Assessments of needs are based on data. There are two major types of data available:

1) primary data — data collected by the network for the purpose of making the assessment; and 2) secondary data — data collected by others and used by the network for planning purposes. Most of the primary data collected for needs assessments will focus on the attitudes and opinions of community members. Most of the secondary data will be empirical measurements of health system events, such as incidence of disease, hospital admissions, and mortality rates. Using secondary data it is possible to compare one community to other similar communities. Six methods of collecting primary and secondary data are:

Primary data

1. Key informant interviews;
2. Strengths, Weaknesses, Opportunities, and Threats Assessments;
3. Focus groups;
4. Community surveys;

Secondary data

5. Service utilization analysis; and
6. Health status analysis.

Each method has distinct advantages and disadvantages. Networks assessing health care needs are advised to use more than one technique to compensate for the limitations of one method, and, perhaps equally as important, to provide potential cross validation of needs.

The data networks use for planning should be based upon the resources available, both time and money. Small-scope interview assessments can be done quickly without using consultants; other methods almost always require time and outside assistance. Some networks hire consultants because they provide a balanced, unbiased assessment of need and can often more easily elicit and present candid opinions from community residents.

Key Informant Interviews

This approach is the most direct and involves obtaining perceptions about local needs from key community leaders and organizations. It assumes that these community leaders have a good understanding of the needs of their communities by nature of their positions within them. Key informants include leaders of churches, hospitals, clinics, nursing homes, businesses, schools, government, media, and community organizations. Reports on key informant assessments summarize the opinions and local beliefs of the interviewees and point to areas requiring further review and study.

One variant of the key informant approach that uses fewer resources is a review of key organizations' policy statements and plans. Rather than schedule and conduct interviews, official documents are obtained and reviewed.

In using this method, all members of the network provide summaries of their institutional plans and highlight the top priorities of those plans that are most appropriate for network consideration. Network staff reviews selected local, state, and federal documents and glean from them major priorities pertaining to health care service development in their rural community. Such documents include:

- Hospital long-range plans;
- County health assessments and health service plans;
- County Medicaid managed care plans;
- County mental hygiene plans;
- Plans of local or regional agencies or the United Way;
- Recent plans or policy statements of state and federal government, such as those defining areas of medical underservice or health manpower shortage; and
- "Healthy People 2000" documents.

Network staff develop a report summarizing the priority needs identified in these documents. The network then reviews this list and network priorities are selected.

The major strengths of this approach are the speed with which it can be conducted, the exposure that network members have to the interests of member organizations, and the potential for shared priorities and development of collaborative actions. An additional advantage of this approach is that the network does not have to develop or purchase expertise in needs assessment, and, consequently, network resources can be directed at pursuing solutions.

The main shortcoming associated with such an approach is that the resulting assessment is only as good as the plans upon which it is based. If the plans of members or various government and quasi-government agencies are incomplete or dated, decisions based on them may be sub-optimal.

Advantages: Reasonably inexpensive and fast; anonymity of informants can be assured if required.

Disadvantages: Responses may not reflect the feelings of the community or the subgroup the informant was selected to represent.

Strengths, Weaknesses, Opportunities, and Threats Assessments

This approach is also a variant of the key informant approach and deals exclusively with organizations who have expressed an interest in collaboration. These assessments collect data from potential network members and catalog each organization's perception of their own strengths and weaknesses and perceptions of opportunities and threats. Organizations are also asked to describe each potential network members' strengths and weaknesses and views of opportunities and threats. These assessments are shared with all participating organizations and validated at a meeting at which all participants are present. These assessments help the network establish common ground through this open validation process and focus its energies on achievable objectives. These assessments can identify similarities in culture, business and/or operational philosophies among potential participants, a compelling need in the community, or potential issues that could be addressed through a collaborative response. Conversely, conflicting perceptions point to areas that will require more time and energy to resolve and which the network should address through future discussions.

Advantages: Reasonably inexpensive and fast; group interaction may stimulate responses; reflects current views.

Disadvantages: Lack of respondent anonymity may inhibit responses; respondents' opinions may not be representative of the larger community.

Focus Groups

Focus groups are used by market researchers to gather opinions about current or future products from potential customers. The focus group provides a format in which group members can interact on a topic. The interaction is unstructured and leads to new insights that come to light through the focus group discussion. Focus group participants are generally chosen to represent certain characteristics of the customers being studied and are usually paid for their participation.

Focus groups are used in health care market research by providers to gather impressions about their services. They are used in circumstances when data is sought on specific conditions, for example, a discussion on the most desirable features of doctors' offices: lighting, seating, size and color of waiting area, time waiting for appointment, location of receptionist, and facility appearance and cleanliness.

Advantages: Reasonably inexpensive and fast; group interaction may stimulate responses.

Disadvantages: Lack of respondent anonymity may inhibit responses; even though respondents were chosen from representative groups, their opinions may not be representative of the group or of the larger community.

Community Surveys

Surveys are a highly structured means of obtaining data. Like the first two methods, they solicit information directly from the community being studied. The survey instrument is designed, a representative sample of the community identified, and the survey is administered. The results are then applied to the community as a whole. The results are frequently expressed with confidence intervals, such as within plus or minus 3 percent. For example, take the finding that 68.1 percent of the community believe that HIV/AIDS education should be started in elementary school. This statement has a margin of error of plus or minus 3 percent, meaning that if all of the community had been surveyed, the percent of the community that believes HIV/AIDS education should be started in elementary school would fall somewhere in the range from 65.1 percent to 71.1 percent.

Advantages: Results are representative of the population; over-sampling allows the opinions and experiences of subgroups (e.g., the poor, elderly, minorities) to be gathered in statistically valid ways.

Disadvantages: May be expensive and time consuming and require outside assistance for design, processing, and interpretation.

Service Utilization Analysis

Data on the use of health care services is one of the most frequently used methods for assessing needs in the community. It permits comparisons between communities or comparisons to standards or norms that identify high- or low-use rates. Unfortunately, these standards may not be widely accepted and there may be reasonable explanations for why certain services are used more or less frequently. This data is useful, however, in helping to discover health care delivery problems. The data describes the magnitude of the need, (i.e., how many people are affected) and is not subject to biases present in some of the techniques previously discussed.

If a network was exploring a service used primarily by Medicare patients, such as an outpatient dialysis center, the network can use Medicare data to determine if existing providers are operating at capacity and whether an additional center may be needed. In some states, managed care networks assess the price competitiveness of their participating hospitals by comparing their charge per discharge for the top 50 DRG's. Exhibit 5 provides a sample output of comparative hospital information.

Advantages: Data exists in a usable format; comparisons across time and communities and comparisons to standards (when they exist) can be made; relatively quick analysis; data is objective.

Disadvantages: May be expensive to acquire (depending on data source); interpretations of data may be difficult.

Health Status Analysis

Quantitative health status data describes the health and well-being of the community. Potential problem areas are easily identified by comparing health status rates or scores to "norms."

There are various sources of data that may be used for health status analyses. Data from birth and death records is collected routinely by each state in the country. In some states it is available in electronic format, which increases its ease of use. In some states birth and death data may be available by geographic units smaller than the county level, for example, towns, villages, ZIP codes, or census tracts.

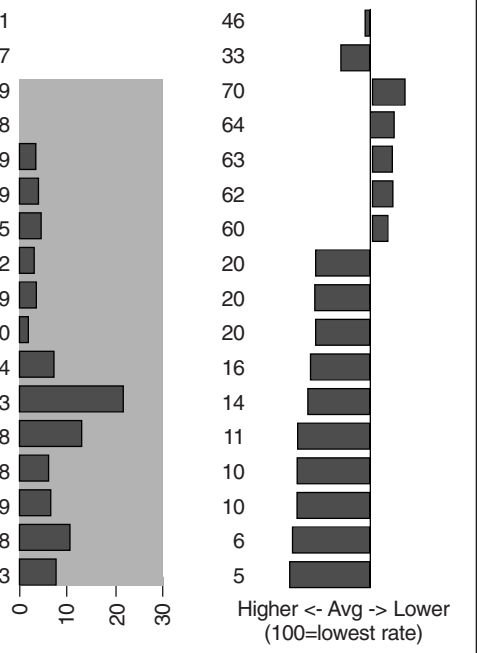
Rural communities' use of such data is limited by their small populations. For example, one neonatal death can result in an unusually high neonatal death rate if there were only a limited number of births in the community studied. These problems can be reduced somewhat by enlarging the data set being used. Two approaches for enlarging the data set are to include several years of data in calculating the rate or include several communities (e.g., towns or counties) in the calculation. In very sparsely populated areas, the two techniques can be combined.

The Behavioral Risk Factor Survey Surveillance System, a national survey of risk behaviors conducted each year in the United States, is another source of data useful for community needs assessments. It provides a wealth of data at the state level. It has limited capacity to describe specific rural communities because its sample size is too small. Yet, data from similar rural areas such as those rural areas adjacent to the network can be grouped together to improve its reliability. This grouping of data makes

EXHIBIT 5

HOSPITAL INPATIENT DISCHARGE PROFILE BY SELECTED TOP 50 DRG's[1]

DRG	General Hospital	Charges (in $,000)	Charges/Discharge (in $,000) All Sexes, All Ages 1996	Percentile	Percentile among NY facilities* (1-50 beds)
—	Total	9808	4.31	46	
—	All Others Except Top 50	3630	4.97	33	
390	Neonate w Other Significant Problems	31	0.89	70	
391	Normal Newborn	181	0.68	64	
132	Atherosclerosis w CC	31	2.79	63	
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	328	3.49	62	
320	Kidney & Urinary Tract Infections Age >17 w CC	102	4.25	60	
098	Bronchitis & Asthma Age >17 w/o CC	37	2.62	20	
139	Cardiac Arrhythmia & Conduction Disorders w CC	43	3.09	20	
373	Vaginal Delivery w/o Complicating Diagnoses	350	2.10	20	
174	G.I. Hemorrhage w CC	160	6.94	16	
475	Respiratory System Diagnosis with Ventilator Support	153	21.83	14	
079	Respiratory Infections & Inflammations Age >17 w CC	105	13.18	11	
015	Transient Ischemic Attack & Precerebral Occlusions	247	5.88	10	
395	Red Blood Cell Disorders Age >17	31	6.29	10	
121	Circulatory Disorders w AMI & Major Comp Disch Alive	173	10.18	6	
294	Diabetes Age >35	122	7.63	5	



* Percentile is the % of facilities which have a higher rate than this facility.

[1] This sample facility had at least 30 discharges in 39 of the top 50 DRG's in its area.

the analysis less valid for the network's particular community because it now includes data on other communities. However it generally provides a better frame of reference then statewide statistics. (This technique would not be used in a single community, but could be used in networks composed of several communities or counties.) Exhibit 6 provides an example of the output of this survey.

Advantages: Data exists in a usable format; comparisons across time and communities and comparisons to standards can be made; relatively quick analysis; data is objective.

Disadvantages: May be expensive to acquire (depending on data source); interpretations of data may be difficult; small numbers of occurences may distort findings; age of data.

PRIORITY SETTING

Needs assessments generally reveal multiple unmet community health needs. Setting priorities among them is an exercise in network consensus-building. The issues that are accorded the highest priority are the ones for which the network will develop action plans. Therefore, the setting of priorities is key to the development of networks. The priorities selected determine the programs undertaken by a network, its staffing requirements, its budget, and the organization of work. Several techniques can be used to determine priorities; most include judging the relative

EXHIBIT 6

SAMPLE SURVEY OUTPUT

Women's Health
Was your last Pap smear done as part of a routine exam, or to check a current or previous problem?

Response	Appalachia %	New York %	USA %
Routine Exam	90.9%	95.4%	94.6%
Check Current or Previous Problem	6.9%	4.1%	4.6%
Other	2.1%	0.6%	0.8%
	100.0%	100.0%	100.0%

Women's Health
Have you had a hysterectomy?

Response	Appalachia %	New York %	USA %
Yes	30.7%	15.6%	21.3%
No	69.3%	84.4%	78.7%
	100.0%	100.0%	100.0%

Women's Health
To your knowledge, are you now pregnant?

Response	Appalachia %	New York %	USA %
Yes	6.4%	3.2%	4.6%
No	93.6%	96.8%	95.4%
	100.0%	100.0%	100.0%

HIV/AIDS
If you had a child in school, at what grade do you think he or she should begin receiving education in school about HIV infection and AIDS?

Response	Appalachia %	New York %	USA %
Kindergarten	17.3%	12.0%	9.4%
Elementary	68.1%	66.5%	72.5%
Junior High	10.5%	16.2%	12.5%
High School	0.4%	4.2%	4.0%
Never	3.7%	1.1%	1.6%
	100.0%	100.0%	100.0%

importance of needs according to several dimensions.

Members of networks may differ in the priority they assign to identified needs. For example, the most important need to a public health representative may be the introduction of HIV education in elementary schools. Hospitals may rate the need for integrated information systems as the most critical. Insurers may want to see a dramatic increase in the number of primary care practitioners.

In setting network priorities, network members should be asked to consider four factors:

1. The seriousness of the problem;
2. The need for a joint response;
3. The appropriateness of the network as the change agent; and
4. The likelihood of success.

Although they are pressing needs, if the need for HIV education can be met through the school system itself, and if greater access to primary care programs can be met by independent action, such as the addition of evening hours by local clinics, they should not be rated as high priority network needs. Unmet needs that require joint action take precedence, because joint action is the reason why a network was formed.

In some structured priority setting processes, needs with the best overall scores become priorities. In other instances, less formal methods can be employed and consensus can be the basis for priority selection. The important element in setting priori-

EXHIBIT 7

POTENTIAL PRIORITY NEEDS

	Health Care Area	Needs	Addressed by Information System	Telephone Interviewees N = 23	Focus Groups N = 10	Total Score
1	Primary Care	More Primary Care MDs		16	7	23
2	Primary Care	Managed care concerns		15	6	21
3	Primary Care	Better coordination		12	8	20
4	Community Education	Info on good health and nutrition		14	5	19
5	Primary Care	Improved quality/attitude		11	7	18
6	Hospital Care	Improved quality/image		15	3	18
7	Access	Transportation		11	7	18
8	Access	Free, low cost services		11	7	18
9	Long Term Care	More services for aging population		11	6	17
10	Primary Care	Trust among providers		11	6	17
11	Community Education	Parenting classes		9	6	15
12	Hospital Care	Appropriate use of ER		9	6	15
13	Community Education	Awareness about available srvs		9	5	14
14	Primary Care	Medicaid underserved		5	8	13
15	Mental Health Services	Improved quality		7	6	13
16	Mental Health Services	Increase outpatient capacity		8	4	12
17	Hospital Care	Greater collaboration		6	6	12
18	Primary Care	Recruitment		7	3	10
19	Mental Health Services	Better coordination		4	5	9
20	Long Term Care	Alzheimer's related services		4	5	9
21	Primary Care	More specialty services		6	2	8
22	Long Term Care	Adequate SNF beds		3	5	8
23	Emergency Medical Services	Better volunteer recruitment		6	2	8
24	Primary Care	Care for uninsured,underinsured		3	4	7
25	Emergency Medical Services	Adequate trauma service		3	4	7
26	Emergency Medical Services	Not used for transport to ER		4	3	7
27	Access	Assistance negotiating system		6	0	6
28	Primary Care	System not overused, misused		2	3	5
29	Primary Care	Impact of correctional facility on system		3	2	5
30	Emergency Medical Services	Lower ambulance cost		3	2	5
31	Access	Convenient hours		2	3	5
32	Emergency Medical Services	Financing		4	0	4
33	Mental Health Services	Service for 21-65 population		1	3	4
34	Long Term Care	Better trained personnel		2	2	4
35	Long Term Care	Respite care needed		4	0	4

ties is that all network members can equally influence the selection of priorities. Exhibit 7 shows a list of potential needs identified by using a combined focus group and key informant needs assessment approach. The importance of each need was initially measured by the number of times it was referred to by participants in these assessments. Three major priorities were selected: 1) the development of an integrated electronic information system; 2) the promotion of primary care and preventive health service programs; and 3) the development of a Medicaid managed care plan, or HMO.

Exhibit 7 demonstrates how an integrated electronic information system was selected as the No. 1 priority, because it dealt with many of the top concerns of the community. Preventive service development also emerged as a priority. This need was identified by health status data that revealed exceptionally high death rates for cirrhosis of the liver and heart disease. The third priority reflected provider and local government concerns about the potential growth of Medicaid managed care plans in the area. All three priorities need to be addressed by multiple agencies. No one agency has the capacity to individually address these priorities. Over time, a network can respond to all three priority issues.

The relationship between these priorities and the interviews that identified the needs is not linear. For example in Exhibit 7 the highest ranked topic in terms of frequency in the interviews (more primary-care physicians) did not become the network's No. 1 priority. This need could be addressed by a private primary care clinic acting individually. The most important issue for joint action was the development of an integrated electronic information system.

ACTION PLANS

Action plans identify the specific actions to be taken by specific parties at specific times relative to network priorities. Action plans flow from enumerated goals, objectives, and related expected benefits. They contain four common ingredients:

1. Activities and associated sub-activities;
2. People and/or organizations responsible for specific activities;
3. Time period during which activities will occur; and
4. Expected outcomes or deliverables associated with each activity.

Activities are general categories of actions that need to take place for objectives to be accomplished. Sub-activities are discrete interdependent actions that are critical parts of the overall activity. Expected outcomes or deliverables are the results of the completed activity; the expected benefit is the final product. Responsible parties identify people with the authority to complete the task and also the people accountable for its completion. Time period identifies the dates when tasks and activities are expected to start and stop. An example of a part of the operational plan for the First Choice Community Health Network is displayed in Exhibits 8 and 9. Exhibit 8 lists the key activities in summary form. Exhibit 9 shows how detailed plans ensure that the necessary steps are taken to produce the desired deliverable.

After plans are established, networks should always keep in mind the iterative nature of network development and operation. As networks gain experience at implementing programs, they often recognize that plans need to be changed to reflect a more accurate or revised appraisal of needs, benefits, and resource requirements.

Tip: Project management software is helpful for both project planning and monitoring purposes. It automatically tracks progress and can be easily adjusted. It also helps to plans at meetings of the committee responsible for plan implementation. It requires that participants focus on tasks associated with the achievement of benefits. When different network members have responsibility for activities, they should provide the critical input for determining the plan schedule. All responsible parties should explicitly sign-off on the plans before they are adopted for action.

EXHIBIT 8

SAMPLE KEY ACTIVITIES – SUMMARY

Activity Name	Person Responsible	Outcome	Start Date	Finish Date
1. Establish network as for profit corporation	Network Leader	New business	7/1/00	10/1/00
2. Meet with key employers interested in self-insurance products	Executive Director	Key client list	9/1/00	10/15/00
3. Contract with employers for administrative services	Executive Director	Clients	10/15/00	12/16/00
4. Assess existing benefit plans of interested employers	Executive Director	Client needs	11/15/00	2/16/01
5. Develop contract format between local preferred providers and employers	Executive Director	Local providers	1/1/01	5/1/01
6. Assist employers in completing other self-insurance requirements	MC Consultant	Clients prepared	12/1/00	3/1/01
7. Represent the employers at meetings pertaining to preferred providers	Executive Director	Service	1/1/01	7/1/02
8. Identify other local employers interested in self-insurance products and repeat activities 1-5	Executive Director	New clients	3/1/01	7/1/01
9. Monitor profit/loss of network	Network Evaluator	Profit/loss	7/1/00	7/1/02
10. Monitor use of services and employee satisfaction	Network Evaluator	Satisfied clients	6/1/01	7/1/02

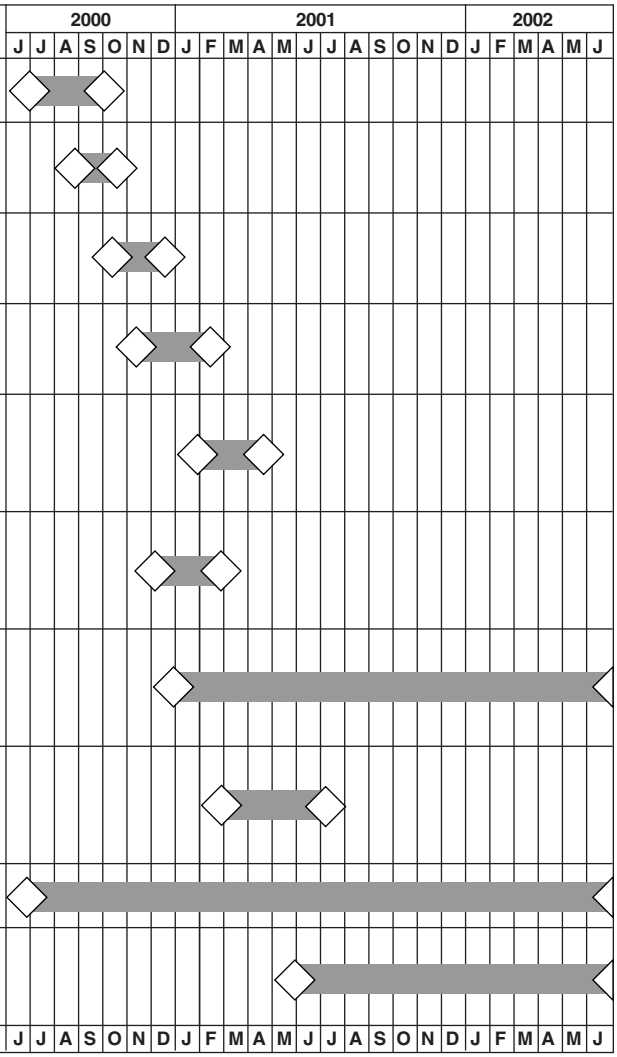
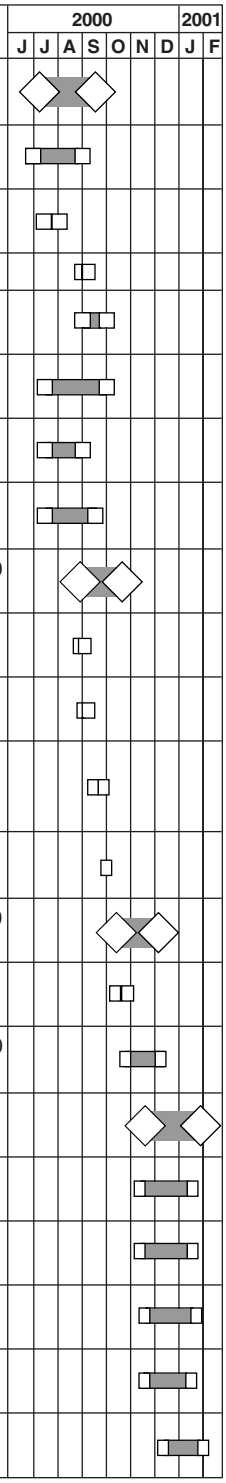


EXHIBIT 9

SAMPLE OPERATIONAL PLAN – DETAILED

Activity Name	Person Responsible	Outcome	Start Date	Finish Date
1. Establish network as for profit corporation	Network Leader	New business	7/1/00	10/1/00
1.1. Develop articles of incorporation	Attorney	Articles of Incorp.	7/1/00	9/1/00
1.2. Elect initial directors Network	Directors	Officers & Directors	7/15/00	8/1/00
1.3. File articles of incorporation	Attorney	Filing	9/1/00	9/10/00
1.4. Obtain approval as corporation	Attorney	Legal entity	9/1/00	10/1/00
1.5. Hire Exec. Dir. and comply with all other requirements of for profit corporations and appropriate business practices	Executive Director	Functional business	7/15/00	10/1/00
1.6. Develop business plan and obtain financing	Executive Director	Viable plan	7/15/00	9/1/00
1.7. Set-up offices and hire staff	Executive Director	Business capacity	7/15/00	9/15/00
2. Meet with key employers interested in self-insurance products	Executive Director	Key client list	9/1/00	10/15/00
2.1. Identify employers within 50 miles of the network service area.	Adm. Assistant	Potential clients	9/1/00	9/5/00
2.2. Contact employers ' administrators and ascertain interest	Executive Director	Interested clients	9/5/00	9/10/00
2.3. Visit interested employers	Executive Director	Meet interested clients	9/15/00	10/1/00
2.4. List employers by degree of interest	Executive Director	Best prospects	10/3/00	10/4/00
3. Contract with employers for administrative services	Executive Director	Clients	10/15/00	12/16/00
3.1. Develop contracts including scope of service and fees	Attorney	Draft contracts	10/15/00	11/1/00
3.2. Execute contracts with employers	Executive Director	Contracted business	10/25/00	12/10/00
4. Assess existing benefit plans of interested employers	Executive Director	Client needs	11/15/00	2/16/01
4.1. Obtain copies of all types of employee contracts	Man. Care Consultant	Current terms	11/15/00	1/15/01
4.2. Obtain copies of current health benefits plans	Man. Care Consultant	Current benefits	11/15/00	1/15/01
4.3. Define scope of services for each plan	Man. Care Consultant	Scope of service	11/22/00	1/23/01
4.4. Detemine enrollment term of the contract	Man. Care Consultant	Enrollment period	11/22/00	1/15/01
4.5. Determine age/sex/marital status characteristics of employees by health care benefit plan and in the aggregate	Man. Care Consultant	Actuarial data	12/15/00	2/1/01



TAKE-AWAY POINTS

1. Strategic planning is important for understanding problems and opportunities and for deciding what to do about them.
2. Formal assessments of need are useful because they can help networks identify health needs that are not immediately obvious.
3. Health needs assessments can be conducted quickly by reviewing the strategic plans of network members. Through such a review members can identify common needs that suggest the potential for joint action.
4. Once compelling needs are identified, assessment activities do not end. Subsequent assessments are designed to develop and help understand new or recently recognized issues. Needs assessments are also a way of helping to identify the expected benefits of network participation for members.
5. The important element in setting priorities is that all network members can equally influence the selection of priorities.
6. Networks should concentrate on priorities that are unequivocally the purview of the network. Such priorities require action by multiple parties to accomplish objectives.
7. The delineation of specific work plans helps networks focus on tasks to be accomplished and to concentrate their efforts and energies on fulfilling network objectives.
8. Network staff should not hesitate to adjust work plans to reflect more accurate appraisals of needs, benefits, or resources. Like any successful complex organization, networks must be prepared to change as relevant circumstances change.

CHAPTER 5

Implementing Successful Rural Health Networks

Successful networking is a complicated, dynamic process. Once consensus is reached on compelling provider and community needs, network leaders face several equally difficult challenges. Expected benefits must be made explicit, and the active participation of key organizations and individuals must be nurtured. Key participants ultimately determine the viability of the network; they must be integrally involved in the design, modification, and implementation of network objectives.

Key participants ultimately determine the viability of the network; they must be integrally involved in the design, modification, and implementation of network objectives.

Rural providers, in some ways, have greater disadvantages than their urban counterparts in networking. Administrative resources required to participate in networks are scarce at most rural institutions. In many instances, the chief executive officer (CEO) is the only person who can appropriately represent the organization at network meetings. Senior vice presidents responsible for extramural development exist in few rural facilities. Hence, network development and operation is an additional demand placed upon the rural provider CEO, who may already be over-extended.

Experience with a variety of rural health networks has shown that the likelihood of success is influenced by a range of factors that create an atmosphere conducive to collaboration and sharing. To the extent that these factors accelerate network development and improve the operation of the network, they may reduce the amount of time required by rural CEOs to obtain their collaborative goals. Network members and managers should keep the following basic rules in mind and review them periodically.

1. Stay on course. Do not stray from stated objectives and work plans.

New events external to the network sometimes seem more timely or important than network objectives identified earlier. For example, it may be wise for networks with long-term objectives, such as developing a joint information system, to avoid spending time developing position statements that oppose proposed cuts in reimbursement rates. While this issue is important, it has the potential of diverting attention away from goal achievement. Rural health networks, especially new ones, will not be able to solve all of the problems of their members. The members of successful networks clearly understand the purpose of the network and focus their energies on achieving objectives associated with the purpose.

Staying on course does not mean that networks cannot consider new topics. In fact, being aware of the environment and being able to shape new objectives will assure the long-term survival of the network. The identification of topic areas and the development of new ideas generally fall within the purview of governing boards. Network staff are typically responsible for fulfilling objectives and work plans that already exist.

Recognizing that these are separate functions may help keep the network on course.

Tip: When local crises move attention away from key objectives, suspend the agenda for a brief period to entertain discussion. Do so in a time-limited way and then refer the matter for further discussion to network leadership. Never dismiss the issue as irrelevant or out of order.

2. Adapt strategies.

Changes in leadership of network member organizations occur frequently and new priorities can supersede previously identified compelling needs. Energies should be directed to areas with the most promise.

Exhibit 7 showed a network (hereafter referred to as the Rural Care Consortium) that had chosen an integrated information system as the No.1 priority. In the Rural Care Consortium, CEOs of two major institutions that were network members left the area. Interim leadership at the organizations was aware of the project, but hesitated to pursue it on an interim basis. According to the plan, these two institutions were to be two of the four phase-one beta testing sites. Because of their current hesitancy, they were rescheduled to later phases of development of the information system.

In some instances, flexibility requires that a balance be struck between the perceived payoff of an action and its ease of accomplishment.

Implementation plans seldom proceed in practice as they were drawn on paper; events intercede, resources fall short, prior steps fail to produce the necessary condition for future steps. Successful rural health networks focus on achieving goals.

They monitor progress, identify problems, and take corrective action. They keep their "eyes on the prize" — the desired outcome of the work. They realize that the method they selected in the work plan for achieving the objective is only one way the objective can be achieved. If, for one reason or another, the first method does not work, successful networks try other methods to satisfy their goals.

In some instances, flexibility requires that a balance be struck between the perceived payoff of an action and its ease of accomplishment. It is better to achieve many small goals than to strive in vain to achieve a single worthy, but unachievable, goal.

Tip: When leadership at member organizations changes, the network executive and the network governing board chairman should meet with the new leader as soon as possible to inform him or her of the network projects that are underway, the importance of their participation to the network, and the prior commitment of his or her governing board to the concept of the network.

3. Collaboration and consensus are key. One-sided decisions are not acceptable.

When differences of opinion impede progress, network managers must foster an atmosphere that promotes compromise among parties. For example, the Rural Care Consortium discussed the type of software that should be installed on the network server and at each particular organization. The most powerful "alpha" organization in the network is a clinic that uses EXODUS practice management software. This clinic strongly suggested that EXODUS be used by all outpatient clinics involved in the network.

The network contains 12 outpatient clinics, four of which are community health centers. Two community health centers had recently acquired RELIANCE practice management software that was designed to be part of an integrated system for community health centers. These centers were hesitant to change software, given their software investment, and because their staff would have to undergo training again.

After an extensive discussion, it was determined that the "alpha" clinic would continue to use EXODUS and the community health centers would continue to use RELIANCE because RELIANCE and EXODUS had compatible features. Resources the network had acquired to purchase software for the

clinic sites were then directed at developing a program to interface between the two types of software. This compromise was essential and repeated in a variety of instances when other software required modification.

The least powerful member of a network, by virtue of its participation in the network, has a right to be heard and influence decisions. Conflict is a trust-building opportunity. Leadership, both staff and board, must demonstrate impartiality.

Tip: Network executive directors should not take sides. Seek the common ground. Never automatically defer to the more powerful network member. If a recommendation regarding the conflict is required of the network executive director, it should be based upon the best interests of the entire network rather than an individual member.

4. Value diversity and use it to the network's advantage.

Different network members bring with them needed skills and assorted perspectives. Although this diversity may cause friction, it can also be an asset if perceived as a way of expanding the variety of perspectives, skills, and resources available to solve problems and manage operations. If participants share the same weaknesses and strengths, they may be no stronger together than if they worked independently. In contrast, complementary strengths and weaknesses as well as diverse perspectives enable more creative and effective solutions than the agencies could develop individually. Effective networks, therefore, value diversity.

Participants in the network must know and see evidence that they are important contributors to the group. Empowerment involves a great deal more than symbolic reinforcement of good behavior or superficial involvement of group members in the decision-making process. The way to make people believe that they have influence is to give them opportunities to act influentially.

Empowerment has to be more than merely a sense of ownership — it must *be* ownership, acting as a true stakeholder in events. To be full participants, network members must not only have something at stake to motivate them to do the hard work of network-building, they must also be given complete information and know how to use their skills and resources in combination with their network partners to meet common goals.

5. Networks create win-win situations.

Avoid all-or-nothing situations. For example, within the Rural Care Consortium, funds had been obtained to acquire and install hardware at the twelve participating organizations. Some organizations required more terminals for data entry and retrieval because of multiple program locations. Even though the need for hardware differed, it was agreed that all organizations should have similar hardware. Additional hardware at clinics with multiple sites would be contemplated after the network system had been implemented. The hardware acquisition and installation objective was a win-win scenario for all organizations. Each benefited equitably from participation.

Every member of a network should have a stake in the network's financial and operational success. Because people have different perspectives, members may differ on how to achieve these shared goals. Without clear communication of these different perspectives, individuals may work in opposition, or become suspicious of others who, while sharing the same broad goal, seem to oppose the perceived logical way of attaining it.

Some network members may assume that other network members are thwarting their efforts. The antidote to this distrust is to require all network agencies to participate in objective-setting and benefit/risk analysis. By doing so, agencies establish their stake, communicate their concerns, and harness their expertise in supporting required activities. Network members must be fully knowledgeable, capable, and willing to act in support of network goals.

Win-win scenarios occur when the interests of different parties merge rather than compete. Trade-offs occur where neither party gets all it wants, yet, both get more than they would if they had not adjusted their position to accommodate the needs of the other party.

Tip: Expected benefits of member participation in the network should be shared. At least twice a year, review expected benefits with network members.

6. Maintain enthusiasm.

Network members will be motivated to invest capital and operating resources in the network if they believe that the goals of the network are worthy and the network possesses the capacity to achieve its goals. One way to maintain enthusiasm in the early stages of network development is for the network to have a series of small successes. These small achievements build trust among members and the belief that the network, as an entity separate from its members, has the ability to accomplish tasks.

Short-term objectives are as important as long-term objectives. Long-term objectives by their very nature take longer periods of time to accomplish. As a result, member attention and energy can dissipate and be easily diverted from network programs when benefits are perceived to be elusive.

Short-term benefits may pertain to services such as group purchasing, joint credentialing, or recruitment. Organizationally diverse, all-inclusive networks may consider community needs assessment or strategic planning as a short-term objective. Successful attainment of short-term objectives demonstrates to members that they are benefiting from network participation, even though the level of benefit may not be consistent with their most pressing interests.

A word of caution is necessary: short-term objectives should not be considered "make work" activity. Network executive directors make a major mistake when they create a reason to meet. If there is no substantive work to be accomplished at a network meeting, network members should not attend just to maintain a sense of network participation.

Tip: Time frames for project milestones, i.e., major accomplishments, should be set for each quarter, not by months or weeks. Network members should be notified when it is apparent that the schedule requires adjustments. Do not assume that all organizations have the same sense of urgency regarding network programs.

7. Build strong governing board and network executive relationships.

Effective working relationships between policy-making boards and executive directors ultimately spell success for networks. Rural health networks differ from most organizations in regard to executive director/governing board relationships in several ways. One difference is the level of communication among board members.

Members of rural health network boards tend to communicate with each other on a regular basis. Most communication is on issues that have no direct bearing on the rural health network. Yet, some of these conversations do affect the network. To make certain that the network executive is fully informed and to avoid the appearance of factions within the network, it is essential that rural health network members open and maintain channels of communication. Open communication promotes trust among members and between members and the executive director of the network. Ultimately, trust among members will bond the network together.

To make certain that the network executive is fully informed and to avoid the appearance of factions within the network, it is essential that rural health network members open and maintain channels of communication regarding network business.

Network boards are typically composed of CEOs from local health care organizations. Because they have operating and clinical experience in the same field as the network executive, they may tend to become involved in network operations to an inappropriate degree. The role of governance is to: 1) appoint a qualified network executive; 2) develop or approve network policies; 3) establish a mission and long-range plan; 4) approve an annual budget; and

5) monitor network performance. The role of network executives (management) is to: 1) establish and maintain systems to carry out plans; 2) hire and supervise staff; 3) support external and board relations; and 4) monitor operations.

TAKE-AWAY POINTS

1. Stay on course.
2. Adapt strategies.
3. Avoid one-sided decisions.
4. Value diversity and use it to the network's advantage.
5. Create win-win situations.
6. Maintain enthusiasm and momentum.
7. Build strong governing board and network executive relationships.

Conclusion

While networking is a strategy that can be used in many different situations, it is not a strategy that will work in every situation, nor is it a strategy that every rural provider will want or be able to use. If you think it will work for you and if you are interested in forming a rural health network, or if you are in the process of forming a network, this primer is but one of a series of resources made available by *Networking for Rural Health Project* for you to use. Other project resources available to you include:

- **Network self-assessment:** A tool for network leaders to profile their organization's strengths, weaknesses, and technical assistance needs.
- **Workshops:** Programs will focus on technical issues relevant to rural networks.
- **Primers and resource guides:** Monographs on issues related to network formation and development.
- **Site visits:** Visits by a team of experts to help networks assess their organizational capacity and readiness to engage in substantive clinical and/or financial activities. (To apply for a site visit you must submit an application consistent with the requirements of the Alpha Center's *Request for Applications.*)
- **Targeted consultation:** Awards of up to $40,000 will be made to rural health networks to purchase customized consulting experience. A dollar-for-dollar match is required from the network. (To apply for targeted consultation funds you must submit an application consistent with the requirements of Alpha Center's *Request for Applications*, which can be found at www.ac.org or by contacting the Networking for Rural Health Project at 1350 Connecticut Avenue, NW, Suite 1100, Washington, DC 20036.)

APPENDIX A

Sample Rural Health Network Memorandum of Understanding

Acacia Area Rural Health Network

I. General Purposes

The need for a rural health network in Pitkin County was jointly assessed by the Throgs Neck Hospital, Acacia Area Health System, Pitkin County Local Health District, Acacia Area Medical Society, and the Acacia Community Health Center. As a result of that assessment, these five agencies agreed to collaborate on projects of mutual concern, coordinate resources, and ultimately develop and maintain an integrated health network for the Acacia area.

These five organizations initially agreed to jointly:

1. Form a rural health network to be known as the Acacia Area Rural Health Network;
2. Assess, plan for, coordinate, and implement or oversee the expansion and delivery of a system of behavioral health, primary care and school-based health programs;
3. Monitor and make recommendations regarding the design, deployment and utilization of emergency services and patterns of hospital transport;
4. Examine local agencies capacities and interests in providing services to the uninsured or underinsured populations and mechanisms for payment for such services;
5. Examine the need for a preferred provider organization that could contract directly with employers who were self-insured; and
6. Develop and disseminate information on local needs and services, especially those relating to new programs or changes in services or coverage by reimbursers.

The Network also agreed to initially concentrate its energies on emergency medical services, services to uninsured populations, and preferred provider organization potential because network members considered them to represent the area's greatest problem or most compelling unmet needs.

II. Operating Parameters

A. Legal Standing

The network will operate as a coalition and consider becoming an incorporated entity. Each agency agrees to obtain legal opinion on its capacity to become a director of a new corporation which advances the purposes listed above within the context of the parameters elineated in the successive portions of this Memorandum.

B. Membership

The five founding directors of the network are: Throgs Neck Hospital, Acacia Area Health System, Acacia Community Health Center, Acacia Area Medical Society, and the Pitkin Local Health District. Each of these organizations will be represented by its chief executive officer and board chairperson. Membership may be expanded to include other organizations and individuals upon a unanimous vote of the founding members.

Upon incorporation, these ten founding directors will become the network's board of directors and thereafter the network will bear full responsibility for all of its actions.

C. Officers and Terms

The network will have four officers: a chairperson, vice-chairperson, secretary and treasurer. These officers will be elected at the annual meeting of the network and serve for three-year terms. Election of these officers will be based upon the following schedule:

First Three-Year Term:
Chairperson - Throgs Neck Hospital
Vice-chairperson - Acacia Community Health Center
Secretary - Acacia Area Health System
Treasurer - Acacia Area Medical Society

Second Three-Year Term:
Chairperson - Acacia Community Health Center
Vice-chairperson - Acacia Area Health System
Secretary - Acacia Area Medical Society
Treasurer - Pitkin Local Health District

Third Three-Year Term:
Chairperson - Acacia Area Health System
Vice-chairperson - Acacia Area Medical Society
Secretary - Pitkin Local Health District
Treasurer - Throgs Neck Hospital

Fourth Three-Year Term:
Chairperson - Pitkin Local Health District
Vice-chairperson - Throgs Neck Hospital
Secretary - Acacia Community Health Center
Treasurer - Acacia Area Health System

Successive terms will be determined by the network.

D. Committees

The network shall have four standing committees, which include Integrated Service Systems, Data and Analysis, Underserved Populations, and Strategic Alliances. Committee chairpersons are appointed by the network and each of the founding organizations will have at least one seat on each committee. Committee members are appointed by the committee chairperson contingent upon approval by the network board.

Each committee will report to the board at least twice a year and review the compelling need it is addressing, the expected benefits of each participating agency, and status of its progress.

Integrated Service System Committee will assess, plan for, coordinate, and implement or oversee the expansion and delivery of a system of behavioral health, primary care and school-based health programs in the county and monitor and make recommendations regarding the design, deployment and utilization of emergency services and patterns of hospital transport. The committee's initial focus will be on emergency services because of the area's high accidental death rate and heavy use of emergency rooms at hospitals located outside of the area. The committee chairperson will be from the local health district.

Data and Analysis Committee shall have the responsibility to catalogue all existing health, social service, community and business databases for the county, region, and state and also develop an inventory of local providers and services. This committee is supportive to the other program committees and centralizes expertise for information collection, analysis, and distribution. The committee chairperson will be from the local hospital.

Underserved Populations Committee shall have the responsibility to assess the need for a special capacity to serve this population and potential sources of funding or new funding arrangements. This committee will address the high level of uncompensated care provided by local agencies and the potential for increased cost efficiency and better care through greater coordination of services and follow-up - two compelling needs. The committee chairperson will be from the community health center.

Strategic Alliances Committee shall have the responsibility for identifying purchasers interested in contracting with networks of local health and behavioral health service providers and examining the terms of interest. Insurance company provider panels are requiring that local residents leave the area for care and are consequently reducing access to and use of local providers - compelling issues that the committee will address. This committee will be chaired by the medical society.

E. Resources

The network will retain a full time coordinator on a contractual basis. The coordinator reports to the chairperson of the network. The coordinator's functions are basically managerial, coordinative, and facilitative. The coordinator will keep all members informed of network business, keep the network on track with its workplan, and assist the various committee chairperson in designing and completing the workplan.

The initial network annual cash budget is $72,500: $50,000 for the coordinator, $10,000 for speakers fees, consultative services and legal filings, and $12,500 in in-kind services such as space, utilities, and secretarial support. Dues are $12,500 per member.

F. Meetings

The network will meet six times a year, monthly for the first three months, and quarterly thereafter. Standing committees will meet as needed - generally, once a month for the first three months of the start of their respective work programs and then every six weeks.

G. Termination/nonparticipation

Organizations can terminate their participation in the network at any time without cause by giving written notice to the network chairperson.

III. Authorization

The undersigned hereby agree to the principles and terms stated above and form the Acacia Area Rural Health Network:

On behalf of Throgs Neck Hospital	Date
On behalf of Acacia Area Health System	Date
On behalf of Pitkin Local Health District	Date
On behalf of Acacia Community Health Center	Date
On behalf of Acacia Area Medical Society	Date

APPENDIX B

Selected Readings and Resources

Chapter 2: Selected Readings

Moscovice I, Wellever A, Christianson J, et al. Understanding Integrated Rural Health Networks. Milbank Quarterly 75: 563-88, 1997.

Moscovice I, et al. Rural Health Networks: Forms and Functions. Minneapolis, MN: University of Minnesota Rural Health Research Center; 1997.

Rural Health Policy Research Institute (RUPRI) Research Report. Changes in The Marketplace of Health Care Delivery: What is the Future for Rural Health Care Delivery? Rural Health Research Institute, 1996. www.rupri.org

Wilhide S. Networking for Success. Medical Group Management Journal 1992 ; 39: 38,42,44.

Zuckerman H, Kaluzny A, Ricketts T. Alliances in Health Care: What We Know, What We Think We Know, and What We Should Know. Health Care Management Review 1995; 20: 54-64.

Chapter 3: Selected Readings

Campion D, Dickey D. Lessons from the Essential Access Community Hospital Program for Rural Health Network Development. Journal of Rural Health 1995; 11: 32-39.

Coddington D, Moore K, Fischer E. Integrated Health Care: Reorganizing the Physician, Hospital and Health Plan Relationship. Englewood, CO: Center for Research in Ambulatory Health Care Administration; 1994.

D'Aunno T, Zuckerman H. A Life-Cycle Model of Organizational Federation: The Case of Hospitals. Academy of Management Review 1987; 12: 534-545.

Size T. Managing Partnerships: The Perspective of a Rural Hospital Cooperative. Health Care Management Review 1993; 18: 31-41.

Teevans J. Rural Health Networks: A Legal Primer. Washington, DC: Alpha Center; 1999 October.

Selected Resources for Bylaws:

Hummel, J. "Bylaws: Playing by the Rules." *Starting and Running a Nonprofit Organization*, 21-28. Minneapolis, MN: University of Minnesota Press; 1996.

Zeitlin K, Dorn S. The Nonprofit Board's Guide to Bylaws: Creating a Framework for Effective Governance. Washington, D.C.: National Center for Nonprofit Boards; 1996.

Selected Resources for Personnel and Financial Management

McMillan E. Model Accounting and Financial Policies and Procedures for Not-for Profit Organizations. Washington, D.C.: American Society of Association Executives: 1999.

Roderer P, Sabo S, ed., Human Resource Management in Associations. Washington, D.C.: National Center for Nonprofit Boards; 1994.

Chapter 4: Selected Readings

Barry, B. Strategic Planning Workbook for Nonprofit Organizations. Amherst H. Wilder Foundation, Publishing Center for Cultural Resources, New York, NY, 1987.

Seifert, R. Using Data: A Guide for Community Health Activists. Boston, MA: The Access Project, 1999. www.accessproject.org

Shortell, S, et al. Remaking Health Care in America. Jossey-Bass Publishers, San Francisco, CA, 1996.

Chapter 5: Selected Readings

Casey M. Integrated Networks and Health Care Provider Cooperatives: New Models for Rural Health Care Delivery and Financing. Health Care Management Review 1997 Spring; 22: 41-8.

Kongstvedt P, Gates R. Ten Critical Success Factors for Integrated Delivery Systems. Gaithersburg, MD: Aspen Publishers; 1996.

Moscovice I, et al. Measuring and Evaluating the Performance of Vertically Integrated Rural Health Networks. Journal of Rural Health 1995; 11: 9-21.

Straub, L, Walzer N, ed., Rural Health Care: Innovation in a Changing Environment. Westport, CT: Praeger; 1992.

Zuckerman H, D'Aunno T. Hospital Alliances: Cooperative Strategy in a Competitive Environment. Health Care Management Review 1990; 15: 21-30.

Other Resources

Federal Office of Rural Health Policy (ORHP)
U.S. Dept. of Health and Human Services
Health Resources and Services Administration
Parklawn Building Room 9-05
Rockville, MD 20857
301.443.0835
301.443.2803 (fax)

National Rural Health Association (NRHA)

National Office
One West Armour Blvd.
Suite 203
Kansas City, MO 64111
(816) 756-3140
(816)756-3144 (fax)
www.nrharural.org
e-mail: mail@nrharural.org

Government Affairs Office
1320 19th St., N.W.
Suite 350
Washington, DC 20036-1620
(202) 232-6200
(202) 232-1133 (fax)
www.nrharural.org
e-mail: dc@nrharural.org

National Rural Health Resource Center
600 East Superior St.
Suite 404
Duluth, MN 55802
218.720.0700
218.727.9392 (fax)
e-mail: nrhrc@ruralcenter.org

Rural Information Center Health Service (RICHS)
National Agricultural Library, Room 304
10301 Baltimore Ave.
Beltsville, MD 20705-2351
1-800-633-7701
301-504-5547
301-504-5181 (fax)
TDD/TTY: 1-301-504-6856
www.nal.usda.gov/ric/richs
e-mail: ric@nal.usda.gov