National Cooperative of Health Networks

SUCCESS STORIES

2010

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Competitive Collaboration

Prince of Wales Health Network

Brief Description

The Prince of Wales Health Network was formed in 2008 and is a vertical network comprised of the primary care providers on Prince of Wales Island, including the regional IHS provider, city government, local public health center, community health center, and a faith based primary care provider and hospital system. Prince of Wales (POW) is a remote and isolated island in SE Alaska with a population of approximately 4600 residents spread out over 2500 square miles. Travel on and off the island is costly, time consuming, and weather dependent. There is no commercial jet service. The Network was formed as an opportunity to address very deep rooted, historic rivalries between the diverse communities on Prince of Wales Island and the providers that serve them, evaluating how through collaboration rather than competition, the communities of POW could be better served. The objectives of the POW Health Network focus on improving quality and access to primary care services on Prince of Wales Island and the infrastructure both on and off island that supports these services.

Resources Used

The POW Health Network is currently funded through a Rural Health Network Development grant from HRSA's Office of Rural Health Policy. Funding supports a full time Network Director, Network office, travel, meeting costs, consulting fees and other overhead costs. Network members each provide one administrative and one clinical representative in-kind to a Steering Committee which meets in person bi-monthly and by telephone during non-meeting months. In addition, all members meet with the Network Director on a regular basis. Recognizing historic rivalries, and the need to collaborate in order to provide the best possible care to POW residents, Network members have shown a strong commitment to their role in the success of the Network. A volunteer-based Community Advisory Group has also been formed and meets quarterly to provide feedback to members of the Steering Committee. Several community stakeholders regularly inform the Network of specific healthcare issues and concerns. An outside consultant was enlisted to aid in the strategic planning process, and additional consultants are utilized to address specific issues identified.

Implementation

The implementation of the POW Health Network entailed a lengthy period of monthly face to face meetings of the Steering Committee, meetings of individual Steering Committee members with the Network Director, and ongoing meetings with community members and stakeholders. This aided in developing relationships based in trust, collaboration and accountability. Monthly face to face meetings served to create familiarity among Network member representatives and build ongoing relationships outside of meeting times. After one year of face to face meetings, the Network held its first strategic planning session, contracting with an outside facilitator already familiar with two of the Network members and healthcare issues specific to rural Alaska.

Lessons Learned, Concerns, Barriers

It has been crucial for the POW Health Network to respect and acknowledge past history and rivalries, without allowing itself to become crippled by doing so. A willingness to acknowledge issues with significant potential of becoming major stumbling blocks to further collaboration has been essential. Setting these issues aside despite their importance, and instead focusing on areas where a clear desire and benefit in collaboration exists for all parties, has been key to forward movement. Flexibility, creativity, and strong leadership requiring accountability of all members has been essential in maintaining momentum with a desire to continue collaboration beyond the period of initial grant funding.

POW is unique in that there are two excellent primary care clinics within 7 miles of each other, as well as several outlying clinics, serving an island population of just 4600. The viability of more than one major healthcare organization on POW is a significant concern to Network members. Members of the POW Health Network, which include an IHS provider, faith based provider, public health center, and community health center, have vastly diverse funding and governance structures. It is necessary to identify possible areas for collaboration that at the same time respect these differing structures.

The Network is continually evaluating ways to best include community stakeholders who hold a strong interest in participating in Network activities. A significant challenge has existed in how to include these stakeholders, creating strong community engagement, while also maintaining the original intent of the Network and respecting the members' needs.

Results

In a short period of time, many areas for collaborative action have been identified where few previously existed. Steps have been taken towards shared electronic medical records and videoconferencing, the Network has facilitated communication and increased support for the local EMS providers, the Network successfully applied for and received funding through the State of Alaska Division of Behavioral Health to provide comprehensive needs assessment and planning for mental health and substance abuse services on Prince of Wales, CME activities have been carried out, strategic planning has occurred, and the Network is jointly addressing recruitment and retention, community education, and elder care for island residents. However, perhaps the largest success has been in the area of communication. Communication between Network members outside of meeting times has increased, resulting in continually improved services. In addition, the Network is increasingly serving as a hub of healthcare information for the Island. Finally, it is important to recognize that this progress has been possible because of the commitment of Network members and their representatives to creating a strong, lasting collaborative network of healthcare organizations on POW.

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Network Development Success

Indiana Rural Health Network

Brief Description

The InSRHN to-date has several projects concurrently in process, as well as some that are completed or in the planning phases. All of the projects are overseen by the Network Director, Cindy Large and the Special Projects Coordinator, Matt Serricchio. The business planning, sustainability of network and return on investment for the network and network members are a collaborative effort between Ms. Large and Mr. Serricchio.

Projects

Roundtables: The InSRHN holds meetings regularly with the CEOs, CFOs, HR, IT, Materials Management and Nurse Executives from 21 InSRHN member organizations. The InSRHN pursued this as a back bone need that our members expressed and were willing to pay for. InSRHN members saw value in the above hospital leaders coming together and discussing current or future problems facing their departments/hospitals and collectively discussing solutions, networking with each other, creating projects for InSRHN staff to facilitate and gaining trust levels amongst the membership to further enhance collaboration.

TeleStroke: The InSRHN CEO's discussed the need for stroke care in their rural and critical access facilities as most of them did not have access to specialists who were trained in triage and stroke care. As of this writing the InSRHN has been awarded $131,000 in funding from the Indiana State Department of Health/State Office of Rural Health via the federal FLEX program to begin implementing a TeleStroke network in 10 InSRHN member hospitals. In addition, as a component of this project InSRHN will be implementing "Get with the Guidelines" evidence-based practice guidelines from the American Heart Association, which will serve as data collection and benchmarking for stroke care in Indiana rural hospitals statewide.

TeleMental Health: The special projects coordinator for the InSRHN received HRSA grant funding via the Outreach program to develop a statewide telemental health network. Due to the overlap of needs the InSRHN has worked together with the telemental health network and as of this writing 6 InSRHN critical access hospitals have telemental health projects either underway, in planning stages or with confirmed interest in participation starting later this year in 2010.

Leveraging Network: The InSRHN has used its collaboration of hospitals to negotiate various projects and purchases in order to provide the most value to its membership. Examples of the various projects and purchases are: Digital Mammography with a savings of $40,000 – 50,000 per unit purchased, Peer Review with a savings of $1500 per record reviewed and the telepharmacy service savings is anticipated to be $50,000 – 60,000 annually per member (based on line per item usage). Digital Mammography equipment was purchased by simply leveraging our group size to negotiate with the vendor to lower the prices and maintenance contracts. Peer Review, as a network signed contracts with 2 vendors to review records at $100- $200 per record with a substantial savings and an increased availability of specialists for review. Telepharmacy services were negotiated as a group to provide 24-hour remote pharmacy services coverage in InSRHN member hospitals at a substantial discount. As a network, InSRHN has also able to apply for funding and negotiate group discounts for educational programs deemed important by membership.

Video Conferencing: The InSRHN is piloting a cost effective means for teleconferencing with our members to increase ease of networks and lower costs associated with travel, time and other expenses regarding communication methods. The InSRHN is piloting a program that will work on the existing infrastructure already in place that can be implemented efficiently with little overhead cost or effort. This is based on the expressed need for such a communication method to solve the above issues. The pilot program is centered around 2 facilities with expected 100% participation in the future.

Resources Used

Roundtables: Staff time to facilitate the meetings as well as planning and administrative work such as scheduling, coordination, meeting minutes, follow up, etc. These are initially funded by the HRSA Rural Health Network Development grant award, but will be self sustaining by current membership fees and other grant support post funding award cycle. Participants are committed to attend meetings, participate in meetings, and participate in planning future roundtable sessions to ensure the highest value to our members. Data collection has included satisfaction surveys and ideas for evaluating and improving services.

TeleStroke: InSRHN staff time to facilitate and oversee the partners in this project to ensure successful implementation of stroke network and "Get with the Guidelines" protocols for stroke care. Flex funding has been awarded through a contract with the ISDH/SORH to pay for an assessment of our participating hospitals current stroke care and technological capabilities, and a partnership with a large hospital system to provide equipment and services. Data collection will be through the "Get with the Guidelines" implementation, as well as an assessment report from a team dispatched to each hospital to evaluate their infrastructure and stroke care capabilities. Commitment from the 10 project member participants is high.

TeleMental: Staff time to facilitate relationships between rural hospitals and mental health centers or practitioners. Staff time to implement and train on equipment use. Funding is from a HRSA Outreach grant. Commitment from the 6 project members is high as this requires internal processes, working relationships and staff buy in to implement.

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Video Conferencing: Staff time to create a business plan, research vendors, garner membership buy in, testing and implementation. Funding is from HRSA Flex program awarded through a contract with the ISDH/SORH. InSRHN is currently piloting a service for beta site testing as of this writing. Data collection will most likely revolve around self reported cost savings such as travel, time and resources saved. Commitment is high as this also requires several different levels of buy in and implementation within our member's facilities. InSRHN anticipates this will be the platform to build out for e-learning throughout the state over the next five years for rural providers and the communities they serve.

Leveraging Network: Staff time is needed to survey membership for needs assessment, vendor selection, negotiation, contract management, project management and oversight. Funding is from the HRSA rural health network development grant as well as network member annual dues. Data collection is tracking cost savings or self reporting of savings/improvements/satisfaction. Commitment level is low as InSRHN staff provide the internal resources necessary for successful network development and leveraging of resources.

Implementation

InSRHN follows a rough plan for all programs/projects implemented:

- Needs assessment (Interest survey, discussion, member suggestions, national/state data, etc.)
- Interest and participation surveys/discussions
- Commitment of interest by members by signed Memorandum of Understanding (MOU)
- Project planning (Funding, resources, scope, etc.)
- Vendor/Partner/Service/etc. evaluation and selection
- Business plan
- Project management
  Implementation
- Satisfaction follow up
- Data collection and program evaluation

Lessons Learned, Concerns, Barriers

Bottom Up and Top Down approaches: When working with hospitals InSRHN often has to have multiple levels of buy in and commitment. The InSRHN CEO's must have buy in from the front line employees; and the front line employees must have buy in from the CEO/CFO.

- Do the upfront work such as creating a solid business plan prior to program planning and development
- Require participants to sign commitment letters or memorandums of understanding outlining expectations and responsibilities
- Survey membership to understand needs before investing time into projects. In other words make sure what we are working on is needed and wanted.
- Be flexible: People and organizations are unpredictable. Be able to think on the fly and change your approaches at the last minute in order to ensure success. Keep the over arching goal in mind, but be flexible on the methodology.
- Prioritize and keep focused: When implementing projects do not overwhelm with possibilities, keep the primary focus on the problem you are solving now, and build from there.

Funding timelines: Working with federal and state funding can be frustrating due to long timelines and arbitrary deadlines. Be sure to be realistic with your goals, flexible with your projects and incorporate as much of the reporting requirements into your projects as possible.

When implementing telemedicine you need both clinical and administrative buy in for successful outcomes.

Results

The InSRHN telehealth projects are increasing availability and quality of services to underserved populations thereby showing an improvement in health outcomes for patients. InSRHN roundtables, video conferencing and leveraging of group resources have all shown successful results regarding time savings, improvement of services, problem solving, efficiencies, networking, cost savings with the ultimate goal of hospital performance improvement.

Other Relevant Information

The InSRHN has developed a network Scorecard that monitors the 'real-time' return on investment (ROI) to members. This has proved as a useful tool in communicating the activities and initiatives of the network to its Board of Directors, members, potential members, and other key stakeholders throughout the state and nationally. The member ROI for 2009 was 477%.

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Managing Prescribing Cost & Quality

Upper Peninsula Health Care Network

Brief Description

Due to the ever-increasing rise in the cost of pharmaceuticals and direct impact that it has on hospital expenses, the 16 members of the Upper Peninsula Health Care Network (UPHCN) partnered with the Upper Peninsula Health Plan (UPHP) to develop a regional pharmacy and therapeutics committee. The goal of the committee is to promote rational, clinically appropriate, safe and cost-effective pharmaceutical care to the residents of Michigan's Upper Peninsula. The goal is pursued through a coordinated effort among independent rural health care providers (UPHCN) and a Medicaid managed care plan (UPHP). To date, 88% or 14 members participate in the committee.

Resources Used

The original project was funded by a three-year grant through the Health Resources and Services Administration, Office of Rural Health Policy. The grant funding primarily covered staff time (administrative & clinical pharmacists, medical director and project coordinator) to conduct drug reviews, evaluate costs and present the findings. UPHCN members along with UPHP provided a 1-1 match for this initiative. Member participation included pharmacy and physician representation from each hospital on the regional pharmacy and therapeutics committee. Delegation Agreements (descriptors of delegated activities) and Disclosure Statements (related to code of conduct) were signed by all Network hospitals.

Implementation

The regional pharmacy and therapeutics committee initially met monthly primarily through video conferencing. The initial objective was to develop and implement a region-wide cooperative pharmacy formulary management system and to implement evidence-based clinical practice guidelines that include pharmaceutical recommendations for a target of 10 disease states associated with major drug classes. The outcome objective was to increase the percentage of Network drug expenditures negotiated on contract and reduce the health plan's per member per month pharmaceutical cost to below the state average. Clinical drug reviews were presented monthly and members voted on the recommendations. Pricing was then negotiated through a contract for the entire group based on the recommendation of the committee.

Lessons Learned, Concerns, Barriers

Some of the challenges encountered, in the attempt to reduce drug costs through group purchasing, include the fact that there continues to be an increasing use of specialty biologic and immunologic agents (such as cancer drugs). These specialty agents are expensive and the pharmaceutical companies that manufacture them do not offer contract pricing. Additionally, time commitment was stated as a barrier especially in the critical access hospitals. Due to limited pharmacy and physician staffing, a schedule of bi-monthly meetings was established to better accommodate the hospitals.

Results

During the first three years of the project, more than 25 drug class reviews were conducted which included treatment guidelines for targeted disease states and 24 new drug reviews were presented, in additional to clinical protocols. More than $380,000 in savings to the combined hospitals occurred through evaluation of fluoroquinolone antibiotics, proton pump inhibitors and hematopoietics.

Project results and achievements are reported to the boards of both UPHCN and UPHP, of which, all hospital CEO's are members. Surveys of the committee members are conducted annually to provide feedback on committee goals and objectives. An independent grant evaluator had this to say about the project, "The drug reviews provide detailed analysis for which most hospitals do not have the resources. The information enables practitioners to make informed decisions without relying solely on information from pharmaceutical companies."

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Physician Recruitment Program

Sunflower Health Network

Brief Description

The Sunflower Health Network (SHN) was formed with the express purpose of, "Facilitating improvement of health status through access, quality, service and cost effectiveness in rural Kansas." It is through the collective power of its members that the Sunflower Health Network brings value to communities throughout Central and North-Central Kansas. In an effort to provide access to health care, SHN entered into an agreement with a member hospital, Salina Regional Health Center (SRHC), for physician recruitment services starting February 1, 2009. The SHN Physician Recruitment Program is available to any SHN member facility that would like to participate.

Through its in-house physician recruitment department, SRHC provides recruitment support by sourcing, screening, and presenting physician candidates to the participating SHN hospital or clinic. Some of the services include preparing an opportunity profile, marketing and sourcing, screening the candidates, scheduling interviews and coordinating site visits, assistance during the relocation process, and assistance with physician retention. Just over half of the network members currently participate in the physician recruitment program.

Resources Used

The SHN physician recruitment program has a dedicated recruiter (0.5 FTE) for participating hospitals (through the contract with SRHC). SHN pays a monthly fee of $4700 for this service. If a hospital signs a physician through the program, the hospital pays the SHN a $20,000 placement fee to help offset the costs of the program.

Communication includes a weekly confidential status report to the network director, weekly status reports to the participating hospitals (from the recruiter), and periodic updates to the SHN board (through presentations at board meetings).

Implementation

After the contract was signed, a training session was held for SHN hospitals on physician recruitment. Eighteen people attended the training. The Physician recruiter conducted site visits to each of the participating hospitals and then developed opportunity profiles. The SHN website was updated to include a physician recruitment page with information about the region and opportunities available.

Lessons Learned, Concerns, Barriers

Physician recruitment is a long and time consuming process. You typically have to allow an average of 18 months to recruit a physician. The SHN was absorbing the cost of the program with no money coming in until physicians were signed. This was a big concern to the board because the program was very important, but not sustainable over several years without an offset in income. After much discussion, several provisions were implemented (including a monthly fee of $250 to participating hospitals) to help generate income for the program.

Other barriers continue to be the physician shortage, recruiting to rural areas, and the increase in physicians choosing to enter specialty fields instead of family medicine.

Results

The program has been in existence for 14 months and, to date, 2 physicians have been signed. There are currently 19 candidates engaged with the SHN recruiter. There has been a large cost savings for those involved in the program. Outside search firms typically charge over double what the hospitals are paying with this program.

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Shredding Services [redacted]

Southwest Idaho Community Health Network

Brief Description

Our network pursued a shredding services contract in a combined effort with The Hospital Cooperative (THC) network from Southeast Idaho. We pursued a network contract for this service because of the following reasons:

- Shredding was used at every network member hospital (nearly all outsourced while a couple of hospitals had their own industrial shredding equipment).
- Shredding is an important part of HIPAA Compliance.
- Our member hospitals were using three different services (competition helps).
- Potential savings opportunity

SWICHN now has 11 of our 12 hospitals or 92 percent of our hospitals utilizing this contract service. The only facility not participating has its own onsite industrial shredder. Although the initial contract included both SWICHN and THC, each network has since done its own RFP and now has separate network agreements with different vendors.

Resources Used

This contract initially took a few months to implement because we did a full RFP process with three vendors and asked that the proposal cover both the SWICHN hospitals and THC hospitals. The main resource used was time in gathering current shredding service volume and price data from the hospitals, preparing the request for proposal, evaluating the proposals, and then getting contracts signed and the service implemented. More recently, my network pursued another RFP process to obtain better pricing than the original agreement.

Implementation

This project began with collecting shredding service volume and price data from the hospitals. SWICHN and PHC hold regular conference calls to discuss various projects and share ideas. During one of those calls, we decided to work together on this project for both of our networks to bring additional volume together and hopefully attract a better price from the vendors. The basic process included preparing a request for proposal, receiving and evaluating the proposals, getting group consensus on selecting a vendor, and then getting the contracts signed and the service implemented. During the more recent RFP process, my network members agreed to request that all of the proposals be priced on a per pound basis versus a per container basis. We found that this change helped us achieve better pricing and also pricing that was easier to compare since each company utilized different sized containers or bags inside of consoles with many variations on whether the hospitals were getting charged for "full" or "partially full" containers.

Lessons Learned, Concerns, Barriers

One of the challenges we had during the initial evaluation phase was that some of the vendors used bags inside of consoles while others used plastic garbage can style containers to collect shredding documents. Since the containers were very different, we had to make sure that we knew what the true capacities were of each container type. We did some sample comparisons to help determine container capacities for the evaluation process. Some companies are able to charge by the pound and so the next time we do a RFP for this service we may consider requesting all prices by the pound to simplify the evaluation process. Another challenge was being prepared for the non-selected vendors to try to match their competitor's price in order to keep their current business. Our philosophy is that the vendors should give their best price in the proposal and that any attempts by non-selected vendors to drop the price after the selection is made should be ignored by the network participants—otherwise the market power of the network is decreased. During the second round of RFPs more recently, we requested that all price quotes be given on a per pound basis and that portable accurate scales be used on-site to allow hospital staff to observe the weighing process at any time. This approach not only helped decrease the price quotes, but also provided a simpler way to compare the proposals. This also provided a less subjective way to bill for the shredding services at our member facilities.

Results

The SWICHN hospitals have been very pleased with the savings and service of this network contract. During the initial years of this contract, the network savings averaged between $30,000 and $45,000. In 2007, our network savings was $55,000 and in 2008 our network savings for shredding services was over $110,000. The jump in savings was due to the new contract that based pricing on a per pound basis, plus 11 of the 12 hospitals were now participating in the service.

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Teleaudiology: *Taking Diagnostics to the Infant*

Upper Peninsula Health Care Network

Contact: Neil Scharpe

Brief Description

The development of this technical protocol is directed by DHHS Health Resources and Services and is to be supplemented with the management protocol and the "tool kit" to assist in the implementation of audiology services via telemedicine technology. While the scope of this work has been done with an emphasis on rural systems, its applications could be used in a variety of areas.

It is the intent of the authors that these documents will provide the framework by which a TeleAudiology service delivery can be established and operated. The objective of these documents is to improve the follow up of infants identified through the Early Hearing Detection and Intervention (EHDI) program. An emphasis is placed on audiologic evaluations of infants who have been referred after failing a minimum of two hearing screening tests.

It is important to identify infants with hearing loss as early as possible and therefore evaluation, while not always optimal, will need to be done with children that are three months old or less. Please note that the Technical Protocol does NOT address sedation but encourages the readiness of the child prior to testing.

TeleAudiology has been shown to be an effective means of offering young children access to needed professionals while remaining closer to home. It can allow audiologists to set up testing sites in areas that have previously been void of professional services. These Spoke sites will include analytic equipment along with the computerization and internet service necessary to communicate with the audiologist at the Hub site; creating the audiologist's virtual presence. Depending on the environment at the Spoke location, there may be several options with respect to the placement of equipment. It can be fixed or mobile; it can be permanent or temporary, etc. Examples of issues that are likely to determine this are network infrastructure, office site availability, monetary and/or resource issues, and required frequency of testing.

Resources Used

Instrumentation discussed in the Technical Protocol will be those used for quantitative hearing analysis, and not specifically tied to distance technology or telemedicine. In other words, they are instruments that are commonly used in traditional audiology testing environments; but also work well in the provision of TeleAudiology. Information on and discussion of the equipment required to provide these services via telemedicine can be found in the Management Protocol.

The analytic equipment used by the authors of this protocol is:

- Intelligent Hearing Systems Auditory Brainstem Response System
- Biologic AudX Otoacoustic Emission System
- Madsen Capella Acoustic Immittance System

These instruments offer an operating system that is compatible with the software described in the management protocol thereby giving the audiologist control of the Spoke site equipment via the telemedicine network.

Implementation

Testing at the spoke site will not generally take place in a sound treated environment. One must be aware that excessively noisy environments may result in inaccurate test data, which can consequently cause unnecessary anxiety in parents. Therefore, every precaution should be taken to insure testing is completed in the quietest environment possible. In the selection and/or preparation process, noise level measurements are recommended to insure that levels in the spoke location are acceptable for testing. The use of insert earphones in a non-sound treated environment will serve to slightly reduce background noise reaching the neonate/infants ear canal (as well as prevent ear canal collapse common in this age group when earphones are used).

Lessons Learned, Concerns, Barriers

This protocol is designed to be used as a Hub and Spoke model with Spoke sites being located in such a manner that parents of infants that require Audiology diagnostics can limit the amount of time and expense spent traveling. Several options are available to the professional utilizing this model, the Spoke site can be static in that equipment and para-professionals can be located at a clinic or hospital, or the equipment can be tied to a mobile unit where the paraprofessional takes the remote site equipment with them to multiple locations.

The option utilized will be dependent on the nature and location of the practice and the results of the needs assessment. Establishing collaborations with Spoke sites that have identified a need for additional services would lead to successful program development.

Because TeleAudiology services can easily cross boundaries that are used to define reimbursement it is imperative that reimbursement issues be addressed prior to completing diagnostic assessments. The standard billing protocol would apply in that the primary care physician (PCP) would authorize the assessment and notification of the third party payer is also recommended.

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Teleaudiology: (continued from page 9)

Reimbursement issues will vary from location to location with each state having specific guidelines for Medicaid reimbursement and each insurance company determining if and in what amount the exam will be reimbursed. These issues will need to be addressed to assure parents and professionals that adequate reimbursement is made.

Development of a telemedicine practice will require substantial administrative start up expense that should be a consideration prior to beginning this process.

Results

The need for using TeleAudiology is prevalent all over the United States but professionals have been slow to adopt it as a means of completing diagnostics. The technology has been proven as effective in diagnosing hearing loss in infants as the regular office visit. Hopefully the publishing of the protocols and tool kit will encourage more pediatric audiologists to use this practice.

Other Relevant Information

Healthcare planners setting up telemedicine services, such as TeleAudiology, should undertake a systematic approach with establishing a new delivery system. A key part of planning a sustainable program is conducting a needs assessment. This should be followed by thorough research of technologic and management options.

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